Published in final edited form as:

Cult Health Sex. 2005 ; 7(6): 615–623. doi:10.1080/13691050500100385.

Who is epidemiologically fathomable in the HIV/AIDS epidemic? Gender, sexuality, and intersectionality in public health

Shari L. Dworkin

HIV Center for Clinical and Behavioral Studies at New York State Psychiatric Institute and
Columbia University, New York, NY, USA

Abstract

This paper examines the shifting nature of contemporary epidemiological classifications in the HIV/ AIDS epidemic. It first looks at assumptions that guide a discourse of vulnerability and circulate around risk categories. It then examines the underlying emphasis in public health on the popular frame of “vulnerable women” who acquire HIV through heterosexual transmission. Drawing on work on gender, sexuality, and intersectionality, the paper asks why a discourse of vulnerability is infused into discussions of heterosexually-active women's HIV risks but not those pertaining to heterosexually-active men's. The paper then moves to current surveillance categories that are hierarchically and differentially applied to women's and men's risks in the HIV epidemic. Here, the focus is on the way in which contemporary classifications allow for the emergence of the vulnerable heterosexually-active woman while simultaneously constituting lack of fathomability concerning bisexual and lesbian transmission risk. Lastly, theories of intersectionality, are used to examine current research on woman-to-woman transmission, and to suggest future more productive options.

Keywords

Gender; intersectionality; vulnerability; HIV/AIDS risks; Surveillance Categories

She is the leading lady in the AIDS epidemic. She was under the surface, hidden, but finally emerged, rushed forward with newfound breath, born into existence with twin shoves: first, feminism; next epidemiological fathomability and visibility. She appeared in 1993 as vulnerable.

By the end of 1992, over 18,500 women in the United States had officially died of AIDS (Centers for Disease Control (CDC) 2002b). At the time, the AIDS case definition used by the US Centers for Disease Control did not include several disease manifestations common to women, including invasive cervical cancer and recurrent vaginal yeast infections (Hankins and Handley 1992). Following pressure from women's groups, a wealth of international data, and in conjunction with Council of State and Territorial Epidemiologists (CTSE), the CDC proposed an expansion of the AIDS surveillance case definition and

solicited public comments in November 1991 (CDC 1992a). On September 2, 1992, the CDC held an open meeting in Atlanta to review information on the need for an expanded case definition (CDC 1992b). The AIDS case definition was formally expanded in 1993 (CDC 1992b, c).

And out she came. Officially via the tropes of heterosexuality and vulnerability. This is not to suggest that such a debut does not reflect a genuine trend in the epidemic at the time. Indeed, from 1987 to 1992, just prior to the CDC change, the number of AIDS cases for women in the USA increased by more than 1000%, with heterosexual contact reported to account for 60% of the identifiable risk for women (CDC 1993). However, once the case definition had changed, there was a veritable and discursive explosion, with reported cases of HIV in women increasing from 6,571 in 1992 to 16,824 in 1993 (Stine 2003).

Newfound visibility meant that women might be less likely to be excluded from drug trials and from studies of disease progression than they had been in the past (Fox-Tierney *et al.* 1999). At the juncture of a continually shifting base of medical knowledge, feminism, epidemiological classifications, sexual stratification systems, and the discursive realm, women were increasingly counted, and their attendant needs for care and prevention made more possible.

But who, precisely, was seen, and how, exactly, was she viewed and why? This paper critically examines the widely offered statement that women are especially vulnerable to HIV/AIDS in the USA and worldwide. It is not the goal to focus only on the *facts* of vulnerability among women and men of different races, sexualities, or regions; nor is it the intention to debate *whether* women or men (or certain women or men) are, in fact, “more” vulnerable. Rather, the goal is to examine the nature of epidemiological classifications and the discourse that surrounds these, to argue that such designations structure and limit current meanings, understandings, and the fathomability of gendered and sexualized vulnerability to HIV (Treichler 1999). The term fathomability here refers to the way in which particular social formations are constituted as identifiable, risky, or vulnerable, while others remain wholly unthinkable (Treichler 1999).

Vulnerable woman, invulnerable man: The (gendered) heterosexual couple

In 1994, heterosexual transmission surpassed injection drug use as the predominant route of transmission in US women with a diagnosis of AIDS (CDC 1995). Currently, heterosexual contact is said to account for approximately 60% of the identifiable risk in women, the largest category of identifiable risk in women (CDC 2002c). This trend is expected to continue, in part because heterosexual women are more likely to encounter an infected man than the reverse (Padian *et al.* 1997).

Within the global HIV literature, women are frequently deemed “more” or “especially” vulnerable to HIV infection than men due to an interaction between biological and social susceptibility factors. Due to genital physiology, gendered power relations, and the nature and pattern of relationships, studies generally suggest that male-to-female transmissibility is about twice that of female-to-male transmission (see, for example, Exner *et al.* 2003, Padian *et al.* 1997).

Numerous social, psychological, cultural, and institutional factors are cited as leading to women's greater vulnerability (Gupta 2002). There is strong evidence for a common sexual double standard, unequal economic and social status, and power differentials that affect safer sex negotiations. Women are often taught to be passive about bodily and sexual needs, and to put their needs aside in the interest of pleasing others (Reid 2000). Women are often most “at risk” with their current long-term male partner, where desires for trust, intimacy, and pleasure can lead to the erroneous assumption that a primary sexual relationship is safe (Simoni *et al.* 2000). Women are also viewed as especially vulnerable to HIV from the stance of much of the literature on sex work, and also in the literatures on rape and sexual violence (Wood and Jewkes 1997, Preston-Whyte *et al.* 2000).

All of the above “gendered” accounts leave heterosexual women hurt, disadvantaged or erased in sexual encounters and sexual safety. While there is a vast amount of evidence for these claims and heterosexual transmission as a risk category currently makes up a larger proportion of women's risk compared to men's risks in the USA (CDC 2002a), the question remains why is sexuality only gendered in the literature when describing women's vulnerability to HIV, when there are simultaneous or competing alternative explanations? How, after 30 years of interdisciplinary challenges to unitary notions of “sex” and “gender” that feature passive, powerless, vulnerable emphasized femininity and aggressive, powerful, violent hegemonic masculinity can this still be the *central* narrative surrounding HIV risk in the gender order (Connell 1987)?

The notion of a sex/gender system was introduced during the rise of second wave feminism, by writers such as Rubin (1975) in her classic essay ‘The Traffic Of Women’. In it, heterosexuality was conceptualized as a specifically gendered and unequal material and social arrangement. The basis for women's oppression, Rubin argued, is the transformation of biological needs (sex) into a system of social relations (gender) through the kinship system. In such a system, women are transacted as gifts in the institution of marriage and it is the exchange partners, men, who are the beneficiaries. This exchange enables men to establish their dominance over women, and constrains women's sexuality into being responsive to men's needs. Furthermore, widely varying cultural valuations of women's and men's tasks fuel gender inequality and make it economically difficult for women to achieve independence on their own without heterosexual relations.

Two main assumptions support the sex/gender system described above. The same two assumptions have worked their way into the literature on HIV and “heterosexual transmission”. First, heterosexual women are conceptualized as categorically oppressed and vulnerable, while heterosexual men are viewed as categorically powerful/invulnerable. Second, there is the assumption that a sex/gender system is constituted by biological women who have one gender role known as femininity (and are hurt by it in the HIV epidemic), while biological men have one gender role known as masculinity (and tend to hurt women with it).

Researchers interested in women's vulnerability to HIV/AIDS privilege the above assumptions that are contained in the logic of a sex/gender system not only when studying women, femininity, and HIV/AIDS, but also when studying men, masculinity, and HIV/

AIDS. Here, men are frequently deemed to have greater decision-making or absolute power in the initiation, pace, and orchestration of sexual activity, sexual practices, and safer sex decisions (Exner *et al.* 1997). Furthermore, narrow cultural definitions of masculinity are said to normalize sex as a competitive, hierarchical win in which “scoring” is defined as a bodily right of access to and pleasure from multiple women's bodies in the sexual double standard (Seal and Ehrhardt 2003). In short, “traditional male gender roles” as these are socialized, and structural inequities in gendered power, are seen to influence risky sexual behavior.

Given that men are conceived of as so masculine, aggressive, unconcerned with partner needs, unable or unwilling to control their bodily needs amidst unwieldy power, needing multiple partners or are viewed as violent, it remains somewhat curious that the term “especially vulnerable” is not taken up more frequently in discussion of men and heterosexual transmission. In reality, men are positioned in quite variable positions within social structures and relationships, experience widely varying benefits of patriarchy, are frequently involved in migration and population movements and are also raped, sexually assaulted, and increasingly need to use sex work for material survival (Preston-Whyte *et al.* 2000). These facts are not frequently considered in a discourse of male vulnerability to HIV. Omitting a discourse of heterosexual men's vulnerability is even more alarming when thinking epidemiologically. That is, women cannot be put at risk via sexual transmission with a heterosexually active male partner unless that male partner is already infected and hence clearly vulnerable and at risk. More adequate analyses of gender in relation to HIV/AIDS need to consider women's and men's simultaneous privileges and inequalities in a triad made up of (1) different groups of women; (2) dominant male groups; and (3) subordinated men, such as marginalized racialized, classed, and sexualized men (Messner 1997, Connell 1995). Can we begin to break down the limitations of the logic of current work that often conceives of passive emphasized femininity and aggressive hegemonic masculinity as the key to understanding inequality in the gender order?

Several possibilities suggest themselves, first, there has been much theoretical challenge offered to concepts of “gendered oppression”. which suggest that power is categorically owned by men and is used to oppress and dominate women. Not only is the assumption that “women” and “men” are unified or homogeneous categories flawed, but also the by structural realities, where both disenfranchised women *and* men in many societies now face massive economic and social destabilization domestically and globally (Parker *et al.* 2000). Class and race also play a large role in structuring the specificities of risk (Zierler and Kreiger 1997).

Second, a similar nuancing is needed for heterosexually-active men's risks. For example, in the USA, men of color in particular have lost tremendous economic ground over the last 30 years due to de-industrialization (Wilson 1996). Worldwide, research has also underscored how women migrants and not simply male migrants have, at times, been the those forced to leave and return home for work, some of whom return home HIV positive to infect their HIV negative male partners (Lurie *et al.* 2003). It remains important, therefore, to uncover the ways in which women and men gain or lose ground in given economies and what impact this has on power, negotiations, and risk in relationships.

Concepts of intersectionality (race, class, gender, and sexuality) may be useful in this context (Collins 1999). Individuals do not have singular identities or experiences within social structures that expand or limit social practices, but rather, intersecting ones. It is evident, for example, that the epidemic in the USA has had disproportionate impact on the poorest and most marginalized women, predominantly women of color living in the inner cities of the northeastern seaboard (Kamb and Wortley 2000, CDC 2002a). Moreover, while overall numbers of women and men with HIV are approximately equal, in young people ages 13–19, a much greater proportion of HIV infections occur among females (CDC 2002a). Thus, the epidemic clearly traverses the fault lines of intersectionality, and transmission and infection (whether by sex or drugs) is linked to social and economic relations of inequality (Zierler and Krieger 1997).

Despite this, surveillance categories do not currently rely on the intersection of several identities or behaviors and therefore do not facilitate easy analysis of the contextual factors that shape risk aside from “heterosexual transmission”, “injecting drug use” or “men who have sex with men” (Young and Meyer in press).

Hierarchical inclusion, heterosexual transmission, and the queer disappearance of queer

In her later work, Rubin (1999) challenged her earlier notion of a sex/gender system when she argued that women do not simply face gendered but also sexual stratification. She challenges researchers to reconsider the automatic use of gender analysis to capture the state of sexuality for women. By extension, it is important to reflect not only on what is inside the frame of the discourse on vulnerability to HIV, but what is excluded or silenced (Lutzen 1995). When the CDC first recognized women's symptomology, women came rushing out of the HIV/AIDS closet. They often did so under the category of heterosexual transmission. Unlike the official categorization of men, which includes injecting drug users (IDU), men who have sex with men, indefinable, and a separate transmission category for men who have sex with men *and* who also engage in injecting drug use, women are said to have the following risks: IDU, heterosexual, and undefinable (Campbell 1999, CDC 2002c). Women who have sex with an injection drug user are added together with women classified under Asex with men@ to create an overall concept of “heterosexual transmission” (CDC 2002c). It is important to examine the way in which women are classified, given that this provides the contemporary basis for the constitution of heterosexual transmission (and implicitly heterosexual identity), while erasing the possibility of bi/lesbian transmission (and therefore identity) (Young and Meyer in press).

Under existing classification systems, a woman who always has had long sessions of oral sex with multiple women but has had one episode of heterosexual contact is counted as having heterosexual risk. A bisexual female who does not use drugs will be counted as having a heterosexual transmission risk. A bisexual woman who has anal sex with a gay man will be classified as having heterosexual transmission risks. A woman who has sex with women and men, and is the partner of both a female and a male injecting drug user, will be categorized as having heterosexual transmission risks.

The need for greater intersectionality in surveillance categories and the discourse that surrounds current modes of risk hierarchicalization becomes even clearer when we look at current research trends. For example, comprehensive reviews have found that large numbers of female injecting drug users are women who have sex with women (WSW) (from 20 to 40% across samples) (Young *et al.* 2000). However, such women are classified as injecting drug users in terms of HIV risks, and sexuality plays little role in prevention work thus far (Friedman *et al.* 2003). Research has also found that WSW IDUs have higher HIV incidence and prevalence rates than heterosexuals IDUs and that WSW IDUs are more likely to engage in sex with MSMs (Friedman *et al.* 2003).

With respect to WSW more generally, it has been found that WSW are more likely than non-WSWs to report sexual contact with a homosexual or bisexual man (Fethers *et al.* 2000). Under present classification systems, these women will be counted as having “heterosexual” transmission risks and may be conceived of as benefiting from HIV prevention interventions that are likely to only take gender inequality into account (Lemp *et al.* 1995). Furthermore, WSW have also been found to have more oral-penile and more anal intercourse and less vaginal intercourse than heterosexual women (Bevier *et al.* 1995). Again, these women will be counted as having heterosexual transmission risks where the literature generally conceives of risk as related to gender inequality.

The current focus not only erases a wide variety of risky sexual practices and identities other than heterosexual, but also leaves many women in a position to not be able to assess their risk accurately (Morrow and Allsworth 2000, Young and Meyer 2005). Lesbians or bisexual women may not think they are at risk due to popular conceptions that woman to woman sex is a no-risk practice (Albert 2001). These are vital considerations when considering that the “first case” of female-to-female transmission of HIV is now documented, reported as being most likely through “the use of sex toys, used vigorously enough to cause exchange of blood-tinged bodily fluids” (Reeves 2003: 29). In this newest case, the HIV-positive partner reports that she was instructed by her physician to use protection only with her male partners.

In Los Angeles, research with “high risk” Latina women reveals widespread bisexual activity. Respondents reported “*Si, tenemos sexo con mujeres, pero no somos marimachas*” (“Sure, we have sex with women, but we’re not lesbians”) (Ramos 1997: 127). In this same study, we learn of Cristina who considers herself “queer”, went through a “slut phase”, attended S&M and leather scenes with women and men, never washed her dildos, used drugs, and had blood squirted on her during a nipple piercing ceremony. There was also the less “unusual” case of Lourdes, who liked to lick her partner when she had her period since “*Me gusta ver el sangrado*” (“I liked to see her blood”) (Ramos 1997: 133). There were also reports of tribadism that occurred (and occur outside of this study), where women rub the wettest part of their genitals together until they explode in orgasm, soaking the sheets (Ramos 1997). There are also clinical cases of those women and men who have oral sex with women, fully adoring of the building moistness, but then are surprised when met with a stream of female ejaculate that squirts into their eyes, nose, and mouth (Darling *et al.* 1990).

The CDC does report that “vaginal secretions and menstrual blood are potentially infectious and that mucous membrane (e.g. oral, vaginal, penile) exposure to these secretions have the potential to lead to HIV infection” and yet “information on whether a woman had sex with women is missing in half of case reports, possibly because the physician did not elicit the information or the woman did not volunteer it” (CDC 2000). Clearly, so as to garner a fuller sense of women's (and men's) sexual health, it would help to tackle heterosexism and homophobia in public health and to instill a conception of the erotic and *sexual* and not simply *gendered* constitution of society (Dowsett 1996, Parker 1999).

Intersectionality that recognizes the simultaneity of behaviors and/or identities could be helpful in enabling researchers to make new inroads into communities of poor inner city queer women whose female partners must sell sex to men to make ends meet. It will also perhaps make better sense of the circumstances and experiences of women in India (Thadani 1999), Mexico (Mogrovejo 1999), in Native American cultures (Lang 1999), in West Sumatra (Blackwood 1999), in Zimbabwe (Aarmo 1999), and all over the world who have sex with women, or with both women and men. How do such women conceive of their risk—and what are their risks?

How will current theories of gender address the butch women who have been studied in Jakarta and Lima (Wieringa 1999) if they might have sex with femme women who have multiple boyfriends (or the reverse)? What are the risks to female partners who conceive of themselves worldwide as embracing “female masculinity” across sexuality categories (Halberstam 1998), and are these different from those who might embrace femme identity across the categories (Pratt 1995)? We simply do not know.

Current epidemiological markings of women require the simultaneous breathing of some women into diseased existence while pushing others into the realm of the unfathomable (Foucault 1978). Since all decisions to draw boundaries around surveillance categories are by definition shifting, problematic, and involve a politics of inclusion and exclusion by their very nature, researchers should think carefully about automatically privileging singular, hierarchicalized categories—or embracing any singular theory of risk that underpins current categories. Theories of intersectionality may not provide a total solution, but this conceptual turn could begin to place some populations, behaviors, and identities into the realm of existence while allowing for much needed contextual understandings and discursive conceptions of “at risk” and “vulnerable”. The US CDC is already moving in this direction in terms of men's categories (e.g., by keeping track of multiple risk behaviors as these intersect), but the thoroughness of a parallel move for the women's categories has yet to be made (CDC 2002c).

While analyses of gender are vital and will continue to take place, pushing beyond the notion that there is a singular sex/gender system in which biological women are feminine, oppressed, and vulnerable and biological men are masculine, invulnerable oppressors will be vital to future progress in the HIV epidemic. Examining intersectionality and the simultaneity of race, class, and shifting gender relations for women and men remains vital. Classification systems that privilege singular categorizations and underlying theories of

gender or sexuality to explain risk are likely to be of limited use both in the USA and world-wide.

Acknowledgments

This research was supported by a training grant from the National Institute of Mental Health (T32 MH19139 Behavioral Sciences Research in HIV Infection; Principal Investigator, Anke A. Ehrhardt). The author is grateful to Gary Dowsett, Susie Hoffman, Jodi O'Brien, Ilan Meyer, Kari Lerum, Theresa Exner, Rita Melendez, Anke A. Ehrhardt, Theo Sandfort, Gary Oppenheimer, Leslie Heywood, Michael A. Messner, Faye Linda Wachs, Pat Warne and Isabel Howe for careful, diligent reads and insightful suggestions.

References

- Aarmo, M. How homosexuality became 'UnAfrican': The case of Zimbabwe. In: Blackwood, E.; Wieringa, SE., editors. *Same Sex Relations and Female Desires: Transgender Practices Across Cultures*. New York: Columbia University Press; 1999. p. 255-280.
- Albert, S. Many Lesbian and Bisexual Women Unaware of Risks. *Gay Health*. 2001. Available at: <http://www.gayhealth.com/iowa-robot/sex/?record'407>
- Bevier PJ, Chiasson MA, Heffernan RT, Castro KG. Women at a sexually transmitted disease clinic: their HIV seroprevalance and risk behaviors. *American Journal of Public Health*. 1995; 85:1366–1376. [PubMed: 7573619]
- Blackwood, E. Tombois in West Sumatra: Constructing Masculinity and Erotic Desire. In: Blackwood, E.; Wieringa, SE., editors. *Same Sex Relations and Female Desires: Transgender Practices Across Cultures*. New York: Columbia University Press; 1999. p. 181-205.
- Campbell, C. *Women, Families, and HIV/AIDS*. New York: Cambridge University Press; 1999.
- Centers for Disease Control. Announcement of Meeting About Revising the AIDS Surveillance Case Definition. *Morbidity Mortality Weekly Report*. 1992a; 41:594–595.
- Centers for Disease Control. 1993 Revised classification system for HIV infection and expanded surveillance case definition for AIDS among adolescents and adults. *Morbidity Mortality Weekly Report*. 1992b; 41:17. [PubMed: 1728728]
- Centers for Disease Control. Revision of the Proposed Expansion of the AIDS Surveillance Case Definition. *Morbidity Mortality Weekly Report*. 1992c; 41:829–830.
- Centers for Disease Control. National HIV Serosurveillance Summary: Results through 1992. Atlanta: US Department of Health and Human Services, Public Health Service; 1993.
- Centers for Disease Control. Update: AIDS Among Women in the United States, 1994. *Morbidity Mortality Weekly Report*. 1995; 44:81–84. [PubMed: 7838086]
- Centers for Disease Control. HIV/AIDS and US Women Who Have Sex with Women (WSW). 2000. Available at: <http://www.cdc.gov/hiv/pubs/facts/wsw.htm>
- Centers for Disease Control. AIDS Cases in Adolescents and Adults by Age: United States, 1994–2000. *HIV/AIDS Surveillance Supplemental Report*. 2002a; 9(1)
- Centers for Disease Control. Deaths among persons with AIDS through December 2000. *HIV/AIDS Surveillance Supplemental Report*. 2002b; 8(1)
- Centers for Disease Control. Cases of HIV Infection and AIDS in the United States, 2002. *Surveillance Report*. 2002c; 14
- Collins, PH. Moving Beyond Gender: Intersectionality and Scientific Knowledge. In: Feree, MM.; Lorber, J.; Hess, BB., editors. *Revisioning Gender*. Thousand Oaks: Sage; 1999. p. 261-284.
- Connell, RW. *Gender and Power*. Stanford, CA: Stanford University Press; 1987.
- Connell, RW. *Masculinities*. Berkeley, CA: University of California Press; 1995.
- Darling CA, Davidson JK Sr, Conway-Welch C. Female Ejaculation, Perceived Origins, the Grafenberg Spot/Area, and Sexual Responsiveness. *Archives of Sexual Behavior*. 1990; 19:29–47. [PubMed: 2327894]
- Dowsett, G. *Practicing Desire: Homosexual Sex in the Era of AIDS*. Stanford, CA: Stanford University Press; 1996.

- Exner TM, Hoffman S, Dworkin S, Ehrhardt AA. Beyond the Male Condom: The Evolution of Gender-Specific HIV Interventions for Women. *Annual Review of Sex Research*. 2003; 14:114–136.
- Exner TM, Seal DW, Ehrhardt AA. A Review of HIV Interventions for At-Risk Women. *AIDS and Behavior*. 1997; 2:93–124.
- Fethers K, Marks C, Mindel A, Estcourt CS. Sexually transmitted infections and risk behaviors in women who have sex with women. *Sexually Transmitted Infections*. 2000; 76:345–349. [PubMed: 11141849]
- Foucault, M. *The History of Sexuality*. New York: Vintage Books; 1978.
- Fox-Tierney RA, Ickovics JR, Cerrata C, Ethier KA. Potential sex differences remain understudied: A case study of inclusion of women in HIV/AIDS-related neuropsychological research. *Review of General Psychology*. 1999; 3:44–54.
- Friedman SR, Ompad DC, Maslow C, Young R, Case P, Hudson S, Diaz T, Morse E, Bailey S, Des Jarlais DC, Perlis T, Holligaugh A, Garfein RS. HIV Prevalence, Risk Behaviors, and High-Risk Sexual and Injection Networks Among Young Women Injectors Who Have Sex With Women. *American Journal of Public Health*. 2003; 93:902–906. [PubMed: 12773350]
- Gupta GR. Gender, sexuality and HIV/AIDS: The what, the why, and the how. *SIECUS Reports*. 2002; 29(5):6–12.
- Halberstam, J. *Female Masculinity*. Durham, NY: Duke University Press; 1998.
- Hankins CA, Handley MA. HIV disease and AIDS in women: Current knowledge and a research agenda. *Journal of Acquired Immune Deficiency Syndromes*. 1992; 5:957–971. [PubMed: 1453325]
- Kamb, ML.; Wortley, PM. Human Immunodeficiency Virus and AIDS in women. In: Goldman, M.; Hatch, M., editors. *Women and Health*. San Diego, CA: Academic Press; 2000.
- Lang, S. Lesbians, Men-Women, and Two-Spirits: Homosexuality and Gender in Native American Cultures. In: Blackwood, E.; Wieringa, SE., editors. *Same Sex Relations and Female Desires: Transgender Practices Across Cultures*. New York: Columbia University Press; 1999. p. 91-118.
- Lemp GF, Kellog M, Nieri TA, Giuliano N, et al. HIV Seroprevalence and risk behaviors among lesbians and bisexual women in San Francisco and Berkeley, California. *American Journal of Public Health*. 1995; 85:1549–1557. [PubMed: 7485670]
- Lurie MN, Williams BG, Zuma K, Mkaya-Mwamburi D, Garnett GP, Sweat MD, Gittelsohn J, Abdool Karim SS. Who Infects Whom: HIV-1 Concordance among Migrant and Non-Migrant Couples In South Africa. *AIDS*. 2003; 17:2245–2252. [PubMed: 14523282]
- Lutzen, K. La mise en discours and Silences in Research on the History of Sexuality. In: Parker, R.; Gagnon, J., editors. *Conceiving Sexuality: Approaches to Sex Research in a Postmodern World*. London: Routledge; 1995. p. 19-32.
- Messner, MA. *The Politics of Masculinity: Men In Movements*. Thousand Oaks, CA: Sage; 1997.
- Mogrovejo, N. Sexual Preference, the Ugly Duckling of Feminist Demands: The Lesbian Movement in Mexico. In: Blackwood, E.; Wieringa, SE., editors. *Same Sex Relations and Female Desires: Transgender Practices Across Cultures*. New York: Columbia University Press; 1999. p. 308-336.
- Morrow KM, Allsworth JE. Sexual Risk in Lesbians and Bisexual Women. *Journal and the Gay and Lesbian Medical Association*. 2000; 4:159–165.
- Padian N, Shiboski S, Glass S, Vittinghoff E. Heterosexual Transmission of human immunodeficiency virus in northern California: results from a 10 year study. *American Journal of Epidemiology*. 1997; 146:350–357. [PubMed: 9270414]
- Parker, R. 'Within Four Walls': Brazilian Sexual Culture and HIV/AIDS. In: Parker, R.; Aggleton, P., editors. *Culture, Society, and Sexuality: A Reader*. London: Taylor & Francis; 1999. p. 253-266.
- Parker R, Easton D, Klein CH. Structural barriers and facilitators in HIV prevention: A Review of international research. *AIDS*. 2000; 14(S1):S22–S33. [PubMed: 10981471]
- Pratt, MB. *S/he*. Ithaca, NY: Firebrand Books; 1995.
- Preston-Whyte, E.; Varga, C.; Oosthuizen, H.; Roberts, R.; Blose, F. Survival Sex and HIV/AIDS in an African City. In: Parker, R.; Barbosa, RM.; Aggleton, P., editors. *Framing the Sexual Subject: The Politics of Gender, Sexuality, and Power*. Berkeley, CA: University of California Press; 2000. p. 165-190.

- Ramos, L. 'Si, Tenemos Sexo Xon Mujeres, Pero No Somos Marimachas' (Sure, We Have Sex With Women, But We're Not Lesbians.): Sexual Diversity in the Los Angeles Latina Community-Ethnographic Findings, 1987–1995. In: Goldstein, N.; Manlowe, J.L., editors. *The Gender Politics of HIV/AIDS in Women*. New York: New York University Press; 1997. p. 127-154.
- Reeves T. Female to female transmission-seeking answers and challenging myths. *HIV Australia*. 2003; 2:29–30.
- Reid PT. Women, Ethnicity, and AIDS: What's Love Got to Do With It? *Sex Roles*. 2000; 42:709–722.
- Rubin, G. *The Traffic In Women: Notes on the Political Economy of Sex*. In: Reiter, R., editor. *Towards an Anthropology of Women*. New York: Monthly Review Press; 1975.
- Rubin, G. Thinking Sex: Notes for a Radical Theory of the Politics of Sexuality. In: Parker, R.; Aggleton, P., editors. *Culture, Society, and Sexuality: A Reader*. London: Taylor & Francis; 1999. p. 143-178.
- Seal DW, Ehrhardt AA. Masculinity and urban men: Perceived scripts for courtship, romantic, and sexual interactions with women. *Culture, Health, and Sexuality*. 2003; 5:295–319.
- Simoni JM, Walters KL, Nero DK. Safer sex among HIV+ women: the role of relationships. *Sex Roles*. 2000; 42:691–708.
- Stine, GJ. *Aids Update 2002: An Annual Overview of Acquired Immune Deficiency Syndrome*. Saddle River, NJ: Prentice Hall; 2003.
- Thadani, G. The Politics of Identities and Languages: Lesbian Desire in Ancient and Modern India. In: Blackwood, E.; Wieringa, SE., editors. *Same Sex Relations and Female Desires: Transgender Practices Across Cultures*. New York: Columbia University Press; 1999. p. 67-90.
- Treichler, P. AIDS, Homophobia, and Biomedical Discourse: An Epidemic of Signification. In: Parker, R.; Aggleton, P., editors. *Culture, Society, and Sexuality: A Reader*. London: Taylor & Francis; 1999. p. 190-266.
- Wieringa, SE. Desiring Bodies or Defiant Cultures: Butch-Femme Lesbians in Jakarta and Lima. In: Blackwood, E.; Wieringa, SE., editors. *Same Sex Relations and Female Desires: Transgender Practices Across Cultures*. New York: Columbia University Press; 1999. p. 206-229.
- Wilson, WJ. *When Work Disappears: The World of the New Urban Poor*. New York: Vintage Books; 1996.
- Wood K, Jewkes R. Violence, Rape, and Sexual Coercion: Everyday Love in a South African Township. *Gender and Development*. 1997; 5:41–46. [PubMed: 12292615]
- Young RM, Meyer I. The Trouble With 'MSM' and 'WSW': Erasure of the Sexual Minority Person in Public Health Discourse. *American Journal of Public Health*. 2005; 95:1144–1149. [PubMed: 15961753]
- Young RM, Friedman SR, Case PL, Ascencio MW, Clatts MC. Women injection drug users who have sex with women exhibit increased HIV infection and risk behaviors. *Journal of Drug Issues*. 2000; 30:499–524.
- Zierler S, Krieger N. Reframing Women's Risk: Social Inequalities and HIV Infection. *Annual Review of Public Health*. 1997; 18:401–436.