

HIV/AIDS in the Lesbian Community

A Senior Honors Thesis

Presented in Partial Fulfillment of the Requirements for graduation *with research distinction* in Women's Studies in the undergraduate colleges of The Ohio State University

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June 2007

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I initially was interested in the topic of the human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) in the lesbian community because I had no knowledge of how the disease affected this particular community. I was aware of how HIV was affecting certain populations of women, like African American women and Latinas, but did not know how lesbians were faring. Through my research, I have learned that HIV/AIDS has had a unique impact on lesbians and that there are several reasons why I was not aware of how lesbians were affected by HIV, even though their influence on the public perception of the disease has been notable.

My approach to this thesis was to conduct extensive research on HIV/AIDS and lesbians. I relied mostly upon medical journals and literature written by lesbians. This proved difficult at times as lesbians are a small group and have not been studied thoroughly in relation to the disease. It is important to define, for this thesis, the use of the terms “lesbian” and “women who have sex with women” because both terms are used in the literature. There is no standard definition of “lesbian,” so for this thesis, the term refers to women who have sex with other women and form emotional partnerships with women. The term lesbian is also a sexual identity that frequently describes a lifestyle and community but does not have the same meaning for women of different ages, races, or cultures. “Women who have sex with women” is a label that categorizes women completely on their sexual behavior. There is no identity associated with this term.

To understand how lesbians are affected by HIV/AIDS, some initial facts are needed. HIV is the human immunodeficiency virus. HIV attacks the immune system and destroys a type of white blood cell (T cells or CD4 cells) that the immune system must have to fight disease. HIV leads to AIDS which is the final stage of HIV illness. Having

AIDS means that a person's immune system has been weakened and cannot fight disease and infection (CDC 2007).

According to the CDC (Centers for Disease Control and Prevention), at the end of 2003, an estimated 1,039,000 to 1,185,000 persons in the United States were living with HIV/AIDS, with 24-27% undiagnosed and unaware of their HIV infection. At the end of 2005, there was an estimated 437,982 people living with AIDS in the United States of which 182,822 were women (CDC 2007). African Americans account for 47% of people living with HIV. Among female cases of HIV, African American women represented the largest percentage in all categories (Prejean 1).

Lesbians are in the CDC's lowest risk group for contracting HIV, so why study this group (Arend)? There is little information on how lesbians as a group contract the disease, transmit HIV or experience the disease. Lesbians have a complicated and diverse experience with HIV and this thesis will examine that relationship using a feminist perspective.

Introduction

From the beginning of the AIDS epidemic, lesbians have played a unique role in the fight against the disease. AIDS began in the early 1980s during a time of liberation for women in general and lesbians more specifically. Gay issues were being brought to the public eye and lesbians as a collective were becoming more comfortable in establishing a public identity. Lesbians were emerging as political and social leaders (Stoller 172). Initially, the disease was treated as a gay-male-only issue by the public and the overall reaction from public health officials was neglect. Many women, including lesbians, worked in jobs like nursing and social work that brought them close to HIV and

also to gay men. Lesbians in these professions and others took it upon themselves to take care of gay men that were contracting HIV. As the AIDS crisis continued, more lesbians became activists and worked alongside gay male leaders to bring AIDS information and research to the public (Stoller).

Women's experiences were not considered central to the AIDS movement. One woman, the coordinator for the women's program for the San Francisco AIDS Foundation in 1985-1986, had made brochures for the organization specifically targeting lesbians. She went to the director of education, a gay male, to get permission to print her brochure. "I was told that my brochure would not be approved for printing because unlike the other groups 'lesbians are not at risk for AIDS'" (Stoller 181). This attitude towards lesbians and HIV/AIDS is still prevalent in the medical community and lesbians are still fighting for recognition.

Lesbians have participated in activist groups that helped to bring media attention to women's experience with AIDS. ACT UP (AIDS Coalition to Unleash Power) was one such organization. ACT UP was founded in New York City in March 1987. The group was "united in anger and committed to direct action to end the AIDS crisis" (Boehmer 15). ACT UP consisted mostly of white gay men and lesbians and received media attention through its acts of civil disobedience. ACT UP also publicized the discrimination that women and people of color with AIDS endured. The group helped women and people of color to be included in experimental drug trials and convinced the CDC to include women specific HIV/AIDS related symptoms in the definition of AIDS (Boehmer, 15).

Being Overlooked in the Health Care System

Lesbians are a small population that is frequently overlooked in the health care system, especially in relation to HIV/AIDS. Since the beginning of the AIDS epidemic, lesbians have not been seen as an affected population and the CDC's hierarchy for classifying women's exposure to HIV reflects this. The hierarchy for women is as follows:

1. Injection drug use (IDU)
2. High-risk heterosexual contact
3. Other (CDC 2005)

High-risk heterosexual contact is defined as, "heterosexual contact with a person know to have, or to be at high risk for, HIV infection" (CDC 2005). Other, "includes hemophilia, blood transfusion, perinatal exposure, and risk factor not reported or not identified" (CDC 2005). These are mutually exclusive groups and if a woman has more than one risk factor, she is categorized by the highest risk factor. At no point is female to female contact mentioned.

Women who do not fit into "injection drug use" or "high-risk heterosexual contact" are placed into the "other" category by the CDC. "Women who may have contracted HIV from their female partners in the past and who had any other risk factors have traditionally been classified either under those risk factors or as 'undetermined'" (Hawkins par 1). 15% of AIDS cases in women are classified as "risk not reported." This is twice the rate of the male cases in the same category (Morrow). This implies that not enough research has been done examining how women contract HIV. Perhaps another category should be added for women, or women's experiences should be more closely documented and examined.

The opportunistic infections women experienced were not classified in the original definition of AIDS. It can be assumed that women's experiences were not being counted or examined by the medical community. It was not considered that women's bodies might deal with the disease differently because HIV was considered a man's disease with infections specific to men only. For instance, in a study done on HIV infection among incarcerated women in 2001, it was discovered that, "women who developed AIDS had a median initial viral load of 17, 149 copies/mL compared to 77,822 copies/mL in men" (Onorato par 3). This sex difference means that the same viral load measurements do not mean the same risk of AIDS in men and women. This is important because under current treatment guidelines of initiation of antiretroviral therapy when the viral load exceeds 50,000, many women are excluded from HIV therapy (Onorato par 3). So, men and women's bodies do not have the same reaction to AIDS and it took years for the medical community to discover this.

In a study done by the CDC in 1999, the CDC stated, "information on whether a woman had sex with women is missing in half of the 109,311 case reports, possibly because the physician did not elicit the information or the woman did not volunteer it" (CDC). With this information missing, it is not possible to know how many women had having sex with women as a risk factor. It also raises the question of why women are not being asked by physicians about the full range of their sexual behavior.

The CDC conducted another study in December 1998 that found that 109,311 women were reported with AIDS. Of those, 2,220 were reportedly women who have sex with women. "Of the 347 (out of 2,220) women who reported to have had sex with women, 90% also had another risk-injection drug use in most cases" (*HIV/AIDS and U.S.*

Women Who Have Sex with Women (WSW), CDC). In a more recent study, according to the CDC, through December 2004,

a total of 246,461 women were reported as HIV infected. Of these, 7,381 were reported to have had sex with women; however, most had other risk factors (such as injection drug use, sex with men who are infected or who have risk factors for infection, or, more rarely, receipt of blood or blood products) (*HIV/AIDS among Women Who Have Sex with Women*, CDC).

The logic here is that the infection came from sharing needles. Though this is not unlikely, it still does not acknowledge the possibility of woman to woman transmission. Only the highest risk factor, intravenous drug use, is considered.

The CDC also has a history of categorizing women according to their *previous* sexual history. If a woman has had sex with a man after 1977, that is considered her primary risk factor. “In 1992, the Centers for Disease Control still excluded any woman from its ‘lesbian’ category if she had sex even once with a man since 1977” (Stoller 182). This means that the CDC has defined a lesbian as a woman who has never had sex with a man which fails to acknowledge multiple factors upon a woman’s sexual identity such as sexual practice or cultural background (Arend). This also effectively rules out woman-to-woman transmission as a possibility because many lesbians have had or are currently having sex with male partners and this heterosexual contact would be the highest risk category. So, women are seen through a less than comprehensive lens because women who have sex with women are viewed through their past sexual risks and not their current risks.

According to the CDC, women who have sex with women must have another risk factor. Having sex with women is not considered a possible factor. There is at least one

case from 2003 of female-to-female transmission of HIV that was proven through virus matching. This particular case involved a twenty-year-old African American woman who had none of the accepted HIV risk factors (including having sex with men or needle sharing). This woman had only one sexual partner throughout her lifetime and that partner was a woman who was openly bisexual and HIV positive. She only used protection while having sex with men, as per her doctor's instructions. Physicians believe that the woman contracted HIV through shared use of sex toys (Kwakwa and Ghobrial). Another woman had a similar experience. At a conference held by the Lesbian AIDS Project, she spoke about being an HIV positive lesbian infected by her HIV positive female partner. She stated, "I have been ridiculed and dismissed in talking about this, but I am here to say that I am not a liar or an exception" (Hollibaugh 192). These cases demonstrate that woman-to-woman transmission is possible and the CDC's guidelines should reflect this fact.

Disclosure

Informing a doctor of one's sexual orientation can be a complicated issue and many women choose not to disclose to their doctors. Lesbians may choose to withhold the full range of their sexual behavior because of the fear of homophobia or of having had a previous negative experience with a health care provider (Pinto 567). Unfortunately, this means that information on lesbians is not as available as for other groups because that information is not being reported.

Many women who identify as lesbian may not want to disclose their full sexual history with their doctors out of fear of the stigma associated with being gay.

Depending on the extent to which sex with women is integrated into their sexual identities, it may be stigmatizing for them to disclose their sexual

activities, and thus, they may define themselves according to only certain types of behavioral acts in which they engage and not disclose activities that could greatly affect their health status (Bell et al. 1066).

Not all women are comfortable enough with their sexual identities to fully detail their sexual practices with their doctor or nurse.

Women who identify as lesbian go to primary care less often than their heterosexual counterparts. This population is also less likely to visit a gynecologist. “In the Seattle Lesbian Health Study, 236 (95%) of respondents believed they should receive pap smears annually or every 2 years after normal smear results, but 90 (36%) provided a reason for not having done so” (Marrazzo 1976). Many of the reasons cited were lack of insurance, a bad experience at the previous Pap smear, and a belief that, “they did not need it because they were not sexually active with men” (Marrazzo 1976). By not visiting doctors regularly and disclosing their sexual orientation, lesbians become even more invisible in the health care system.

In one study conducted in 2001, only 54% of “American health care providers even considered the sexual orientation of female patients. 60% of women in one study self-disclosed sexual orientation to their health care providers (Fishman 50).” Almost half of women who visit their doctors are not being asked their sexual orientation. This means that a very large number of women are not receiving information pertinent to their sexual health. Either doctors are assuming their patients are heterosexual or their patients are not having sex. It is promising, though, that 60% of women in that study self-disclosed. This means women are becoming comfortable enough with their sexual identity to seek knowledge on their own.

Because of their association with gay men, lesbians have been treated with homophobic neglect. For instance, one woman who was diagnosed with breast cancer in 1991 was ignored by her nurses and doctors out of fear of AIDS. Her partner and two of their friends tried to donate blood for her and were denied because of concerns of AIDS transmission (DeLombard 357). Because the two women were lesbians and thus associated with the stigmatized gay community, it was assumed that they were HIV positive.

Some women who want to know about safer sex and HIV are afraid to ask questions of their physicians. One woman stated, “Doctors never ask about sex with women, so I’m uncomfortable talking with them about it. How am I ever going to learn what I need to know to make sure I don’t get HIV” (Stevens 350)? This is a pretty common sentiment. While there is a growing movement to use the term “partner,” many doctors still assume a patient is heterosexual. Worse yet, if she is not, and the doctor knows this, the topic of sex may be skipped over entirely because woman-to-woman transmission of sexually transmitted infections (STIs) and HIV is not believed to be a problem. This reflects several myths and stereotypes about lesbians and lesbian sex held by both the medical and lesbian communities.

Myths

There is reluctance in the medical and lesbian communities to categorize lesbian sex as a factor in HIV transmission because there are numerous myths surrounding lesbians and lesbian sex. One of the oldest beliefs is that the lesbian community is comprised of middle-aged white women (Stoller). Although this belief is becoming less and less prevalent, it is still a problem. Sexual orientation is not dependent upon age and

race. Women of color, for example, are the fastest growing group of people contracting HIV and some of these women are lesbians (CDC). Education about HIV transmission should be available to all ages and races.

Another popular myth is that lesbians do not have much sex and therefore do not need to be studied or taught HIV prevention. This was demonstrated in the late 1980s by one CDC physician who stated publicly, “lesbians don’t have much sex (Goldstein 87).” This makes educating women who have sex with women about safer sex a non-issue for doctors because they are supposedly not engaging in risky sexual behavior. It does not matter, though, how much sex a person is having. Everyone still needs HIV education.

There are also myths within the lesbian community that put lesbians at risk. For instance, there is a general belief among the lesbian community that lesbians are immune to HIV and STDs simply because they are lesbians. It is believed that sex with women is safer than sex with men because there is less of an exchange of fluid. One woman exemplified this belief by stating, “I guess maybe it’s easier to get HIV when semen is shooting up into you than it is when your girlfriend’s fingering you and she’s got a cut on her finger” (Dolan 56). Semen is seen as a bigger risk than a cut on a woman’s finger. Men are the carriers of disease, not women. In reality, women do contract STIs including vaginitis and human papillomavirus (HPV), from their female partners. If STIs are being transmitted, it is possible that HIV could be transmitted as well (Dolan and Davis).

Another dominant belief held by lesbians is that a woman can tell simply by looking at her partner if she is “clean.” If she looks healthy, she must be healthy. But, STIs and HIV do not necessarily make a person visibly sick and the only way of knowing whether or not a woman is uninfected is for her to be tested (Dolan). Similarly, some

women believe that lesbians cannot spread disease because lesbians have immunity to STIs. In an interview done in 1999, one woman, Sally, discussed her belief that lesbians believe it to be unlikely to transmit STIs or HIV between women. She stated, “But I think we still assume that the risks are low and that there is something special about women and the relationships that we have that offers some kind of cosmic protection” (Dolan 55). This “cosmic protection” is not reflected in studies done on STI and HIV transmission between women. It also has been referred to as “Amazonian protection.” In the same interview from 1999, a different woman, Becca, described immunity in this way:

The image is that lesbian means I’ve never touched a man, and never will. And a sort of hypothetical Amazon sisterhood, where we’re all perfectly well behaved, none of us use drugs, none of us share blood, and it’s just totally safe. None of us are into penetration. We all just hang out. We’re sexual somehow, but there are no risk factors (Dolan 57).

Becca knew that lesbians engage in risky behavior but she still understood that some lesbians refuse to acknowledge various risks.

Some lesbians believe that monogamy keeps a woman safe. If a woman is with the same partner for more than six months (the amount of time that it takes for HIV to be detected) and both partners know their status is negative at the beginning of the relationship, this is relatively safe logic. Monogamy, though, does not mean the same thing to every lesbian. Some view monogamy as having one long-term partner, while others believe that sex outside of the primary relationship is acceptable as long as protection is used. A phenomenon called “serial monogamy” is frequently practiced in the lesbian community. Women will be involved in relationships lasting from a few weeks to a few months and then immediately find a new partner (Dolan). So, though she

may only be having sex with one partner at a time, she is still having sex with multiple women. It is possible she will contract or transmit HIV or an STI because multiple partners put women at risk.

There is also a stigma surrounding women who identify as bisexual. They are seen by some women who identify as lesbian as potential carriers for disease and are sometimes shunned for having sex with men. Men are seen by some lesbians as carriers of disease. Because of this, a woman may be afraid to ask her partner to use a barrier method. This implies that she is unclean, not to be trusted or not a lesbian and, therefore, not cosmically protected. In an interview done in 2005, one woman exemplified this belief. When asked if she would be offended if a partner pulled out a glove during sex, she responded,

Oh, I'd be completely offended. A glove! Oh, my God! I would think we probably shouldn't be having sex. I would be so turned off. I would be like, "We need to just stop if that's the way you feel." A glove, God, like you're going into surgery or something (Dolan, 64).

So, in this woman's experience, having safer sex is a turn off, an accusation, and a reason to not have sex at all.

What are the risks for women who have sex with women?

The risks for women who have sex with women are the same as for any woman. Lesbians are unique, though, in that they have sex with women but may have had sex with men in the past or in the present. So, unprotected sex with men is one risk lesbians expose themselves to. Just because a woman identifies as lesbian does not mean she is only having sex with women.

Pregnancy may be viewed as more of a risk than STIs or HIV by lesbians who are having sex with men. Women are more informed on preventing pregnancy than disease and some prefer the use of birth control pills rather than convincing male partners to wear condoms (Sexuality and Safer Sex: The Issues for Lesbians and Bisexual Women, 445). Birth control pills do not protect women against STIs or HIV so women who have unprotected sex are more likely to contract diseases. Moreover, studies suggest that among sexually active female teenagers, those who identify as lesbian or bisexual are more likely to report frequent heterosexual sex, are more likely to have unprotected sex, and have more pregnancies than their heterosexual counterparts (Stevens and Hall). So, lesbians are more likely to engage in risky behavior earlier than other women.

Injection drug use is another HIV infection risk. IDUs are in the CDC's highest risk category and women who have sex with women, as a group, are more likely than heterosexual women to use injection drugs. One study from 1998 found that, "Women who have sex with women comprise 20 percent to 30 percent of American women IDUs" (Friedman et al. 902). This overrepresentation of women who have sex with women is alarming. Considering that lesbians comprise a very small percent of the overall population, these numbers are significant for HIV transmission in the lesbian community.

Another study from 2006 showed that women who have sex with women IDUs are twice as likely as women who have never had sex with women IDUs to "be homeless, to have been incarcerated, and to have obtained money from transactional sex (as opposed to welfare benefits)" (Bell et al. 1070). The study also showed that, "compared with never WSW, WSW begin sexual activities earlier, engage in sex and unprotected sex more frequently, and more often trade sex for money or drugs" (Bell et al. 1066).

WSW were also more likely to have reported having sex with a partner who was diagnosed as having an STI or being diagnosed with an STI themselves (Bell et al. 1066).

A study from 2003 found that WSW IDUs were more likely to have reported having, “unprotected sex with men who have sex with men; having sex with an IDU or someone they knew or thought was infected with HIV” (Friedman et al. 904). Women who have sex with women and use injection drugs are engaging in dangerous behavior that can lead to HIV infection and engage in more dangerous sexual and drug-use behaviors than women who have never had sex with women.

Women who share needles are at a higher risk for contracting HIV than women who do not. One woman admitted that she did not think twice about sharing needles with other lesbians because she assumed there were no disease risks (Dolan 56) and another woman believed she was safe because she *only* shared needles with other lesbians. This refers back to the belief that lesbians are immune to disease and are cosmically protected, even if they are engaging in risky behavior.

Being under the influence of drugs or alcohol also impairs a woman’s judgment which means she is more likely to have unprotected sex with men or women. One woman described alcohol as affecting her sex life in this way: “There are times you are drinking until you are really blitzed and you end up falling in with somebody and you’re not really aware of sex or even if you consider using barriers, you are so drunk and sloppy that it isn’t effective” (Dolan 82). In this woman’s experience, being drunk or high makes her less likely to consider using protection or to use protection properly.

Because it is now accepted that women can transmit STIs during sex with women, unprotected sex with women is a risk. Yeast infections, HPV and chlamydia are three of

the primary STIs passed between women (Marrazzo 1974). As previously noted, there are cases of woman to woman transmission and a documented case of HIV transmission between two women verified through virus matching.

Artificial insemination is also a possible source of HIV infection. Sperm from a sperm bank is tested for STDs and HIV before being used. Some lesbians, though, decide to have children through artificial insemination using fresh sperm from live donors. Doctors recommend that patients wait six months before using a live donor's sperm and to follow standard STD and HIV protocols to avoid transmission of disease (Luce 50).

Prevention

How are women, regardless of sexual orientation, taught to protect themselves against sexual risks? Pregnancy prevention is generally viewed as the primary concern for sexually active women and sex is viewed in the context of child-bearing. Birth control pills and condoms (both male and female condoms) are often treated as the catch-all for women's sexual health safety. This is acceptable if the patient is having sex with men exclusively. Women who have sex with women need more prevention education, though, and there are several known methods for preventing woman to woman HIV transmission.

Women who have sex with women should use condoms with sex toys and should change the condom for each partner. Toys should also be washed after each use. For oral sex, it is advisable to use either a dental dam or non-microwavable plastic wrap (the pores in microwavable plastic wrap are large enough to allow transmission of HIV). Some women cut condoms down the middle to act as a barrier (Marrazzo).

Another prevention technique is to use finger cots or latex gloves for digital sex. Women should not have oral sex during menstruation because menstrual blood is a potential carrier of HIV. Though this case was not proved through virus matching, one woman who had no other risks was diagnosed with HIV in 1997 after performing oral sex during her partner's menstrual period (Arend 41). Women should not brush or floss before engaging in oral sex as it is possible to lacerate the gums leaving an opening for HIV. According to the CDC, anal tissue may be more susceptible to HIV infection because this tissue is more prone to tearing than vaginal tissue. It is especially important to use a barrier method to protect against blood sharing through anal sex play.

It is interesting to note that no barrier method has been created specifically for women who have sex with women. Dental dams were originally designed by dentists to isolate teeth for cleaning, not as a sexual barrier method. Dental dams are also small and many women complain that it is not possible to tell whose fluid is whose. To counter this problem, one couple got creative and stretched a dental dam with an embroidery hoop! Another woman commented that during oral sex, the dental dam was stretched too tightly and it went flying through the air. Obviously, this is not the ideal situation as an airborne dental dam does not exactly "set the mood." In one study, one woman complained

Why can't they make a latex barrier that is big enough for oral sex with women? Why can't it be thin like a condom and packaged like a condom? Why can't it be cheap and easy to find like a condom? It seems like it would be easy. The technology is there. And it wouldn't just be for women who have sex with women. Straight women need this kind of barrier, too (Stevens 350).

Dental dams are also expensive, ranging from fifty cents to three dollars each. However, dental dams are becoming more readily available, which is a positive step for safer sex for women who have sex with women.

There are many possible reasons for why there are no barriers specifically designed for women who have sex with women. There is still the belief that woman-to-woman transmission is not possible so a barrier method is not necessary. This is not accurate but is still a dominant idea. The lesbian community is also relatively small with about 2.3 million American women identifying as lesbian. This is a small percentage when considering the population of the United States is about 300 million (CDC HIV/AIDS and U.S. Women). There is also a lack of demand for dental dams in the heterosexual community so there is no push to make dental dams readily available.

More importantly, though, is the fact that there is not much of a demand amongst women who have sex with women for safer sex. Many women view dental dams as unnecessary, unsexy and cumbersome. In one study, 56% of the sample told researchers, “that when they had sex with women it was done without using barriers. Reported activities included unprotected oral, vaginal, and anal sex with women and sharing uncovered dildos and sex toys” (Stevens 350). Many of these women simply did not know where to get the facts on safer sex and many were afraid to ask questions of their physicians.

Being tested for HIV is critical for practicing safer sex because knowing a positive status means knowing precautionary methods are necessary. Of course, a woman knowing her status does not mean she will disclose that information to her partner. But, the greater problem seems to be that women do not know their status. Unfortunately, the fear itself of being HIV positive keeps many women from being tested. However, women appear to know that having multiple partners increases risk. One study found that “college education and race were not significantly associated with

the probability of having had an HIV test but having had multiple partners in the past year was associated with a 65% increased chance of having had an HIV test (Morrow and Allsworth 161).”

Coping

How do lesbians who are HIV positive experience HIV/AIDS? Lesbians who are HIV positive cope with their disease in different ways as demonstrated by sixteen WSW who were interviewed in a study from 2003. The study found that the women fell along a “spectrum of coping which ranged from the most physically and emotionally impoverished women to the most healthy, self-confident women who were motivated to take care of themselves and others suffering from stigmas against HIV and lesbian identity (Arend, 41).” The coping process began for most of these women when they were able to change destructive lifestyles and behavior. It was a conscious decision to improve the quality of life. But, women who had basic needs, such as a roof over their head and the necessary medication, were able to cope better with the disease than the women who did not have those needs met. This implies that lower class women may have the most trouble coping as they are the least likely to be able to meet basic needs.

Women who were open about their sexual orientation with friends, family and doctors were better suited to cope with HIV than those women who were not. The most successful copers were the women who sought and utilized health care and social services. These women also, “utilized the highest number of physical and emotional support networks, which in turn cultivated greater desire and motivation to increase their level of disclosure and utilize more support networks to the greatest possible degree”

(Arend 44). Lesbians who found adequate sources of support, emotional and physical, were more confident in their ability to fight the disease.

Conclusion and Implications for the Future

Although lesbians are a small population who do not contract HIV at high rates, HIV has impacted this community. Lesbians have fought for recognition of gay men, lesbians, and women in general, so why has this population been so invisible in the medical and public health communities? The answer lies in the intersectionality of oppression. It appears that lesbians who are injection drug users, have sex with men, are lower class or are women of color are the most likely to be left out of receiving information on HIV.

Lesbians face several forms of discrimination that lead to marginalization. Lesbians cross all ethnic, cultural and racial lines; thus some lesbians experience racism, xenophobia and ageism. Due to fear of homophobic reactions, lesbians may not describe a full range of their sexual behavior to physicians and that information is then not included in medical studies. The government also does not track or study lesbians as in depth as other subgroups (Hollibaugh 193). Until lesbians are included in more studies and viewed as an HIV affected population, the cycle of invisibility will continue.

To stop the spread of HIV, several changes should be made. For example, the medical community should continue to adopt neutral terms like partner when asking patients about sexual behavior. In order to dispel myths and assumptions, physicians and nurses should also ask about sexual behavior and not sexual orientation. Many lesbians who are HIV positive contracted the disease through injection drug use. Perhaps more needle exchange programs should be implemented in areas known for drug abuse and

prisons. Studies have shown that needle exchange programs do not increase drug use but do help to decrease the transmission of disease (Heines). More intensive HIV/AIDS awareness programs should be incorporated into school systems. The curriculum should include safer sex methods for women who have sex with women.

The lesbian community is a small group that has influenced how HIV is seen by the public and the medical community. Lesbians have worked to be included in HIV studies, dispel homophobic myths and gain recognition as contributors to AIDS activism. Though the lesbian community has been important to fully understanding HIV/AIDS, lesbians are still an invisible population in HIV/AIDS research. It is likely that it will fall to lesbians themselves to continue to make changes in how HIV/AIDS is understood because small groups must fight for recognition and acceptance.

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