

Barriers:
An Analysis of the Use of Safer Sex
Methods in the Queer Community

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Introduction

A generation of queer women is coming of age right now that has never known the world without HIV and AIDS. These women have grown up knowing how to use a condom, the importance of being tested for sexually transmitted infections, what it is like to get tested for HIV, and who provides testing for free.

Unfortunately, they were not raised to know where to go for dental dams or with the awareness that women can transmit infections to each other.

Two summers ago, I had conversations about safer sex with queer women in several different West coast cities. I found that women I knew in one area (the San

Francisco Bay Area) were using latex barrier methods with nearly all of their casual partners. Women I knew in other cities (Olympia and Seattle, Washington) were not. I tried to find published research to explain this phenomenon. I asked other sex educators, people who taught me everything I know, people who should have all the answers, but the answers just did not exist.

I want to know whether women who have sex with women are using barrier methods with their female partners. I want to know why they are and why they are not. I want to know if they make different decisions in different circumstances and, if they do, I want to know why. Since I cannot find the answer to my questions in the existing literature, I will use this project to create it.

Literature Review

When I was at a bar recently, a straight man struck up a conversation with me. We chatted while in line to purchase drinks. As I turned to go back to my table, he asked me if he could sit with my friends and me to continue talking. I said he was welcome to and explained that I was queer in case his interest was not purely conversational. He was struck by my use of the word “queer”, and once at my table barraged me with questions regarding that and my sexuality in general. In the course of conversation, my thesis project came up. I told him that I was researching whether and why queer biologically female-bodied folk practice safer sex. He was surprised. He did not understand why we would need to use barrier methods. A victim of the same cultural myth that prevents so many queer women from practicing safer sex, he did not believe that women could transmit infection to one another.

Queer¹ women's sexual health has been a much-evaded topic in mainstream and professional literature for some time. Only within the past five years has it become an area of interest to researchers. Prior to that, academia referenced WSW² sexual health only long enough to state that, due to assumptions about female sexuality and sexual practices, WSW were at negligible risk for sexually transmitted infections and should not waste resources by getting tested or having annual pap smears. The use of barrier methods was treated as something of a joke. Current medical research is indicating, however, that these assumptions are false at best and dangerous to queer women at worst.

Women who have sex with women (WSW) have been viewed traditionally as a low- to no-risk category for the transmission of most common sexually transmitted infections (STI)³. However, several studies have shown, alarmingly, that WSW are more likely than their heterosexual counterparts to engage in a multitude of high-risk sexual behaviors. In one 1995 study, behaviorally bisexual women in New York were found to be infected with HIV in higher numbers than matched heterosexual or homosexual women due to a host of risk factors ranging from injecting drugs and using crack cocaine to having sex for crack⁴.

Women who have sex with women are also much more likely to engage in such high-risk behaviors as intercourse (protected and unprotected) with gay and bisexual men, as well as with HIV positive and injection drug using (IDU) men. Even women who

¹ The word "queer" has a long and negative history. It does, however, have the benefit of addressing gays, lesbians, bi- and pansexuals, transgender folk, etc. in one fell swoop. I will therefore be using it throughout this paper.

² WSW is an acronym for "women who have sex with women" and is the most commonly accepted way to refer to biologically female-bodied persons who engage in sexual activities with same. I will be using this term out of ease but not without knowledge of its inherent complications and limitations.

³ Marrazzo, J.M., Stine, K., Koutsky, L. (2000). Genital human papillomavirus infection in women who have sex with women: A review. *American Journal of Obstetrics and Gynecology* (183) 3, 770-774.

⁴ Bevier, P.J., Chiasson, M.A., Heffernan, R.T., & Castro, K.G. (1995). Women at a sexually transmitted disease clinic who reported same-sex contact: their HIV seroprevalence and risk behaviors. *American Journal of Public Health*, (85), 1366-1371.

claim exclusive homosexuality are more likely than heterosexual women to have sex with men in these high-risk categories^{5,6,7,8}.

In the 1993 National Lesbian Healthcare survey⁹, fewer than one quarter of the women surveyed expressed concern about contracting STIs and only 18% reported being tested on a regular basis. This is of great concern considering that 21% of all respondents had been diagnosed with a sexually transmitted infection at some point¹⁰.

In a 2001 study, 13% of participants (n=39) reported never having had sexual contact with a man. Of these 39 women, only 4 reported being tested for STIs regularly. As other studies have shown that there is a definite risk of female-to-female transmission, the discrepancy between the numbers of sexually active women and those being tested for STIs alludes to the possibility of undiagnosed infections¹¹.

In the Lesbian Sex Project conducted in Atlanta, Dolan and Davis found that WSW were engaging in extremely high-risk behaviors without using barrier methods. Participants in this study were engaging in activities such as fisting, a somewhat forceful act that can lead to tears on the walls of the vagina. They were also engaging in oral-anal contact, or “rimming,” an activity that carries an exceptionally high risk for hepatitis exposure. Perhaps most alarmingly, participants were giving oral sex to their

⁵ Fethers, Katherine; Marks, C., Mindel, A., Estcourt, C. (2000). Sexually Transmitted infections and risk behaviours in women who have sex with women. *Sexually Transmitted Infections*, (76), 345-349

⁶ Hughs, C., & Evans, A. (2003). Health Needs of Women who have sex with Women. *British Medical Journal*, (327), 939-940.

⁷ Marrazzo, J.M., Koutsky, L.A., Handsfield, H.H. (2001). Characteristics of Female Sexually Transmitted Disease Clients who Report Same Sex Behaviour. *International Journal of STD & AIDS*, (12), 41-46.

⁸ Marrazzo, J.M., Stine, K., Koutsky, L. (2000) Genital human papillomavirus infection in women who have sex with women: A review. *American Journal of Obstetrics and Gynecology*, (183), 770-774.

⁹ As cited in Bauer, G.R., Welles, S.L. (2001). Beyond Assumptions of Negligible Risk: Sexually Transmitted Diseases and Women Who Have Sex With Women. *American Journal of Public Health*, 91, 1282-1286.

¹⁰ Ibid.

¹¹ Ibid.

menstruating partners, an activity that entails direct blood-mucous membrane contact—a classic avenue for HIV transmission¹².

The failure to use safer sex practices does not mean that WSW are natural risk takers or are masochistic. The problem lies in the ways WSW conceptualize risk.

In their study, Dolan and Davis consider three theoretical frameworks to explain why WSW engage in these known high-risk behaviors. The first theoretical framework is termed “Essentially Invulnerable.” Women placed in this framework believe that lesbians cannot or do not transmit infections to one another; one woman mentioned that this was one of the “perks” of being a lesbian. This assumption is sometimes very wrong.

Another woman remarked, “People never ask [about STIs]. Because I run, I think they assume that I am healthy and that I don’t do drugs. They assume if you look healthy, you don’t do anything unhealthy.” This participant is addicted to crack cocaine.

The second category is called “Socially Inoculated” and refers to several fallacies that are perpetuated in the WSW community. One myth is that it is possible to intuit or detect whether a potential partner is infected. Another myth is that women are inherently trustworthy (and therefore clean). Along with inherent trust comes the idea that “honesty and communication ward off infection.”¹³

The third framework is “Fundamentally Vulnerable.” Those categorized as such feel that the risk of STIs is real and that due caution is necessary. Many of the women who fall into this category are or have been safer sex educators, have friends with HIV or have contracted a STI themselves. According to this frame, WSW, like any other sexually

¹² Dolan, K., Davis, P. (2003). Nuances and shifts in lesbian women’s constructions of STI and HIV vulnerability. *Social Science & Medicine*, (57), 25-38.

¹³ Dolan and Davis, 2003, p.32

active population, should practice safer sex; accordingly, women in Dolan and Davis' study who ascribed to the values of "fundamental vulnerability" were more likely to practice safer sex with their partners.

WSW *are* vulnerable to infection. The Institute of Medicine's assessment of lesbian health¹⁴ concedes that WSW (whether they identify as lesbian or bisexual) may have a higher seroprevalence of HIV than exclusively heterosexual women. Marrazzo analyzed with the prevalence of various sexually transmitted infections in WSW. In her study of 2,392 subjects, she found that 8% carried herpes simplex virus-2 (HSV-2), the type most commonly found genitally. A further 46% carried herpes simplex virus – 1 (HSV-1), the type that more commonly appears in the form of "cold sores." Bacterial vaginosis occurred in over 50% of WSW^{15,16}. Bacterial vaginosis is associated with pelvic inflammatory disease, which can lead to sterility, and has been associated with adverse pregnancy outcomes¹⁷.

Fethers et al.¹⁸ studied 1,402 WSW (matched with a control group of 1,423 exclusively heterosexual women) in Sydney, Australia. Among WSW in this study, bacterial vaginosis, previous STI diagnosis, and seropositivity for hepatitis B and C were more common than in the control group. Gonorrhea, chlamydia and HIV were found to be equally prevalent in the two groups. WSW were less likely than exclusively heterosexual women to contract genital warts, however.

¹⁴ Institute of Medicine. *Lesbian Health: Current assessment and directions for the future*. Washington DC: National Academy Press, 1999.

¹⁵ Hughs, C., & Evans, A. (2003). Health Needs of Women who have sex with Women. *British Medical Journal*, (327), 939-940.

¹⁶ Marrazzo, J.M. (2000). Sexually transmitted infections in Women who have Sex with Women: Who Cares? *Sexually Transmitted Infections*, (76), 330-332..

¹⁷ Marrazzo, J.M., Stine, K., Koutsky, L. (2000) Genital human papillomavirus infection in women who have sex with women: A review. *American Journal of Obstetrics and Gynecology*, (183), 770-774.

¹⁸ Fethers, Katherine; Marks, C., Mindel, A., Estcourt, C. (2000). Sexually Transmitted infections and risk behaviours in women who have sex with women. *Sexually Transmitted Infections*, (76), 345-349.

In summary, WSW are actually *more* likely than other female populations to engage in high-risk behaviors. WSW are contracting most STIs in equal or greater numbers than exclusively heterosexual populations of women. And, WSW do not have an accurate conceptualization of risk factors. They are not getting tested for common STIs at recommended intervals and they are not using barrier methods with casual partners¹⁹.

Hypotheses

1. WSW who have had education on safer sex practices are more likely to practice safer sex than women without such education.
2. WSW who have had safer sex education that directly addressed the risks to WSW will be more likely to practice safer sex than women whose training did not include such specific information.
3. WSW living in urban setting are more likely to have access to safer sex education.
4. WSW in urban areas are more likely than those from smaller geographic centers to practice safer sex.

¹⁹ Marrazzo, J.M., Stine, K., Koutsky, L. (2000) Genital human papillomavirus infection in women who have sex with women: A review. *American Journal of Obstetrics and Gynecology*, (183), 770-774.

Methods

Biologically female-bodied people who had a history of sexual activity with other biologically female-bodied people and were at least 18 years of age were recruited for this study by means of a recruitment script (see Appendix A) posted on two popular websites, LiveJournal (<http://www.livejournal.com>) and Friendster (<http://www.friendster.com>). On LiveJournal, the recruitment script was posted in my personal online journal. People who read the journal and script were asked to forward the information to other interested parties. On Friendster, I utilized the site's bulletin board feature. The bulletin board allows users to post a message that will then be visible to all other users affiliated with the posting user. Again, I requested that the recruitment script be forwarded. At least two other Friendster users (neither of whom lives in the Seattle area) re-posted my script to their own bulletin boards, thus expanding the field of Friendster users who would potentially see the notice. I also solicited a relatively small number of subjects through direct word-of-mouth. A notice of the study was also sent out

on Ewomen, an email list for people affiliated with or interested in the Women Studies department at the UW.

I believe that the final demographics of my participants were heavily influenced by the methods I utilized to recruit subjects. Users of websites such as LiveJournal and Friendster tend to be young, urban, and have ready access to the Internet.

Prospective participants were directed to an online consent form (Appendix B). After reading the consent form, prospective respondents chose whether or not to continue on to the survey. Those who chose to continue were asked to complete a 23-item questionnaire online through the Catalyst system's WebQ (Appendix C). The questionnaire could only be accessed through the web-based consent form, the URL for which was given out via the recruitment script. The WebQ survey was totally anonymous; I had no way of ascertaining the identity of any respondent.

The survey was opened on 23 March 2004 and stayed open until 29 April 2004.

Data Analysis

Demographics

There were 92 respondents to this survey, ranging in age from 18 to 43 years (mean age = 22.5 yrs.). Most respondents were relatively well-educated; 19% have a graduate degree or have attended graduate school. A further 16% have a four-year degree and 44% have some college experience but have not earned a four-year degree. Only 13% had a high-school diploma or less education.

Most (60%) live in urban areas with populations above 500,000. An additional 16% live in areas with populations between 250,000 and 500,000. The remaining 25% live in smaller communities; 7% in areas with populations between 100,000 and 250,000, 9% in communities of 30,000 to 100,000 and 9% in very small communities of under 30,000 people.

Forty-one percent of all respondents self-identified as queer (n=38) and 36% as lesbian (n=33). Six respondents identified as bisexual, two as straight, and one as trans. Twelve chose “other” as their response. These respondents qualified the choice as follows:

- “I can’t see myself with a man in the future but who knows what the future holds. I don’t find myself attracted to men.”
- “I live in SF so it’s not so cut/dry...i’m a dyke...but also gender queer.”
- “dyke with a FTM partner”
- “i am what i am”
- “open minded”
- “pansexual (there are more than two genders, I don’t identify with “bi”sexual)”
- “queer and trans” (two respondents)
- “queer trans fag”
- “queer/bi-dyke”
- “queer/trans”

Of the 41 subjects who self-identified as lesbian, bisexual, or straight, fewer than half (n=19) lived in urban areas with populations of more than 500,000 people; in fact, none of the straight-identified respondents and only one third of the bisexual respondents lived in large urban areas. Of the 38 subjects who self-identified as queer, almost 70% (n=26) lived in the largest urban areas.

Safer Sex Education

Ninety-two percent of respondents had been exposed to some sort of formal safer sex education in their lives. Not surprisingly, however, the proportion of respondents who had safer sex education specifically targeting WSW was much lower: only 53%. Age, however, was not a determining factor for participants’ exposure to safer sex education

targeting WSW. The participants reporting exposure to safer sex education specifically targeting WSW were distributed evenly throughout the age range reported.

Subjects reporting exposure to safer sex education specifically targeting WSW (n=43; 47% of all subjects) reported more frequent use of safer sex methods with every partner. Of those with WSW-specific safer sex education, nearly two-thirds report using safer sex methods “sometimes” “often” or “always”. For those lacking WSW-specific safer sex education (n=49; 53% of all subjects), reports of similarly frequent usage dropped to 49%.

Several respondents spoke directly about their lack of education regarding relevant safer sex techniques. One respondent noted, “I’ve never been given complete information on how to practice safer lesbian sex or when it is needed.” Another wrote, “I also feel that female on female sex, while knowing it is risky, is not as risky as female-male or male-male sex...though I feel I have never been properly educated to back up this belief.” Still other respondents wrote that the risks of unprotected sex between women do not feel “real and pressing” in the heat of the moment or that they are “not sure how important” safer sex really is in their sexual relationships with other female-bodied partners.

These statements combined with the relationship between WSW-specific safer sex education and implementation of safer sex practices show that population-specific safer sex education is crucial for women who have sex with women.

Testing and Conceptualizations of Risk

“But the other thing that I think effects it is that everyone says lesbians are the lowest risk group, etc...although I know it's not a rule, and the statistics can change at any time, but I guess I think about it less than I should.”²⁰ (respondent comment)

Respondents having exposure to safer sex education targeting women who have sex with women were slightly more likely to have been tested for sexually transmitted infections (STIs). Seventy-four percent of respondents who had been exposed to WSW-specific safer sex education had been tested for STIs at least once. Of the 49 subjects who were never exposed to WSW-specific safer sex education, only 61% had ever been tested for STIs.

The likelihood that a respondent had ever been tested for sexually transmitted infections also increased with the number of biologically female-bodied sexual partners. Of the respondents reporting five or fewer female-bodied partners (n=46), nearly half (n=21) reported never having been tested for a sexually transmitted infection. That number decreased to 26% among those reporting 6-10 sexual partners and 20% among those with 11-15. Of respondents reporting 16 or more past female-bodied sexual partners (n=13), only one had never been tested for any STI. There was no apparent relationship between the respondent's age and the number of female-bodied sexual partners reported. Of the 26 respondents in the 18-21 age category, 42% (n=11) reported having had genital contact with between two and five biologically female-bodied partners. A similar percentage of respondents aged 22-24 reported having had the same number of sexual partners. The only respondents who were likely to have had more than five female-bodied sexual partners were those identifying as being between the ages of

²⁰ sic.

25 and 30. Seventy-two percent (n=8) reported six or more biologically female-bodied sexual partners.

There is a serious disconnect between participants' conceptualizations of the risks of lesbian sexual behavior and the importance of practicing safer sex, and their actual use of safer sex behaviors. Seventy-five percent of participants identified the health risks of unprotected sex between female-bodied partners as being "moderate" "high" or "very high" (n=69). Ninety percent of respondents (n=83) claim that it is either "somewhat" or "very" important personally for them to practice safer sex. However, nearly three quarters (n=66) have only practiced safer sex with "a few" or even "none" of their reported sexual partners.

Reasons to Practice Safer Sex

"I dated a girl with Genital Warts²¹. She told me before we had sex and I realized that she could have kept it a secret. Now I use safer sex every time." (Respondent comment)

Respondents were asked, "What factors cause you to practice safer sex?" Of the 92 survey respondents, 13 did not respond to this question and ten responded that they do not practice safer sex. For the remaining 71 respondents, STI prevention (n=20) and lack of familiarity with one's partner (n=20) tied as the top reason to practice safer sex. Twelve respondents cited a confirmed STI in either the respondent or her partner as a reason to practice safer sex. Familiarity with one's partner was the third most frequently

²¹ sic.

cited reason for not practicing safer sex, edging out “intoxication” by just three votes and lagging a scant four votes behind “being tested for STIs”

The following list notes the reasons respondents cited for using safer sex methods. The number in parenthesis indicates the number of respondents who endorsed that reason.

- Lack of familiarity with partner (20)
- STI prevention (20)
- Partner/self has STI (12)
- Non-monogamy (8)
- Partner/self not tested (6)
- Using sex toys (6)
- General health (6)
- Engaging in high-risk behaviors (4)
- Partner request (4)
- New partner (4)
- Proximity of safer sex supplies (2)
- Novelty (2)
- Easier clean-up (2)
- Having sex with biological men (2)
- Respect for self or partner (2)
- Menstruating partner (1)
- Personal values (1)
- Safer sex is sexy (1)

- Partner has sex with biological men (1)
- Partner is drug user (1)
- Sobriety (1)
- Engaging in sex work (1)
- Sanitation (1)

Reasons to Not Practice Safer Sex

“I have been in a committed relationship for over a year now, and have grown up a lot in the process, but in my hayday a drunken stupor and being overly trusting has contributed to a lack of diligent safe sex.”²² (Respondent comment)

The most oft-cited reason for not practicing safer sex was monogamy or being fluid-bonded with one’s partner. Not all subjects reported being tested with this partner, however; in fact, nearly a third did not. Familiarity with one’s partner was the third most frequently cited reason for not practicing safer sex, edging out “intoxication” by just three votes and lagging a scant four votes behind “being tested for STIs”

The following were cited by respondents as reasons for not practicing safer sex:

- Monogamy/Fluid bonding (29)
- Partner/Self tested (20)
- Familiarity with partner (16)
- Intoxication (13)
- Low perception of risk (12)
- Inconvenience (11)

²² sic.

- Lack of materials (10)
- Barriers impair sensation (8)
- Subject does not like available methods (7)
- Heat of the moment (6)
- Partner does not want to (5)
- Not comfortable requesting use (4)
- Lack of education regarding use of safer sex methods (3)
- Partner's virginity precludes need (3)
- Love (1)
- Never thought to (1)

Types of Safer Sex Behaviors

Sixty-five percent of subjects report having used gloves as a barrier method (n=41) and both dental dam-style barrier methods for oral-vaginal sex and condoms for sex toys have been used by 57% of respondents.

Unfortunately, 16% of respondents rely on communication as a safer sex method, even though communication offers no technical protection whatsoever against sexually transmitted infections. While more than one-third (36%) report using monogamy or fluid bonding as an excuse to not practice safer sex, only three (5%) identified these behaviors as safer sex methods.

Ironically, not one respondent cited familiarity as a safer sex method, though between twenty and thirty percent stand behind it (or a lack thereof) when questioned about why they do and do not practice safer sex.

The following methods of safer sex were utilized by respondents:

- Gloves (41)
- Dental dams or saran wrap (36)
- Condoms on sex toys (36)
- None (15)
- Not sharing toys (14)
- Communication (10)
- Getting tested (10)
- Sanitizing toys (8)
- Engaging in no-risk behaviors (5)
- Abstention from oral sex (4)
- Fluid bonding or monogamy (3)
- Abstention in absence of fluid bonding or monogamy (3)
- Abstinence from all sexual behavior (2)
- Consent (2)
- Finger cots (2)
- Lube (2)
- Abstention when STI present (1)
- Purchasing only toys that can be sterilized (1)

Behaviors Engaged in Without Protection

Subjects report willingness to engage in the following specific activities without the use of a barrier or other safer sex method²³:

- Mutual masturbation or other manual/vaginal activity (34)
- Oral Sex (24)
- Anything²⁴ (17)
- Kissing (16)
- Using or sharing sex toys (11)
- Tribadism, frottage, rubbing, hugging, fondling over clothing, etc. (10)
- Anything with a monogamous or fluid bonded partner (4)
- Varies from partner to partner (3)
- Anal sex (2)
- Fisting (2)
- Will not engage in any behavior without a safer sex method (2)
- Rimming/oral-anal contact (1)

²³ Most subjects listed several behaviors they would engage in without the use of a barrier method, therefore, the numbers listed will not add up to 92. Twelve subjects did not respond to this question.

²⁴ Several respondents qualified “anything” by indicating “anything but anal sex” or “anything but oral-anal”; however, no other behavior was qualified by any respondent.

Discussion

Several findings from this survey are of great interest to me. First, I am interested in the role culturally specific safer sex education seems to play in influencing both STI testing prevalence and frequency of barrier method usage. The relationship suggests that formal safer sex education is an important motivator for the use of safer sex methods. I would like to see further research analyzing why WSW who have accessed culturally specific safer sex education are more likely to practice safer sex. I would be especially interested in knowing what information is imparted by safer sex education but is not common knowledge in WSW communities. In light of the divergent behaviors indicated by participants with and without WSW-specific safer sex education, culturally specific safer sex education does impart knowledge that does not otherwise exist in WSW communities.

Also of concern to me are the conceptualizations of what constitutes “risky” sexual behavior. I am intrigued and alarmed by respondents who do not, for example, characterize unprotected oral sex with a menstruating partner as risky. Further study could potentially prove that culturally specific safer sex education provides essential information about the inherent risks of sexual behaviors that may be considered irrelevant or deviant by heteronormative safer sex education .

Limitations

The biggest limitation of this study is the homogeneity of the sample. The facts that I solicited the majority of my primary respondents through personal contacts and through youth-oriented websites and relied heavily upon “snowballing” are possible explanations for the demographics of my sample, namely that a majority of participants were young, educated, and lived in urban areas. The number of people who took the survey is also a limitation. Ninety-two respondents is just not an adequate sample; the responses of 92 people who are demographically homogenous just cannot be generalized.

Conclusion

Conceptualizations of the risks of sexual contact were appropriate among respondents as was the desire to practice safer sex. Lacking, however, were the tools necessary to implement safer sex behaviors: appropriate education and access to barrier methods.

Culturally relevant safer sex education would aid in dispelling myths of invincibility or decreased risk of STI transmission between WSW. It would also familiarize WSW with where to obtain and how to use barrier methods such as dental dams and latex gloves.

Further research should be done to devise, implement and disseminate culturally specific safer sex education curricula for queer women's communities

References

- Bauer, G.R., Welles, S.L. (2001). Beyond Assumptions of Negligible Risk: Sexually Transmitted Diseases and Women Who Have Sex With Women. *American Journal of Public Health, 91*,1282-1286.
- Bevier, P.J., Chiasson, M.A., Heffernan, R.T., & Castro, K.G. (1995). Women at a sexually transmitted disease clinic who reported same-sex contact: their HIV seroprevalence and risk behaviors. *American Journal of Public Health, (85)*, 1366-1371.
- Dolan, K., Davis, P. (2003). Nuances and shifts in lesbian women's constructions of STI and HIV vulnerability. *Social Science & Medicine, (57)*, 25-38.
- Fethers, Katherine; Marks, C., Mindel, A., Estcourt, C. (2000). Sexually Transmitted infections and risk behaviours in women who have sex with women. *Sexually Transmitted Infections, (76)*, 345-349,
- Hughs, C., & Evans, A. (2003). Health Needs of Women who have sex with Women. *British Medical Journal, (327)*, 939-940.
- Institute of Medicine. *Lesbian Health: Current assessment and directions for the future*. Washington DC: National Academy Press, 1999.
- Marrazzo JM, Koutsky LA, Stine K, Kuypers J, Grubert T, Galloway D, Kiviat N, Handsfield HH. (1998). Genital HPV Infection in Women Who Have Sex With Women. *Journal of Infectious Disease, (178)*, 1604-1609.
- Marrazzo, J.M. (2000). Sexually transmitted infections in Women who have Sex with Women: Who Cares? *Sexually Transmitted Infections, (76)*, 330-332.

- Marrazzo, J.M., Stine, K., Koutsky, L. (2000) Genital human papillomavirus infection in women who have sex with women: A review. *American Journal of Obstetrics and Gynecology*, (183), 770-774.
- Marrazzo, J.M., Koutsky, L.A., Handsfield, H.H. (2001). Characteristics of Female Sexually Transmitted Disease Clients who Report Same Sex Behaviour. *International Journal of STD & AIDS*, (12), 41-46.
- Marrazzo, J.M., Koutsky, L.A., Eschenbach, D.A., Agnew, K., Stine, K., Hillier, S.L. (2002). Characteristics of Vaginal Flora and Bacterial Vaginosis in Women Who Have Sex with Women. *Journal of Infectious Diseases*, (185), 1307-1313.
- Marrazzo, J.M., Stine, K., Wald, A. (2003). Prevalence and risk factors for infection with herpes simplex virus type-1 and -2 among lesbians. *Sexually Transmitted Diseases*, (12), 890-5.
- McCaffrey, M., Varney, P., Evans, B., and Taylor-Robinson, D. (1999). Bacterial vaginosis in lesbians: evidence for lack of sexual transmission. *International Journal of STDs and AIDS*, (10), 305-308.
- Myer, L. (1997). "Lesbians and HIV/AIDS: The clean and the free?" [Electronic version] Master's thesis, Department of Social Work, University of Nevada, Reno, NV.

Appendix A

Recruitment Script for Electronic Mail

I am a senior in the Women Studies Department at the University of Washington conducting my senior thesis on the use of safer sex practices by women who have sex with women. I am looking for women over the age of 18 who have sex with other women. If you or someone you know fits this description and would like to take a survey for this project, please go to <http://students.washington.edu/angelina/consent.html>

If you have questions about this project, please email me at angelina@u.washington.edu or through an anonymous email system called Umail at

<http://catalyst.washington.edu/webtools2/umail/index.cgi?owner=angelina&id=1290>

Thank you for your time.

Angelina Allen

Appendix B

(Found online at

<http://students.washington.edu/angelina/consent.html>)

Researcher: Angelina Allen, UW Women Studies. 206.726.6567

UNIVERSITY OF WASHINGTON CONSENT FORM

Women's Safer Sex Survey

RESEARCHER'S STATEMENT

I am a senior in the Women Studies Department at the University of Washington conducting my senior thesis on the use of safer sex practices by women who have sex with women. I am looking for women over the age of 18 who have had genital contact with other women. If you fit these criteria please continue on.

We are asking you to be in a research study. The purpose of this consent form is to give you the information you will need to help you decide whether to be in the study or not. Please read the form carefully. You may ask questions about the purpose of the research, what we would ask you to do, the possible risks and benefits, your rights as a volunteer, and anything else about the research or this form that is not clear. Questions can be asked before you begin the survey through anonymous e-mail contact with the investigator. See below for details on how to do this. When we have answered all your questions, you can decide if you want to be in the study or not. This process is called 'informed consent.'

PURPOSE AND BENEFITS

The purpose of this study is to examine why women who have sex with women choose to have safer sex with their female partners. There will be no direct benefit to anyone who takes part in this survey.

PROCEDURES

This study involves a 23-question online survey. The survey should take about 15 minutes to complete. The survey will ask you questions such as, "How many female-bodied partners have you had genital contact with in your lifetime?" You may refuse to answer any question at any time. This survey is voluntary and your results will be anonymous.

RISKS, STRESS, OR DISCOMFORT

Many questions in this survey are of a personal nature. You may be uncomfortable answering some of the questions. You may refuse to answer any question at any time. If you have a problem with a question asked in this survey, please feel free to contact the researcher. Participation in this survey is entirely

voluntary. The survey asks for no information that can be used to identify you and all responses are totally anonymous.

OTHER INFORMATION

Participation in this survey is voluntary and all of the results will be anonymous. The researcher will have no way of identifying participants.

If you have any questions about this survey, please contact Angelina Allen at 206.726.6567 or at angelina@u.washington.edu. If you wish to ask a question anonymously, please use [UMail](#), an anonymous electronic mail service. If you choose to utilize UMail, the answer to any question you submit will be posted on [this website](#).

Subject's Statement

This study has been explained to me. I volunteer to take part in this research. I have had a chance to ask questions. If I have questions later about the research, I can ask the researcher listed above. If I have questions about my rights as a research subject, I can call the Human Subjects Division at (206) 543-0098.

[I accept](#) (Links to the survey form)

[I decline](#) (Links to <http://www.washington.edu>)

Safer Sex Survey

Thank you for participating in this study. Please answer questions accurately and to the best of your knowledge. You are free to refuse to answer any question for any reason. If you have any questions about this survey, you may contact Angelina Allen at angelina@u.washington.edu or at (206)719-0279, or by using an anonymous electronic mail form called [UMail](#) before you proceed.

Question 1. How old are you?

Question 2. What level of education have you completed?

Question 3. How many people live in your city or town?

- Under 30,000
- 30,000 to 100,000
- 100,000 to 250,000
- 250,000 to 500,000
- More than 500,000

Question 4. How do you self-identify?

- lesbian
- bisexual
- queer
- straight/heterosexual

- trans
- other (please explain)

Question 5. Have you ever had any formal safer sex education?

- yes
- no

Question 6. Have you had any safer sex education specifically targeting women who have sex with other women?

Question 7. The health risks of unprotected sex between female-bodied partners are:

- very low
- low
- moderate
- high
- very high

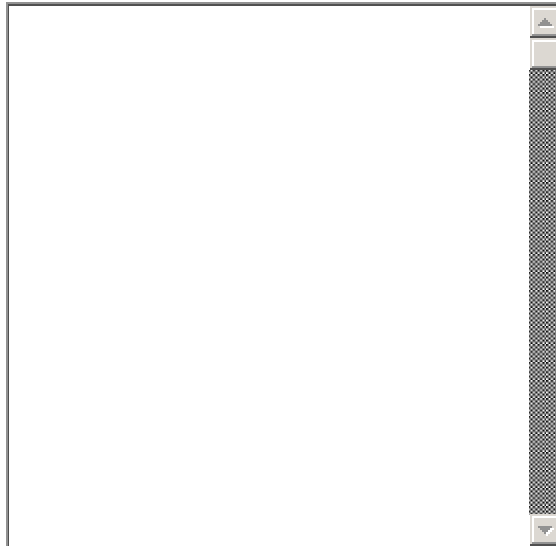
Question 8. Of the following options, which do you consider to be a part of safer sex?

- Using dental dams, saran wrap, or other barrier methods for oral sex
- Using gloves for manual/vaginal activities
- Using condoms on sex toys
- Not sharing sex toys
- Getting tested with a new partner before having

sex

- Other (please explain in question 9)

Question 9. If you answered "other" to question 8, what other activities do you consider to be a part of safer sex?

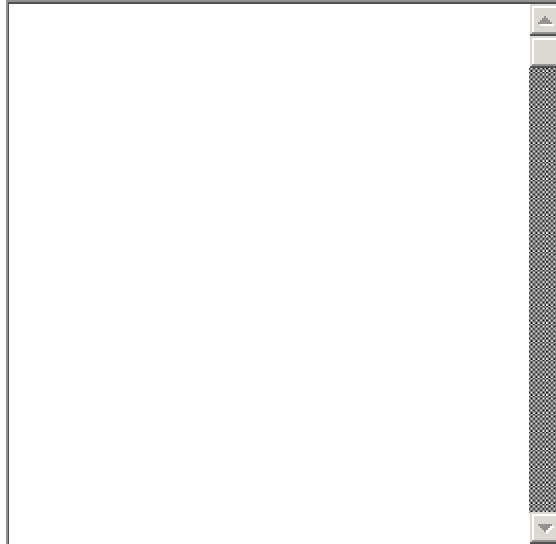


Question 10. How important is it for you personally to practice safer sex?

- not important at all
- somewhat important
- very important

Question 11. Have you ever been tested for a sexually transmitted infection (STI)?

Question 12. If you answered "yes" to question 11, please answer the following three questions. If you answered "no" to question 11, please continue on to question 13. How often are you tested? When were you last tested? Have you ever tested positive for any sexually transmitted infection?



Question 13. How many female-bodied partners have you had genital contact with in your lifetime?

Question 14. Of the partners listed in question 13, with how many did you practice safer sex?

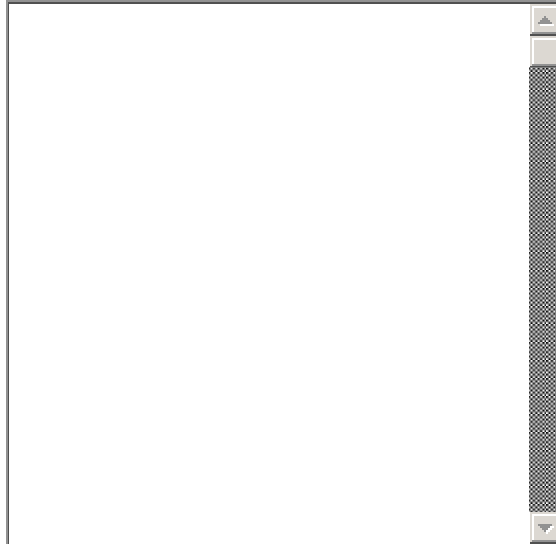
- none
- a few
- a lot
- most
- all

Question 15. How often do you practice safer sex with a given partner? Is it every time you have sex? Never? Somewhere in between?

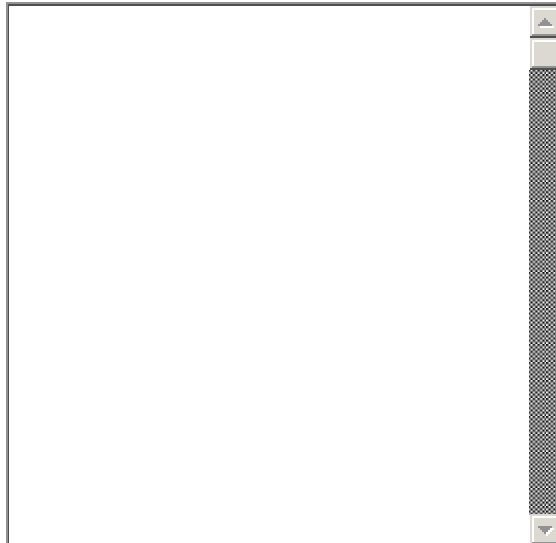
- never
- rarely
- sometimes

- often
- always

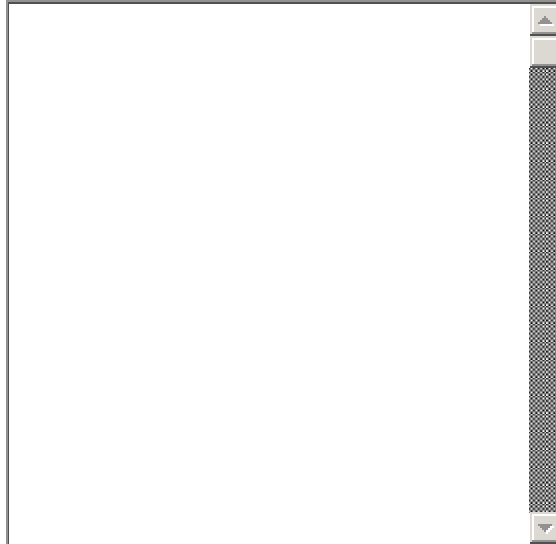
Question 16. What factors cause you to practice safer sex?



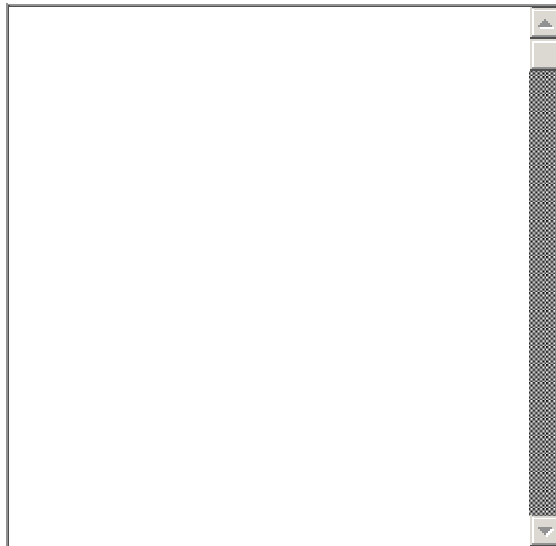
Question 17. What factors cause you to *not* practice safer sex?



Question 18. What safer sex methods have you practiced with female-bodied partners?



Question 19. What behaviors do you or would you engage in without using a safer sex method?



Question 20. Do you discuss safer sex with your friends?

- Never
- Rarely
- Sometimes
- Often

If you answered "yes" to question number 20, please answer the next three questions. If you answered "no" to question number 20, you are finished!

Question 21. Do you and your friends have similar opinions about safer sex?

Question 22. Do your friends' opinions influence your decision to practice or not to practice safer sex?

Question 23. To the best of your knowledge, do your friends practice safer sex?

Thank you for taking this survey. Your help is greatly appreciated. If you have any questions, you may contact Angelina Allen (206)726-6567 or angelina@u.washington.edu