The Trouble With "MSM" and "WSW": Erasure of the Sexual-Minority Person in Public Health Discourse

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Men who have sex with men (*MSM*) and *women who have sex with women* (*WSW*) are purportedly neutral terms commonly used in public health discourse. However, they are problematic because they obscure social dimensions of sexuality; undermine the self-labeling of lesbian, gay, and bisexual people; and do not sufficiently describe variations in sexual behavior.

MSM and *WSW* often imply a lack of lesbian or gay identity and an absence of community, networks, and relationships in which same-gender pairings mean more than merely sexual behavior. Overuse of the terms *MSM* and *WSW* adds to a history of scientific labeling of sexual minorities that reflects, and inadvertently advances, heterosexist notions.

Public health professionals should adopt more nuanced and culturally relevant language in discussing members of sexual-minority groups. (*Am J Public Health*. 2005;95:1144–1149. doi:10. 2105/AJPH.2004.046714)

THE BEHAVIORAL CATEGORY

men who have sex with men has been used in HIV literature since at least 1990. The acronym *MSM*, coined in 1994, signaled the crystallization of a new concept.[1,2] *MSM* and, more recently, *WSW* (women who have sex with women) have since moved beyond the HIV literature to become established in both research and health programming for sexual-minority people. In part because the terms held the promise of reducing AIDS stigma, which has been irrationally attached to gay men and lesbians, we, the authors, helped to promulgate these now-familiar acronyms.[3] But we have become increasingly troubled with the way these terms are used, especially when they displace rather than coincide with information about sexual identity. The 10th anniversary of these terms provides a good occasion to reflect on their meaning, utility, and limitations.

The argument for *MSM* and *WSW* seems to be driven by the convergence of 2 perspectives. The first is an epidemiological perspective: by using identity-free terms, epidemiologists sought to avoid complex social and cultural connotations that, according to a strict biomedical view, have little to do with epidemiological investigation of diseases. Accordingly, *MSM* was introduced to reflect the idea that behaviors, not identities, place individuals at risk for HIV infection, a particularly important distinction given that scientific

and medical experts had initially identified gay identity as a risk for HIV/AIDS, a characterization that stigmatized lesbian, gay, and bisexual (LGB) populations and confounded efforts to prevent HIV infection.[4,5] *WSW* was introduced shortly thereafter, in the context of controversy over the meaning and salience of lesbian identity in terms of HIV-related risk behaviors, including sex with men.

Social construction is the second perspective driving the adoption of *MSM* and *WSW*. Social construction suggests that sexualities (like other social categories) are products of social processes. A central tenet of social construction is that particular sexual practices cannot be interpreted as though they carry fixed meanings. Thus, long before the terms *MSM* and *WSW* appeared, social constructionists challenged the idea that sexualities are categorical and rejected the use of sexual identity terms across different cultural and historical contexts. While the epidemiological perspective aimed to reduce *gay* and *lesbian* to what is thought of as their necessary core—sexual behaviors that place individuals at risk—the social constructionist critique, with its origin in gay and lesbian studies and feminist and queer theory, seeks to do the opposite: it seeks more textured understandings of sexuality that do not assume alignments among identity, behavior, and desire.

Perhaps because of the conflict between these perspec-

tives—or because labels, once unleashed, tend to develop a dynamic of their own—the labels *MSM* and *WSW* have accomplished few if any of the aims that prompted them. Ironically, while *MSM* and *WSW* have succeeded in forcing a conceptual shift in public health from identity-based to behaviorally based notions of sexuality, they have not generated more complex approaches to sexuality. While the behavioral focus is useful in specific contexts, indiscriminate labeling of *MSM* and *WSW* is problematic, as we will argue, on theoretical, political, ethical, and epidemiological grounds. We are concerned that the ubiquitous use of *WSW* and *MSM* (1) undermines the self-determined sexual identity of members of sexual-minority groups, in particular people of color; (2) deflects attention from social dimensions of sexuality that are critical in understanding sexual health; and (3) obscures elements of sexual behavior that are important for public health research and intervention.

There are important differences between *MSM* and *WSW* that we do not enumerate here (e.g., *MSM* is used more frequently). Because more health research is conducted on sexual-minority men than on sexual-minority women, more of our examples are based on the use of *MSM*. Still, we consider both terms because they share some underlying problems and important yet distinct social issues.

WHAT'S IN A NAME?

In their naming practices, scientists reflect the attitudes and constructions of their culture and also advance and promote such attitudes.[6] The history of scientific nomenclature referring to sexual minorities is a good example. Richard von Krafft-Ebing's *Psychopathia Sexualis* introduced the notion of "antipathic sexual instinct," used interchangeably with "homo-sexual instinct" and referred to as "anomaly," "abnormal," "tainted," "neuropathic," "degenerate," "inverted," and "injurious."[7] Later terms, which similarly advanced a disease model, included "sexual psychopaths" and, indeed, "homosexuals."

Sexual-minority people—like other oppressed groups—have fought pitched battles over the right to determine the names by which they will be known in public discourse. As stated by Epstein: "Power inheres in the ability to name . . . what we call ourselves has implications for political practice."[8(p241)] In the 20th century, many sexual-minority men and women fiercely rejected *homosexual* in favor of self-chosen terms such as *homophile*, *gay*, *lesbian*, and more recently *DL* (down low), *two-spirited*, and *transgender*, among others. Even disparaging terms, for example, *queer*, have been reworked, redefined, and reclaimed.

It is important to recognize that people vary in regard to self-identity labels historically and cross-culturally and that, at any time or place, self-identities vary according to gender, culture, social class, ethnicity, and cohort, among other factors.[9–12] Cutting-edge work on identity, such as Crenshaw's theory of intersectionality,[13] challenges the implication that individuals have one central identity and that identities are fixed. In contrast to the notions that identities are hierarchically ordered and that a salient identity could potentially suppress or displace other identities, intersectionality suggests that identities are mutually constitutive. The central tenets of this approach are as follows: (1) no social group is homogenous, (2) people must be located in terms of social structures that capture the power relations implied by those structures, and (3) there are unique, nonadditive effects of identifying with more than one social group.[14] Combined with social construction theory, an intersectional understanding of sexual identity suggests that sexual identities, while incorporating diversity, can be meaningful, powerful forces for group affiliation and political action.[15]

Any term applied generally obscures important distinctions. However, terms such as *sexual minorities* and *gay*, *lesbian*, and *LGBT* (lesbian, gay, bisexual, transgender) have acquired global resonance and political and cultural meanings. The diffusion of these terms has led not to homogenization but to a multiplication of identities, as Western and non-Western categories and practices mix and reconfigure.[16–18] Despite their limitations, there is ample evidence that the terms *gay*, *lesbian*, and *LGBT* are widely used alongside local terms, signifying liberationist ideologies for sexual-minority people in many cultures.[9–11] These terms have been used by such organizations as Amnesty International, Human Rights Watch, and the International Lesbian and Gay Association. The latter is a federation of national and local community-based groups with representatives from 90 countries, "dedicated to achieving equal rights for lesbian, gay, bisexual and transgendered (LGBT) people everywhere."[19]

UNDERMINING SELF-DETERMINED SEXUAL IDENTITIES

Gay men, lesbians, queers, two-spirited people, and men on the DL prefer to use their own identity terms, but many contemporary public health writers prefer the terms *MSM* and *WSW*, ostensibly because these terms avoid assumptions about a singular, misleadingly coherent gay identity. In practice, however, *MSM* and *WSW* often signify not a neutral stance on the question of identity but a decided lack of sexual-minority identity. More important, by implication, *MSM* and *WSW* imply absence of community, social networks, and relationships in which same-gender pairing is shared and supported.

We are also concerned with the ways the terms have been racialized. As historian Allan Berube observed, "In the United States today, the dominant image of the typical gay man is a white man who is financially better off than most everyone else."[20(p234)] Just as gay and lesbian are often coded as "White," *WSW* and *MSM* often implicitly refer to people of color, poor people, or racially and ethnically diverse groups outside the perceived mainstream gay and lesbian communities.

To understand how *MSM* is read, it is important to examine how explicit and implicit boundaries are drawn around the category *gay*. Consider, for example, a passage from Paul Farmer in which he claims that, in recent years, there have been fewer HIV cases than predicted among gay men in the United States, a category he implicitly racializes as White via the contrast with "injection drug users, inner-city people of color, and persons originally from poor countries in sub-Saharan Africa or the Caribbean."[21(p47)] He further excludes *gay* from *poor* and suggests that "males involved in prostitution are almost universally poor, and it may be their poverty, rather than their sexual preference, that puts them at risk of HIV infection. Many men involved in homosexual prostitution, particularly minority adolescents, do not necessarily identify as gay."[21(p47)] With this juxtaposition, Farmer seems to suggest that same-gender behavior among poor men of color (especially youth) is sex work rather than sex for pleasure and is devoid of identity and community; same-gender behavior among White men is read as synonymous with gay identity.

Compare these assumptions with a recent ethnographic report on men at risk for HIV in Dakar, Senegal.[22] While many of these "men who have sex with men" are poor and engage in sex work, the authors found that they have indigenous sexual-minority identities that are differentiated and socially meaningful. Senegalese sexual-minority identities serve as a basis for social organization, including, but not limited to, sexual roles. The authors describe *ibbi* as men who "tend to adopt feminine mannerism[s] and to be less dominant in sexual interactions,"[22(p505)] whereas *yoos* are men who "are generally the insertive partner." They also stress that the categories have "more to do with social identity and status than with sexual practices."[22(p506)] Despite their careful attention to local sexual identities of men in Senegal, the authors referred

to them in the title and elsewhere as "men who have sex with men." With this usage, the rich information on identity is lost, with *MSM* conveying transactional, decontextualized same-gender acts. Ironically, applying *MSM* in this way universalizes a culturally specific phenomenon in much the same way that critics say does the term *gay.*

The same is true of depictions of non-White populations within the United States. For example, Malebranche et al. studied Black men, recruited primarily from Black gay organizations, to assess the impact of a social environment characterized by prejudice on health services provided to these men.[23] In qualitative interviews, the respondents talked about the challenges of being Black and gay men. They reported that conflicts among and displacement from communities are important aspects of their lives. Regarding health services, one respondent poignantly said: "When I go to a physician's office, and when I identify myself as a gay person, part of that is looking for acceptance from them, because I haven't gotten it from my family, you know?"[23(p100)]

In this context, where communities and identities explain the substance of the concerns raised by the article, especially in a qualitative piece that purports to explore meanings, it is important to be vigilant in regard to named identities and communities. Yet, here too the authors referred to their respondents as *BMSM* (Black men who have sex with men). This seems especially amiss because so many of the respondents belonged to Black gay organizations—for example, the explicitly named "New York State Black Gay Network"—and

because most reported that they used an identity term to describe themselves (53% *gay*, 12% *bisexual*, 12% *same-gender-loving*, 12% *homosexual*). It is an ironic commentary on the pervasiveness of *men who have sex with men* and *MSM* that the authors of the Senegalese and BMSM articles provided a nuanced cultural analysis but resorted to a deliberately anticultural term in describing the groups of men they studied.

In contrast, Munoz-Laboy[24] observed complex sociosexual identities and meanings among US Latino men, noting that some adopt and others reject sexuality as an important feature of their identity. We concur with the author's conclusion that "Latino *MSM* is far from being a homogeneous sexual category, and, as a framework, [the category *MSM*] is insufficient to capture the multidimensional aspects of Latino male bisexuality."[24(p75)]

Is *MSM* a useful term for describing groups that eschew prominent LGB categories? Much has been made of the fact that men on the DL lead secret lives and do not consider themselves gay.[25,26] But *DL* is not a behavioral category that can be conveyed as *MSM*. As Frank Leon Roberts has put it, "DL is . . . about *performing a new identity* and embracing a hip-hop sensibility [italics added]."[27] *DL* functions not as a nonidentity but as an alternative sexual identity and community denoting same-gender interest, masculine gender roles distinct from the feminized *sissy* or *faggot*, Black racial/ethnic identity, and a dissociation from both White and Black middle-class gay cultures.[26–28]

Certainly not all individuals experience sexual identity as salient. This is as true of White

men and women as it is of people of color. Our point is that discourse on sexual minorities should attend to identity. To label as *MSM* and *WSW* people who describe themselves as gay or lesbian or use another identity term is to deny their self-labeling and, by extension, their self-determination. We believe that this is ethically indefensible. As stated by Battle et al.: "Debates about identity are not insignificant since they determine not only the public identity of the group, but also help to build and solidify feelings of pride, empowerment, and political purpose among group members. Thus, the politics of identity are an essential component of the politics of recognition and distribution."[11]

OBSCURING THE SOCIAL MEANING OF SEXUALITY

We agree that sexual identity is not sufficient for understanding the epidemiology and prevention of HIV/AIDS or other health problems, but it is far from irrelevant. In modern social studies of sexuality, distinctions have been made among sexual identities, desires, and behaviors.[29,30] Indeed, understanding that these dimensions of sexuality do not always travel together in predictable ways was one impetus for introducing the terms *MSM* and *WSW*. But *WSW* and *MSM* can obscure critical inquiry into the social meaning of sexuality. Thinking in flat behavioral terms may lead us to ignore affiliation networks and communities that are important sources of information, norms, and values and that provide resources for health promotion efforts.

A striking case in point is the study of elevated HIV rates among sexual-minority female

injection drug users relative to other injection drug users.[3,31] Many such women are typically thought of as situational *WSW*, in reference to same-gender behavior that is purportedly engaged in purely for material or social gain rather than for erotic or romantic purposes. Such women are considered the most appropriate subjects for an identity-free label such as *WSW*. To the contrary, however, Young and colleagues found that female injection drug users in New York City described complex social situations that included emotionally and erotically invested relationships with their female partners; most identified themselves as *gay*, a term often preferred by these women over *lesbian.*[32]

To understand the consistently elevated rates of HIV among these women, it is important to consider precisely the sort of shared social experiences that *WSW* obscures. In fact, we believe that *WSW* may thwart understanding of risk for HIV among these women because it focuses attention on purely behavioral factors. But HIV risk among *WSW* injectors cannot be explained as a direct result of woman-to-woman sexual behavior. The pattern only makes sense when we understand that *WSW* injectors also share a sexual-minority status that involves exposure to discrimination and exclusion, relationship patterns, and subcultural norms. These insights can be extended to other health disparities, such as smoking or obesity, that also differ between sexual-minority and other women but that are not connected directly to, and cannot be explained by, sexual behavior.

For men, too, the narrow focus on sexual behavior reflected in the use of *MSM* clouds under-

standing of HIV (and other health concerns). We use as one example the EXPLORE project, an HIV prevention trial aimed at *MSM*.[33,34] A majority of the 4295 men who participated in EXPLORE were apparently recruited from predominantly gay venues, and many enrolled in the study for altruistic reasons such as "helping stop the AIDS epidemic" and "giving to their community."[33(p928)] The authors suggested that attention to sexual self-identification, affiliation with the gay communities, and perceived community norms are important factors in HIV prevention. Despite this recommendation, the authors referred to respondents as *MSM* and provided no information on self-identification or sociosexual affiliations. This exemplifies a missed opportunity for public health research to more fully describe sociocultural factors related to HIV prevention.

BEHAVIORAL TERMS THAT SAY LITTLE ABOUT BEHAVIOR

Purportedly, one of the greatest advantages of *WSW* and *MSM* is that unlike *lesbian* and *gay*, they are anchored in concrete behaviors that are more relevant than identity terms to epidemiological investigations. *MSM* and *WSW* have often been understood as stand-ins for presumed risk behaviors. With this usage, researchers ignore the important task of describing actual sexual behaviors, even though this information has greater relevance to public health.

For example, reports about the risks of sexually transmitted infections involved in woman-to-woman sex typically fail to provide any information regarding specific sexual practices between women.[35,36] While important knowledge has been gained about the risk of sexually transmitted infections (including HIV) among sexual-minority women from analyses of data collected for other purposes, specific same-gender practices are rarely assessed and reported.[31,37] Studies on the specific sexual practices of women are critical if models are to be built that combine biological plausibility with empirical information on associations between sexual practices and incidence rates of sexually transmitted infections. Without such data, public health professionals cannot provide sexual-minority women with meaningful harm reduction information.

Similarly, gay and bisexual men organize sexual behavior in a variety of ways that *MSM* does not convey. As noted by Ayala:

> HIV prevention has become synonymous with condom use and condom use has become solely about anal sex. . . . This focus on anal sex and condom use is reductionist; it narrows the sexual possibilities for gay and bisexual men of color. It also limits HIV prevention messages in the media, as well as the individual- and group-level interventions conducted by [community-based organizations]. Within this rubric there is little room for discussing, understanding, or promoting other sexual options and choices apart from anal sex and condom use.[38(p8)]

Ignoring identity in HIV prevention efforts can be perilous, because sexual identities may provide important clues for public health prevention efforts. In his study of Latino sexuality, Munoz-Laboy noted: "The problem with the *MSM* category is that many men do not identify with the label, which leads to their increased alienation from HIV prevention strategies."[24(p58)] This led Munoz-Laboy[24(p59)] to advocate that "we . . . move beyond *MSM*" so that we gain a more nuanced understanding of sexuality. With such attention to identity and labels, for example, Black men who identify as gay, DL, or who claim no sexual identity would require different HIV prevention approaches.

Similarly, "top" and "bottom," to denote sexual roles, and "bareback," to denote sex without condoms, are part of a sex culture and connote meanings as well as behaviors that are associated with HIV risk and are relevant to HIV prevention.[39,40] These terms and others could be more useful than *MSM* in public health research and intervention in that they reveal more nuanced information about sexuality, identity, and risk for HIV infection.

CONCLUSIONS

MSM and *WSW* have become ubiquitous terms in public health discourse but have failed to live up to their promise. We do not advocate the demise of *MSM* and *WSW*, but we believe that, a decade after their introduction, the terms have become institutionalized and risk inattentive usage.

Readers of an earlier version of this article—having been convinced by arguments against *MSM* and *WSW*—were frustrated that we did not provide a list of acceptable terms and usages. We continue to balk at that task. We believe that the solution resides not in discovering better terminology but in adopting a more critical and reflective stance in selecting the appropriate terms for particular populations and contexts.

Rather than offer a menu of terms, our aim here is to open a discussion among colleagues. In our analysis of current usages of *MSM* and *WSW*, we hope it is clear that the task of naming is challenging and is thoroughly engulfed in the substantive context of the text. It is the intellectual responsibility of writers to disentangle meanings within contexts and to carefully choose the terms that best fit their purpose. Despite our reluctance to offer solutions to the labeling question, our article reveals at least 4 principles: (1) we view *MSM* and *WSW* as lowest denominator terms that tell us little about risks for HIV/AIDS or any other disease; (2) at the most general level, we prefer terms, such as *sexual minorities*, that allow for sociocultural and political contexts; (3) in more specific contexts, we prefer local terms that respect the self-identifications of the populations in question; and (4) when relevant to the research question, we would report the full range of identity terms represented in samples, and, when discussing individuals, we would use the terms they use.

It has also been suggested to us that some investigators might prefer *MSM* or *WSW* because the terms allow important but potentially controversial research to fly under the radar of social conservatives who want to block research on sexual minorities. We disagree. First, the strategy does not work. Many grants on the infamous list of the National Institutes of Health–funded studies that were targeted by the Traditional Values Coalition as a "waste of tax-payer's money"[41] used *WSW* or *MSM*, not the identity terms that are supposedly risky. Second, even if this strategy did keep our work from being attacked, it is perilous because the terms we use are not

merely a matter of semantics but are referents for important constructs. Using inappropriate constructs can compromise the integrity of our work.

We recognize that *MSM* and *WSW* may also have strategic appeal for international work, especially in instances in which "gay and lesbian" work may be blocked. Here, too, we caution that this strategy is risky because it may reinforce the position of local conservatives who portray minority sexualities as Western, foreign, and corrupt. Contemporary work on sexuality and human rights shows that local struggles over the meaning and legitimacy of particular sexual forms are often cloaked in the language of "tradition" versus "modern corruption" or "local" versus "Western" sexual norms and behaviors.[42] In such a context, *MSM* and *WSW* may inadvertently undermine local struggles for sexual rights.

We have argued that use of reductive labels is unethical because it denies the right of identity to members of sexual-minority groups whose marginalization and mistreatment in medical settings have been amply documented and to whom we have the responsibility of heightened sensitivity.[43,44] Sensitivity in discussing the health needs of members of sexual-minority groups requires neither avoiding identity simply because it is complex nor retreating to yet another generic term. Instead, researchers should aim for a deeper understanding of variations in the meaning of sexual identity and community. ∎

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References
1. Glick M, Muzyka BC, Salkin LM, Lurie D. Necrotizing ulcerative periodontitis: a marker for immune deterioration and a predictor for the diagnosis of AIDS. *J Periodontol.* 1994;65:393–397.

2. Dowsett GW. Reaching men who have sex with men in Australia—an overview of AIDS education, community intervention and community attachment strategies. *Aust J Soc Issues.* 1980; 25:186–198.

3. Young RM, Friedman SR, Case P, Asencio MW, Clatts M. Women injection drug users who have sex with women exhibit increased HIV infection and risk behaviors. *J Drug Issues.* 2000; 30:499–524.

4. Treichler P. *How to Have Theory in an Epidemic: Cultural Chronicles of AIDS.* Durham, NC: Duke University Press; 1999.

5. Herek GM, Glunt EK. An epidemic of stigma—public reactions to AIDS. *Am Psychol.* 1988;43:886–891.

6. Gergen KJ. Psychological science in a postmodern context. *Am Psychol.* 2001;56:803–813.

7. von Krafft-Ebing R. *Psychopathia Sexualis, With Especial Reference to the Antipathic Sexual Instinct: A Medico-Forensic Study.* Brooklyn, NY: Physicians and Surgeons Book Co; 1930.

8. Epstein S. Gay politics, ethnic iden-tity: the limits of social constructionism. In Stein E, ed. *Forms of Desire: Sexual Orientation and the Social Constructionist Controversy.* New York, NY: Routledge; 1992:239–293.

9. Altman D. *Global Sex.* Chicago, Ill: University of Chicago Press; 2001.

10. Adam BD, Duyvendak JW, Krowel A. *The Global Emergence of Gay and Lesbian Politics: National Imprints of a Worldwide Movement.* Philadelphia, Pa: Temple University Press; 1999.

11. Battle J, Cohen CJ, Warren D, Fergerson G, Audam S. *Say It Loud, I'm Black and I'm Proud: Black Pride Survey 2000.* Washington, DC: Policy Institute of the National Gay and Lesbian Task Force; 2002.

12. Ponse B. The social construction of identity and its meanings within the lesbian subculture. In: Nardi PM, Schneider BE, eds. *Social Perspectives in Lesbian and Gay Studies: A Reader.* New York, NY: Routledge; 1998:246–260.

13. Crenshaw K. Mapping the margins: intersectionality, identity politics, and violence against women of color. In: Crenshaw KN, Gotanda GP, Thomas K, eds. *Critical Race Theory.* New York, NY: New Press; 1996:357–383.

14. Stewart AJ, McDermott C. Gender psychology. *Annu Rev Psychol.* 2004;55: 519–544.

15. Glenn NE. The social construction and institutionalization of gender and race. In: Marx Ferree M, Lorber J, Hess BB, eds. *Revisioning Gender.* Walnut Creek, Calif: AltaMira Press; 2000:3–43.

16. Donham DL. Freeing South Africa: the "modernization" of male-male sexuality in Soweto. *Cult Anthropol.* 1998; 13:3–21.

17. Brooks P, Bocahut L. *Woubi Cheri* [videotape; French with English subtitles]. France/Ivory Coast; 1998.

18. Swarr AL, Nagar R. Dismantling assumptions: interrogating "lesbian" struggles for identity and survival in India and South Africa. *Signs.* 2004;29: 491–516.

19. International Lesbian and Gay Association. About ILGA: working to achieve equal rights on a global scale since 1978. Available at: http://www.ilga.org/index.asp. Accessed April 30, 2004.

20. Berube A. How gay stays white and what kind of white it stays. In: Rasmussen BB, Klinenberg E, Nexica IJ, Wray M, eds. *The Making and Unmaking of Whiteness.* Durham, NC: Duke University Press; 2001:234.

21. Farmer P. *Pathologies of Power: Health, Human Rights, and the New War on the Poor.* Berkeley, Calif: University of California Press; 2003.

22. Niang CI, Tapsoba P, Weiss E, et al. 'It's raining stones': stigma, violence and HIV vulnerability among men who have sex with men in Dakar, Senegal. *Cult Health Sexuality.* 2003;5:499–512.

23. Malebranche DJ, Peterson JL, Fullilove RE, Stackhouse RW. Race and sexual identity: perceptions about medical culture and healthcare among black men who have sex with men. *J Natl Med Assoc.* 2004;96:97–107.

24. Munoz-Laboy M. Beyond "*MSM*": sexual desire among bisexually-active Latino men in New York City. *Sexualities.* 2004;7:55–80.

25. Vargas A. HIV-positive, without a clue: black men's hidden sex lives imperiling female partners. *Washington Post.* August 4, 2003:B1.

26. Denizet-Lewis B. Double lives on the down-low. *New York Times Magazine.* August 3, 2003:28.

27. Roberts FL. Beyond the down-low: the East Bay's black scene provides a safe space for all. Available at: http://www.youthoutlook.org/stories/2003/07/15. Accessed August 13, 2003.

28. Boykin K. Anatomy of a media frenzy. Available at: http://content.gay.com/channels/news/boykin/boykin_36.html. Accessed August 13, 2003.

29. Vance CS. Social construction theory: problems in the history of sexuality. In: van Kooten Niekerk A, van der Meer T, eds. *Homosexuality, Which Homosexuality.* Amsterdam, the Netherlands: An Dekker/Schorer; 1989: 13–34.

30. Laumann EO, Gagnon JH, Michael RT, Michaels S. *The Social Organization of Sexuality: Sexual Practices in the United States.* Chicago, Ill: University of Chicago Press; 1994.

31. Friedman SR, Ompad D, Maslow C, et al. HIV prevalence, social marginalization, risk behaviors, and high-risk sexual and injection networks among young women injectors who have sex with women. *Am J Public Health.* 2003; 93:902–906.

32. Young RM, Case P, Friedman SR. Exploring an HIV paradox: an ethnography of sexual minority women injectors. *J Lesbian Stud.* In press.

33. Koblin BA, Chesney MA, Husnik MJ, et al. High-risk behaviors among men who have sex with men in 6 US cities: baseline data from the EXPLORE study. *Am J Public Health.* 2003;93:926–932.

34. Chesney MA, Koblin BA, Barresi MJ, et al. An individually tailored intervention for HIV prevention: baseline data from the EXPLORE study. *Am J Public Health.* 2003;93:933–938.

35. Bauer GR, Welles SL. Beyond assumptions of negligible risk: sexually transmitted diseases and women who

have sex with women. *Am J Public Health.* 2001;91:1282–1286.

36. Fethers K, Marks C, Mindel A, Estcourt CS. Sexually transmitted infections and risk behaviors in women who have sex with women. *Sex Transm Infections.* 2000;76:345–349.

37. Bevier PJ, Chiasson MA, Heffernan RT, Castro KG. Women at a sexually transmitted disease clinic who reported same-sex contact: their HIV seropreva-

lence and risk behaviors. *Am J Public Health.* 1995;85:1366–1371.

38. Ayala G. Reconceiving the whole: a framework for HIV prevention and gay men of color. Paper presented at: *MSM* of Color Summit, May 2003, Los Angeles, Calif.

39. Wegesin DJ, Meyer-Bahlburg HFL. Top/bottom self-label, anal sex practices, HIV risk and gender role identity

in gay men in New York City. *J Psychol Hum Sexuality.* 2000;12(3):43–61.

40. Yep GA, Lovaas KE, Pagnosis AV. The case of "riding bareback": sexual practices and the paradoxes of identity in the era of AIDS. *J Homosex.* 2002; 42(4):1–14.

41. Brainard J. NIH begins review of studies that were questioned at a congressional hearing. *Chronicle of Higher Education.* November 7, 2003:24.

42. Narayan U. Undoing the "package picture" of cultures. *Signs.* 2000;25: 1083–1086.

43. O'Hanlan KA, Cabaj RP, Schatz B, Lock J, Nemrow P. A review of the medical consequences of homophobia with suggestions for resolution. *J Gay Lesbian Med Assoc.* 1997;1:25–39.

44. Lewin S, Meyer IH. Torture, ill-treatment and sexual identity. *Lancet.* 2001;358:1899–1900.