WOMEN’S SEXUAL HEALTH:
The Need for Feminist Analyses
in Public Health in the Decade of Behavior

Hortensia Amaro, Anita Raj, and Elizabeth Reed
Boston University School of Public Health

Women’s sexual health is directly affected by women’s low status in society. This low status, and subsequent lack of sexual autonomy, not only increases risk for sexual health problems, it also decreases ability to obtain treatment and support when a sexual health concern arises. This has clearly been demonstrated in the HIV epidemic within the U.S. Earlier in the epidemic, women were simply ignored by public health research and practice. Once they could no longer be ignored, they were blamed and viewed as vectors. Current seroprevalence rates among men reveal that women are not significant vectors. In contrast, rates among women indicate that infection from men is the primary mechanism by which women are contracting HIV, and male-controlled sexual decision-making, male partner violence against women, and histories of sexual assault all contribute to increased HIV risk for women. Once infected, women are not given the support and resources they need as mothers and caretakers of HIV-positive partners and/or children. These findings are especially true for marginalized women such as women of color, poor women, women addicted to alcohol or drugs, and women who exchange sex for drugs or money. Findings from this review demonstrate the need for feminist approaches in understanding and addressing this issue in the Decade of Behavior. Such approaches must include an understanding of the needs of diverse women. An empowerment approach is needed to better contend with the sexual health needs of women; this must include the goal of ensuring women’s control of their own bodies.

A review of abstracts from psychology, sociology, and medicine databases (i.e., PsycLit, Sociological Abstracts, and Medline) across the past three decades reveals an increasing recognition of the importance of sexual health and well-being for women and underscores the need to develop new perspectives in such research in the Decade of Behavior. For each decade within each database, the number of women’s sexual health articles has increased two- to fourfold. This may in part be attributed to increased national epidemiologic data demonstrating disproportionate sexual health concerns and subsequent outcomes for women.

Review of databases reveals that sexually transmitted diseases (STDs)—including HIV/AIDS—are at the forefront of current women’s sexual health research and public health practice. This emphasis on STDs is not surprising given the increasing numbers of women contracting these infections each year. AIDS is currently the fourth leading cause of death among U.S. women 25–44 years of age.


Address correspondence and reprint requests to: Hortensia Amaro, Ph.D., at Boston University School of Public Health, 715 Albany Street, T2W, Boston, MA 02118. E-mail: hamaro@bu.edu (Center for Disease Control [CDC], Office of Women’s Health, website), and HIV rates are continuing to rise, particularly among adolescent girls, who now account for the majority of youth infected with HIV (CDC, 2000). Other STDs are also at epidemic proportions among women in the U.S. (CDC Office of Women’s Health, website). An estimated 1 in 10 adolescent girls and 1 in 20 women of reproductive age are infected with chlamydia. Pelvic inflammatory disease (PID) affects 750,000 women per year. And human papilloma virus remains a major risk factor for cervical cancer, a cancer that causes 4,500 deaths among women in the U.S. each year.

High STD rates among women have resulted in increased reproductive health concerns, as well. The CDC Office of Women’s Health (website) estimates that as much as 30% of infertility in women may be related to preventable complications of past STDs. Ecstatic pregnancy, most often a complication from PID or other STDs, has increased about six-fold over the past 2 decades. Further, over 10% of all hospitalizations of women of reproductive age are from complications from reproductive tract disorders such as fibroid tumors, which affect up to 40% of women and endometriosis which affects over five million women every year. Over 50% of hysterectomies in the U.S. are performed due to fibroids and endometriosis.
In addition to sexually transmitted diseases and reproductive problems, rates of sexual dysfunction are also very high among women. A recent U.S. population-based study found that 43% of women as compared with 31% of men reported some form of sexual dysfunction (Lauman, Paik, & Rosen, 1999). Twenty-two percent of women reported low sexual desire, 14% reported sexual arousal problems, and 7% reported sexual pain. This study also found that sexual dysfunction was highly associated with negative experiences in sexual relationships and overall well-being.

Consistent with epidemiologic data, our review of the academic databases demonstrates that, despite increased recognition of women's sexual health, women's sexuality is still primarily conceptualized from a medical model/disease-focused perspective. Abstract topics in literature databases are primarily limited to sexual dysfunction including dyspareunia and low sexual arousal, reproductive organ dysfunction such as menstrual pain or irregularity, gynecological disease including STD/HIV and cancers of the sexual and reproductive organs, and sexual violence including rape and genital mutilation. Although our review demonstrates some research on sexual satisfaction in women, even these primarily focus on women who are ill or in recovery. An analysis and critique of sexual health research, practice, and policy clearly is in order.

Our goal in this article is to critically reflect on how women's sexuality has been defined and studied and the implications of this for services for women's sexual health in the Decade of Behavior. We will discuss feminist definitions and understandings of sexuality and analyze how the understanding of sexual health has been limited by a lack of feminist approaches. Using HIV/AIDS as an example, we then discuss how, even within the limited definitions of sexual health as disease and dysfunction, sexism has increased women's sexual health risk and feminist approaches have increased our understanding of women's risk. Finally, we describe the limitations of using the feminist lens of analysis based on its own biases stemming largely from the experience of White, middle-class, educated women. Based on our analysis, we will conclude with implications for development of a more inclusive approach to women's sexual health that includes addressing issues of race, class, culture, and gender.

**Feminist and Public Health Approaches to Sexuality**

In contrast to traditional biologically oriented scientific and medical approaches to sexuality, feminist scholarship on sexuality stresses the interactive and contextual aspects of sexuality (White, Bondurant, & Travis, 2000). The tenet that the ‘personal is political’ is relevant to a feminist perspective of sexuality, which stresses that even the most intimate details of our lives are structured by larger social relations. Further, feminist writers have argued that the social construction of sexuality defines sexuality in terms of male sexual practice and male sexual needs (Fine, 1988; Jackson, 1978; White, Bondurant, & Travis, 2000).

Travis and White (2000) offer the following definition of sexuality in their book *Sexuality, Society, and Feminism* published by the American Psychological Association:

Specifically, sexuality is a meaning system that organizes interactions and governs access to power and resources. Sexuality is not so much an attribute of persons, but rather exists in transactions between people (p. 4).

Understanding sexuality includes not only understanding its biological aspects but also deconstructing sexuality within a social framework. This includes analyzing the role of culture, values, and politics in sexuality and also in the creation of knowledge about sexuality (White, Bondurant, & Travis, 2000). Thus, from a feminist perspective, understanding sexuality requires analyses of the dynamics of marginalization that include naming the attributes of low and high status groups and the inherent biases in the creation of “knowledge” (Amaro & Raj, 2000). Generally, feminists argue that the existing knowledge base is flawed and the response has included varied approaches including: (1) feminist empiricism, which endorses the use of the scientific method in non sexist research, (2) feminist standpoint epistemologies, which assumes that oppressed people have the best ability to observe and describe their own and their oppressors’ realities, and (3) feminist postmodernity, which argues for the use of multiple methods and voices and attention to the personal, social and political context (White, Bondurant, & Travis, 2000).

A review of how female sexuality is presented in Western European culture shows that archetypes of women represent them as either good or evil: “The good woman will be represented biologically as virginal (i.e., pure, innocent, and naive) and psychologically as self-effacing, self-denying earth mother. The evil woman is seen as a whore; she is a scheming, ambitious, and a clever seductress” (Reid & Bing, 2000, p. 144). While the stereotypes of women’s sexuality vary somewhat by racial and ethnic group (Reid & Bing, 2000), a constant is that they serve to reinforce negative and/or disempowering labeling of women.

While recognizing biological influences on sexuality, scholars generally agree that sexuality is a social phenomenon based on prescribed arrangements and sexual scripts that provide guidelines for gender-appropriate behavior. These guidelines vary historically and across cultures (Schneider & Gould, 1987). Socially approved sexual scripts provide individuals with clear guidelines for behavior; Gagnon (1984) noted: “Sexual scripts are the plans that people may have in their heads for what they are doing and what they are going to do, as well as being the devices for remembering what they have done in the past” (cited in Schneider & Gould, 1987, p. 128).

Schneider and Gould (1987) point out that “scripts vary by gender, from culture to culture, and by subgroup within the culture” (p. 129), and individuals’ adherence to scripts may vary from cultural prescriptions and across
situations. They note that sexual scripts have the following five components:

(1) whom does a woman have sex with, that is, what are the limits and constraints of appropriate partners? (2) what acts does a woman engage in sexually from the whole range of possible sexual acts? (3) when is sex done, that is, at what times of the day, month, or year and in one's life cycle? (4) where, in setting or circumstance, does sex occur? and (5) why do people have sex, that is, what are the culturally approved accounts for doing sexual things that people provide for themselves and others?" (p. 129).

As a social phenomenon, women's sexuality is embedded in and reflects women's ascribed lower social status. Schneider and Gould (1987) note that "gender domination suggests that women's sexual meanings and sexual language flow from male experience and male definitions of desire" (p. 130). They identify the following four major assumptions as the basis of the current understanding of sexuality: (1) maleness and masculinity provide the normative baseline for understanding human sexuality, (2) heterosexuality is viewed as the only normal expression of sexual intimacy, (3) confusing sexuality with reproduction blurs the intricate meanings of both phenomena, especially for women, and (4) it is empirically unsound and conceptually unwise to detach sexuality from economic and political relations (Schneider & Gould, 1987). Consequently, one cannot discuss women's sexuality without acknowledging the influences of culture, societal oppression (i.e., racism, ethnocentrism, classism, heterosexism, and sexism), and institutional oppression biases in public health research and practice.

An important aspect of feminist analyses of sexuality is to observe what is studied and what is not studied. Feminists have argued that research on sexuality largely reflects existing sexual scripts and cultural notions of female sexuality. For example, cultural norms hold that girls do not have sexual desire and that their sexual activity occurs in the service of relationships and intimacy. As a result, with few exceptions (e.g., Fine, 1988), most studies ignore desire as part of girls' sexuality (Tolman, 2000). Tolman (2000) points to the discrepancy between girls' experience in adolescence as they begin to experience their bodies as sexual objects and the majority of research on girls' sexuality that focuses on danger and violence. In the area of HIV, existing sexual scripts that have stered-typed women have shaped HIV research, which until recently has been largely on prostitutes or pregnant women (Amaro, 1995; Correa, 1992).

Traditional public health approaches to sexuality have reflected a lack of contextual understanding of sexuality in women and men. Studies of sexual behavior in public health and medicine have medicalized women's sexuality. As is the case with other areas of public health, the focus has not been on health but rather on pathology and on public health problems "caused" by sexuality (e.g., adolescent pregnancy, sexually transmitted diseases). Studies have rarely investigated the sexual scripts or the economic and political relations described by Schneider and Gould (1987). While sexologists might believe that they have been more sensitive than those in public health to the study of women's sexuality, feminist researchers have argued that sexology research has reflected inherent biases such as holding heterosexuality as an imperative and natural order and viewing sex solely as a biological instinct (Tiefer, 2000). Further, where heterosexism biases have been used to eliminate lesbians from the sexuality literature, the sex-solely-as-biological-instinct bias has been used to legitimize male sexual violence against women (Tiefer, 2000).

Most public health approaches to HIV prevention for example, have not reflected a contextual understanding of women's sexuality. Public health models used are largely a rational-choice concept of safer sex that is based on an individual view of behavior that assumes that people are free to make rational choices—i.e., it assumes equality between women and men (Amaro, 1995; Amaro & Raj, 2000; Holland, Ramazanoglu, Scott, Sharpe, & Thomson, 1994). As a result, interventions are often at the medical, biological, or individual behavior levels. Feminist theory and research are rarely used to inform public health problems related to sexuality and research does not address the contextual factors noted as critical by feminist researchers (Zierler & Krieger, 1989).

Feminist Analysis of the HIV/AIDS Epidemic among Women

The HIV epidemic is a perfect example of how society lacks a female-centered approach to issues concerning women's sexuality. In general, this epidemic clearly demonstrates how society depicts HIV-positive women as vectors of disease because these women are visualized as sexually deviant. Society has blamed women for having HIV and for spreading HIV to men and children. Feminist approaches that acknowledge women's sexuality, sexual power, and account for culture, race, and socioeconomic status in relation to HIV among women are needed to develop effective HIV prevention approaches.

Although in the United States, HIV/AIDS prevalence remains higher for men, the rates of infection have been increasing at much higher rates for women. Between 1987 and 1992, the number of AIDS cases for women in the United States increased by more than 1000% (CDC, 1993). Black and Hispanic women represent a disproportionate percentage of AIDS cases (77%; CDC, 2000), although Blacks and Hispanics are only 12.3% and 12.5% of the U.S. population, respectively (U.S. Census 2000 website). This epidemic has hit women hard, yet the HIV-related needs of women continue to receive minimal attention.

Historic invisibility of women in the HIV epidemic. Women have historically been underrepresented in medi-
ical research in this country (Cohan & Atwood, 1994; Fox-Tierney, Ickovics, Cerretta, & Ethier, 1999; Lawless, Kippax, & Crawford, 1996; Strebel, 1995); therefore, it is not surprising that women have also been ignored in the development of appropriate diagnoses, treatment, and prevention of HIV/AIDS. Initially, in the early 1980s, AIDS was newly defined but almost solely addressed as a man’s disease (Corea, 1992). During the early epidemic, AIDS symptomology was being seen among women who were drug users, prostitutes, or in prison, but they were not diagnosed with AIDS because it was considered a man’s disease (Corea, 1992). By the mid-1980s, the numbers had risen among more diverse women including middle-class wives and mothers; AIDS among women could no longer be ignored.

Despite increasing numbers of reported AIDS cases among women in the 1980s, during the early epidemic, women and women’s perspectives were excluded from research. The scant prevention research with women largely centered on them as mothers or prostitutes, i.e., vectors of disease (Amaro, 1995; Cohan & Atwood, 1994; Corea, 1992; Sacks, 1996; Strebel, 1995; Welch, Cline, & McKenzie, 1996). Prevention research was largely based on male-centered approaches, such that women’s issues were not acknowledged (Amaro, 1995). Further, women were excluded from clinical trial research (Fox-Tierney, Ickovics, Cerretta, & Ethier, 1999; Strebel, 1995). In consequence, AIDS in women has remained less understood (Corea, 1992).

One of the first textbooks devoted to AIDS, written in 1984, included only one chapter on women and AIDS, and that chapter was devoted to a description of prostitutes and mothers spreading HIV to men and their children (Rodriguez, 1997). Although women were initially viewed as infectors of men, from a biological standpoint, women are three to five times more likely to become infected through heterosexual transmission than are men (Strebel, 1995). Whereas, 8% of AIDS cases among males are attributed to heterosexual contact, 40% of women diagnosed with AIDS were infected by their male partners (CDC, 2000). Nonetheless, sex workers in particular were viewed as reservoirs for infection and blamed for spreading HIV/AIDS to their male clients who were in turn spreading it to their wives and children. Sex workers were portrayed as the root cause of spreading HIV to the general population (Berer, 1993). In reality, sex workers were not found to have a higher incidence of HIV than other women in general (Ickovics & Rodin, 1992). Further, those sex workers who were HIV-positive were overwhelmingly infected through injection drug use (Anastos & Marte, 1989; Campbell, 1991). All HIV-positive women were stigmatized as drug users and/or prostitutes, and the acknowledgement of sex trade and drug use as social problems rather than consequences of individual choice were rarely included in this early analysis.

As vectors to children, the woman’s needs were viewed as secondary to that of the child or fetus. Pregnant women, particularly lower income racial/ethnic minority women, have been vulnerable to forced or coercive HIV testing and treatment (Amaro, 1990; Corea, 1992). Advice to women infected with HIV has stressed avoiding pregnancy via sterilization or, if already pregnant, abortion (Strebel, 1995). Societal notions that women who have HIV were prostitutes and/or drug users reinforced the belief that they are unfit mothers who cannot best make decisions for their child or fetus (Cohan & Atwood, 1994).

Early prevention research employed existing behavioral theories in an effort to understand why people engaged in risky sexual practices. Rational-cognitive theories including Social Cognitive Theory (Bandura, 1977; 1989), Theory of Reasoned Action (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975), and Transtheoretical Model of Behavior (Prochaska & DiClemente, 1983; Prochaska, Redding, Harlow, Rossi, & Velicer, 1994) were used to explain people’s behavioral risk based on their safer sex behavioral intention, motivation, self-efficacy, attitudes toward condoms, risk perceptions, and social norms. Such research did find that these individual-level cognitive-behavioral factors were related to increased sexual risk-taking for both female adults and adolescents (Catania, Coates, Kegeles, Fullilove, Peterson, Marin, Siegal, & Hulley, 1992; Gielen, Faden, O’Campo, Kass, & Anderson, 1994; Heckman, Sikkema, Kelly, Fuqua, Mercer, Hoffman, Winett, Anderson, Perry, Roffman, Solomon, Wagstaff, Cargill, Norman, & Crumble, 1996; Raj & Pollack, 1995; Sikkema, Koob, Cargill, Kelly, Desiderato, Roffman, Norman, Shabazz, Copeland, Winett, Steiner, & Lemke, 1995; Sikkema, Heckman, & Kelly, 1997; Wagstaff, Kelly, Perry, Sikkema, Solomon, Heckman, & Anderson, 1995; Wingood & DiClemente, 1996; 1998; Worth, 1989). However, these variables only explained a fraction of the behavior. By the mid-1990s, researchers began to recognize how decontextualized these models were and how little they offered for understanding women’s risk for HIV infection (Amaro, 1995). Male condom use has been typically targeted as a risk reduction method in HIV prevention efforts targeted primarily at women, but male condoms are not under women’s control. Further, women’s status in society, her autonomy in her sexual relationship, and her personal history of disempowerment all affect her self-efficacy in general and her sexual self-efficacy in particular, but none of these theories acknowledged these facets of the woman’s life. Consequently, little research addressed these factors (Amaro, 1995).

Early HIV/AIDS treatment research did not address the needs of women either. As mentioned previously, initial clinical trials for HIV/AIDS treatments did not include women (Fox-Tierney et al., 1999). Consequently, this research did not focus on the manifestations of HIV in women or the progression of AIDS among women (Berer, 1993) — two areas that are essential to understand in order to effectively diagnose the disease in women and to provide appropriate care to women who are infected with
HIV/AIDS. This general paucity of research on HIV among women led to a male-centered case definition of AIDS that did not include symptoms common among women (Berer, 1993; Cohan & Atwood, 1994; Strebel, 1995). Thus, initially women were misdiagnosed leading to treatment that was delayed or not provided (Cohan & Atwood, 1994). Later, due to women's symptoms not being included in the AIDS definition, treatment was not covered by government aid, and women were unable to procure it (Corea, 1992). Historically and currently, women living with AIDS tend to have worse prognoses compared to men, including increased morbidity and lower life expectancy (Cohan & Atwood, 1994; Strebel, 1995; Lawless, Kippax, & Crawford, 1996).

Current understanding of HIV risk for women. Through contributions of feminist researchers and advocates, new research has emerged in HIV prevention that has begun to gain a more contextual understanding of women's HIV risks (Amaro & Raj, 2000). Research on women is no longer limited to defining women as vectors, and more gendered perspectives have begun to be used in prevention research. The National Institutes of Health now requires that women be included in clinical trial research unless outstanding justification is given, and AIDS diagnoses now include symptoms more common among women such as yeast infections. Nonetheless, women remain at high risk for HIV because the low status of women maintains risk. Further, for more marginalized women such as women of color, women in prison, women who have sex with women, and women involved in sex trade for substance abuse, risk remains disproportionately higher (Amaro & Raj, 2000; Raj, Reed, & Amaro, 2001; Raj, Silverman, & Amaro, 2000).

As mentioned previously, although individual level cognitive-behavioral factors are related to increased sexual risk taking for both female adults and adolescents, more recent research guided by feminist perspectives indicates that these factors are not sufficient in explaining women's risk. Contextual factors are needed to understand why HIV rates are continuing to increase among women (Amaro, 1995). Recent studies indicate that dyadic relationship factors have greater impact on women's sexual risk behaviors than cognitive-behavioral factors. Numerous studies reveal that women in monogamous relationships have lower HIV risk perceptions and are less likely to use condoms (Bowleg, Belgrave, & Reisen, 2000; Castañeda, 2000; Misovich, Fisher, & Fisher, 1997; Simoni, Walters, & Nero, 2000; Wyatt, Vargas Carmona, Burns Loeb, Guthrie, Chin, & Gordon, 2000). Further, according to Deren, Shedlin, and Beardsley (1996), women find it difficult to use condoms once the sexual relationship without condoms has already started (Deren, Shedlin, & Beardsley, 1996). Condoms represent mistrust in relationships, and women define steady relationships as those in which there is trust (Fulfilove, Fulfilove, Haynes, & Gross, 1990). For some women, this can mean defining your relationship as steady because you are faithful although your partner may not be (Fulfilove et al., 1990) or engaging in unprotected sex even if your partner is HIV-positive (Simoni, Walters, & Nero, 2000). These findings suggest that many women may not be invested in using condoms regardless of the level of risk in the relationship in large part due to their desire for a steady relationship and their perceptions that condoms represent casual sexual relationships.

Even in situations where the woman would like to use condoms, it may not be possible if the male partner is unwilling (Amaro, 1995; Amaro & Raj, 2000; DuGuerny & Sjoberg, 1993). Studies show that male willingness to use condoms is highly predictive of condom use (Fleisher, Senie, Minkoff, & Jaccard, 1994; Raj, Amaro, Lopez-Gomez, & Cabral, 1999). Society dictates that men are supposed to control sex and women are to be passive. In fact, research indicates that the frequency and type of sex in which women engage, are most often determined by men (Gomez & Marin, 1993). Further, the main method of STD/HIV control remains the male condom, a male-controlled device. Although a female condom is available, both higher cost and negative attitudes toward it prohibit its widespread usage (Gollub, 2000).

Male attitudes appear to be especially important in relationships characterized by male abuse. Women who fear anger or abuse from their partner in response to requesting use of condoms during sexual intercourse are less likely to use condoms (Gomez & Marin, 1993; Wingood & DiClemente, 1998). Further, women in abusive relationships appear to be significantly less likely to use condoms (Amaro & Raj, 2000; Wingood & DiClemente, 1997). They are also more likely to have a partner who has refused to use a condom, and the probability of having such a partner increases with severity of partner violence (Russo & Denious, 2001). Additionally, women victimized by their current male partner are significantly more likely to have had a STD (Martin, Matza, Kupper, & Daly, 1997) as compared with women not in abusive relationships.

Women's histories of physical and sexual abuse also affect their HIV risk. Women with such abuse histories are more likely to engage in sex trade, have multiple partners, engage in casual sex, become pregnant during adolescence, have an unwanted pregnancy, choose a high risk sexual partner, and abuse substances including injection drugs (Cohen, Deament, Barkan, Richardson, Young, Holman, Anastos, Cohen, & Melnick 2000; Cunningham, Stillman, & Dore, 1994; Golding, 1996; Irwin, Edlin, Wong, Faruque, McCoy, Word, Schilling, McCoy, Evans, & Holmberg, 1995; Pichta & Abraham, 1996; Raj, Silverman, & Amaro, 2000; Zierler, Feingold, Laufer, Velentgas, Kantrowitz-Gordon, & Mayer, 1991). These findings clearly demonstrate that substance abuse, violence against women, and HIV risk interact to jeopardize the health of women and adolescent girls.

Substance use, primarily injection drug use (IDU), and crack-cocaine use, has only recently begun to be
addressed as a primary risk factor for women’s HIV acquisition via heterosexual contact. Despite the fact that IDU is the second most common means of HIV transmission for women, only seven articles related to IDU and women’s sexual risk could be found. None of these focused on HIV risk behaviors among this population outside of indicating that HIV-positive female IDUs were more likely to have HIV-positive people in their social networks (El-Bassel, Cooper, Chen, & Schilling, 1998). Other research indicates that young women are often introduced to substance use by their male partners (Amaro & Hardy-Fanta, 1995; Amaro, Zuckerman, & Cabral, 1989; Anglin, Hser, & McGlothlin, 1987; Hser, Anglin, & McGlothlin, 1987; Rosenbaum, 1981; Worth & Rodriguez, 1987), and abused women are two times more likely to have a male substance-abusing partner (Amaro, Fried, Cabral, & Zuckerman, 1990). These findings suggest that IDU women are at risk for HIV not only via needle use but also via sex with a high-risk partner.

More research has been conducted on crack-cocaine use among women; however, most of this research has been limited to predominantly African American and Latina samples. Numerous studies have found that STD and HIV prevalence is higher among crack-cocaine users as compared with non-drug users or other drug users (DeHovitz, Kelly, Feldman, Sierra, Clarke, Bromberg, Wan, Vermund, & Landesman, 1994; Edlin, Irvin, Faruque, McCoy, Word, Serrano, Inciardi, Bowser, Schilling, & Holmberg, 1994; Lindsay, Peterson, Boring, Gramling, Willis, & Klein, 1992; Raj, Marsh, DeLuca, Wingood, & DiClemente, 1997; Schwarchz, Bolan, Fullilove, McKnight, Fullilove, Kohn, & Rollis, 1992). Raj et al., (1997) additionally found that among their sample of African American substance users and nonusers, inconsistent condom use, and condom intentions were highest among female crack users. These findings indicate that women wanted to use condoms but were unable to effectively use them at every intercourse.

The above studies provide evidence that the social construction of women’s sexuality is highly related to the high STD and HIV rates among women. Women’s lower power and status, sexual violence against women, and gender role stereotypes prevent women’s control of their own bodies. For more marginalized women, such as women addicted to alcohol or drugs or in the sex trade, risk is even greater and autonomy even less. Not coincidentally is the fact that both street level sex trade and crack-cocaine addiction are disproportionately prevalent among African American and Latina women and women who are poor and homeless, all of which are associated with higher STD and HIV rates (Elwood, Williams, Bell, & Richard, 1997; Lindsay et al., 1992).

**Current accessibility to appropriate care for HIV-positive women.** Although there may be greater recognition and acknowledgement of HIV in women than seen in the past, women who are HIV-positive still routinely face barriers to receiving appropriate health care. HIV-positive women are still classified as prostitutes or drug users who have brought the disease upon themselves (Lawless, Kippax, & Crawford, 1996). Consequently, they are often treated badly by health care professionals when obtaining health care (Lawless, Kippax, & Crawford, 1996).

Negative preconceptions of HIV-positive women among health care professionals have affected the way in which women have been diagnosed with HIV as well as the appropriateness of their HIV treatment in many ways (Lawless, Kippax, & Crawford, 1996). For women who do not fit the “stereotype” of the HIV-positive women (i.e., women who are White, higher income, professional), HIV diagnosis may be delayed because the doctor does not perceive her to be at risk for HIV, regardless of her presenting symptoms for the disease (Wyatt, Moe, & Guthrie, 1999). Late diagnosis results in delayed treatment that may in part explain why many women first receive medical treatment when they are in later stages of the disease (Cohan & Atwood, 1994; Hellinger, 1993). On the other hand, women who are perceived to be at risk (i.e., racial/ethnic minority women, poor women, or women with histories of drug use or prostitution) may be given tests for HIV but not post-test counseling or follow-up care such as appropriate treatment options, financial assistance, or referrals to social or health service programs (Weissman, Melchior, Huba, Smereek, Needle, McCarthy, Jones, Genser, Cottler, Booth, & Altice, 1995; Huba & Melchior, 1994).

Many HIV-positive women already face discrimination and decreased access to health care due to racial and socioeconomic factors or history of drug use. Research shows that racial/ethnic minority women, in general, report lower satisfaction and greater discrimination in regards to their health care (The Henry J. Kaiser Family Foundation, 1999). Further, women with a known or perceived history of drug use or sex work, typically poor and minority women, have experienced difficulty in accessing nonjudgmental medical care, support, and services (Lawless, Kippax, & Crawford, 1996). In addition, recent studies indicate that histories of domestic violence and childhood sexual abuse are also highly common among HIV-positive women, as well as among women with a history of substance abuse and sex trade (Cohen et al., 2000; Weissman et al., 1995). These women are often treated with additional trauma by receiving a diagnosis of HIV infection (Weissman et al., 1995). Consequently, the quality of health care for these more marginalized HIV-positive women is of even greater concern.

Women who face discrimination repeatedly while obtaining health care may be more likely to “hide” their HIV status, or history of drug use or prostitution when seeking medical care, which again, limits the appropriateness of care they may receive (Lawless, Kippax, & Crawford, 1996). Studies show that few discussions take place between patient and provider concerning HIV infection (Wyatt, Moe, & Guthrie, 1999). It appears likely that
found that less than 50% of the facilities offered services (1998), the authors surveyed local facilities offering health. In a study done in a Midwest city by Russel and Smith (1998), the authors noted that less than 50% of the facilities offered services. In addition, there were limited connections established between clinical trials and drug treatment programs for women who are HIV-positive (Weissman et al., 1995). In addition to discrimination due to racial/ethnic minority status, socioeconomic status, or history of drug use or sex work, there is a general discrimination against women, resulting in a lack of programs that offer services specific to the needs of women. One example is the lack of coordinated services for women and their children. Women who have HIV-infected children often must bring their children to be treated in one place and go for their own treatment in a different facility (Cohan & Atwood, 1994; Russel & Smith, 1998). For women who are injection drug users have been found to use decreased medical services (Solomon, Stein, Flynn, Schuman, Schoenbaum, Moore, Holmberg, & Graham, 1998). Discrimination may also cause many women to internalize the stigma associated with their HIV status. Women who are HIV-positive are often made to feel undeserving, and this type of internalization may affect the way in which women seek and demand appropriate care (Lawless, Kippax, & Crawford, 1996); further, the stress of stigmatization may compound the effects of HIV on their bodies.

For women, drug addiction can serve as a major barrier in accessing medical services for treatment of HIV as well as adherence to medication (Weissman et al., 1995). Drug addiction may contribute to behaviors, specifically sexual behaviors that may put women at risk for reinfec tion with HIV (Weissman et al., 1995). Substance abuse treatment programs rarely include a gendered approach to recovery and often overlook issues relevant to many women's lives such as resolving experiences of physical and sexual abuse, parenting issues, and responsibilities for childcare while residing in the treatment program (Weissman et al., 1995). Not only is it difficult to find openings in treatment programs for women who are HIV-positive, but it is even more rare to find programs that help women care for their children or arrange for their children to be cared for while they are in treatment (Weissman et al., 1995). In addition, there are limited connections established between clinical trials and drug treatment programs for women who are HIV-positive (Weissman et al., 1995).

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In summary, despite increased recognition of the HIV epidemic among women, HIV-positive women's needs are still not being met well. As a result of multiple types of discrimination, poverty, women's overall lower status in society, and a medical field dominated by a male-centered approach, many HIV-positive women do not access the medical care and services that are most appropriate and relevant for their needs. If the goals of the Decade of Behavior are to be achieved, feminist approaches to both HIV prevention and treatment are needed to address these issues.

Limitations of Feminist Approaches to Sexuality

The Women's Health Movement in the United States that emerged in the 1970s was rooted in principles of equality for women and clearly brought many benefits to women overall. Nonetheless, it also contributed to the dynamics of marginalization (Amaro & Raj, 2000) through the exclusion of the voices and lived experiences of women of color and poor women (Reid, 1993; Reid & Kelly, 1994). All too often, feminist researchers and health advocates have formulated their ideas from their own elitist perspective, constructing a legacy that even today challenges the achievement of diversity in feminist thought and research (Weisman & Ruzek, 1998). As psychologist Pamela Reid has noted (Reid, 1993), even in research on the psychology of women “... poor women have been shut out and also shut up, that is, effectively silenced” (p. 143). A decade ago, Reid and Kelly (1994) emphasized that while feminist researchers have long argued that women's experiences cannot be represented by those of men, some have been all too willing to assume that there is an essential nature of women's experiences—a notion of the “universal” woman that effectively denies the diverse lived experience of many women (see Russo & Vaz, 2001, this issue for an examination of these issues).

Consequently, the Women's Health movement has often mirrored the prejudices and biases of the general society and reflected the priorities of the “universal” middle-class urban White woman. An example comes from the history of the women's movement in promoting access to abortion and sterilization. Reproductive health issues affect all women, including women of color, but the interactive effects of race, ethnicity, class, and gender shape the form and meaning of the issues and strategies for dealing with them. Thus, in the 1970s the Women's Health movement stressed women's rights to easily accessible abortion and sterilization. This almost single-minded focus on access resulted in advocacy against a waiting period for sterilization. This stance failed to consider that key issues of reproductive rights for poor women and women of color were the right to choose not to be sterilized or forced to have an abortion and the right to have appropriate...
informed consent for both procedures. These issues resulted in a great clash between the mainstream women's movement and women advocates within communities of color. Women of color organized to protest the Public Health Service Sterilization Campaign of women in Puerto Rico and sterilization abuses by medical providers targeted to women of color throughout the United States (Aptheker, 1974; Herold, Warren, Smith, Rochat, Martinez, & Vera, 1986; Lopez, 1985; Rodriguez-Trias, 1984; Schenshul, Borrero, Barrera, Backstrand, & Guarnaccia, 1982; U.S. General Accounting Office, 1976; Warren, Westoff, Herold, Rochat, & Smith, 1986).

The most recent stage of the Women's Health Movement, the development of the Women's Health Agenda in the 1990's, is the first time that women's health issues became institutionalized into the national scientific agenda (Weisman & Ruzek, 1995). However, as the women's health agenda was adopted by government institutions, the effort became professionalized and headed by a highly educated elite. It lost much of its feminist analyses of women's sexuality and sexual health and came to be largely defined by a biomedical model (see Travis & Compton, 2001, this issue, for more in-depth discussion of women's health issues). Further, diversity in this new context has been even more difficult to achieve and much headway that had been made in increasing the representation of women of color in health policymaking and the development of the women's health agenda at the federal level has been lost. Organizations like the National Women's Health Project, National Latina Women's Health Organization for Reproductive Rights, the Native American Women's Health Education and Resources Center, and the National Asian Women's Health Organization have been critical in broadening the agenda of the women's health movement. The participation of these groups brought to light the need to incorporate other issues such as access to medical care for low-income women, to find ways for paying for abortions no longer covered under the health plans for poor women, and the focus on diseases that disproportionately affect poor women and women of color (Weisman & Ruzek, 1998). From the women's health movement we learned that for women of racial and ethnic minority groups in the United State, race and class oppression are more salient in everyday life than sex-based discrimination. That history also teaches us that women of color needed to find a place for their authentic voices and the efforts to integrate them into mainstream women's organizations rarely worked because often the dynamics of race and class oppression were replicated within these groups. Once women of color had created their own organizations, then collaboration could occur on more equal ground.

Women's power over their sexuality has been an important cornerstone of the women's movement and feminist analyses. However, feminist perspectives in the early women's movement were shaped largely by the reality of economically privileged White women who did not repre-

sent the lived experience of poor women or women of color in the United States. The priorities they chose and the lenses through which they conducted their analyses did not reflect well the diversity of women's experiences.

For example, the early focus of the women's health movement on women's right to abortion, and stand against a waiting period for sterilization did not reflect the priorities of women of color and poor women, who emphasized coercion as well as access, and who had a broader array of health, social, and economic concerns (see Travis & Compton, 2001; Vaz & Russo, 2001, for discussions of these issues).

In summary, a feminist-centered approach is necessary in regards to women's sexual health research in order to deliver appropriate and relevant health programs, disease prevention efforts, and medical treatment to women in the Decade of Behavior. But, it is imperative that this approach also include the needs and priorities of diverse women. The end result should be a feminist focus on women's sexuality that acknowledges the diversity of women's experiences.

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REFERENCES


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