



bisexual health

AN INTRODUCTION AND MODEL PRACTICES
FOR HIV/STI PREVENTION PROGRAMMING

by Marshall Miller,
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Cover photo: Kuwaza Imara, RN, Highland Hospital Emergency Room, Lavender Caucus SEIU
616 (Service Employees International Union), co-founder 3x3 Bisexual People of Color, 1989

The National Gay and Lesbian Task Force Policy Institute

is a think tank dedicated to research, policy analysis and strategy development to advance greater understanding and equality for lesbian, gay, bisexual, and transgender people.

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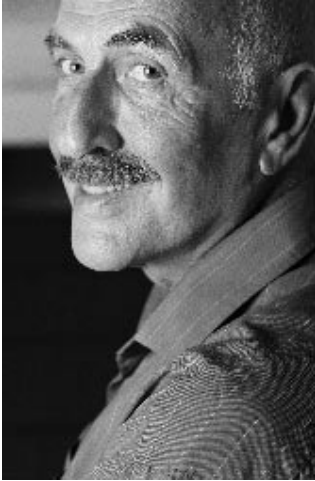
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This publication is dedicated to the memory of Dr. Fritz Klein [1933-2006]. Dr. Klein was one of the first people to research bisexuality in the United States. He established the credibility of research on bisexuality, fostered international networking and generously supported grassroots organizing among bisexuals. He was also the founding editor of the *Journal of Bisexuality* and founder of the American Institute of Bisexuality.



BISEXUAL HEALTH

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foreword

BY LUIGI FERRER, M.S.

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Board Member, Bisexual Resource Center

It is with great pleasure and a deep sense of appreciation for the National Gay and Lesbian Task Force, The Fenway Institute at Fenway Community Health and all those involved in this project that I sit down to write this foreword. The document you are about to read was born out of the grassroots efforts of countless bisexual activists, organizers, nurses, doctors, patients/clients, researchers, health educators and HIV-prevention workers, who for more than 35 years have struggled to bring about greater visibility, understanding and inclusion of bisexuality. The bisexual point of view has been and is still sorely missing from the public health discourse in our country and throughout the world.

The fact that bisexual people and people who have sex with more than one gender exist is undeniable. However, there is still considerable controversy as to the size of these segments of the population, how to define them, and what the public health implications of bisexual identity or of having sex with more than one gender (with or without a bisexual identity) really are. Most public health officials appear to be at a loss to understand these issues and dismiss them as unimportant because “they affect such a small number of people.” Sadly, more often than not, they honestly believe that there are more pressing priorities.

I was 21 in 1979 when I was infected with HIV as I began to explore my sexual desires for men for the first time. This was before any of us had heard of GRID (1981), AIDS (1982) or HIV (1983), and long before there was an HIV test available to the general public (1985) or any sort of treatment (i.e. AZT monotherapy in 1987). I lived through the dark ages of the early days of the AIDS pandemic, lost too many dear friends, and survived.

In the 21 years since my HIV-positive diagnosis in 1985, I helped build a thriving bisexual community in Miami, served as executive director of an AIDS services organization, worked on a number of lesbian, gay, bisexual and transgender (LGBT) community building and political organizing projects and have served on numerous local, state and national health care advisory boards and health services policy, planning and evaluation groups. I came to this work reluctantly and at times feeling unprepared, but I was drawn to it by my personal need for support and information and by the needs and encouragement of my gay, lesbian, bisexual, transgender,

The bisexual point of view has been and is still sorely missing from the public health discourse in our country and throughout the world.



The bottom margins of the pages of this publication also include a brief timeline of the bisexual health movement's history.

HIV-positive and Latino/a brothers and sisters. Antiretroviral medications keep me alive, but it's the strength and support of community that allows me to thrive in the face of adversity.

Today, as part of a team of peer facilitators for a coming-out support group for bisexuals, I find it troubling to not have answers to simple questions, like: What is the prevalence of HIV among sexually active bisexuals? Are bisexuals (or people who have sex with more than one gender) at greater risk for HIV or sexually transmitted infections (STIs) than the average person on the street? Are bisexual women at greater risk than bisexual men? The list of questions goes on and on. Given that the way most public health data are collected and analyzed in this country does not allow us to answer these basic questions, I am also troubled when I hear public health officials assert that "the needs of bisexuals are already addressed by prevention efforts for men who have sex with men," that "bi women, for example, are probably at low risk" or that "bi women are not a priority population."

There is a great deal of work to be done in the emerging field of bisexual health. Throughout the past 20 years I have been the only out bisexual voice at far too many meetings. I appreciate the progress we have made, but I also know how far we still need to go and how critical it is that out bisexuals are at the table and part of the discourse.

I came on the scene just as BiNet USA was formed and was honored to serve as one of its six initial national coordinators. By then, BiNet USA and bisexual movement leaders had made presentations to the board and staff of the National Gay and Lesbian Task Force and were a visible presence at the annual Creating Change conference. In 1995 BiNet activists worked with the Task Force to create a professional press packet which produced a cover story on bisexuality in Newsweek magazine that was the first balanced portrayal of bisexuals in the mainstream media.

In the pages that follow, celebrated author and sex educator Amy André provides an introduction to the topic of bisexuality, which is followed by a brief review of some of the available academic literature on issues affecting the health of bisexuals, with a focus on HIV and STI prevention. The second half of this publication outlines the work of Marshal Miller and Julie Ebin at the BiHealth Program at Fenway Community Health in Boston, Mass., with the goal of providing model policies and practices that healthcare providers and activists can replicate around the country. In order to increase the visibility of and acknowledge the accomplishments of bisexual activists and leaders, the bottom margins of the pages of this publication also include a brief timeline of the bisexual health movement's history.

I hope this publication will inspire a new cohort of bi-health activists here in the US and throughout the world.

Enjoy!

executive summary

INTRODUCTION

- Who are bisexual people?
- Why do some people who have sex with both men and women choose not to identify as bisexual and how can HIV and sexually transmitted infection (STI) prevention programs be more effective in reaching them?
- What are the particular sexual health issues that affect bisexual people and how can agencies, funders, researchers, counselors and activists help bisexual people to address them?

The National Gay and Lesbian Task Force Policy Institute, the Fenway Institute at Fenway Community Health in Boston, Mass., and BiNet USA created this report to answer these questions and offer a model practice HIV/STI prevention program that successfully educates bisexuals and those who have sex with both men and women but do not identify as bisexual.

We created this publication because sexual health issues affecting bisexuals have been largely ignored and under-represented in discussions of heterosexual and/or lesbian, gay and transgender health. Bisexual men and women are expected to have the same health concerns as either heterosexuals or gay men and lesbians, and therefore their unique concerns are seldom addressed.

This publication is designed to meet the needs of many populations. For journalists, researchers, counselors and anyone seeking to better understand bisexuality and HIV/STI prevention, we describe bisexuality and HIV/STI transmission, and offer language for understanding and explaining these trends clearly and accurately. For staff of HIV/STI prevention programs, bisexual activists, public health departments and funders we detail existing programs' challenges and offer solutions.



Key Terms

Bisexuality: the capacity for emotional, romantic and/or physical attraction to more than one sex or gender. That capacity for attraction may or may not manifest itself in terms of sexual interaction

MSMW: men who have sex with men and women (including transgender people)

WSMW: women who have sex with men and women (including transgender people)

Sex: a person's sexual characteristics (including anatomical, chromosomal, hormonal, and/or physiological) as male, female, both or neither. Transgender people and people with intersex conditions may have sexual characteristics that do not entirely align with the typical definition of "male" or "female"

Intersex: refers to a variety of conditions in which a person has (or had) reproductive or sexual characteristics that do not fit the typical definition of "male" or "female"

Gender: the collection of characteristics culturally associated with being "male," "female," both or neither¹

Heterosexism: the assumption that heterosexuality is the "norm" and other sexual orientations are deviant. Often, homosexuality is viewed as in opposition to heterosexuality, rendering bisexuality invisible and irrelevant

Biphobia: the fear or hatred of bisexuals

Bi-invisibility: the lack of acknowledgement and ignoring of the clear evidence that bisexuals exist

KEY QUESTIONS, DEFINITIONS AND THEORIES WHAT IS BISEXUALITY?

The term "bisexual" is used to describe the capacity for emotional, romantic and/or physical attraction to more than one gender. That capacity for attraction may or may not manifest itself in terms of sexual interaction.²

Who is a bisexual person?

A person who identifies as bisexual affirms her/his capacity for attraction to more than one gender. Not everyone who experiences attraction to different genders chooses to identify as bisexual. A bisexual orientation speaks to the potential for, but not requirement of, involvement with more than one gender. Bisexual, lesbian, gay and heterosexual are sexual orientation labels, not sexual behavior or relationship descriptors.

What is the frequency of bisexuality in the US?

The answer to this question is surprisingly complex, based on whether bisexuality is defined in terms of behavior, attraction, or self-identity and, if in terms of behavior, exactly which behaviors—and at what ages—count.³ While numbers vary from study to study, as detailed in this report, the 2002 National Survey of Family Growth found that nearly 13 percent of women and nearly 6 percent of men said they were attracted to men and women, and 2 percent specifically identified as bisexual. By comparison, 1.8 percent identified as gay/lesbian.⁴

The 2002 National Survey of Family Growth found that nearly 13 percent of women and nearly 6 percent of men said they were attracted to men and women.

What does it mean to have, or be open to having, sex with partners of a same or different gender?

Some bisexuals have not yet had sex with anyone. Others have only had same-sex experiences or have only been with partners of a different gender from their own. Many people who identify as lesbian, heterosexual, gay or another label have had sex with partners of more than one gender, and are often referred to in the professional and academic literature as men who have sex with men and women (MSMW) and women who have sex with men and women (WSMW).⁵

Theories describing bisexuality

Dr. Alfred Kinsey was one of the first to describe human sexual behavior in relation to sexual activity with partners of more than one gender.⁶ This report outlines Kinsey's human sexuality model (the 'Kinsey scale,' with complete heterosexuality on one end and complete homosexuality on the other), as well as Dr. Fritz Klein and Dr. Paula Rust's theories.

Klein's model, 'the Klein grid,' examines the relationships among several variables, including attraction, fantasy, heterosexual and homosexual community involvement and social and emotional preferences, over an individual's lifetime.⁷ Rust does not use a scale or grid. Rather, she argues that bisexuality, like any other sexual orientation, is "a description of one's social location."⁸

Race, ethnicity and bisexuality

Every race and ethnicity has members who identify themselves as bisexual. Racial/ethnic politics, oppressions and privileges impact individuals' bisexuality, and vice versa. It is well documented that people of color face health care access, delivery and experience challenges unknown to white people. This report discusses the dual challenges MSMW/WSMW of color face.



Biphobia, bi-invisibility and health

Biphobia is the fear or hatred of bisexual people. Bi-invisibility refers to a lack of acknowledgement of the clear evidence that bisexuals exist. Both oppressive phenomena work together to negatively perpetuate stereotypes alleging that bisexual people are hypersexual, responsible for AIDS, incapable of commitment and simply going through a phase.⁹

Biphobia and bi-invisibility affect the health and well-being of bisexuals and MSMW/WSMW. A small but growing body of research shows that bisexual people experience greater health disparities than the broader population, including a greater likelihood of suffering from depression due to biphobia.¹⁰ This publication serves as a guide for how to deal with biphobia and bi-invisibility in order to effectively reach bisexual clients in an HIV/STI prevention program.

In addition to the effects of biphobia and bi-invisibility, bisexuals have unique sexual health concerns, which are detailed in this report.

What are bisexual health issues within the context of HIV and STI prevention?

In addition to the effects of biphobia and bi-invisibility, bisexuals have unique sexual health concerns, which are detailed in this report. Concerns differ among specific bisexual demographics. Research shows that bisexual women are twice as likely to have never given birth compared to heterosexual women.¹¹ Yet among women who had given birth, bisexual women were twice as likely as heterosexual women to have done so during their teenage years. Not giving birth may put bisexual women at greater risk for ovarian and endometrial cancers, and teenage pregnancy also has health implications.¹² Additionally, although bisexual men are stereotyped as being a vector for HIV transmission from gay men to heterosexual women, Izazola et al. concluded that the MSMW in their sample had a much lower risk of acquiring HIV because they had fewer male partners and were less likely to have anal intercourse with them. As a group, the MSMW in their sample did not appear to have a high prevalence of HIV and may not be an effective epidemiological bridge for HIV transmission.¹³

This report shines a spotlight on specific challenges related to HIV/STI prevention among MSMW and WSMW, including:

- **Challenges related to the lack of available research:** The majority of social science research including bisexuals lumps bisexual data into either “lesbian” or “gay male” categories, making it difficult to draw any conclusions about bisexuals specifically, and affecting findings about lesbians and gay men. Without adequate epistemological data to legitimize MSMW/WSWM sexual health concerns, it is difficult to know how to target effective HIV/STI prevention, and it is difficult to convince funders that bisexual HIV/STI prevention efforts are important.

- **Challenges related to health care providers:** Research shows that many bisexuals have negative experiences with healthcare providers, including providers who may be gay or lesbian, whether it is because they are afraid to come out to their providers, or because their providers give them improper or incomplete information on HIV/STI prevention.¹⁴

We recommend that healthcare providers do the following to better treat bisexual clients:

- Add new services or expand existing services to cater to bisexual people;
- Ensure safe and accessible services for bisexual individuals;
- Educate other providers about the special needs of the bisexual community.¹⁵

Healthcare providers can look to the BiHealth Program at Fenway Community Health in Boston, Mass., for an excellent example of how to effectively reach out to bisexual people, MSMW and WSMW, and their HIV/STI prevention needs.

THE BIHEALTH PROGRAM AT FENWAY COMMUNITY HEALTH IN BOSTON, MASSACHUSETTS

The BiHealth Program, an HIV/STI prevention education program at Fenway Community Health in Boston, serves as a good model for people in other communities seeking to educate about and advocate for bisexual health. This report details the BiHealth program: how and why it started, its challenges and successes and how it can serve as a model for other HIV/STI prevention programs aimed at MSMW/WSMW.

Key concept: The difference between behavior and identity

A foundation of the program is the key concept that identity and behavior are fundamentally different. Identity refers to the words people use to describe themselves, such as heterosexual, gay, lesbian or bisexual. Behavior, on the other hand, refers to what people actually do sexually, with whom they have sex and whether they put themselves at risk for HIV and STIs. There is no such thing as “bisexual behavior” because bisexuality is an identity, not a behavior.

Putting theory into practice

Examples of replicable initiatives include:

A foundation of the program is the key concept that identity and behavior are fundamentally different.

There is no such thing as “bisexual behavior” because bisexuality is an identity, not a behavior.



- **Safer-sex brochure distribution:** The BiHealth Program developed two safer-sex brochures, which can be seen on pages 58 and 59, to reach those who identify as bisexual and those who do not. One brochure mentions bisexuality directly while the other educates about safer sex with people of all genders.
- **Bi-curious men's group:** Bisexual and bi-curious men's support groups appeal to men not reached by programs specifically branded for the lesbian, gay, bisexual and transgender (LGBT) community. This report provides detailed information about what types of men attended the bisexual and bi-curious men's group at Fenway, the structure and format of the group and how to start one in your local community, including how to select a location, choose facilitators and advertise.
- **Safer-sex educator team:** This report details how to start a safer sex educator team-based on BiHealth's cost-effective, high-result, "increasingly intensive intervention" model, which engages those most at risk.¹⁶ It is a multi-stage model, with the first stage being a public outreach campaign designed to introduce the priority population to the prevention program and encourage individuals to get involved. Next the participants examine some of the root causes for HIV transmission in their community. The volunteers then seek to address these issues in their community by educating their peers. In the final stage, this group of empowered educators tackles the root causes by organizing for social change. This report includes a sample safer-sex educator team workshop agenda, educational resources and ideas on where to find volunteers.

NEXT STEPS

Creating a More Bi-Friendly Culture

Biphobia (including biphobic care providers, cultural/institutional biphobia, internalized biphobia and fear of experiencing biphobia) is a major barrier to bisexuals' access to appropriate health care and health education. Programs like BiHealth can play an important role in creating a more bi-friendly, less biphobic culture on interagency, local and national levels, potentially improving health outcomes.

What You Can Do

- Providers of HIV/STI prevention programs and services, counselors and therapists need to create programs and outreach materials that specifically target MSMW/WSMW.

- Researchers and journalists should avoid sensationalizing stories/research, and need to include bisexual people's perspectives.
- Departments of public health, foundations, and other funding agencies need to fund programs like BiHealth at Fenway and recruit bisexuals to participate in advisory groups and to provide input on and/or write and review grant applications.
- Bisexual people, MSMW/WSMW and concerned allies can participate in bisexual organizations and advocate for bisexuals in other groups.

CONCLUSION

For far too long, bisexual health needs have been ignored — especially with concern to HIV/STI prevention. This report explains that health care providers must not assume their clients' risk level for HIV/STIs based solely on clients' current or past partners. HIV/STI prevention educators must target bisexuals, MSMW and WSMW specifically in outreach efforts in order to effectively reach those whose health concerns have been overlooked by heterosexual- or gay male/lesbian-centered sexual health education and health care.

It is our hope that this report will change the way that people educate about and advocate for bisexual health, and that bisexual people's identities and behaviors are no longer ignored by their communities and healthcare providers.

For far too long, bisexual health needs have been ignored — especially with concern to HIV/STI prevention.



introduction and literature review

BY AMY ANDRÉ¹⁷

“She actually preferred that I date women because they can’t get me pregnant.”

— white bisexual female¹⁸

“Where I was raised, in Compton, California, same-gender sexual behavior was not accepted.”

— black heterosexual female¹⁹

“I am open to sexual relations with [men] on occasion. [But, a period of identifying as a bisexual was] a confusing and depressing time, and not so fulfilling.”

— white lesbian²⁰

“The world is not to be divided into sheep and goats. Not all things are black nor are all things white.”

— Alfred Kinsey, 1948²¹

What did researcher Alfred Kinsey have in common with the women quoted above? All four individuals had or have had sexual relationships with women and men. Yet, despite this common experience, not all of them used the word “bisexual” to describe themselves.

What is bisexuality? Who is a bisexual person? What does it mean to have, or be open to having, sex with men and women but not identify as bisexual? How do the answers to these questions interact with HIV and sexually transmitted infection (STI) prevention services? Negotiation of sexual identities and practices can raise multiple issues, from pregnancy to safer sex, from social constructions to familial pressures, from dealing with secrecy to handling depression and more.

This publication addresses the invisibility and ignorance that bisexuals and people who have sex with more than one gender encounter when accessing health care, with a specific focus on HIV and STI prevention. Our goal is to describe the issues that these people face and highlight field-tested tactics for delivering optimal health care. To achieve this goal, we first provide an overview of some of the pressing health issues facing the bisexual community within the broader context of providing culturally competent HIV/STI prevention services. This is followed by a comprehensive case study of the BiHealth Program at Fenway Community Health in Boston, Mass., a successful bisexual health education program for bisexual people and for those who have sex with people of more than one gender but do not identify as bisexual.

Whether you are a health care provider, a health care advocate, a health researcher, a funder, a member of a bisexual community or an interested person of any background or identity, this publication will provide you with valuable information on this under-researched topic.

Key Terms

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Intersex: refers to a variety of conditions in which a person has (or had) reproductive or sexual characteristics that do not fit the typical definition of "male" or "female"

Gender: the collection of characteristics culturally associated with being "male," "female," both or neither²²

Heterosexism: the assumption that heterosexuality is the "norm" and other sexual orientations are deviant. Often, homosexuality is viewed as in opposition to heterosexuality, rendering bisexuality invisible and irrelevant

Biphobia: the fear or hatred of bisexuals

Bi-invisibility: the lack of acknowledgement and ignoring of the clear evidence that bisexuals exist



WHAT IS BISEXUALITY?

“Bisexuality is the potential for being sexually and/or romantically involved with members of any gender.”²³

Historically, bisexuality has been defined in a variety of ways. Like other sexual identities such as lesbian, heterosexual and gay, bisexual is a culturally-specific, socially constructed term. In this publication, the term bisexual is used to describe the capacity for emotional, romantic and/or physical attraction to more than one gender. That capacity for attraction may or may not manifest itself in terms of sexual interaction.²⁴

The fact that many people experience romantic and/or sexual attraction to other people is a basic tenet of humanity. It is also evidence that romantic and/or sexual attraction itself is not bound by the real or perceived gender of another person. For a variety of reasons, most cultures construct and promote the concept that an individual can only experience attraction for people of a different gender; or that an individual can only experience attraction either for people of a different gender or for people of the same gender. The existence of bisexuality challenges this binary thinking, by shifting social consciousness from an either/or modality to a both/and potentiality.

Three of the leading theorists on bisexuality and human sexual behavior, Dr. Alfred Kinsey, Dr. Fritz Klein and Dr. Paula Rust put forth definitions of bisexuality that challenge binary thinking; their work will be briefly summarized later in this publication.

TIMELINE: THE BISEXUAL HEALTH MOVEMENT IN THE US

By Lani Ka’ahumanu

This timeline is a work in progress and only a sample of what has been collected. These bisexual individuals have contributed to the mental and physical health and well being of bisexual identified people and/or have promoted a better understanding of sexuality and sexual health as it relates to LGBT people.

Note: In the 1960s to mid-1970s the word “gay” was a generally accepted umbrella term that included lesbian, gay, bisexual and transgender people.

Stephen Donaldson (nee Robert Martin, 1946-1996) founds the Student Homophile League at Columbia University and New York University; in 1967 Columbia University is first in United States to officially recognize a gay student group.

1966

What is the frequency of bisexuality in the US?

As researcher Paula Rust explains, The question, “How many people are bisexual?” is deceptively complex. The answer depends on whether bisexuality is defined in terms of behavior, feelings or attraction, or self-identity and, if in terms of behavior, exactly which behaviors — and at what ages — count.²⁵

According to Rust, data collected before 2000 indicated that:

- At most 5.8 percent of men and 3.3 percent of women are bisexual (if sexual behavior since puberty is considered);
- At least 0.7 percent of men and 0.3 percent of women are bisexual (if sexual behavior in the previous year is considered);

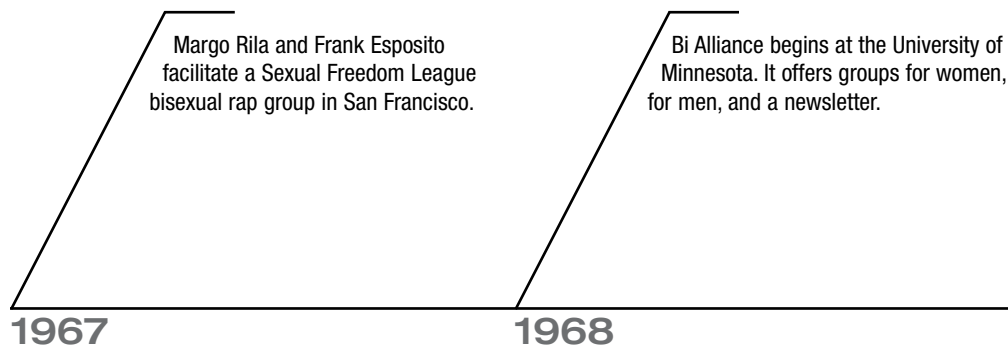
- At least 0.8 percent of men and 0.5 percent of women self-identify as bisexual.

More recent analysis of data from the 2002 National Survey of Family Growth²⁶ indicates that the bisexual population may be larger:

- 1.8 percent of men and 2.8 percent of women ages 18 to 44 identify as bisexual. By comparison, 2.3 percent of men identify as gay and 1.3 percent of women as lesbian.
- 12.9 percent of women and 5.9 percent of men ages 18 to 44 said they were attracted to both sexes: 10.2 percent to “mostly males,” 1.9 percent to “both” and 0.8 percent to “mostly females.” Another 0.8 percent were “not sure.”

WHO IS A BISEXUAL PERSON?

A bisexual person is anyone who identifies with the term. As with any other sexual orientation label, applicability of the term belongs to those who choose to use it. A person who self-identifies as bisexual affirms his or her capacity for attraction to more than one gender and acknowledges a reality outside the either/or identity categories of heterosexual or gay/



lesbian. This binary is the foundation supporting heterosexism, which is the assumption that heterosexuality is the “norm” and homosexuality is its deviant flipside. This assumption renders bisexuality invisible.

Some of the people who experience attraction to women and men choose to use the word “bisexual” to describe themselves, while others choose not to do so or choose to use other terms like “queer.” Reasons vary for choosing not to use the word bisexual, and can stem from things like the silencing effect of internalized and/or externalized biphobia, which is defined as the fear or hatred of bisexuals. A more comprehensive discussion of biphobia is included later in this section.

A bisexual orientation speaks to the potential, but not the requirement, for involvement with more than one gender. This involvement may be sexual, emotional, in reality and/or in fantasy. Some bisexuals may be monogamous, some may have concurrent partners, others may relate to different sexes/genders at various periods of time and others still may be celibate. Bisexual, lesbian, gay and heterosexual are sexual orientation labels, not sexual behaviors or relationship descriptors. Thus, two men in a relationship are a same-sex couple, not a “gay” couple, and a woman and a man in a relationship are a different-sex couple, not a “heterosexual” couple.

The reason for viewing bisexual, lesbian, gay and heterosexual as sexual orientation labels rather than as behaviors or relationship descriptors is that people have many kinds of sex and a variety of relationships without labeling themselves, their relationships, or their sexual activities. Two women having sex are engaging in same-sex sex, not “lesbian” sex, and a man and a woman having sex are engaging in different-sex sex, not “heterosexual” sex. It is important for health care providers and researchers to be as inclusive and nonjudgmental as possible.

Bisexual, lesbian, gay and heterosexual should be viewed as sexual orientation labels rather than as behaviors or relationship descriptors.



Maggi Rubenstein

Maggi Rubenstein, RN, comes out during a staff meeting at a San Francisco mental health facility serving lesbian, gay, transgender and heterosexual people; bisexuals then included in programming.

Brenda Howard (1946-2005) conceives and coordinates a one-month Stonewall Rebellion anniversary rally, and later, a one year march and celebration. This became the annual New York City Pride March that, in turn, spawned Pride Marches around the country and the world.

1969

WHAT DOES IT MEAN TO HAVE, OR BE OPEN TO HAVING, SEX WITH PARTNERS OF A SAME OR DIFFERENT GENDER?

Some bisexuals have not yet had sex with anyone. Others have only had same-sex experiences or have only been with partners of a different gender from their own. Still others have had sex with partners of more than one gender.

The same can be said for people who do not identify as bisexual. Many lesbian, heterosexual and gay individuals — as well as individuals who use other sexual orientation labels — have had sex with partners of more than one gender, and are often referred to in the professional and academic literature as men who have sex with men and women (MSMW) and women who have sex with men and women (WSMW). Therefore, people of any identity may be MSMW or WSMW. This is similar to the way in which anyone, using any label for their sexual orientation, may have experienced attractions to other people.

Terms like MSMW and WSMW have been critiqued for being used without respect to the identity descriptors that individuals apply to themselves, for being unclear for the purposes of harm-reduction in the way they describe sex in relation to partners' gender(s), and for being reductive by focusing on dyadic relationships rather than cultural contexts and social affiliations.²⁷ The terms MSM, MSWM, WSW and WSWM have also been critiqued by members of the transgender community, whose self-identification as transgender women, transgender men or transgender people is erased and instead replaced with identification based on sexual anatomy. When possible, healthcare professionals should use terms that reflect self-chosen identities and terms that focus on harm-reduction in relation to safety behaviors.

Don Fass founds the National Bisexual Liberation group in New York City. The group's goal is social and consciousness-raising. It publishes a pamphlet, "Bi-Sexual Expression."

Maggi Rubenstein, RN provides bisexual content for the University of California's San Francisco Sex Counseling Program.

Bill Beasley, veteran of black civil rights movement, is core organizer of first Los Angeles Gay Pride March and active with Gay Liberation Front.

1972



THEORIES DESCRIBING BISEXUALITY

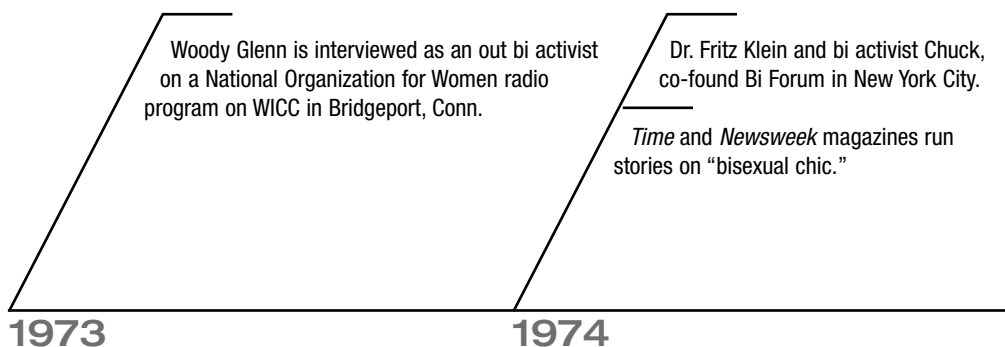
As we have seen, identifying as a bisexual and participating in sexual behavior with partners of more than one gender are separate categories and exist apart from heterosexual and homosexual (gay or lesbian) categories. In addition, identity is distinct from behavior. Bisexual people may or may not be sexually active, may or may not have been sexual with more than one person, or may never have been sexual at all. As with all sexual orientations, whether one is being sexual with people of any gender or not has nothing to do with the validity of a self-professed identity. In other words, a lesbian is still a lesbian, a gay man is still a gay man, and a heterosexual remains a heterosexual whether he or she is being, or has ever been, sexual. The same holds true for bisexuals.

Dr. Alfred Kinsey was one of the first sexologists to comprehensively describe human sexual behavior in relation to sexual activity with partners of more than one gender.²⁸ With the help of his colleagues, he conducted large-scale, interview-based surveys of the sexual lives of more than 10,000 predominantly white Americans. He crafted a scale model to serve as a descriptor of his theory of human sexuality. This model, known as the ‘Kinsey Scale,’ posited that exclusive sexual activity with partners of the same sex or with partners of a different sex were extremes of human sexual behavior, and that sexual activity with partners of more than one sex was common, if not normative. To a large extent, his survey results bore out evidence of this theory.

Kinsey’s life work was to describe sexual behavior, not identity. But his findings, which were mostly about quantifiable behaviors, have been largely interpreted to apply to identity. In this vein, they offer a narrow view of identity, namely the idea that one’s sexual orientation is reduced to analysis of the sex(es)/gender(s) of one’s partner(s). Contemporary thought on sexual orientation recognizes that it is comprised of much more.



Kinsey



Between 1978 and 1980, in an attempt to broaden the scope of understanding on both sexual orientation label and sexual behavior, Dr. Fritz Klein created and developed the ‘Klein grid,’ a system of charting sexuality by examining the relationships among several variables, including attraction, fantasy, heterosexual and homosexual community involvement and social and emotional preferences, over the lifetime of the individual filling out the grid.²⁹ The grid has been critiqued as overly simplistic, but has played an important part in drawing attention to some of the complexities of human sexuality.

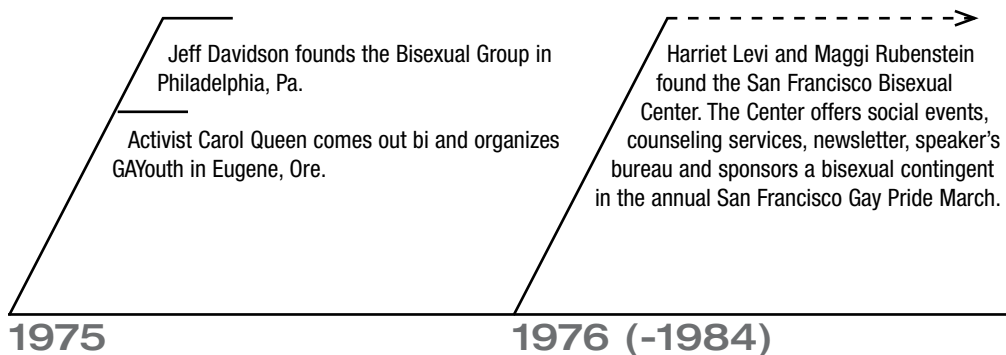
In the 1990s, Dr. Paula Rust published a new theory about sexual orientation, based in part on her research on sexual identity formation in bisexual women and lesbians.³⁰ Unlike Kinsey and Klein, Rust does not use a scale, grid, or another model to describe her theory. She locates her theory within the field of social construction, arguing that bisexuality, like any other sexuality, is “a description of one’s social location.”³¹ Bisexuals have no monopoly on sexual fluidity, which can also be a part of the lives of those who are not bisexually-identified.

Despite the theoretical constructs that some academics have crafted to describe bisexuality and sexuality in general, biphobia continues to permeate cultural understandings of bisexual people’s lives and the lives of MSMW and WSMW.

GENDER, SEX AND BISEXUALITY

“From the earliest years of the bi community, significant numbers of [transgender people] have always been involved in it. The bi community served as a kind of refuge for people who felt excluded from the established lesbian and gay communities.”

— Kevin Lano³²



Transgender people can have any sexual orientation, including bisexual.

Gender and sex interact with bisexuality and with the lives of people who have sex with partners of more than one gender. Gender is defined as the collection of characteristics culturally associated with being “male” or “female,” both or neither. While the most common genders are woman and man, some people use others like genderqueer or genderfluid to describe their experience and expression of their genders. Some people do not describe themselves as having a gender at all.

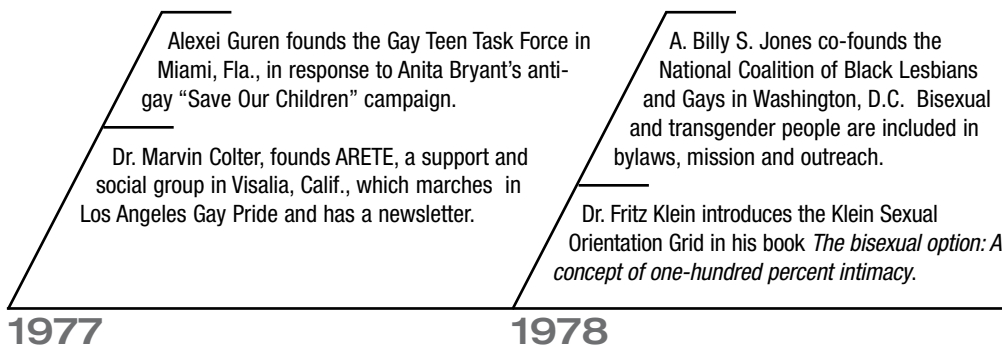
Transgender is the “umbrella” term used to describe this wide range of identities and experiences and is used to refer to many types of people, including transsexual people, cross-dressers, androgynous people and other gender non-conforming people whose appearance or characteristics are perceived to be gender atypical. Just like people who do not identify as transgender, transgender people may use words like “woman,” “man,” “genderqueer,” “genderfluid” or other terms, to describe their gender identity or expression. Transgender people can have any sexual orientation, including bisexual.

According to researcher Anne Fausto-Sterling, about 1.7 percent of people are born with intersex conditions, a variety of conditions in which a person has or had reproductive or sexual anatomy that doesn’t fit the typical definition of male or female.^{33,34} Some intersex people identify their sexual orientation as bisexual.

Every gender has members who identify themselves as bisexual and bisexuals may be of any biological sex. In addition, there are some bisexual people who do not describe themselves as having a gender. Gender politics, sexual politics and gender-related oppressions and privileges may intersect with bisexuality and impact health care.³⁵



Alexei Guren



RACE, ETHNICITY AND BISEXUALITY

Every race and ethnicity has members who identify themselves as bisexual. Race and ethnicity can be defined as a social construction of categories linking heritage-based groups transnationally. Racial/ethnic politics and race/ethnic-related oppressions and privileges impact individuals' bisexuality and vice versa. Culturally competent health care includes an understanding of the intersection of race, ethnicity and sexual health. In working with patients and clients of all races/ethnicities, it is important to be mindful that every individual is affected by race and ethnicity. When we interact with other people, these socio-historical relationships are always at play, including in the clinical setting.

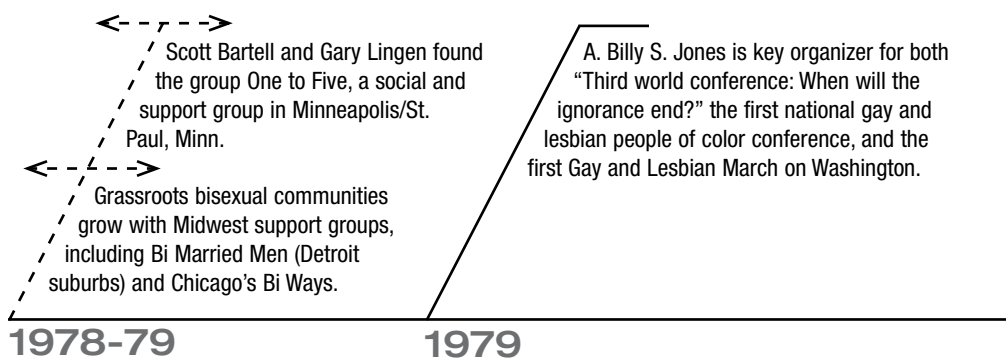
Much has been written about the intersection of race, ethnicity and health, as well as race, ethnicity and health care.³⁶ For example, it is well documented that people of color have challenges around healthcare access, delivery and experience that white people do not typically face. Both bisexual people of color and people of color who have sex with partners of more than one gender must navigate those additional challenges, as well as some of the challenges faced by white bisexuals and white people who are MSMW and WSMW. This combination of race/ethnicity and bisexuality creates a particular interaction effect, which in turn further impacts health and health care.³⁷

Race impacts health research findings and reports, as we can see in this excerpt of a research article published in the *Journal of Urban Health*:

Black Americans are becoming HIV infected at rates comparable to those seen in parts of the developing world and at rates three to four times higher than members of other racial/ethnic groups in the United States. Recent and dramatic increases in HIV-incidence rates have been documented for black men who have sex with men (MSM) and black women.

Every race and ethnicity has members who identify themselves as bisexual.

Jessica Xavier, M.P.H, (below), bisexual transsexual woman, LGBT and HIV healthcare researcher, activist, singer-songwriter with her band Femme Messiah



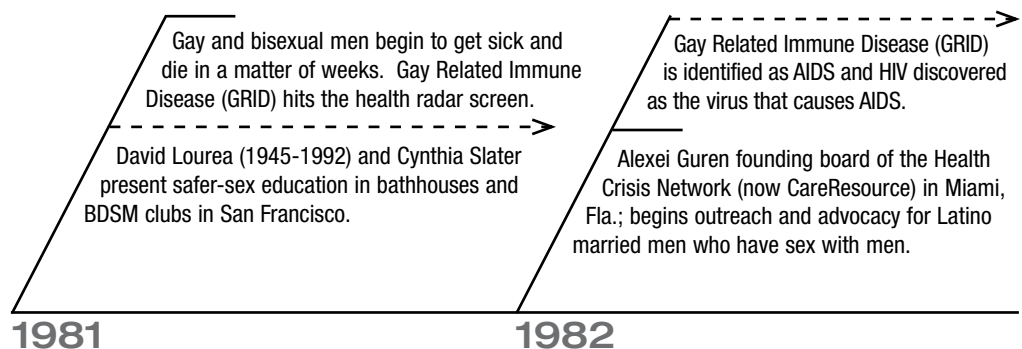
Jessica Xavier



Moreover, MSM have been recently identified as the primary cause of infection among black men, while the heterosexual acquisition of HIV, increasingly through sex with MSM, has been the primary cause of infection among black women since 1995. Therefore, in black communities, men are the main source of sexually transmitted HIV infection for both black men and black women. However, little is known about the sex practices and preferences of black men... Black MSM are less likely to disclose their sexual orientation, are less likely to identify as homosexual, and a larger proportion self-identify as bisexual as compared with White MSM... MSM has become a more visible HIV-transmission route in the black community, in part due to intense media attention on the phenomenon referred to as black men on the “down low” (i.e., maintaining a “straight” public appearance and having sex with men on the side). [We] expected difficulty...recruiting a diverse and hidden sample of black MSM, many of whom were anticipated not to identify as gay.³⁸

This excerpt conflates notions of sexual orientation, behavior, gender of partners and disease transmission, while overlooking the socially constructed nature of sexual orientation identities described by Rust.³⁹ These errors are compounded by the racialized sexism of down low hysteria.⁴⁰ Consider the changed tone and content of the piece if the excerpt were re-written as follows, with new text in bold:

Black Americans are becoming HIV infected at rates comparable to those seen in parts of the developing world and at rates three to four times higher than members of other racial/ethnic groups in the United States. Recent and dramatic increases in HIV-incidence rates have been documented for Black men who have **unprotected** sex with men **and women** (MSMW) and Black women **who have unprotected sex with MSMW**. Moreover, **MSM unprotected sex with male partners** has been recently identified as the primary cause of infection among Black men, while the **heterosexual** acquisition of HIV, **increasingly**



through **unprotected** sex with MSMW, has been the primary cause of infection among Black women since 1995. Therefore, in Black communities, ~~men are unprotected sex among MSM and with MSMW is~~ the main source of ~~sexually transmitted~~ HIV infection for both Black men and Black women. ~~However, little is known about the sex practices and preferences of Black men...~~ Black MSMW are less likely to disclose their sexual orientation **in certain social and relational contexts**, are less likely to identify as homosexual, and a larger proportion self-identify as bisexual as compared with White MSMW... **Unprotected sex among MSM and with MSMW** MSM has become a more visible HIV-transmission route in the Black community, in part due to intense media attention **hysteria around the concept of** phenomenon referred to as Black men **who are** on the “down low” (i.e., ~~maintaining a ‘straight’ public appearance men who do not identify as homosexual but instead identify as heterosexual or bisexual and having sex with men on the side who have sex with male and female partners~~). [We] expected difficulty... recruiting a diverse and hidden sample of Black MSMW, many of whom were anticipated ~~not to identify as gay to identify as heterosexual or bisexual.~~

Notice how these changes more accurately depict the lives of bisexuals and of people who have sex with people of more than one gender. They also paint a more accurate picture of the medically-recognized way in which HIV may be transmitted between sexual partners: HIV is not transmitted because of men having sex with men. It is transmitted through unprotected sexual behavior.

In relation to race, the original text makes a significant number of erroneous assertions about black male sexuality, while simultaneously claiming that “little is known” about it. The implications that the down low is specific to black male culture, which is incorrect, and that there

HIV is not transmitted because of men having sex with men. It is transmitted through unprotected sexual behavior.

David Lourea is appointed to SF Mayor Dianne Feinstein's AIDS Education Advisory Committee.

Autumn Courtney, Lani Ka'ahumanu, Arlene Krantz, David Lourea, Bill Mack, Alan Rockway (1944-1987) and Maggi Rubenstein organize BiPOL (a bisexual feminist political action group) to build a visible bisexual community and viable political movement to counter “bisexual as ‘typhoid Mary’/scapegoat” stereotype.

1983

A. Billy S. Jones (with G. Gerald and Craig Harris) organizes first federally funded national “AIDS in the Black Community Conference” in Washington, D.C.

David Lourea convinces SF Dep't of Public Health to include bisexual men in weekly “New AIDS cases and mortality statistics” report. This model is then used by other department of public health offices around the country.

1984

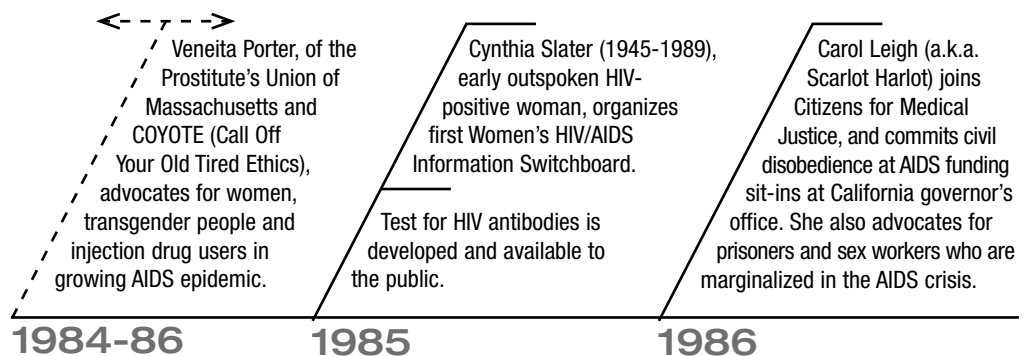


is something noteworthy about the fact that black MSMW might identify as heterosexual and bisexual rather than as gay, and that black men are “less likely” to reveal their sexual orientations are especially problematic, because each of these interpretations tends to stigmatize black MSMW more than MSMW of other races/ethnicities with the same behavior.

If a black MSMW identifies as heterosexual, he *is* revealing his sexual orientation. Even if he were to eschew sexual orientation labels altogether, he would still be revealing his sexual orientation — as being nil. As we know, a heterosexual identity does not equate to exclusive sexual behavior with partners of a different gender. If the “down low” describes a heterosexual or bisexual person who has sex with men and women, then all races/ethnicities have members who are on the down low.

Another example that purports to report on race and bisexuality but really more accurately serves to illustrate about how a lack of clarity in terminology obfuscates critical health information is contained in this *International Nursing Review* study abstract:

Public health messages urging women to seek health care services such as sexually transmitted diseases (STD) and cervical cancer screening or family planning services fail to address women who have sex with women (WSW). This negligence may have led to a false sense of security amongst WSW concerning sexual risk behaviour. Research has shown that WSW engage in more high-risk sexual behaviours than heterosexual women. WSW has been identified as an important vector in the spread of STDs in all populations because of bisexuality. To prevent and reduce transmission of STDs amongst WSW, perceptions of risk for STD amongst WSW need to be understood so that effective interventions may be developed. AIM: To describe the relationship between sexual risk and protective behavior and STD transmission amongst bisexual minority women with



a history of STD. Life history methods were used to interview 23 African-American bisexual women with a history of STD. Various themes unfolded during analysis of the patient interviews, including bisexual women's perception of STD risk, the context of sexual relationships with women and STD prevention, screening and treatment practices. The contexts of sexual relationships including multiple or concurrent partner relationships with both men and women placed these women at high risk for STD. Regardless of the type of relationship or belief [that] it is possible to get an STD, protection was often not used. These circumstances identify an extremely high-risk population of women with need for more extensive research to identify strategies for health care interventions.⁴¹

The text of the abstract makes it impossible to discern whether this was research on women who identify as bisexual ("bisexual women"), women who have sex with men and women ("relationships with both men and women"), or women who have sex with bisexual women ("WSW has been identified as an important vector in the spread of STIs...because of bisexuality"). The statement that "the context of sexual relationships...with both men and women placed these women at high risk for STD" is inaccurate, as it is unprotected sex that places women at risk, not multi-gendered sexual relationships. Likewise, it is confusing to say that "WSW has been identified as an important vector in the spread of STIs...because of bisexuality," as it is unclear as to whether the authors are describing bisexually-identified women who only have sex with women or women who only have sex with bisexuals — and it is unclear what these identities and practices have to do with WSW being a "vector" for STIs.

Lesbian, gay, bisexual and transgender (LGBT) youth of color often have a difficult time finding acceptance in their communities due to gender-role stereotypes that are enforced and expected in their cultures. According to Advocates for Youth, "many ethnic minority communities reinforce negative cultural perceptions of homosexuality," with about 46 percent

Newsweek portrays bisexual men as "the ultimate pariahs" of AIDS epidemic, bi activist and person with AIDS Alan Rockway of BiPOL is quoted speaking against the stereotype.

Veneita Porter, director of the New York State Office of AIDS Discrimination, helps design first educational projects and trainings for state workers, hearing judges and legal staff.

Denise Penn founding board of AIDS Walk in Orange County a Southern California conservative stronghold represented by Sen. William Dannemeyer. Dannemeyer sends letters to editors and elected officials demanding they pull support for the walk.

1987



BISEXUAL HEALTH

of bisexual and other sexual minority and questioning youth reporting experiences of physical abuse related to their sexual orientation.⁴² Additionally, in many Latino communities, the combined effects of “machismo” and devout Catholicism can fuel homophobia, and in some cases, forbid the use of condoms, creating a barrier to sexual health education and HIV prevention information for Latino bisexual and gay youth.⁴³

African-American gay and bisexual youth are confronted with the challenges of intersecting identities of race and sexual orientation, whereby they have to navigate through both white gay communities and the homophobic segments of black communities.⁴⁴ Black and Latino communities, while successful at instilling cultural pride and traditions, can sometimes create a hostile environment for sexual exploration and development for sexual minority youth.⁴⁵

Culturally enshrined ideas about masculinity play a great role in the sexual health and behavior in many cultures, especially among Latino men. A 2001 study of roughly 1,200 Latino gay and bisexual men (84 percent self-identified as gay and 15 percent self-identified as bisexual) found that 64 percent of respondents experienced verbal harassment during their childhood for being gay/effeminate, and 20 percent were harassed by the police because of being gay. Respondents also reported powerful messages — both explicit and covert — in their communities, telling them that their homosexuality made them “not normal” or “not truly men;” that they would grow up alone without children or families; and that ultimately their homosexuality was dirty, sinful and shameful to their families and loved ones. Latino gay and bisexual men also reported experiencing racism not only from society at large, but also the LGBT community, whether in the form of exclusion from social venues or sexual objectification by white non-Hispanic same-sex partners or lovers.⁴⁶

A study of the use of protective barriers by Latino men published in 2005 found that notions of masculinity played a great role in HIV/STI risk behavior practices that often manifested



Cliff Arneson

The East Coast Bisexual Network establishes the Bisexual History Archives with Robyn Ochs' initial collection; archivist Clare Morton hosts researchers. The group becomes Bisexual Resource Center in 1993.

BIPAC New York successfully challenges Hetrick-Martin Gay and Lesbian Health Clinic to remove a “Bisexual men: Fact or fiction?” workshop from curriculum.

Cliff Arneson, first non-heterosexual veteran invited to testify on gay, lesbian and bisexual veteran's health issues including HIV/AIDS, Agent Orange, post traumatic stress and homelessness before U.S. House Committee on Veterans Affairs Subcommittee on Oversight and Investigations.

1989

in inconsistent condom use.⁴⁷ The authors concluded that it is necessary to frame HIV/STI prevention strategies in terms of culturally sensitive notions of masculinity when working with Latino men who have recently had sex with both men and women.⁴⁸

Researchers whose work takes race and ethnicity into account (ideally, this should include all researchers) should maintain linguistic precision and accuracy so they do not confuse the reader and exacerbate racial and sexual stereotypes in the academic literature. For example, if the aim is to educate others on the sexual health of bisexual people of color and people of color who have sex with men and women, significant changes need to take place in the way the research is typically reported.

BIPHOBIA, BI-INVISIBILITY AND HEALTH

Biphobia and bi-invisibility are oppressive conditions that are specifically relevant to the lives of bisexuals. Bi-invisibility refers to a lack of acknowledgement and ignoring of the clear evidence that bisexuals exist. As an example of the extent and depth of biphobia, a study published in the *Journal of Sex Research* reported that heterosexuals rate bisexuals as a group less favorably than any of a number of groups (including Catholics, lesbians, people with AIDS and people who are pro-life), except for the category of people who inject illegal drugs.⁴⁹

A common misconception is that all bisexuals are more promiscuous than members of other societal groups. According to an article in the *Journal of Bisexuality*, “Ideas about the ‘commitment-phobic’ bisexual result from cultural understandings about bisexuality that see non-monogamy as a necessary condition of being bisexual and the further association between non-monogamy and infidelity.”⁵⁰ In fact, studies show that many bisexuals are in

A study of Latino men found that notions of masculinity played a great role in HIV/STI risk behavior practices that often manifested in inconsistent condom use.

A common misconception is that all bisexuals are more promiscuous than members of other societal groups.

BiPOL San Francisco produces the first National Bisexual Conference, with bisexual health one of eight workshop tracks. “NAMES Project” quilt displayed with bisexual quilt pieces; 465 people attend representing 20 states and five countries.

Carol Leigh, (a.k.a. Scarlot Harlot,) arrested at 6th International AIDS Conference in full flag regalia during women’s protest against scapegoating of prostitutes in AIDS crisis.

1990



BISEXUAL HEALTH

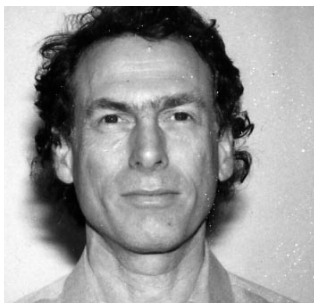
monogamous relationships. Like heterosexual, gay and lesbian people, each bisexual person in a relationship chooses whether to be monogamous, have dishonest affairs, or have an honest open relationship (sometimes called polyamory). Contrary to stereotypes, bisexuals do not necessarily require partners of more than one gender in order to be satisfied.⁵¹

Bisexuals and WSMW/MSMW can succumb to the societal stigma and oftentimes internalize the biphobic messages to which they are constantly exposed. Internalized oppression has been defined as:

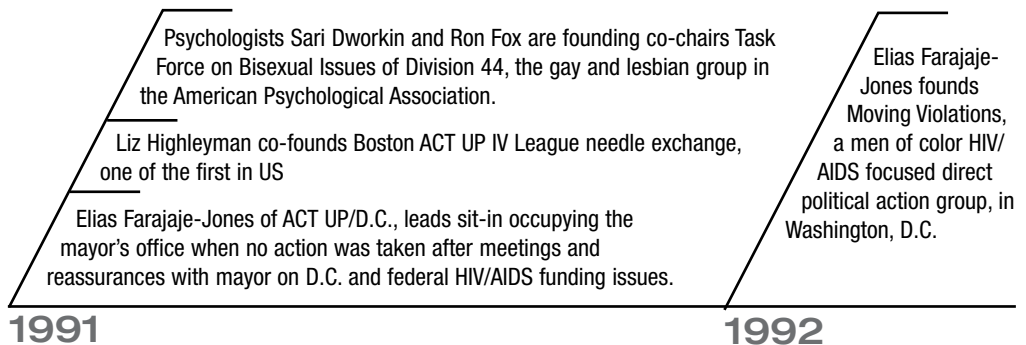
...the set of feelings and misinformation that individuals carry about themselves and other members of their own group. It is the turning inward of, and adopting as true, the misinformation that is directed toward oppressed people by external oppression, and it is any way in which we treat other members of our group as if these things were actually true of them.⁵²

Some of the negative feelings often experienced by bisexual people struggling with internalized biphobia include:

- We do not exist; we are invisible; bisexuality is not real.
- We are supporting the patriarchy; we are deserting feminism.
- We are responsible for the spread of AIDS.
- We are “on the fence,” incapable of commitment.
- We do not know who we are; we’re just “in a phase.”
- We are hypersexual, “on the prowl” at all times.⁵³



Ron Fox



Biphobia results in debilitating discrimination against bisexuals, which in turn creates a significant impact on bisexual health. A study published in 2001 in the *Journal of Public Health* found that bisexual (and gay) people reported more lifetime and daily experiences with discrimination than heterosexuals, and that “approximately 42 percent attributed this to their sexual orientation, in whole or part.”⁵⁴ Additionally, the study found that “perceived discrimination was positively associated with both harmful effects on quality of life and indicators of psychiatric morbidity.”⁵⁵

Biphobia results in debilitating discrimination against bisexuals, which in turn creates a significant impact on bisexual health.

Victims in the Shadows

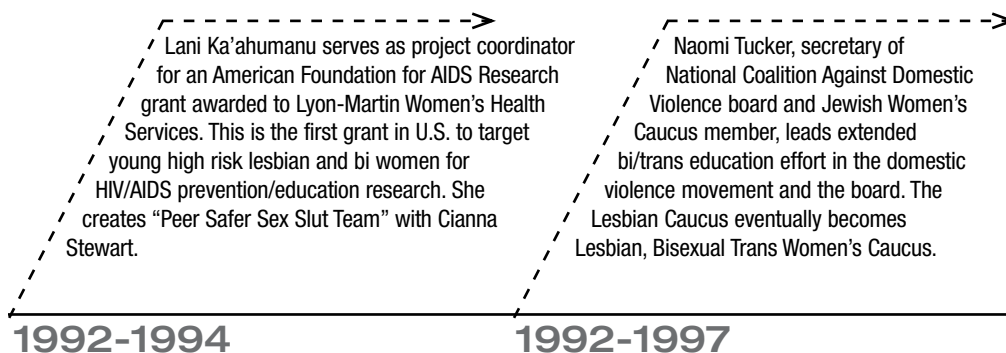
What we know about bisexuals and the violence they experience is minimal at best. The lack of research and documentation compounds the stereotypes that bisexuals lead more privileged, safer lives than their gay and lesbian contemporaries.

The U.S. Department of Justice, which tracks the race, gender (male or female) and age of victims of all crimes, does not ask about sexual orientation unless the crime is bias-motivated. So we have no large scale government studies of how many bisexuals face domestic violence, sexual assault, murder, police misconduct and other types of crime.

The Department of Justice does track hate crimes with an anti-bisexual bias. In 2004, however, it only identified 17 such incidents in the entire country. They were able to find twice as

many anti-heterosexual hate crimes. Other cases involving bisexual victims were likely categorized as being anti-homosexual based on the bias language used or on quick assumptions made by the responding officers.

With a dozen reporting sites covering more than a quarter of the nation’s population, the National Coalition of Anti-Violence Programs documented more than three times as many anti-bisexual hate crimes as did the federal government, but it still reported more anti-gay/anti-transgender hate crimes affecting heterosexual victims than bisexual victims. In 2004 agencies reporting to the national coalition worked with 59 openly bisexual survivors of hate violence. Beyond these numbers, the coalition’s annual reports contain case narratives including crime victim and murder victim narratives of bisexuals.⁵⁶



BISEXUAL HEALTH

The Nation Coalition of Anti-Violence Programs is one of the few groups in the country publicly tracking the sexual orientation of domestic violence survivors. Each year, approximately 4 percent, or about 260, of the LGBT domestic violence cases they report involve a bisexual victim. This number does not include survivors who sought services at mainstream domestic violence agencies.

Bisexual survivors who reach out to traditional shelters most often have their experience statistically erased by program staff who mistakenly believe that recording the sexual orientation of their clients is violation of that client's privacy. Even when shelters record sexual identity, clients may not be asked directly but rather have staff assume sexual iden-

tity based on the gender relationship between the survivor and the batterer.

The sparse reporting of violence against bisexuals may lead bisexuals to internalize a sense of safety leading and to a deprioritization of bisexual-related violence prevention, education and documentation efforts. We as a bisexual community must come together to have a frank conversation about our lived experience of violence before we can expect the broader world to find us in the shadows.

— Jennifer Rakowski, M.P.A., Associate Director, Community United Against Violence; Board Treasurer, National Coalition of Anti-Violence Programs

Biphobia and bi-invisibility do not just impact bisexual people; they also impact all MSMW and WSMW who do not identify as bisexual.

Biphobia and bi-invisibility do not just impact bisexual people; they also impact all MSMW and WSMW who do not identify as bisexual. While there are many reasons why some MSMW and WSMW might not identify as bisexual, one primary reason is the magnitude of biphobia and bi-invisibility. Biphobia and bi-invisibility render choosing to openly identify as a bisexual unacceptable and/or unavailable to many who might otherwise consider choosing it. Biphobia and bi-invisibility also affect heterosexual, lesbian and gay people, both as allies who may have bisexual lovers, friends or family members, and in general by promoting a narrow view of the world and limiting their own self-acceptance and experiences.



Laura Perez

Ron Fox authors first large scale research study on bisexual identity, establishes and maintains comprehensive bibliography on bi research.

Hap Stewart, M.S.W. (1934-1996), early outspoken advocate for alternative holistic HIV/AIDS care and treatment with ACT UP San Francisco, is appointed to Marin County (California) AIDS Commission.

1993

Elias Farajaje-Jones, Lani Ka'ahumanu, Laura Perez and Victor Raymond, The Indigenous Queers/Bisexual Caucus, present "Preaching to the Perverted or Fluid Desire" at the National HIV Prevention/Education Summit held by the Association of Physicians for Human Rights (now the Gay and Lesbian Medical Association).

1994

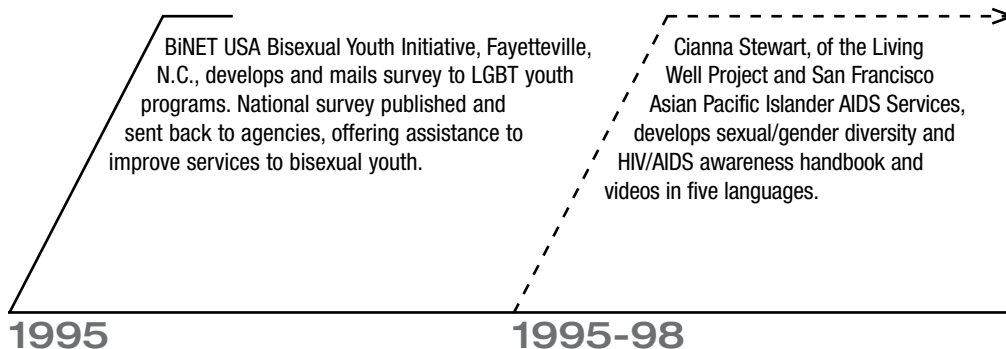
The following excerpt from a publication by Lani Ka’ahumanu, a long-time health activist and advocate for bisexual rights, and Rob Yaeger, health activist and safer sex educator, describes some roots of biphobia:

Biphobia manifests itself in various ways, including through the dissemination of stereotypes and misunderstandings about bisexual people. Examples include: viewing a bisexual orientation identity as a passing phase, an anomaly, and not a “legitimate” sexual orientation identity; targeting and scapegoating bisexual people as the carriers of HIV/STIs to heterosexuals and homosexuals; and not educating bisexual people about sexual health because they “don’t exist.”⁵⁷

Bisexuals cannot be defined by the gender of their partner(s) or potential partner(s). For example, if a bisexual woman happens to be partnered with another woman, she is still a bisexual woman, not a lesbian. Assumptions often make bisexuals “invisible,” which would be the case if this bisexual woman was walking down the street holding hands with her female partner because they would not be seen as a “bisexual woman and a lesbian” or as “two bisexual woman,” but as “two lesbians.” The same would apply to a bisexual woman holding hands with a man, except in that case there may be no recognition at all that the woman has any sexual orientation other than heterosexual. This invisibility is one of the most challenging aspects of being an out bisexual.

Therefore, in order for a health program or an HIV/STI prevention program to be effective, it needs to address the specific needs of bisexual people and the needs of those who have sex with people of more than one gender, with an awareness of the impact that biphobia and bi-invisibility have on the lives of those patients and clients.

In order for an HIV/STI prevention program to be effective, it needs to have an awareness of the impact that biphobia and bi-invisibility have on the lives of those patients and clients.



BISEXUAL HEALTH

Negative and sensationalistic response to the down low is the result of biphobia combining with racist and sexist attitudes towards African-American men and women.

Thus far, the strategies for sexual health education and HIV/STI prevention have had a binary focus. For example, for the most part, bisexual men and MSMW are still expected to get their “gay” safer sex and risk reduction information from the agencies serving gay men, and then are told to go elsewhere for anything related to safe sex with women. This expectation perpetuates the assumption that gay-identified men do not have sex with women, and it also does not hold men accountable for the health of the women with whom they are being sexual. As many public health workers would point out, it also does not reach men who identify as heterosexual but who also have sex with men.⁵⁸

As discussed earlier, biphobia intersects with racism and sexism, particularly in the case of the “down low,” which has been the focus of racialized media attention, casting African-American men as deceitful, cheating partners and African-American women as victims.⁵⁹ Among all races and ethnicities are individuals who cheat on their partners and individuals who do not talk about the sex they are having. Negative media attention, however, has focused on this one racial group. Negative and sensationalistic response to the down low is the result of biphobia, as well as racist and sexist attitudes towards African-American men and women.

Biphobia can have an effect on health because poorer health conditions are frequently the result of oppressive and/or high stress environments. When someone is subjected to hatred and fear based on their identity as a bisexual or their sexual activity with partners of more than one gender, that person’s health care and health status is compromised. Demographic characteristics such as race, income level, age, ability and gender may, and often do, compound these health conditions as well.



Angel Fabian

Gary Wolverton, HIV prevention counselor and Jon Spinner, found Bisexuals of Greater Kansas City, Missouri, which meets at Kansas City Free Health Clinic

Angel Fabian co-organizes National Task Force on AIDS Prevention’s first Gay/Bisexual Young Men of Color Summit at Gay Men of Color Conference, Miami Fla.

“What’s bisexuality got to do with it?” training held in conjunction with California’s Lesbian, Gay and AIDS LIFE Lobby and Institute. Coordinated by Stephanie Berger, Elias Farajaje-Jones, Lani Ka’ahumanu, Felicia Park-Rogers, Brandon Taylor, Roland Sintos Coloma and Cianna Stewart.

1996

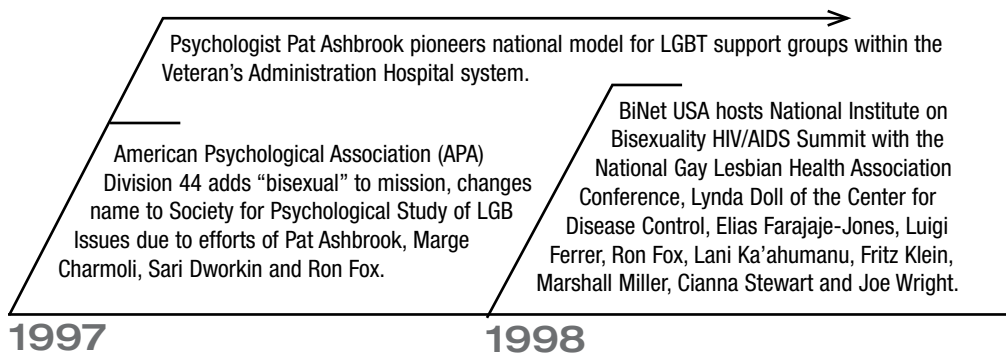
BISEXUAL YOUTH

“They used to call me all kinds of names – faggot and stuff like that... The worst thing about my first school was that they were screaming things to me in the hallways. Sometimes they would say these names in class.”⁶⁰

— Jesús M., a bisexual, seventeen-year old high school student in Long Beach, California

Youth who are exploring their sexual orientation and may or may not begin to identify as bisexual, lesbian or gay raise concerns in the minds of many parents. Anti-LGBT political and religious leaders frequently warn parents that gender-atypical behavior in children may be early signs of homosexuality. Research indicates that family members who do not accept the possibility that their children may grow up to be something other than heterosexual try to change gender-atypical behavior to prevent homosexuality, especially for males.⁶¹

LGBT youth face pervasive barriers to positive development of self-esteem and access to proper health information and care. In addition to the challenges that many youth face in learning accurate and complete sexual health information, when such information is available (i.e. in health classes or other sources), youth may only be offered information about sexual health between a legally married man and woman. LGBT youth must also confront societal stigma through the primary relationships in their life, including their parents and caretakers. Hurtful experiences at home are compounded by the harassment LGBT youth face in school, which are exacerbated by discriminatory behaviors of teachers and administrators who oftentimes refuse to acknowledge the harassment and/or protect the students. The failure on the part of school officials to protect their students and punish the offenders results in “students who are the targets of harassment (getting) the message that they are not worthy of protection,



Bisexual and lesbian girls are more likely to be sexually harassed and threatened with sexual violence than heterosexual girls.

(while) the students engaging in acts of harassment get the message that they can get away with harassing their gay peers.”⁶²

Additionally, there are gender differences in peer harassment of sexual minority young people. Bisexual and lesbian girls are more likely to be sexually harassed and threatened with sexual violence than heterosexual girls.⁶³ A study of students in western Massachusetts in 2000 revealed that 63 percent of lesbians and bisexual girls reported being “touched, brushed up against, or cornered in a sexual way” compared to 52 percent of heterosexual girls.⁶⁴ Unfortunately, the harassment often escalates to violence, with 23 percent of the bisexual and lesbian girls in that study reporting that their peers “attempted to hurt them in a sexual way (attempted rape or rape),” compared to just 6 percent of the heterosexual girls in the sample.⁶⁵

The short and long term negative effects of exposure to this type of perpetual harassment, both physical and verbal, add up to devastating health consequences for sexual minority youth. Many bisexual youth are reprimanded for exploring or expressing their same-sex attractions, and many suffer severe physical and emotional wounds that they carry throughout their lives.⁶⁶

One area where we see the effects of biphobia and bi-invisibility is in the health and well-being of bisexual people.

WHY FOCUS ON BISEXUAL HEALTH?

One area where we see the effects of biphobia and bi-invisibility is in the health and well-being of bisexuals, MSMW and WSMW. This is because, as confirmed by the available research, these groups experience greater health disparities compared to the broader population, and they continue to experience biphobia and bi-invisibility from healthcare providers, including providers who may be gay or lesbian, or are knowledgeable about homosexuality and accepting of their gay and lesbian clients.

Center for Disease Control/UCLA School of Nursing hosts a Bisexual People of Color HIV Prevention and Education Summit that was conceived by Bill Wedin, co-coordinated by Lani Ka’ahumanu with, Elias Farajaje-Jones, Ron Fox, Karl Hamner, Dominique RosaNegra Leslie and Cianna Stewart.

Dr. Fritz Klein founds *Journal of Bisexuality*, the first academic, quarterly journal on bisexuality.

Marshall Miller founds BiHealth Program at Fenway Community Health, the first funded bisexual-specific program targeting bisexual people and MSMW (men who have sex with men and women) and WSMW (women who have sex with men and women) who don’t identify as bisexual. Program publishes “Safer sex for bisexuals and their partners” brochures.

1999

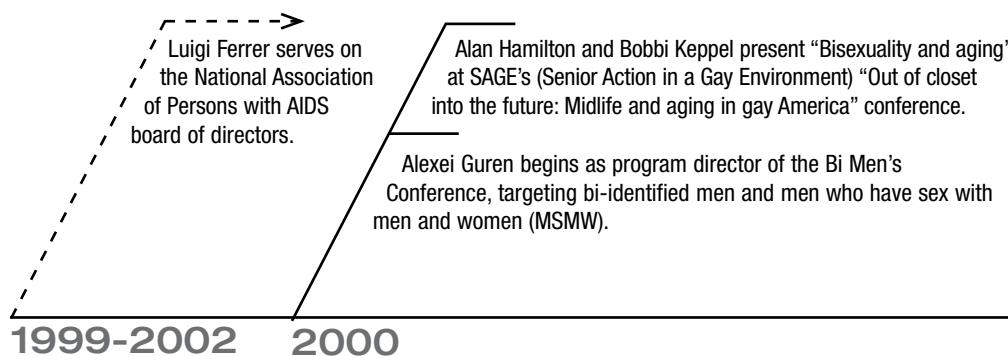
Although we have some information about the health of bisexual people and of men and women who have sex with more than one gender, there is still much that we do not know. It is important for researchers to employ methodologies that group bisexuals together, or that group together people who have sex with partners of more than one gender; rather than only the more common practice of grouping gay and bisexual men or lesbian and bisexual women together, never separately examining attributes of and needs of the latter. Why? Because bisexual women's issues are not always the same as lesbian issues, even for bisexual women who only have sex with partners of the same gender or for lesbian-identified women who have sex with men as well as women. Bisexual men's issues are not always the same as gay male issues, even for bisexual men who only have sex with partners of the same gender or for gay-identified men who have sex with women as well as men. Likewise, heterosexuals' issues are different from those of bisexuals, even among heterosexually-identified MSMW and WSMW.

Why would health issues be different for people who share similar lived experiences but use different sexual orientation labels? Some of the issues would be similar, including some concerns related to sexual health. But because of biphobia and bi-invisibility, which affect bisexuals on an immediate, personal level, bisexuals may have very different health experiences. These differences may result from increased stress and experiences of discrimination in general, and/or more specifically from experiencing biphobia from healthcare providers.

Focusing on bisexual health can help improve the quality of life of bisexuals by having more factual information about how bisexuality intersects with health concerns, and by promoting education about the experiences and needs of bisexuals in healthcare settings. Focusing on bisexual health is a means of eradicating biphobia and creating visibility for bisexuals and people who have sex with partners of more than one gender. This kind of inclusiveness can create the conditions for better health care for all individuals, including bisexuals.

Focusing on bisexual health can help improve the quality of life of bisexuals by having more factual information about how bisexuality intersects with health concerns.

Mary Murphy (below), health unit coordinator, University of Minnesota Medical Center Fairview, Bisexual Organizing Project [BOP] Chairperson.



While not generalizable to all bisexuals, an article published in the *British Journal of Psychiatry* reported that bisexuals in a community survey of young and middle-aged adults reported poorer mental health than people of any other sexual orientation in the sample.⁶⁷ This has important implications for health research, such as studies of mental health which group together homosexuals and bisexuals.⁶⁸

...bisexual orientation is associated with worse mental health than heterosexual orientation on a range of measures of psychological distress, with the homosexual group falling between the two. *Previous studies may have overstated the risk of mental health problems for homosexuals by grouping them together with bisexuals* (emphasis added).⁶⁹

BISEXUALITY AND SOCIAL SCIENCE RESEARCH

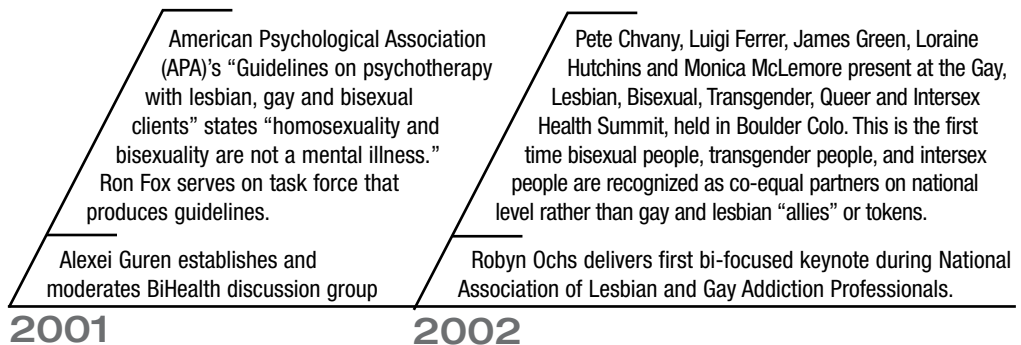
Only a handful of studies separate out bisexuals and/or report on their bisexual-specific findings. Fewer compare bisexuals to people who are not bisexual.

Many social science and health research papers have been published about lesbian and gay populations. The research that takes bisexuality into account often folds bisexuals into gay and lesbian populations, comparing “gay and bisexual men” or “lesbian and bisexual women” to heterosexual men or heterosexual women, respectively. Thus any particular needs of bisexuals are eclipsed and conflated. Only a handful of studies separate out bisexuals and/or report on their bisexual-specific findings. Fewer compare bisexuals to people who are not bisexual.

Definitions of what it means to be lesbian, heterosexual, gay, or bisexual have not been standardized in the academic or medical literature. For example, some studies will categorize a participant as a lesbian if she so describes herself; others will categorize her as such if she reports only having had sex with same-sex partners, regardless of how she might identify



Monica McLemore, RN, Ph.D.



herself. Some studies will categorize a participant as bisexual if she reports having sex with men and with women, again regardless of how she might identify herself. What if a person such as the white lesbian quoted at the beginning of this publication participates in these types of studies? What can then be verified about lesbians, bisexuals or MSMW and WSMW? Or, from other studies about gay men, bisexuals or MSMW? About bisexuals in general? How can one compare the findings from one study to another? The answer, sadly, is that researchers often cannot glean data specific to bisexual people from this reductionist approach.

Researchers should use standardized definitions of sexual orientation labels, such as bisexual, remaining extremely clear about what those definitions are throughout the course of their work, both in conducting studies and in reporting findings. A good set of guidelines is to allow participants to self-report their own gender and sexual orientation labels and to describe the gender(s) and sexual identit(ies) of their sexual partner(s). Reported analyses should reflect these identities. For example, we provide the following *hypothetical* findings:

- Participants who identified as bisexual, regardless of whether or not they were MSMW and WSMW, were more likely to report depression than participants who did not identify as bisexual, regardless of whether or not they were MSMW, MSM, MSW, WSMW, WSW or WSM;
- Participants who were MSMW and WSMW, regardless of how they described their sexual orientation, were found to be at greater risk for STIs when compared to participants who had only had sex with partners of one gender, regardless of how they described their sexual orientation;
- Participants who identified as heterosexual and were WSMW were less likely to schedule routine mammograms, in comparison to participants who identified as heterosexual and had only had sex with partners of one gender.

North American Conference on Bisexuality hosts Bi Health Summit organized by Cheryl Dobinson, Luigi Ferrer and Ron Fox , and the first Bi People of Color Summit is coordinated by Angel Fabian and Penelope Williams.

Center for Sex and Culture, founded by Carol Queen and Robert Lawrence in 1994, opens archive and sexuality research library, becoming the first public non-profit community-based space designed for adult sex education, including continuing professional education.

Loraine Hutchins and Linda Poelzl graduate from The Institute for the Advanced Study of Human Sexuality's first California Sexological Bodyworkers Certification Training as part of new movement of somatic erotic educators.

2003



These statements are all examples of the type of language that can be used in public health and policy research and reporting.

SEXUAL PREJUDICE: A CASE STUDY ON THE ERASURE OF BISEXUALS IN ACADEMIA AND THE MEDIA

By Loraine Hutchins, Ph.D.⁷⁰

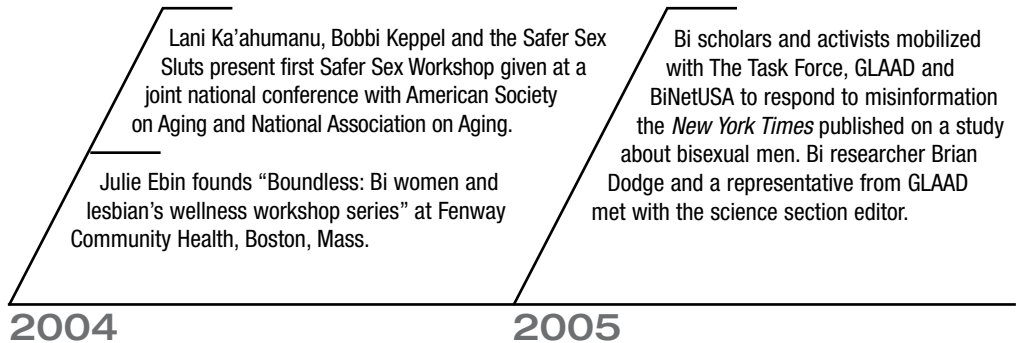
The scapegoating of bisexual men

If you had flipped to the front page of the *New York Times* science section on July 5, 2005,⁷¹ you'd have read that men who call themselves bisexual are liars. Why on earth did an otherwise reputable newspaper make such an outlandish, inaccurate and harmful claim?

The article, "Straight, gay or lying: Bisexuality revisited," was written by *New York Times* reporter Benedict Carey. It was based on his reading of "Sexual Arousal Patterns of Bisexual Men," by Gerulf Rieger, Meredith L. Chivers and J. Michael Bailey, published in *Psychological Science*, the journal of the American Psychological Society.⁷² The article questions the veracity of bisexual men's self-definition, and thus the very legitimacy of bisexuality as an orientation, at least for men. (Women, the authors say, are not as easily quantified. They have done other research showing ALL women are essentially bisexual, but that is another story.) This study focused only on men.

What they used on the men — a group of about 100 who were pretty evenly divided into those

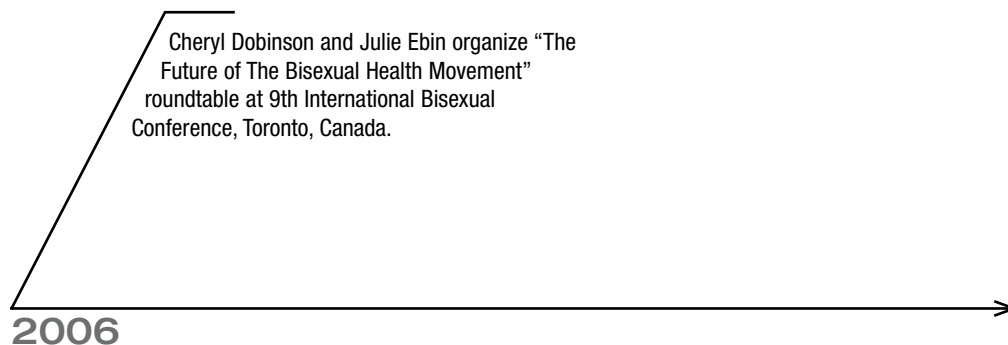
Miriam Friedland, Esq., (below) of Maryland and Washington D.C. focuses her legal practice on family, bioethics and guardianship proceedings, active with local Muscular Dystrophy Association.



who self-labeled as homosexual, heterosexual and bisexual — was a penis-meter (plethysmograph) that measured genital blood flow or level of erection while they watched pornographic films. No subject was offered film footage representing penile-vaginal intercourse because, as the researchers explained, they were afraid that kind of footage would be too confusing to evaluate. Each subject was therefore shown several two-minute male/male porn films and also several two-minute clips of female/female porn. Because the researchers threw out 35 percent of their sample as “non-responders” (the guys of all orientations for whom the lab/wiring/porn thing did not work to get them aroused), and since out of that remaining group the men who self-identified as bisexual had penises that, for the most part, did not become erect during the two minute woman-on-woman clip(s), the researchers concluded that the bisexual men were only masquerading as such and were actually homosexuals. Further, they took as given that *arousal* in men equals *orientation*, and therefore that bisexual men do not exist.

Casting doubt

The study might have been just another that never made it out of the pages of research journals, but reporter Benedict Carey picked up on the advance copy the researchers sent to him and wrote “... a new study casts doubt on whether true bisexuality exists, at least in men.” By saying that the study “casts doubt on” the existence of bisexuality, the *New York Times* moved away from objective reporting on the study and toward taking a position on its validity. The *Times* effectively endorsed Rieger et. al’s opinion, giving their research much more credibility than it would otherwise have had. The story made its way into other news media and was reprinted and commented on around the world.



The organized response

Within 24 hours of the article's release, an ad hoc coalition of LGBT activists and academics came together under the leadership of the National Gay and Lesbian Task Force to coordinate a national response. The Task Force prepared a press release and a fact sheet critiquing the study the article was based upon.⁷³ More importantly, they enlisted BiNet USA: The National Bisexual Network and the Gay and Lesbian Alliance Against Defamation (GLAAD)⁷⁴ in a series of nationwide conference calls that helped strategize a way to hold the *New York Times* accountable for its misinformation. At least one group beyond the LGBT community — the progressive media watchdog group Fairness and Accuracy In Reporting (FAIR) — also issued a statement protesting the *Times* handling of the research.⁷⁵ The ad hoc coalition moved ahead with plans to arrange a meeting with the editor of the *New York Times* science section to discuss the newspaper's coverage of Bailey et. al.'s research and their future coverage of bisexuality and other sexual orientation/identity issues. A meeting did finally take place on July 27, 2005, and coalition representatives aired their concerns and suggestions, with the *New York Times* promising to take them into consideration in future reporting.

The research flaws

The Task Force, with input from LGBT academics who had read advance copies of the Rieger et. al. study, developed a preliminary fact sheet, which stated that the study's assertion that arousal in men equals sexual orientation is a ridiculous oversimplification of the complexity of sexual desire. Rather, arousal is "... a combination of cognitive and physical responses, not educible to genital responses to pornography."⁷⁶ They also questioned the validity of the plethysmograph, a controversial device whose past includes being used to screen out alleged homosexuals seeking government service or U.S. citizenship.

The Task Force fact sheet further asked how seriously one could take any study that had to throw out 35 percent of its respondents as non-responders (those men who had no measurable erections while watching the films), and pointed out that the researchers said that this study was part of a larger group of other such studies, but that it really was not.

In addition to the above methodological problems, the fact sheet noted a number of serious controversies that have plagued one of the study's authors, Dr. J. Michael Bailey. The *New York Times* did not mention that Bailey's research reputation has been seriously questioned.⁷⁷ For example, Bailey made an unwelcome name for himself within the transgender community in 2003 after the publication of his book about feminine gay men and transgender women, *The Man Who Would Be Queen: The science of gender-bending and transexualism*. In reviewing the book, *Publishers Weekly* wrote:

Bailey tends towards overreaching, unsupported generalizations, such as his claim that “regardless of marital laws there will always be fewer gay men who are romantically attached” or that the African-American community is “a relatively anti-gay ethnic minority.” Add to this the debatable supposition that innate “masculine” and “feminine” traits, in the most general sense of the words, decidedly exist, and his account as a whole loses force.⁷⁸

Sexuality research: The larger picture

According to bisexual psychologist and author Ron Fox, the field of psychology has been evolving through a three stage reinterpretation of sexual orientation since the early ‘70s, when therapists stopped seeing homosexuality as an illness. At the first stage it is acceptable to be lesbian or gay because homosexuality is no longer an illness. But sexual orientation itself is still seen as dichotomous, either/or, same-sex OR different-sex oriented, with nothing in between. Most of psychology has now moved beyond that stage and sees dichotomous sexual orientation as too simplistic.

At this second stage, bisexuality is recognized as a legitimate orientation. When the multi-dimensionality of sexual orientation is sufficiently explored, it becomes clear that gender identity and expression also exist along a continuum. This is the third stage where, as a result of lesbian, gay, bisexual and transgender psychologists working together with heterosexuals to develop a more complex understanding of sexual orientation, the same complex understanding of gender becomes integrated into how psychology and sexuality research is conducted and taught.

Our response to the *New York Times* article elapsed over a mere month in time. But the larger picture of how this experience relates to other LGBT stories with unexplored bisexual angles remains to be told. Related discussions are needed on the developing definition of bisexual orientation, the relationship between transgender and bisexual identities, the cultural and political framing of the DL (down low) phenomena among men of every race and ethnicity who have sex with more than one gender, and so-called ex-gay “conversion therapies” and their relation to bisexuality.⁷⁹

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WHAT ARE BISEXUAL HEALTH ISSUES WITHIN THE CONTEXT OF HIV AND STI PREVENTION?

There are health issues that are specific and generalizeable to bisexuals as a group and health issues that are specific and generalizeable to people who have partners of more than one gender as a group. This literature review shines a spotlight on specific challenges related to HIV and STI prevention among bisexuals, WSMW and MSMW.

Unfortunately, existing research on this topic is scarce. Much of it lumps bisexuals into either “lesbian” or “gay male” categories, making it difficult to draw any conclusions about bisexual health. Data on bisexual women’s sexual health is less prevalent than men’s, particularly data on WSMW. Additionally, not all researchers take into consideration whether their study participants identify as bisexual, MSMW, WSMW or something else.

It is important to recognize that many, if not most, bisexual people do not come out to their health care providers or to researchers due to judgments that silence, stereotypes that shame, and assumptions that erase bisexual identity. When a woman is partnered and says she is using birth control, there may be an automatic assumption that she is monogamous and heterosexual. A man in a same-sex relationship is assumed to be gay and therefore not in need of information about sex with women. When a man says he is married or partnered, there are often no subsequent questions asked about other sexual partners. Health care providers need to become aware of how to serve this often-overlooked community and its unique concerns, looking at a patient’s sexual behavior rather than simply a patient’s sexual identity.

Bisexual women and WSMW

Little information is available about female sexual health, especially in regards to WSMW. A study published in the *American Journal of Public Health* 1998 is a perfect illustration. The report featured statistics about both the male and female study participants, all of whom were receiving treatment for HIV. However, the researchers identified all women as simply “women,” with no sexual orientation descriptors. In contrast, the men in the study were categorized as either gay men, bisexual men or heterosexual men.⁸⁰

One study that actually does highlight bisexual women’s health is a 1996 study by Cochran and Mays, which found that bisexual women are more likely than lesbians to use latex or plastic barrier protection for oral sex with women.⁸¹ More recent research, like Cochran and Mays, found that among WSW and WSMW, having larger numbers of female partners is positively correlated with having vaginal infections, specifically bacterial vaginosis, trichomonas vaginalis and herpes.^{82,83} These findings were consistent regardless of numbers of male

Many, if not most, bisexual people do not come out to their health care providers due to judgments that silence, stereotypes that shame, and assumptions that erase bisexual identity.

partners, indicating that these vaginal infections may be a female-to-female STI. The available research indicates that healthcare providers working with WSMW should screen for vaginal infections and educate patients on safer sex between women.

“Straight” MSMW?

Recent analysis of data from a study of men in New York City collected in 2003 indicates that a significant percentage of MSMW identify as heterosexual:⁸⁴

- 10 percent of men in New York City who identify as heterosexual have had sex with at least one man in the past year;
- 73 percent of men in New York City who have had sex with men identify as straight;

- These men are less likely than self-identified gay men in New York City to use condoms or be tested for HIV.

These data indicate that health care professionals should not rely solely on clients' sexual orientation labels for assessing HIV/STI risk.

Bisexual men and MSMW

In a study published in 2003, Ciccarone et al. reports that 40 percent of HIV-positive gay and bisexual men have had sex without disclosing their HIV status to their sexual partners, usually within the context of a “casual dating” or a nonexclusive relationship.⁸⁵ The study does not distinguish between its gay and bisexual participants, which makes it impossible to extrapolate data specific to the bisexual cohort. Nevertheless, HIV prevention programs working with HIV-positive clients should take relationship context into account when discussing disclosure and behavior.

Crepaz and Marks studied safer sex practices and disclosure of status to partners, among HIV-positive men.⁸⁶ They found no differences between men who have sex with women (MSW), men who have sex with men (MSM) and MSMW regarding which group was more likely to practice safer sex techniques and/or disclose serostatus to their partners. Unfortunately, their reporting confuses these groups (MSW, MSM and MSMW) with sexual orientation identities. For example, the use of the phrase “heterosexual men as well as men who have sex with men” does not account for men who identify as heterosexual but also have sex with men.⁸⁷ They also state that in their research “sexual orientation was defined behaviorally (sex with men only, mostly men, men and women equally, mostly women, women only),”⁸⁸ which conflates sexual orientation with data on the gender of sexual partners. This is another example of how



Bisexually-identified MSMW in San Francisco were not a common vector or “bridge” for spreading HIV from male partners to female partners due to high rates of using barrier protection and extremely low rates of risky behavior.

imprecise categories limit the ability to obtain information about MSMW and WSMW.

Internationally, Filipe et al. (2005) studied 250 HIV-positive, heterosexually-identified and bisexually-identified MSW in Brazil and found that the majority of bisexual HIV-positive men did not use condoms — and did not perceive themselves as being at risk for HIV — before learning they were HIV-positive.⁸⁹ Izazola et al. found that MSMW in Mexico have more anal intercourse with female partners than MSW and less anal intercourse with male partners than MSM.⁹⁰ Among MSMW in their study, preferred sexual behaviors with male partners were oral sex and mutual masturbation. While not generalizable to all bisexuals, the findings of these studies are just one example of why health care practitioners working with bisexually-identified men, as well as with men of other sexual orientations, need to encourage barrier use and HIV testing for patients and their partners.

Izazola et al. concluded that the MSMW in their sample had a much lower risk of acquiring HIV because they had fewer male partners and were less likely to have anal intercourse with them. As a group, the MSMW in their sample did not appear to have a high prevalence of HIV and may not be an effective epidemiological bridge for HIV transmission.⁹¹ Ekstrand et al. also found that bisexually-identified MSMW in San Francisco were not a common vector or “bridge” for spreading HIV from male partners to female partners due to high rates of using barrier protection and extremely low rates of risky behavior.⁹² This was further confirmed by James Kahn and colleagues, who found that in a sample of 40,000 new HIV infections in the US, only 1 percent occurred in women who had contracted the virus from MSMW.⁹³ It is important to note that these studies are all at least 10 years old, which highlights the need for further research.

Injection drug use and sexual health

Kral et al. found that 45 percent of gay-identified MSM who are injection drug users (IDU) in their study were HIV-positive, compared to 25 percent of bisexually-identified MSM-IDU. Gay MSM-IDU and bisexual MSM-IDU were equally likely to have anal sex with men, and both groups were equally likely to report having had six or more male partners in the past six months.⁹⁴ Given that bisexual MSMW-IDU are having the same types of sex with the same numbers of men as gay MSM-IDU, it is likely that the lower rate of HIV-positive status among bisexual MSMW-IDU in this study is either because of a lower likelihood of sharing needles or a greater likelihood of using barrier protection. While not generalizable to the entire population, this study indicates that bisexual MSMW-IDU may be contracting HIV less frequently and could be studied as role models for MSM-IDU who want to stay HIV-negative. What are bisexual MSMW-IDU doing to keep from seroconverting and how can others follow that model? More research is needed to answer these important questions.

In an article published in 2005 in the academic journal *AIDS*, researchers compared gay and bisexual IDU to other gay and bisexual men. They found that IDU were more likely than other men to be white and to identify as bisexual, and that these men reported less education, less income, more anxiety, more hostility, more childhood sex abuse and greater unemployment.⁹⁵ Gay and bisexual IDU engaged in more unprotected sex than gay and bisexual men who did not use drugs. The researchers concluded that health care providers should pay attention to the interaction effect of these variables.

Sexual health issues for bisexual youth

“Everyone thought I was a freak – I tried to show off, always had a boyfriend to prove I was okay...In tenth grade I got pregnant.”

—Kelsie N., a young woman from Texas⁹⁶

Many youth who identify as lesbian, gay, or bisexual, engage in same-sex and different-sex sexual activity. Unfortunately, some of this includes risky sexual behaviors, including unprotected sex that can lead to exposure to HIV, STIs and pregnancy. The Human Rights Watch found that 31.6 percent of sexually active students who either identified as gay, lesbian, or bisexual or have had same-sex sexual experiences had been pregnant or had gotten someone pregnant.⁹⁷

Case et. al. found that bisexual women were twice as likely to have never given birth compared to heterosexual women.⁹⁸ However, among women who had given birth, bisexual women were twice as likely as heterosexual women to have done so during their teenage years. Not giving birth may put bisexual women at greater risk for ovarian and endometrial cancers, and teenage pregnancy also has health implications.⁹⁹

In 1996 Cochran and Mays published a study that analyzed sexual behavior and HIV risk among young lesbians and bisexual women.¹⁰⁰ Participants were recruited at gay pride events, potentially excluding bisexual women who are in different-sex relationships and who socialize in heterosexual communities. The researchers found that, while the overall majority of women do not use barrier protection during oral sex with women, those participants who do use barriers during oral sex with women are *most likely* to identify as bisexual. Despite that finding, Cochran and Mays reported that “high-risk sexual experimentation... is most likely to occur among teenagers who do not yet consider themselves to be lesbians.”¹⁰¹ It is important to note, however, that bisexual identification is not necessarily transitional, simply “experimentation,” or a teenage phase. Researchers should be aware of unintentional implications that bisexually-identified clients are not “yet” gay or lesbian and/or are necessarily engaging in high-risk behavior.

An article published in 1996 in *Family Planning Perspectives* reported that female bisexual teens were more likely than their heterosexual counterparts to have a history of physical and sexual abuse.¹⁰²

While the overall majority of women do not use barrier protection during oral sex with women, those who do are most likely to identify as bisexual.



They also reported twice as many pregnancies. Health care providers working with female teens should be aware of the implications of these findings and should be prepared to give referrals for counseling, birth control and pregnancy planning advice. As the article concludes:

...clinicians who provide reproductive health and family planning services should not assume that their pregnant adolescent clients are heterosexual or that adolescents who identify themselves as lesbian or bisexual do not require family planning counseling.¹⁰³

Several studies of bisexual and gay young men in San Francisco, Berkeley, Calif., and New York provide evidence of sparse condom use in this group. In San Francisco and Berkeley, 33 percent of sexual minority young men surveyed had engaged in unprotected sex in the previous six months, and in New York, 28 percent of the sample reported having unprotected sex in the previous year.¹⁰⁴

Bisexual youth, along with other sexual minority youth, are at particularly high risk for negative health consequences if they experience homelessness. Youth who explore their sexuality and live with homophobic parents or in abusive foster homes wind up on the streets where they experience substance abuse, greater risk for mental health problems, and may be forced to resort to survival sex in exchange for food, shelter, or money.¹⁰⁵

Sexual health issues for bisexual elders

Physicians and mental health providers should pay special attention to the needs of bisexual elders. Older bisexual individuals are at risk for feeling isolated from their community.

Physicians and mental health providers need to also pay special attention to the needs of bisexual elders. Older bisexual individuals are at risk for feeling isolated from their community, which may eventually lead depression and social isolation. Many bisexual older people have identified as heterosexual or homosexual for a very long time and find it difficult to engage with the rest of the bisexual community.¹⁰⁶

Existing social groups and coming out groups oftentimes focus on younger people and gay men/lesbians, possibly leaving the aging bisexual population out of their programming. Additionally, HIV/AIDS prevention programs are “seldom prepared to consider aging issues,” much less bisexual issues.¹⁰⁷ Additional research is needed to ensure that the unique needs of bisexual elders are understood and included in future programming.

Health care implications

It is imperative for health care providers to create a safe, affirming atmosphere for bisexuals, MSMW and WSMW in order to facilitate dialogue on well-being and improve the delivery of health care to minority populations. Many members of the bisexual community have negative experiences with health care providers, with problems ranging from disclosure of sexual orienta-

tion to distribution of improper or incomplete sexual health information. Cheryl Dobinson and colleagues explain that disclosure is important for bisexual clients for many reasons, including:

...the desire to be seen as a whole person, with bisexuality being part of who they are, to increase comfort levels and understanding, so proper diagnoses can be made and relevant information given, so providers can be sensitive and understanding to the issues being faced, for appropriate resources referrals, and generally because it is important for mental health and emotional wellness.¹⁰⁸

Clients who experience homophobia, biphobia or ignorance when dealing with health care providers may not receive appropriate information about sexual health, with some physicians “equating bisexuality with having multiple partners, not receiving appropriate information about safer sex with male and female partners, voyeurism, inappropriate jokes or comments, bisexuality being seen as the problem, and being told that you’re either gay or straight.”¹⁰⁹ For example, women who identify as lesbian to their health care provider may not be given any information on safer sex techniques with men because it may be assumed that the client’s only sexual activity in the past and in the future is solely with women.

This kind of misinformation has especially devastating effects on youth who are just beginning to explore their sexuality. Bisexual youth are becoming sexually active without being provided with the information they need to responsibly and safely engage in sexual activity. However, in order to receive proper information, youth have to inform even the most sensitive health care providers of their sexual activity and identity. Unfortunately, disclosure is particularly problematic for sexual minority young people in the health care setting. According to The National Association of Pediatric Nurse Practitioners:

Most nonheterosexual youths will not disclose their sexual orientation to their primary health care provider without being asked. Therefore, providers should raise issues of sexual orientation and sexual behavior with all adolescent patients in a sensitive clinical environment.¹¹⁰

Dobinson et al. recommend that health care providers take the following steps to treat bisexual clients:

- Add new services or expand existing services to cater to bisexual people;
- Ensure safe and accessible services for bisexual individuals;
- Educate other health providers about the unique needs of the bisexual community.¹¹¹

Health care providers can look to the BiHealth Program at Fenway Community Health in Boston, Mass., for an excellent example of how to effectively reach out to bisexual people, MSMW and WSMW, and their HIV/STI prevention needs.

Women who identify as lesbian to their health care provider may not be given necessary information on safer sex techniques with men.



the bihealth program at fenway community health in boston, massachusetts

INTRODUCTION¹¹²

While the BiHealth Program's approach is unique, it can easily be replicated and adapted by other programs around the country.

This is a “how-to” guide about implementing HIV and STI prevention strategies designed for people who identify as bisexual and people who have sex with men and women but who do not identify as bisexual.¹¹³ We describe approaches developed and field-tested at the BiHealth Program at Fenway Community Health in Boston.¹¹⁴ While the BiHealth Program's approach is unique, it can easily be replicated and adapted by other programs around the country seeking to be more effective at meeting the needs of bisexual people in their communities.

Who will benefit from reading this guide?

- **Staff and managers of existing HIV and STI prevention programs.** Historically, many HIV and STI prevention programs have either ignored bisexual people entirely, or included them in their efforts under the banner of “gay and bisexual men;” “lesbians and bisexual women” or “gay, lesbian and bisexual people.” This guide will explain the limitations of these approaches and address how even simple modifications to existing prevention programs can yield extraordinary results.
- **Journalists, researchers, counselors, therapists, sex educators and members of the general public seeking to better understand bisexuality and HIV/STI prevention.** Many media outlets and other information sources have provided, and often continue to provide, a confusing and inaccurate portrait of bisexuality and HIV/STI transmission and prevention. This guide provides a way to understand the issues clearly and accurately, and offers language for explaining the trends to general public. Counselors and therapists may find the explanation in this guide of the differences between behavior and identity particularly helpful when working with clients who are questioning or coming out. (See page 48, “Key concept: The difference between behavior and identity”).
- **Departments of public health, foundations and other funding**

agencies. Many funders correctly identify a need for prevention efforts for bisexual people and people who have sex with men and women, but lack models to implement these efforts. This guide provides a blueprint for starting similar programs in other communities. Since its inception, funding for the BiHealth Program has ranged from \$60,000 to \$225,000 per year, but many of the highlights of this program could be implemented with a \$5,000 or \$10,000 grant. A committed group of community activists could at least begin to accomplish much of what's described in these pages on a budget of next to nothing, and demonstrate to their larger communities the need for sustained funding and support.

- **Bisexual people and communities.** Historically, bisexual people have faced several interconnected challenges regarding HIV prevention. The first problem was one of invisibility and ignorance of bisexual people's existence and lives. Out bisexual activists were on the front lines early in the HIV epidemic (see timeline on p.18), yet bisexuals were not included in prevention education efforts, or even in the statistics about those contracting HIV and dying of AIDS. Once bisexual people were acknowledged, they were scapegoated as "carriers" of HIV from gay men to heterosexual women. Bisexual women were also scapegoated as carriers of disease from their male sexual partners to the lesbian community. The scapegoating was very visible in the 1980s and early 1990s, and, unfortunately, still continues today.¹¹⁵

To the contrary, many self-identified bisexuals say they have a strong personal commitment to safer sex. As a result of the difference between public perception of bisexuals and actual behavior, some self-identified bisexuals are quick to draw distinctions between themselves and the (potentially larger) group of men who have sex with men and women (MSMW) and women who have sex with men and women (WSMW) but who do not identify as bisexual.¹¹⁶

Instead of drawing distinctions, self-identified bisexual communities are well-positioned to provide prevention programming for larger groups of WSMW and MSMW. Most bisexual communities openly accept and understand the experience of those who have attractions to both men and women. Many bisexual community institutions – support groups, hotlines, speaker's bureaus and organizations – already provide resources and support to MSMW and WSMW. Offering effective HIV and STI prevention programming is a logical extension of these efforts.

Bisexual people also benefit in other ways from the capacity-building opportunities afforded through grants and other funding for HIV/STI prevention. While the bisexual community has had several nonprofit organizations working on local, national and even international levels to educate about bisexuality, it has lacked the funds to support paid staff. Seeking funding from

A committed group of community activists could begin to accomplish much of what's in these pages on a budget of next to nothing, and demonstrate to their larger communities the need for sustained funding and support.



This guide will detail how to leverage a bisexual health program to not only provide direct service to clients, but also to educate other providers, the media and the general public about bisexuality.

departments of public health and private foundations kills the proverbial two birds with one stone, addressing the HIV prevention needs of the community and also the secondary benefit of having full-time staff devoted to bisexual community organizing. This guide will detail how to leverage a bisexual health program to not only provide direct service to clients, but also to educate other providers, the media and the general public about bisexuality.

THE BEGINNINGS OF BIHEALTH

When I (Marshall Miller) started working at Fenway Community Health in 1997, my salary was funded by an HIV-prevention grant from the Massachusetts Department of Health. Fenway Community Health is named for the neighborhood in Boston in which it is located. Fenway's clients – most of whom identify as gay, lesbian, bisexual and/or transgender – are served through its medical and mental health departments, and through the Fenway Institute, its center for health-related research, advocacy and education.

Boston has one of the most active bisexual communities in the country and is home to the Bisexual Resource Center (www.biresource.org). Seeing the opportunities to introduce the public health community to the bisexual community and vice versa, I applied for a \$5,000 mini-grant from the Massachusetts Department of Health to fund a conference titled, "Playing safe with both teams: Bisexuality and HIV prevention." The conference, held in 1999, was co-sponsored by Fenway Community Health and the Bisexual Resource Center.

The conference broke new ground in several important ways. It served as a great introduction to bisexuality and biphobia for the public health officials in attendance, most of whom were very sympathetic to the issues presented but had never had a chance to hear them directly addressed. The conference was also very motivating to the bisexual-identified people in attendance, many of whom were eager to get involved in community HIV prevention efforts but had not found a way yet. The attendees gave the conference rave reviews, and the momentum it created made the BiHealth Program possible.

Key concept: "Increasingly Intensive Intervention"

The conference coincided with a shift in thinking at the Massachusetts Department of Health as to how best to address the HIV-prevention needs of high-risk populations. The department adopted a theory they called "Increasingly Intensive Intervention," an approach to HIV prevention that seeks to empower those most at risk for the virus. This group of people the program would empower was termed a "priority population."

"Increasingly Intensive Intervention" is an approach to HIV prevention that seeks to empower those most at risk for the virus.

It is a multi-stage model, and the first stage is a public outreach campaign designed to introduce the priority population to the prevention program and encourage their involvement. Then the participants examine some of the root causes, or underlying reasons, for HIV transmission in their community, such as poverty, racism, sexism, homophobia and inequities in relationships. The participants then seek to address these issues in their community by educating their peers. In the final stage, this group of empowered educators tackles the root causes by organizing for social change. This final stage can include everything from lobbying legislators to educating medical providers about homophobia to starting a support group for youth, depending on the needs of the community and the interests of the educators.

The magic of increasingly intensive intervention is that it can foster personal change while also addressing larger societal problems. The core group of priority population members receive the benefit of an extensive education in HIV and STI prevention, an opportunity to be a role model for others, and the chance to see the firsthand impact of their efforts at making things better for their communities. Going through this process helps them feel empowered and therefore much less likely to engage in risky behavior themselves. Meanwhile, communities get the benefit of all the additional volunteers working on educating about HIV and STI prevention. At its best, a committed group can also bring about lasting, long-term changes in their communities and the world at large through their social change activism.

The success of the increasingly intensive intervention model speaks to one of the themes of this guide: The costs are minimal but the return is great. At the heart of the model is a highly motivated, empowered and self-educated *volunteer* corps. When trained and sent along the right path, these volunteers can make an amazing difference in their community, while making healthier decisions in their own lives.¹¹⁷

Increasingly intensive intervention works best within very specific communities, since both the micro and macro HIV prevention needs of each community vary tremendously. After attending the “Playing it safe with both teams” conference and discussing it with the other staff at the Massachusetts Department of Health, Fenway’s contract manager at the Department suggested that I focus my prevention efforts on bisexual people. After further discussion, this priority population was defined as “bisexuals and other people who live in the greater Boston area who have sex with people of more than one gender.” The BiHealth Program was born!

Key concept: The difference between behavior and identity

At the core of the BiHealth Program is a simple but extremely important concept: the difference between *behavior* and *identity* and the ways both relate to sexual orientation.¹¹⁸ Identity

When trained and sent along the right path, volunteers can make an amazing difference in their community, while making healthier decisions in their own lives.



refers to the words people use to describe themselves. The most common identity labels for sexual orientation are heterosexual or straight, gay, lesbian and bisexual. Most people choose their identity labels based on to whom they are sexually *attracted*.¹¹⁹ People who choose the label “heterosexual” or “straight” say they are attracted to people who are a different gender than they are; those who choose the labels “gay” or “lesbian” say they are attracted to people who are the same gender they are; and those who choose the label “bisexual” say they are attracted to more than one gender.¹²⁰

Behavior refers to what people actually do sexually, with whom they have sex and whether they put themselves at risk for HIV and STIs. People’s sexual behavior can vary based on many factors, including any combination of what’s listed below, and more:

- **Sexual anatomy of partners:** male, female, both or neither
- **Sexual acts:** anal, vaginal, oral-genital and/or oral-anal sex; “outercourse;”¹²¹ other sexual acts at lower risk for HIV or STI transmission; complete abstinence
- **Serostatus:** one or more partners are infected with HIV and/or an STI; all partners have been tested and believe themselves not to have HIV and/or STIs; the serostatus or STI status of one or more partners is unknown
- **Safer sex:** sex with or without condoms, latex dams,¹²² or other barrier methods; using other ways to reduce or eliminate contact with bodily fluids or STIs
- **Number of partners:** no partners (celibacy/abstinence/asexuality); one partner (monogamy); one partner after another (serial monogamy); multiple partners (non-monogamy, polyamory, and/or polyfidelity);¹²³ multiple partners at once (group sex)
- **Consent:** consensual and non-consensual sex; sex in which one or both partners are under the influence of alcohol or other drugs; “date rape drugs;” unequal power relationships; sexual assault; sexual abuse
- **Alcohol and drug use:** responsible use; sharing needles, cottons, cookers and/or other works used to inject drugs;¹²⁴ sharing bumpers or other inhaling tools; drugs often used in the context of sex (poppers, crystal meth, ecstasy, etc.); the impaired judgment that can result from alcohol or drug use; alcohol and drug addiction; sex in exchange for drugs or money to buy drugs
- **Other behaviors:** sharing needles for piercings, steroids, hormones or tattoos; sharing other personal items such as razors or sex toys that come in contact with blood or other bodily fluids; sex for money

While this list is by no means exhaustive, it does provide a general overview of the diversity

and complexity of factors that can contribute to a person's risk for HIV and STIs. From an HIV prevention perspective, it is *behavior*, not *identity* that puts a person at risk for HIV. HIV is simply a virus that travels primarily in blood, semen and vaginal fluids. No matter who a person is — gay, lesbian, bisexual or heterosexual — if they do not come into contact with the bodily fluids of an infected person, they are not going to become infected with HIV. Given this, any particular person's HIV risk is a complex combination of factors, and successful risk management can take a variety of forms. For example:

- A monogamous couple might choose to get tested to be sure they are both negative for HIV and do not have any STIs. As long as they continue to be monogamous (and honest if they are not), they will not be at risk unless exposed by some other means, like sharing needles for injecting drugs with an outside partner.¹²⁵
- A couple of mixed status (in which one person is positive and the other is negative), might choose always to use condoms and/or latex dams and/or avoid sexual activities with a higher risk for HIV/STI transmission.
- A person might choose to be non-monogamous and be honest and open with his or her partners about the non-monogamy, and also consistently use condoms and/or latex dams with all partners.

For most educators, this is HIV prevention 101: Look at a person's behavior and find strategies for reducing or eliminating their risk of getting or transmitting HIV, usually by either putting up a barrier between the infected bodily fluid and the uninfected individual or by reducing the chances that the bodily fluid contains HIV in the first place. Yet despite this core understanding about the reasons a virus can be transmitted from one person to another, many HIV-prevention programs confuse behavior with identity, particularly when it comes to bisexual people.

Here is a quick quiz to further examine this point and test your assumptions. Imagine that your work involves addressing people's risk for HIV and STIs. Perhaps your work at an AIDS service organization involves working directly with clients. Perhaps you are an HIV test counselor, a peer educator, or a medical provider. Imagine there are clients walking into your office, and they tell you their sexual identities as part of your intake survey. Make note of your absolute first gut assumption about what type of sex they have. Do not think about it too hard, do not analyze, just make note of your gut reaction.

Clients walk into your office and describe themselves as:

1. Gay men. Your gut reaction: what type of sex do they have?
Note your response here: _____

Many HIV-prevention programs confuse behavior with identity, particularly when it comes to bisexual people. It is behavior, not identity that puts a person at risk for HIV.



BISEXUAL HEALTH

2. Heterosexual women. Your gut reaction: what type of sex do they have?
Note your response here: _____
3. Heterosexual men. Your gut reaction: what type of sex do they have?
Note your response here: _____
4. Lesbians. Your gut reaction: what type of sex do they have?
Note your response here: _____
5. Bisexual men. Your gut reaction: what type of sex do they have?
Note your response here: _____
6. Bisexual women. Your gut reaction: what type of sex do they have?
Note your response here: _____

Ready to consider your answers?

Most people immediately assume gay men have anal sex with each other, heterosexual men and women have vaginal sex together, and lesbians – if they can fathom what lesbians do in bed together – perhaps have oral sex.

In reality, most people's gut reactions about these groups above may or may not be accurate. Yes, many gay men have anal sex with each other, but not all gay men enjoy, want or choose to have anal sex. Likewise for heterosexuals, not all of them enjoy, want, or choose to have vaginal sex. According to the CDC, approximately 40 percent of men and 35 percent of women in the US between the ages of 25 and 44 have had anal sex with a different sex partner. And for some, it is their preferred sexual practice.¹²⁶ And so on for lesbians: they might have oral sex, they might not. They might choose other sexual activities, including vaginal or anal penetration with a sex toy, fingers or hand, or they might not.

How did you answer the question about the bisexual men? Again we want your gut, first reaction. Was it one of these?

- A man having some kind of sex (oral and/or anal) with another man;
- A threesome of some variety (a man with another man and a woman);
- An image of a man out having sex with a male partner, cheating on his unknowing wife or girlfriend;
- An image of a string of many male and female partners, one after the other;
- Something else?

And, how about the bisexual women? Did you picture?

According to the CDC, approximately 40 percent of men and 35 percent of women between ages 25 and 44 have had anal sex with a different-sex partner.

- A woman having some kind of sex (oral and/or penetrative) with another woman;
- A threesome of some variety (a woman with a man and another woman);
- An image of a woman cheating on one partner to have sex with one of a different gender;
- An image of a string of many male and female partners, one after the other;
- Something else?

Let's explore each of these responses and their implications for HIV and STI prevention.

Bisexuality is not an extension of homosexuality

Many people pictured the first bulleted item on the list, either a man with a man, or a woman with a woman. Historically, this has been the predominant approach that many HIV prevention programs have taken to programming for bisexual people. Many programs, for example, advertise that they are targeted to “gay and bisexual men” or “lesbians and bisexual women.” This, of course, is a very positive step towards inclusion, in that there are other programs that do not welcome bisexual men and bisexual women at all.

There is a content challenge to matching the full spectrum of information with the stated target populations, however, in that some educational groups, programs, and/or services add the phrase “and bisexual” to their name, but their content does not change. In this case, a group would advertise itself to “gay and bisexual men” but then focus exclusively on sex and relationships with men. Or the group might be for “lesbians and bisexual women” but only address sex and relationships with other women. An HIV test counselor or medical provider operating from this assumption might focus his or her conversation with the client on their same-sex sexual behavior, overlooking that the person may also have different-sex sexual behavior as well.

There are two significant weaknesses to this approach. First is the obvious point that an educational group that only addresses same-sex sexual behavior is not inclusive of bisexual people, because many of those bi-identified people may also have sex with different-sex partners. The second and even more critical point is that a group for lesbian-identified women and/or gay-identified men that focuses exclusively on same-sex sexual behavior many not be inclusive of the *lesbians* in the group who have sex with men, and the *gay men* in the group who have sex with women. Programs that target heterosexuals are similar, with most not addressing same-sex sexual risks, doing a disservice to MSMW and WSMW who do not identify as bisexual, as well as not being a welcoming place to those who *do* identify as bisexual.

Some educational groups, programs, and/or services add the phrase “and bisexual” to their name, but their content does not change.



Bisexuality does not require both male partners and female partners

The remaining categories mentioned above as quiz responses — the threesome and the multiple partner variations — speak to the gut reaction that in order for a person to have a bisexual identity, ongoing sexual experience with both men and women is required. In order for this to happen, they would need to be non-monogamous, or at least serially monogamous with a high turnover rate. This view assumes that bisexuality is defined by behavior. In order to be bisexual, the reasoning goes, a person would need to be sexually active with both men and women. It evokes images of frequent sex with more than one partner, either sequentially or concurrently.

The fact that a bisexual person is attracted to both men and women does not mean he or she needs to be sexually active with both men and women in order to be satisfied.

Bisexual people have done an excellent job of educating others that these views are myths. Yes, some bisexuals are non-monogamous, as are some heterosexuals and some gays and lesbians. Just like their heterosexual counterparts, some are honest and negotiate open relationships, while others have affairs they hide from their partners. The fact that a bisexual person is attracted to both men and women does not mean he or she needs to be sexually active with both men and women in order to be satisfied. Many people who identify as bisexual are in long-term monogamous relationships.

Some people are confused by this. They might ask a woman, “How can you be bisexual and be in a long-term relationship with a woman? Doesn’t that make you a lesbian?” Or they might say to her, “How can you be bisexual and be in a long-term relationship with a man? Does that make you straight?”

The answer emerges from a clear understanding of the differences between behavior, attraction and identity. Most people who choose the label “bisexual” to describe themselves do so because they are attracted to both men and women. This attraction remains whether they choose to act on it or not. This same decision is made by heterosexual, gay and lesbian people who are attracted to another person and must make a choice, based on their values and agreements, whether to act on it or not. The behavior of bisexual people in monogamous relationships does not include sex with men and women, even though they are attracted to both men and women.

Even for heterosexual people, behavior is an unreliable indicator of a person’s sexual orientation. Consider the following cases:

- A 15-year-old male is attracted exclusively to females, describes himself as heterosexual, but has never had a girlfriend or any sexual experience with anyone. No one would insist that he can not call himself heterosexual even though he has never had sex with a woman.
- A couple, married for 40 years, is no longer sexually intimate. Can they still call

themselves heterosexual even though it has been years since either of them had sexual intercourse? Of course they can.

- A single woman, divorced three years ago, would like to find a new boyfriend, but has not had any luck finding one yet. Her current sexual behavior might be described as “involuntarily celibate” but she is still entitled to see herself and have others see her as heterosexual.

Despite the differences between behavior and identity, many people make an assumption — either consciously or unconsciously — about people’s behavior based on their identities. Yet most people choose the identity labels they use for themselves based on their attraction, not their behavior.

This quiz, in which you were told people’s identities and then asked what your gut assumptions were about their behavior, teaches two important lessons:

1. Our gut assumptions about a person’s behavior may or may not be accurate. Just because a person is a gay man does not mean he has anal sex, or is even sexually active at all.
2. Many people’s gut reactions to bisexuality are based on popular conceptions of how bisexuality fits into the wider landscape of sexuality, and, likewise, these conceptions may or may not be accurate.

Behavior and identity can be wildly different

Anyone who works directly with clients in the health field knows the diversity of human sexual behavior firsthand. What people do sexually together is incredibly diverse, and varies enormously based on the desires of each of the individuals and any number of factors in the relationship. Therefore, it should not come as a surprise to say that not all gay men have anal sex, or not all lesbians have oral sex or not all heterosexuals have vaginal sex.

But to understand that difference is just the tip of the iceberg. More important than the variation of sexual behavior within each relationship or sexual interaction is the gap that can emerge between how people self-identify and what they actually do sexually. The classic case, of course, is the person who identifies as heterosexual but whose sexual behavior includes people of the same sex. This person might be a married man, who, unbeknownst to his wife, secretly seeks sex with other men. In this case, the desire for sex with someone of the same sex is present, the behavior is present, but the identity, at least as the man describes himself, is heterosexual.

The potential for a gap between behavior and identity is not limited to self-identified heterosexual men seeking sex with other men. Here are few other examples of how this can play out:

- A self-identified gay man might find himself falling in love with his female best friend, and that relationship could become sexual even though no one predicted it would.

More important than the variation of sexual behavior within each relationship or sexual interaction is the gap that can emerge between how people self-identify and what they actually do sexually.



- A married heterosexual woman might be having sex with another woman unbeknownst to her husband or, possibly, with his consent and encouragement.
- A lesbian might choose to have sex with men in exchange for money, drugs or shelter, even though she does not feel sexual desire for them.
- A heterosexual man might choose to have sex with other men while incarcerated, due to a lack of availability of female sexual partners.
- A heterosexual woman might find that in the right situation, and perhaps the right amount of alcohol, she would choose to have sex with another woman.¹²⁷
- A teenager growing up in a homophobic community in the early stages of questioning his or her sexual orientation might actively seek a different-sex relationship as a way to avoid having anyone suspecting he or she is gay, lesbian or bisexual.

The term MSM recognizes that while almost all gay-identified men have sex with men (or at least would like to), a large number of men who have sex with men do not identify as gay.

The HIV prevention community has become increasingly aware of the challenges in addressing the gap between behavior and identity. One sign of this awareness has been the development of behaviorally-based categories, in particular, men who have sex with men, or MSM. This term appears frequently in medical and epidemiological literature as well as in popular news articles about the latest HIV or STI statistics. Some HIV prevention programs describe their target population as MSM.

The introduction of the term MSM has been incredibly useful in helping providers realize there are men who have sex with men who do not identify as gay. Ironically, although the use of the term “men” who have sex with “men” moves away from labeling a person’s identity with regard to sexual orientation, it does not address the fact that not all people with male sexual anatomy identify as men, a problem that has not yet been properly addressed.¹²⁸

The term MSM recognizes that while almost all gay-identified men have sex with men (or at least would like to), a large number of men who have sex with men do not identify as gay. Recognizing the overlap and the differences between these two categories is where some of the most creative work of successful HIV prevention programming is being accomplished.

With the advent of the term MSM, the terms WSW (women who have sex with women) and MSMW (men who have sex with men and women) and WSMW (women who have sex with men and women) have followed. But a quick Google search is telling in terms of the level of awareness about each of these terms -- searching for “men who have sex with men” on September 28, 2006 produced about 842,000 entries, “women who have sex with women” a little more than 41,000; “men who have sex with men and women” about 979; “women who have sex with men and women,” a little more than 120 results.¹²⁹

This guide is about those two latter categories that have not received as much attention: how to conduct successful HIV-prevention education and outreach campaigns to MSMW and WSMW, especially those who do not identify as bisexual. We know there are many people who fit this description; the challenge is how to reach them effectively.

This guide is also about how to implement successful prevention programming based on both behavior and identity, while treating these as the two distinct categories they are. Successful HIV-prevention efforts recognize that behavior is a more useful indicator of a person's HIV risk than a person's identity, but that identity plays an important role in how people think of themselves, and therefore, how they can be reached. For some people, their identity is also a source of community, support and self-esteem, all of which can indirectly lower their risk for HIV.

Successful HIV-prevention efforts recognize that behavior is a more useful indicator of a person's HIV risk than identity.

Section summary: Key conclusions

1. Many people choose identity labels to describe their sexual orientation. The most common ones are heterosexual/straight, gay, lesbian and bisexual. Most people choose a label that describes to whom they are attracted: men, women or both.
2. Sexual behavior is what people actually do sexually. From an HIV- and STI-prevention standpoint, behavior is very important. It is a person's behavior, specifically whether they are exposed to HIV or an STI through sexual activity (or through other behaviors like needle sharing), that puts them at risk.
3. Knowing whether a person identifies as heterosexual, gay, lesbian, or bisexual is not an accurate way to predict whether or not they have sex with men, women, both or neither, or to predict what kind of sexual activities they do with others. Yet, people often do make assumptions, consciously or unconsciously.
4. The distinctions between behavior and identity are particularly important when talking about bisexual people. A person can have a bisexual identity even if he or she is not having sex at all, or is in a monogamous relationship with a man or a woman. Likewise, there are large numbers of people who have sex with men and women and who identify as gay, lesbian, heterosexual or bisexual.
5. Successful prevention programming addresses both behavior and identity, while always being aware of the differences between the two.



Quiz: What could be improved about this advertisement?

You can test your knowledge of what you just read by studying this advertisement. It was part of a groundbreaking campaign in the Bronx, a borough of New York City, to reach out to men who have sex with men. The organization that created the ad wisely recognized the large and potentially high-risk population of men living in Bronx who have sex with men but do not identify as gay. They created an advertising campaign for bus

stops, knowing this would be a highly effective way to reach lots of men who might not otherwise see advertising marketed within the “gay community.”

Like many innovative new approaches, the ad accomplished a great deal, and there is also a way it could be improved to make it even more effective in reaching this population of men. What is it?

"I'm not gay but I sometimes have sex with other guys. People don't understand."

bronx
lesbian & gay
health resource consortium, inc. we understand

If you're a guy who has sex with guys, sometimes or everytime, you have special healthcare needs. Let us help you find a supportive Bronx doctor that understands.

866-4-GAY-CARE
or **866-442-9227**
Your call is free, anonymous and confidential

Answer: Ideally, the phone number shouldn't be listed as "866-4-GAY-CARE." Why would a man who says he is "not gay" call a phone number called "4-GAY-CARE"? If you answered, "removing the words 'Lesbian & Gay' from the advertisement, that might also have made an impact. What is the alternative? Many programs reaching out to MSM simply call themselves the

"Men's Program" and stay away from sexual orientation labels.

Unfortunately, the ads provoked a homophobic response and were taken down from the bus stops. At the same time, the controversy helped draw attention to the existence and health needs of MSMW living in the Bronx.

PUTTING THEORY INTO PRACTICE

In this section, we discuss several specific HIV-prevention strategies implemented by the BiHealth Program:

- The development and distribution of two safer sex brochures;
- The facilitation of a monthly support and discussion group for bisexual and bi-curious men;
- The creation of a peer educator team that conducted outreach in bars, clubs and coffeehouses.

The purpose of this section is twofold. First, it can be read as a guide to implementing any one or more of these initiatives in other communities. Second, it provides real-life case studies for how to be thoughtful and strategic when developing HIV prevention programs that are savvy to the differences between behavior and identity.

Safer sex brochure development and distribution

Safer sex brochures are a very tangible example of some of the prevention education challenges discussed here. Many brochures are well-intentioned but fail to provide anything more than the most basic information about condom use. Others exclusively target gay men or heterosexual audiences, without even an acknowledgement that the readership might also need safer sex education about sex with both same-gendered and different-gendered people.

San Francisco writer and activist Liz Highleyman wrote an excellent brochure about safer sex for the bisexual community in the early 1990s. A decade later the information it contained was out of date. When BiHealth held a series of community meetings to discuss the prevention needs of the community, one message was loud and clear: the bisexual community wanted a new safer sex brochure written by and for bisexual people.

Drawing on my experience educating about HIV prevention in individual and group settings, I drafted the text for two safer-sex brochures.

I then recruited a team of community members to edit, revise and improve it, with input from Fenway's Associate Director of Medical Research, Dan Cohen, M.D., to ensure its technical accuracy. This final draft was submitted to a graphic designer, whose initial design was subjected to another round of community review, both via email and in-person meetings. Each person offered insights on the text and the accompanying images, and the group as a whole discussed the merits of the suggestions. The final products were the brochure you see on page 59, and a second brochure described in the section below, and seen on page 60.¹³⁰

From initial conception to final distribution, the production of the brochures took nearly

Safer sex brochures are a very tangible example of some of the prevention education challenges discussed here.



**safer
SEX**
FOR **Bisexuals
AND THEIR
Partners**

MANY BISEXUALS ALREADY HAVE SAFER SEX to protect themselves and their partners from unplanned pregnancies and sexually transmitted diseases (STDs), including HIV. HIV is the virus that causes AIDS. If you already practice safer sex, you can use this brochure to teach a friend. It talks about some of the ways you can reduce your risk of getting HIV or STDs. If you already have HIV or an STD, safer sex can help you avoid passing it to a sex partner. It is also important to protect your own health by avoiding other infections.

It's Not Who You Are
Safer sex is about what you do. It is not about who you are. HIV is spread through blood, semen, vaginal fluids, and breast milk. For some STDs, like Herpes, skin-to-skin contact can pass them from one person to another. Using condoms, dental dams, and other safer sex supplies greatly reduces the chances of getting or passing on HIV and other STDs.

THINKING ABOUT RISK
Some people do not have sex with anyone because they are worried about HIV and other STDs. Other people do not worry at all and take a lot of risks. Most people try to find a good balance. They know sex can be wonderful, and that sex is more fun if you are not afraid. But they also know that HIV and other STDs are real. They make an effort to protect themselves. Finding a good balance means thinking about what risks you are willing to take and which ones you do not want to take. Your own "risk limits" can change over time as you learn new things or as your own needs and wishes change.

The risk of getting an STD is like other risks in life, such as driving a car. Some people might choose never to ride in a car because they are afraid of getting into a car accident. But most people accept the risks and find ways to reduce them. You know that you can wear your seat belt to reduce the chances that you'll die if you get into an accident. Cars have safety supplies you can use, like seat belts, that make it safer to ride in a car. Condoms, dental dams, and other supplies make sex safer.

DECIDE YOUR RISK LIMITS
One way to think about risk is to write down on a piece of paper (or think through in your head) what sexual activities you are comfortable with and consider safe for yourself. For many people, these include things like kissing, hugging, or bringing pleasure to a partner with your hands. Some people might also include having oral, anal, or vaginal sex with a condom or dental dam. Then make a list of the things you are not comfortable with or think are too risky. There may be some activities that you may feel comfortable with part of the time, as well as activities that you are not certain how you feel about. Writing these things down gives you a visual idea of what you consider too risky or not risky, and helps you to think through in advance what you would do in a sexual situation.

Once you have a good idea of what your own risk limits are, you can work to avoid engaging in sexual activities that fall outside of your risk limits. Most people do not want to put themselves at risk for HIV and other STDs. At times, mistakes happen. One thing leads to another, and you find yourself having a sexual experience that you later worry about. Thinking in advance about what you are and are not comfortable with can help to avoid this.

Talking with a safer sex counselor is one way to sort things out. It can help you figure out ways to avoid doing risky things in the future. If you have thought things through, it can be easier to know what to do "in the heat of the moment." At the end of this brochure is a listing of bisexual-supportive safer sex resources where you can get information and help.

FENWAY COMMUNITY HEALTH
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7 Haviland Street
Boston, Massachusetts 02115
617-927-6012
www.fenwayhealth.org
BETH ISRAEL DEACONESS MEDICAL CENTER
A member of CareGroup
Affiliated with Beth Israel Deaconess Medical Center

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FENWAY COMMUNITY HEALTH
Fenway
www.fenwayhealth.org

two years and involved more than two dozen people. At first thought, that may seem like an extensive investment for a couple of simple brochures, but the benefits of such a thoughtful, community-based process soon became apparent.

First, the brochure creation experience followed the increasingly intensive intervention model. The bisexuals who volunteered to serve on the writing and review committees took their jobs seriously, not only refining their own knowledge of safer sex practices, but also wearing their peer educator hats. They volunteered their time because they felt this brochure would make a difference in the safer sex practices of others in their own community. The second benefit of such an involved community process was the quality of the brochure itself. Each word had been carefully chosen, sometimes after painstaking

The brochure creation experience followed the increasingly intensive intervention model.

discussion; the merits of each photo dissected and debated. The end result was extremely well received by the community with no complaints.

Finally, and perhaps, most importantly, the committee members had discovered something in the process of writing this brochure. The committee had convened to fill a gap in the available prevention materials and create a brochure targeted to bisexual people. But in the process, they produced a brochure that addressed safer sexual behavior with people of any gender. The information described could apply to anyone who had sex, whether they had sex with men, women, or both, or identified as heterosexual, gay, lesbian, bisexual or some other label. Anyone — regardless of their sexual orientation — could benefit from what the bisexual community had created.

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safer SEX

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“Safer sex for bisexuals and their partners” vs. “Safer sex”(a.k.a. identity vs. behavior)

At first glance, the brochure you see on page 59 and the one on page 60 might appear oddly similar yet different. The reason why provides a quick example of identity-based vs. behavior-based approaches to outreach and education. The text in the two brochures is nearly identical, except for one key difference. The first brochure prominently uses the word “bisexual” on the cover and in the first paragraph. The second brochure makes no mention of the word. The first brochure also includes information on bisexual resources, such as the Bisexual Resource Center, while the second brochure does not.

The first brochure is an HIV- and STI-prevention strategy based on identity. Having the word “bisexual” in big, bold letters and in the first sentences sends the loud and clear message this is a brochure for people who identify as bisexual. Given how few publications of any kind are targeted to bisexuals, it’s sure to catch the eye of anyone who identifies as bisexual. Many bisexual people have said, “Finally, a brochure for us,” and take the time to read it primarily because it has their identity label on the front cover.

Health care providers who take the simple step of displaying this brochure in their offices are, in effect, telling their clients, “I’m aware that some of my clients are bisexual or are questioning if they might be bisexual. I’m comfortable with that.” This goes a long way towards building trust, creating safe space for patients to be honest about the range of their sexual behaviors and enabling the provider to give more effective care.

Anyone reading the brochure will find that the information inside applies to anyone who has sex, regardless of whether they have sex with men, women or both.

The second brochure uses an HIV- and STI-prevention strategy based on behavior. It does not make mention of sexual orientation because it does not need to. Anyone reading the brochure will find that the information inside applies to anyone who has sex, regardless of whether they have sex with men, women or both. This is a significant break from many brochures that either explicitly or subtly suggest that that the reader is expected to have sex only with men or only with women.

Health care providers who hand someone a copy of the green “Safer sex” brochure are not going to put their clients on the defensive. The client will not respond, “I’m not gay” or “I’m not bi” because the brochure does not imply that they are. But it does address behavior that can put anyone at risk for HIV and STIs, and also behavior that can reduce one’s risk for HIV and other STIs, from safer sex to communication to getting tested.

After publishing these brochures in 2001, I recruited a student intern to help me “viral market” them on Internet email lists.¹³¹ The result was thousands of free downloads from around the world and paid orders for thousands more copies. Both brochures are now

regularly stocked in college health centers, Planned Parenthood clinics, AIDS service organizations and community group offices throughout the country. On May 23, 2005, they were the #1 and #2 search results on Google.com for “bisexual safer sex brochure,” and for “safer sex brochure,” respectively.¹³²

Bisexual and bi-curious men’s group

Support and educational groups are part of many successful prevention programs. They seem to be particularly effective at achieving a number of objectives at once. Support groups provide an opportunity for:

- Direct education of participants about safer sex;
- Camaraderie and peer support, as participants explore similar life challenges and dilemmas together;
- Referrals to other types of groups and programs for further support.

Many cities throughout the country and the world have bisexual support and social groups that serve the three purposes above.¹³³ For some people, these groups are part of their coming out process. For others, it is primarily an opportunity to talk about what is on their minds and make new friends.

In 1999, Boston was already home to a support group that met twice per month, “Coming out as bisexual,” under the umbrella of the Bisexual Resource Center. This group drew both men and women as participants and had an active volunteer core that facilitated the meetings.

The city is also home to the Boston Bisexual Women’s Network (BBWN), a group for women with its own newsletter, calendar of events and social events. BBWN hosts “Bi rap” a discussion group for bisexual, bi-friendly and questioning women. The group meets monthly at the Women’s Center in Cambridge, a city bordering Boston.

Given that the Boston area already had a successful mixed-gender group and a successful women’s group, the BiHealth Program sensed a need for more bisexual men’s programming, built on these successful models. BiHealth introduced the “Bi-curious men’s group,” with its name revealing the two key distinctions from the “Coming out as bisexual” group and the “Bi rap.” It was a men’s-only group, with the hope of reaching men who might not otherwise attend a co-ed group because of shame or embarrassment about talking in front of women about their attraction to and sex with other men.

The group also used the title “bi-curious.” The choice of that word was based on several factors. First, we wanted the group to appeal to men who did not identify as bisexual and may

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never identify as bisexual. As a result of their participation in the group and other factors in their life, it is certainly possible that some of them could choose to identify as bisexual in the future. But this was not an expected outcome of the group, as it would be with a name like “Coming out as bisexual.”

There is an obvious challenge to using phrases like “a man who has sex with men and women” when encouraging participation in a support group. While MSMW may be an accurate description of behavior, it is rarely an identity label that people would actually use to describe themselves. The “bi-curious” label had already made its appearance in popular culture, showing up regularly in personal ads, porn titles and in the back pages of magazines for those looking for phone sex or “escort services.”

The BiHealth Program placed an ad in a local alternative weekly newspaper, the *Boston Phoenix*. While Boston is home to two LGBT papers, *In Newsweekly* and *Bay Windows*, BiHealth decided that it had better reach our target audience by advertising in the *Phoenix*. *The Phoenix* is an alternative weekly known for its political coverage and city events listings. While anyone seen carrying *Bay Windows* around the streets of Boston might be assumed to be gay, this was decidedly not the case with the *Phoenix*.

BiHealth placed ads in two sections: the “Marquee” page, a pastiche of ads located on the back cover of the paper, publicizing services ranging from penis enlargement to recovery from heroin addiction.

We also placed an ad in the adult “Variations” section, amidst the sex-related personal ads, although that did not garner as many responses. Both advertised the availability of the support groups. This advertising was supplemented with calendar listings in an array of newspapers, including *Bay Windows*, *In Newsweekly*, and mainstream dailies like the *Boston Globe*, as well as newspapers targeting specific neighborhoods and those for various communities of color. The group was also listed online and on posters that were hung throughout the city.

The response was outstanding: The phone rang regularly with men seeking more information about the group, and the group consistently drew five to 15 participants each month. The youngest participants in the group were in their late teens, the oldest in their 70s and 80s, with the majority in the range of 25 to 65. They were a diverse group in terms of educational and class status: some did not have a high school diploma and others had advanced degrees; some clearly were financially well-off and others were working class or poor.



The majority of the group's participants were white. However, African-American, Asian-American and Latino men also attended. The group more closely reflected the racial demographics of the state of Massachusetts, not the city of Boston. One goal for future groups of this type would be to reach more men of color. In general, the bisexual and bi-curious men's group drew three distinct types of men in terms of their thoughts, feelings and experiences around bisexuality. These three types are as follows:

First stop in the journey

The first and largest group consisted of men who were in the very early stages of questioning their sexual orientation and/or coming out. For many of them, this group was the very first event/meeting/support group on LGBT issues they had *ever* attended. Many of them arrived very nervous, and by the end of the two hour session, were visibly relieved and pleased with how quickly the time had gone by, and how much they had in common with the other attendees.

This group included many men in their mid-forties and up, who had grown up in a culture far more homophobic than the one we live in now. Some had had sexual experiences with other men many years before; others were attracted to men but had not had sexual experiences. Some were currently married to women, some were divorced and others were single.

Contrary to the stereotype, most married men had already shared with their wives that they were attracted to other men. Of that group, most of the wives and girlfriends were accepting of the attractions. The issue on the table was not one of coming to terms with attractions, but rather of behavior. Actually having a sexual relationship with another man was an issue that often brought up deep conflicting feelings for both the group participant and his spouse or female partner, if he had one.

As a matter of principle, the group facilitators encouraged honesty, particularly with sexual partners. The men who had not shared with their wives were gently encouraged to do so, with plenty of acknowledgment that it is not an easy process.

"The first stop in the journey" crowd included a smaller but significant number of men in their late teens and twenties. This group tended to be very diverse in terms of geography (with many living in the Boston suburbs), race/ethnicity and class, with working class men without a college degree attending in greater numbers than their college educated peers.

Most of the men in this younger group did not come out in high school (or college, had they gone), for any number of reasons. Many had lived in very homophobic communities, and it was only at the point of becoming adults and having the freedom to travel to Boston

Contrary to the stereotype, most married men in the group had already shared with their wives that they were attracted to other men.



One definitely got the feeling that we were catching them at exactly the right moment: in most cases, not yet sexually active with men, but seriously considering it. This provided opportunities for education on a number of topics.

without anyone knowing they were there that they began to figure out the next steps in defining their sexuality.

From an HIV prevention perspective, educating the “first stop in the journey” participants in the support group was especially rewarding. One definitely got the feeling that we were catching them at exactly the right moment: in most cases, not yet sexually active with men, but seriously considering it. This provided opportunities for education on a number of topics:

- **Dating among gay and bisexual men:** where to meet other men, pros and cons of different dating Web sites, bars, social groups, etc.
- **Safer sex with men and women, HIV and STIs:** there was definitely an eagerness among these men to make sure they understood how to reduce their risk.
- **Negotiating sex with other men:** most men are socialized to be the initiators of sex with women; women are socialized to set limits and say no. Men who have been the initiators of sex their whole lives can easily find themselves unprepared when it is their turn to set limits and say no. The group provided an opportunity to give a gentle warning, “Be careful, you could find yourself in over your head with a partner pushing you to do things, in a way you’ve never experienced with a woman. Think about this in advance.”
- **The LGBT community:** many of these men arrived at the group with little of no knowledge of the LGBT community. The group provided a great opportunity for referrals, whether it was to LGBT-supportive health care at Fenway Community Health, the social opportunities available through the Bisexual Resource Center or even something as simple as the names of the LGBT newspapers in Boston and where to find them.

Bisexual and bi-curious men’s group curriculum

Group begins with an opening statement from the facilitator, who:

- Introduces the group and makes sure people are in the right room;
- Introduces himself;
- Provides some background information about sex educator team, the LGBT community and the group;
- Reviews the ground rules with the group.

Ground rules:

- We make space and time for everyone who wishes to speak;
- We respect each other;
- There are no right or wrong answers — each person’s experience is valid;
- We use “I” statements, which means we speak from our own personal experience, instead of making generalizations, particularly about groups of people;

- This a confidential group; If we choose to discuss issues that come up here with people outside of the room, we do not identify people by name;
- We do not assume everyone in the room identifies as bisexual.

After the ground rules are read:

- The facilitator notes that the group is a chance for people to "think outside of the box" and have a discussion about sexuality and what it means in their lives in a way they may not have had an opportunity to do before.

The facilitator then invites the group members to introduce themselves, and opens it up for discussion.

The discussion is usually:

- Lively, with most people participating, except for a few

- which prefer to mostly listen, which is fine;
- Focused around bisexuality, sex and dating with men, and safety and safer sex with men.

Twenty minutes before the end of the group, the facilitator:

- Discusses safer sex and asks if there are any questions about it if the topic has not come up beforehand (which it usually does);
- Offers a chance for anyone who has not spoken to speak.

As part of the group, there is a resource table with:

- Safer sex supplies, including condoms, lube and Reality condoms;
- Safer sex brochures and information;
- Information about LGBT community organizations and resources.

Already bi-identified

When the group first began, it was simply called the "Bi-Curious Men's Group," in hopes of reaching as many men in that category as possible. But the group also turned out to be popular among men who openly identified as bisexual. Some would even come with apologies, "I'm not bi-curious, but..." After a few experiences with this, the group was renamed "The Bisexual and Bi-Curious Men's Group." This group of already-identified men tended to fall into three categories. The first had just moved to Boston, picked up a copy of the local LGBT paper, saw a listing with the word "bisexual" in it, and thought, "I'll check that out." The second category of men tended to be long-time members of the Boston bisexual community who would stop by to see what this group was all about. The third category is less common, but includes bisexually-identified men who felt a need for support around a recent issue in their lives, perhaps coming out to a new person. Some in this last category of men may have also attended the group previously, even up to years earlier, and remembered it as a source of support.

Gay identified, bi-questioning

The group also provided welcoming space for gay-identified men who were coming to terms with their attraction to women. Although these attendees were fewer in number than those



transitioning from heterosexual to some non-heterosexual identity, this situation is more common than many people realize. Many of these gay men had positive relationships with the women in their lives, but the thought that sexual attraction could be part of those relationships was new for them. Some found themselves falling in love with a female friend, but struggling to come to terms with the stereotypes, misunderstandings, misogyny and ambivalence about bisexuality (and about women's bodies and sexuality) present in gay male communities.

Structure of the group

A typical group meeting lasts two hours, often with a break in the middle. It starts with an introduction by the facilitator, a review of the ground rules (see the bisexual and bi-curious men's group curriculum) and an introduction in which participants share in response to the question, "What are the thoughts, feelings or experiences around bisexuality that have brought you here tonight?" This open-ended question works well for inviting the participants to share briefly, and getting a quick snapshot of some of the common themes and issues in the group.

The facilitator then summarizes some of the common themes the participants brought up, and invites open discussion. This role of facilitator includes making sure everyone who wishes to speak has the opportunity to do so, mediating any differences of opinion, and providing occasional reminders about the ground rules as needed. This facilitator role also provides opportunities for group education, whether it is taking a moment to explain the Kinsey scale, describing the difference between behavior and identity as it relates to the experiences of the group members or providing information about local LGBT resources.

The educator's hat is formally worn at least one point during the evening session because support for the program is funded through HIV-prevention dollars.

This educator's hat is formally worn at least one point during the evening session. Because support for the program is funded through HIV-prevention dollars, the Massachusetts Department of Health asked all of its funded programs to be certain that a direct HIV/STI prevention piece is included in every event. At some point in the evening, usually right after the break, the facilitator announces that we are now going to hear "a word from our sponsor" and uses the latest DPH initiative (whether it's encouraging syphilis testing or World AIDS Day), as a springboard for starting a discussion about HIV and STIs.

Unlike a television commercial break that viewers tolerate in order to return to their favorite show, this section of the group has been extremely well-received by participants. Participants often have questions about HIV and STI-related topics, and many are interested in pursuing related resources, like getting tested for HIV. Safer sex supplies and educational brochures are made available to participants.

Although not an official part of the group itself, phone counseling is a significant offshoot

of the advertising efforts for the group. Many men call asking for more information about the group, but are not at the point where they are comfortable attending a group session. The phone provides an opportunity for informal, often spontaneous one-on-one counseling, addressing many of the same issues that were discussed in the group setting.

The phone and Internet have also proved to be effective ways of educating about HIV and STIs as well. Many men and women as well contact the BiHealth phone line or email address with specific questions about a particular STI, STI testing or safer sex issues.

An index-sized card with information on the front and back can be a great way of spreading the word about the services you offer.

The image shows the front of a white index-sized card with a black border. The text is centered and reads: "Are **YOU** bisexual?" where "YOU" is in a larger, bold font and enclosed in a small rectangular box. Below this, it says "WONDERING IF YOU MIGHT BE BI?" in all caps. Then "ARE YOU A..." followed by "partner, lover, or friend" on separate lines. At the bottom, it says "OF SOMEONE WHO IS?" in all caps.

The image shows the back of a white index-sized card with a black border. At the top, a box contains the text "BIHEALTH IS A PROGRAM FOR YOU." Below this, the text reads: "BiHealth is a free, confidential place to talk about bisexuality. You can talk to a counselor by phone, email, or in person, learn about bisexual social activities, support groups, and other events. Call Marshall at 617-927-6032 or email mmiller@fenwayhealth.org today." Then "BIHEALTH IS A PROGRAM OF" followed by "FENWAY COMMUNITY HEALTH" and the Fenway logo (three horizontal lines above the word "Fenway"). Below the logo, it says "Care YOU can BELIEVE in." and at the bottom, "Affiliated with Beth Israel Deaconess Medical Center".

Creating a bisexual and bi-curious men's group in your community

With a few committed volunteers, a group like this can be run on a shoestring budget. Here are some issues to consider if you're planning on starting one in your community:

Location and Frequency

The most important factor in the deciding where to hold the group is finding a space where group members will feel safe and comfortable. Ideally, it should be a neutral space: public libraries, community centers and classrooms at community colleges all can work well. Less desirable locations include churches (these can bring up feelings of guilt or shame for some

The most important factor in the deciding where to hold the group is finding a space where group members will feel safe and comfortable.



potential participants, or ambivalence about the way many denominations view of LGBT people, or simply discomfort attending an event in the space of a religion other than the participant's own faith); visibly gay locations, particularly in small towns (raises fears of being seen entering the establishment); and places that are used primarily to address another, also-stigmatized topic (mental health centers, drug rehab, psychotherapists' offices).

The room itself should have doors that can be closed for privacy; not have glass windows in which passerby could look in; be big enough to accommodate a good turnout but not so big as to feel cavernous. The location should be accessible to people with disabilities, and provide options for both arriving by car (including parking), and arriving by public transit. It can also help to list the route names or numbers, and the closest stop for public transit. In all the advertising for the group, note that the building is wheelchair accessible, using the access symbol on flyers or including it in the script as part of any other PSA.

Put signs on the door to the building pointing the way to the room. The signs should say, "Men's Group," not "Bisexual Men's Group." If the building has front desk staff or a door person, be sure that the facilitator introduces himself to any staff and alerts them to the group meeting that night.

A group like this works best when it meets the same date and time every month, month after month. For example, the group might meet on the second Tuesday of every month from 7:00 p.m. to 9:00 p.m. Avoid the temptation to have the group meet too frequently, like once a week. Participants are more comfortable when there is a critical mass of other participants – say, at least five – and groups that meet more frequently tend to be smaller because potential participants spread themselves out among the more frequent meetings. These very small groups, with one or two participants each, are at high risk of losing momentum over time if they inadvertently reinforce participants' insecurity that "there are not many people like me."

These kinds of logistical considerations, which may seem minor to organizers, can take on tremendous importance to participants and prospective participants. When I was one of the facilitators of Rhode Island's bisexual support group, participants regularly told us that it took many trips to actually walk through the group's doors. It was not uncommon for a prospective participant to drive by the library where the group was held to scope out the scene, but not park or come inside. The next month or two they might come inside the library and check out the signs for the group, browse around, but never come into the room where the group was held. After several months of this, they would finally actually come inside and join the group, later admitting what a long and difficult process it had been to work up the courage to do so. Of course, the facilitators inside the room where the group took place had no idea these prospective participants were driving by the library or wandering through the

library. But, the experience reveals the value of having a group that meets at a consistent place and time and makes the process of coming in as easy and non-embarrassing as possible.

Facilitators

There are several qualities to look for in potential facilitators:

1. **Availability and reliability:** Given the value of regular meeting times, you should look for a facilitator who is available on a consistent basis on the day the group will be held, and also can be counted on to arrive on time and facilitate the group.
2. **Facilitation skills:** Good facilitation is a skill like any other, for which some people have a natural knack and others can develop with training. A good facilitator is a combination of referee, coach and teacher, in that order. The support group has clear rules and expectations, and like a referee, the facilitator gently puts an end to any inappropriate behavior (such as one person dominating the entire conversation or invalidating another participant's experience). Like a coach, the facilitator helps move the discussion forward, encouraging the group to address issues they might not have considered before, and encouraging the participation of all. Occasionally, the facilitator also plays the role of teacher, educating the group about topics and issues with which they may be less familiar.

While the facilitator doesn't need to have an advanced degree in counseling or extensive crisis management training, organizers will want to be sure that the facilitator is the kind of person who has a good head on their shoulders. They should have good common sense instincts and the ability to make appropriate referrals in a crisis situation. Facilitators should be trained to understand the diversity of people who may attend the group, including people of color, people from poor and working class backgrounds and elders.

Participants may arrive at the group with differing expectations of when and how it is appropriate to express disagreement with the comments of another participant. The support group models have been in many cases been developed on a white, middle-class model of communication and can benefit by being adapted for use by various groups. In our experience, the bisexual and bi-curious men's group worked very effectively with diverse groups, but the facilitator must be aware of how race/ethnicity, culture and class can shape a person's behavior in the group.

Facilitators should also be prepared to be inclusive of men who are transgender, and of men who may be questioning their gender identity as well as their sexual orientation. Because of the many support groups and other resources in the Boston area for trans people, very few transmen attended the bisexual men's group because their need to discuss gender and sexuality issues were being met elsewhere. It was more common for men to attend who wanted support

Facilitators should be trained to understand the ethnic, class, and age diversity of people who may attend the group.

Facilitators should also be prepared to be inclusive of men who may be questioning their gender identity as well as their sexual orientation.



around cross-dressing and/or exploring the possibility of adopting a female gender identity. We suspect that in communities with fewer resources, a group of this type may draw even more transgender participants, and facilitators should be knowledgeable and comfortable with transgender issues.

Given the potential for safer sex education that occurs within these groups, facilitators should have a working knowledge of safer sex practices, as well as safety practices for IDU (i.e. sharing needles for hormones and/or drugs).

While it is certainly not a requirement that the facilitator identify as bisexual, you should be absolutely certain that he or she is knowledgeable and comfortable with bisexual issues.

The BiHealth Program always had a bi-identified male facilitator for the group. In our experience, this was one situation in which many men attending the group expected and were reassured to find the presence of a male facilitator, because it is a men's group. While it is certainly not a requirement that the facilitator identify as bisexual, you should be absolutely certain that he or she is knowledgeable and comfortable with bisexual issues. It is particularly important to differentiate between people who are familiar with the LGBT community as a whole, and those who have cultural competency around bisexual and bi-questioning people. Some gay and lesbian-identified counselors and therapists hold (often unconsciously) myths about bisexuality, such as the belief that bisexuality is only a transition phase between heterosexuality and coming out as gay.

Boundaries

Prior to starting the group, there should be a clear sense of what the boundaries are between facilitators and group participants. In most cases, the facilitator of the group is part of the same LGBT community as the participants and therefore conflicts of interest may arise. It would not be appropriate, for example, after a meeting for the facilitator to express interest in having a relationship with one of the participants. If six months later, the two of them ran into each other at a community social event, it might be acceptable at that point. There are no easy answers on this issue, but the questions should definitely be discussed in a theoretical sense before real-life situations arise. In general, it is important for facilitators not to get involved romantically or sexually with participants because it would risk clouding the issues for the participant. Facilitators need to keep in mind that participants are often wrestling with a complexity of issues in their life, and the facilitator's role is to offer support and help, not to make the participant's life more complex by making the professional-participant role less clearly defined.

Facilitators also need to respect confidentiality, and not share with others information about who attends the group or what particular people say in the group.

Advertising

As discussed in the previous section, there are numerous options for advertising. In general, a combination works well, including, but not limited to:

- Calendar listings in local LGBT, alternative and mainstream papers;
- Web site calendar listings;
- Newspaper advertisements (as shown above);
- Radio and television community service announcements;
- Email announcements and online discussion groups;
- Posters and flyers (particularly if distributed at local adult stores, bars, etc.);
- Business cards advertising the group (something small enough for someone to slip into their pocket);
- Networking with local LGBT or coming out groups and with therapists.

On each advertising piece, include contact information for how to find out more information about the group. If you have a phone number listed for more information, include an outgoing message with details about the group. This makes it easier for participants to get the information right away, without having to leave a number for a return phone call.

Building a safer sex educator team

One of the challenges of HIV prevention is that those who need the education the most are among the least likely to show up at a support group or educational forum. There is definite appeal in taking the message “to the people,” as opposed to waiting for the phone to ring or for them to get in touch with us. Fenway Community Health’s safer sex educator team was founded on this understanding.

The program started in 2001 as the result of several convergent factors. First, there was increased pressure from the Massachusetts Department of Health for all of its funded programs to conduct more bar and club outreach about safer sex, HIV and STIs. Bar and club outreach, a mainstay of HIV prevention programs in the 1980s and early 1990s, had become a rare occurrence. After 20 years of HIV prevention messages, the novelty of bar outreach had worn off, for both the HIV prevention staff and for the bar patrons.

The low-paying, entry level outreach jobs had high turnover and low job satisfaction. Being snubbed 100 times in one night by people they were trying to help was not much fun. From the patrons’ perspectives, having the people continue to push condoms on them in the same

One of the challenges of HIV prevention is that those who need the education the most are among the least likely to show up at a support group or educational forum.



locations every week started to wear thin. The challenges of bar and club outreach did not diminish its importance. Bars and clubs remained a common way for prospective sexual partners to meet each other, and the use of alcohol and other drugs made consistently having safer sex that much more difficult.

At the same time, another trend was underway in Boston's LGBT community, namely a shift from being a mostly gay and lesbian community to one that was significantly more inclusive of bisexual and transgender people. While some gays and lesbians felt as though they had "been there, done that" with their HIV prevention volunteerism, bisexual and transgender members of the community were discovering their political power. Eager to participate in LGBT community life – and welcomed by their gay and lesbian peers with enthusiasm that was not present in years past – bisexual and transgender people were volunteering in large numbers to assist with LGBT community projects. Many young heterosexual people, as well, who had come of age with high school Gay-Straight Alliances and out gay friends, were eager volunteers within this burgeoning community.

It was time to move beyond the model in which only gay men conducted outreach in gay bars, assuming that everyone with whom they chatted only had sex with other men.

By 2001, how to fit the varied pieces of the outreach puzzle together became clear. First, the Massachusetts Department of Health communicated to BiHealth that bar and club outreach was a requirement of the program, not a choice. Second, a successful outreach program would need to take into account the inherent challenges of the job and the high burnout rate. Finally, there was a remarkable opportunity to put to use what the program had already learned about HIV prevention, namely that anybody of any sexual orientation could teach safer sex to anybody, with a few exceptions, given the proper training in HIV/STIs, outreach and cultural competence. It was time to move beyond the model in which only gay men conducted outreach in gay bars, assuming that everyone with whom they chatted only had sex with other men.

From this framework, the safer sex educator team was born. At its core, the team worked like this:

- Twice per year, the program would host a safer sex educator training, usually lasting two days, (see "Sample safer sex educator training curriculum" on the following page). The opportunity to attend the training would be widely advertised to people of all sexual orientations and gender identities.
- The training would be its own educational intervention, in which participants would receive in-depth information about HIV, STIs, condoms and other barriers, sexuality and diversity, as well as basic outreach skills.
- At the training, participants would be given the opportunity to sign up to volunteer to conduct outreach at local bars and clubs.

- The new volunteers would be supervised on-site by experienced volunteers, known as “team leaders.”

The model provided a steady stream of new volunteers, giving the opportunity for those who enjoyed the work to be promoted to leadership positions. Those who found outreach was not a good match for their interests still received an amazing education in HIV/STIs, and in how to educate others about safer sex. People were not required to sign up as volunteers in order to attend the trainings, so many members of the public received in-depth training about STIs and HIV that they could share informally in their own friend and community networks.

Sample safer sex educator training curriculum — Day 1

9-9:15 Registration

STIs, and hepatitis A, B & C

- Education on interaction between HIV and other STIs, and HIV and Hepatitis C
- Education on post-exposure prophylaxis (PEP)

9:20 Ice breaker

9:30 Introductions

- Welcome
- Big picture/purpose of training – goals and objectives of training
- Agenda
- Ground rules
- Group introductions activity: What’s your motivation for attending?
- Info about our organization, our program, and our safer sex educator team

12:00 Lunch

12:45 HIV counseling and testing; STI testing and treatment; hepatitis services

- Overview of various types of HIV tests (serum, rapid and oral tests) and their time frames
- Logistics of 1) local HIV counseling and testing, including confidential vs. anonymous testing; 2) hepatitis A, B & C local services; and 3) local STI testing and treatment services

10:10 Safer sex supplies

- Safer sex supply demonstrations: Condom, Reality condom (anal and vaginal use), latex dam/plastic wrap, gloves and how to safely remove them, lube
- Participants practice educating about condoms and Reality condoms for both vaginal and anal sex

1:15 What does outreach look like?

- Goals of our program’s outreach
- Demonstrations of various types of outreach

10:45 Break

1:45 Risk motivation and healthy supports

- Why do people practice or not practice safer sex? Why do people get tested or not get tested?
- How can we address some of these things during outreach?

10:50 Name that STI

- Interactive overview of HIV/AIDS,



BISEXUAL HEALTH

2:15 Drugs and alcohol

- Overview of various drugs and their effects
- HIV/STI/hepatitis risk associated with drug and/or alcohol use/abuse, including shared needles, syringes, cottons and/or cookers
- Needle and syringe cleaning demonstration
- Outreach tips: if a client is on drugs
- LGBT-competent drug and alcohol treatment services nearby

3:15 Break

3:25 Sexual identity and behavior

- LGBT 101

- Sexual identity vs. sexual behavior
- Applied use in outreach (for example: case studies)
- Resources (identity support)

4:10 The art of outreach: How to reel 'em in

- How to get people to talk to you during outreach
- Basic outreach skills: What are they, do's and don'ts
- What not to do during outreach with respect to our host bars and clubs

4:40 Day 1 evaluations and wrap-up

- Logistics, policies and procedures
- Signing the volunteer agreement

Sample safer sex educator training curriculum — Day 2

9:15-9:45 Sign-in and breakfast

9:45 Morning warm up and wake up activity

10:00 Basic risk assessment

- How to assess someone's risks for HIV and STIs
- Clarifying ambiguous statements/assessing someone's risk in a club setting

10:25 Harm reduction

10:55 Break

11:05 Client-centered referrals

11:25 Walking the walk: A personal risk assessment

- Solo reflections on possible gaps between new HIV/STD/hepatitis knowledge and personal safer sex practices
- Solo listing of challenges and supports for safer sex practices

- Creation of personal risk reduction plan
- (Optional) Group discussion about sexual challenges, supports and risk reduction plans

12:25 Lunch

1:10 Outreach practice

1:55 Sign-up time: Choosing your outreach schedule

2:10 Sexuality and diversity panel

3:10 Break

3:30 Taking care of yourself during outreach

- Tips for safe and healthy outreach
- Challenging outreach scenarios and how to handle them

4:30 Day 2 evaluations and wrap-up

4:45 Closing reflections

The model's success surpassed expectations, with more than 500 people trained, and 50 active volunteers at any one time. The volunteers have logged thousands of hours of outreach at bars, clubs and coffeehouses throughout Boston. Most locations were chosen because of the presence of bisexual people and/or people who have sex with men and women but do not identify as bisexual. Outreach locations included mixed gender clubs; a bar catering to male-to-female transgender sex workers and their clients; a coffeehouse popular among lesbian and bisexual women, a monthly club night primarily for female to male transmen; and several clubs and bars with a mostly gay and bisexual male clientele.

In terms of bisexuality and HIV prevention, several important conclusions can be drawn from the work of the team. First, the team proved the success of using a model in which we recruited people of all genders, sexual orientations, races and ages to conduct outreach to people of all genders, sexual orientations, races and ages. This model turned out to be more successful than many people first believed would even be possible. It was widely believed that many gay men would prefer only to talk to male outreach workers. This turned out not to be the case, in fact, a significant number of the men preferred to talk to women. In part, the men did not feel a need to impress or flirt with a female outreach volunteer. They would often be more open to asking questions or talking, the same way one might with a friend, as opposed to a prospective date in a bar.

Second, as we have emphasized throughout this guide, the most effective prevention programs make no assumptions about sex, gender identity, or sexual orientation. The safer sex educators were carefully trained not to speak about sexuality in ways that made assumptions about either gender identity or sexual orientation. A classic example is not to use gender specific language when referring to sexual partners, saying "your partner" instead of "he." The team also worked hard to successfully develop language that separated body parts from gender identities, which not only remained neutral about the male or female gender of a person's partner(s), but also recognized that the transgender experience included people who identified as men who had vaginas, and people who identified as women who had penises. A condom, for example, is ideally described as a safer sex supply used with "a penis or a sex toy" not something to "put on a man's penis."

Third, the recruiting of new volunteers used an interest-based instead of an identity-based approach (see "Recruiting safer sex educators" on p. 76). The call for volunteers sought people who "liked to talk about sex" and who "wanted to make a difference in the community," without reference to sexual orientation. This approach proved to be very effective in recruiting exactly who we hoped would respond: a diverse group of volunteers who were comfortable discussing sexual behavior with strangers and who wanted to volunteer out of a genuine desire to help others.

A significant number of the men preferred to talk to women. In part, the men did not feel a need to impress or flirt with a female outreach volunteer.

A condom is ideally described as a safer sex supply used with "a penis or a sex toy" not something to "put on a penis."



Finally, we worked hard to educate our volunteers about the diversity of people they were going to meet in the field. In addition to a detailed HIV/STI education, as well as tips for conducting effective outreach, the hallmark of the safer sex educator trainings was a “sexuality and diversity panel,” which featured four to six panelists representing a wide range of races, ethnicities, gender identities, sexual orientations, fetishes/kinks, socioeconomic classes, ages and life experiences. The panelists, drawn from the community, were asked to speak not just about their identities, but also their sexual behaviors, including times in their life when they had practiced safer sex, and times in their life when they had not.

This panel proved to be a favorite of attendees, and seemed to be particularly helpful in bridging the gap between volunteers with very limited life experience and those whose life experience included a range of things that can put a person at high risk for HIV and STIs, whether through drug use, sex work, poverty, homelessness, sexual addiction, or other factors. While discussion of these issues was interwoven throughout the training, they had particular resonance when people spoke about their firsthand experience with them and answered trainees’ questions about them based on their own lives.

As with the other elements of the BiHealth Program, the entire safer sex educator team model, or just pieces of it, can easily be replicated in other communities. A training can be organized by volunteers on a shoestring budget. For existing programs, minor modifications, whether they be a greater awareness of the difference between behavior and identity or acknowledgment of bisexual-identified people, can make a huge difference. Clients, volunteers and entire communities as a whole are all impacted in positive, powerful ways.

Recruiting safer sex educators

Email proved to be a highly effective tool for recruitment. The text below is a sample email, sent to Boston-area email lists.

Looking for a fun way to volunteer in the community?

Like to talk about sex?

Want to help prevent HIV and STI transmission and help people stay safe?¹³⁴

Join the Safer Sex Educator Team at Fenway Community Health!

Join the team by registering for the free Safer Sex Educator Training, taking place on Saturday, September 21 and Sunday September 22, 20__, 9:00 a.m. to 5:00 p.m. at Northeastern University,¹³⁵ Boston, Massachusetts (registration below). By attending the training and joining Safer Sex Educator Team, you’ll become part of a group of people who conduct safer sex outreach and education in bars, clubs and other venues in the Boston area. Team members work in small groups at Manray, Jacques, Diesel Cafe, Club Cafe, Rise,¹³⁶ and other places in the Boston area for as few as two hours a month and as many as

20.¹³⁷ There they give away safer sex supplies, answer questions about safer sex, STIs, HIV testing and provide referrals and information. Fenway volunteers can also host safer sex education events in their home or conduct online outreach on the Internet.

As a member of the team, you'll:

- Make a difference in the fight against HIV;
- Gain new knowledge and learn new skills;
- Meet some really cool people and make new friends;
- Have the freedom and responsibility of working in small, peer-led teams;
- Have access to free safer sex supplies for yourself and your friends;
- Generally have the chance to have fun while helping others stay safe and healthy!¹³⁸

Just a few of the things current team members are saying:

"After attending the Safer Sex Educator Training, I had my first opportunity to do outreach at a club in Central Square called ManRay. It was fantastic! There was such a diverse crowd, and I really enjoyed the challenge of trying to engage people in conversations about safer sex. It blew my mind that just by donating a few hours of my time, I could potentially be saving someone's life!"

—Abby Francis

"Trying to scare people into having safer sex doesn't work. If you're in a social setting like a bar or a club and you start shouting at the patrons about diseases, they're going to tune you out. We change people's attitudes by engaging people and making safer sex seem fun and exciting."

—Ethan Jacobs

"The training gave the nuts and bolts for how and why this work is important, but the people I met inspired me to get out there and just do it. Since then we've become friends and co-

volunteers promoting safer, healthier and happier sex — and what could be better than that? It's wonderful to be part of the Safer Sex Educator Team."

—Sunny Schettler

To register, fill out the application below. Registration deadline for the training is September 9, 20__. Registration confirmation will take place by September 12, 20__. Note: You don't need any prior experience to join our team. We'll train you on September 21st and 22nd and you'll work with experienced team leaders who will show you what to do and answer all your questions.

Registration Application:

Name:

Email address:

Mailing address:

Phone number:

Why do you want to attend this training?

Do you plan to volunteer for health education programs at Fenway Community Health? If so, how many hours per month do you think you'll be able to commit during the next six months?

Do you have any dietary, accessibility, or other special needs during the training? If so, let us know and we will try to accommodate them. (The building is wheelchair accessible and vegetarian food will be provided.)

Email your answers to the questions above to _____ at _____@fenwayhealth.org or mail it to us at Fenway Community Health, 7 Haviland St., Boston, MA 02115. If you have any questions, you can also email them to us.

Registration deadline is _____. Detailed directions and registration confirmation will be emailed by _____.

Please forward this message to any groups or individuals who may be interested. Thank you!¹³⁹



Hosting a safer sex educator training in your community¹⁴⁰

The costs of hosting a training can be relatively low if you are able to draw on local resources and volunteers. Whether you already train outreach educators (volunteer or otherwise) and are looking to make it more bisexual-inclusive, or are creating a new BiHealth-focused training, here are some of the basic elements:

Audience and advertising

As we noted earlier, it is helpful to target a diverse group of people who will make good, open-minded educators, regardless of their sexual orientation, rather than only targeting gay men. As part of this group, it is helpful to get some people who are well-connected and can help serve as points of entry into their diverse communities. Drawing a diverse group is also helpful for people to learn from each other about the diversity of sexuality and the people they may encounter during their educational activities.

Similar to the bisexual and bi-curious men's group's advertising, advertising beyond the gay male community can help with this diversity. A good technique is to advertise for trainees who want to learn about sex and sexuality for themselves, who like to talk about sex and who want to help the community. Once you have the team established, current volunteers are a great recruitment source for new volunteers, both through their educational outreach and also from their communities.

Resources to host a training

If you search for them, you will find many organizations and individuals who will gladly give their resources for good causes, including donations of space, time, food and even condoms. In order to effectively teach people about safer sex supplies, have supplies that cover a range of sexual practices, as well as plenty of them on hand, since many people may not have ever used some of the supplies and may want to practice putting them on/in a model, such as a dildo or the circle of someone's hand.

Because talking about sex and sexuality for an extended period of time can trigger difficult sexual issues that trainees may have experienced, such as abuse, we have found it useful to have two kinds of resources on hand. It is helpful to have books about various sexual health topics and sexual lifestyle issues, including information and resources about sexual abuse. The second, and perhaps more important, is having one or two designated counselors "on call" present at the training. These are people who have had training and experience in dealing with personal issues that may arise for trainees. Identify both of these kinds of resources to trainees early on, and let them know they can pull aside the counselors on call to talk at any time.

Topics to cover

In BiHealth's history, we have put on both one-day and two-day trainings and could probably think up enough important topics to take up a week of training. Given that few people have the time or motivation for a such a week, however, we have found the two-day format to be the best balance of giving enough training for educators to be successful in the field and invested in the training, but having it be short enough that most people will attend (see "Sample safer sex educator training curriculum" on pp. 73–74). In those two days, the most important topics to cover are: 1) information about HIV, STIs and prevention (safer sex, injection safety information), 2) information about sexual behavior and identity and 3) outreach skills and practice. Here are some basics about each of these categories:

1. **Information about HIV, STIs and safer sex.** This includes information about the most common and dangerous STIs, including: prevention, transmission, symptoms, treatment and/or cure, if any, and the effects that each STI has on the body. We include hepatitis A, B and C in this category, even though they are transmitted through non-sexual means as well. The second element is detailed information about safer sex supplies. We include a range of information because we have found that knowing how to respond to people's concerns about safer sex supplies, even concerns that do not necessarily directly relate to STIs, can help people prevent HIV. For example, if someone says "I don't like how condoms feel" then the educators may be able to respond with tips on how to make them feel more comfortable, or on checking for latex allergies, which may result in helping people to use appropriate barriers. We also make sure to include lube in this category, because lube can make sex more comfortable and also safer by making the condom less likely to break, and the anus, rectum or vagina less likely to tear.

Make sure to demonstrate all supplies and ideally give people a chance to practice demonstrating the supplies as well, including safer injection practices, such as cleaning needles, cottons and cookers. The last element of this topic is information about HIV, STI and hepatitis testing and vaccination procedures in order to help people know their HIV status, get tested and treated for STIs and get screened and/or vaccinated for hepatitis, preventing their further spread.

2. **Information about sexual behavior and identity.** By spending time educating volunteers about the differences between sexual behavior and sexual identity, as we discussed earlier in this document, educators can address behavior in terms of HIV and STI risks, and can address identity if people have questions or concerns about it. In a BiHealth-specific training, we have found it helpful to leave time for people to talk about their own configurations of sexual identity, behavior and attractions, if they have felt comfortable doing so.

Make sure to demonstrate safer injection practices such as cleaning needles, cottons and cookers.



Sometimes we have young, straight-identified college students who attend our training. Before sending them out into the field, it is helpful to do some basic education about LGBT issues.

Educating participants about basic concepts like gay, lesbian, bisexual, heterosexual, transgender and intersex, as well as various other identities, sexual communities, and practices is also important. Some of the people who attend the training may have different understanding of what these terms mean and they will be educating people who have many different kinds of experiences and identities. For example, sometimes we have young, straight-identified college students who attend our training. They are interested in helping prevent HIV transmission, but some of them do not know what it means to be LGBT. Or we may have gay, lesbian, or bisexual-identified people who come to our training but have misconceptions about what it means to be transgender. Before sending them out into the field, it is helpful to do some basic education about LGBT issues.

The training also draws participants who may be questioning their sexual orientation. Some of them may be people who have sex with people of more than one gender, who fantasize about people of various genders, or who might be questioning what label to use to describe their sexuality to others. We teach about the differences between sexual attraction, behavior and identity and one can almost see the light bulbs going on over their heads. By using a variation of Klein's sexual orientation grid¹⁴¹ we have been able to support people's sexual identity development this way. We do this partly because research has shown that for some people, an increased comfort with their own sexual identity was related to having lower sexual risk.¹⁴²

3. Outreach skills and practice. There are a few basic skills that we teach at the training with the understanding that as the volunteers go out into bars, clubs and other venues they will be paired with a more experienced, mentor volunteer. The mentor will help them learn more and practice more. The basic skills taught at the training include:

- a. Building trust with clients
- b. Listening
- c. Conducting basic education about HIV, STIs, hepatitis, safer sex supplies and injection safety information
- d. Answering client questions about safer sex
- e. Conducting risk assessments
- f. Providing client-centered referrals

During the training we discuss ways to do all of these and practice several of them in pairs and/or small groups. In addition, we talk about some basic outreach do's and don'ts of getting people to talk to us in the first place and making sure that we stay on our hosts'

good sides (in most cases, this is the club management).

In addition to these three basic areas, other areas to cover that have a significant effect on our trainees' learning and participation are:

- **Ice-breaker and team-building activities.** These allow people to feel more connected to the team, and this connection helps them to be more involved long-term. They also help them to feel more comfortable talking about sex. For example, a fun and easy activity we have used that accomplishes both of these goals is the game sexual pictionary.¹⁴³
- **Detailed information about how to get tested for HIV and STI, including local resources.** This helps to demystify the process both for trainees and for the people they will later reach.
- **Harm reduction.** Harm reduction is an approach to HIV prevention that focuses on reducing people's HIV risks through less risky ways of having sex and shooting drugs, rather than touting an often ineffective abstinence-only approach. Harm reduction information helps to give trainees a relative risk context for the HIV and STI information that they learn, as well as a framework for how to work with others.
- **Learning about diverse communities and sexual practices.** This helps prepare people for the kinds of people and activities they are likely to encounter during outreach. This can be done through a sexuality and diversity panel, through videos or readings from plays, articles, or fiction, as well as by asking the audience to share their experiences if they are comfortable doing so. The element of using personal stories helps trainees to understand that there are real people behind these practices. This is especially useful if you can have someone on the panel who is HIV-positive and/or who is living with a long-term STI, such as herpes or HPV (human papilloma virus).
- **Discussing sexual risk motivations, challenges and supports.** These discussions can help to humanize the motivations behind risky behavior, as well as to bring up the realities that may be similar to trainees' own realities, helping trainees gain support for themselves as well as understanding of others. At our trainings we have often used the sexuality and diversity panel to reinforce this, although it can be challenging to find people who are willing to publicly talk about times when they have been in sexually risky situations. Make sure to make clear what you are looking for in a speaker and/or to interview potential panelists, as we have had some unhelpful panels where most of the panelists were very low risk for HIV and STIs — good for them, but not as helpful to learn from.
- **Personal risk assessment.** This is a chance for trainees to think about their own

Using personal stories helps trainees to understand that there are real people behind these practices.



sexual behavior given the new information they have learned at the training. Specifically, we give them time to process which of their sexual behaviors they feel comfortable with in terms of risk levels, and which behaviors they might want to change because of risk level. We usually do this activity as a solo writing exercise, with an optional full group discussion and/or small group brainstorming at the end.

Presenters and volunteers

Putting on a training can be much easier if you have some volunteers to help with logistics and if you know where to find presenters. If you already have a volunteer team, of course they are the best source to draw on for training help, especially on the logistics side. If you are starting from scratch, a good place to look for logistics volunteers are people in your local LGBT community and people from your organization. In terms of presenters, if your program already has done a training, presenters for some topics can be drawn from your volunteer pool. We have had the most success using volunteers for the following parts of the training: safer sex supply demos and practice, ice breakers and team-building exercises, outreach demonstrations, skills and practice, a sexual diversity panel, and we have also considered using them for basic information about HIV, STIs and hepatitis.

If you use volunteers for any of these areas, make sure that they have clear instructions and that they have appropriate skills for this area. This includes making sure they have good group facilitation skills if they will be leading a large or small group. Or, if they are doing a supply demonstration, making sure they are comfortable with that particular supply and/or have practiced demonstrating it. Other than volunteers, here are some suggestions for where to look for possible presenters.

- For presenters for HIV/STI 101, safer sex supply demonstrations, harm reduction information, sexual risk motivations and/or a personal risk assessment: local sexual health experts, such as an STI clinic staff person, an independent sexuality educator, local AIDS service organization staff, a community-minded doctor. These resources can also help with testing, treatment and vaccination logistics, especially if they are the main location that you will refer to for these services, as they can also detail all of the logistics associated with their site.
- For a counselor on call: local social work schools, rape crisis, sexual health and/or suicide hotline staff or volunteers.
- For information about sexual orientation, gender identity and sexual identity and behavior: someone with training specifically on LGBT sexuality is helpful. A good resource to teach yourself is a flyer distributed through the Bisexual Resource Center titled “Sexual and affectional orientation and identity scales.”¹⁴⁴

Resources to hand out

What will trainees need to walk away with? It is helpful to have much of the information they have learned in a written format so they can refer to it later. This includes a set of the pamphlets or brochures they might use during outreach as well as supplemental information that they will need at the training and also to cover some of the topics that are not able to get covered at the training. Many Web sites have helpful and appropriate HIV and STI information that can be downloaded for free, including Fenway Community Health's Web site. Having written information about the logistics of whatever testing sites they may send people to, including location, hours, cost, contact people and services offered, is also very helpful.

The Bisexual Resource Center has many excellent pamphlets on bisexuality available on their Web site (www.biresource.org). Having information on harm reduction, outreach skills, and other sexual health and sexuality related topics (i.e. living with HIV, polyamory) are also useful. A good source for harm reduction fact sheets is the AIDS InfoNet (www.aidsinfonet.org).

The Bisexual Resource Center has many excellent pamphlets on bisexuality available on their Web site (www.biresource.org).

ADDITIONAL CHALLENGES AND BENEFITS OF A BIHEALTH PROGRAM

The BiHealth Program encountered an unexpected challenge and an unexpected benefit, both worth mentioning here so that anyone considering replicating this model is better prepared.

Challenge: Community needs vs. funding priorities

As described at the beginning of this guide, the birth of the BiHealth Program was a product of "increasingly intensive intervention" and other concepts being implemented by the Prevention and Education Department of the AIDS Bureau of the Massachusetts Department of Health in late 1999 and early 2000. Trainings on empowerment emphasized the importance of a grassroots process driven from the bottom-up, not the top-down, and the value of empowerment.

In the first few years of the BiHealth Program, the program's activities were primarily shaped by the needs and ideas that community members expressed. This included many of the things mentioned earlier: the creation of a safer sex brochure when the community said there was a need for one; the founding of the bisexual and bi-curious men's group when it was clear this was an unfilled need in the community; trainings to empower community members to be safer sex educators.

Unfortunately, the bursting of the tech stock bubble brought severe cuts to the state of



Massachusetts' tax revenue and to the budget of the Massachusetts Department of Health. Priorities were refocused as the budget decreased. When the department looked at the latest epidemiological data on HIV infection rates, it was clear that men who have sex with men were still becoming infected with HIV in disproportionately large numbers. The rates of infection for MSM are significantly higher than they are for WSW and WSMW.

Faced with this data and the harsh reality of funding priorities in lean times, the BiHealth Program's contract manager at the Massachusetts Department of Health made clear that the program should focus its energies on MSM or MSMW, but not women. This resulted in a number of soul-searching conversations among staff and volunteers of the BiHealth Program. On the one hand, the Public Health Department's logic was reasonable and supported by epidemiological data. But on the other hand, focusing on men would be fundamentally contrary to the fundamentally inclusive principles upon which the program was founded.

In all its activities, whether it was our outreach campaigns, our trainings, or the creation of the safer sex brochures, BiHealth was a mixed-gender program.

In all its activities, whether it was our outreach campaigns, our trainings, or the creation of the safer sex brochures, BiHealth was a mixed-gender program. The only exception was the bisexual and bi-curious men's group, single gender only because its women's-only equivalent already existed through the Boston Bisexual Women's Network. Also, BiHealth's sheer number of dedicated female volunteers was a huge factor in the program's success in reaching men. Pulling away from our efforts to include women would not only mean women would not benefit from our work, but that men would suffer as well. Women comprised the majority of the program's safer sex educator team, and if those women weren't part of the program, they would not be outreaching to men, either.

After further conversations with the Public Health Department, the result was a two-fold approach. Women would continue to be actively involved in the program as volunteers and educators, but only our outreach efforts to men in bars and clubs would be "counted" on official forms submitted to the Department of Public Health. We would continue to outreach at Diesel, the cafe popular among lesbians and bisexual women, except that those activities would be funded through other sources, like private donations. Fortunately, because many aspects of the program can be run on a very small budget, this was not difficult to do.

Nonetheless, it can be challenging to sustain a large gap between funding priorities and community interest for very long. Eventually, in subtle and direct ways, the needs of the funder shaped the future of the program. In 2004, the core of the funding for the BiHealth Program was designated for the Safer Sex Education Program, primarily an outreach and education program for men who have sex with men, of which only a portion of those are men who have sex with men and women. Through its "Virus and Infection Prevention (V.I.P.)

Crew,” the new outreach volunteer corps, the program’s outreach continues to encourage and train female volunteers and to reach women who frequent the largely gay and bisexual male-oriented venues where the V.I.P. crew conducts outreach.

The program is, however, run by a bisexual woman, Julie Ebin, who started as a volunteer for BiHealth, later became a full-time employee at Fenway, and is now Fenway’s Prevention and Education Programs Manager. Julie continues to support BiHealth on a smaller scale as a subset of the safer sex education program; sustaining the existence of the bisexual and bi-curious men’s group; providing phone and email counseling about bisexuality and HIV/STIs for those who respond to the group’s ads; continuing to distribute the “Safer sex for bisexuals and their partners” and “Safer sex” brochures to those who request them through Fenway’s Web site; and occasionally presenting at conferences.

Julie has also found other ways to carry forward the original mission of BiHealth. Among other things, she organizes “Boundless,” an educational event series for lesbian and bisexual women designed to promote more holistically healthy communities. The events are all transgender-inclusive and are frequently open to people of all genders and orientations, including welcoming men as well. The series started as four unaffiliated events in 2003, moved to its current brand of “Boundless” in 2004, and now in its fourth year, continues to host four to six events per year. Past events have included bisexuality-focused events, such as “Bisexuality, strength and courage,” “Creating a both/and identity in an either/or world,” and the debut event, “Bisexuality, feminism, heterosexual privilege and our bodies,” with Boston bisexual activist Robyn Ochs. It also features more general, but bi-inclusive events, such as “Getting the queer sex you want” (on communication and negotiation), “You flirt” (a skill-building workshop) and “The legalities of same-sex marriage,” designed to educate couples about legal factors to consider for their relationships after Massachusetts’ historic ruling.

While the success of Boundless is reassuring, there is no clear “moral to the story” for the challenge the BiHealth Program encountered as its funder shifted priorities. On the one hand, the BiHealth Program would not exist if not for government, HIV-prevention funding. On the other hand, it no longer truly exists – at least in the mixed-gender form in which it was originally conceived – because of the limitations of that very same HIV-prevention funding. These are issues of which anyone seeking to replicate this model should be aware as they move forward, particularly if they are seeking outside funding.

Benefit: Creating a more bi-friendly culture

An unexpected but powerful benefit of the creation of the BiHealth Program was the visibility it created at Fenway, in the Boston community and nationally for bisexual health issues. This



BISEXUAL HEALTH

visibility provided a platform for education and advocacy that might not have existed otherwise. Here are a few examples of the ways in which program staff were able to have an impact:

Within our own agency:

- In-service trainings on bisexuality and MSMW/WSMW, including trainings for mental health providers, research and evaluation department staff, interns from local social work schools and the agency's board of directors.
- Creation of bi-specific information on agency Web site and materials provided (such as the brochures described above) for use by other individuals and departments.
- Advocacy to make existing programs more inclusive of bi-identified people. One educational workshop series, for example, was expanded to be inclusive of bisexual men after a series of discussions with program staff. A telephone hotline name was changed to reflect the gay, lesbian, bisexual and transgender clients it serves, instead of being called the "gay and lesbian" helpline.
- Being known throughout an agency of 100+ people as the person who runs the bisexual program gives co-workers a place to turn with their questions about bisexuality. Some were themselves questioning or coming out as bisexual. Others were skeptical about bisexuality, but willing to talk, ask questions, listen and learn.

In the local and national communities:

- Co-sponsorship of activities and events with the Bisexual Resource Center, including Celebrate Bisexuality Day (held on September 23 of each year). This garnered the attention of The Boston Globe and other media outlets.
- Trainings at regional and national conferences for other providers and for community members. These trainings addressed many of the same issues detailed in this guide: how to create a BiHealth Program, how to make existing programs more inclusive, as well as how to work with bisexual clients.
- Shaping the work of others. Fenway's

**Your Strongest Link
to Bisexual Health...**

**BiHealth at
Fenway Community Health and the Bisexual Resource Center**

BiHealth provides HIV/STD prevention education, and addresses health concerns whether one identifies as bisexual, bi-curious, bi-questioning, pansexual, heterosexual, gay, lesbian, transgender, or no label at all. BiHealth is a program based at Fenway Community Health in Boston.


Call or email for counseling, support, or for resources and advice on setting up a similar program in your community or agency.

For more information contact Marshall at bihealth@fenwayhealth.org, or call 617-927-6032.

FENWAY COMMUNITY HEALTH

Fenway

7 Haviland Street
Boston, Massachusetts 02115
www.fenwayhealth.org



The Bisexual Resource Center provides education, information and referral services on bisexuality and bisexual issues to (mostly the English speaking) world, through publications in print and on the web. The Bisexual Resource Center advocates for bisexual issues both in the BGLTQ communities and in society at large. Our flagship publication is the Bisexual Resource Guide, listing 352 bi groups and 2129 bi-inclusive groups in 66 countries, as well as bibliographies, film guides, quotes and photos.

For more information visit our websites at www.biresource.org and email brc@biresource.org, or call 617-424-9595.

**Bisexual
Resource
Center**

www.biresource.org

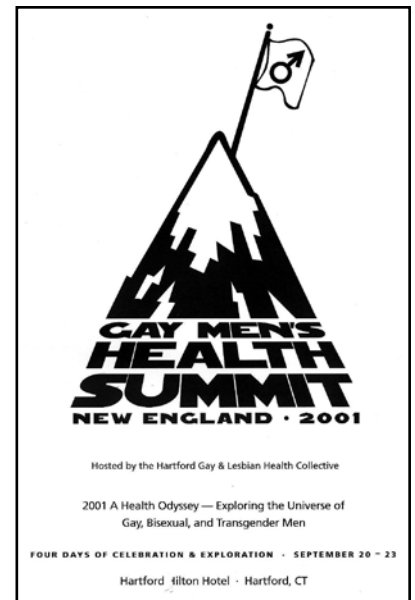
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Research and Evaluation Department was a site for a federally-funded research study of men who have sex with men. This study (known as “Explore!”) involved more than 5,400 men nationally, in cities including New York, Chicago, Denver, San Francisco, Seattle and Boston. It was a behavioral intervention that involved counseling men about HIV risk reduction.

The first versions of the script for the counselors to use included no questions about sex with women, despite the fact that research shows that a significant percentage of men who identify as gay have sex with women as well as men, and despite the fact that the intervention did not specify that clients be gay-identified. For counselors working with men to reduce their HIV risk, it would be important to be able to address the full picture of the client’s sex life. BiHealth initiated a group that reviewed the manual, and suggested changes that were implemented on a national level. Then, armed with the confidence that the study was reflective and inclusive of the experiences of men who have sex with men and women, BiHealth helped recruit bisexual men to participate in the study. Now those men’s experiences help inform the research.

- BiHealth Program staff and volunteers have been actively involved in national meetings and discussions about the future direction of the LGBT health movement. This has included online discussions among professionals working in the field, articles in publications such as the Journal of Bisexuality and the newsletter of the LGBT Caucus of the American Public Health Association, and presentations at conferences like the National Gay and Lesbian Task Force’s Creating Change, the Gay Men’s Health Summit and the National Gay and Lesbian Health Conference.

These are just a few examples of what was an ongoing process of seizing opportunities that arose. One of the very positive long-term effects of making Fenway more inclusive and welcoming of bisexual people and MSMW/WSMW is that it has resulted in more of those people participating in research studies and educational programs, receiving their health care at Fenway, and applying to work there. This, in turn, has resulted in the agency becoming even more responsive and inclusive, which has resulted in even greater community interest. This process is self-perpetuating and self-reinforcing and, as it continues, can have a tremendous impact on the agency’s ability to serve the community effectively.



Plenary Sessions

FRIDAY 9AM

Bisexual Health: Are We Dangerous Yet?

Description: Bisexual men (and bisexuals in general) are frequently portrayed in mainstream media as dangerous sexual risk-takers, experimenters, confused about our sexuality, and beyond the reach of gay + queer community health resources due to closeting. How much of this is myth or self-fulfilling prophecy, how much is challenged or belied outright by the experiences of queer-identified bisexual health activists and safer-sex experts? Our expert panel will outline what bisexual health activists are already doing for bisexual communities and for LGBT health organizing; challenges bisexuals face in health care settings and what can be done to moderate or eliminate them; and what bisexual and bi-friendly health activism can contribute to ongoing struggles against HIV and STDs and creating and sustaining diverse, healthy, LGBT communities.

MODERATOR: Pete Chvany, bisexual activist, Bisexual Resource Center and Consultant,

Bi Health Program at Fenway Community Health

PRESENTERS: Marshall Miller, Coordinator, Bi Health Program, Fenway Community Health,

Bobbi Keppel, BLTG health activist and consultant, Bi Health Program,

Alan Hamilton, President and co-founder, Bisexual Resource Center and consultant,

Bi Health Program

DATE • TIME: Friday, September 21 • 9:00-10:45AM

LOCATION: CT Ballroom



next steps

There are many ways that you can have a positive impact on improving the health of people who have sex with men and women, however they identify.

In order for the bisexual health movement to go forward, it needs the time and energy of concerned people; it needs access to resources, the public view, and places where it can have an impact; and it needs support — funding, and the backing of public health officials, health care providers, decision-makers and most importantly, bisexual individuals and people who have sex with people of more than one gender.

Some of the efforts already under way are described in this section. However, more efforts are still needed. Whether you are a healthcare provider, researcher, therapist, journalist, bisexual person or concerned community member at large, there are many ways that you can have a positive impact on improving the health of people who have sex with men and women, however they identify. In this section we also provide suggestions of some specific ways that you can help, whatever your level of ability and interest.

CURRENT BISEXUAL HEALTH PROJECTS AND RESOURCES

Bisexual Health Summit and organizing

In the past decade, a few Bisexual Health Summits have been held throughout the country. These summits are one or two day events and are designed to bring together bisexual people and allies to address bisexual health issues. Often, the summits are held in conjunction with other conferences, such as the Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Health Summit,¹⁴⁵ and national and international bisexual conferences. Attendees have said they found these summits incredibly valuable for their work as educators and activists. The summits also take time and energy to plan.

There is currently no declared home base conference for the Bisexual Health Summit, and if the Americas Conference on Bisexuality does not continue regularly, the Summit may be subject to the same scheduling challenges. Hosting the summit at an international conference, while widening the scope of input and reach of such a meeting, would, depending on the location, also mean limiting the number of people from the US who would be able to

attend, somewhat defeating continuity. The Bisexual Health Summit is one vibrant and vital means of sharing information updates and resources from across the US and beyond, and as a grassroots effort, needs health providers, researchers and concerned community members to take leadership roles in organizing and presenting at it in order to continue.

The bisexual health community online

Online, the bisexual health community continues to come together through an e-list that can be accessed by going to <http://health.groups.yahoo.com/group/BiHealth>. Interested community members, health providers, researchers and others are encouraged to join and contribute to this helpful virtual forum on bisexual health. The group also includes some resources that can be downloaded from its “files” section. Additionally, a “wiki” (an online database to which anyone can contribute) is currently being created on www.binetusa.org in hopes of capturing the broader historical milestones of bisexuals and the bisexual health movement in the United States.

A “wiki” (an online database to which anyone can contribute) is currently being created on www.binetusa.org to capture the milestones of the bisexual health movement in the US.

A top ten list of bisexual health concerns

Cheryl Dobinson, former Project Coordinator at the Sherbourne Health Centre in Toronto, Ontario, has put together a preliminary list of bisexual health concerns from research on broad, population-based studies that include bisexual individuals and/or MSMW/WSMW and report on them as a distinct group. This list can currently be accessed through the BiHealth yahoo group and is also available in Appendix A of this publication. Cheryl is working with the Gay and Lesbian Medical Association (GLMA) to publicize this list along with their top 10 lists of health concerns for gay men, for lesbians and for transgender people. Although further research is needed on bisexual health issues and on health issues for WSMW/MSMW, this is a good place to start understanding these concerns, whether you are a health provider, community member, HIV/STI service provider, funding provider or other interested individual/organization.

Brochures for bisexual people and/or for MSMW/WSMW

As mentioned earlier in this guide, Fenway Community Health’s BiHealth Program has put out two brochures, “Safer sex for bisexuals and their partners” and “Safer sex.” Updated versions of these brochures are expected to be released in early 2007.¹⁴⁶ Sherbourne Health Centre also has a wonderful brochure with general information on bisexual health, which is available on its website.¹⁴⁷

“Tips for working with bisexual clients,” also available in Appendix B, is a helpful, one page



primer that various health providers may find useful as a brief starting place for themselves, for their colleagues, or that health consumers may find useful to give to their providers.

WHAT YOU CAN DO

Counselors, therapists, healthcare providers, providers of programs and services for WSMW/MSMW and bisexual individuals

Programming

- With resources, you can create programs that specifically target bisexual people and other MSMW/WSMW, based on the models outlined in this document, tailoring them according to the needs of the community in your area. Even if it's not feasible for your organization to replicate these programs at this time, you can still revise existing programs to be more inclusive based on the information in this report.

Welcoming environment and outreach

- Take non-programmatic steps to make your agency or practice as a whole more inclusive of bisexual people and WSMW/MSMW by having posters and pamphlets with “bisexual” or “LGBT” prominently mentioned (rather than “gay and lesbian”) in your waiting area. Use these terms in advertising and outreach materials (or, depending on your population's cultural norms, indicate you are non-judgmental about people's sexual practices).
- Join the Bisexually Aware Professionals (BAP) list.¹⁴⁸
- In any online listings, particularly in listings provided by insurance companies, list in your profile that you are a trans- and bi-friendly provider (not just lesbian- and gay-friendly), and that couples in polyamorous and/or BDSM¹⁴⁹ relationships can also feel safe and comfortable accessing your services.

Approach

- Understand the difference between sexual identity and sexual behavior. Promote this understanding with your colleagues, staff and boss. Encourage or create training in this area for yourself and other staff, specifically:
 - To routinely ask about sexual behavior in a non-judgmental way (“Do you have sex with men, women, both, neither?”) even when a client or patient has stated

their identity. Use open terms such as “partner” or “significant other” rather than “boyfriend” or “girlfriend.”

- To be open to people asking for services outside of their stated or perceived orientation. Set aside expectations and judgments. Further reading on issues of bisexuality, behavior and identity can help providers respond to people respectfully and in an informed way.
- To make space for, bring up and address issues of sexual behavior and attraction to people of the same gender with individual, heterosexual-identified clients or groups of clients.
- To make space for, bring up and address issues of sexual behavior and attraction to people of a different gender with individual, gay or lesbian-identified clients or groups of clients.
- Particularly for therapists and counselors: understand that not all clients who are attracted to people of the same sex or who have sexual experiences with people of the same sex are gay or lesbian. Some may come to identify as bisexual, some may identify as heterosexual, and some may prefer not to use an identity label at all.

Researchers and journalists, and concerned members of the public

Research

- More research is needed, particularly research that targets bisexual people and MSMW/WSMW specifically, asking both behavioral and identity-based questions. We have some bare bones information about health disparities of bisexuals and of WSMW/MSMW, but further research is needed comparing the health and quality of life of these individuals both to their MSW/WSM and heterosexually-identified counterparts and also to their MSM/WSW and gay- and lesbian-identified counterparts. The research is fundamental to other efforts in this field, as funders and practitioners need it to be able to fund and create programs and services.
- Research needs to be done not only in areas of sexuality and sexual practices, but especially in areas of general health and well being, including overall physical health, mental health and specific areas with a lack of knowledge about bisexual people and WSMW/MSMW, including intimate partner violence, hate crimes and violence and sexual abuse and assault.



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Public conversation and awareness

- Journalists, researchers and other concerned people can help by thoughtfully bringing community and public attention to quality research on bisexuality, bisexual issues, and issues relating to people who have sex with more than one gender. Most importantly, these people can:
 - Avoid sensationalizing stories or research that relate to these areas.
 - Ask insightful and thought-provoking questions about research that has questionable legitimacy (as they would with other research).
 - Include perspectives of bisexually-identified individuals and/or MSMW/WSMW in the writing process and in the research planning process (choosing and pursuing research topics, methods, recruitment and dissemination).

Departments of public health, foundations and other funding agencies

Funding and funding requirements

- Fund programs! Recognize that there are significant health disparities and that traditional gay or lesbian-focused programs and services do not necessarily address the needs of MSMW/WSMW of any identity.
- Add provider training and cultural competence in working with WSMW/MSMW to grantee competence guidelines and requirements.

Planning and policy

- Recruit MSMW/WSMW and bisexually-identified individuals for policy and/or funding advisory groups and grant/proposal readers.
- Ask grantees to require representation in this area on their service advisory boards.

Bisexual people, WSMW/MSMW and concerned allies

Advocacy

- People can continue to advocate for themselves and for bisexuals and MSMW/WSMW in general, by becoming part of health advisory boards at local and national organizations, health centers, non-profit and for-profit research agencies and government-sponsored bodies. These groups play a vital role in recommending the what, how and even for whom of many services and research efforts. This can include helping providers and

researchers with appropriate language for their programmatic and outreach efforts, as well as recommending places for them to reach their target audiences. Through these boards or through individual suggestion, people can encourage their local “gay and lesbian” group or gay men’s/lesbian health service to include bisexual and transgender individuals in name and in fact, and offer to give them pointers to revise their curricula, policies, and recruitment efforts. Through similar means, people can ask their local health centers to address issues relating to sexual health between people of the same gender and different sexes/genders.

- Advocacy can also occur through involvement in the media, either proactively, as with bisexual perspectives/coverage of relevant health and research issues, or in response to coverage of such issues that does not adequately express a bisexual perspective.

Do-it-yourself community services, education and training

- Bisexual communities can come together to organize and form volunteer-run efforts such as bisexual support groups, safer sex educator teams and safer sex theater groups.
- Work together to provide trainings on bisexuality for local health groups, distribute information on bisexuality (such as the Bisexual Resource Center’s pamphlets or “Safer sex for bisexuals and their partners”) to your own and area health providers, ask your own and other doctors/counselors/therapists to have the materials available for their colleagues, in their waiting rooms and anywhere that bisexuals might need to be welcomed. Concerned community groups or individuals can also give providers a copy of this publication and ask them to read it.
- When participating in health- and sexuality-related research, bisexual people can ask that perspectives of MSMW/WSMW be included and that they record both sexual behavior and identity.

Everyone

Bring a bisexual voice or voice of an ally to the table

- In the general health arena, attend professional and grassroots national health conferences, such as the American Psychological Association if you are a member or the Lesbian Health Summit. At these meetings, speak out on issues that affect MSMW and WSMW and bisexuals. Say the words “bisexual,” “women who have sex with women and men” and “men who have sex with men and women” as appropriate. Answer questions about what these terms mean.



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- In the bisexual arena, support health organizing and educational efforts at national and international bisexual or bisexually-inclusive conferences, like the International Conference on Bisexuality or the National Gay and Lesbian Task Force's Creating Change conference.¹⁵⁰ Bring a bisexually-inclusive, health-oriented voice to the table.
- Help the Bisexual Health Summits to go forward.

Support bisexual community organizing

- Volunteer your time, skills and/or money to local or national organizations doing the work of educating, advocating, or researching bisexual health issues. The possibilities are endless but doing even just one action can have a tremendous impact. Better yet, folks can team up with others who feel as they do and support each other to prevent burnout! Whether you act on a small scale or a grand one, be a part of the movement in whatever way you can.

endnotes

executive summary

- 1 Some people believe that sex should be considered part of gender because sex and the meaning ascribed to anatomical, chromosomal, hormonal, and/or physiological sexual characteristics are also culturally determined.
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- 11 Case, P., Austin, B., Hunter, D. J., Manson, J. E., Malspeis, S., Willett, W. C. & Spiegelman, D. (2004). Sexual orientation, health risk factors, and physical functioning in the Nurses' Health Study II. *Journal of Women's Health*, 13(9).



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introduction and literature review

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the bihealth program at fenway community health in boston, massachusetts

- 112 Many thanks to Loraine Hutchins, Lani Ka’ahumanu, Ramki Ramakrishnan, Dorian Solot, Pete Chvany and Denise Penn for their editorial contributions to this section. The BiHealth Program described here would not have been possible without the strong support of Fenway Community Health, the Bisexual Resource Center, the Massachusetts Department of Health and the generous, passionate contributions of hundreds of BiHealth Program volunteers. Special thanks to Jason Cianciotto at the National Gay and Lesbian Task Force for his incredible patience and strong commitment to see this document published.
- 113 As discussed in the introduction and literature review, “bisexual” refers to an identity label some people use to describe themselves. “People who have sex with men and women” is a description of behavior.
- 114 For further reading about the BiHealth Program, see Ebin, J. & Van Wagenen, A. (2006). Developing successful sexual health and support services for bisexual people: Lessons learned from the BiHealth program. *Journal of Bisexuality*, 6(1). Also in Fox, R. (ed.) (2006). *Affirmative psychotherapy with bisexual women and bisexual men*. (First ed.) New York: Harrington Park Press.
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- 116 Research shows that many, if not most, men who have sex with men and women (MSMW) and women who have sex with men and women (WSMW) identify as something other than bisexual. See “What is the frequency of bisexuality in the US?” on p.11 of this publication. See also “‘Straight’ MSMW?” on p.39 of this publication. Using heterosexual, gay, lesbian, “just sexual” or using no label at all are common for MSMW and WSMW.
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- 118 “Bisexual” is an identity label, not a type of behavior. Therefore, terms like “bisexual behavior” or “behaviorally bisexual” are misleading and inaccurate. See section, “Who is a bisexual person?” on page 11 of this publication for more discussion.
- 119 People may also choose their identity label based on cultural or political reasons. For example, terms such as “same gender loving” may be more frequently used by people of color who do not identify with mainstream LGBT culture. A survey of 2,048 attendees at nine Black Pride celebrations around the country in 2000 found that 8 percent identify as same gender loving. Men were twice as likely as women to use that identity label. See Battle, J., Cohen, C.J., Warren, D., Ferguson, G., & Audam, S. (2001). *Say it loud I’m black and I’m proud: Black pride survey 2000*. New York: The Policy Institute of the National Gay and Lesbian Task Force. pp. 18-19.

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- 121 “Outercourse” is a term used to describe sexual activity that does not involve penetration or oral sex. Some sex educators, particularly those working with youth, say that outercourse can be a good low-risk alternative to anal or vaginal sex.
- 122 These safer sex supplies are known by some as “dental dams.” They provide a barrier during oral-anal, oral-vulval, or oral-vaginal contact. Plastic wrap, available in kitchens throughout the world, is also a very effective and inexpensive barrier. Some people have heard that microwaveable plastic wrap should be avoided because it becomes porous, although in reality that seems to be more urban legend than fact because it only becomes porous at very high temperatures. While non-microwaveable plastic wrap is probably the best, any barrier is better than none.
- 123 Polyamory means “many loves” and is a term some people use to describe the process of having or seeking to have honest, open, sexual relationships with more than one partner. Polyfidelity is a form of group relationship where all the members agree to be sexually exclusive with each other.
- 124 Injection drug use can include heroin or other drugs, but also steroids, hormones, and any other substance that is injected using needles.
- 125 One term for this concept is “negotiated safety.”
- 126 See: Mosher, W. D., Chandra, A. & Jones, J. (2005). Sexual behavior and selected health measures: Men and women 15-44 years of age, United States, 2002. *CDC: Advance Data for Vital and Health Statistics*, 362. See also Taormino, T. (1998). *The ultimate guide to anal sex for women*. San Francisco: Cleis Press. See also: Morin, J. (1998). *Anal pleasure and health*. San Francisco: Down There Press.
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- 129 When conducting this search we also switched terms around (e.g. “women who have sex with men and women,” and “women who have sex with women and men”) and then added the search results together in order to get a more accurate count.
- 130 Note that the latest brochures are available to download for free or to order at the Fenway Web site: www.fenwayhealth.org/bihealth
- 131 Viral marketing is a strategy that encourages people to forward the email messages they receive to others in order to reach even larger numbers of people.



- 132 Unfortunately, the brochures have since lost their Google rank due to a redesign of Fenway Health's Web site.
- 133 The Bisexual Resource Center (<http://www.biresource.org>) and the *Bisexual Resource Guide* (published by the resource center) provide listings of bisexual social and support groups around the world.
- 134 Note that all three of these questions are behavior-based. We're looking for people who want to volunteer, talk about sex and prevent HIV. It does not say that we're looking for "gay men" or "bisexual people."
- 135 Northeastern University generously provided the space for our trainings. Contact the government and community relations department at your local college or university to explore the possibility of free or low-cost training space.
- 136 These are bars and clubs in the Boston area. Diesel Café is a coffeehouse.
- 137 Providing a wide range of hours allows for highly motivated people to jump in with both feet, and for those who are less certain to start out slowly.
- 138 Listing concrete benefits is very useful when recruiting volunteers.
- 139 The "please forward" line is a great tool for reaching people and communities that may not already be familiar with or connected to your work. This technique is often referred to as "viral marketing" (see http://en.wikipedia.org/wiki/Viral_marketing for more discussion of this technique).
- 140 This section was written by Julie Ebin, Prevention & Education Programs Manager, The Fenway Institute, Fenway Community Health.
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- 142 Boulton, M. & Fitzpatrick, R. (1993). The public and personal meanings of bisexuality in the context of AIDS. *Advances in Medical Sociology*, 3.
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- 144 As of September 2006, the information is available at <http://www.biresource.org/pamphlets/scales.html>

next steps

145 For more information on the LGBTI Health Summit planned in 2007, see <http://www.healthsummit2007.org>

146 Check for updates at <http://www.fenwayhealth.org/bihealth>

147 As of September 15, 2006, the brochure is also available online at <http://www.sherbourne.on.ca/PDFs/Broch-letstalkaboutbihealth06.pdf>

148 Available at <http://www.bizone.org/bap/>

149 BDSM: bondage/dominance and sadism/masochism

150 See <http://www.creatingchange.org>



appendix a

TOP TEN BISEXUAL HEALTH ISSUES

By Cheryl Dobinson
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Sherbourne Health Center, Toronto

Based on:

- Research that explicitly includes bisexual people as their own category and compares to them to gay/lesbian and/or heterosexual people;
- Studies of adults – not including the range of studies on youth;
- Research using different definitions of “bisexual” – identity or behavior.

Limited by:

- Lack of studies addressing bisexual men in particular;
- Lack of population-based or large studies on gay and bisexual men with a heterosexual comparison group;
- A lot of research tends to put gay and bisexual men or lesbian and bisexual women together.

1. Drug use

- **Women:** Research shows that bisexual women have higher rates of drug use than heterosexual women. Some studies indicate that the rates are similar to those of lesbians and some are slightly higher.
- **Men:** Research on adult men has not tended to look at bisexual men separately from gay men. Gay men (or MSM) report higher rates of substance use than the general population, but differences between adult gay and bisexual men are not known.

2. Alcohol use

- **Women:** In several studies, bisexual women report the highest rates of alcohol use, heavy

drinking and alcohol related problems when compared to heterosexual and lesbian women.

- **Men:** The picture here is less clear. Of the two studies I found which include bisexual men:
 - 1) In one study, bisexual men did not report more alcohol problems or use than men of other sexual orientations.
 - 2) In the other, bisexual men and women did show higher rates of alcohol misuse.

3. Sexual health

- **Women:** Bisexual women report higher risk sexual behavior than heterosexual women – such as having sex with a known MSM, sex with an HIV+ man, multiple male sexual partners, sex with IDU, sex partner who has had sex with a prostitute, less likely to report condom use with non-steady partner and anal sex.
 - Compared to heterosexual women and lesbians, bisexual women have the highest rates of combining substance/alcohol use and sex.
 - Some STIs can be spread between women (i.e.: herpes, HPV and trichomoniasis).
- **Men:** The increased risk of HIV infection for men who have sex with men is well known. Sexually transmitted infections such as syphilis, gonorrhea and Hepatitis A and B also occur in higher rates in MSM. Bisexual and gay men are more likely to report having an STI.
 - One study shows that bisexual men report less risky sexual behavior with males (less anal, less anal receptive) than gay men.
 - This study also reports that bisexual men more likely than heterosexual men to have sex with female prostitute, but more likely than heterosexual men to use a condom. It also reports bisexual men are more likely to have anal sex with women.

4. Tobacco use (Factors contributing to higher smoking rates may include high stress levels and higher rates of alcohol and drug use.)

- **Women:** Bisexual women smoke at higher rates than heterosexual women, and at about the same rates as lesbians.
 - 13.9 to 14.9% of heterosexual women smoke
 - 25.3 to 50% of bisexual women smoke
- **Men:** Less is known about bisexual men's smoking habits. In one study, bisexual men's rates of smoking were similar to heterosexual men (slightly lower). Gay men smoke at higher rates than bisexual men or heterosexual men.



5. Cancer

- **Women:** A large U.S. study of women ages 50-79 indicates that bisexual women have higher rates of breast cancer, and bisexual women reported having any type of cancer in higher rates.
 - **Breast cancer:** Risk factors that are higher among lesbian and bisexual women include:
 - 1) Not having given birth (bisexual women not as high as lesbians, but higher than heterosexual women)
 - 2) Being more likely than heterosexual women to give birth after age 30 (risk for bisexual women not as high as lesbians, but higher than heterosexual women)
 - 3) Alcohol consumption
 - 4) Protective: for parous women, also twice as likely as heterosexual women to have given birth at or before 19
 - **Lung cancer:** High rates of smoking can increase risk
 - **Cancer Screenings:** Bisexual women are less likely to have never had a mammogram or to have appropriate levels of mammography.
 - 1) Among heterosexual/lesbian and bisexual women, bisexual women have the highest rate of never having a pap test
 - 2) Women who have sex only with women still need pap tests
- **Men:** Bisexual men who are sexually active with men (and anyone who has receptive anal sex) are at higher risk for anal cancer due to an increased rate of HPV, the virus that causes genital and anal warts. Smoking is also a risk factor for anal cancer (which actually may be more relevant for bisexual women than men.)

6. Nutrition, fitness and weight

- **Women:** Lesbian and bisexual women have higher (lesbians highest) rates of being overweight and obese when compared with heterosexual women (lesbians are most at risk). However, more bisexual women are underweight than heterosexual and lesbian women.
 - One study shows bisexual women's patterns of physical activity are more similar to heterosexual women's and lower than lesbians'. However, a study of women aged 50-79 showed bisexual women highest rates of physical activity.
 - Lesbian and bisexual women eat fewer fruits and vegetables.
- **Men:** Although there are no studies I know of which look at bisexual men separately

from gay men with regard to nutrition, fitness and weight, some of the things which affect gay men may also have an impact on bisexual men.

— For some gay and bisexual men, the pressure to achieve the perfect body has resulted in compulsive exercising, steroid use, poor body image and eating disorders.

7. Heart health

- **Women (women only):** In one study, bisexual women reported higher rates of heart disease than heterosexual women, but lower than lesbians.
 - Risk factors for heart disease:
 - 1) Smoking – high in bisexual women
 - 2) High blood pressure – higher in bisexual women than heterosexual and lesbian women
 - 3) BMI – higher than heterosexual women (lower than lesbians)
 - 4) High cholesterol - bisexual women highest
 - 5) Cholesterol screening – bisexual women lowest
 - 6) Alcohol use – high in bisexual women

8. Depression and anxiety

Bisexual men and women report consistently higher levels of depression and anxiety than heterosexuals, in some studies similar to lesbians and gay men, and in other studies higher.

9. Social support, general emotional well-being and quality of life

- **Women:** Bisexual women have the lowest levels of support. Their quality of life is low compared to heterosexual women, and is lower to or similar to lesbians. Bisexual women (and men) have the lowest emotional well-being.
- **Men:** Bisexual and gay men have lower support levels when compared with heterosexual men. There is no information about their quality of life. However, bisexual men (and women) have the lowest emotional well-being.

10. Self harm and suicide attempts

Bisexual men and women report higher levels of self-harm, suicide attempts and thoughts of suicide than heterosexuals, and in many studies, higher than gay men and lesbians as well.



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appendix b

TIPS FOR HEALTH CARE PROVIDERS WHEN WORKING WITH BISEXUAL CLIENTS

by Marshall Miller and Dorian Solot

There are three golden principles:

1. Don't make assumptions
2. Support and validate people's diverse experiences and identities.
3. A person's sexual behavior and a person's sexual orientation are two different things.

Definition of terms:

Bisexual: This is a term some people use to describe their sexual orientation. In a health care setting, these are people who will come to your office and if asked about their sexual orientation, will say they are “bi” or “bisexual.” There are many ways to make people who identify as bi feel comfortable in your office, including having bisexual brochures available, using the word bisexual in addition to gay and lesbian when talking about sexual orientation and being willing to ask about and discuss the client's sexual experience with men, women, and transgender people.

Men who have sex with men and women (MSMW) / women who have sex with men and women (WSMW): These are terms that accurately describe behavior. These terms recognize that people have sex with more than one gender, but may or may not identify as bisexual. They may identify as questioning, bi-curious, heteroflexible, gay, lesbian, heterosexual, some other term or they may not identify as anything at all.

Five points to consider:

1. The fact that someone is sexually active with someone of a different sex does not automatically make that person heterosexual. The fact that someone is sexually active with someone of the same sex does not automatically make that person gay or lesbian.

2. Because of negative experiences and lack of understanding they may have encountered in the past, bisexual people may not “volunteer” their sexual orientation. They may look to you for clues about whether you want or need the information and how you will respond if they come out to you. You can make your office more welcoming of bisexuals by:
 - Visibly displaying pamphlets about bisexuality. See <http://www.biresource.org/category/publications> to read and order pamphlets that you wish to photocopy and make available.
 - Adding the word “bisexual” some or all of the time when you talk about “gay and lesbian” issues with clients communicates to them that you are comfortable discussing bi issues.
 - Adding the word “bisexual” to your written materials in order to communicate your comfort.
3. Whether or not you know you have bisexual clients, you almost certainly already do. It’s impossible for you to guess accurately which of your clients are bisexual or MSMW/WSMW based on their age, marital status, political beliefs or the way they dress or behave.
4. Health care providers should think carefully about what you need to know and what questions you want to ask. For example, HIV is spread through bodily fluids, therefore whether or not people are at risk for HIV depends on their behavior, not their identity. You cannot determine someone’s HIV risk by asking about her or his sexual orientation. You can learn more by asking about her or his sexual behavior.
5. Bisexuals can be monogamous or non-monogamous. Bisexuality is a sexual orientation; it is independent of the decisions about monogamy. It is a mistake to assume that because someone has the potential to be attracted to men and women they must have (or desire) twice as many sex partners.

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LESBIAN, GAY, BISEXUAL AND
TRANSGENDER YOUTH

An Epidemic of Homelessness

by Nicholas Ray

Between 20 percent and 40 percent of all homeless youth identify as lesbian, gay, bisexual or transgender (LGBT), a grossly disproportionate number. This report examines the consequences of homelessness for the community's most vulnerable youth. With best practice chapters contributed by exemplary service providers around the country, and a series of practical policy recommendations aimed at all levels of government, this report is a comprehensive analysis of an issue that has remained unaddressed for far too long.

2007

False Promises

HOW THE RIGHT DEPLOYS
HOMOPHOBIA TO WIN SUPPORT
FROM AFRICAN-AMERICANS

by Nicholas Ray

False Promises highlights Republican attempts to bring African-Americans "back home" to the Republican Party by focusing on so-called "moral values" issues, specifically the supposed threat of same-sex marriage. Within the context of this strategy to attract black voters, we analyze the voting behavior of key conservative members of Congress. We find that the strongest advocates of a "morals values" agenda are the members of Congress least likely to support issues of real significance to the African-American community.

April 2006

Youth in the Crosshairs

THE THIRD WAVE OF
EX-GAY ACTIVISM

by Jason Cianciotto and Sean Cahill

Youth in the Crosshairs examines the ex-gay movement's new tactic of targeting lesbian, gay and bisexual youth for "conversion therapy" and "preventive" measures for its own political gain. It reveals how groups such as Exodus International and Focus on the Family promote widely discredited theories on homosexuality and recommend treatments for children as young as five years old despite the growing body of research that shows these treatments to be ineffective and extremely harmful for many participants.

March 2006

Hispanic and Latino Same-Sex Couple Households in the United States

A REPORT FROM THE 2000 CENSUS

by Jason Cianciotto

Post the success of anti-same-sex marriage ballot measures in the 2004 election, anti-LGBT political and religious leaders are supporting the next wave of anti-marriage and anti-parenting laws and ballot measures in a number of states with large Hispanic populations, including California and Florida. This study sheds light on the over 105,000 Hispanic same-sex couple households counted in the 2000 Census, nearly half with children, who are disproportionately harmed by such anti-LGBT legislation.

November 2005

Selling Us Short

HOW SOCIAL SECURITY
PRIVATIZATION WILL AFFECT
LESBIAN, GAY, BISEXUAL AND
TRANSGENDER AMERICANS

by Mandy Hu

Selling Us Short highlights the disproportionate impact of President Bush's plan to privatize Social Security on LGBT Americans. LGBT Americans, on average, have lower incomes than their heterosexual counterparts, and they are less able to keep what they earn. This translates into lower Social Security payments in retirement. This report also explains how the cuts in retirement benefits for all but the poorest workers inherent to Bush's plan will disproportionately hurt LGBT elders.

August 2004

Transitioning our Shelters

A GUIDE FOR MAKING
HOMELESS SHELTERS SAFE
FOR TRANSGENDER PEOPLE

by Lisa Mottet and John M. Ohle

The problem of unsafe shelters for transgender people is pervasive. *Transitioning our Shelters* is a guide designed for shelters that want to provide safe shelter for transgender people but are not sure how to do so. A joint publication of the Task Force and the National Coalition for the Homeless, the Guide provides many answers to concerns about safety and privacy for transgender residents based on successes at real shelters across the country, the bulk of which are addressed without monetary expenditures.

January 2004