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Resourced and Under-resourced women-who-have sex-with-women (WSW) in Tshwane aged 18-40 2007/8

Out

Lesbian • Gay • Bisexual • Transgender
(LGBT) WELL-BEING

This needs assessment was funded by the Dutch Ministry of Foreign Affairs, in collaboration with the Schorer Foundation. The needs assessment was conducted by OUT LGBT Well-being.

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ABOUT OUT Lesbian/Gay/Bisexual/Transgender (LGBT) WELL-BEING

OUT is a progressive non-profit LGBT organisation in Pretoria. In operation since 1994, the organisation works in the following domains: direct Sexual and Mental Health services, Research, Mainstreaming and Advocacy. Their website address is www.out.org.za

ABOUT THE SCHORER FOUNDATION

Founded in 1967 in The Netherlands, Schorer provides direct services to LGBT people, conducts research, and engages in mainstreaming general health care settings. Schorer is specialised in HIV prevention and HIV care, and works with LGBT communities through educational materials, websites, workshops, and buddy care. Schorer is active in The Netherlands, as well as in Europe, Latin America, and Southern Africa. Schorer's work is financially supported by, among other donors, the Dutch Ministries of Health and Foreign Affairs. Their website address is www.schorer.nl

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1. BACKGROUND TO THE NEEDS ASSESSMENT

The completed needs assessment discussed in this report forms part of a broader programme. This programme is done as a collaborative effort between Lesbian/Gay/Bisexual/Transgender (LGBT) partners in Southern Africa, Latin America and the Schorer Foundation (located in the Netherlands). Over 4 years (2007-2010), the broad aim is to upscale HIV/AIDS prevention programmes targeting LGBT people. The needs assessment is a first phase, which will inform programme design and implementation. In itself, the needs assessment, and its findings, is useful in light of the fact that little researched knowledge is available on sexual practises of LGBT people in a region such as Southern Africa. The collaborative programme in Southern Africa is called Prevention Initiative for Sexual Minorities (PRISM) and is funded by the Dutch Ministry of Foreign Affairs, in collaboration with the Schorer Foundation. In Southern Africa, the participating partner organisations are OUT-LGBT Well-being (Tshwane), the Durban Lesbian and Gay Community and Health Centre (Kwa Zulu Natal), the Triangle Project (Cape Town), the Rainbow Project (Namibia), Lesbians and Gays in Botswana (LEGABIBO), and the Gay and Lesbian Association of Zimbabwe (GALZ).

In the needs analysis phase, each participating organisation had to identify relevant target groups. OUT identified women-who-have-sex-with- women who engage in casual sex as the target group. These groups were identified so as not to only have a focus on men, and given the focus on casual sex, to rather focus on those sections/behaviours of LGBT people that could carry the most risk of engaging in risky sexual behaviours. More details on the selected target groups are discussed under 3.1.

2. AIMS OF NEEDS ASSESSMENT

The needs assessment has two primary aims:

- Firstly, to contribute to the body of knowledge on risky behaviours among women-who-have-sex-with-women in Tshwane; and
- Secondly, to use such knowledge to inform programmes for this selected target group.

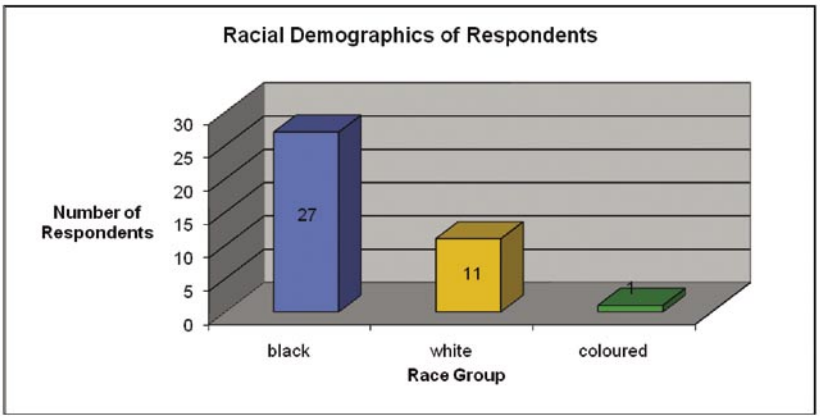
3. THE NEEDS ASSESSMENT RESULTS (INTEGRATION WITH VARIOUS FORMS OF DATA)

3.1 Target Group

Thirty-nine (39) women-who-have-sex-with-women (WSW) were included in the needs assessment. The profile of the respondents is as follows:

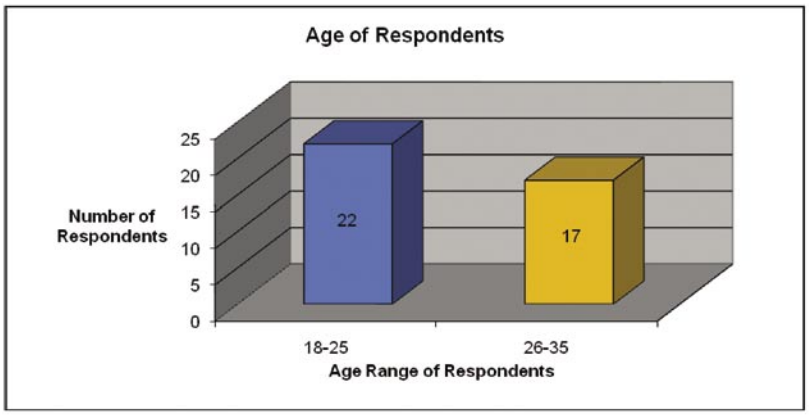
Racial Demographics:

69% of respondents indicated that they were black, 28% were white and 3% were coloured.



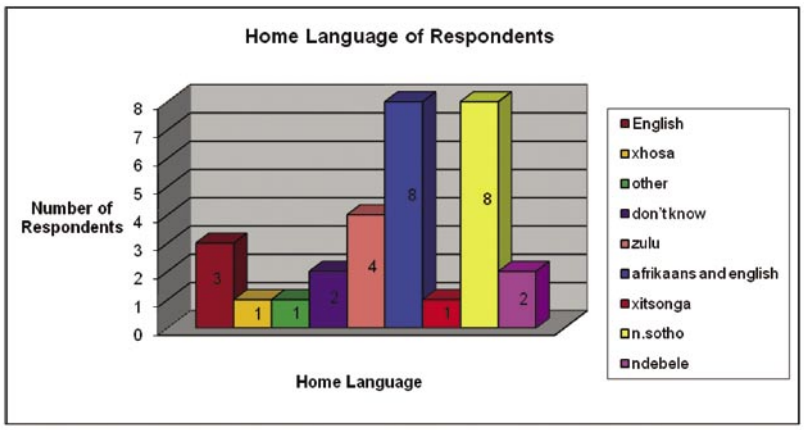
Age:

The mean age of respondents was 25 years. 56% were between the ages of 18 and 25 and 44% were between the ages of 26 and 35 years old.



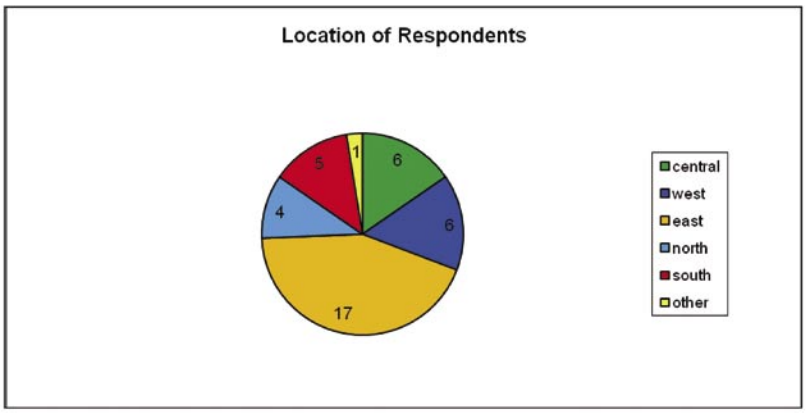
Home Language:

21% of respondents spoke Afrikaans and English, and 21% spoke Northern Sotho. This was followed by 20% of respondents speaking isiZulu.



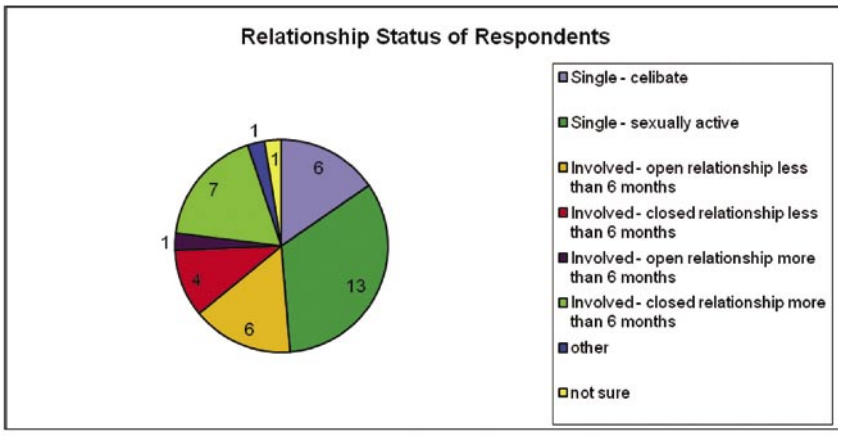
Location:

The majority of respondents reside in the East of Tshwane (44%). This is followed by the West of Tshwane (15%), Tshwane Central (15%), the West of Tshwane (12%), and the North of Tshwane (10%). 3% resided just outside Tshwane but work and socialise in Tshwane.



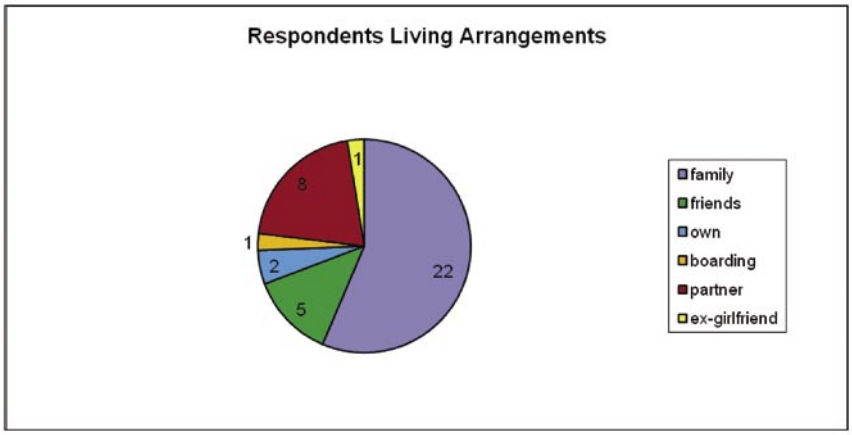
Relationship Status of Respondents:

49% of respondents indicated that they were currently single. Of those respondents 31.5% indicated that they were not sexually active and 68.5% indicated that they were. 46% indicated that they were currently involved in a relationship: 33% in an open relationship of less than 6 months and 6% in an open relationship of more than 6 months; 22% in a closed relationship of less than 6 months and 39% in a closed relationship of more than 6 months.



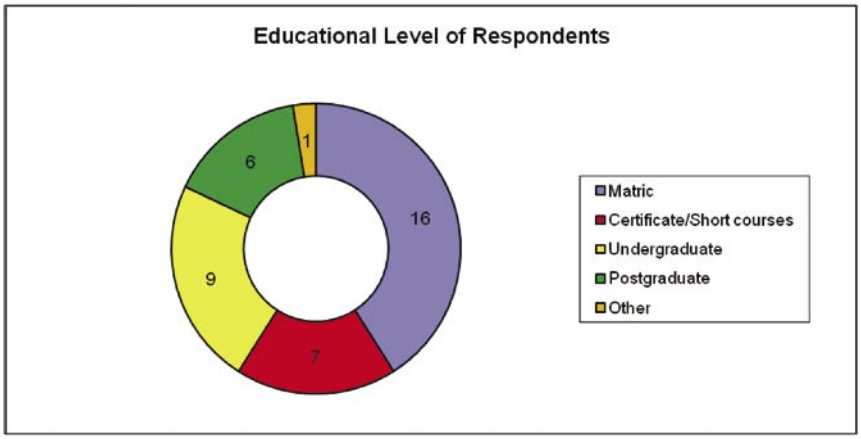
Living Arrangements:

The majority of respondents indicated that they lived with their family (56%). This was followed by respondents who lived with their partner (20%), with their friends (13%). A small number of respondents stayed on their own (5%), boarded (3%) and stayed with an ex-partner (3%).



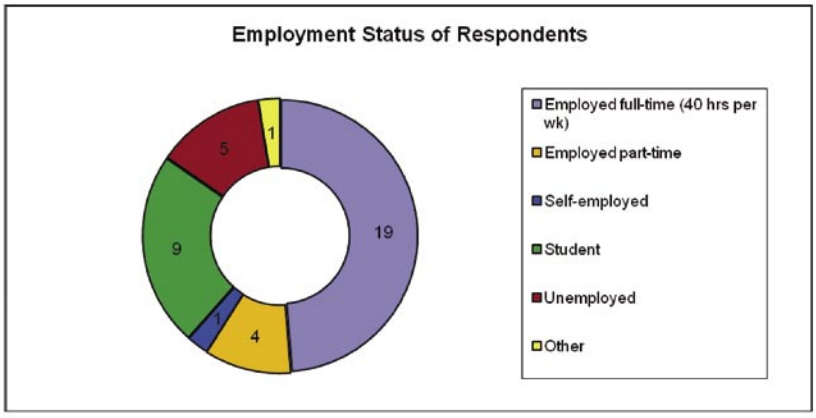
Educational Level of Respondents:

41% indicated that they had successfully completed their matric and did not study further. 18% indicated that they went on to complete a number of short courses. 23% indicated that they achieved an undergraduate level of study and 15% indicated that they have obtained a postgraduate degree.



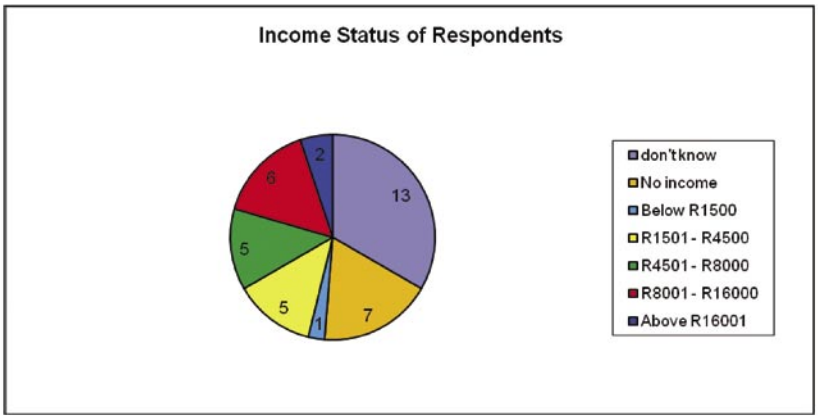
Employment Status of Respondents:

Approximately half of the respondents indicated that they were employed full-time (49%). 10% indicated that they were employed part-time and 3% indicated that they were self-employed. 23% indicated that they were currently studying. And 13% indicated that they were currently unemployed and looking for work.



Income Status of Respondents:

18% of the respondents indicated that they received no income and 3% indicated that their income was below R1500. 13% indicated that their income was between R1501 – R4500. 13% indicated that they earned between R4501 – R8000. 15% indicated that their income was between R8001 – R16000. 5% indicated that their income was above R16001. A large portion (33%) of the respondents did not seem to know what their income was.



3.2 The Research Question

The research questions focussed on the determinants of casual sexual risk-taking among both resourced and under-resourced women-who-have-sex-with-women (WSW) in Tshwane.

The research questions explored biographical data and background information, perceptions on health issues facing WSW, as well as respondents' own experiences of risk behaviours. Please refer to the appendix for a further discussion on the research methodology.

3.3 The Health Problems

3.3.1 The Health Problems

Sexually transmitted infections (STIs) are a major public health concern in southern Africa (van Dyk, 2001). It has been estimated that more than 1 million patients seek treatment for STIs every year (van Dyk, 2001). As has been well documented, the presence of STIs is problematic for the following reasons:

(i) The presence of an STI increases one's susceptibility to HIV infection;

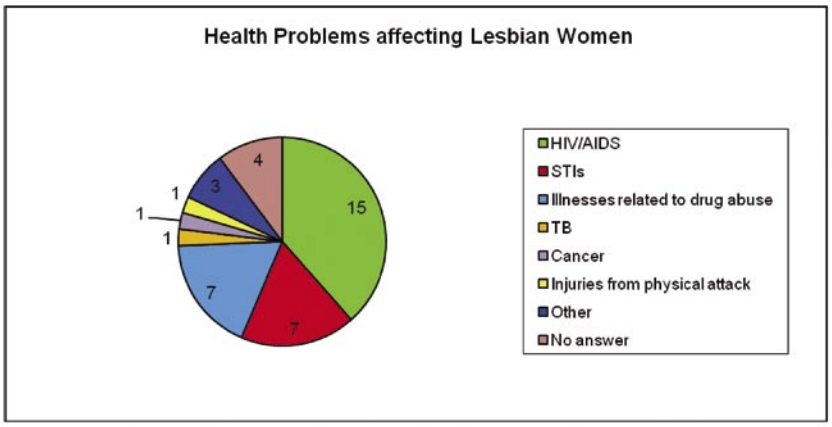
(ii) The presence of an STI may be an indication of engaging in unprotected sex with multiple partners, thus increasing one's risk of coming into contact with STIs and HIV.

Hughes & Evans (2003) reports that HIV has been isolated in vaginal secretions, cervical biopsies and menstrual blood. Sexual practices such as digital-vaginal or digital-anal contact, as well as sex with shared penetrative toys, may well serve as means for transmission of HIV-infected cervicovaginal secretions (Marrazzo 2004).

According to Marrazzo et al (2001), despite the evidence that WSW are at risk, there is very limited understanding of the frequency and range of behaviours that put WSW at risk for STI and HIV acquisition. According to the South African Department of Health Study, 2006, the estimated HIV prevalence among antenatal clinic attendees in 2006 in Gauteng was 30.8 %.

This statistics indicates that the sample would not necessarily include lesbian women, since the point of entry, antenatal clinics, are not a preferred health service utilized by lesbian women. The non-scientific and a common perception is that lesbian women are not at risk of being infected with HIV and or other STI's. STIs and HIV infections are reported in studies, which used samples of women whose sexual contacts were reported to be exclusively with other women (Solarz, 1999). 40 % of respondents in a Lesbian Sexual Health Survey that was conducted by OUT in 2006 / 2007 reported NOT being at risk for HIV (OUT Report, 2007). 45% reported being too scared to go for testing. Research conducted by OUT (in collaboration with the UNISA Centre for Applied Psychology) in 2003, indicates the percentage of black females with STIs as 13.6%. The number of black women who are unsure whether they have an infection or not is the highest (16.2%) in the overall sample (Wells & Polders, 2004). According to this report the amount of HIV + lesbians are relatively high in comparison to international figures. Again, this is contradictory to the belief that WSW is relatively risk free.

The need to focus on STIs, including HIV, appears to be supported by the Needs Assessment (NA).
38% of respondents indicated that HIV was the biggest health problem confronting lesbian women in South Africa. This was followed by STIs (18%) and illness related to substance use (18%).



3.3.2 Risk Behaviour: Sexual Risk-taking in Casual Encounters

3.3.2.1 The concepts of Risk and Casual Encounters

a) The Concept of Risk

The concept of risk is seen simply as any danger from future damage (Douglas, 1992). Elsewhere, risk has been referred to as "the probability of a generally negative outcome, accompanied by the magnitude of the damage which it will do" (Joffe, 1999, p.4). Theorising risk therefore involves universally applied standards that indicate the 'deleterious consequences' attached to certain behaviours and the probability of adverse outcomes developing if such behaviours are not avoided or adapted.

The myth that sexual activity between women poses no risk for HIV transmission exists among health care professionals as well as among many women-who-have-sex-with-women themselves (Johnson, 2007).

In public health, considerable attention has been placed on establishing a hierarchy of risk associated with STI and HIV transmission (See Shernoff 1988). The hierarchy range from minimal risk (abstinence) to highest risk (anal intercourse with internal ejaculation). This might not be as relevant to lesbian women, but for example, practicing cunnilingus while menstruating, could count as a high risk. Although seemingly clear, it seems that there are differences between public health and folk constructions around relative risks of STI and HIV transmission (Levine & Siegel, 1992). Certain activities are seen as ambiguous in terms evaluating risk. These include, unprotected sex in ongoing relationships, being the insertive partner while finger fucking, cunnilingus with ejaculation, cunnilingus without ejaculation, tribadism, sex during menstruation and sharing sex toys (Dolan, 2005). This ambiguity is reinforced by the marginalization and invisibility of the sexuality of lesbian women and their relationships (OUT, 2007). As such, there exists a common perception that lesbian women are at lower risk of being infected by STI's or HIV (Haldiman, 2006) but, several studies indicate that WSW do still indeed test positive for a number of STI's and HIV (Haldiman, 2006). Faced with these ambiguities, coupled with a lack of recourses and prevention technologies, it appears that WSW incorporates official and unofficial knowledge in order to arrive at a personal solution towards sexual risk behaviour, which might include being overly safe or simply not safe enough (Haldiman, 2006).

b) Casual Encounters

Casual sexual encounters create opportunities for increased vulnerability amongst WSW especially when the perception of risk is flawed and consequent safer sex behaviour is not carried through. So, it is not the casual sexual encounter per se, but rather the risk taking behaviour that occurs during the encounter that increases one's risk. Casual sex can be defined as having sex with someone at a given time, without wanting a relationship (Hemker & Hermans, 2003).

According to respondents, casual sex can be described as follows:

> *"…with somebody you haven't known for so long, you don't intend a relationship with her, just sex for the sake of sex.. sex without commitment.."*
>
> (27, Coloured, closed relationship)

> *"… sex with no emotion…no strings attached …getting together once in two months and sleep together…"*
>
> (22, Black, single, sexually active)

"Cheating on someone… going out with people and sleeping around and coming back to your relationship…"

(20, White, open relationship)

From these quotes it appears that, casual sex for them, involves a brief encounter without commitment or emotional attachment that is physical in nature and could possibly exist concurrently with an existing primary relationship.

3.3.2.2 Individual Determinants of Risk Behaviour

a) Substance use

A number of studies argue that both alcohol consumption and mis/use of drugs are associated with higher risk behaviours (e.g. Hughes, Johnson & Wilsnack, 2001) and elevated risk experiences for STI/ HIV infection among lesbian women (Hefferman, 1998; Leigh and Stall, 1993; Perry, 1995; Stevens, 1994a; Young et al., 2000). Internationally, Richters et al (2004) reports in the Sydney Women and Sexual Health (SWASH) survey that 50% of the respondents used one or more illicit drugs in the past six months. Rates of drug use were much higher than in the general population. Locally, the OUT Lesbian Sexual Health Survey (LSHS) (2007) reported that the majority (more than 35%) of the respondents claimed that they sometimes have sex after using alcohol / drugs. 50,5% reported that they never practice safer sex after using alcohol / drugs. In support of the studies, the NA results indicate that the majority mostly consume alcohol frequently. More specifically, increased alcohol use took place during the time leading up to the casual sexual encounter.

"You need to use alcohol to hook up with someone… "

(19, Black, single, sexually active)

"I think the fact that knowing that you are high gives you excitement that you need to have a sexual encounter…"

(39, Black, open relationship)

"When you are drunk… you are not scared of anything or anyone…"

(21, White, single, sexually active)

"Drinking of alcohol is more fun and you are not being cautious… you just do it… and only think about it in the morning…"

(26, Black, single, sexually active)

"Yes, definitely… I loose all kind of inhibitions… that is the problem…"

(21, White, single, sexually active)

From the above quotes, it would appear that respondents use alcohol to develop courage and reduce their inhibitions so that the casual sexual encounter can take place. For others alcohol use was a form of coping:

"It is a way for me for dealing with my stress…"

(25, Black, single, sexually active)

Of concern here, is a general feeling amongst a few of the respondents, that they are not particularly concerned about their safety when blacking out. They don't appear to know what happens when severely intoxicated or passed out.

"Tend to drink too much, get black out… I'm not worried about safety when I'm drunk…"

(26, Black, single, sexually active)

"I perform twice as much, but get tired easily… If you go down too much, chances are you won't make it and pass out…"

(22, Black, single, sexually active)

b) Impulsivity and inability to delay gratification

Impulsivity is described in the literature as the inability to delay gratification and appears to be the inverse of self control (Monterusso and Anslie, as cited in Arce & Santisteban, 2006). It has also been suggested that people often engage in risky behavuors when in a deprived state, without any regard for the long term consequences (Arce & Santisteban, 2006). The notion of impulsivity as a contributing factor to risk taking is supported by the following quotes:

"I see person at a party… I know her… go to the bathroom… wherever private, and get it on. Say two days later... I feel guilty… and promise not to do it again… but then I do... "

(22, Black, single sexually active)

"I tell my parents I go out… we drink and as the night goes on, I will meet someone that I am attracted to… we'll talk and come to some sort of agreement… we'll kiss and make out… we'll usually go to a room outside at my friend's place… I can't go home due to my parents… we'll have oral sex and finger fuck…"

(18, Black, bisexual, relationship unknown)

"I really get drunk… meet someone, then go to the bathroom… and do something and come back and have a next round of drinks and carry on…"

(20, white, involved in open relationship)

The above quotes are stated by mainly young WSW. It could imply that through the mere nature of being an adolescent or young adult, the level of impulsivity could be higher.

From the above quotes, it appears that the availability of sex facilitates immediate gratification.

> "To mix with other people… it's exciting and naughty… "
>
> (27, Coloured, closed relationship)

From the above quote, it would appear that notions of impulsivity may also include thrill seeking tendencies.

c) Internalized homophobia

Society in general can be described as heterosexist and homophobic. Given this, WSW in general are pathologised, and seen as unnatural, immoral, deviant, and inferior (Davies & Neal, 1996). Given these prevailing attitudes, many WSW have experienced some form of rejection or another by society, family and friends because of who they are. Further more, many WSW have internalized and generalized this rejection to some degree, often at an unconscious level (Davies & Neal, 1996). As such, many WSW feel inadequate, insecure and ashamed, exhibit low self esteem, became fatalistic and self destructive (Davies & Neal, 1996). This may give rise to a 'spoiled identity' (Goffman, 1963). It has been shown that fatalistic attitudes, particularly in South Africa, coupled with negative coping strategies, tend to result in reckless and irresponsible sexual behaviour (Leclerc-Madlala, 1997). Research conducted by OUT found that a significant positive correlation existed between risk of depression and frequency of alcohol use (Wells & Polders, 2004). Further more, 21% of the sample had attempted suicide in the past and black females appeared to display suicidal ideation more often than white females. It has been argued that internalized homophobia plays a central role as a predisposing and perpetuating factor, in various aspects of ill health and may affect health related decision making processes that could have a significant effect on the prevention of illnesses such as STI / HIV infections (Williamson, 2000).

According to the OUT LSHS (2007) the respondents themselves had their own internal challenges of accepting themselves. For instance, the negative sentiments expressed by some of the respondents towards other lesbian groupings and/or establishments could be indicative of the internalised challenges of self-acceptance. A big percentage also expressed emotions indicating that they were (also) uncomfortable of being found out or of being associated with being a 'lesbian' by others (who were non lesbian).

Although this NA did not explore internalised homophobia directly, it can be inferred as a contributing factor to risk taking from the respondent's decision making processes around risk. The internalized homophobia is deeply unconscious and subtle. For example, the majority of respondents indicated that they engaged in unprotected sex during their last casual sexual encounter, that no safer sex negotiations took place and that they will intentionally omit telling their primary partner about the casual encounter. These choices are possibly indicative of underlying self destructive tendencies, placing themselves and others at risk for potential ill health.

> *"That is why I say that we get HIV/AIDS from being unfaithful to our partners. I was unfaithful… my partner did not know about it… and she did not find out… which means that I am a good cheater…"*
>
> (27, Black, open relationship)

> *"No, when it comes to casual sex you don't think about using protection, you just have sex… you don't have the whole hour to think about it…"*
>
> (23, Black, single, sexually active)

Possibly linked to internalized homophobia, is internalized misogyny, which could complicate the devaluing of the self as a woman even more. The woman as a sex object could be internalized. Unconsciously, this unacceptable feeling towards the self could be projected onto other women.

d) Erroneous risk perception and negative attitude towards barrier methods

Research has found that people tend to make automatic assessments about each other when they meet. People tend to make assessments of potential partners based on such attributes as their social class, appearance, social demeanour, and whether or not they are judged to be "like me" (Lupton & Tulloch, 2002). Decisions about trust are established rapidly and possible concerns around contamination dissipate (Lupton & Tulloch, 2002). Sex with that person is no longer seen as risky, and barrier methods are considered unnecessary. When a woman calls herself a lesbian, she is by virtue of that label, infection free (Dolan, 2005).This superficial assessment is illustrated in the following quotes:

> *"60% safe, because I've known her for a long time…"*
>
> (24, Black, open relationship)
>
> *"Pretty safe… caught her with a man in the toilet… she is bisexual and I know her…"*
>
> (34, White, closed relationship)
>
> *"…safe because I knew that person and we don't have protective stuff with lesbian sex…"*
>
> (32, White, closed relationship)
>
> *"Unsafe, but with women you don't need protection…"*
>
> (23, Black, single, sexually active)
>
> *"STI's or HIV, no I have reasons to assume that that person is negative… but she is the kind of person that have never slept with a guy before and she is that kind of person that will say I can do you, don't do me…"*
>
> (Focus group participant, 22, open relationship)

In the above quote, the participant seems to assess the casual partner's status by assuming that she had no risky sexual encounters with high risk partners. In addition, she maintains a sense of safety by being the active partner.

The vast majority of literature identifies the following characteristics placing WSW at risk of contracting an STI or HIV: (i) "unprotected" sex with men and women; (ii) "unprotected" sex with gay and bisexual men; (iii) use of injection drugs; (iv)use of crack cocaine; and (v) exchange of sex for drugs or money (Marrazzo et al, 2001). Although not widely known amongst WSW, these characteristics appear to be severe enough to overshadow and de-emphasize other modes of transmission. For example, the details surrounding the first case of female-to-female transmission were released only in February 2003.

In this case a 20-year-old woman with no additional risk factors other than her sexual relationship with a female partner, tested positive for HIV in which the infecting strain matched that of her partner. The route of transmission was determined to most likely have come from the use of sex toys (Kwakwa & Ghobrial, 2003). The example illustrates the extent of which other modes are silenced giving the erroneous impression of minimal risk.

This is further evident in the finding that lesbian women were not greatly concerned about acquiring an STI from either their male or female partner (Haldiman, 2006). They did not rate many of the high-risk sexual behaviours as being risky. Dolan and Davis (2003), Marrazzo, Coffey and Bingham (2005), and Fisham and Anderson (2003) came to the same conclusion. This implies that WSW tends to believe that they are not at risk regarding STI's. OUT research indicates that 67% of white lesbian women and 50% of black lesbian women "did not think that they are at risk for HIV" (Wells & Polders, 2004).

The following quotes illustrate the majority of respondent's misperception of their level of risk:

> *"I'm bisexual; with men I use a condom, with women nothing…"*
>
> (18, Black, bisexual, unknown)

> *"I am always making sure that I am safe… by being on top… making sure that I am the one driving… I am the orchestrating the whole thing… so I should be the one that is controlling and giving the direction…therefore, I'm not at risk. I would always call the doctor every now and then to make sure…"*
>
> (26, Black, single, sexually active)

> *"There is this misperception about safety between lesbian women…"*
>
> (Focus group participant, 29, Black, single sexually active)

According to a study by Dolan (2006), WSW respondents considered barrier methods as "stupid", "confusing", "too much trouble", "less enjoyable" and "potentially offensive". This appears to be echoed in the NA:

> *"I don't use protection… I find it awkward and not much fun… It can really kill the mood…"*
>
> (23, White, involved in closed relationship)

> *"When it comes to dental dams… they are thin in the way they are structured.… And very ugly… it has to be like condoms, more flexible and with some sort of flavour…"*
>
> (Focus group participant, 22, Black, involved in open relationship)

> *"I was busy with foreplay… and the glove just tore…"*
>
> (Focus group participant, 29, Black, single, sexually active)

It appears that the most preferred form of barrier method is gloves and condoms.

3.3.2.3 Environmental Factors

a) Spaces

The majority of the participants indicated that clubs and private parties are the most frequented social spaces. These clubs include some straight, but lesbian friendly clubs:

> "Anytime and anywhere… firstly in clubs… private parties… anywhere where there is a woman…"

(22, Black, single, celibate)

It appears that respondents are drawn to these spaces because of their accessibility and the opportunity of sex offered there:

> "Clubs are a good place to meet a variety of people…"

(34, white, involved in closed relationship)

> "The availability of women is the best part…everything is safe, private and open…"

(26, Black, single, sexually active)

b) Relationships

As previously indicated, approximately half of the respondents are currently involved. Within these relationships, the majority indicate that they are not using protection or negotiating the use thereof. In addition, they report knowing their partner's HIV status. Similarly, these respondents claimed to know their own sero-status.

In total, more than half of all respondents indicated that they have participated in casual sex. In most cases they indicated not knowing their casual partner's status and admitted not using protection. Furthermore, they reported not negotiating safer sex. In almost half the cases, respondents indicated that they would not tell their primary partner about the casual sexual encounter.

From this it appears clear that in most cases, the casual sexual encounter is potentially risky and highly secretive, which poses a threat to all those concerned, including unsuspecting partners who believe they are in "monogamous" relationships. It does not appear as if these women communicate about safer sex, perhaps due to the fact that they don't see themselves to be at risk.

> *"I think it is normal… it is just having fun and it is part of life…"*

(26, Black, single, sexually active)

> *"…if the relationship is on the brink, and I want a way out, I'll tell her… But if I'm in a healthy relationship, I won't… as I will ruin the relationship…"*

(28, Black, involved, closed relationship)

"No I don't know my casual partner's status, but I think being lesbian… it is not easy being infected..."

(34, White, closed relationship)

In addition to the individual determinants discussed above, it is not clear what it is about the relationship itself that possibly contributes to the decision to engage in casual sexual activities.

c) Friendship circles

It would appear that some of the respondents are heavily reliant upon their seemingly enmeshed (and complicated) friendship circles. These circles appear to be a source of an endless supply of sexual possibilities. In addition, norms within these networks encourage casual sex amongst friends. Sexual escapades are known to all, but discussed by none as they are shrouded in secrecy. But this does not preclude any of them from being involved with an "outsider".

"One's circle of friends has casual encounters…"

(24, Black, open relationship)

"Between people that take sports together… Some know one other, others don't… some are likely to be strangers…"

(34, White, closed relationship)

"Normally from my personal experience... I get involved with friends who do everything together, we club together and if I say to my friend at the club… that I like that girl, I think I am going to do her tonight, do you mind, she would say … Ok! go ahead…"

(Focus group participant, 22, Black, open relationship)

"In my circle of friends it does happen … but there are friends with benefits who have no problem… and there is no problem with them because we operate the same… and we come to a point where, if I have a need for someone, I can call a friend and she comes… and then we do our business and there is no emotional attachment or anything.

(Focus group participant, 29, Black, single, sexually active)

"Number four does not know that I am doing things with number one and chances are that I might do the same thing with number four... I won't tell them… the level of secrecy is very high and I don't want my circle of friends to know what I am doing with some friends..."

(Focus group participant, 22, Black, open relationship)

3.3.2.4. Summary of Determinants

WSW in general believe that they are not at risk of contracting STIs or HIV. This sentiment is echoed within broader society as well. The deliberate de-prioritization and exclusion of WSW issues and interests serves to re-enforce their erroneous sense of invulnerability. Many do not identify with characteristics of risk behaviour that are presented widely (e.g. Intravenous Drug Use). For them their behaviour carries minimal risk.

The NA supports the finding that both alcohol consumption and mis/use of drugs is associated with higher risk behaviours and elevated risk experiences for STI/ HIV infection among WSW. It would appear that the majority consume alcohol most frequently and this is most likely to take place during the time leading up to the casual sexual encounter. The use of alcohol reduces their inhibitions so that the casual sexual encounter can take place. And for others alcohol use is a form of coping. Of concern was the high rate of black out amongst a few of respondents. Many claimed not to know what happens when severely intoxicated or passed out.The notion of impulsivity, coupled to thrill seeking tendencies, as a contributing factor to risk taking appears to be supported by the results of the NA.

Further more the results of the NA lend some support to the claim that internalized homophobia (and possibly internalized misogyny) may play a role as a predisposing and perpetuating factor. Internalized homophobia is also a factor in various aspects of ill health and may affect health related decision making processes that could have a significant effect on the prevention of illnesses such as STI / HIV infections. It can be inferred from respondents' decision making around safer sex practices that they continuously undermine there own self worth.For most WSW; sex with another woman is associated with no risk. The majority engage in superficial automatic assessments about potential sexual partners, which is considered by them to be an adequate means of evaluating their own risk.

In terms of environmental factors, the majority of the participants appeared to be utilizing clubs and private parties as a means to access others for casual sexual purposes. These spaces reinforce the perception that casual sex is the norm and that partners are ready and willing. The same can be said for some of their friendship circles. In some of these circles there is the unspoken rule that, casual sex is permitted, but the details thereof are never disclosed. And within the boundaries of relationships, it would appear that partners are not talking about safer sex, sero-status and extra-relational sexual activities, placing all those concerned, including unsuspecting partners, at risk.

3.3.3 Consequences of the Health Problem for the Individual

The presence of an STI can increase an individual's vulnerability to contracting HIV. STIs weaken the immune system and the stage is set for HIV infection to take place via sores and cuts. STIs, if left untreated, can have other health consequences. For example, Hepatitis B can, in the long term, result in life threatening liver damage.

Both STIs and HIV would necessitate the need to seek health care at some point or another. In South Africa, a resourced individual can access adequate treatment and care through Health Insurance at a cost of approximately R1400.00 (approximately 140 Euros) per month. This will allow the individual ongoing routine medical check-ups, treatment and care. For all chronic illnesses, Health Insurance will provide individuals with a chronic care plan. Under-resourced individuals, however, would need to make use of Government Clinics and Hospitals. Appointments are provided on a first-come-first-serve basis and anti-retroviral therapy (ART) is available to limited numbers.

3.3.4 Effects of the Health Problem in Society

The number of people estimated to be living with HIV is 5.5 million; 18.8% of adults 15-49 are HIV-positive. More than 70% of people infected with HIV in the world are found in sub-Saharan Africa. This represents two thirds of the world prevalence rates. Beyond this, 90% of all people living with HIV/AIDS are found in developing countries (Kometsi, 2004).

In 2006 more than 300 000 people living with HIV started treatment in public and private sectors making it one of the largest programmes in the World. In 2006 the national funds spent by government from domestic sources amounted to $446 461 994.00. Only 21% of infected HIV individuals were receiving anti-retrovirals (ARVs) (UNAIDS, 2006).

The new National Strategic AIDS Plan (NSP) in South Africa aims to provide ARVs to 80% of individuals needing treatment by 2011. Beyond availability is the question of accessibility. Stigma and discrimination as well as the lack of access to accurate information impact on people's ability to make informed choices, and influence access to appropriate health care. Confusing and/or inaccurate information about HIV treatment options and the use of ARVs impact on the extent to which people are in the position to access available HIV treatment services (Kehler, 2008).

3.4 Community/Participation

On the whole, it would seem that WSW in Tshwane are not organised. There are pockets of organised activity such as the lesbian action cricket scene, the MCC Church in Sunnyside, as well as OUT. OUT has increasing programmes for a range of target groups as well as active community building activities such as its OUTside social programme. Working with WSW as a target group is new to OUT as the organisation focused much of its previous HIV/AIDS work on black gay men in township areas.

It is assumed that the majority of WSW in Tshwane belong to informal friendship and sexual networks. Access to these will be very important for future programmes and research. In doing this needs assessment, there were various attempts to access these informal networks. Overall, it was difficult to do this. One can also assume that it takes time and effort to gain credibility within these informal networks.

There are a few key, visible people among the WSW sector. These are OUT staff, staff at WSW venues as well as gay/lesbian ministers. They have a willingness to co-operate, initially and in principle. Maintaining this and seeing programme implementation through might be a bit more challenging. It takes time to build commitment to programme implementation and one should secure benefits for both parties.

4. PRELIMINARY ANALYSIS OF DETERMINANTS

The deprioritization of women's interests and needs in general by addressing only maternal health and vertical transmission, increases their vulnerability to risk. Huge gaps exist on various levels, ranging from research to the implementation of sexual health programmes. As a result, a great deal of ambiguity exists around the level of risk when it comes to WSW. This ambiguity is reinforced by the marginalization and invisibility of the sexuality of WSW and their relationships. As such, there exists a common perception that WSW are at a lower risk of being infected by STI's or HIV. This serves to re-direct resources and research away from WSW in favour of the heterosexual majority and to a lesser extent, gay men. It ultimately places WSW at risk. WSW, based on the above, may incorporate official and unofficial knowledge in order to arrive at a personal solution towards sexual risk behaviour, constructing their own hierarchy of risk.

As a result, they might act overly safe or simply not safe enough. Once the tenuous hierarchy is established, it appears that most WSW make automatic assessments of potential sexual partners. Invariably, this is inadequate, placing them at risk. What complicates this picture even more is the use of alcohol and / or other substances, which further interferes with their already erroneous risk perception.

On an individual level, it was found that participants' responses could be organised according to two sets of major motivating factors when it comes to casual sex. These sets are not fixed and at different times or at different stages, respondents could move between sets. The strongest and most common motivating set of factors appears to resemble 'manic-like' factors. We termed this set as such because of its force and strength in compelling someone to act without much thought or reasoning in order to achieve a release for built up tension. According to participants' responses, this set of factors includes an urge/need, desire, lust, physicality, courage, opportunity, availability, impulsivity, release and excitement. Sex, as a thrill-seeking behaviour, is seen to afford individuals a temporary release. These elements compel one to act out their internal state as reflected in thrill seeking behaviours. There is a pronounced sense of excitement and pleasure that is derived. These 'manic-like' factors also serve to manage internalised homophobia.

The second set of factors appears to resemble 'neutral/positive' factors. We termed this set as such, because of the positive motivating aspects of the elements causing action that do not fit into the 'manic-like' set. According to participants' responses, this set of factors entails entertainment value, relaxation and stress relieve, an enhanced relationship, curiosity, excitement and satisfaction. These elements frame sexual risk-taking in a more positive light.

These two sets of motivating factors appear to influence decisions around casual sex and sexual risk-taking. These factors are mediated by certain spaces and substance use. Gay and lesbian clubs, some straight clubs and private parties as venues facilitate the possibility of casual sex. These spaces are, according to respondents, sexually enabling and exhilarating. In addition to the spaces, there are certain codes around casual sex, which involves a certain look and some flirting, a way to indicate that one is available for sex. These venues are frequented more often at night and are invariably linked with substance use. Substances play a major role in facilitating sexual risk-taking. Most respondents acknowledged that substance use increased their risk considerably (i.e. they did not make use of barrier methods, did not negotiate safer sex, were more likely to do things they wouldn't normally do). For respondents substances allow escapism, intensity and the removal of inhibitions. Even where respondents demonstrate the self efficacy to manage their sex lives and risky behaviours, substances enable the 'manic like' motivating factor to come to the fore. As such, the enabling spaces, codes and substances appear to tip the scales in favour of motivating factors.

Behaviourally, the majority of respondents currently engage in casual sex. A small number claim to have never engaged in casual sex. The general trend appears to be that barrier methods are not always used when having sex with a complete stranger. When having sex with a sexual partner that is more familiar (such as a primary partner, friend or a friend of a friend), no barrier methods are used. Many claimed not to know their casual partner's sero-status. Of those in relationships, the majority claimed to be in closed relationships, claiming to know their partner's sero-status. However, most of them claimed that they would not inform their primary partner of their casual sexual encounter. As mentioned before, the use of substances increases the possibility of sexual risk-taking, irrespective of who the person is with.

A significant section of respondents still did not know about OUT and its services to the LGBT community. Although someone commented "They are doing everything; it's just that we lesbians don't get to understand the fact that they are helping us. We are ignoring it in a way…" this attitude seems to be that of the minority. It is uncertain whether they truly did not know about OUT or whether they chose to deny its existence. In the latter, OUT and OUT's work on social issues is possibly an unwelcome reminder of what so many try to deny, that they are vulnerable and at risk.

This will have a direct bearing on community-based STI/HIV/AIDS programmes. A priority is to develop a greater sense of community, so as to counter norms promoting a move away from sexual safety towards individual sexual freedom and sexual risk-taking. But that is not to say that complex individual determinants should be overlooked.

5. SUMMARISING CONCLUSIONS

The NA was a first step in exploring determinants of casual sexual risk-taking among resourced and under-resourced women-having-sex-with-women in Tshwane. Three broad areas were explored, i.e. biographical data, views of health problems and solutions and lastly, sexual behaviour and the determinants thereof.

It became clear that HIV, STIs and alcohol abuse are seen as serious health problems confronting WSW. The ambiguity around risk perception is detrimental to the health and well-being of WSW as a whole. Casual sex seems to be occurring often, where motivating and de-motivating factors are mediated by the type of venue and substances used. There seem to be no regular testing for STIs or HIV, no consistent use of barrier methods during casual sexual encounters, there is no negotiated safety or barrier use in steady relationships and casual encounters, and where monogamy is claimed but not carried out, codes are used and a high level of secrecy surrounds the casual encounters taking place within friendship circles. It is clear that this situates these WSW as being at risk of contracting and transmitting an STI or HIV. An intervention is needed to deal developing problem.

No group has been more abandoned within STI and HIV programming than same-sex practicing women. A more complete and thorough understanding of the complexities of the lives of same-sex practicing women and the nature of their HIV-related risk is necessary. Women need to be trained about their risks and health care providers need to be sensitized on the specific health and HIV prevention needs of lesbians and other women-who-have-sex-with-women.

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7. APPENDICES

Appendix 1: Research Method

Target Group
From a brainstorming session held by the project team, it was decided that the characteristics of the target group would include the following:

- They are from various racial groups;
- They are resourced and under-resourced;
- They are able to understand and speak English;
- They reside in and around Tshwane;
- They are self-identified as lesbian, bisexual or women-who-have-sex-with women (WSW);
- They are between the ages of 18 and 40;
- They engage in a wide range of sexual activities within casual and non-casual encounters; and
- They may or may not concurrently be in a same- or opposite-sex monogamous relationship.

Sampling of Participants
For the purpose of the needs assessment the project team decided that 40 participants from the target group would be included in the needs assessment. 40 participants would be interviewed and 10 of these participants would be invited back to attend a focus group session. Furthermore, it was decided that, for the purposes of the needs assessment, that the target group would be divided into two sub-groups, defined primarily in terms of an age range. As such, one sub-group consists of participants between the ages of 18 and 25 and the other sub-group consists of participants between the ages of 26 and 40. The rationale behind creating two sub-groups is that although there may be an overlap in health problems, risk behaviour, determinants and environmental factors, there may be specific nuances within each sub-group that may be overlooked if handled separately. For example it can be suggested that the younger sub-group are more likely to frequent night clubs, whereas the older sub-group are more likely to frequent house parties or socials, thereby encountering different environmental factors.

The 40 participants were selected using the non-probability technique of opportunity sampling (see Rosnow & Rosenthal, 1996). The reason for using this sampling technique is that representative lesbian or women-having-sex-with-women populations are inherently difficult to access. However, the project team was well situated to gain direct access to a number of participants, from this population. Although 40 participants were targeted, one interview had to be excluded due to the poor sound quality of the recording. This indicates that 97.5% of the target number was achieved.

Data Collection Instruments and Procedures
From the brainstorming sessions, the project team decided that the data should be collected via one-on-one audio-recorded structured depth interviews. As part of a needs assessment (or situational analysis), interviews are useful for (i) identifying areas for more detailed exploration; (ii) yielding in-depth information that is relatively easy to quantify; (iii) ensuring comparability of questions across respondents; and (iv) ensuring that all the necessary topics to be investigated are included (Breakwell, 1998). It was envisaged that the 60 minute interviews would be followed up by a 90 minute audio-recorded focus group session. The questions for the focus group were derived from observations and analyses of the interviews. The focus group is useful for (i) assessing respondent's reactions to the interviews; (ii) explore the cognitive and social processes involved in answering; and (iii) interrogate certain themes or patterns obtained in the interviews (Millward, 1998).

An interview schedule was developed consisting of three sections: (i) Demographics; (ii) Health-related Problems and Services; and (iii) Casual Sexual Risk Taking.

Once developed it was submitted to the advisory group for input. Once amended it was piloted on fieldworkers. Thereafter the interview schedule was finalised and ready for administration. Fieldworkers were given some basic training around the aims of the needs assessment, interviewing skills, and research ethics (including the use of a consent form). Each fieldworker was tasked with doing between 10-14 interviews, depending on how many participants they had access to. After each interview, fieldworkers were requested to invite participants to participate in the focus group. As indicated above, 39 interviews were deemed suitable for analysis.

Of the participants who were interviewed, ten participants indicated that they would be willing to participate in the focus groups. However, as the scheduled date for the focus group drew closer at the beginning of 2008 only four people remained open to participating. With little time to set up another focus group at a later date, the project team decided to proceed with the 4 participants. Although some useful information was obtained, the focus group is largely limited in scope.

Data Analysis
A systematic thematic analysis was conducted on the data obtained in the interviews. A thematic analysis involves (i) examining all transcripts and developing a coding frame; and (ii) then applying these codes to the themes identified in each transcript (Joffe & Yeardley, 2003). A combination of deductive and inductive coding was used in the construction of the coding frame (Joffe & Yeardley, 2003). That is to say that, the themes were identified both by imposing existing theoretically derived themes on the data, and by drawing on emerging themes from the raw data.

The thematic analysis was conducted by two independent analysts in order to minimise bias, reduce potential coding errors, and ensure a relatively high level of inter-coder reliability (Rosnow & Rosenthal, 1996).

Appendix 2: Collaboration

The Project Team
A project team (consisting of a Project Coordinator, a Research Manager [time-limited], an independent research consultant, three fieldworkers and two analysts) was set up during the initial phases (and later stages) of the needs assessment. The aim of the project team was to brainstorm, develop and execute the needs assessment. The Project Coordinator in collaboration with the Research Manager brainstormed what was known about the target group in terms of existing research, commonly held beliefs and professional experience. They then brainstormed the data collection methodology for the needs assessment. Once this was done, they developed a first draft of the interview schedule. The research findings, information and draft interview schedule were then taken to the Advisory Group (see below). Inputs given at that meeting were used to expand on the research findings and information already gathered, and to adjust the draft interview schedule where necessary.

The independent research consultant was then brought on board to pilot the interview schedule, make the necessary final adjustments to the interview schedule, and to train fieldworkers (in interviewing skills and research ethics). Three fieldworkers were recruited and subsequently attended the training session. Once trained, the fieldworkers were given the necessary tools (e.g., interview schedule, consent forms, and contact sheets) to carry out the fieldwork. Thereafter the fieldworkers had two follow-up meetings with the independent research consultant. The first meeting served to monitor each fieldworker's progress, and the second meeting served as a closure and debriefing for each fieldworker.

Once the data was collected and transcribed, the two analysts and independent research consultant set about developing a coding frame. This was then used (and updated) by the two analysts.

The analysts met on separate occasions to discuss: (i) the coding frame; (ii) updates to the coding frame; (iii) the themes extracted from the interviews; (iii) consistencies and inconsistencies in the themes; and (iv) the interplay between various themes. These themes were then organised and presented to the Advisory Group for input and discussion.

The Advisory Group

An Advisory Group was set up during the initial phases of the needs assessment. The role of the Advisory Group was to serve as a reference point to the needs assessment. They were tasked with providing input, and refining conclusions, made by the project team, in terms of the target group, related health problems, research questions, research methodologies, and research findings. It was envisaged that the Advisory Group would be composed of the following:

- An OUT staff member (Project Coordinator);
- The research consultant;
- An expert in the field of STIs/HIV/AIDS;
- An expert in the medical field;
- An expert in the research field; and
- Target group representatives.

The Advisory Group met once during the initial phases of the needs assessment. At that meeting, individuals gave input around the (i) aims of the needs assessment, (ii) themes to be explored in the needs assessment; (iii) research findings and information gathered; and (iv) interview schedule. The Advisory Group then met again once the data gathered in the interviews had been analysed. Although very few respondents admitted to the use of Cannabis before engaging in unprotected casual sexual encounters, the advisory group indicated that this might not be a true reflection of what is actually happening. This might have been due to the fact that the respondents knew their interviewers and did not feel comfortable in sharing their possible abuse of Cannabis.

The group indicated that a deeper understanding of gender identity could have been elicited. There should also be a deeper understanding of women's fear, in general, to talk about sex.

What is interesting to note, was that the majority of Advisory Group members appeared surprised about the fact that STIs, specifically Herpes, can be transmitted through minimal bodily contact. This then begs the question, how can we expect WSW in general to know about the details of STI transmission, when the majority of the Advisory Group members seemed not to be fully informed.

Appendix 3: Interview Schedule

KEY INFORMANT INTERVIEWS FOR WOMEN WHO HAVE (HAD) SEX WITH WOMEN

Read consent form. Ensure all participants understand and sign consent form.

Note to interviewer: the following must be recorded at the start of the interview:
1. **Interviewer's name**
2. **The date of the interview**
3. **Acknowledgement that the consent form has been read and signed.**

A. DEMOGRAPHIC QUESTIONS
[Note to interviewer: circle appropriate responses]

Sex **[Note to interviewer: code by observation]**
Female 1
Other 2 _____

Race **[Note to interviewer: code by observation]**
Coloured 1
Black 2
White 3
Indian 4
Other 5 _____

Can we start? I would like to ask you a few general questions about yourself.

1. How old are you?_____

2. What is your home language? [Note to interviewer: wait for response]
English 1
Afrikaans 2
Other 3 _____

3. Where do you stay? [note to interviewer: wait for response]
Pretoria North 1
Pretoria East 2
Pretoria West 3
Pretoria South/Centurion 4
Other 5 _____

4.Who do you live with majority of the time? [wait for response]
Stay on own 1
Stay with friends 2
Stay with partner 3
Stay with family 4
Stay with parents 5
Other 6 _____

5. What is your current relationship status?
[note to interviewer: wait for response, but prompt for clarification]

Single - celibate	1
Single - sexually active	2
Involved - open relationship less than 6 months	3
Involved - closed relationship less than 6 months	4
Involved - open relationship more than 6 months	5
Involved - closed relationship more than 6 months	6
Married	7
Civil Union	8
Other	9 _____

6. What is your current (completed) educational level? [wait for response]

Standard 5/ Grade 7 and below	1
Standard 8/ Grade 10	2
Matric	3
Certificate/Short courses	4
Undergraduate	5
Postgraduate	6
Other	7 _____

7. What is your current employment status? [note to interviewer: wait for response]

Employed full-time	(40> hrs per week)	1
Employed part-time		2
Self-employed		3
Student		4
Unemployed - looking		5
Unemployed ą not looking		6
Other		7 _____

8. What is your current net (after deductions) monthly personal income?
[note to interviewer: wait for response]

No income	1
Below R1500	2
R1501 - R4500	3
R4501 - R8000	4
R8001 - R16000	5
Above R16001	6

B. NEEDS QUESTIONS

Now I would like to ask you some questions about issues facing lesbians or women who have/had sex with women. Let's start with health issues...

1 a. What do you think is the most serious health problem facing lesbians or women who have (had) sex with women in South Africa today? [Note to interviewer: wait for response, circle all called out responses]

HIV/AIDS	1	
STIs	2	
Recreational drugs	3	
Alcohol	4	
TB	5	
Cancer	6	(a) breast (b) Cervical
Injuries from physical attack	7	
Other	8	_____

b. If multiple responses were given, ASK - Can you say what the ONE most serious health problem is?

2. What are some of the contributing factors to this health problem [mention it] that you've mentioned?

3. Who do you think should be involved in addressing this health problem?

4. What do you think government is doing or can do to address this health problem?

a. How can government improve its role?

5. What do you think organisations are doing to address this health problem?

a. How can organisations improve their role with regards to this health problem?

6. What do you think private sector / business can do to address this health problem?

a. How can private sector/business improve their role?

7. What health services do you think are lacking for lesbian, gay, bisexual, transgender persons?

a. If "I don't know" (skip to question 11)
b. If mentioned some (proceed)

8. Of the health services you have mentioned, which of these would you say are the most important?

9. What obstacles do you think might stand in the way of stakeholders such as government, organisations and private sector/business in providing these services?

a. What suggestions could you make to overcome these obstacles?

10. What obstacles do you think might stand in the way of individuals accessing these services

a. What suggestions could you make to overcome these obstacles?

11. Do you know about OUT LGBT Well-being?

a. If "YES", proceed to 12
b. If 'NO" (explain about OUT and then proceed to 12)

12. In what way do you think OUT could play a role in addressing some of the health problems you mentioned?

C. CASUAL SEXUAL RISK-TAKING

Now I would like us to discuss issues around casual sex and sexual risk taking. Again, I'd like to remind you that this is confidential and that your name will not be included in the study.

13. From your own knowledge and what you've heard or observed about other lesbians or women who have (had) sex with women...
Can you please tell me in as much detail as possible about casual sexual encounters that take place between women? For example, can you start by explaining to me...

- How would you define casual sex?
- How casual sexual encounters take place between women?
- Where do they usually or generally take place?
- What happens exactly?
- From what you know or have heard, how close are the people having a casual sexual encounter? Do they generally know each other? What else can you tell me about them?
- What other information or detail can you give me about these sexual encounters?
- On a personal level, how do you feel about casual sex encounters?

14. Have you ever participated in casual sex?
If yes, continue to question 15.
If No, move to question 21.

15. Would you be prepared to talk about your own personal casual sexual encounters?
a. Yes ą proceed
b. No [move to Question 21]

16. Thank you for allowing us to proceed. Now, looking at your own casual sexual encounter ą I don't want to know who you were with, but can you tell me...

- How do these encounters take place?
- How often do you engage in a casual sexual encounter?
- What would you consider to be a motivating factor for you to engage in casual sex?

[NOTE: Ask these questions only if they were not covered under Q16]

17. In terms of VENUE or place and space:

- How do you / did you go about hooking up with a casual sexual partner? Or specifically, where do you meet?
- Is this the best place to hook up?
- Are there other places/spaces you could hook up? Which ones?
- What is it about this place/space/media that enables you to hook up?

18. In terms of SUBSTANCE USE (such as drugs and alcohol) during a casual sexual encounter:

- Were you using any substance? Which one/s?
- What were your motivations for using this substance?
- How does substance use affect sexual activity?
- Would you say you are likely to take more sexual risks when using a substance? Please explain

19. Now, looking at the actual casual SEXUAL encounter, can you please tell me...?

- Was this an unprotected sexual encounter (that is, sex without barriers such as condoms or latex)? (elaborate)
- How safe would you say the encounter was? (elaborate)
- Was there any safer sex negotiation between you and your casual sexual partner? (elaborate)
- Did you tell your primary partner about your casual encounter?

20. With regards to Sexually Transmitted Infections (STI) / HIV:

- At the time of your casual encounter, did you know your STI/HIV status?
- At the time of your casual encounter, did you know your casual sexual partner's STI/HIV status? How did you establish this? Is this important for you?
- Do you consider yourself to be at risk of an STI or HIV?
- How do you feel about being tested for STIs and HIV?

Remember the interviewee relationship status or go back to QUESTION A5. If not in relationship, ask question 22

21. If interviewee is in a RELATIONSHIP currently ASK

- In your relationship, are you currently engaging in unprotected sex?
- Would you tell your partner if you had a casual sexual encounter?
- Do you know your partner's HIV status?

22. Do you think that your experience (of casual sexual encounters) is shared by other women who have sex with women? To what extent and in what way?

23. Well, I have asked all the questions that I wanted to ask you. Are there any comments you would like to add/make or questions you would like to ask me?

We have come to the end of our interview. Thank you very much for your time. Just to remind you again that your name or any identifying information will not be used during this study.