“We women are women with a different manner”

Sexual Health of WSW in Four Western Cape Communities

Jill Henderson
Allanise Cloete
Mikki van Zyl

Triangle Project

December 2011

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Challenging Homophobia
Appreciating Sexual Diversity

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List of Acronyms and Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
CDC	Centers of Disease Control and Prevention
CEEP	Community Engagement and Empowerment Programme
CSOs	Civil Society Organisations
FG	Focus group
FGD	Focus group discussion
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HPV	Human papillomavirus
HSRC	Human Sciences Research Council
HSSP	Health and Support Services Programme
IDU	Injection drug use
lgbti	Lesbian, gay, bisexual, transgender and intersex
msm	Men who have sex with men
OSISA	Open Society Initiative for Southern Africa
PET	Public Education and Training Programme
PIT	Provider Initiated Testing
RAPP	Research, Advocacy and Policy Programme
REC	Research Ethics Council
SPSS	Statistical Package for the Social Sciences
STIs	SexuaLlly transmitted infections
VCT	Voluntary Counselling and Testing
wsw	Women who have sex with women

NOTE

HIV and AIDS terminology in this report follows the conventions recommended by the UNAIDS terminology guidelines (January 2011). Furthermore, we do not capitalise terms such as 'lgbti' to avoid essentialisation of identities (see Van Zyl, 2005; Epprecht, 2008).

EXECUTIVE SUMMARY

"We women are women with a different manner"

Sexual Health of Wsw in Four Western Cape Communities

Introduction

This research was initiated by Triangle Project and was funded by a grant from Schorer as part of the organisation's ongoing work to promote the sexual and reproductive health and rights of lesbian and bisexual women and other wsw.[1]

Triangle Project is an NGO situated in Cape Town and focuses on the rights and interests of the lesbian-gay-bisexual-transgendered-intersex (lgbti) community through education, research, publications and campaigns. It has four programmes: Community Engagement and Empowerment Programme (CEEP); Health and Support Services Programme (HSSP); Public Education and Training Programme (PET); Research, Advocacy and Policy Programme (RAPP). Participants for the study were accessed through the CEEP's work in the rural and peri-urban areas of Paarl, Stellenbosch, Vredenburg and Touwsrivier.

The primary aim of this study is to contribute to the evidence-based knowledge necessary for related to the sexual and reproductive health and rights of lesbian and bisexual women and wsw. It also aims to develop the capacity of under-resourced communities to respond and mobilise the resources necessary to address issues of HIV and AIDS and STIs in relation to wsw.

1. We break with convention and choose not to capitalise terms that are linked to identities, in order to acknowledge their fluidity (See also Van Zyl, 2005; and Epprecht, 2008).

Context of Wsw

After two decades of HIV and AIDS activism, there is still a common belief that women in same-sex relationships are among those least at risk of contracting HIV. This tendency excludes lesbians and women who have sex with women (wsw) from discourses on vulnerability to HIV and AIDS and sexually transmitted infections (STIs). The dominant view is that this exclusion is evidence-based, but a more politicised view proposes that the exclusions determine the evidence. Dworkin (2005) argues that the epidemiological categories employed in the surveillance of HIV and AIDS have placed heterosexual transmission, particularly for women (and implicitly female heterosexual identity) at the centre of inquiry, thereby rendering woman-to-woman transmission "unfathomable".

The concepts of 'wsw' and 'msm' are used by researchers, public health policy-makers and the lesbian, gay, bisexual, transgender and intersex (lgbti) sector in South Africa on the grounds of being identity-free terms that refer to all women and men who have sex with people of the same sex, whether or not they identify as lesbian, gay or bisexual. However, we acknowledge that wsw does not refer to uniform groupings, and that sexual and gender identities are crucial aspects of the social, political and cultural contexts that are explored in this study. In the study we sought out the variation in terms of sexual identity, sexual practices and risk behaviours, as well as other divisions related to for example race and class.

Embedded heterosexism or homophobia in research agendas and knowledge production have led to a lack of research on HIV in relation to same-sex oriented practices and identities in Africa, and particularly to the unintelligibility of HIV in relation to wsw. This in turn has meant not only an absence of funding for research and programming related to prevention, treatment and care, but also a denial of risk among lesbian and bisexual women and other wsw. Therefore, Johnson (2009: 132) argues that "Wsw may be the most 'at risk' group of all, not due to biological susceptibility, but to sheer neglect."

Provisional studies, anecdotal reports and previous research conducted by Triangle Project suggest that a substantial number of lesbians are living with HIV in South Africa. The silence of lesbians around HIV and their HIV status can be linked to a denial of risk, limited information as well as stigmatisation in lesbian circles due to assumptions that HIV transmission occurs through heterosexual sex.

It is known that mucous membrane exposure to vaginal fluids and menstrual blood can lead to HIV infection. Sexual practices of wsw therefore cannot be disregarded in HIV risk and vulnerability. Further, evidence shows that wsw are at risk of a variety of STIs. Discrimination and homophobia by service providers in

health care settings means that lesbians and wsw experience specific forms of marginalisation which prevent them from accessing appropriate sexual health care and HIV prevention and treatment, which is their right. Therefore wsw education on HIV and STI risk and vulnerability should be placed in the context of sexual and reproductive rights and the provision of appropriate, relevant and non-discriminatory health care and support services.

Methodology

This study sought to explore and document the sexual practices of women who have sex with women (wsw). It enquired about sexual behaviour related to risk around HIV infection and STIs, and the social, cultural and economic factors that impact on STI and HIV risks. It elicited the choices of wsw around risky and safer sex practices, and their perceptions of the accessibility and availability of health-related services specific to their sexual health needs.

Women living in under under-resourced communities in four rural and peri-urban areas of the Western Cape Province were selected using convenience sampling that drew on the existing networks established through Triangle Project's on-going community based work in these areas. They were asked to complete a self-administered questionnaire as well as attend a focus group discussion (FGD) in their area. Four fieldworkers were trained on the administration of the survey questionnaire, group facilitation skills and the basic principles of ethical research. A consultant from the Human Sciences Research Council (HSRC) assisted with the training of the fieldworkers, data collation and presentation of a draft report.

Data from the survey were analysed using Statistical Package for the Social Sciences (SPSS) Version 17.0. SPSS, and the focus groups were recorded and transcribed, translated where necessary and analysed using thematic analysis. The quantitative and qualitative were integrated in presenting the results.

The research was approved by the HSRC's ethical committee. Participants were assured of anonymity and about how the information would be used. Focus groups were introduced by both the participants and the facilitator making explicit commitments to safeguarding the confidentiality and respecting the privacy of all group members.

The sample for the survey is very small, and the quantitative information could not be used for multivariate analyses, but did provide useful descriptive information, enabling a profile for the sexual health needs of the wsw in those areas.

Results and Discussion

Demographic profile of participants

A total of 51 women participated in the survey: 29 from Mbekweni, 9 from Kayamandi, 8 from Vredendal and 5 from Touwsrivier. More than half the participants came from Mbekweni, which determines the racial profile of around 75 per cent black African participants. Thirty-four women participated in the FGDs, with less than half of the Mbekweni participants attending.

The participants were young, with an average age of 23 years, and most identified as "black African", with a quarter being "coloured" (mixed race). The distribution of race in terms of geographical location still reflects apartheid racially classified segregation.

The majority (82%) of the women had never been married, and three were married to a woman. Nine women had children, only one of whom was coloured. Seven of these had never been married, one was divorced from a man, and one was married to a woman. Most of the women said they were Christian.

Only two women had not reached a secondary education level, with ten having achieved tertiary education. Twelve women had steady jobs, and 32 were unemployed. Only half of those with tertiary education had steady jobs. Half were living in an 'owned' house, and almost half (47%) of the women depended on the income of other family members.

Sex/gender identities

In terms of gender identification, almost 76.4 per cent (n=39) reported that "I see myself as a woman"; 21.6 per cent (n=11) of them indicated that "I see myself as a man", and one participant was careful to explain her/his gender identity as follows – "I see myself as a man in a woman's body". In terms of sexual orientation, 37 women identified as lesbian, 11 as bisexual, two as heterosexual and one as "a man in a woman's body".

In spite of viewing gendered identities in the dominant heteronormative binary, in their relationships the participants did not subscribe to the same power inequalities they saw in heterosexual relationships. Heterosexual relationships were viewed negatively and characterised by male domination, abuse and violence, and some romanticised lesbian relationships. Others remarked on how the lesbians who identified as 'men' took on masculine behaviour, but more than 80 per cent of the participants said that they "both equally make decisions within the relationship". Since dominance and violence in intimate heterosexual

relationships are implicated in HIV risk, it is important that more egalitarian relationships indicate a greater potential for negotiating safer sex among wsw.

Belonging

Belonging is complex and layered, emerging through self-identifications, social relationships as well as political values. Participants were asked about their sense of belonging and acceptance in their communities.

Around 90 per cent of the participants said that "all" or "some" of their families knew about their same-sex attraction, and 86 per cent said their households knew. Therefore only five participants' families and households did not know – two identified as "lesbian", two "bisexual" and one "heterosexual". These women were all from Mbekweni and Kayamandi. The sample is too small to determine if these are linked to a greater fear of homophobic violence in the townships.

Most of the participants felt part of their communities, and thought that people accepted them when answering the survey questions. However, in the FGDs participants spoke about the insults and bad treatments that they suffered. One participant spoke about hiding her identity in order to be accepted. These included threats of rape, typified by male claims to women's bodies. Understanding that feelings of belonging may include a 'longing to belong', it is important that some of the participants actively claimed their right to belong. Belonging is an important trope in discourses of HIV risk and vulnerability, as it speaks to belief in one's self-worth.

Vulnerability and risk

Interventions on HIV prevention were overwhelmingly focused on "heterosexual transmission between couples" (Shisana et al., 2008: 1), until epidemiological evidence showed that HIV transmission was fare more diverse. Nonetheless, the continuing heteronormativity and phallocentrism of beliefs about what constitutes 'real' sex has contributed to the exclusion of wsw from research on transmission of HIV and STIs.

Dominant discourses of risk consider 'age of sexual debut' a crucial factor in HIV vulnerability, as well as the age difference between the partners. However, these need to be situated in a social context which explicitly acknowledges the power dynamics and sexual practices in the relationship. It was found that on average sexual debut with a female partner happened earlier than with a male partner, but that the age difference was about 2 years older for women, and four years older for men. Almost half the participants had had sex with men. Two

participants were currently living with a man, six participants said that they were currently involved with women as well as men, while the rest were involved with women.

Seven women had ever had sex with only one woman, while 35 had had sex with more than one woman, though only seven had had sex with more than ten, and three with more than 20. A general factor in increasing HIV transmission risk in dominant discourses is related to the number of sexual partners of a person. Specific factors for HIV risk in wsw's sexual relations with men need to be explored. When young women are exploring their sexualities, they may be at increased risk because of not getting guidance from usual sources of support.

Sexual practices

It is known that HIV vulnerability and risk are associated with sexual practices where blood, vaginal secretions or semen come into contact with sensitive mucous membranes (CDC, 2009). Common sexual practices reported by the participants in this study include: vaginal penetration with fingers; cunnilingus (oral-genital contact); clitoral stimulation with hand; and tribadism (rubbing wet part of vaginas together). Twenty-eight per cent of the wsw reported having sex with another woman whilst she or her partner were menstruating. Less common sexual practices involving oral-anal contact and anal penetration were reported by a minority of participants. Certain co-factors like other STIs, genital sores, menstrual blood and the viral load of HIV positive sexual partners can increase the risk of HIV transmission in these practices, though the precise risks are not known.

When asked about practising prevention methods for HIV or STI transmission during sex with women, 38 participants did not do anything to prevent HIV, and 31 didn't do anything to prevent STIs. When asked why they did not use prevention methods, the main reason given was that they "had not thought about it". Other reasons included the difficulty of obtaining protective measures, not knowing of ones that can be used in sex between women, or that they are unpleasant to use. Nine women referred to their partners not liking it or refusing to use protection. Almost 10 per cent said that protection against HIV and STIs "is not necessary for sex between women". Seven women who had had sex with men in the previous six months reported him inserting his penis into their vagina. Four of those who had vaginal sex did so with no protection. One had unprotected anal sex.

Risk behaviours

Sexual risk behaviours are compounded by other factors such as the power relations in sexual relationships or partnerships, as well as knowledge and

availability of HIV and STI prevention methods. Key risk behaviours are associated with substance use, transactional sex, but neither of these were found to be significant for this sample of wsw. These participants could be deemed to be most at risk due to not using protection during sexual practices associated with transmission risks.

Vulnerability

Three of the study participants reported that they had been forced to have sex with another woman, whilst seven women reported forced sex perpetrated by a man against them. More than a quarter of the participants did not respond to this question. Eight women indicated that they had experienced violence from members of the police service.

The exclusion of wsw in discourses of sexual health regarding HIV and STI transmission, prevention and treatment, in itself creates vulnerability. Though about 60 per cent of the women demonstrated reasonable knowledge about HIV and STI transmission between women, this knowledge did not translate into practice. Most of the women (70.6%) had tested at some time for HIV, with 31 using public health facilities. A quarter of the participants did not answer this question. The main reasons given for testing were to “know my HIV status”. Of the 36 who had tested, 33 reported a negative status. No one reported an HIV-positive response. Twelve participants had never tested for HIV because they “trusted their partner”, didn’t perceive themselves to be at risk, or were afraid or not ready for a test.

When asked about being diagnosed with STIs, 42 participants said “no”, but six had had STIs, with three having been treated, and two not. When asked if any had had a papsmear, more than three quarters (76.5%) of the participants had not. This indicates how lack of appropriate support, if at all, from the healthcare system makes wsw vulnerable to HIV.

Like many other groupings participants in this group showed that their knowledge and perceptions of risk are not translated into behavioural changes. Though they exhibited high degrees of knowledge related to HIV transmission, and many tested for HIV, they also engaged in sexual practices where bodily fluids would likely have been exchanged. Nonetheless they did not see themselves as at risk. The manner in which vulnerability emerged in the context of this study, can therefore be linked to dominant discourses of non-vulnerability for lesbians and wsw.

Gender identifications and other sexual and reproductive identities such as motherhood should also be integrated into discourses related to wsw risk and

vulnerability to HIV and STIs. Competition between social movements and groups working on HIV for available resources has led to a fragmentation of advocacy, creating gaps in the knowledge about wsw and HIV risk and vulnerability.

Where to Next?

Heteronormativity and phallocentrism are the ideological underpinnings for the exclusion of wsw from discourses of risk and vulnerability to HIV and AIDS. Notions that HIV risk is associated with heterosexual sex, and that women are the 'most' vulnerable, have focused programmes on heterosexual transmission of HIV. Heterosexual sex as 'real' sex is centred on penis-vagina penetration. In the absence of a penis, risk and vulnerability to HIV and AIDS all but disappear. Hence wsw have also been excluded from same-sexualities discourses which focus on msm. Even where women have become visible as 'more vulnerable' (than men), wsw are excluded because they are not perceived to be 'real' women and do not have 'real' sex. Similarly, the identity of motherhood is linked primarily to heterosexual sex, and in spite of multitudes of programmes focusing on prevention of mother to child transmission, wsw are excluded as 'real' mothers.

Policy Framework

Despite widespread acknowledgement that addressing the complex issues woven through sexuality – identities, cultures, social regulation – the South African National Strategic Plans (NSP) have not addressed it until the 2012–2016 NSP. Nor have they acknowledged the existence of wsw as a grouping who may be potentially vulnerable to HIV in spite of well-publicised media reports on the rape of lesbians due to their sexual identity. In the latest NSP they subsume wsw under msm as vulnerable to stigmatisation, but without any reference to their sexual practices.

In contrast, the Department of Health's policy guidelines on Sexual and Reproductive Health and Rights (SRHR) speaks directly to gender inequalities, gender variability and sexual diversity. They show a sensitivity to stigmatisation of certain groups, including "transgender people … and people with diverse sexual orientations". Regrettably the gender inequalities as they pertain to the sexual and reproductive rights of lesbians, bisexual women, wsw, transgendered individuals, intersex persons, gay men and msm are not explored. However, the intention to address existing norms through education and skills development opens a welcome gap for civil society organisations to challenge the government to include the sexual and reproductive rights of gender non-conforming individuals in these programmes.

Recommendations

Advocacy

1. Educate the public on the real risks and vulnerabilities of wsw, based on evidence which is appropriate and relevant in:
   - wsw communities
   - research
   - advocacy and lobbying
   - service delivery
   - media.

Identitities

1. In campaigns around safer-sex for wsw, emphasise the value of egalitarian relationships as a context where safer sex practices may be negotiated.
2. Hold meetings and discussions with wsw to provide a platform where heteronormative roles in wsw relationships may be debated challenged.
3. Hold workshops which address the stigmatisation of wsw who have sex with men. Wsw may want to have sex with men in order to get pregnant.
4. Advocate for the inclusion of same-sex identities as part of the curriculum.

Sexual practices

1. Provide sexual health and education programmes which address:
   - Number and sex of sex partners
   - Specifically risky practices, e.g. having sex during menstruation
   - HIV and STI as compounding risk factors
   - Prevention methods.

   These programmes should be targeted at service providers as well as wsw, and HIV activist groups with an emphasis on the fluidity of sexual practices.

Violence

1. Disseminate information on post-exposure-prophylaxis to wsw.
2. Identify sympathetic service providers to provide emergency PEP.
3. Educate gender-based violence service providers on sexual violence against wsw.

HIV and STI prevention

1. suitable information regarding sexual health and reproduction specifically for wsw.

2. Provide access to respectful sexual and reproductive health services for wsw and msm
   - dental dams and lubricants
   - condoms
   - HCT
   - pre-exposure prophylaxis
   - post-exposure prophylaxis
   - STI management
   - TB screening.

Policy

1. Strategic objectives must address the specific access needs of particular groups such as women (pregnant, with child-bearing potential or post-menopausal, lesbian, bisexual and other wsw), men, adolescents, children, persons with disabilities etc.
2. Access to health service must be ensured which
   - acknowledge and integrate the specific needs of wsw;
   - address the social, cultural and other barriers that may stand the way of accessing services.
3. Comprehensive sexual and reproductive health and rights services must
   - include all aspects of promoting a culture of respect for sexual and reproductive rights; and
   - all aspects of prevention, diagnosis, treatment and care in relation to sexual and reproductive health.
   - should be age appropriate and relevant, including services for marginalised or vulnerable populations, such as persons with disabilities, transgender and intersex persons, same-sex practising persons, sex workers and people living with HIV, among others, and
   - must be provided without prejudice or bias.
4. Services should be guided by a clear understanding of sexuality and the relationships between sexual behaviour, sexual pactices and sexual identitites.
5. Contraception, fertility management services (including termination of pregnancy services) must be provided to all communities to improve planning for safe and desired preganacies.
6. Concepts that relate to human sexual and gender diversity must be incorporated and explicitly defined in national policy documents such as the NSP.

7. Develop interventions and advocacy to support the DoH's education programmes on sexuality.

Directions for future research

1. Research which explores factors based on gendered identities needs to be based on concepts that have been elicited and developed from lived identities and meanings from that research context.
2. There is a need to fund research that improves our understanding of SRHR of wsw and lgbti groups in relation to HIV and STI risk and vulnerability.
3. Replicate the study in other areas, and do comparative analyses.
4. Use the current study as a basis for further investigations regarding HIV and STI risk and vulnerability for wsw.
5. Specific questions arising around the apparent visibility of wsw raised in this study:
   - Has the increased visibility of 'homosexuality' as a public phenomenon provided a point of recognition for lesbians and bisexuals to openly claim their same-sex desires and identities?
   - Have the legal and constitutional protections helped lesbian and bisexual women in urban, peri-urban and rural communities feel able to claim their sexual rights?
   - How do lesbian and bisexual women experience the role of these paper rights in their lives?
   - Has there been a real shift in the often lamented invisibility of lesbian identities in various communities?
   - To what extent are the increasing reports of violent attacks targeting lesbians a backlash against increased visibility of lesbianism both as a public phenomenon and as an identity openly claimed by individual women in local communities?

CHAPTER ONE

Introduction

In this chapter we introduce the theme of wsw vulnerability, and locate the study within the programmes of Triangle Project.

Visibility of Wsw Vulnerability

After two decades of HIV and AIDS activism, there is still a common belief that women in same-sex relationships are among those least at risk of contracting HIV. This tendency excludes lesbians and women who have sex with women (wsw) from discourses on vulnerability to HIV and AIDS and sexually transmitted infections (STIs). The dominant view is that this exclusion is evidence-based, but a more politicised view proposes that the exclusions determine the evidence. Dworkin (2005) argues that the epidemiological categories employed in the surveillance of HIV and AIDS have placed heterosexual transmission, particularly for women (and implicitly female heterosexual identity) at the centre of inquiry, thereby rendering woman-to-woman transmission "unfathomable".

This study sought to explore and document the sexual practices of women who engage in wsw practices. It enquired about sexual behaviour related to risk around HIV infection and STIs, and the social, cultural and economic factors that impact on STI and HIV risks. It elicited the choices of wsw around risky and safer sex practices, and their perceptions of the accessibility and availability of health-related services specific to their sexual health needs.

This research was initiated by Triangle Project and was funded by a grant from Schorer. Triangle Project is the lead organisation in the research project. The study is part of the organisation's ongoing work to promote the sexual and reproductive health and rights of lesbian and bisexual women and other wsw. Discussions at a symposium entitled *The silence is political: HIV & WSW* hosted by the Triangle Project in October 2009 provided the impetus for this project.

Triangle Project

Triangle Project is a human rights organisation located in Cape Town, South Africa. It works to ensure full realisation of equality and human rights for lesbian, gay, bisexual, transgender and intersexed (lgbti) persons. Triangle Project's programmes are driven by the recognition that (in)equality based on sexual orientation and gender identity cannot be separated from social power relations based on race, class, nationality and gender (more broadly). These programmes are as follows:

1. Community Engagement and Empowerment Programme (CEEP)
2. Health and Support Services Programme (HSSP)
3. Public Education and Training Programme (PET)
4. Research and Advocacy Programme (RAP)

Work across all programme areas is focused on four intersecting themes, namely:

- Gender and sexuality based violence
- Sexual and reproductive health and rights in relation to lgbti
- Community empowerment and leadership
- Lgbti human rights and citizenship.

Purpose of the Study

The primary aim of this study is to contribute to the evidence-informed knowledge necessary for advocacy targeted at government (national, provincial and local) and relevant civil society organisations (CSOs) in relation to the sexual and reproductive health and rights of lesbian and bisexual women and wsw.

Additionally this project aims to:

- Challenge and shift the research agendas, policies, dominant epistemologies and research methodologies of key research institutions/units involved in HIV and AIDS in South Africa;
- Develop the capacity of under-resourced communities to respond and mobilise the resources necessary to address issues of HIV and AIDS and STIs in relation to wsw; and
- Produce knowledge that guides the work of Triangle Project's health and support, public education and community empowerment programmes.

Report outline

In chapter two we address the theoretical issues relevant to the study, and contextualise wsw in the communities of the study locations.

Chapter three covers methodological issues, while chapter four discusses the findings. Chapter five briefly engages with relevant policies, and in the final chapter we make recommendations emerging from the evidence gathered by the research.

Note on Language

We often use the term (or variations) 'same-sex sexualities' rather than 'homosexuality' to indicate a range of erotic practices, behaviours and orientations that involve people of the same sex. In this study we use terms such as 'lesbian', 'gay', 'bisexual', 'transgender', 'wsw', 'msm', 'butch', 'I am a man', 'I was not born female', consciously and conscientiously to indicate specific identities, gender orientations or sexual practices.

We also do not capitalise 'lgbti' to avoid essentialisation of identities which are fluid and vary from place to place and over time (Van Zyl, 2005; Epprecht, 2008). These shift the meaning towards more descriptive and fluid adjectival ones, rather than the rigidity of nominal meanings. Moreover, in spite of assertions that 'wsw' is supposed to be 'identity-free' we regard 'women' as a gendered identity, and therefore also use lower case letters for 'wsw' and 'msm'. Similarly we also do not capitalise racial identities such as 'coloured' and 'black'.

In the next chapter we contextualise the study both theoretically and geographically.

CHAPTER TWO

Context of Wsw
Risk and Vulnerability

In this chapter we examine how HIV and AIDS discourses on vulnerability excluded woman to woman sexual practices through the simultaneous heterosexism of HIV and other STI risks assessments, and the assumption that the African HIV and AIDS epidemic is heterosexual.

Defining 'Wsw'

'Wsw' and 'msm' refer to all women and men respectively who have sex with people of the same sex, regardless of whether they identify as lesbian, gay or bisexual. From an epidemiological perspective it is argued that 'wsw' and 'msm' convey the meaning that practices and behaviours, as opposed to identities, place individuals at risk for HIV infection (Young & Meyer, 2005). Therefore, using 'wsw' and 'msm' may be useful to signify that sexual identity does not always determine sexual practice. For example, women who identify as lesbian may also have sex with men, and women who see themselves as heterosexual may also have sex with women. Used as a catch-all category, 'wsw' not only displaces information about sexual identity and gender expression, but also obscures other social and political dimensions of sexual behaviour (Young & Meyer, 2005).

These categories need to be problematised in discourses aimed at behaviours for reducing the risk of HIV infection, since gender and sexual prejudices and inequalities intensify the vulnerability of lgbti people to HIV. Vulnerability to, and risk of, HIV infection is not only related to sexual behaviour but also to sexual identity and/or gender expression. For example, the sexualities and gender identities that challenge heteronormative constructions of gender and sexuality are often under direct attack in South Africa (Judge, 2009). Sexual violence, in particular, is a prominent feature of attacks directed against lgbti people in South Africa (Reid & Dirsuweit, 2002).

Embedding the terms 'woman' or 'man' immediately speaks of gendered identities which reinforce and reproduce gendered dichotomies. Therefore 'msm' and 'wsw', locked into a binary gender classification as they are, do not encompass fluidity and complexities of gender and gender identity. Therefore transgender people can, at best, only ever occupy a very uncomfortable space within these concepts. Intersexed people are rendered entirely invisible by the use of such terms. Lastly, knowledge and understanding of the range of sexual identities and gender expressions of wsw within South African contexts is essential for the development of appropriate public health prevention initiatives and therefore cannot be glossed over (Young & Meyer, 2005).

Yet, the concepts 'wsw' and 'msm' have gained currency among researchers, public health policy-makers and the lesbian, gay, bisexual, transgender and intersex (lgbti) sector in South Africa. We use 'wsw' as a generic term which refers to a heterogeneous group of women, and we acknowledge their diversity in sexual identity, sexual practices and behaviours. We concur with Wieringa (2008) who points out that there is a great multiplicity of ways in which women live their desires, influenced by differences related to, inter alia, class, religion, ethnicity, legal systems, political cultures and gender regimes. She also states that "the present-day discourses on wsw are rather inadequate to capture this wide variety of practices, desires and identities" (Wieringa, 2008: 10).

However, in order to engage with existing discourses we stick to the conventions and use the terms 'wsw' and 'msm', but do not capitalise them. Van Zyl (2005) and Epprecht (2008) argue that capitalising terms such as 'lgbti' tends towards essentialising identity categories, and does not acknowledge their fluidity from place to place and over time. Therefore we use 'wsw' loosely, knowing that they do not refer to uniform groupings. We acknowledge that within these categories there is much variation in terms of sexual identities, sexual practices and risk behaviours, as well as other identity intersections related to for example race and class.

Heterosexist Exclusion of Wsw Practices

During the emergence of HIV and AIDS as health issues in the global North in the 1980s and 1990s, women became increasingly visible in discourses of vulnerability due to feminist interventions (Dworkin, 2005). By the mid-1990s discourses of heterosexual transmission of HIV centred on women being more at risk than men due to a range of inequalities – economic, social and cultural power differences. The gendered sexualisation of powerful masculinities and vulnerable femininities have become essentialised without regard to the multiple intersections of gender

with race, class, place and sexualities. Dworkin (2005: 618) asserts that epidemiological categories do no include intersections of identities and behaviours and therefore "do not facilitate easy analysis of the contextual factors that shape risk". Dominant terminologies for HIV risk, such as 'heterosexual transmission', 'injecting drug use', 'transactional sex' and 'men who have sex with men', meant that wsw were either subsumed or excluded by the categories, and consequently became invisible in any programmes or policies addressing HIV risk and vulnerability.

In South Africa, the exclusion of lesbians and women who have sex with women from HIV and AIDS programmes around risk and vulnerability occurred against the backdrop of two dominant discourses: the increasing recognition of women as a vulnerable grouping (Richardson, 2000), and the construction of a heterosexual African epidemic. The heteronormativity implicit in these discourses ensured the exclusion of wsw. Firstly, the construction of a 'heterosexual African sexuality' led to a heterosexually-based AIDS epidemic in Africa (Epprecht, 2008), inextricably bound up with beliefs and assumptions that same-sex practices are unAfrican, and therefore 'don't exist' or 'shouldn't exist'. This has had a powerful influence on HIV and AIDS research in Africa, where questions about same-sex relations are seldom, if ever, asked in national or representative surveys. When challenged, South African demographers have justified these absences by arguing that South Africa is an 'Africanist' context and that such questions would offend respondents and harm the research process (Sember, 2009). Sember (2009: 29) argues that "without investigation the opinion of the populace is a blank slate, available for the projection of prejudices rooted not in the population but in those in authority". Secondly, 'woman' is predominantly employed as a homogenising category in which heterosexuality is not merely the assumed norm, but also becomes the defining criterion. Lesbians are then typically placed outside the normative boundaries of the category 'woman' (Richardson, 2000).

Discourses which transcend the boundaries of heterosexuality and include men who have sex with men (msm) originated in understandings of the 'gay epidemic' emerging from the global North, and similarly excluded women who have sex with women. Therefore even within non-heteronormative discourses lesbians, bisexual women and wsw are marginalised categories. Compounded by the homophobia around same-sexualities in Africa, this conceptual invisibility impacts negatively on service delivery, proactive health interventions, safe sex practices and advocacy. This absence in discourse has also led to beliefs among lesbians and wsw themselves that they are not at risk of HIV infections.

Consequently, embedded heterosexism, homophobia and phallocentrism in research agendas and knowledge production have limited our capacity to speak knowledgeably about HIV and AIDS in relation to wsw. The overall lack of research on HIV in relation to same-sex oriented practices and identities in Africa, and moreover the unintelligibility of HIV in relation to lesbians, bisexual women and wsw have stifled the impact of advocacy efforts by activists. Despite South Africa's non-discrimination clause in the Constitution, the South African government has not included msm in government reporting on HIV (Foundation for AIDS Research, 2008), even though msm have been identified elsewhere amongst 'vulnerable groupings'. The persistent exclusion of same-sex practices and identities from HIV and AIDS discourses is itself a source of vulnerability. Not only has it meant an absence of funding for research and programming related to prevention, treatment and care, but also a denial of risk among lesbian and bisexual women and other wsw. Johnson (2009: 132) posits that "WSW may be the most 'at risk' group of all, not because of biological susceptibility, but due to sheer neglect."

Provisional studies (Wells & Polders, 2004; Wells, Mbatha & Van Dyk, 2007; Judge, 2008) and anecdotal reports suggest that a substantial number of lesbians are living with HIV in South Africa. In addition, research conducted by Triangle Project in both urban and rural settings in the Western Cape indicate that the silence of lesbians around HIV and their HIV status is related not only to a denial of risk or limited information, but also to the possibility of stigmatisation from within lesbian circles. Because of the almost automatic association of an HIV positive status among women with heterosexual transmission, lesbians who are living with HIV may fear censure from other lesbians (Henderson, 2008). Bisexual women are also stigmatised as 'the AIDS carriers' by lesbians.

Lesbians and wsw are not insulated, by virtue of their same-sex desires, from the risks of HIV and AIDS (Cloete, Sanger & Simbayi, 2011). Hence, it is important to place the issue of HIV and wsw in the context of sexual and reproductive rights and the provision of appropriate, relevant and non-discriminatory health care and support services which they are currently being denied.

Woman to Woman Transmission of HIV and Other STIs

While much has been written about the vulnerabilities to HIV infection of men who have sex with men (msm), the silence on the sexual health concerns of wsw is considerable (Wieringa, 2008). The common belief is that the risk of HIV or STI infection for wsw is minimal. A particular concern is that this belief has become internalised by lesbians, who view themselves as virtually immune to HIV and who are generally unconcerned about the use of prevention measures (James, 1995;

Matebeni, 2009). For example, in focus groups conducted by Triangle Project with lesbian and bisexual women in the Western Cape, participants believed that, in contrast to heterosexual sex, sex between women was safer sex and served as protection from HIV and STI infection (Henderson, 2008). Lesbians in particular were therefore viewed as not being vulnerable to HIV and STI infections and that the use of any preventive measures during sex between women were not even considered.

We need to interrogate what lies at the root of this belief that sexual activity between women poses little or no risk of HIV transmission. HIV and AIDS research, policy, programmes and services are dominated by heteronormative assumptions about sexual practices, which reduce HIV transmission risk to penetration with a penis and HIV prevention to condom use. Within this phallocentric view, wsw and sexual practices between women are non-existent and invisible. If considered at all, knowledge of wsw are based on vague presumptions about woman-to-woman sexual practices. The understanding that a range of sexual practices may occur across both opposite-sex and same-sex partnerships is generally absent from HIV and AIDS and sexual health research, programmes and services. Instead, categories of sexual identity and even the more practice-based terms, such as wsw and msm, are used as stand-ins for presumed sexual behaviours.

Without knowledge of the specific woman-to-woman sexual practices that wsw from different contexts engage in, the HIV transmission risks of sexual activities between women cannot be assessed, and without such information health workers cannot provide wsw with meaningful harm-reduction information. The true risk of HIV transmission through female-to-female sex remains unknown since same-sex sexual practices and behaviours between women is either excluded in risk classification schemes in surveillance research, or subsumed under a hierarchy of behaviours regarded as higher risk, such as 'substance abuse' or 'heterosexual sex' (Marrazzo, 2004; Kwakwa & Ghobrial, 2003).

It is known that mucous membrane exposure (such as oral and vaginal) to vaginal fluids and menstrual blood can potentially lead to HIV infection (Centers for Disease Control and Prevention (CDC) 2007). The true risk of HIV transmission through oral sex (oral-genital or oral-anal contact) is not known and difficult to determine. Most individuals who practise oral sex also practise other forms of sex regarded as more risky (e.g. anal or vaginal sex) (CDC, 2009). Consequently, like female-to-female sexual practices the risk associated with oral sex is subsumed under a hierarchy of other sexual practices with higher risk. Nevertheless, numerous studies have demonstrated oral sex can result in the transmission of HIV and other STIs (CDC, 2009). The risk of HIV transmission through oral sex increases

if: the person preforming the oral sex has sores or cuts around and in their mouths and throats; or if the person receiving oral sex has genital sores or another STI (CDC, 2009); or is at the beginning, middle or end stages of her menstrual period (Gay Men's Health Crisis, 2009; NAM AIDS Map, 2011). In addition, sexual practices, such as using sex toys vigorously enough to cause exchange of blood-tinged bodily fluids, pose a reasonable theoretical risk of HIV transmission (Kwakwa & Ghobrial, 2003). The possibility of female-to-female transmission of HIV therefore cannot be disregarded (Kennedy, Scarlett, Duerr & Chu, 1995). Kwakwa and Ghobrial (2003) warn about the danger of ignoring the potential HIV transmission risks of sex between women. They advise that HIV-seronegative and HIV-seropositive wsw be counselled to use safe-sex practices with female partners.

Although research remains limited, the available data clearly indicate that STIs are transmitted in sex between women. This risk varies according to the specific STI under consideration and the sexual practices involved (Singh and Marrazzo, 2009; CDC, 2010). Wsw are at risk of a variety of STIs, including human papillomavirus (HPV), herpes simplex virus infections, chlamydia and syphilis (Marrazzo, 2004). Research indicates that wsw have a higher prevalence of bacterial vaginosis as opposed to women who have sex only with men (McNair, 2005). Overall, data from studies conducted in Western countries indicate that the prevalence of STIs in wsw is as high as that of heterosexual women, if not higher for some sub-groups of wsw (McNair, 2005).

Social Dimensions of Risk and Vulnerability

Wsw engage in sexual behaviour, and may adopt sexual and gender identities that challenge heteronormative social prescriptions that institute heterosexuality as the only 'normal' or 'natural' form of sexuality. Normative heterosexuality relies on the gendered notions of only two opposites sexes, with males/men as masculine and females/women as feminine (Judge, 2009). Sexualities and gender identities that challenge the heteronormative are silenced, undermined and at times, directly "attacked" (Judge, 2008: 9). This plays a central role in vulnerability to HIV and AIDS. As argued above, one consequence of heteronormativity is the pervasive silence surrounding HIV and sexual health as it pertains to wsw. This silence therefore becomes one of the social and political dimensions that in itself is a source of vulnerability, and which contributes to the neglect of sexual health information, resources and services for wsw (Johnson, 2007).

Since the belief that they are a low-risk group for HIV infections may be internalised by lesbians, lesbians who test HIV seropositive may be stigmatised, especially in contexts of general and ongoing stigmatisation of people living with

HIV. Stigmatisation is not merely the creation of boundaries between 'us' and 'them', but also acts as a psychological mechanism for feeling safe through according blame – unlike 'them', the person pointing the finger has done nothing to 'deserve' being a 'victim' (Van Zyl, 2006). Stigmatisation may prevent people seeking support or advice since they become 'marked' merely by speaking about HIV prevention. Furthermore, the dominance of condom use as protection may also be stigmatised amongst lesbians and wsw because of its association with sexual practices involving males.

In addition, gender-based violence is often directed at lesbian women in South Africa because of their sexualities. This violence includes harassment, physical assault, rape and murder. Sexual violence appears to occupy a central space in the attacks directed against lesbian, gay and transgendered persons in South Africa (Reid & Dirsuweit, 2002). No specific research has been done on the relationship between lesbian rape and HIV infection, but Dunkle et al. (2004b) showed a strong correlation between sexual violence and HIV infection. Research and media reports suggest that black lesbians, particularly in townships, are increasingly targeted for rape because they are seen as transgressing patriarchal gender norms which prescribe what a woman should look like and how a woman should behave (Mufweba, 2003; Nel & Judge, 2008; Polders & Wells, 2004; Reid & Dirsuweit, 2002; Smith, 2004). The term 'corrective rape'[2] is commonly used in South Africa to refer to rape that is justified by the claim that rape 'corrects' or 'cures' a lesbian by turning her into a 'real (heterosexual) woman'. Moreover, in a country that has one of the highest rates of rape generally, wsw are vulnerable to rape and HIV-infection simply by virtue of being women. Using sexual violence to police dominant gender and sexuality norms is an obvious illustration of the ways in which gender and sexuality power dynamics compromise the sexual and reproductive health and rights of wsw and heightens their vulnerability to HIV and STIs.

Heterosexism and sexual prejudice also manifest in health care settings where the ignorance or hostility of health providers hinders access to sexual health and HIV-related prevention, care and treatment. Wsw are not a homogeneous grouping. Other axes of power based on racial and economic realities intersect with sexuality and gender inequalities. Wsw living in under-resourced settings are likely to experience very particular forms of marginalisation that hinder access to health care and increase exposure to risk factors (such as sexual violence and

2. The term 'corrective rape' has become popularised by the media and in some anti-violence campaigning. It has become a central element in the sensationalist depiction of violence against lesbians in South Africa and has disturbing political implications of reproducing the myth. Triangle Project is therefore opposed to the uncritical use of the term.

transactional sex) associated with HIV and STIs. Other risk factors for wsw include the effects of alcohol and drug use.

Wsw Risk and (In)Visibility

How does one make visible risk to HIV infections in female to female sexual practices when they have been doubly erased through discourses of heterosexism and phallocentrism? Though clinical research shows that any behaviours where blood or bodily fluids are exchanged are theoretically risky for HIV transmission, this knowledge has been condensed into risk being associated predominantly with penile penetration and prevention with condom use.

The predominance of heterosexist assumptions about HIV and AIDS in Africa has led to the exclusion of wsw practices in risk assessments. South Africa has one of the highest rape rates in the world, and compounded by homophobia has led to lesbians and wsw being specifically targeted for sexual violence that is mistakenly labelled 'corrective' rape, with the consequent risks of HIV infection.

Since wsw encompass a range of groupings of varying social locations, these differences as well as other risk behaviours such as alcohol and drug use need to be factored into understanding vulnerability. Moreover, the belief by lesbians themselves that they are not at risk of HIV infection may persuade them that they need not take precautions.

Furthermore, discrimination and homophobia by service providers in health care settings means that lesbians and wsw experience specific forms of marginalisation which prevent them from accessing appropriate sexual health care and HIV prevention and treatment, which is their right.

Therefore risk and vulnerability to wsw is complex, and complicated by discourses of heteronormativity and phallocentrism which exclude wsw and lead to beliefs by researchers, activists and wsw alike that they are not at risk.

In the next chapter we describe the methodologies used and introduce the participants and their localities.

CHAPTER THREE

Methodology

In this chapter we provide an overview of the aims of the study and introduce and situate the participants.

Objectives of the Study

1. To explore the sexual and reproductive health of wsw in general.
2. To describe the sexual practices that wsw engage in, in relation to risk around HIV infection and STIs.
3. To gather information around the social and economic factors that contribute to the vulnerability of wsw and lesbian and bisexual women to HIV infection and STIs.
4. To document perceptions, and the accessibility, as well as availability, of health-related services specific to the sexual health needs of wsw.

Study Locations

Rural communities, almost by definition, are relatively resource poor compared to their urban counterparts. The majority of women living in rural areas and peri-urban centres in the Western Cape rely on seasonal work on farms or in canning factories to sustain themselves. This in turn means that 'out of season' they rely on male relatives to provide for their basic needs. This dependence on men increases the vulnerability of women and limits their choices around sexual health and places women at particular risk.

For the purposes of this study we have selected the Cape Winelands and West Coast regions because of their rural characteristics. There is little consensus on what constitutes a rural area. In this study, the focus is on areas that are characterised by:

- Inadequate access to health and other services;
- The predominance of land-based livelihoods.

Based on consultations with Triangle Projects' Community Engagement and Empowerment Programme (CEEP), the following four sites based in the areas within which CEEP is active were selected:

BOX 1. DATA COLLECTION SITES

Town/Township	Local Municipality	District Municipality
Mbekweni (Paarl)	Drakenstein	Cape Winelands
Kayamandi (Stellenbosch)	Stellenbosch	Cape Winelands
Touwsrivier	Breede Valley	Cape Winelands
Vredendal	Matzikama	West Coast

MAP

WESTERN CAPE

SOURCE: Wikipedia, http://en.wikipedia.org/wiki/File:Road_map_of_the_Western_Cape_with_towns.svg

The Cape Winelands district is known particularly for its viticulture; its cellars are well-known for the export quality wines it produces, and the resultant wealth of

the farm owners in the region. It is the largest wine-producing region in South Africa (Western Cape Provincial Treasury, 2010). However within this social context of 'rich' and 'poor', farm workers have continued to lead lives locked in cycles of poverty, dependent both socially and economically on their employers. Most farm workers who live on farms have no access to public transport, limiting their access to health care (Human Rights Watch, 2011). According to the *Community Survey of 2007* conducted by Statistics South Africa, the unemployment rate by gender is as follows: male, 14.0 per cent vs. female, 18.6 per cent (Western Cape Provincial Treasury, 2010).

Mbekweni and Kayamandi are two townships near the two prosperous semi-rural towns of Paarl and Stellenbosch respectively. Mbekweni is a black township established during apartheid to house the workers for Paarl, and which now has a population of between 30 000-40 000 Xhosa-speaking people, with most people being under 18 years, and many people living in informal housing.

Kayamandi lies on the doorstep to Stellenbosch as you enter the town from the North. It was established as a 'non-white location' for mostly Xhosa-speaking migrant labourers in the early 1940s. Currently it has a population of around 33 000 people or more, most of whom live in informal dwellings without suitable infrastructure such as electricity, sanitation and water.

The rural town of Touwsrivier was developed around a railway depot in the late 19th Century. It is the doorway to the Great Karoo, and lies on the main N1 highway between Cape Town and Johannesburg. Most of its population is coloured Afrikaans-speaking people (StatsSA, 2001). Nearly 40% are under the age of 18.

People in the West Coast region of the Western Cape have been engaged in various marine resource use activities for many generations. In this region there are low levels of education and high levels of unemployment, a lack of access to formal employment opportunities, and few opportunities for locals in the formal fishing industry. Poverty is prevalent in many households. The region in general and the settlements in particular, have low levels of basic infrastructure and bulk services (Cardoso, Fidding & Sowman, 2006).

Vredendal is a rural town on the West Coast lying in the Olifants River valley in the transition zone between the West Coast and Namaqualand climates. It has a population of around 14 000 of predominantly coloured people, and lies towards the coast off the main N7 freeway to Namaqualand.

Introducing the Participants

This study purposively sampled wsw who are 18 years and older from primarily Afrikaans— and Xhosa-speaking communities in the Cape Winelands and the West Coast areas of the Western Cape province of South Africa.

Wsw describes women who participate in sexual practices with other women. These sexual practices may, or may not, be related to sexual orientation – wsw may identify as lesbian, bisexual, or heterosexual. Wsw may have sex with women as a matter of preference, or because of circumstances (e.g. migrant workers living in all-women hostels, homeless youth). Wsw may be 'out', but are often 'closeted' (secretive) about their sexual behaviour or sexual identities. Wsw may, or may not, also have sex with men. For the purpose of this project, wsw referred to all participants who identified as biological females at the time of the study, and who engaged in same-sex practices.

We have found the concept wsw useful for sampling, insofar as it enabled us to avoid restricting the study only to wsw who identify as lesbian or bisexual, nor did we make presumptions about the self-identifications of wsw who participated in this study. However we did not use the term 'wsw' in isolation, but alongside explorations of sexual and gender identities. Our criteria for inclusion in the study was a matter of ongoing discussion and debate. As the research progressed, it was decided by the research team that six women who identified as lesbian, but who had not yet 'had sex' with another woman, were also eligible to participate in the study. Though this may seem anomalous, but points to the problems of heterosexist and phallocentric conceptions of what 'having sex' means. But semantic arguments do not put the women beyond risk and vulnerability of HIV and STI infections, thus we conceded that either same-sex behaviour or same-sex identity could serve as a basis for inclusion in this study. Inclusion on the basis of sexual identity is based on the understanding that self-identified lesbians who have not 'had sex' with another woman, may nevertheless face other vulnerabilities related to their sexual identity or gender expression (e.g. rape), or other social and economic factors (e.g. transactional sex with men).

Sampling was also determined by convenience since the study was conducted in the locations of Triangle Project's ongoing CEEP. The context of this community-based work is around the sexual and reproductive health and rights of lesbian and bisexual women living in the selected Cape Winelands and the West Coast areas. While Triangle Project works with lesbian, bisexual and wsw generally, the organisation has a specific mandate to extend our programmes and services to lesbian and bisexual women who, as a result of an intersection of social inequalities (based on sexuality, race, socio-economic circumstances, nationality

and geographic location), do not have adequate access to resources and services. Hence, the focus of this study is on women located in rural and peri-urban areas who have limited access to resources and services. Based on the profile of the women who are part of Triangle Project's community programmes, it was possible to predict that participants in this study would most likely be 'indigenous African', or more specifically 'AmaXhosa' and 'coloured' wsw who self-identify as lesbian or bisexual. However, there was no conscious attempt to exclude or include women whose sexual orientation or racial and ethnic identities differed from our expectations.

Data Collection

Four focus group discussions (FGDs) and a survey of wsw in four peri-urban areas in the Cape Winelands and West Coast region of the Western Cape province of South Africa was conducted. We collected information on the social, cultural and economic factors that impact on STIs and HIV risks and the choices of wsw around risky and safer sex practices. For both data collection methods, convenience and purposive sampling was used to recruit wsw into the study using the existing networks and relationships of CEEP. Four fieldworkers were trained during a two-day workshop on the administration of the survey questionnaire, group facilitation skills and the basic principles of ethical research.

Survey

At each of the four study locations, participants were recruited and asked to complete a self-administered questionnaire consisting of the following twelve sections:

BOX 2. SECTIONS OF THE SURVEY QUESTIONNAIRE

Section 1	Demographic Information
Section 2	Sexual orientation and gender
Section 3	Sexual partners and relationships
Section 4	HIV and STI prevention
Section 5	HIV and AIDS awareness
Section 6	Sexual health
Section 7	Sex, money and favours
Section 8	Alcohol use
Section 9	Use of other substances
Section 10	Experiences of violence with women

Section 11	Experiences of violence with men
Section 12	Perceptions of risk

Focus Group Discussions

A total of four FGDs were conducted in each of the four study locations. An interview guide was used to explore the following: challenges faced by wsw; issues of gender identity (i.e. what does it mean to be a woman who loves another woman); sexual behaviours and practices; the use of preventive measures for HIV and STIs and the accessibility and availability of health care services and wsw's experiences of them. The duration of the FGDs was approximately one hour. FGDs were conducted in the participants' language of choice.

Data Handling and Analysis

The FGDs were audio-recorded, transcribed verbatim, translated where necessary, and thematic analysis was used to analyse and interpret the data. Descriptive statistics were used to analyse the demographic, health and behaviour characteristics of the sample. Data analysis of the survey data was conducted using the Statistical Package for the Social Sciences (SPSS) Version 17.0.

Our approach to reporting the results was to integrate the quantitative findings with parallel issues raised in the qualitative FGDs.

Ethical Considerations

The study received ethics approval from the Human Sciences Research Council (HSRC) Research Ethics Committee (REC). Standard procedures of informed consent were followed for both the survey administration and the FGDs. Participants were asked to sign consent forms prior to participating in the survey and in FGDs. Participants had the option of participating in either the survey or the focus group (FG), or both. The voluntary nature of participation was emphasised and potential participants were assured that non-participation or withdrawal from the study at any point would in no way affect their access to Triangle Project's programmes or services. All participants were given the name and telephone number of the project coordinator, the HSRC's Ethics Hotline as well as Triangle Project's Counselling Helpline.

Participants were informed of potentially sensitive questions beforehand and were told that they could skip questions that they did not feel comfortable in answering. Fieldworkers were trained to debrief participants after the FGDs and

survey administration and make referrals if necessary. All participants were made aware of the following support services: counselling through Triangle Project's helpline and face-to-face counselling and health services provided by Triangle Project. All participants were given an information sheet about the study, the FGDs and the survey. The information sheets were available in isiXhosa, Afrikaans and English.

Participants were informed about how the information gathered would be used and were assured that names or personal identifiers would not be recorded on questionnaires or in any reports, presentations and publications arising from the study. Focus groups were preceded by discussions regarding confidentiality and respect for privacy. Both the participants and the facilitator were required to make explicit commitments around confidentiality and respecting the privacy of all group members.

Methodological Considerations and Study Limitations

Results of this study should be interpreted in light of the methodological limitations below.

Questionnaire development

The overall aim of the study guided the development of the survey questionnaire. Items included in the questionnaire reflected those of sex practices between women, HIV/AIDS and STI risk perceptions, stigma and discrimination experiences etc. (for more information see Box 2). In addition we also incorporated items on experiences of violence with men and women. These items were used in a previous study funded by the Open Society Initiative for Southern Africa (OSISA), 2010-2011.

Language

The survey questionnaire was originally developed in English and then translated into isiXhosa and Afrikaans. IsiXhosa and Afrikaans are the two predominant languages spoken in the four communities where the study was conducted. Ensuring that participants were able to complete the questionnaire in their home languages, had, in our view, important implications for both the ethics and validity of the study. During administration of the survey, first language Afrikaans speakers from Touwsrivier and Vredendal primarily completed the Afrikaans version of the questionnaire, while the opposite was true for isiXhosa-speakers. The majority of the participants in Kayamandi and Mbekweni completed the English version of the questionnaire.

For young isiXhosa-speakers, there seemed to be a disjuncture between written and spoken isiXhosa, which appears to be based on the dominance of English within South African schools. Even though spoken isiXhosa may be used by educators for instruction, all written work is done in English (with the exception of Xhosa as a subject). What this may mean for young isiXhosa speakers is that there is no written first language. In light of this, a self-administered questionnaire may not have been the most suitable research instrument. It is difficult to say whether and how this may have impacted on the way isiXhosa speakers completed the questionnaire. It was noted that the initial English version questionnaires filled in by isiXhosa came back incomplete and with many gaps. This may of course be due to a variety of other factors. Nevertheless, to counter this, fieldworkers took a more active role in explaining questions to participants as they worked through the various sections of the questionnaire.

Generalisability

The sample was small and though we were able to draw some conclusions from the main study findings, their generalisability is only very tentative. Purposive and convenience sampling of wsw was limited to the four recruitment areas and based on Triangle Project's existing work and networks within these areas. Hence the method of sampling led to the selective inclusion of wsw and the findings cannot be seen as representative of all wsw living in these four areas.

Other characteristics related to age and race also limit the generalisability of the findings. The study sample is young and the majority of the participants described themselves as "black African". The majority of the FGD participants were proudly lesbian and out to most of their family members. They might differ in important aspects to those who are not open about their sexual orientation. The majority of participants identified themselves as lesbian or bisexual, two as heterosexual and one person did not identify as any of the above. We believe that this study is one of the first to explore the lives of wsw in rural and peri-urban areas.

The study also relied on self-reported information and the sample size was small. The quantitative results apply only to the people who took part in the survey and not those who took part in the FGDs. Though the quantitative data did not yield enough information for multivariate analyses, they have yielded much useful descriptive information. In particular, the findings provide a fairly good indication of the profile and sexual health needs of the women who are currently participating in Triangle Project's community-based programmes in these four

locations. The information also identifies other research areas that could be explored further in other more in-depth studies and larger behavioural surveys.

Researching sexual practices

Fieldworkers who administered the survey and who facilitated the FGDs were known to most of the participants through Triangle Project's existing work in these areas. In the case of Mbekweni, fieldworkers involved in administering questionnaires and facilitating the focus groups lived in the area and knew many of the participants as friends. Consequently, underreporting on sensitive topics, such as sexual behaviours, drug use, HIV status and experiences of sexual violence might have occurred. On the other hand, pre-existing trust relationships could have contributed towards disclosure of information on sensitive issues.

However, researching the specificities of sexual practices is not without difficulties. Sexual practices are generally viewed as belonging to the private sphere, which raises the question of whether some participants experienced the survey questionnaires as invasive. Given the sensitive and private nature of the topic also raises concerns about the reliability of information from respondents (Heilborn & Cabral, 2006b).

Moreover, sexual practices have a social life.

> To conceptualise sexual practices is a complex task, since the body techniques amenable to classification as sex acts are the object of social and historical definitions and thus vary according to the cultural context (Heilborn & Cabral, 2006a: 1472).

In spite of the almost clinical sounding list of physical acts listed in the survey, it is impossible to bypass the social and cultural meanings that vary over time and from place to place.

Reflexivity

The partnership between Triangle Project and HSRC proved problematic when the report was being written, as the parties had different expectations about their roles and responsibilities. A consultant was called in to help complete the report.

In retrospect, the questionnaire focused in detail on issues that did not pertain to the sample participants, possibly making the questionnaire too long. This would have been remedied if the questionnaire had been designed after the qualitative focus group discussions which would have provided a conceptual framework for the development of the questionnaire.

Secondly, the sample was extremely small, and though valuable information was collected, multivariate analyses that would assist in identifying risk and vulnerability factors for wsw could not be done. However, since the research is situated in an organisation with presence in the communities surveyed, the information will be used to inform existing programmes and advocacy on the sexual health needs of wsw in those communities.

Due to space limitations, the report has focused more on the quantitative results, but information from the focus group discussions can be used to refine the research design and point to how the research could be replicated in other areas.

In the next chapter we explore the findings from the study.

CHAPTER FOUR

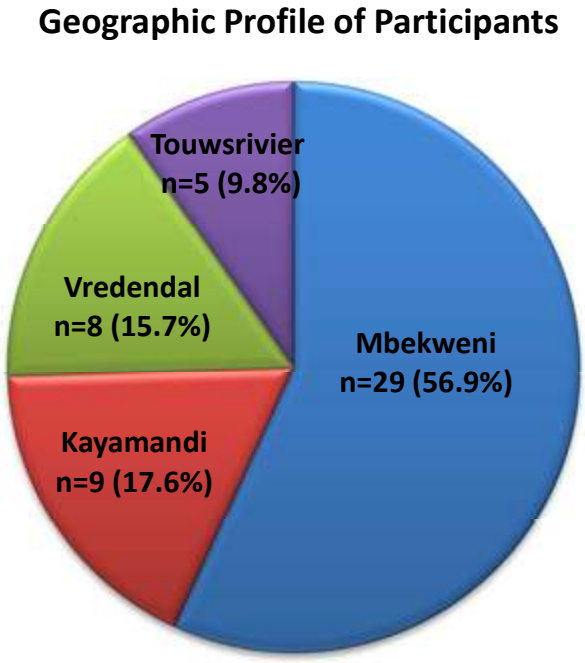
Results and Discussion

In this chapter we discuss the findings from the study. First we provide a demographic profile of the women, before we discuss their gender identifications. We look at the dynamics in their relationships, and how they experience their sexualities. We then present their experiences, perceptions and knowledge of HIV and AIDS, and link these to other forms of vulnerability such as violence.

Demographic Profile

In total 51 women participated in the survey study. Survey participants were sampled from Mbekweni (n=29); Kayamandi (n=9); Vredendal (n=8) and Touwsrivier (n=5). They were recruited from these four areas because of the ties and social networks that had been established through previous work with Triangle Project. In areas such as Mbekweni where Triangle Project has an established presence, recruitment was found to be easier. In areas such as Touwsrivier where ties and social networks with were not so well-established, recruitment proved to be challenging. This is reflected in the much larger sample of participants from Mbekweni (n=29) as opposed to the number of survey participants from Touwsrivier (n=5). Therefore more than half the participants were from Mbekweni (57 per cent), and consequently 74.5 per cent were black African, because almost 20 years after democratisation geographic locations largely still correspond to apartheid racial divisions.

FIGURE 1. GEOGRAPHIC PROFILE OF PARTICIPANTS



The total sample size for the focus group discussions (FGDs) was somewhat smaller. In total 34 women from the four research sites participated in the FGDs. In Vredendal and Kayamandi, the sample for the survey and the FGDs were identical. In Touwsrivier, participants who completed the self-administered survey chose not to participate in the FGD and other participants had to be recruited from this area. In Mbekweni, the FGD participants consisted of a smaller sample (n=12) of the survey participants (n=29). Table 1 outlines the number of women who participated in the survey and the focus group discussion in the four study areas.

TABLE 1. SAMPLE SIZE FOR SURVEY AND FOCUS GROUPS IN FOUR STUDY AREAS

Study area	Survey	FGD
Mbekweni	29	13
Kayamandi	9	9
Vredendal	8	8
Touwsrivier	5	4
Number of participants	**51**	**34**

Describing the participants

The majority of women (70.6%) were under the age of 25 years. Participants' ages ranged from 18 to 37 years, with a median age of 22 years and a mean age of 23 years. Hence the study sample was young and results cannot be generalised to older wsw living in the four study areas.

Almost 75 per cent of the women described themselves as "black African", whilst a quarter described themselves as "coloured" (mixed race). The distribution of race in terms of geographical location still reflects apartheid racially classified segregation. In this study, participants who described themselves as "black African" resided in areas previously classified as the 'black townships' of Stellenbosch and Paarl, i.e. Kayamandi and Mbekweni respectively. Participants who described themselves as "coloured" lived in Touwsrivier and Vredendal, rural towns.

Three women said they were married to a woman, while 82 per cent reported never having been married. None was currently married to a man. One was "divorced or separated from a man", but none was "divorced or separated from a woman". One said she was "widowed", though she did not specify the sex of her deceased partner. While only a small proportion of the participants reported same-sex marriages, it has only been legalised in South Africa since December 2006. Two of these were younger than 25 years old.

Nine women in the sample reported having children, only one of whom identified as "coloured". Six had only one child, with two having two children. Of the nine wsw who reported having children, six of the participants were under 30 years of age. Four of those with children live in a house which was owned, while two reported living in a house on a farm/smallholding, two lived in a Wendy house or bungalow on someone else's property, and two lived in a "shack". Seven of these women had never been married, one was divorced or separated from a man and the other was married to a woman. Four of the nine participants with children reported having a steady job. Four of the nine participants identified as lesbian (one of whom gender-identified as a man), while the remaining five identified as bisexual. Two of these had partners as dependents as well as their children, and two others had other family members also depending on them.

Fourteen women did not belong to a religious grouping, one did not answer the question, and thirty-six said they did belong to one. Three women said they were following traditional African religion, one said "other" and eleven did not answer the question. The rest (n=36) said they were Christian. Three who said they did not belong to a religious grouping nevertheless said they were Christian. Therefore 70.6 per cent of the participants identified as Christian.

Sixteen women said they had attended "higher education". However this could have been confused with "secondary education" as four of these had only completed Grade 12. Ten indicated diplomas, certificates or degrees as their highest qualification, while two had started but not completed their tertiary education. Out of 33 women who said they had attended "secondary school", seven women did not indicate what their highest level of education was. Only two women had been only to "primary school" – one did not indicate the highest level of education achieved, and the other one had attained Grade 5. Most of the women in the sample had achieved an education beyond Grade 8. Regrettably they were not asked if any of them were still at school or university at the time of the study.

Four participants did not complete the question regarding employment; 12 had steady jobs and 32 were unemployed. One each said she had occasional work, one did volunteer work and one did "other" work. Only half of those with tertiary education had steady jobs while 62.7 per cent of the women in the sample were "unemployed" at the time of the survey. However, one cannot assume the reasons for being unemployed – whether they were looking for work or were still studying. From answers to another question regarding same-sexualities at schools, universities or colleges, it could be inferred that 17 were not studying. Of these, six indicated that they had a steady job, and eight were unemployed. One did not complete the question on employment, one said "other" and the other one had occasional work. Over forty per cent of the study sample were dependent on the income of other family members.

Fifty one per cent are reported to be living in a house (owned). Since the study sample is young, it is likely that most of the participants are living with their parents or guardians. Forty seven per cent of the sample depended on the income of other family members. Table 2 summarises the main characteristics of the sample.

TABLE 2. MAIN DEMOGRAPHIC FEATURES OF PARTICIPANTS

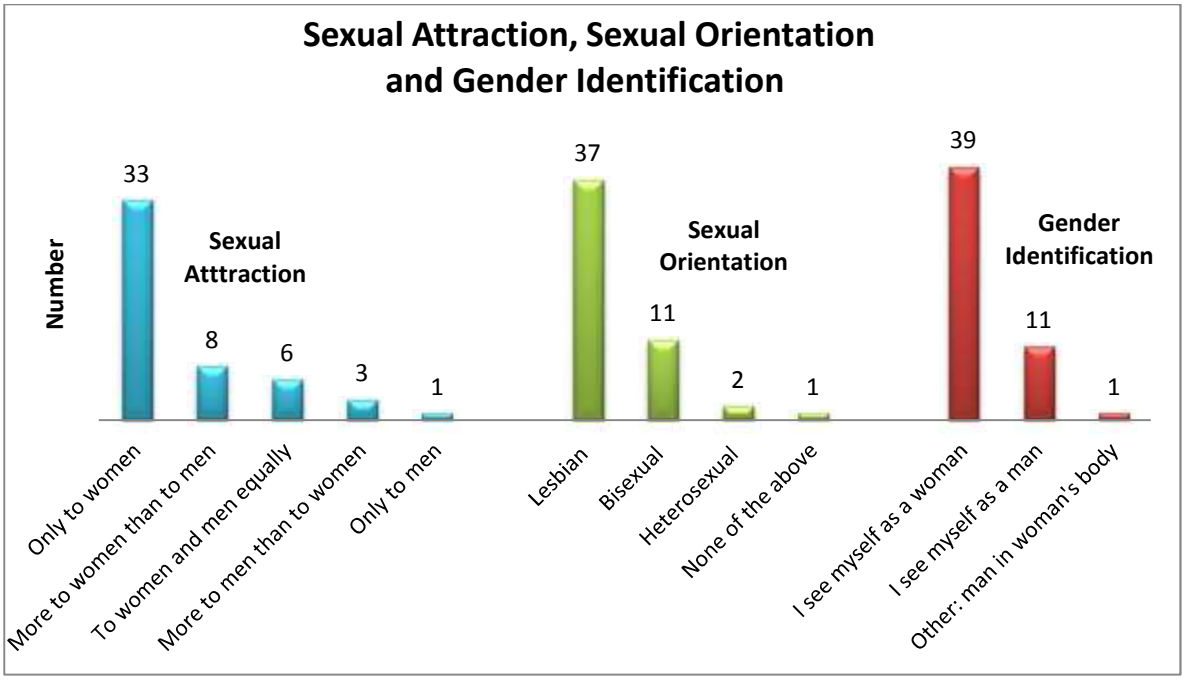
Demographic Features	Number	Per cent
Age		
Under 20	18	35.3%
20-24 years	18	35.3%
25-29	7	13.7%
30 years and older	7	13.7%
No response	1	2.0%

Demographic Features	Number	Per cent
Race		
Black African	38	74.5%
Coloured (mixed race)	12	23.5%
Marital status		
Never been married	42	82.4%
Married to a woman	3	5.9%
Others: including 1 divorced from man, 2 widowed, 1 blank, 2 "other"	6	11.8%
Children		
No	42	82.4%
Yes	9	17.6%
Education		
Secondary	37	72.5%
Tertiary	12	23.5%
Primary	2	3.9%
Employment status		
Unemployed	32	62.7%
Steady job	12	23.5%
Occasional work	1	2.0%
Voluntary work	1	2.0%
Other (including 4 blanks)	5	9.8%
Shelter		
In a house (owned)	26	51.0%
In a shack	9	17.6%
Other (including 1 blank)	5	9.8%
In a rented house	4	7.8%
In house on farm/smallholding	3	5.9%
Wendy house/bungalow	2	3.9%
In a flat/apartment	2	3.9%
Sources of income		
Other family member's income	23	45.0%
Own income	15	29.4%
Partner's income	6	11.8%
Other	3	5.9%
Government grant	2	3.9%
Friends helping out	2	3.9%

Same-Sex Sexualities and Gender Identity

In this study we use the term 'women who have sex with women' to explore the vulnerabilities of wsw to the risk of HIV infection and STIs; the use of the term does not imply a particular identity such as lesbian or bisexual (or gay). Those wsw who do not identify as lesbian or bisexual could indicate a lack of identification with sexuality-based marginalised grouping. This could mean an absence of community, networks, and relationships in which same-sex pairings mean more than merely sexual behaviour (Young & Meyer, 2005). On the other hand, identities are complex and layered, and different aspects of one's identity may be foregrounded at different times (Van Zyl, 2011b) precisely to gain acceptance in communities. This study is based on the epistemological assumption that sexual behaviour, vulnerabilities to HIV infection and STIs, and choices related to risky and safer sex, do not exist in a vacuum beyond social, political and cultural influences and contexts. Moreover, knowledge and understanding of the sexual identities and gender expressions of wsw within South African contexts is essential for developing appropriate public health prevention initiatives.

FIGURE 2. GENDER AND SEXUALITY



The majority (72.5%; n=37) of the 51 participants self-identified as "lesbian"; 23.5 per cent (n=12) described their sexual orientation as "bisexual" and 3.9 per cent

(n=2) as "heterosexual". Two per cent (n=1) did not identify as lesbian, bisexual or heterosexual.

In terms of gender identification, almost 76.4 per cent (n=39) reported that "I see myself as a woman"; 21.6 per cent (n=11) of them indicated that "I see myself as a man", and one participant was careful to explain her/his gender identity as follows – "I see myself as a man in a woman's body". Though only one participant claimed not to be born female, it was not the above participant. This highlights the fluidity of even an apparently fixed category such as sex, as well as the fluidity of gender.

We also explored sexual attraction: of the 51 wsw, 64.7 per cent (n=33) reported being sexually attracted "only to women"; 15.7 per cent (n=8) reported sexual attraction "more to women than to men"; 11.8 per cent (n=6) reported sexual attraction to "women and men equally"; 5.9 per cent (n=3) reported sexual attraction "more to men than to women"; two per cent (n=1) reported sexual attraction "only to men".

Most participants in this study described themselves as lesbian. Of the 37 who described themselves as lesbian – the majority (n=32) reported feeling sexually attracted only to women, whilst 4 were sexually attracted more to women than to men. Two thirds (n=24) see their gender identities as being "a woman", whilst just below a third (n=11) of the wsw who described themselves as lesbian reported that they see themselves as "a man". (See Table 3 below).

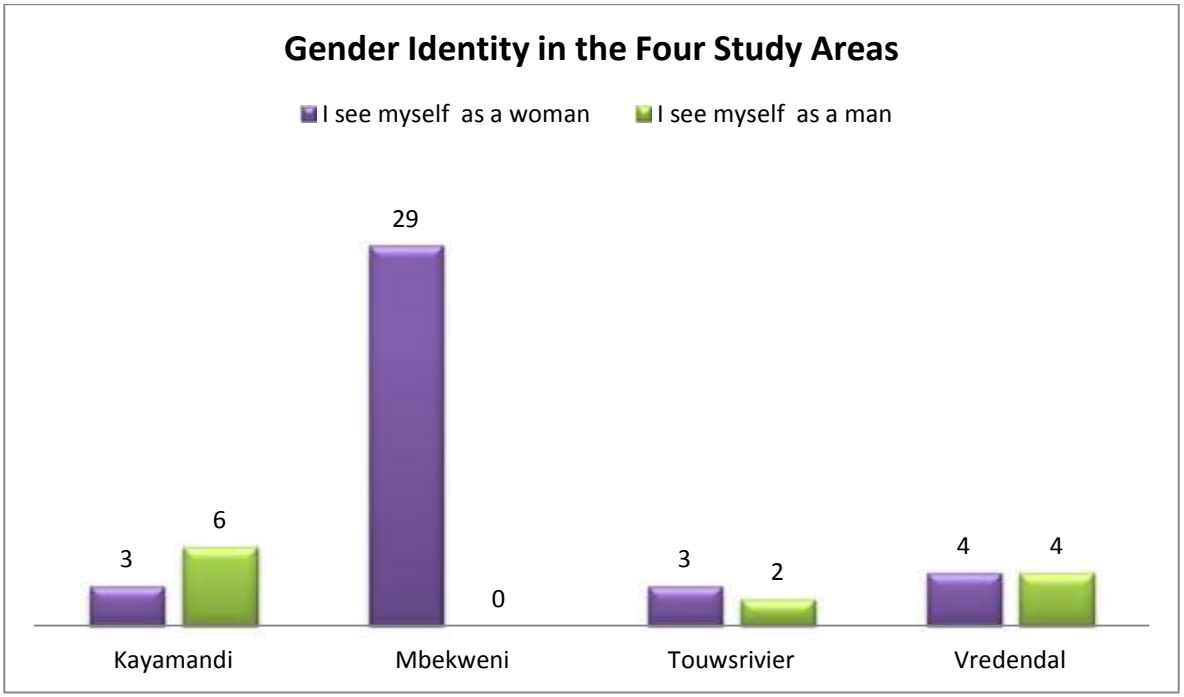
TABLE 3. PARTICIPANTS WHO IDENTIFY AS LESBIAN (N=37)

Characteristic	Number	Per cent
Sexual Attraction		
Only to women	32	86.4%
More to women than to men	4	10.8%
To women and men equally	1	2.7%
Gender description		
I see myself as a woman	25	67.6%
I see myself as a man	11	29.7%
I see myself as a man in a woman's body	1	2.7%

Overall, almost a quarter (23.5%) of the total sample, or almost a third (32.4%) of the participants who identified as lesbian reported that they identified as 'men'. Four came from Vredendal, two from Touwsrivier, six from Kayamandi and none

from Mbekweni. Half (n=6) of the 12 participants[3] who saw themselves as men were from Kayamandi. Thus the majority (6 out of 9) of participants from Kayamandi, and half the participants (4 out of 8) from Vredendal reported that they identified as men. None of the Mbekweni study participants saw themselves as men, but 2 out of 5 in Touwsrivier identified as men.

FIGURE 3. GEOGRAPHIC AREA AND GENDER IDENTIFICATION



Of course the over-simplified way in which this is expressed (i.e. I see myself as a man) is largely a construction of the way questions and responses are framed in the survey questionnaire. The fact that none of the Mbekweni sample reported that they saw themselves as men, does not mean that none of these participants expressed their gender as masculine. It simply indicates that the term, 'man' did not fit the way in which participants understood their gender roles or expressions. The focus group data indicate that Mbekweni participants more commonly use the terms 'butch'/'gati' and 'femme'/'letti'.

Gender identification

Overall the survey responses say virtually nothing about how masculine identities are constructed and performed by participants. It is tempting to conclude that the adoption of masculine identities by lesbians reflect the extent to which heteronormative gender roles are internalised and lived out within lesbian

3. This number includes the 11 participants who identified as men as well as the one participant in Vredendal who identified as a man in a woman's body.

relationships. Such a conclusion would be supported by the fact that for both heterosexual and same-sex relationships, heteronormativity remains the dominant model for intimate relationships. However, such blanket conclusions should not be made without a more in-depth and qualitative exploration of how masculinities are constructed and lived out in specific contexts. The overweening dominance of the binary gender classification may also mean that participants see these as the only available gender identifications in 'formal' language. Terms for interstitial positions may be invented as part of everyday spoken languages of in-groups (see Cage, 2003), but they may not have wider currency. For example, whilst terms such as 'lesbian' and 'bisexual' are familiar to the participants, the term 'transgender' was never used.

In various African and Asian countries (including South Africa, Namibia, Uganda, Thailand, Taiwan, Hong Kong and Indonesia) self-styled butch-femme[4] communities exist (Wieringa, 2008). 'Butch' partners may, however demonstrate varying degrees of masculinity. Some may reject femininity entirely, describing themselves as men caught in women's bodies. In such instances, Wieringa suggests, the term 'female-bodied' is more fitting than the term 'woman'. Regardless of how stereotyped outward gender appearances may be, the research conducted with butch-femme communities also indicates far more complexity in gendered subjectivities (Wieringa, 2008).

The qualitative data provide further insights into participants' understandings of gender norms and power relations in both heterosexual and lesbian relationships, but also raise questions which were not sufficiently addressed in this study. While it is evident that butch/femme gender roles and relationships exist in all four of the study areas, there was no further exploration regarding how pervasive butch/femme relational patterns are amongst participants, nor the extent to which relationships outside this gender binary are experienced.

In the Vredendal and Touwsrivier FGDs, participants expressed masculine identities in terms of seeing oneself as a man or feeling like a man. Participants also described masculine identities in ways that constructed a disjuncture between their internal masculinity and their physical female bodies.

> Participant 1: *I accept that we are all women, but … how can I explain this … we women are women with a different manner, we just live differently*.
>
> Participant 2: *I have the body of a woman, but the thoughts or mind of a man*.

4. Wieringa (2008: 8) uses the term 'butch/femme'as a general term "indicating a couple of two female-bodied persons in which the butch partner assumes the social role of a male and the femme partner the (social) role of a female".

Participant 1: *Yes, yes, that is what it is.*

Vredendal

Participant: *So the psychologist told me that I am a man trapped inside a woman's body, my manners everything … Look here, many times I feel, if I can be honest, then I feel uncomfortable with my body. Nobody would understand … I wish I could change into a man, but it is too expensive. I'm not shy, and I'm not saying this softly, I'm saying it out loud*.

Touwsrivier

Whereas participants in Vredendal and Touwsrivier spoke about gender roles using the terms, 'man' and 'woman', participants in Kayamandi and Mbekweni used the terms like 'butch' and 'femme' or 'gati' and 'leti' ('gati' and 'leti' are colloquial terms with similar meaning to the terms butch and femme).

During the Vredendal FGD, some participants argued strongly for traditional gender binaries within lesbian relationships. In fact, some asserted that there had to be one partner within the relationship who would take on a more masculine role, as opposed to a 'softer' feminine role. This was contextualised as being necessary to protect the more feminine partner from harassment by heterosexual men.

Participant 1: *I would say that if a girl is playing the softer role, then she won't be demanding, she shouldn't be demanding* [laughing].

Facilitator: *And then sometimes in relationships, is there one person who plays a more manly role, and the other one who plays a more female role?*

Participants 1, 2, 3: [simultaneously] *… it must be like that…*

Participant 2: *Even though we both are [women], there must be one who can stand up for both of you.*

Participant 3: *Yes, what I want to say is, should you be walking down the street and a man wants to mess with her, then you must stand up for her. I am not going to leave it like that,* [all the participants nod their heads in agreement] *I am going to stand up for her. I won't withdraw.*

Vredendal

In Kayamandi, being butch was associated with being in control.

You see – I'm butch, or I am a tomboy. We like to be in control.

Kayamandi

More in-depth discussions about gender roles were found in FGD participants' comparisons between lesbian relationships and heterosexual relationships, and in descriptions of gender roles performed during sex. It is important to note that the question on the differences and similarities between lesbian relationships and heterosexual relationships immediately led to discussions of: power and domination; abuse and violence; and fidelity. This of course highlights the extent to which gender power characterises and is at the centre of everyday understandings of heterosexuality.

Bisexuality

The survey data revealed that 11 wsw described their sexual orientation as bisexual. Even though Triangle Project is defined as an lgbti organisation, with the 'b' referring to bisexual, bisexuality as a self-asserted identity has remained largely invisible in the organisation's work with wsw in the Western Cape. It is not uncommon to hear bisexuality spoken about disparagingly within lesbian circles. For example, bisexual women are viewed as sitting on the fence, as wanting 'the best of both worlds' or as 'virus carriers' who bring HIV into lesbian communities (WCNOVAW, 2009).

In the survey data, 11 participants identified as bisexual: 1 from Kayamandi, 1 from Vredendal and 9 from Mbekweni. Therefore there were proportionately two and half times as many bisexually identified wsw in Mbekweni than in the other areas. The profile of FGD participants however, looked somewhat different in terms of same-sex identification. Of the 34 women who participated in the FGDs, only 4 identified as bisexual, which is proportionately similar to the survey participants in Vredendal (1:8) and Kayamandi (1:9). However, since these numbers are extremely small they cannot indicate any general trends.

During the FGDs, only one participant in Vredendal spoke openly about her attraction to both women and men, and even then she presented it as a problem and spoke about it with anxiety. It should be noted that in the context of the FGD, this participant did not use the term 'bisexual' to define herself. Instead her anxiety seemed to stem from a need to define her sexuality in terms of the heterosexual-homosexual binary in which bisexuality is not seen as a 'legitimate' sexual identity. Thus, this participant presented herself as confused and her sexuality as somehow malformed.

> *I really don't know what I am, but I enjoy both … I don't know, sometimes I say to myself, when I am with a woman, then I feel angry … then I will ask myself, why can't I just be a man? Because you see, I know how to treat women, since I am a woman. It makes me really angry, this is the thing that*

> *really makes me confused … am I a lesbian or what? I have many questions that I ask myself … You know, to me, sex with men and women are just as pleasant, I don't know what it is with me, there is something inside me … that eats me from the inside. It is just one of those things about me … I am not ok with it … I don't know what it is with me* [looking at the floor shaking her head].
>
> Participant, Vredendal

In the Mbekweni FGD, bisexuality is spoken about in relation to the 'other' as opposed to the self.

> *Personally I don't like bisexuals because they are having the best of both worlds which puts us lesbians at risk with their boyfriends, and leave us heart-broken.*
>
> Participant, Mbekweni

Relationships

Overall, heterosexual relationships were viewed negatively and characterised by male domination, abuse and violence. On the other hand, some participants presented an idyllic picture of lesbian relationships. As is evident below, participants spoke about lesbian relationships in ways that distanced these relationships and themselves from the violence they associated with heterosexual relationships and normative masculinity.

> Participant 1: *It's not the same because dating guys has a lot of complications – more than dating girls.*
>
> Participant 2: *A woman would never beat another woman. It's very rare that you get abusive relationships with lesbians.*
>
> Mbekweni
>
> Participant 1: *When a man hits he hits, but we actually feel for each other.*
>
> Participant 2: *Yes, I agree, we as lesbians, we have respect for each other.*
>
> Participant 3: *Yes, men differ, but they are always violent.*
>
> Kayamandi
>
> Participant 1: *No. That's now one thing. I would never hit a woman. I was created as woman by God, not as a man. A woman is a gift from God.*

Participant 2: *That is one thing, she will never hit me.*

Touwsrivier

This idyllic picture however was challenged by contrasting depictions of lesbian relationships.

Participant 1: *For me I would say it depends on someone's personality, because I was in a relationship with this other girl, and in that relationship I felt like I was dating a guy because she never considered my feelings at all. It was either her way or the highway. So I don't think people should have the misconception that when you date a girl it's much easier. I would say regardless what kind of a relationship you are in, the personality gives a person the benefit of the doubt.*

Participant 2: *I've been in that situation before ... She used to beat me up! And so this thing of having differences between us, such as being Butch and Femme … give people powers to act in certain ways. Maybe if there weren't such things, it would be different, but they already exist … Because people become big-headed, and say that they are the man in the household which means they get to make the decisions.*

Participant 3: *It happened to me too, but the thing is my partner was Femme but she was acting Butch … It's like if she would call me and ask where I am for instance. I would be with my friend and she wanted to see me then and there. I would have to hurry up and go to her or else she will throw me with a brick.*

Mbekweni

Participant 1: *I am trying to understand what you are saying. Are you saying that in heterosexual relationships, the woman is beaten? Is that what you mean? But I want to disagree with that. Okay, yes. You can say that, because men have more power than women. But I have seen cases where there are two women, where they fight. I have seen a woman pick up a 'bottelkop' [broken top of bottle] and try to stab the other one – as much as men have done it … I have seen girls beating other girls … massive cuts here (showing head) losing eyesight, you see and so on. It happens. It is just that sometimes we do not see these things. It does happen.*

Kayamandi

For the FGD participants, heterosexual relationships were also characterised by male sexual entitlement, sexual coercion and infidelity. In addition, heterosexual men were depicted as lacking respect, care and consideration for their partners.

Participant 1: *Men have the assumption that they can always have sex with their previous girlfriends while they are in a relationship with someone else. With us lesbians it's totally the opposite.*

Participant 2: *Guys don't consider our feelings, whereas when you're dating a girl it's better because we think alike as emotional beings, which means you don't do what you would not like to be done to you.*

Participant 3: *Because you also don't want it to happen to you.*

Participant 4: *So you make sure you apologise if you did anything to hurt your partner.*

Participant 5: *A man would have five girlfriends besides you and you wouldn't know anything about it. This is what I have experienced. I don't know about others.*

Mbekweni

Participant 1: *We as lesbians we have respect for each other.*

Participant 2: *When it comes to us as lesbians, we do sit down and talk.*

Participant 3: *Men do not ask nicely [for sex], if at all.*

Participant 4: *In many relationships where there is a man and a woman, there is that belief that if a guy says something to a girl, that's it. The guy draws the line. When it comes to us as lesbians we do sit down and talk about issues and we try to understand each other. That's me, I discuss things, but most of the time when it is a guy he will say that's it – that is what I think is the difference between us and them.*

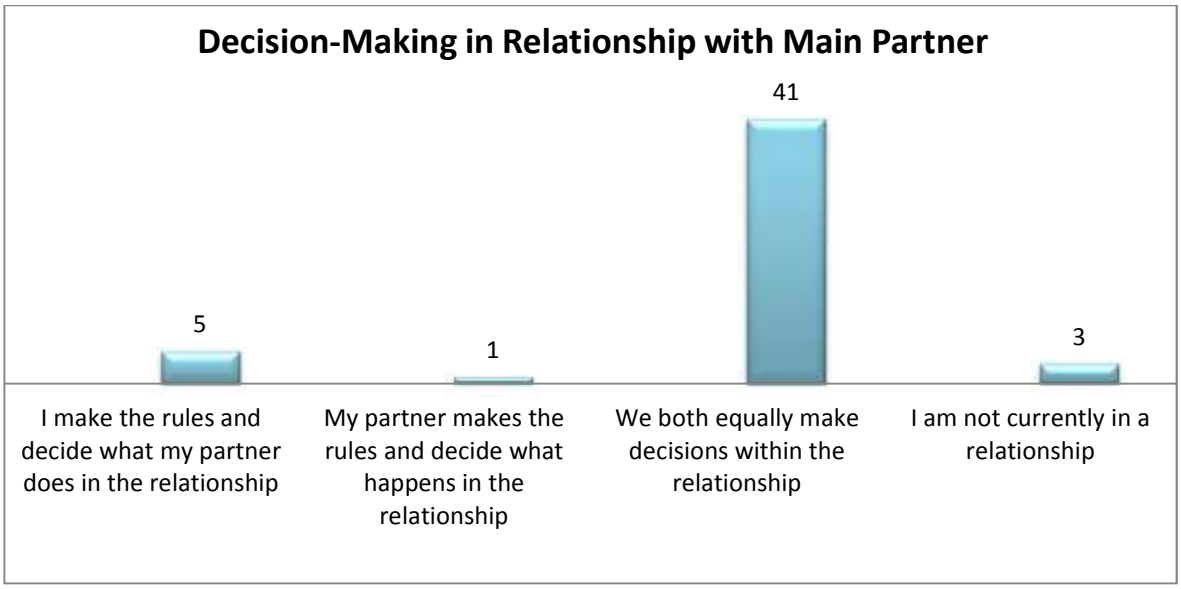
Kayamandi

Related to the issue of power dynamics in relationships, one of the survey items asked participants about the balance of power in decision making in their current relationships.[5] An overwhelming majority of participants (80.4%) reported that "we both equally make decisions within the relationship". It cannot be said with certainty what kinds of decisions are made by whom, and therefore whether the relationships are necessarily egalitarian. The participants that indicated that only one person makes the decisions all said they were single or not living together. Sharing decision-making could also be a bias reflecting choices perceived as

5. Forty of the 51 participants (78.4%) indicated that their current sex partner is female, while six reported to currently having both female and male sex partners. Three reported that their current partner is male. Two did answer the question.

socially desirable. Also, perception does not necessarily reflect reality. Bearing in mind the small sample size, the data do not allow for correlation between gender role and perceptions of the balance of power in decision-making. Only two of the five participants who reported being the decision-maker in their relationships, identified as men. Nine of the 12 participants who saw themselves as men, reported that decisions were made in an egalitarian way within their relationships.

FIGURE 4. DECISION-MAKING IN RELATIONSHIP WITH MAIN PARTNER



It has become widely accepted that gender inequality and the dominant norms associated with the masculine-feminine binary play a profound role in increasing women's vulnerability to HIV infection. These gender inequalities and norms inhibit women's ability to negotiate safer sex and expose women to sexual coercion and violence within intimate heterosexual partnerships (Dunkle et al., 2004b). Despite participants' idealisation of lesbian relationships, it is clear that the masculine-feminine binary and the gendered power imbalances do play out in lesbian relationships, though not necessarily in predictable ways. Indeed, some participants saw the masculine-feminine binary and its normalised power differentials as self-evident and even as a necessary features of lesbian relationships. Three participants reported that they had been forced into sex by another woman. Nevertheless, participants' efforts to distance themselves and lesbian relationships from the model of domination, abuse and violence that they associated with heterosexuality, at the very least conveys aspiration toward egalitarian relationships. Other researchers (Van Zyl, 2011; Riggle et al., 2008) have noted that egalitarian relationships are a positive aspect sought after and appreciated by lesbians in their relationships.

It appears that for this study sample, gender power relations and norms around decision-making play a much less significant role in vulnerability to HIV infection than it does in heterosexual relationships. Also, it is not possible to ascertain whether the extent to which traditional gender scripts and power differentials influence women's ability to negotiate safer sex in lesbian relationships. However, at this point in time, most wsw are not negotiating safer sex at all.

Overall, the fluidity of gender identities, the variability of gendered social roles and the consequent power dynamics in sexual relationships confirms the inescapable need for contextualising gendered identities before generalisations can meaningfully be made.

Belonging and Acceptance

In a study on same-sex marriage Van Zyl (2011b) argues that feelings of belonging are complex and shaped by self-identifications ('stories' people tell about themselves), social structures and institutions, location and political values. Wsw in this study have intersectional positions regarding race, place and gender identity. However, they all have the overarching human rights framework of the Constitution protecting them against discrimination – at least on paper. Moreover, belonging is not static, but shifts over time and place.

Participants were asked who in their immediate community were aware that they were attracted to women. Though one cannot necessarily infer that they had 'come out' to these people, one may assume that the taken-for-grantedness of heteronormativity would mean that the wsw had signalled implicitly or explicitly that they were 'different', and therefore were 'out'. Further, the fact that the participants knew that the other people knew, indicates that some communication had been exchanged about their same-sex attraction.

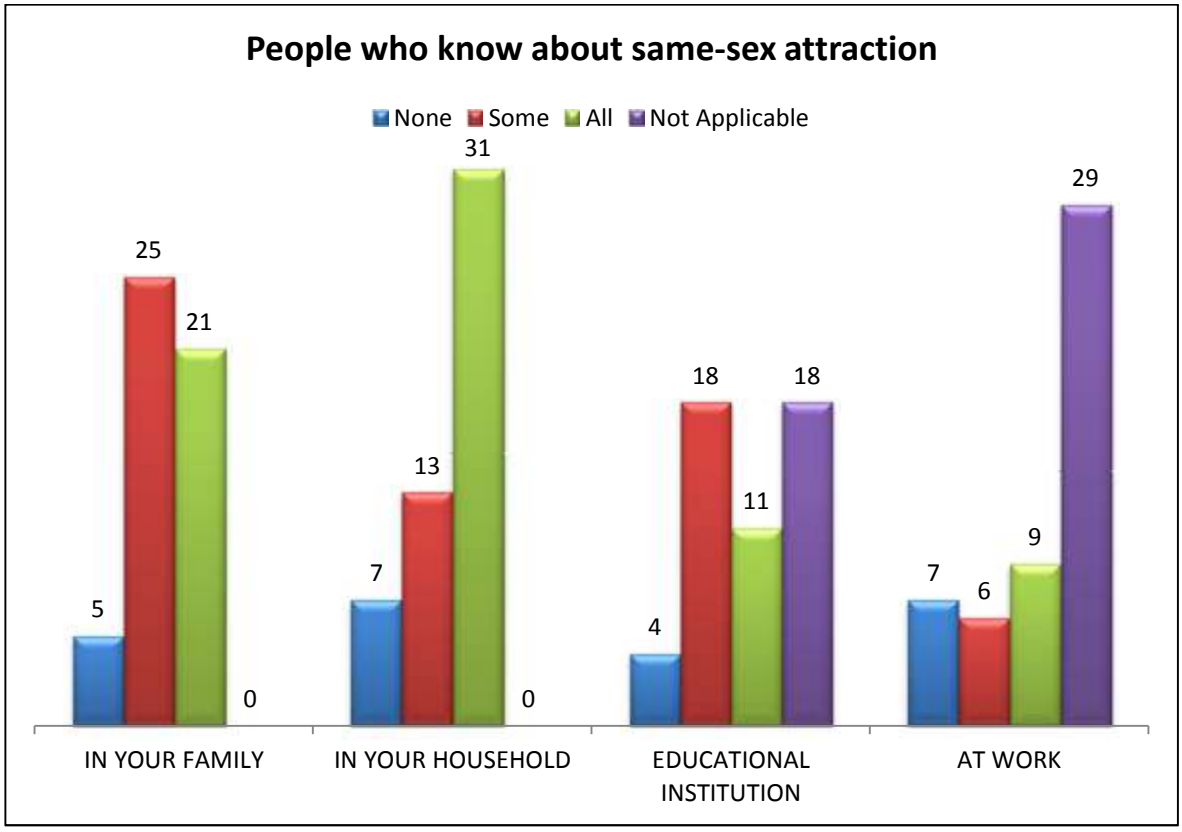
Who Knows?

The participants were asked how many people in their families, households, at school or at work knew they were attracted to persons of the same sex. Those who were not employed or not at an educational institution or who did not answer the question are both listed under 'not applicable'.

Families and households

Participants in the study were asked how many people in their families and in their everyday contexts knew about their same-sex attraction. “All” members of their family knew about their same-sex attraction for 41.2 per cent of the participants, while 49 per cent reported that “some” members of the family were aware of their same-sex attraction. Similarly, 60.8 per cent of the study sample indicated that “all” members of their household knew about their same-sex attraction, and 25.4 per cent said “some” knew. This meant that only around ten per cent of participants’ families and households did not know about their same-sex attraction. Of the five participants whose families did not know, only two identified as “lesbian”, two as “bisexual” and one as “heterosexual”. For those whose households did not know, there were three who identified as “lesbians”, three as “bisexuals” and one as “heterosexual”. The same participants who said no one in their families knew, also said that no one in their households knew about their sexual attraction to people of the same sex. The wsw whose families or households did not know came mostly from Mbekweni, with one from Kayamandi. This could indicate that there may be greater fear in being ‘out’ in the townships. It could also indicate that heteronormative behaviour can serve as a shield for same-sex identities. However, the figures are too low to make generalisations.

FIGURE 5. PEOPLE AWARE OF PARTICIPANTS’ SAME-SEX ATTRACTION



School and workplace

Of the 33 participants who indicated that they were attending school, college or university, 11 (33.3%) said that "all" people at their educational institution knew about their same-sex attraction, while 18 (54.5%) of them said "some" knew. Two lesbians and two bisexual women from Mbekweni said "none" knew.

Of the 22 participants who answered the question about the workplace, nine of them said that "all" people were aware of their same-sex attraction, while six were said that "some" knew, and seven said "none". Of those who said "none", four identified as bisexual, and three as lesbian. One was from Vredendal, one from Kayamandi and the rest lived in Mbekweni.

Motherhood

An aspect of belonging that is important in the context of family, especially for black African lesbians (Van Zyl, 2011b), is having children. Eight of the nine participants with children in this sample were black women. Four women who said they had sex with men mainly to have children had children: two had two each, and two had one each. However, they were not asked if they were the biological mothers. African culture is more fluid than Western culture about who is considered a mother – Western biologistic categories separate them into 'social' mothers and 'biological' mothers. For instance, in Xhosa tradition, when an unmarried woman has a child, the child 'belongs' to the mother (and her kinship line) and the child is regarded as her mother's child, though the daughter is the biological mother (Van Zyl, 2011b).

TABLE 4. WSW WITH CHILDREN

Characteristic	Number
Age	
18 to 24	4
25 to 38	4
Age missing	1
Race	
Black African	8
Coloured	1
Sexual Orientation	
lesbian	4
bisexual	5

Characteristic	Number
Gender identity	
I see myself as a woman	8
I see myself as a man	1
Marital status	
Married to a woman	1
Divorced or separated from a man	1
Never been married	7

In this study, the women with children ranged along the age spectrum of the sample. Five identified as bisexual, while four said they were lesbian. One mother saw herself as a 'man'. Seven had never been married, one was divorced from a man, and the other was married to a woman. However, the *identity* of motherhood was not investigated in this study. Since this identity is a significant trope of belonging in Xhosa society, it is an important aspect of sexuality to explore because it could impact identifications of bisexuality, and also implies unprotected sex with a man. Furthermore, one of the most vigorous areas for HIV risk programming is centred around pregnancy and motherhood. Because wsw are not perceived as having sexual practices focused on reproduction, i.e. without a penis, they are *de facto* excluded from any PMTCT programmes.

Being 'Out'

The high proportion of participants who reported that they were 'out' to some or all people in their everyday settings is a substantive finding. However, the degree of 'outness' of women who participated is most likely not a general reflection of wsw living in these areas. Triangle Project works explicitly with lgbti issues, and by drawing mostly on a convenience sampling of women who are already to some extent engaged in Triangle Project's CEEP, we were aware that it would skew our sample towards women who are more open and visible in terms of their same-sex sexuality.

Especially in Vredendal and Touwsrivier, Triangle Project has a less established presence, and in Touwsrivier particularly, recruitment of wsw for the study proved difficult. This could imply that not many wsw in those areas were out. However, of those who did participate in the study, only one was out to "none" of her co-workers. Of the four participants who were not out to anyone in at least three environments, three lived in Mbekweni and one lived in Kayamandi. Three identified as bisexual and one only as a lesbian. These figures are much too small

to draw general conclusions, and are in proportion to the number of participants in the study from each area.

On the whole, there is a high level of openness amongst participants about their sexual orientation given the context of an increase in reports of hate crimes, violence and discrimination towards women (and men) who are open about their same-sex identification (Mkhize et al., 2010). In South Africa, for example, women who do not conform to stereotypical ideas of what a woman should look like and whom she should love and have sex with (gender non-conforming women) are sometimes subjected to rape by men (where men justify the rape with claims that it turns lesbians into 'real' women). This violence presents a high risk for HIV transmission (Cloete et al., 2011). The everyday threat of being violently assaulted because of one's same-sex desires and the imposition of heterosexist norms can contribute to women hiding their same-sex desires and the invisibility of women who love other women.

Ingram et al. (1997) assert that violence and the threat of violence is one of the most effective means of control. In a study conducted in a coloured township in the Western Cape, study participants reported on the apparent invisibility of lesbians. Participants suggested that the invisibility of lesbian relationships was connected to their scarcity. Unlike male homosexual relationships, lesbian relationships were simply not there to be seen; others suggested that the invisibility was at least partially rooted in the choices made by same-sex practising women themselves and partially rooted in the hostile environment in which they found themselves (Sanger & Clowes, 2006).

However, the relationship between (in)visibility and violence is not necessarily as simple or as unidirectional as this, i.e. that violence or the threat of violence enforces and results in hiding and invisibility of same-sex desires and identities. Violence could also be a backlash against increased visibility and claiming of rights for same-sex sexualities. Over the past decade and a half and in the context of South Africa's progressive equality[6] jurisprudence, 'homosexuality' has emerged as a highly visible and contested phenomenon within the public discourse (Reddy, 2002). Given this context, several questions arise in relation to this study's findings that the majority of participants are 'out' about their sexuality to different people and in the various spaces (home, school, work) they inhabit.

6. This includes the South African Constitution of 1996; the Domestic Violence Act of 1999; the Rental Housing Act of 1999; the Employment Equity Act of 1998; the Medical Schemes Act of 1998; the Labour Relations Act of 1995; the Promotion of Equality and Prevention of Unfair Discrimination Act of 2000; and the Civil Union Act, No. 17 of 2006. This entails as well the decriminalisation of same-sex acts in 1998.

Does the apparent level of 'outness' in this study only indicate that convenience sampling is most likely to be skewed towards women who are 'out' about their same-sex desires and identities? Has the increased visibility of 'homosexuality' as a public phenomenon provided a point of recognition for lesbians and bisexuals to openly claim their same-sex desires and identities? Have the legal and constitutional protections led to an increase in the extent to which lesbian and bisexual women in urban, peri-urban and rural communities want to openly claim their sexual rights? Indeed, how do lesbian and bisexual women experience the role of these paper rights in their lives? Has there been a real shift in the often lamented invisibility of lesbian identities in various communities? To what extent are the increasing reports of violent attacks targeting lesbians a backlash against increased visibility of lesbianism both as a public phenomenon and as an identity openly claimed by individual women in local communities? These are important questions for further exploration in future studies.

Family acceptance

The FGD data did to some extent reveal the gap between legal and constitutional protections and the everyday lives of participants. Also, the high proportion of participants indicating that they were 'out' to all or some members in their families does not mean that their families are necessarily accepting of their same-sex identities. Stigmatisation, rejection and repression of same-sex relationships and non-conforming gender expressions persist in many South African communities. Participants of the Kayamandi FG related that they are labelled as witches by family members:

> Participant 1: *Some parents accept us. Some tell us they cannot stay with us. Some will call us witches and they cannot stay with a witch.*
>
> Participant 2: *I think Kayamandi is small and it has old people. People are ignorant and you are afraid they might want to disown you. They will tell you that you are cursed – you are a girl; if you do not want to be a girl you are cursed. They do not want to face the truth. They just have to accept that there are people like us.*
>
> Participant 3: *Here in Kayamandi we come from different places mostly from the Eastern Cape where they say if you are a woman and you sleep with another woman to you have a snake, a frog or a duck.*
>
> Kayamandi

Family responses to non-conforming sexualities and gender expressions proved to be an emotional and painful topic for FG participants from Vredendal. Here participants describe how their families more or less successfully attempt to regulate their behaviour and dress within the home.

> Participant 1: *You see, my situation is a bit different. The way I was raised is different, you understand … my mother and father, how do I put this … I can't dress like this at home because my parents are converted, you see, so we were raised in the church … and a woman may not wear pants.*
>
> Participant 2: *I mean, you know … I was raised in a house where it is wrong to be like this … I was taught that I may not be like this … I must enjoy myself outside of my home, I … can't be myself with my family … [starts crying] … I can't be … myself … with my ….family. They don't know …. I am …. like this.*
>
> Participant 3: *I am just saying, my parents have always tried to get me to wear a dress, but really, I am asking you, can you honestly see me in a dress? [All the participants laugh].*
>
> Vredendal

Experiences of rejection by family were also related in other FGDs:

> Facilitator: *How did your parents take it when they discovered that you were lesbians?*
>
> Participants 1, 2, 3: *Our parents did not accept us, especially not my father.*
>
> Touwsrivier

This rejection from family members was also based on cultural norms around marriage as well as Christian religious beliefs.

> *Some parents want cows for me [lobola]. They expect you to get married. [They say] I have taken you through school yet here you do not want o get married* [Participant, Kayamandi].
>
> *My mother is constantly crying about me, saying that Dear Jesus made me a woman and I may not get together with women and I am going to hell and things like that [clearing her throat]. I don't know … [shakes her head and goes quiet]. Yet that is how I am, I can't help for the way that I am and for the way that I feel inside myself* [Participant, Vredendal].
>
> *Because our parents are still old fashioned, they see it as sin to be in a same-sex relationship because they are Christians and believe every word in the Bible. But to some it's easy because they have understanding parents, and if*

you take note in the age group between 18 and 20 yrs, their parents are old fashioned [Participant, Mbekweni].

Some hide behind the bible telling you that God made Adam and Eve, which means a man and a woman [Participant, Kayamandi].

However some FG participants spoke of being accepted by family members:

She doesn't accept it, but I think she's coming around now because she doesn't talk about it. All my other relatives and my sister have accepted it [Participant, Mbekweni].

In my situation, it is different, since my parents accept me as I am, so I will never wear a skirt, because it just doesn't feel right to me [Participant, Vredendal].

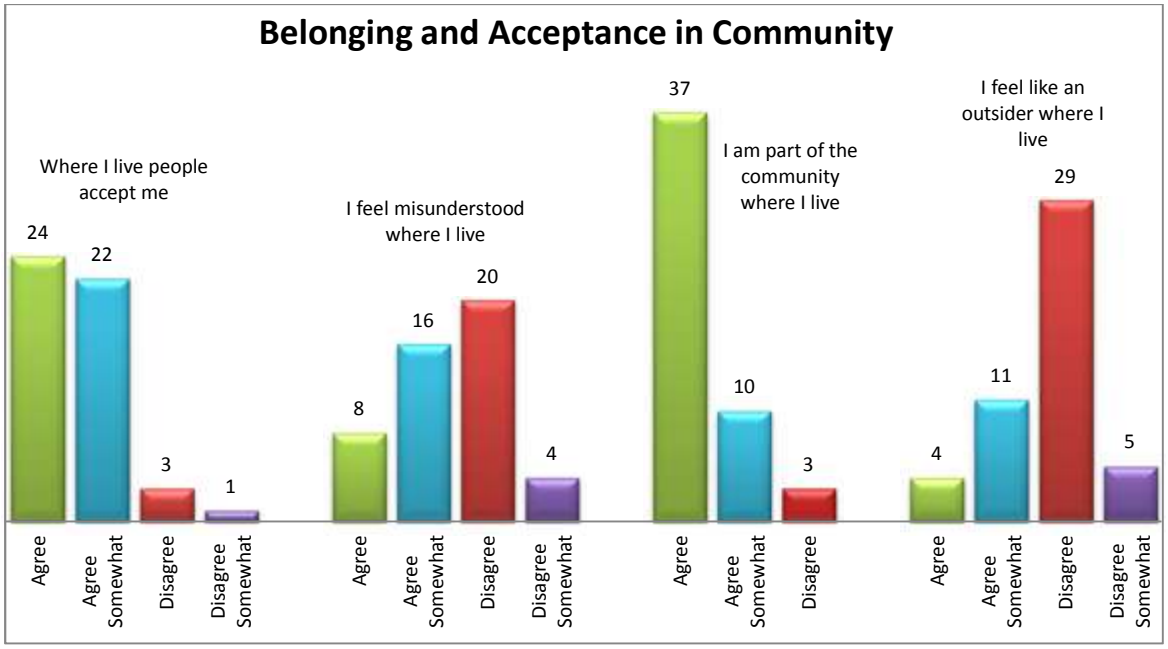
In my case, my friends, cousins and my other aunts know and accept me. But my parents don't know because I still have fears of their reaction, so … [Participant, Mbekweni].

Community acceptance

The survey data revealed that a high proportion of the participants reported being open about their same-sex identification. However we also wanted to examine participants' sense of acceptance and belonging within the communities that they live.

Overall, participants reported positively on their feelings of acceptance and belonging (see Figure 6). (Some participants did not complete all the answers, therefore the totals do not all add up to 51.) Most of them (72.5%) reported that they feel part of the community in which they live, and 47.0 per cent reported that where they live people accept them. In contrast, only eight agreed that they felt misunderstood and only four agreed that they felt like an outsider.

FIGURE 6. SENSE OF BELONGING AND ACCEPTANCE WITHIN COMMUNITY



The complexity of belonging was illustrated during FGDs, where participants described their communities as hostile environments for lesbian and bisexual women. Participants in the Vredendal FG described their community as follows:

> *Yes, people in the community, most times … when you walk in the street with a girl, they always criticise and intimidate us.*
>
> Participant, Vredendal

Vredendal participants also related some of the insults and names that were directed at them by people in the community:

> *Hey you rotten thing [showing her hands away from herself].*
>
> *You lesbian thing.*
>
> *You man-vrou (man-woman).*
>
> *[Everybody giggles]*
>
> *Yes, yes, man-vrou, they like to call us that one.*
>
> *Yes, man-vrou, they also call me that, where I live, but I don't let it bother me.*
>
> Vredendal

Participants in the Touwsrivier FG spoke about how they were treated by other people in the town:

They are very ugly with us. They tell us a lot of things.

Look not everyone is ugly with us, there are a few that's nice to us.

But very few people are nice to us.

Touwsrivier

Others hide their same-sex identification in order to be accepted in their community, as is evident from this FG in Kayamandi:

> *At school I used to pretend that I am not a lesbian but I have come to a point where I said, whether people accept me or not I am what I am and I am not going to change … they have to accept me. In your own community you want to be accepted – there is this that you will act as if you are not lesbian because you want to be accepted* [Participant, Kayamandi].

There was agreement amongst FG participants that community members generally do not understand same-sex relationships between women, as is evident from the quotation below:

> *You see when I first arrived here in this place and I got involved with her [pointing to other participant], we went to go live in her sister's house, and we love each other a lot and people don't understand the love that women have for each other, you see?* [Participant, Touwsrivier]

Participants' experiences of stigmatisation manifest in the names and insults that community members routinely use to characterise same-sex relationships and identities. Many of these names or insults were related to the subversion of gender norms. The following is a list of such names that were related by participants in the FGDs.

TABLE 5. NAMES AND INSULTS FOR SAME-SEX IDENTIFICATIONS

Name	English Translation	Focus Group
Onongayindoda	Man look-alike / butch lesbian	Mbekweni
Sizenza amadoda	A woman pretending to be a man	
Usisbhuti	A woman/man	
Isitabane/ Izitabane (pl)	Roughly the word means 'hermaphrodite' It is used to refer to gay men as well as lesbians	Kayamandi
Tomboy	Used to refer to a butch lesbian	
Moffie	A South African slang word meaning	

Name	English Translation	Focus Group
	a boy/man who dresses and acts like a girl/woman. It does not necessarily refer to all gay men. It is mostly used to refer to effeminate gay men or drag queens and cross-dressers etc.	
Moffiekazi	Female moffie	
Amadoda oqobo	'real' man	
Mannetjie-wyfie	A female who is trying to be a man	Vredendal

Some of the insults were focused on sexual practices between women. The quotations which follow give some indication of the common community perceptions of what wsw do in bed.

> *Yes. you know the Xhosas like saying if a woman sleeps with a woman, that woman has a snake that she uses when having sex* [Participant, Kayamandi].
>
> *They say we have snakes* [Participant, Mbekweni].
>
> *They say we're … going to scratch the hole again (gaan julle alweer gaatjie krap?)* [Participant 1, Vredendal]
>
> *But that is not all we do, I mean … there are other things we also do* [Participant 2, Vredendal].
>
> *I can have sex with a woman without putting a finger in her* [Participant 3, Vredendal].
>
> *Some men say we are ornaments … They are actually saying we do nothing; therefore are ornaments, meaning we are not sexually active. They do not know we do it 24/7* [Participant, Kayamandi].

It is important to note these characterisations of sex between women (or the lack thereof), as they are likely to be shared by health care workers who live and work in these communities.

The notion that lesbians should be raped 'right' or raped in order to show her that she is a woman or girl was also prominent in participants' experiences with men in their communities. This was found in both Afrikaans-speaking 'coloured' communities and Xhosa-speaking communities. Some participants recognised that these threats or experiences of rape and violence were embedded in perceptions that they were seen as a threat to male power. When examining the discourses

underlying men's threats of rape and violence directed at lesbians,[7] it is possible to see how violence against lesbians is rooted in patriarchal norms around male sexual entitlement and ownership of *the* female body. Lesbians threaten this ownership in two ways: (1) their own sexual unavailability to men; and (2) being viewed as sexual rivals who dare to compete with men's sexual access to other female bodies. This was also found in interviews with lesbians living in Gauteng townships, Kwa-Thema and Soweto (Reid & Dirsuweit, 2002).

> *Ok, many men in the community, they have a belief that a woman is made for men* [Participant 1, Vredendal].
>
> *It will be years next year. How many years have you been in town? Five years already. They say that we must be fucked. You must be fucked right that is what they tell us* [Participant, Touwsrivier].
>
> *Some men want to show you that you are a woman/girl by wanting to rape you. Others do rape you – it hurts* [Participant 1, Kayamandi].
>
> *Some say we take their girls/women* [Participant 2- Kayamandi].
>
> *Others hit us and say we are ruining their girls* [Participant 3, Kayamandi].

How do we make sense of this seeming contradiction between FGD data where participants depicted their communities as hostile to lesbian and bisexual women and the survey data where the majority of participants reported positively on their sense of belonging and acceptance in relation to the communities within which they are located?

Belonging is complex and shaped both by internal identifications as well as structural factors (Van Zyl, 2011b). Therefore a person might identify culturally with their environment, but feel compromised by one facet of a complex identity. This could account for answers such as "somewhat agree" and "somewhat disagree". A closer examination of the survey data reveals that participants' sense of belonging or acceptance is not straightforward or uniform. For example, 7 of the 37 participants who strongly agreed that they feel part of the community within which they live also said that they felt "somewhat" like outsiders within their communities. Six of the 24 participants who "strongly agreed" that they are accepted by people where they live also stated that they felt "somewhat misunderstood" by people where they live. Arguably these contradictions indicate that participants occupy spaces in which they simultaneously experience both

7. Here men's sense of entitlement is focused through the lens of sexuality, but like all sexual harassment, threats of violence and sexual assaults of women more generally, are an expression of men's 'right' to 'ownership and control' of women's bodies.

acceptance and misunderstanding, both a sense of belonging and a sense of being outsiders.

Communities are not homogeneous entities. It may also speak to the fact that even though the participants occupy identities that are stigmatised in the communities where they live, these women are not passive recipients or victims of the hostilities and negative perceptions that they face. Instead, they actively negotiate and assert their place and their belonging in the communities in which they live.

Like the participants in the study by Van Zyl (2011b) the participants in this study actively claim their belonging in the places where they live. In the FGDs some participants spoke about claiming a space in defiance of community expectations and judgements.

> *I came to a point where ukuba (that) [I said] "screw my community". Sorry for ilanguage yam … whatever they say behind my back, whatever they say in front of my face or whatever. That's their opinion, it is their problem … When you are in your community you want to be accepted, you want to belong somewhere. If it was five years back and still at school I would have wanted to belong somewhere. I would have pretended I am not a lesbian, but now I have come to a point that who am I, where I am going and whatever people say whether they accept me or not, it is up to them. I have come to a point that they say statements or discriminate, but I know myself – I am not going to change* [Participant, Kayamandi].

Belonging is complex and layered, based on numerous intersectional identifications, such as race, class, gender identity, sexuality, age and place and time. Yet, belonging is an important trope in safe sex, as it speaks to belief in one's self-worth.

Vulnerability and Risk

Sexual transmission is the dominant mode of HIV transmission in South Africa, where heterosexual transmission is reportedly the highest, followed by sex work, intravenous drug use and sex between msm. However, until recent epidemiological evidence showed that transmission was more diverse than was generally believed, interventions focused on "heterosexual transmission between couples" (Shisana et al., 2008: 1). Though only working with a small sample, this study contributes to the understanding of this diversity.

Sexual Practices

The heteronormativity and phallocentrism of beliefs about what constitutes 'real' sex has contributed to the exclusion of wsw from research on transmission of HIV and STIs.

First sexual experience and first sex partner

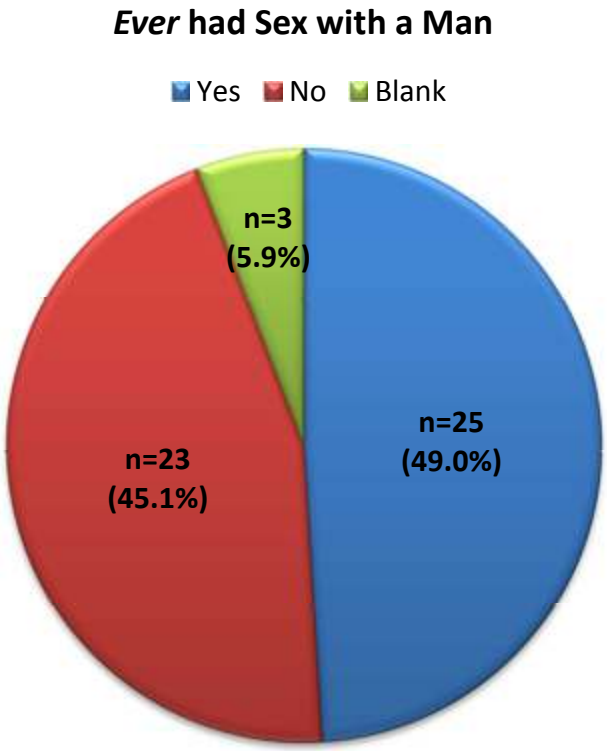
Age of sexual debut is regarded in South African research (amongst heterosexuals) as a crucial factor in vulnerability of youth to HIV infection (Shisana et al., 2009), especially within the context of the high HIV prevalence rate among South African youth (Anderson, Beutel & Maughan-Brown, 2007). According to Shisana et al. (2009), early sexual debut increases vulnerability to HIV infection among young people, especially females. It is thus important to know the age at which sexual debut occurs in order to inform HIV prevention interventions targeted at young people.

TABLE 6. AGE OF SEXUAL DEBUT AND AGES OF FIRST SEX PARTNERS

Age of Sexual Debut and Age Range of First Male and Female Sex Partner			
Characteristic	**Age Range**	**Mean**	**Median**
Age at first sex with a woman	10 – 27	17	17
Age of woman you had sex with for the first time	12 – 36	19.4	19
Age at first sex with a man	13 – 23	17.6	17
Age of the man you had sex with for the first time	16 – 32	21.9	20

Table 6 above reports the age of sexual debut and age of first sex partner in this study. For example the mean age of participants' first-sex with a woman was 17 years of age, whilst the mean age of their first-sex female partner was 19.4 years. The mean age of first-sex with a man was at 17.6 years of age. For the wsw their first male sex partner was found to be four years older than themselves (mean 21.9 years of age). In a nationally representative survey, Pettifor et al., (2009) revealed that the mean age of sexual debut for females was found to be 16.8 years. In addition, our study confirms the findings in Pettifor et al.'s (2009) study that young women's first partners were generally 1-4 years older than themselves.

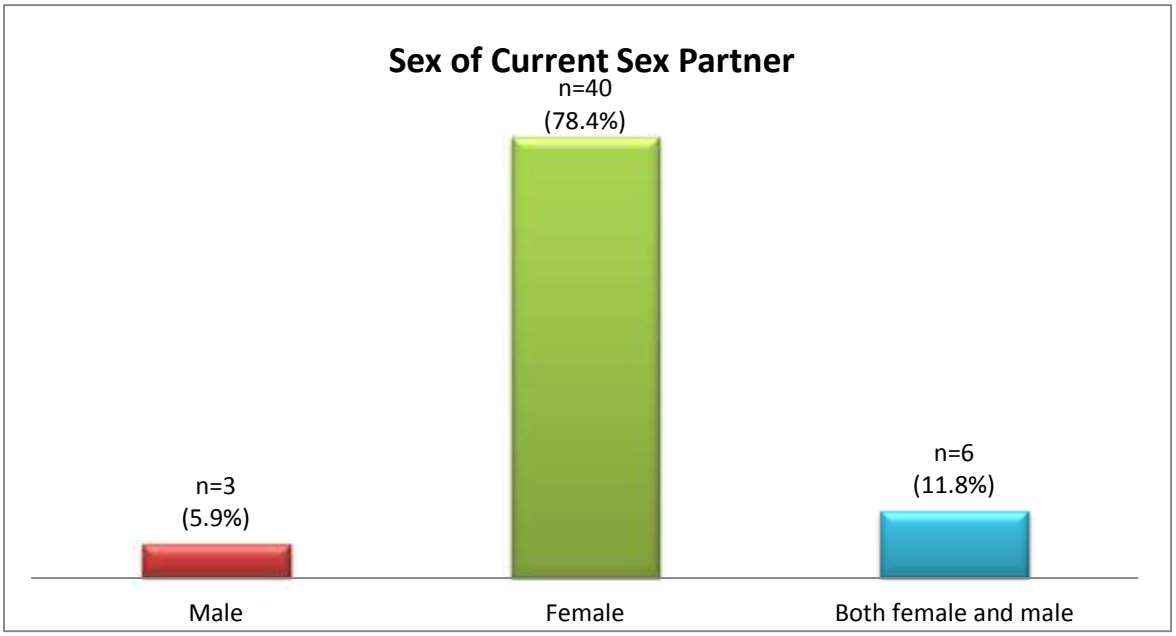
FIGURE 7. SEX WITH A MAN



In this study 25 out of 48 (52.1%) participants who answered the question had had sex with a man. From this study it is clear that many wsw have had sexual experiences with both men and women. According to Vance (1995) constructions of sexual identity vary during an individual's lifetime. In addition, sexual expression is influenced by social context and a person's sexual identity may not always be in harmony with their sexual practices throughout the course of a lifetime (Fry 1982; Costa 1994; Vance 1995; Heilborn 1996, 2004; Dolan 2005; Carrara & Simões 2007; Fachinni 2008). There is often an element of instability and contradiction in the expression of sexuality, and fluidity in sexual activity and identity has been observed in the biographical trajectories of lesbians, bisexuals and other wsw (Diamant et al. 1999; Richardson 2000; Bailey et al. 2003; Dolan & Davis 2003; Dolan 2005; Fachinni 2008).

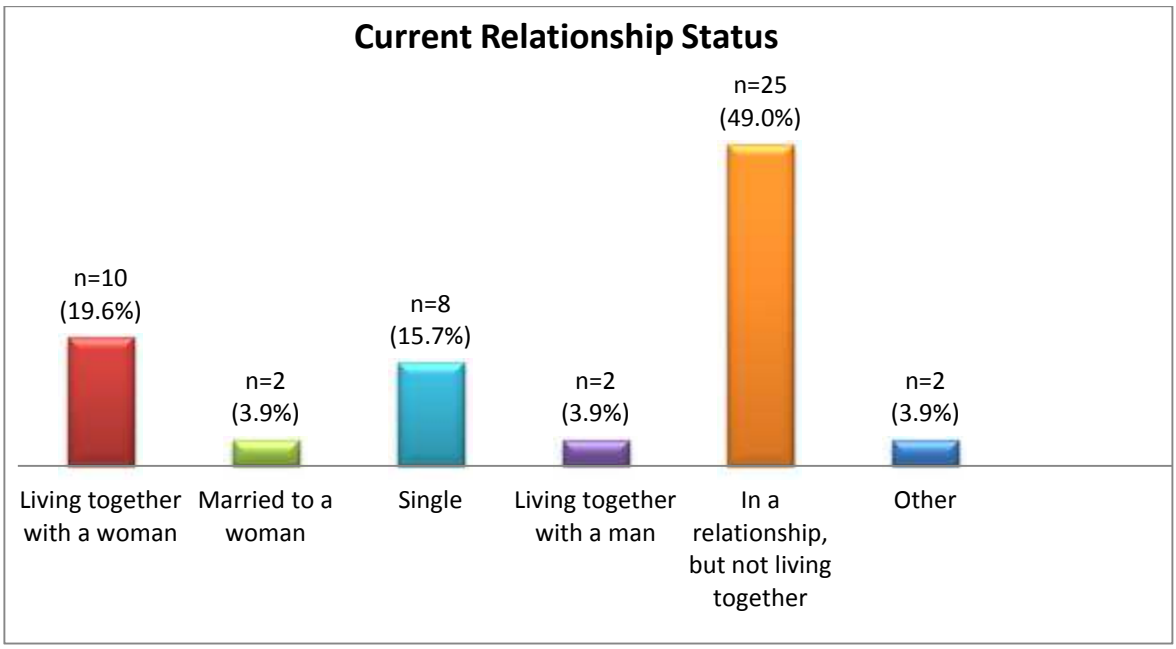
Sexual Partnerships and Relationships

FIGURE 8. SEX OF CURRENT SEX PARTNER



The majority of the study sample (78.4%) indicated that their current sex partner is female, whilst 11.8 per cent reported to currently having both female and male sex partnerships. This coincides with data reported on earlier, where 11.8 per cent of the study sample reported sexual attraction to women and men equally.

FIGURE 9. CURRENT RELATIONSHIP STATUS

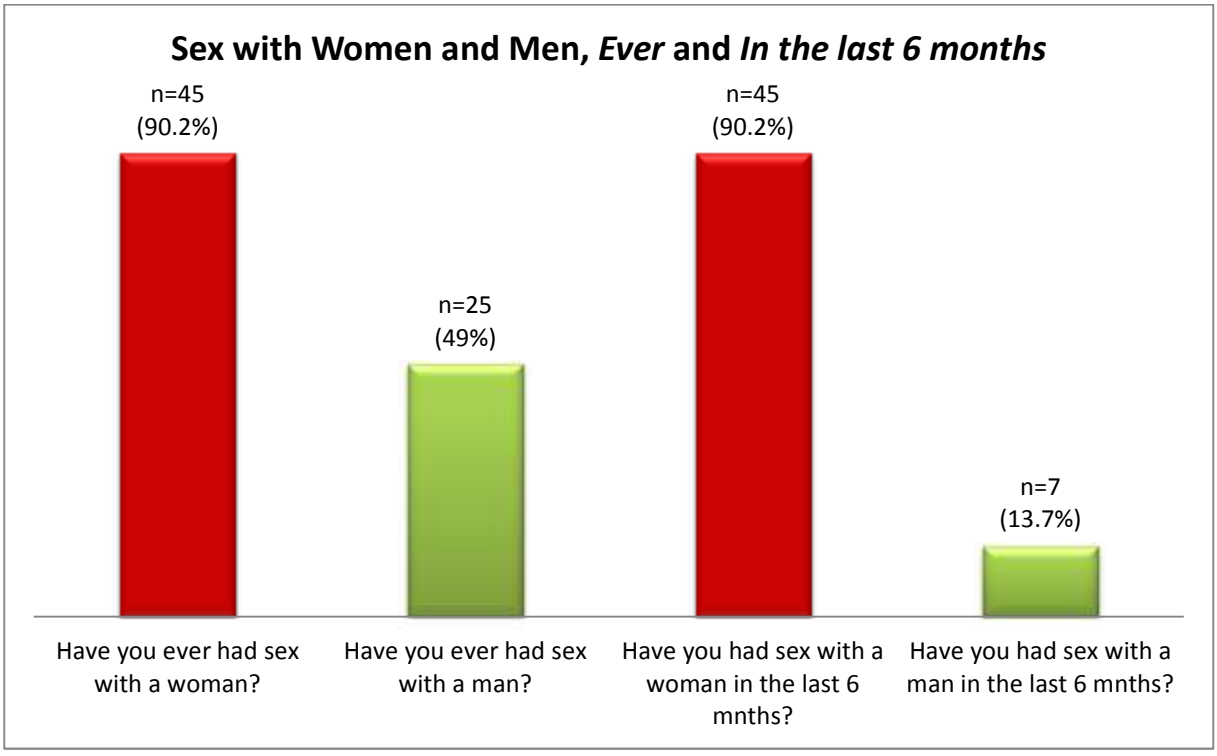


Almost 20 per cent of the participants live with another woman, whilst almost half of the study participants (n=25) are in a relationship, but do not live together. Of those, three said they were currently in relationships with a male, three said they were having relationships with both males and females, and 19 were currently in a relationship with a female.

Sex with women and men

In this study, sex was defined according to a list of sexual practices (see Questionnaire, Appendix). Ninety per cent (90.2%) of the study sample reported ever having had sex with a woman, all of whom had also had sex with a woman in the last six months. Seven women had ever had sex with only one woman, while 35 had had sex with more than one woman. The number of partners ranged from two to 50, with an average of 7.6, though only seven had had sex with more than ten, and three with more than 20. A general factor in HIV transmission risk in dominant discourses is related to the number of sexual partners, as well as to people's sexual practices – how they do 'it'.

FIGURE 10. SEX *EVER* AND *IN THE LAST SIX MONTHS* – WOMEN AND MEN



About half (49.0%) of the study sample reported ever having had sex with a man. A small proportion (13.7%; n=7) reported having had sex with a man in the last six months. Of the seven who reported sex with a man in the last six months, five wsw also reported having had sex with a woman in the last six months (Table 7). Six

participants claimed *not* to have had sex with a woman. When compared to ever having had sex with a man, four of these said "yes", one said "no" and a third did not fill in the question. The participants weren't asked how many men they had ever had sex with.

In terms of risk, according to Mercer et al. (2007), some wsw may in fact be at greater risk than some women in relationships only with male partners. Wsw who engage in other high-risk behaviours such as injection drug use, or who have unprotected vaginal sex with gay/bisexual men are at risk. In the study by Mercer et al. (2007), wsw who reported sex with women and men also reported greater male partner numbers than women who had sex exclusively with men. They also reported greater incidences of other risk behaviours such as alcohol consumption, smoking, unsafe sex and injection drug use. They also were more likely to have induced abortions and infection by STIs which placed wsw who have sex with men at increased risk.

TABLE 7. WSW WHO HAD SEX WITH WOMEN AND MEN IN LAST SIX MONTHS

Behaviour	Number
Sex with both women and men in last 6 months	5
Sex with only men in the last 6 months	2

Of the seven wsw who reported having had sex with a man in the last six months, six reported to be attracted to both men and women (bisexual) and one described her sexual orientation as heterosexual. In terms of attraction to women or men, two reported to be sexually attracted more to women than to men, three indicated sexual attraction to both men and women equally, one indicated sexual attraction more to men than to women and one reported sexual attraction to men only.

TABLE 8. GENDER IDENTITY AND SEXUAL ATTRACTION OF THOSE WHO HAD SEX WITH A MAN IN THE LAST SIX MONTHS

Sex with Men: Gender Identity and Sexual Attraction	
Identification	**Number**
Bisexual (attracted to both men and women)	6
Heterosexual (straight)	1

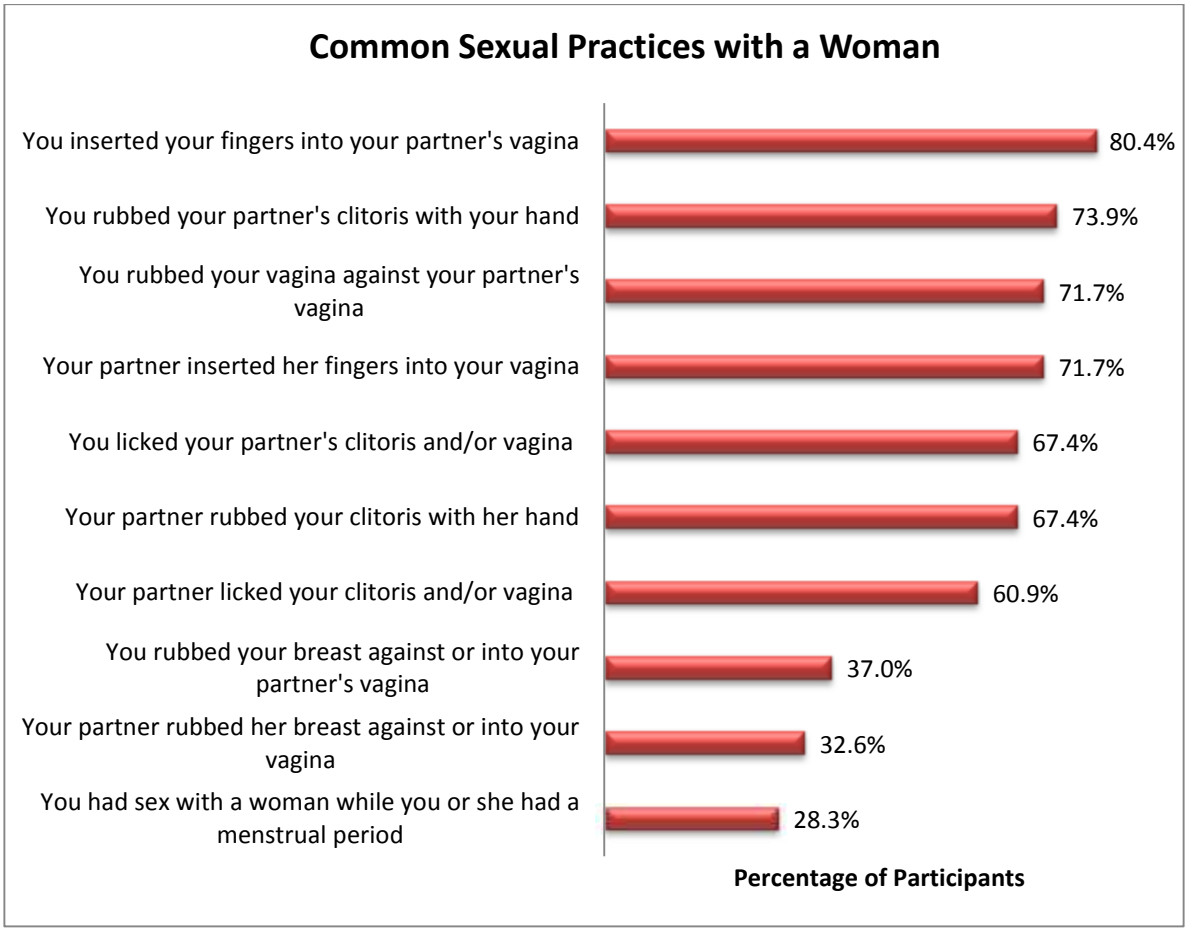
Attraction	Number
More to women than to men	2
To women and men equally	3
More to men than to women	1
Only to men	1

Since the participants were a youthful sample, it could indicate that younger women in particular may express a versatility of attraction towards, and practices with, peers of the same and opposite sex (Maguen, Armistead and Kalichman 2000; Eugênio 2006; Heilborn & Cabral 2006a; Goodenow et al. 2008). Hence for young wsw who are learning to explore intimacy and sexuality, it is also a time of increased vulnerability, including risk of HIV infection. Due to factors such as stigmatisation, these experiences become more complex for lgbti youth who often negotiate them without guidance or help from adults who routinely provide support for children and adolescents (Ryan, 2003).

What wsw do in bed

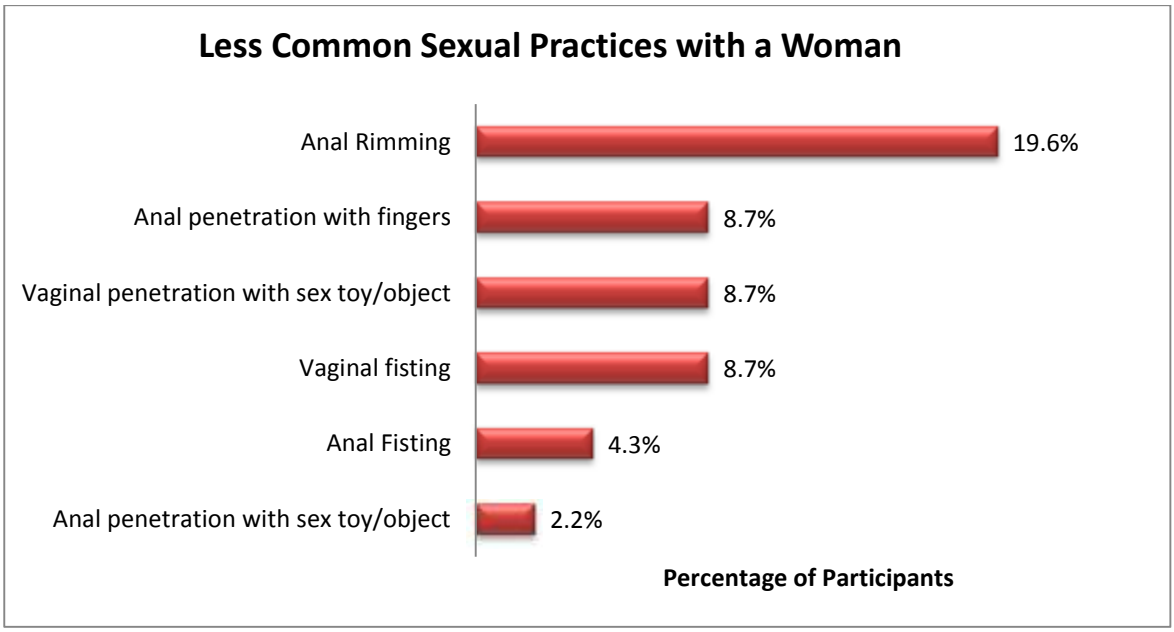
It is known that HIV vulnerability and risk are associated with sexual practices where blood, vaginal fluids or semen come into contact with sensitive mucous membranes. Survey participants were asked about the specific sexual practices that they engaged in with other women during the last six months. Figure 11 depicts the more common female to female sexual practices reported by participants, while Figure 12 presents the less common sexual practices that participants engaged in. The percentages contained in Figure 12 reflect the overall percentage of participants who have engaged in the named sexual practice either as the partner who has performed the sexual act or as the partner on the receiving end.

FIGURE 11. COMMON SEXUAL PRACTICES WITH A WOMAN IN LAST SIX MONTHS



Common sexual practices reported by the participants in this study include: vaginal penetration with fingers; cunnilingus (oral-genital contact); clitoral stimulation with hand; and tribadism (rubbing wet part of vaginas together). Of concern is that 28.3 per cent of wsw reported having had sex with another woman whilst she or her partner had a menstrual period.

FIGURE 12. LESS COMMON SEXUAL PRACTICES WITH A WOMAN IN LAST SIX MONTHS



Although less common, a significant proportion (19.6%) of participants reported anilingus (oral-anal contact, commonly referred to as 'anal rimming') practices during the last six months. Sexual practices, such as cunnilingus and tribadism involve mucous membrane exposure to vaginal secretions and menstrual blood. Even though the precise risk is not known, HIV transmission resulting from these sexual practices is possible. There are also certain co-factors such as the presence of other STIs, genital sores, menstrual blood and the viral load of HIV positive sexual partners that can increase the risk of HIV transmission (NAM AIDS Map, 2010). In addition, the STI transmission risks associated with these sexual practices should not be overlooked. For example, STIs such as herpes and syphilis are easily transmitted through oral sex (NAM AIDS Map, 2010).

Information on HIV transmission risks and safer-sex practices in relation to sexual practices other than vaginal and anal penetration with a penis has in general been absent from HIV/AIDS awareness and prevention programmes. In fact, even though the CDC fact sheet on oral sex states that HIV can and has been transmitted through anilingus (CDC, 2009), more detailed information about the risk associated with this sexual practice or the co-factors that might increase the possibility HIV transmission is hard to come by. It is important to point out that this kind of information is relevant not only to wsw, but to anyone who engages in the sexual practices mentioned.

We asked study participants about the use of sex toys or objects in vaginal or anal penetration. None used toys for anal penetration, but a small minority (8.7%)

reported the use of sex toys or objects for vaginal penetration. In addition, a small minority of participants reported high risk sexual practices, such as vaginal fisting (8.7%) and anal fisting (4.3%). The repertoire of common female to female sexual practices amongst the wsw who participated in this study should not be seen as static. It must be remembered that study participants are mostly quite young. Many are still in the process of learning sexuality. As more sexual experience is gained, new practices may be added to the initial repertoire or there may be shifts in preferred sexual practices (Heilborn & Cabral, 2006b).

Sexual practices and gender identity

In two FGDs (Mbekweni and Vredendal), the relationship between sexual practices and gender identity was discussed in terms of the sexual roles that may be played out by 'butches' and 'femmes' or 'men' and 'women'. This led to some debate and the way in which participants spoke about the topic involved self-positioning in terms of these roles. Participants implicitly (and sometimes explicitly) positioned themselves as 'butch', 'femme' or 'not butch' and 'not femme'.

These sexual roles were constructed variously in terms of who penetrates and who is penetrated, who is active and who is passive, who is on top and who lies on their backs and who is naked and who remains clothed.

> Participant 1: *There are situations like that where your [butch] partner only wants to pleasure you and doesn't understand how they get satisfied.*
>
> Participant 2: *Or sometimes you [butch] guys would be having sex and they refuse to take their clothes off.*
>
> Participant 1: *And you would be the only one who is undressed?*
>
> Participant 3: *Like me, I never used to take my clothes off. Sometimes I would not even take off a single part of my clothing. I would be wearing my shorts, my pants and make sure my belt is tight and I would still enjoy myself.*
>
> Mbekweni

Similar themes were echoed in the Vredendal FGD:

> Participant 1: *You're the woman and I am the man. I am on top. I am not going to lay on my back for you.*
>
> Participant 2: *Yes, a woman can't touch me [pointing to her vagina]. This … it's mine, it belongs to me, I am the man.*

> Participant 1: *Yes I don't like it when a girl touches me when we are busy. That is the easiest way to get me angry; a woman mustn't touch me.*
>
> Participant 2: *She must give!*
>
> Participant 1: *Yes, she must just lay there and feel.*
>
> Vredendal

These statements echo Sinnott's (2004) descriptions of Tom-Dee (Butch-Femme) relationships in Thailand and uses the term 'untouchability' in reference to the hegemonic code that regulates tom-dee sex. Reflecting on her interviews with toms and dees, Sinnott explains that sexual acts were almost always described as one-way. According to Sinnott (2004: 135):

> Untouchability refers to the practice whereby toms (or "stone butches" in the West) do not allow their partners to touch them sexually. This practice is explained by saying that toms, like men, are "active" and dees, as is considered normal for women, are "passive".

Like the FG participants in Mbekweni and Vredendal, the tom-identified interviewees in Sinnott's ethnographic study explained how during sex they would usually remain clothed. The reason is simply put by an interviewee in Sinnott's study: "If I took all my clothes off, it would not be the same; it [my body] would become a woman" (Sinnott, 2004: 137).

In both the Mbekweni and Vredendal FGDs butch-femme sexual roles as described above were questioned and even challenged by other participants. The extent to which 'butch' lesbians are able to experience sexual satisfaction from doing sex in this manner was questioned. In response to this question, a participant who positions herself as 'butch' explains:

> *To your question of how you do not understand how does your [butch] partner feel when you do not penetrate [them]? It happens that some of us enjoy pleasuring others and in that way we get pleasured. It's like getting a massage. It feels good* [Participant 5, Mbekweni].

In the Mbekweni FGD, one participant pointed out that there is often a difference between what 'butches' say they do and what they actually do:

> Participant 4: *My question is why is it that when you're in a relationship with a butch lesbian she doesn't want her friends to know that her partner penetrates her? They become so defensive and claim they don't do such things.*

Participant 5: *As butch lesbians we don't talk about how our girlfriends penetrate us because it makes us feel like a femme, whereas we carry ourselves like man!*

Participant 1: *Are you ashamed of being penetrated by your partner?*

Participant 3: *Yes, when she goes around talking about it.*

Mbekweni

Similarly, Sinnott (2004) comments there are often discrepancies between lived reality and the hegemonic codes associated with tom-dee sex, with sexual reciprocity being practised more commonly than is acknowledged by toms.

Butch-femme sexual dynamics were also challenged as being unfair and inequitable.

Participant 3: *That is what I prefer, it should be equal.*

Participant 1: *But it doesn't work like that.*

Participant 3: *But why not?*

Participant 4: *That is unfair!*

Participant 3: *It's unfair yes, because we are both women and the fact that you are a woman, I am saying now, you are just a woman but I know you are also a man. But when it comes to the bedroom then it is about both of us. Even though you are a man on the outside, we are together, it will only work if we are both satisfying each other in the way that we are, you see, it is just us* [everybody mumbles simultaneously].

Vredendal

Below is a list of all sex practices that the 12 wsw who reported that *I see myself as a man* engaged in in the last six months.

TABLE 9. SEXUAL PRACTICES OF WSW WHO SAID *I SEE MYSELF AS A MAN*

Sexual Practice	Number
You rubbed your partner's clitoris with your hand	8
Your partner rubbed your clitoris with her hand	3
You inserted your fingers into your partner's vagina	10
Your partner inserted her fingers into your vagina	4
You inserted your fist (whole hand) into your partner's vagina	1

Sexual Practice	Number
Your partner inserted her fist (whole hand) into your vagina	1
You licked your partner's clitoris and/or vagina	8
Your partner licked your clitoris and/or vagina	2
You inserted your fingers into your partners anus (butt)	0
You partner inserted her fingers into your anus (butt)	0
You inserted your fist (whole hand) into your partner's anus (butt)	0
Your partner inserted her fist (whole hand) into your anus (butt)	0
You licked your partner's anus/butt with your tongue	2
Your partner licked your anus/butt with her tongue	2
You rubbed your breast against or into your partner's vagina	3
Your partner rubbed her breast against or into your vagina	3
You rubbed your vagina against your partner's vagina	8
You inserted a sex toy into your partner's vagina	1
Your partner inserted a sex toy into your vagina	1
You inserted a sex toy into your partner's anus	1
Your partner inserted a sex toy into your anus	1
You had sex with a woman while you or she had a period	5
In the last 6 months have you had consensual sex with a woman where you did things that caused either of you to bleed?	1

From the sexual practices listed above, it seems that wsw who see themselves as 'men' are protective of penetration of their vaginas and clitoral stimulation, as they acted upon their partner's vagina and clitoris about twice as many times as they allowed it to happen to themselves. This would confirm Sinnott's (2004: 136) observation that while the rules relating to one-way sexual activity in tom-dee or butch-femme sex is ostensibly to keep the maleness of the masculine partner intact, the "extreme irony of untouchability is that, rather than imitating sexual behaviours of men, it most fully demonstrates the femininity of tom identity". By placing the sexual satisfaction of their partners above their own, toms are inadvertently adopting a role that is more aligned to normative femininity than to normative masculinity. In addition, in contrast to the dominant norms associated with heterosexual sex, the sexual desire and satisfaction of the feminine partner is granted primacy (Sinnott, 2004).

HIV or STI prevention

We also assessed whether wsw used HIV and STI prevention measures in the last six months when having sex with men and/or other women.

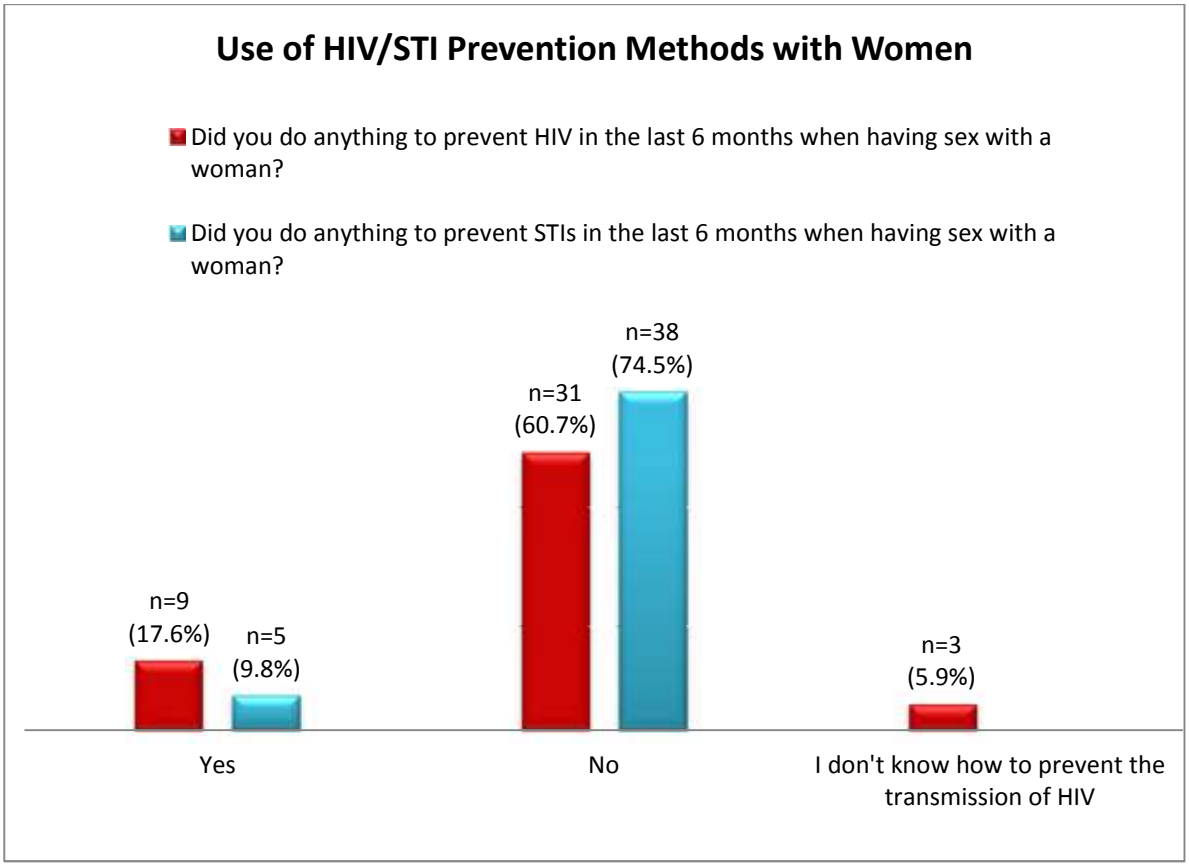
Doing 'it' with women

Data revealed that 71.2 per cent of the sample did not do anything to prevent HIV in the last six months when having sex with other women. An even higher proportion of participants reported not to have used STI prevention methods when having sex with other women in the last six months. Nineteen of the 46 (41.3%) participants who had sex with a woman in the past six months reported that they had never thought about using HIV/STI prevention methods when having sex with another woman. Other reasons were related to: the inaccessibility of preventative measures (17.4%); lack of safer sex knowledge and information relevant to sex between women (13.0%); and perceptions that protection against HIV and STI infection is unnecessary for sex between women (10.9%).

These reasons indicate that, on the whole, at present the participants do not practise safer sex in their sexual relations with other women. The silence around HIV and STI risk and prevention in relation to wsw and the assumption of no or low risk is so pervasive that many participants have not even considered using prevention methods. The possibility that partners would disapprove of safer-sex suggestions was also cited by 13.0 per cent of the participants.

Only nine participants reported using HIV prevention methods when having sex with a woman in the past six months, and five said they used prevention methods for STIs such as Hepatitis B and C, Herpes, Gonorrhoea, HPV, Chlamydia, Syphilis. Thirty-one participants claimed not to use any HIV prevention methods, and 38 participants said they did not use STI prevention methods. Six "did not know how to prevent the transmission of HIV when having sex with women", whilst another six did not answer either the question on HIV prevention or STI prevention. (See Figure 13).

FIGURE 13. HIV/STI PREVENTION METHODS WITH WOMEN IN LAST SIX MONTHS



A list of HIV prevention methods was provided in the survey, and we wanted to explore usage of these prevention methods. The majority of participants (between 62% and 75% said 'no' to each of these) have not used dental dams, cling wrap, latex gloves, finger cots and condoms on sex toys. Only one participant said that she wasn't sure what any of these were. Hence, even though participants in this study engage in sexual practices with other women that might put them at risk of HIV and STIs (i.e. oral sex and having sex with another woman during menstruation), the majority of the sample do not use prevention methods or have not thought of using any prevention methods.

Asking women how often they used protective methods elicited only five who said they "always" used them; one said "almost every time", seven said "sometimes" while 32 said "never" and six did not answer the question.

FIGURE 14. HIV PREVENTION METHODS WITH WOMEN IN LAST SIX MONTHS

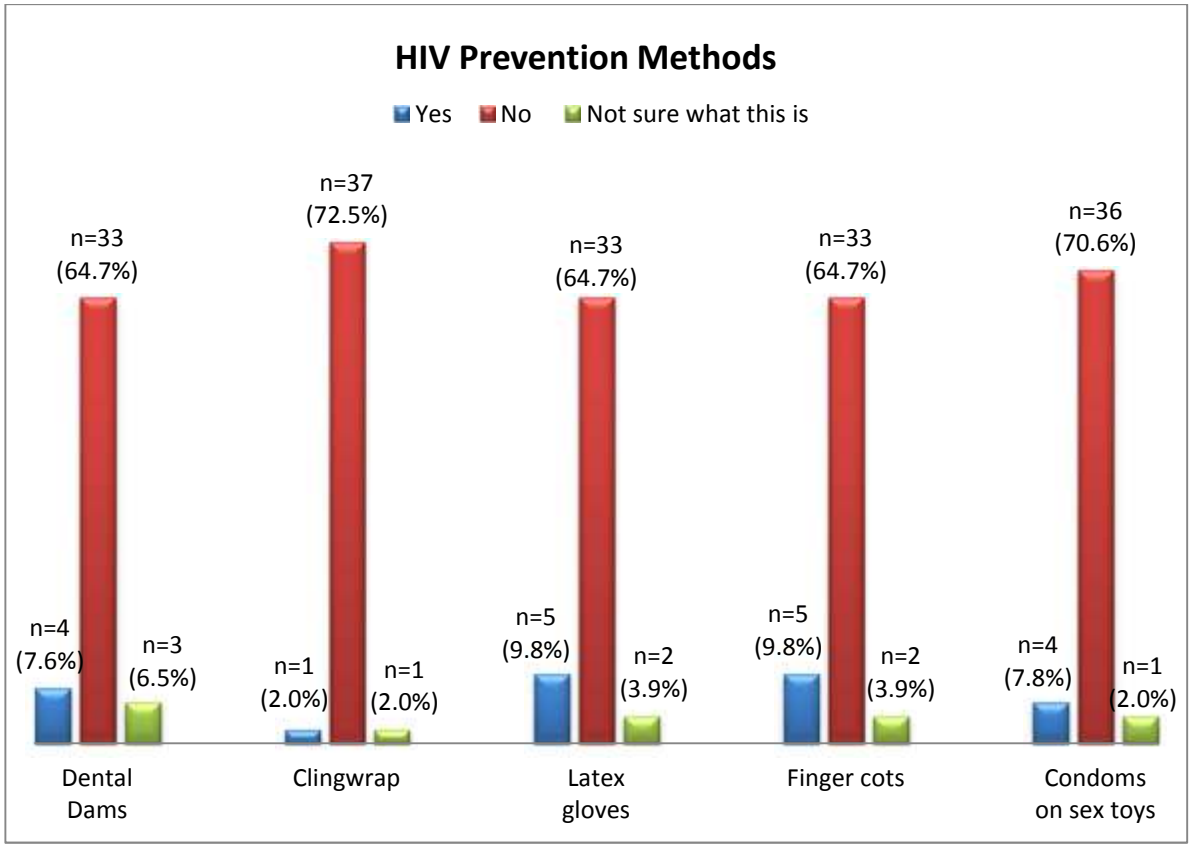
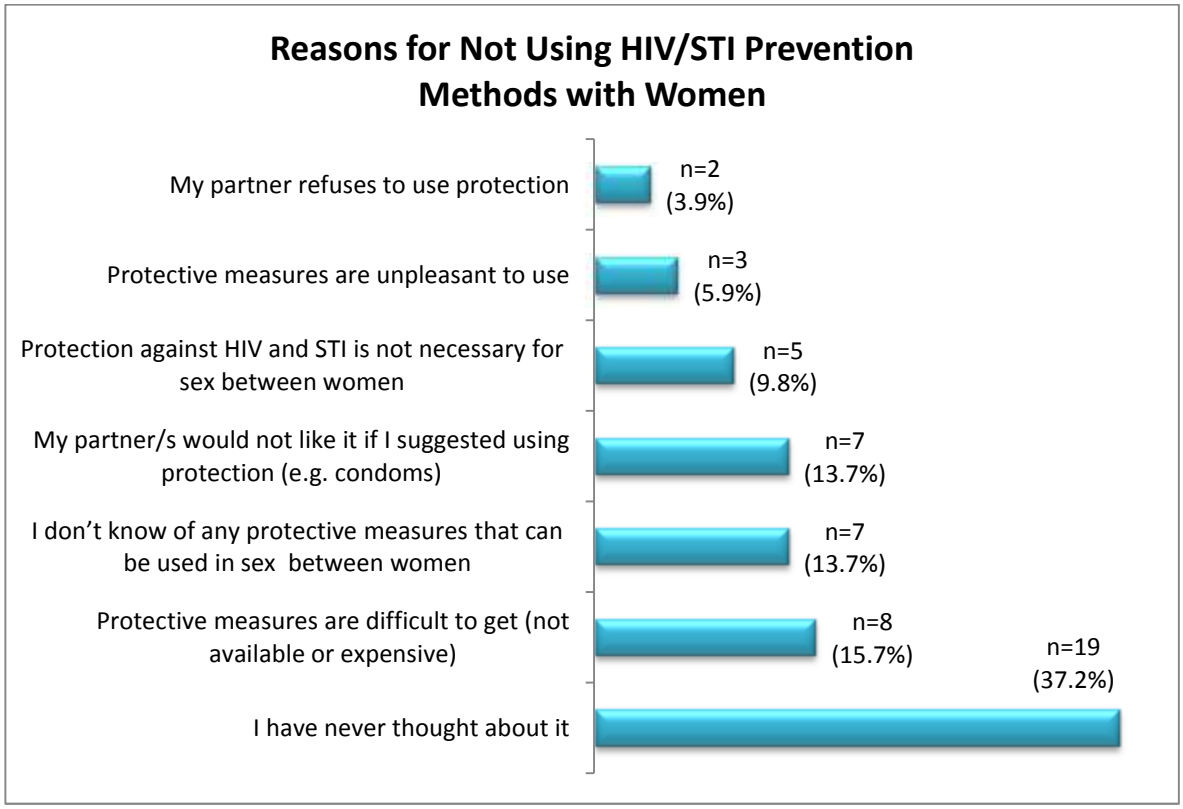


FIGURE 15. REASONS FOR NOT USING HIV OR STI PREVENTION METHODS WITH WOMEN

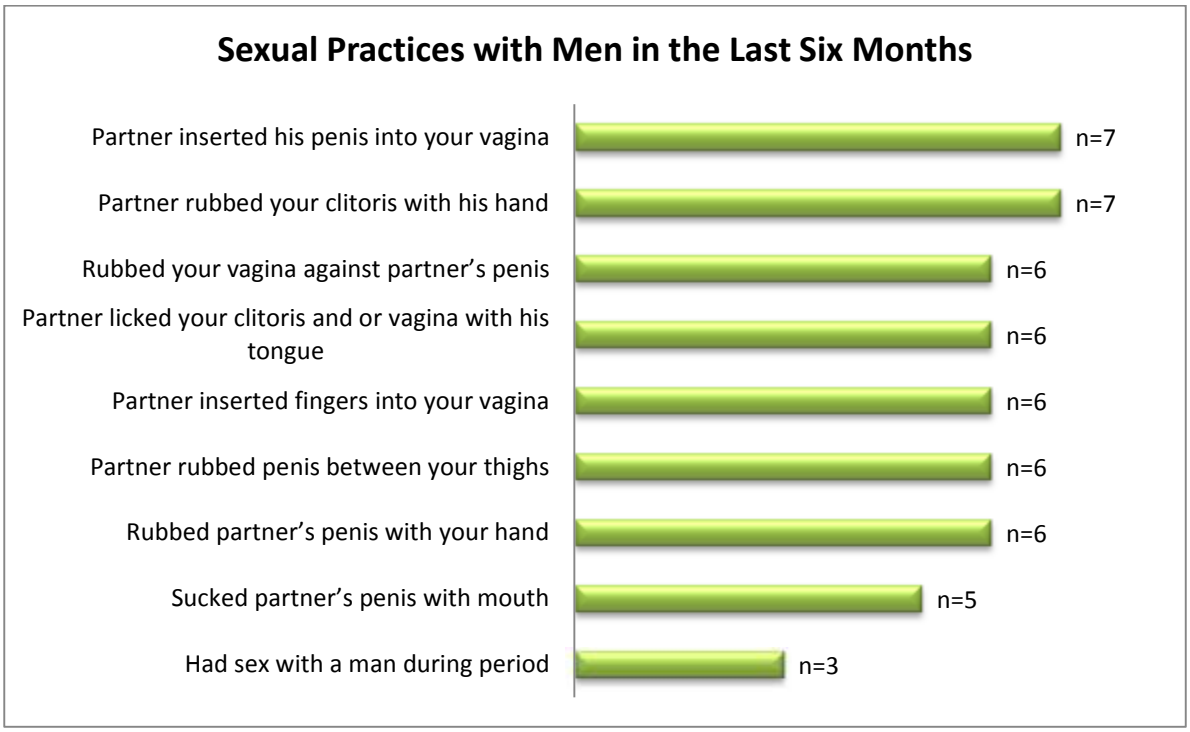


Female to female sex practices, globally, but especially in African contexts remain under-researched and are only now starting to be documented. This study on sex practices between women in South Africa is therefore a potentially valuable contribution to this field of knowledge.

Doing 'it' with men

Twenty-three participants said they had never had sex with a man and three did not answer the question, but 25 said they had had sex with a man. Of those, seven said they had had sex with a man during the last six months. Figure 16 lists most of the sexual practices that the participants engaged in with men in the last six months. All seven participants who reported sex with men in the last six months engaged in vaginal sex (i.e. "your partner inserted his penis into your vagina") and five took the man's penis in her mouth – oral sex. Only one of the five who performed fellatio on their partner used protection. Four of those who had vaginal sex did so with no protection. One had unprotected anal sex.

FIGURE 16. SEXUAL PRACTICES WITH MEN IN THE LAST SIX MONTHS



Four of the seven women who had had sex with a man in the last six months said they had also had sex with a woman during that time. Only one reported not to have had sex with a woman during that time, while the other two did not answer the question.

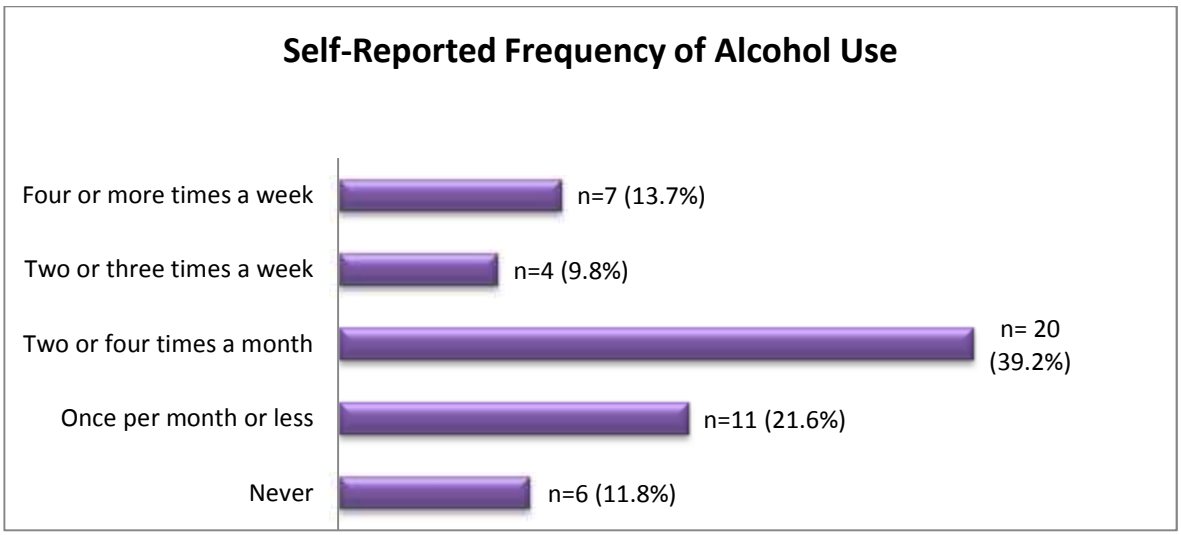
Risk Behaviours

Sexual risk behaviours are often compounded by other risk behaviours which may influence the mental state of the person. Other factors which need to be taken into account are the power relations in sexual relationships or partnerships, as well as knowledge and availability of HIV and STI prevention methods. Economic vulnerability is also a major factor in a person's ability to negotiate safer sex. Therefore risk is a complicated and complex issue potentially exacerbated by substance use, transactional sex and violence. Mainstream studies have 'picked up' wsw risk and vulnerability through these categories (CDC 2007) rather than through a primary focus on wsw risk and vulnerability.

Substance use

Research on alcohol-related influences on HIV risk behaviours has demonstrated cognitive and affective processes that link alcohol expectancies with sexual risk-taking (Weinhardt & Carey, 2000). In this study, 20 (39.2%) participants reported use of alcohol two or four times a month, whilst six (11.8%) of the participants reported to have never used alcohol. In addition, five (9.8%) reported alcohol use of two or three times per week and seven (13.7%), indicating a high frequency of alcohol use for almost a quarter of the sample. Over half (51%) of the study sample reported feeling that they should cut down on their drinking and almost 40 per cent reported feeling guilty about their alcohol use, indicating the possibility that participants may have under-reported the frequency of their alcohol use. It should also be noted that 33.3 per cent of the participants reported being told by other people to cut down on their drinking during the previous 12 months.

FIGURE 17. SELF-REPORTED FREQUENCY OF ALCOHOL USE



However, the study didn't identify any significant risk behaviours associated with alcohol use. Though 18 (35.3%) of the participants who indicated that they sometimes engaged in sex after drinking never made use of prevention methods, it should be seen in the context of most participants (60.7%) not making use of prevention methods under any circumstances. Of the 29 people who said they had sex after drinking, 24 said it was with a stable partner. Two common beliefs about HIV transmission could account for them not using prevention: firstly that wsw are not vulnerable to HIV, as well as the belief that one is not vulnerable in a stable or faithful relationships.

We also examined drug use of study participants in the last six months, and asked participants to indicate whether various drugs were used in the last six months. Besides the use of dagga by 23 participants, their responses show that only one woman had used mandrax, and one had taken Ecstasy, but none had used cocaine, tik, crack, mandrax, heroin or 'sniffed' glue, petrol or paint thinners. Also, none of the study participants reported ever having used needles to inject drugs.

Transactional sex

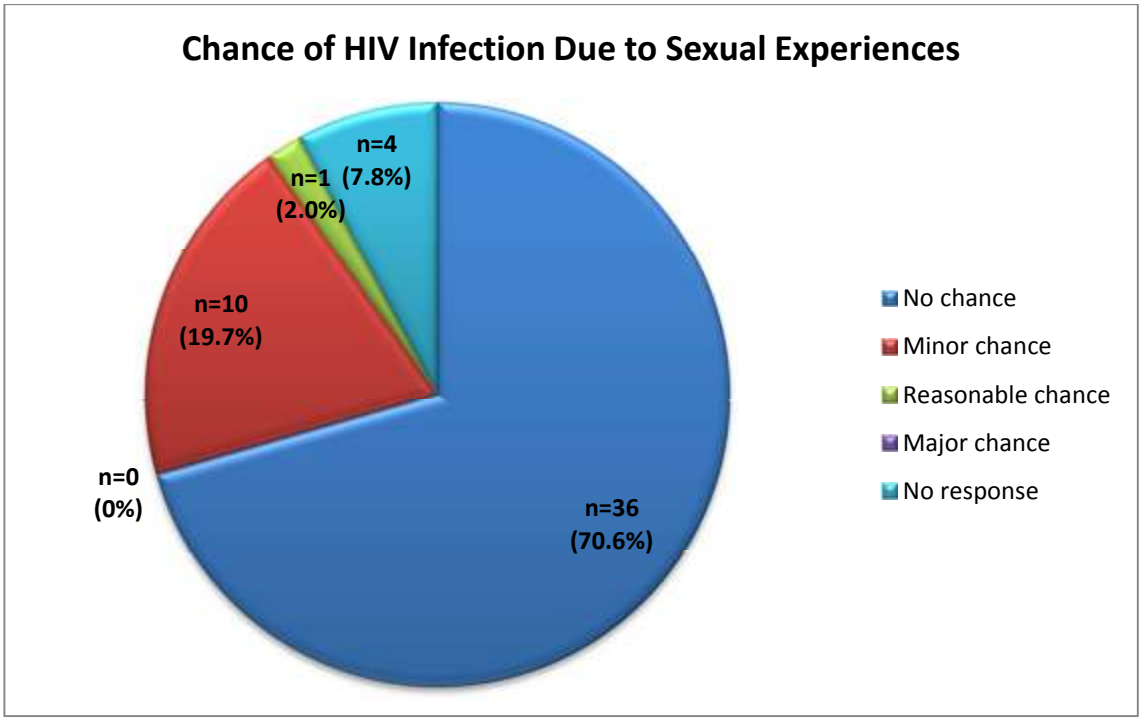
The survey also posed questions related to experiences of transactional sex with women and men. Forty-six participants said they had never exchanged goods or money for sex with women, while the rest of the answers were left blank. Only one person said they had exchanged sex for money with a man. Therefore the exchange of sex for money, drugs, shelter and other material goods is not a significant feature in the lives of the participants in this study.

Wsw risk behaviours

Unlike many earlier studies which identified wsw sexual practices as risky only when seen through the lens of other risk behaviours such as substance abuse and transactional sex, the participants in this study are not identified as high risk due to substance abuse or transactional sex. However, they could be most at risk from unprotected sex with men or from female to female sexual practices which include exposure to blood or mucosal secretions.

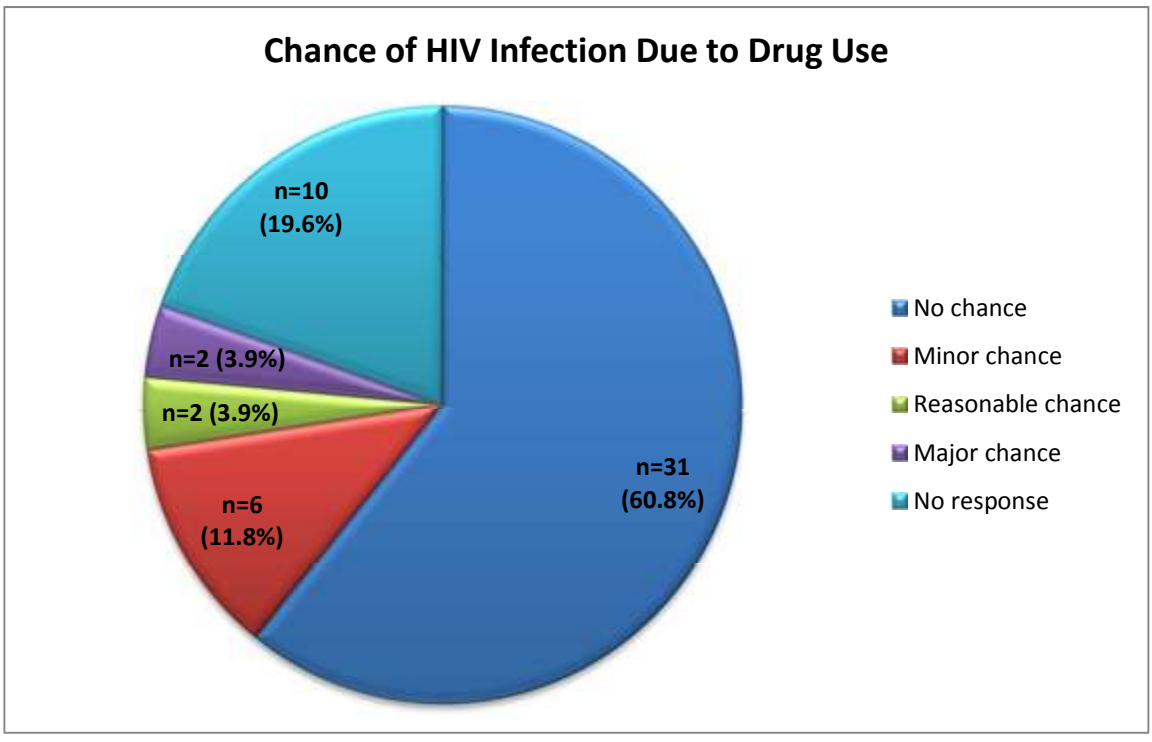
When asked what they thought their risks of infection to HIV were in light of their sexual experiences over the past 12 months, 36 participants (70.6%) said there was "no chance at all". Ten thought there was "a minor chance", and only one said there was "a reasonable chance". No one thought there was "a major chance". Four didn't answer the question.

FIGURE 18. HIV INFECTION RISK DUE TO SEXUAL EXPERIENCES



Alcohol and drug use are also considered as factors which exacerbate risk of HIV infection. Participants were more cautious about risks associated with drug use than their sexual experiences. Thirty-one (60.8%) thought there was “no chance at all” that they would be infected with HIV as a result of their drug use in the last 12 months.

FIGURE 19. HIV INFECTION RISK DUE TO DRUG USE

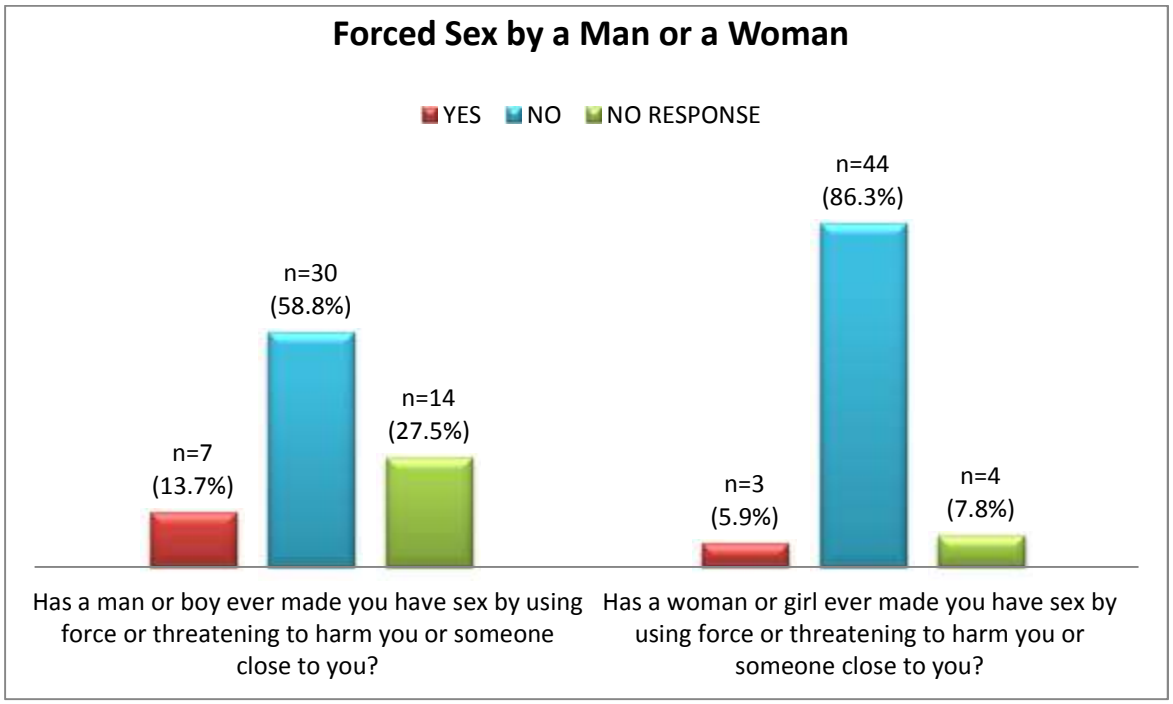


Transactional sex is another behavioural risk factor which has been identified for wsw, but which wasn't applicable in this study. Another major vulnerability factor, especially in South Africa is related to gender-based violence.

Experiences of Violence

Three of the study participants reported that they had been forced to have sex with another woman, whilst seven (13.7%) women reported forced sex perpetrated by a man against them. It is also notable that while 58.8 per cent of the study participants indicated that they had not been forced into sex by a man, a substantial proportion (i.e. 27.5%) did not respond to this question at all. In contrast, responses to the question pertaining to forced sex by a woman were more complete and definitive, with only 4 participants (7.8%) not responding.

FIGURE 20. FORCED SEX BY A MAN OR A WOMAN



Ten participants (19.6%) reported experiences of forced sex – three with women and seven with men. The experiences with women were rated as "not severe at all" to "mildly severe", but the ones with men or boys viewed as "very severe" to "extremely severe". None said that these experiences has happened within the last six months, but the youthfulness of the participants would indicate that these sexual assaults would likely have happened within the last ten years, and therefore would have made them vulnerable to HIV infection. These were within the times of heightened visibility of HIV and AIDS risks of infection, yet no one had sought

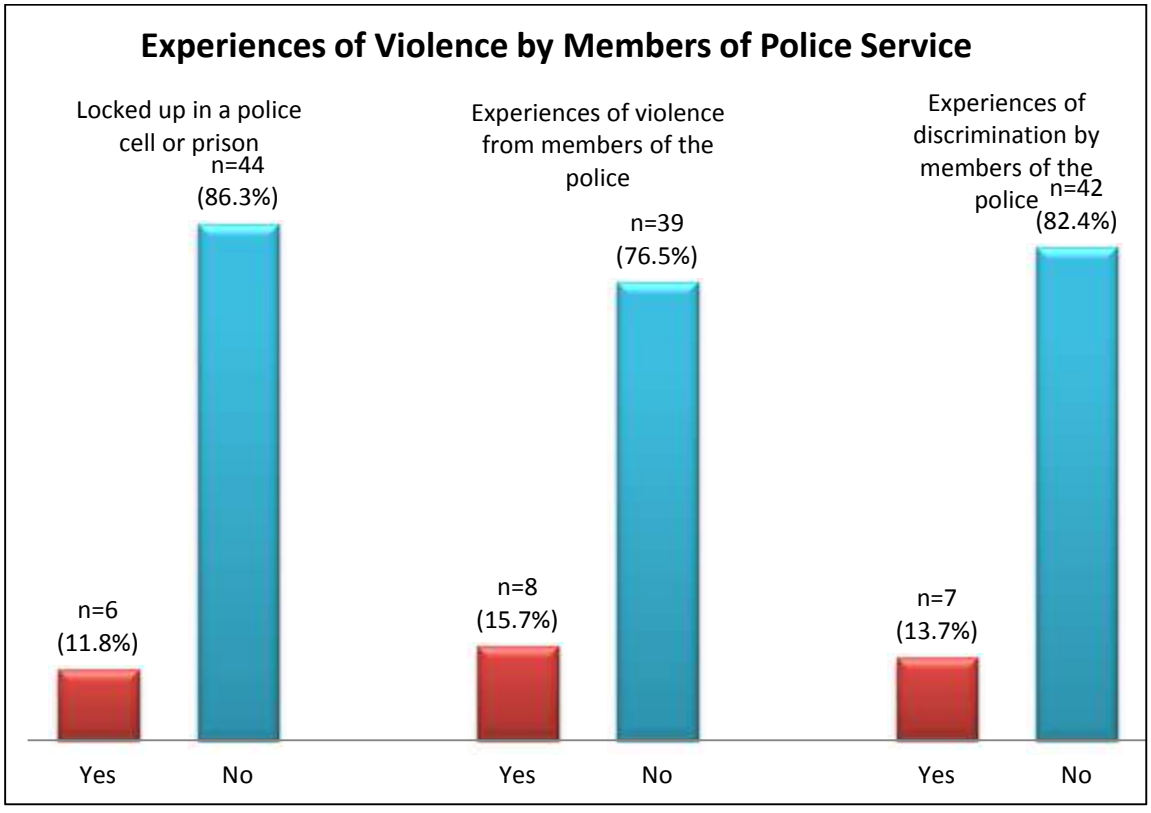
ARV treatment. Due to stigmatisation and fear of violence by service providers, including the police, wsw are unlikely to report these incidents and take post-exposure prophylaxis (PEP).

History of Imprisonment

A significant minority indicated that they had experienced violence from members of the police service, whist others had experienced discrimination by members of the police services. When wsw experience discrimination or perceive police service members to be hostile to them because of their same-sex desires, this might have an additional impact on them failing to report domestic or sexual violence.

Reporting of sexual offences to the police in South Africa is estimated at one person in 36, with only 15% of those leading to convictions. But information from community-based surveys estimate that one in three women in South Africa experience forced sex (Survivor Journey – Guest Board, 2011), which is confirmed by Jewkes and Abrahams (2002) who found that a third of adolescent girls are initiated into sex through rape. Furthermore, a quarter of men confessed to having sexually coerced a woman, many more than once (Jewkes & Abrahams 2002). This context of gender-based violence, compounded by hate crimes targeting lesbians, predicts it would not be unrealistic for the participants in this sample to have experienced sexual violence.

FIGURE 21. EXPERIENCES OF VIOLENCE BY MEMBERS OF THE POLICE SERVICE



Gender-based violence towards lesbians and wsw in South Africa because of their sexualities, and these attitudes are also reflected in service delivery (Nel & Judge, 2008), including healthcare systems as well as the criminal justice system. Experiences of sexual violence combined with stigmatised identities as well as poor services all impact on the vulnerability of wsw regarding HIV and STI infections.

We propose that gender-based violence poses a much greater risk of HIV infection to the wsw in this study than any other previously identified factors such as alcohol or injecting drug use or transactional sex.

HIV and STIs Knowledge

The HIV and AIDS pandemic has foregrounded sexuality issues in development, but the sexual health and rights of wsw and lesbians have not been represented in research, information campaigns, or policies and prevention guidelines (Lenke & Piehl, 2009). This exclusion from the knowledge production around risk and vulnerability to HIV and STIs would lead one to conclude that wsw might not know about sexual health issues regarding HIV and STI transmission, prevention and treatment. Furthermore, there is ample evidence from the mainstream to show that knowledge of prevention does not necessarily lead to safer sex practices.

In this study, results indicated that almost 60 per cent (58.8%) of the sample had never heard of HPV. Nonetheless almost 60 per cent indicated that they believe that wsw and lesbian women can transmit an STI during sex with each other.

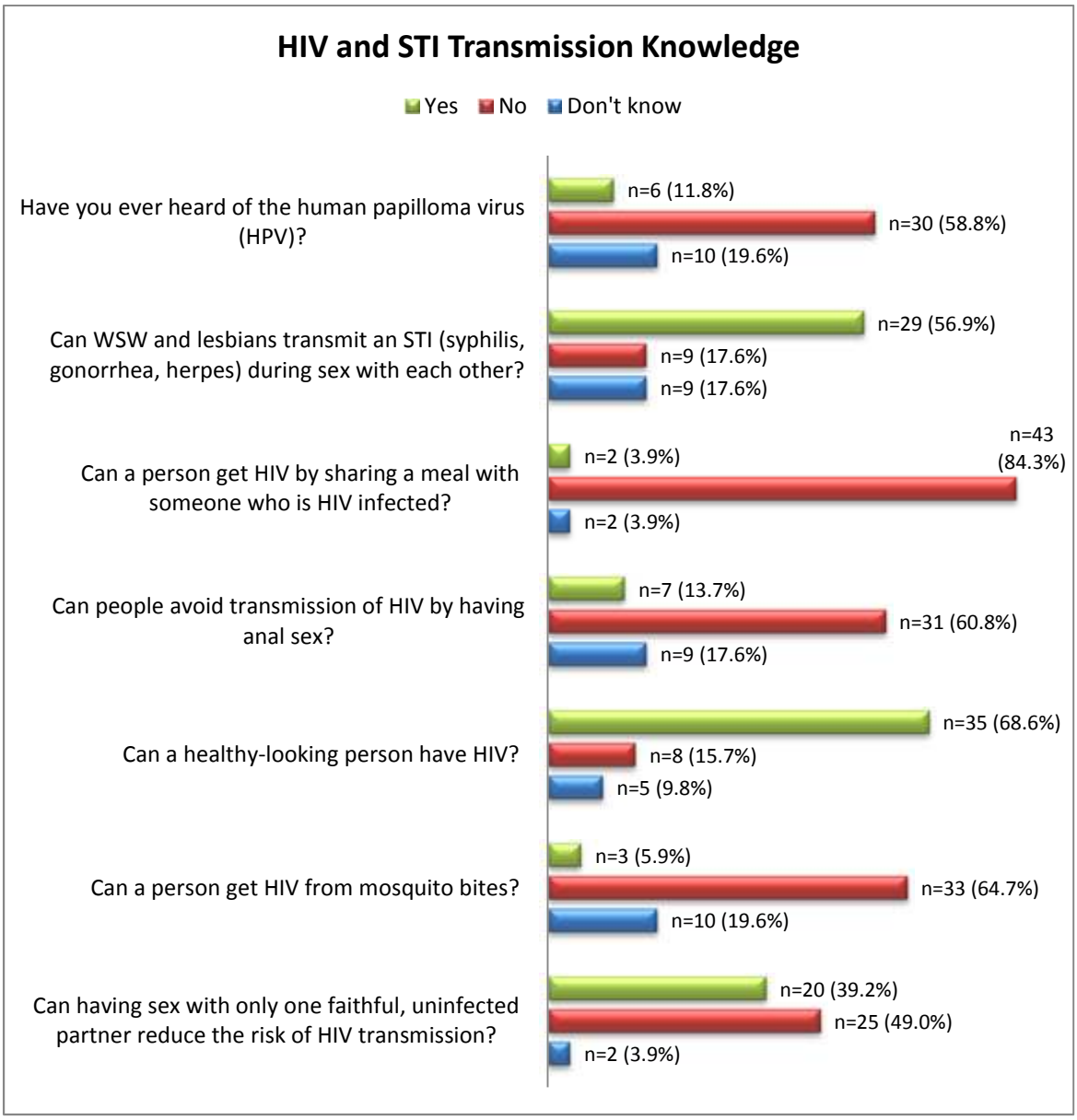
Taking into consideration the silence around wsw and their vulnerabilities to STIs and HIV in public health discourse, the high proportion of participants in this study (56.9%) who believed that an STI can be transmitted through female to female sex is substantial. This might be related to Triangle Project's work around sexual health in the study areas. This percentage, however stands in direct contrast to the participants' reports about the use of measures to prevent the transmission of STIs during sex with women. This kind of contradiction is reflective of similar beliefs in research on other populations regarding HIV knowledge and sexual health behaviours (Akande 2001; Eaton, Flisher & Aaro 2003; Strebel & Perkel 1991).

Shisana and Simbayi (2003) remark that knowledge alone cannot change behaviour. Certain communities may perceive themselves as 'immune' due to a variety of factors including perceptions of privilege and stigmatisation of groups deemed to be vulnerable, i.e. it happens to 'them' and not 'us'. While women generally are deemed more vulnerable than men, under the same-sex sexualities

umbrella, msm have dominated discourses of risk and vulnerability to the exclusion of wsw.

Transmission knowledge

FIGURE 22. HIV AND STI TRANSMISSION KNOWLEDGE



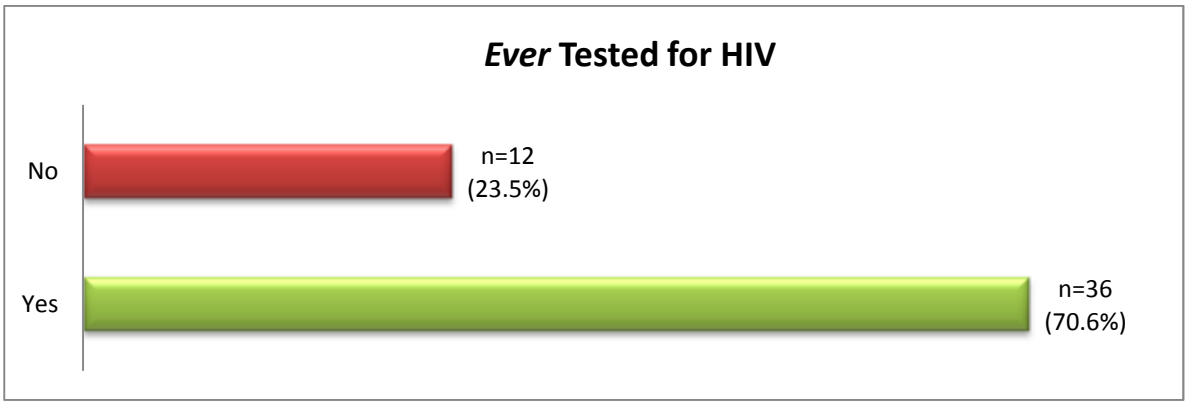
It has been shown that masculinity is deeply implicated in risk-taking behaviour generally, as well as in sexual behaviour (Shefer, Buikema et al. 2004; Shefer, Ratele et al. 2007). Therefore issues of masculine identifications such as 'butch' or 'man' among wsw indicate a channel for investigation, to assess whether risk-taking behaviour is a characteristic of cross-gender identifications too.

HIV testing and STI diagnosis

In South Africa, The National HIV survey conducted by the HSRC every three years since 2001, reported that there had been a dramatic increase from 2005 to 2008 in the percentage of the population who reported awareness of their HIV serostatus (Shisana et al., 2009). Until recently, the predominant HIV testing approach in South Africa was client-initiated individual HIV Counselling and Testing (HCT) carried out in a health facility. This form of HCT, usually referred to as *voluntary counselling and testing (VCT)*, operates from the premise that individuals who voluntarily make a decision to request HIV testing are more likely to be motivated to change their risk behaviour (Swanepoel, 2004). However, since the World Health Organisation's (WHO) change of approach to Provider Initiated Testing (PIT) in 2007 there has been a drive to scale up HIV testing. The new South African Policy Guidelines (Dept. of Health, 2010) shifted from client-initiated VCT to PIT. However the dangers to women of this approach in the context of a society rift by deep gender inequalities, and overlaid by authoritarian cultures among health providers, was illustrated in research done by Kehler, Cornelius, Blosse and Mthembu (2010). They showed how health providers in public facilities disregarded the rights to confidentiality, consent, and access to health of women in a drive to coerce them to test. For groups such as wsw who are already marginalised and stigmatised by the health care system it does not bode well for encouraging them to test.

In this survey we explored the HIV counselling and testing (HCT) practices of participants. We asked participants to indicate whether they have ever tested for HIV; awareness of their closest HCT facility; times tested for HIV; when last tested for HIV; most recent test result; place of most recent HIV test, main reason for most recent HIV test and reasons for never having been tested for HIV. Figure 21 shows the proportion of the sample who have ever tested for HIV. Three people did not answer this question.

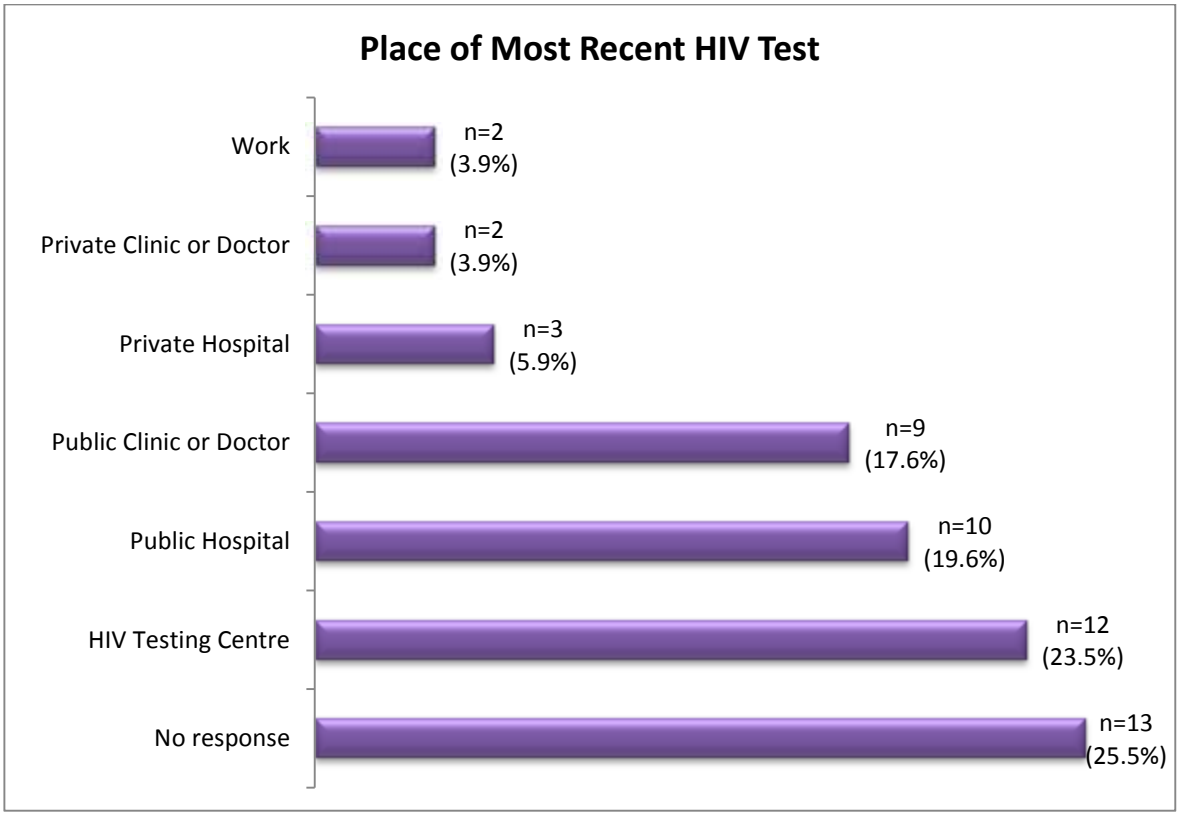
FIGURE 23. *EVER* TESTED FOR HIV



In this study, 70.6 per cent of the study sample reported having tested for HIV on at least one occasion. Of these, just over half (51%) of the sample reported that their most recent HIV test was less than a year ago, whilst 15.7 per cent had tested between one and two years ago. Some participants had tested as many as eight times, and the average number of times participants had tested was 2.2 times. Twenty-three had tested more than once. Thus a substantial proportion of the participants have tested for HIV, in spite of prevailing perceptions among participants that their risk of HIV infection is minimal.

When asked where they had tested, more than a quarter (25.5%) of the participants did not answer this question because they had not *ever* tested for HIV. In this study, the study participants had their most recent HIV test at a HIV testing centre (23.5%); public hospital (19.6%) and at a public clinic or doctor (17.6%). The other seven had tested at private facilities. (See Figure 22).

FIGURE 24. PLACE OF MOST RECENT HIV TEST



Thus the majority of the participants made use of testing facilities in the public health care sector. In general HIV prevention, treatment, counselling and care services are implemented within a heteronormative framework. Therefore, even though wsw are able to, and, as indicated in this study, do access HCT within the public health sector, it is unlikely that the counselling, information and resources provided will be relevant to women's sexual relationships with other women. This

would tend to support the view that lack of appropriate services for wsw in sexual health is itself a source of HIV and STI vulnerability for wsw.

The study also assessed the main reasons for participants having taken their most recent HIV test. Fourteen participants (twelve of whom had never tested) did not respond to this question. The majority (58.8%) said "I wanted to know my HIV status", which constitutes 80.6 per cent of those who have *ever* taken an HIV test. Other reasons included two being asked by a partner to test, feeling sick and applying for a loan. One person tested after having unprotected sex with a man, indicating an awareness of heterosexual transmission risk.

FIGURE 25. MAIN REASON FOR TAKING LAST TEST

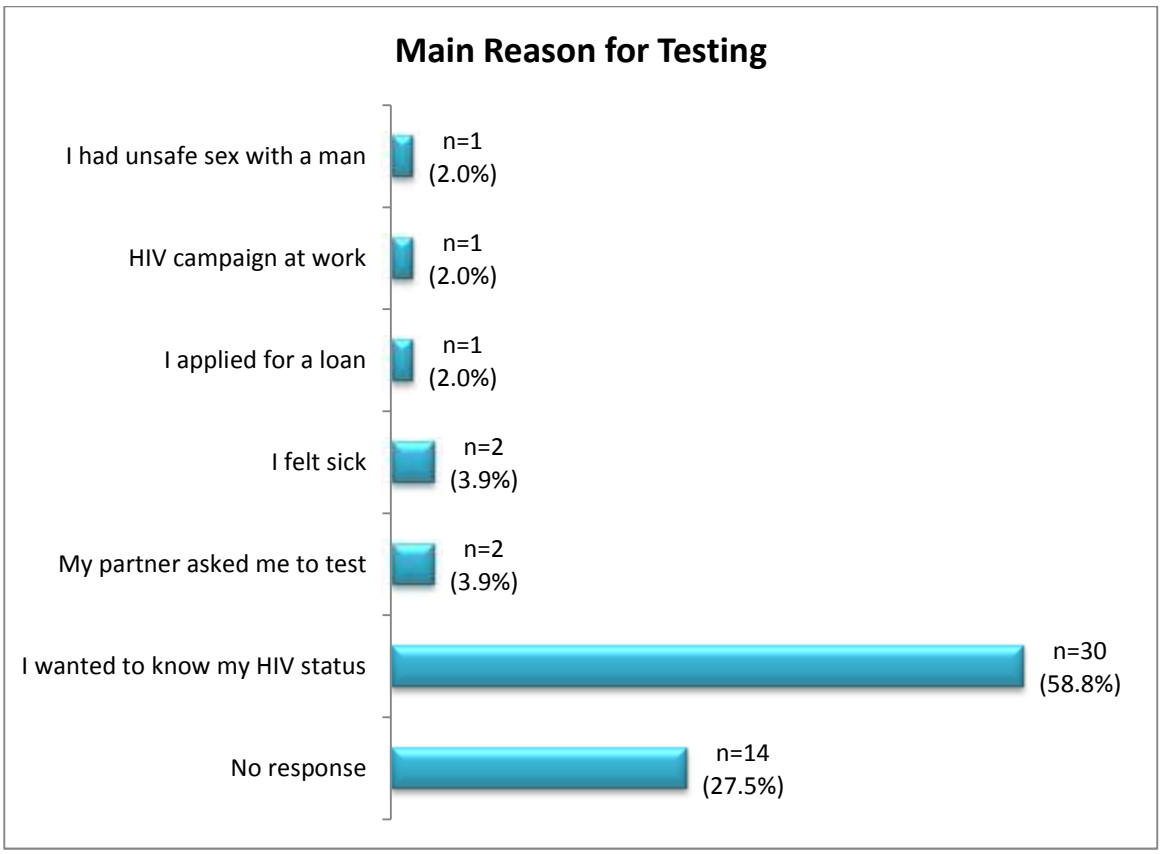
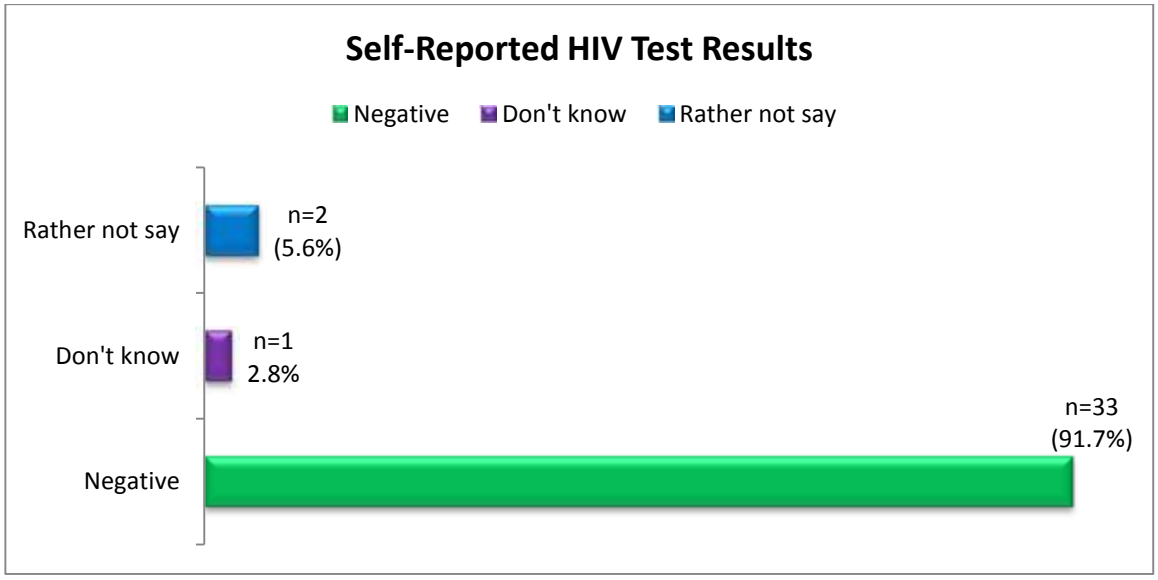
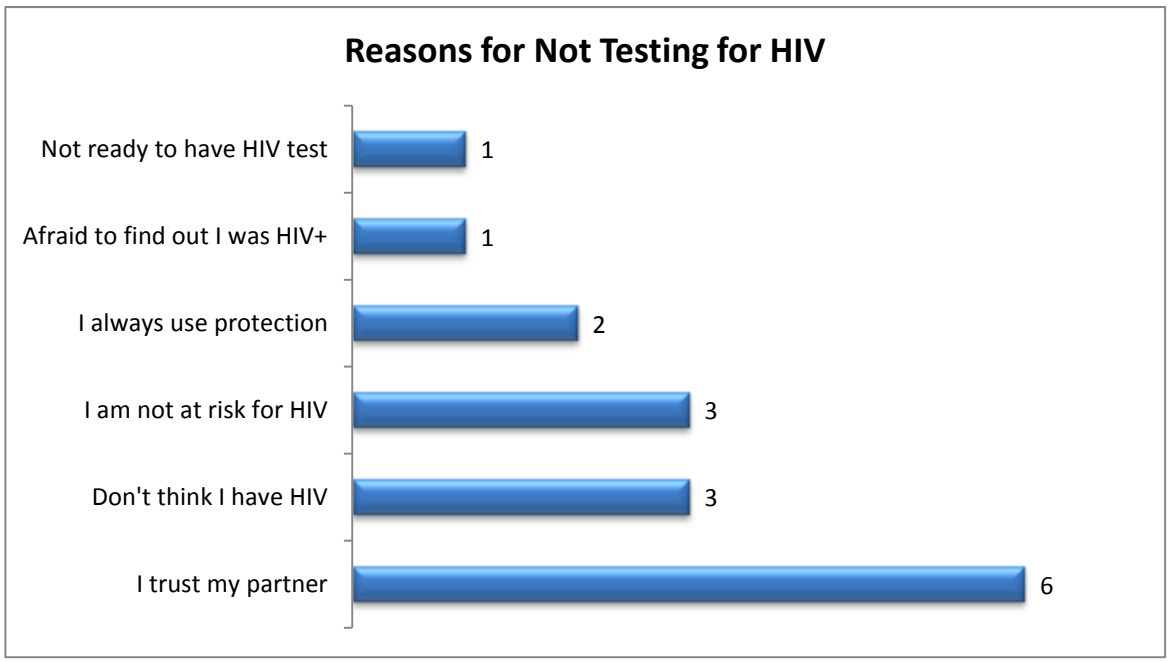


FIGURE 26. SELF-REPORTED HIV TEST RESULTS



Of the 36 who had tested, 33 (91.7%) of the 36 participants reported a HIV negative status, two would "rather not say" their HIV status, whilst one indicated that "I do not know/I never collected my result". In the survey there was also an "HIV-positive" response category. In this study sample no one reported an HIV-positive status. This may be because survey participants knew the fieldworkers. No anonymous HIV testing was done to assess HIV prevalence in this study sample. Relying therefore only on self-reported status, the HIV prevalence rate amongst participants who know their status appears to be close to zero.

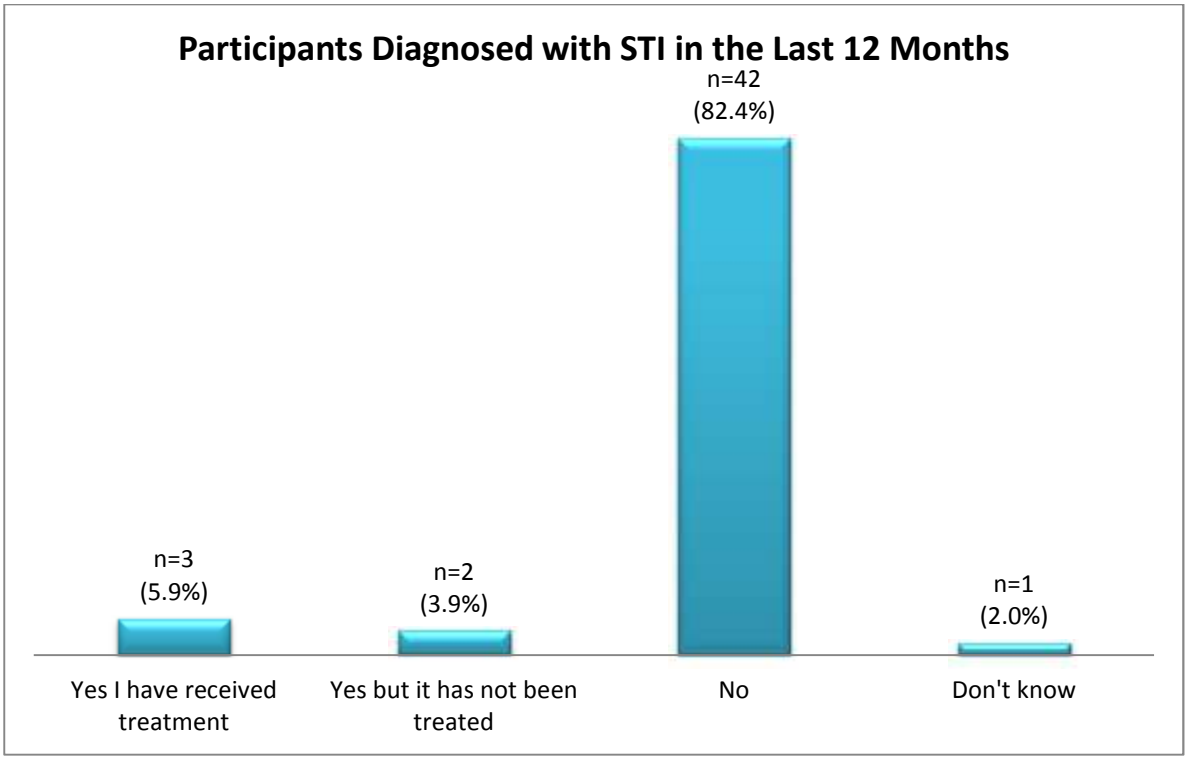
FIGURE 27. REASONS FOR NOT TESTING FOR HIV



It should be noted however, that 12 participants – almost a quarter (23.5%) – of the sample had never had an HIV test. The 12 participants provided a total of 16 reasons for not testing. The main reasons reported for not testing are: I trust my partner (6); I don't think I have HIV (3); I am not at risk for HIV (3); I always use protection (2); I was afraid to find out I was HIV-positive (1) and I was not ready to have an HIV test (1). These reasons are shown in Figure 25 above.

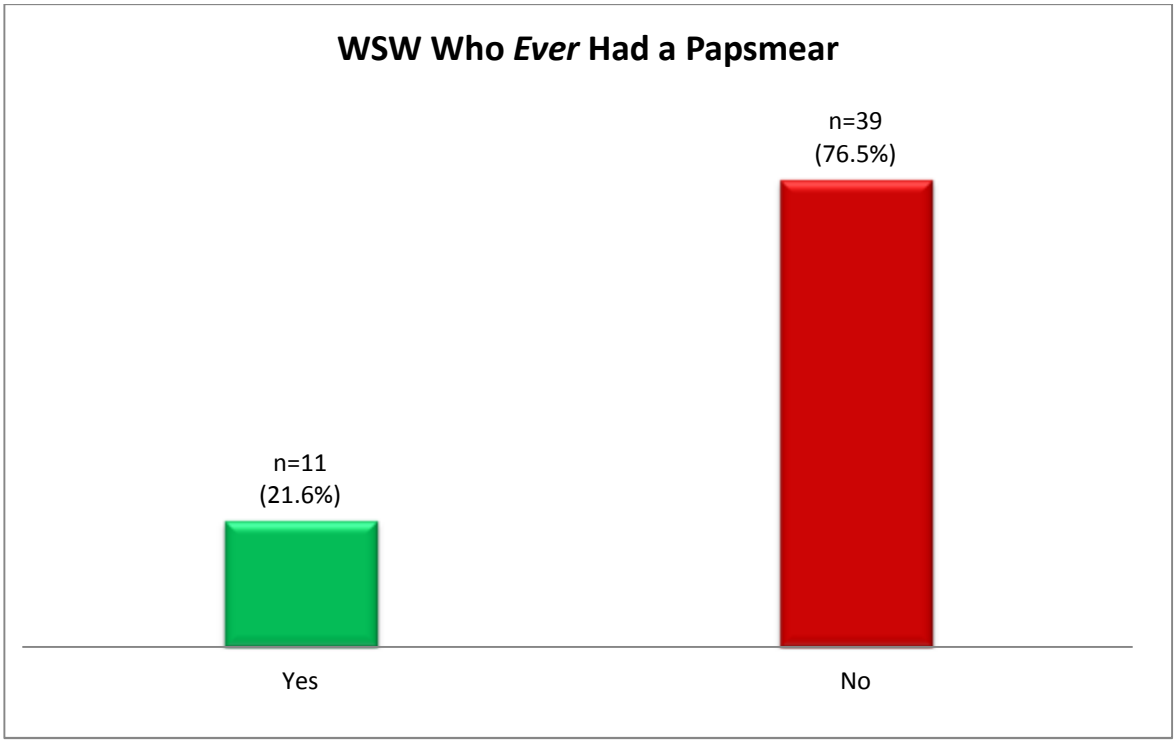
When asked whether they had been diagnosed with an STI such as Hepatitis B and C, Herpes, Gonorrhoea, HPV, Chlamydia or Syphilis, three participants did not answer the question. The vast majority (42 – 82.4%) of the study participants reported no history of STIs, whilst three reported having been diagnosed with a STI, and having received treatment. Two reported a history of STIs that had not been treated.

FIGURE 28. PARTICIPANTS DIAGNOSED WITH STIS IN THE LAST YEAR



Pap smears are routine tests to screen for pre-cancerous or cancerous cells in the neck of the vagina, near the cervix. Changes in are usually caused by sexually transmitted human papillomaviruses. Regular screening is recommended for women who are sexually active, including wsw.

FIGURE 29. WSW WHO HAD A PAPSMEAR



One person did not answer this question, but 39 participants (76.5%) said they had not had a papsmear. Only 11 participants had had a papsmear, which could reflect the young age cohort of the participants. However, it could also indicate that there is a belief that wsw are not at risk of HPV.

Wsw – HIV and AIDS

The HIV and AIDS epidemic was one of the key factors responsible for placing sexual behaviour and practices on research agendas (Heilborn & Cabral, 2006b). However, the surveillance of sexual behaviour as part of HIV research is usually focused on vaginal intercourse in relation to heterosexual relationships, while other types of sexual practices in relation to both heterosexual and same-sex partnerships are not specified (Heilborn & Cabral, 2006b). This is especially true about same-sex sexual practices between women. Therefore it is not surprising that the manner in which vulnerability emerged in the context of this study, is linked strongly to dominant discourses of non-vulnerability for lesbians and wsw.

Like many other groupings their knowledge and perceptions of risk are not translated into behavioural changes. Though they exhibited high degrees of knowledge related to HIV transmission, and many tested for HIV, they also engaged in sexual practices where bodily fluids would likely have been exchanged. Nonetheless they did not see themselves as at risk.

Gender identifications are also factors which needs to be taken into account when working with wsw on sexual health. It is important to consider reproductive health too, especially among black African wsw, as motherhood might be considered a desirable identity linked to womanhood.

Dworkin typified the process by which heterosexual women gained visibility in the context of the HIV and AIDS pandemic as follows:

> She is the leading lady in the AIDS epidemic. She was under the surface, hidden, but finally emerged, rushed forward with newfound breath, born into existence with twin shoves: first, feminism; next epidemiological fathomability and visibility. She appeared in 1993 as vulnerable (Dworkin, 2005, p. 615).

Furthermore she asks: "But who, precisely, was seen, and how, exactly, was she viewed and why?" (Dworkin, 2005: 616). This is the preamble to an examination, not of the 'facts' of HIV as experienced by women, but how discourses of HIV vulnerability are shaped by, and shape what is imaginable or meaningful in relation to gendered and sexualised categories.

Therefore, do the designations "vulnerable group" or "most at risk population" (MARP) create any shifts in the allocation of and access to resources and the provision of appropriate health services? And what does visibility in the context of public health mean?

However, vulnerability is more nuanced, and groups need to be viewed through an intersectional lens (Dworkin, 2005). Surely heteronormative masculinities which construct 'risk-taking' as a desirable attribute (Shefer et al., 2003) make heterosexual men vulnerable, inasmuch as its corollary, rape, makes women vulnerable?

At present, there is a general perception that the risk of HIV infection for wsw as a grouping is negligible and that there is certainly not enough 'evidence' to suggest inclusion in HIV/AIDS-related policies, programmes and services. For activists who want to challenge the invisibility of wsw in policies and programmes, that they need to present evidence to demonstrate the 'vulnerability' of wsw (as if there is some competition for recognition). This sense is tangible from government policy-makers as well as other advocates and activists in civil society – particularly those focused on public policy in relation to sexual health needs of msm or gay men.

The current situation regarding public health discourses around key populations and MARP has resulted in a fragmentation of advocacy into competing interest groups, where all are impelled to emphasise and demonstrate exactly how

vulnerable the grouping that they represent is, and vying for greater consideration and a bigger portion of the resources allocated to HIV and AIDS programming.

This study contributes to the field of wsw vulnerability and risk by bringing some evidence as well as texture to these discourses.

In the next chapter we provide a brief overview of the policy framework in South Africa for sexual and reproductive health. We also make recommendations based on the findings in this study.

CHAPTER FIVE

Where to Next?

In this final chapter we give a short overview of the policy framework for sexual and reproductive health in South Africa, then briefly review the findings from the previous chapter and draw recommendations from them.

Heteronormativity and phallocentrism are the ideological underpinnings for the exclusion of wsw from discourses of risk and vulnerability to HIV and AIDS. Notions that HIV risk is associated with heterosexual sex, and that women are the 'most' vulnerable, have focused programmes on heterosexual transmission of HIV. Heterosexual sex as 'real' sex is centred on penis-vagina penetration. In the absence of a penis, risk and vulnerability to HIV and AIDS all but disappear. Hence wsw have also been excluded from same-sexualities discourses which focus on msm. Even where women have become visible as 'more vulnerable' (than men), wsw are excluded because they are not 'real' women and do not have 'real' sex. Similarly, the identity of motherhood is linked primarily to heterosexual sex, and in spite of multitudes of programmes focusing on prevention of mother to child transmission, wsw are excluded as 'real' mothers.

HIV and STI Policy Framework

> Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors (WHO, http://www.who.int/reproductivehealth/topics/gender_rights/sexual_health/en/#)

The World Health Organisation recognises that sexuality is a central aspect of people's humanity (WHO, n.d.), and key authors on policy acknowledge that

"sexuality is not a side issue but a core issue that lies at the heart … of the HIV/AIDS pandemic …" (Petchesky, 2007:14). Until the latest South African National Strategic Plan on HIV (2011) they were eerily silent on sexuality generally, but lesbians and wsw get no mention at all (Dept. of Health, 2006). Msm are identified as part of 'Populations at higher risk', though the report states that "Whilst HIV infection amongst MSM was a focus in the early phases of the epidemic in South Africa, there is very little currently known about the HIV epidemic amongst MSM in the country. MSM have also not been considered to any great extent in national HIV and AIDS interventions" (Dept. of Health, 2006: 35). This self-confessed exclusion affirms the centrality of heteronormativity in the South African policy framework.

In the National Strategic Plan (NSP) of 2012–2016 (Dept. of Health, 2011), 'sexuality' has its debut in the form of guidance through "sexuality counselling" (p. 7) and "intergenerational conversations with young people on sex and sexuality" (p. 36). It is also recognised as a form of stigmatisation and discrimination where illnesses intersect with "sexuality and gender identity" (p. 36). For the first time they recommend "sexuality education … through the curriculum in all schools" (p. 75).

After their complete absence in previous NSPs, wsw have been defined in the current plan (p. 7), but only get mentioned in the report as an add-on to msm where "social norms may also promote discrimination against … those with different sexual orientations (e.g. MSM and WSW)" (Dept. of Health, 2011: 39). While msm are identified for interventions, wsw disappear out of the plan, thereby reconfirming the phallocentric and heteronormative bias of government's policy guidelines. It also shows no understanding of the relationships between sexuality and sexual behaviour, sexual practices and sexual identities and the multitude of risky sexual practices which can be performed regardless of sexual or gender identification.

While there is an acknowledgement that inequalities in 'gender roles and norms' contribute to women's vulnerability to HIV infection, some categories of 'women' are identified as 'populations at risk', e.g. young girls, pregnant women and sex workers. Yet women are still represented as homogeneous, and little acknowledgement is given to how gender inequalities intersect with other social divisions based on class, age, race, gender identity and sexuality.

In contrast to the invisibility of sexuality in the NSP, a literature review (Klugman et al., 2011) undertaken to inform the Department of Health's policy guidelines on *Sexual and Reproductive Health and Rights: Fulfilling our Commitments. 2011–2021 and Beyond* (SRHR), speaks directly to gender

inequalities, gender variability and sexual diversity in the context of sexual and reproductive health rights. In consequence the policy guidelines (Dept. of Health, 2011b: 25) reflect a sensitivity to stigmatisation of certain groups, including "transgender people … and people with diverse sexual orientations". However, regrettably the gender inequalities as they pertain to the sexual and reproductive rights of lesbians, bisexual women, wsw, transgendered individuals, intersex persons, gay men and msm are not explored. Therefore proposals that advocate "education, information and ideas that … challenge gender stereotypes and fearful or negative attitudes towards sexuality and towards those who engage in non-conforming … sexual practices" (p. 13) do so in a vacuum.

However, the general injunction to challenge existing norms through education and skills development for the public as well as service providers, opens a welcome gap for advocacy by civil society organisations to pressurise the Department of Health explicitly to address the sexual and reproductive rights of gender non-conforming individuals.

Recommendations

This pervasive invisibility of lesbians, bisexuals and wsw in discourses of HIV risk and vulnerability has contributed the lack of recognition of wsw in research, policies, education, services and programmes on HIV prevention and treatment. This invisibility has translated into the meaning that 'wsw are not at risk of HIV infection', even among wsw themselves. Therefore the main recommendation arising out of this study is:

Advocacy

> **Educate the public on the real risks and vulnerabilities of wsw, based on evidence which is appropriate and relevant in:**
>
> - **wsw communities**
> - **research**
> - **advocacy and lobbying**
> - **service delivery**
> - **media.**

Though this study is small, it provides evidence which can be integrated with other work on the subject.

Identities

Overall, heterosexual relationships were viewed negatively and characterised by male domination, abuse and violence. In spite of heteronormative identifications in their roles in partnerships, more than eighty per cent of the participants claimed that decisions were made equally in their relationships, showing that, unlike the HIV vulnerability due to gender power relations in heterosexual relationships, wsw are in a stronger position to negotiate relationships.

- **In campaigns around safer-sex for wsw, emphasise the value of egalitarian relationships as a context where safer sex practices may be negotiated.**
- **Hold meetings and discussions with wsw to provide a platform where heteronormative roles in wsw relationships may be debated challenged.**

With the dominance of heteronormativity fostering 'compulsory' heterosexuality, girls and women may have sex with men. Furthermore, sexualities are fluid, and a 'learning process'. Motherhood is a strong feminine identity, especially amongst black African women, and some lesbians may choose to sleep with men to get pregnant.

Hold workshops which address the stigmatisation of wsw who have sex with men. Wsw may want to have sex with men in order to get pregnant.

The fluidity of gender identities, the variability of gendered social roles and the consequent power dynamics in lesbian sexual relationships confirms the inescapable need for contextualising gendered identities. Without a contextual framework for understanding gendered identities in particular locations research tools may be inappropriate to 'measuring' what it aims to research.

Research which explores factors based on gendered identities needs to be based on concepts that have been elicited and developed from lived identities and meanings from that research context.

For the first time the NSP (Dept. of Health, 2011) has included an aim of implementing sexuality education in schools.

Advocate for the inclusion of same-sex identities as part of the curriculum.

Sexual practices

More than 90 per cent (n=42) of the study sample reported ever having had sex with a woman, while 35 had had sex with more than one woman. Number of

sexual partners has been identified as a risk factor in HIV transmission in heterosexual sex practices.

In examining sexual practices experienced by the participants, it was clear that many involved mucous membrane exposures to bodily fluids like blood or vaginal secretions. More than a quarter of the women reported having sex when they had menstrual periods. A minority of participants spoke about less common practices like anal stimulation. All these practices can potentially lead to HIV transmission, especially in the presence of other STIs such as genital sores.

Provide sexual health and education programmes to communities which address:

- **Number and sex of sex partners**
- **Specifically risky practices, e.g. having sex during menstruation**
- **HIV and STI as compounding risk factors**
- **Prevention methods.**

These programmes should be targeted at service providers as well as wsw, and HIV activist groups with an emphasis on the fluidity of sexual practices.

Violence

Ten participants reported sexual coercion: three were by women, and seven with men. They categorised the sexual violence from women as “not severe” or “mildly severe”, but the experiences with men were viewed as “very severe” to “extremely severe”. Due to stigmatisation and fear of violence by service providers, including the police, wsw are unlikely to report these incidents and take PEP.

- **Disseminate information on pre-exposure-prophylaxis (PrEP) and post-exposure prophylaxis (PEP) to wsw.**
- **Identify sympathetic service providers to provide emergency PEP.**
- **Educate gender-based violence service providers on sexual violence against wsw.**

HIV and STI prevention

The participants were marginally more careful of STI transmissions than HIV. Though 36 of them (70.6%) had taken HIV tests, only 11 had had a papsmear. Like the myths of wsw and HIV vulnerability, there are assumptions that wsw are not vulnerable to HPV.

Produce suitable information regarding sexual health and reproduction specifically for wsw.

Provide access to respectful sexual and reproductive health services for wsw and msm:

- **dental dams and lubricants**
- **condoms**
- **HCT**
- **pre-exposure prophylaxis**
- **post-exposure prophylaxis**
- **STI management**
- **TB screening.**

Policy

Any national policies regarding HIV – the NSP, or sexual and reproductive health policies must take as a starting point the fundamental constitutional right of access to health care services, where the state has the primary responsibility for ensuring access.

Strategic objectives must address the specific access needs of particular groups such as women (pregnant, with child-bearing potential or post-menopausal, lesbian, bisexual and other wsw), men, adolescents, children, persons with disabilities etc.

Ensuring access to health care services requires that interventions be planned and implemented in a manner which

- **acknowledges and integrates their specific needs;**
- **addresses the social, cultural and other barriers that may stand the way of accessing services.**

The delivery of integrated SRHR services as part of the primary health care (PHC) approach within a district health system (Dept. of Health, 2011b) is a prerequisite for the success of the National Strategy Plan (NSP). Comprehensive sexual and reproductive health and rights services must

- **include all aspects of promoting a culture of respect for sexual and reproductive rights; and**
- **all aspects of prevention, diagnosis, treatment and care in relation to sexual and reproductive health.**

Services and prevention information and methods to all clients

- **should be age appropriate and relevant, including services for marginalised or vulnerable populations, such as persons with disabilities, transgender and intersex persons, same-sex practising persons, sex workers and people living with HIV, among others, and**
- **must be provided without prejudice or bias.**

The understanding that a range of sexual practices may occur across both opposite-sex and same-sex partnerships and that sexual identity does not always determine sexual behaviour (for example women who identify as lesbian may also have sex with men, and women who see themselves as heterosexual may have sex with women) should be integrated into services.

Services should be guided by a clear understanding of sexuality and the relationships between sexual behaviour, sexual practices and sexual identities.

Sexual and reproductive health rights are often interpreted to apply to women of child-bearing age and their children – eliding into 'maternal health'.

Contraception, fertility management services (including termination of pregnancy services) must be provided to all communities to improve planning for safe and desired pregnancies.

There is little or no recognition in policies of the differences between sexual behaviours (msm, wsw), diversity in sexual orientation and identity (lesbian, gay, bisexual, heterosexual), non-normative expressions of gender (transgender) and biological variability beyond the male–female binary (intersex).

Concepts that relate to human sexual and gender diversity must be incorporated and explicitly defined in national policy documents such as the NSP.

Both the NSP and the SRHR documents make recommendations for education and skills development on sexuality. This is an opportunity for civil society organisations to provide appropriate interventions and advocacy on people with non-conforming gender identities.

Develop interventions and advocacy to support the DoH's education programmes on sexuality.

Directions for Future Research

The invisibility of wsw in HIV risk and vulnerability research agendas has left a lacuna in the field of knowledge. Therefore, in line with the UNGASS document:

> **There is a need to fund research that improves our understanding of SRHR of wsw and lgbti groups in relation to HIV and STI risk and vulnerability.**

Though not widely generalisable, information from this study can form the basis for further studies.

> **Specific questions arising around the apparent visibility of wsw in this study:**
>
> - **Has the increased visibility of 'homosexuality' as a public phenomenon provided a point of recognition for lesbians and bisexuals to openly claim their same-sex desires and identities?**
> - **Have the legal and constitutional protections helped lesbian and bisexual women in urban, peri-urban and rural communities feel able to claim their sexual rights?**
> - **How do lesbian and bisexual women experience the role of these paper rights in their lives?**
> - **Has there been a real shift in the often lamented invisibility of lesbian identities in various communities?**
> - **To what extent are the increasing reports of violent attacks targeting lesbians a backlash against increased visibility of lesbianism both as a public phenomenon and as an identity openly claimed by individual women in local communities?**
>
> **Replicate the study in other areas, and do comparative analyses.**
>
> **Use the current study as a basis for further investigations regarding HIV and STI risk and vulnerability for wsw.**

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Questionnaire

Promoting the sexual & reproductive heath & rights of

Promoting the sexual & reproductive heath & rights of

HIV/STI STUDY OF LESBIAN, BISEXUAL AND OTHER WOMEN WHO HAVE SEX WITH WOMEN (WSW) IN RURAL AND PERI-URBAN AREAS WITHIN THE WESTERN CAPE

SELF-ADMINISTERED QUESTIONNAIRE, 2010

Thanks for taking time to fill out this survey.

Please answer all questions honestly.
Try not to skip any questions.
You may stop doing the survey at anytime.

Please do not put your Name on this questionnaire

If you have any questions or you wish to make any additional comments, please contact Jill Henderson: (021) 448 - 3812

GEOGRAPHIC AND INTERVIEW PARTICULARS

Name of Town	
Name of township or neighbourhood where you live	
How long have you lived in this area?	

To be filled in by fieldworker

Questionnaire number	
Interviewer's surname	
Today's date d d m m y y	

REFUSAL PARTICULARS (IF APPLICABLE)

AT WHAT POINT DID THE RESPONDENT REFUSE?
1 = After explanation of the survey and the process
2 = During the individual interview
3 = Other _____
_____

Do you wish to say why you don't want to take part? You don't have to say
Specify_____

SECTION 1: DEMOGRAPHIC INFORMATION

1.1 How old are you? _____

1.2 Which country were you born in? _____

1.3 How would you describe your race? (Please choose one and circle the corresponding number)

1. African
2. Coloured
3. White
4. Indian
5. Other; please specify_____

1.4 How long have you been living in the Western Cape Province?

1. I was born here
2. More than one year
3. Less than one year

1.5 What language do you speak most often at home?

1. Afrikaans
2. isiXhosa
3. English
4. Other; please specify _____

1.6 What is your current marital status? (Please choose one)

1. Married to a woman
2. Married to a man
3. Divorced or separated from a woman
4. Divorced or separated from a man
5. Widowed
6. Never been married
7. Other, please specify _____

1.7 Do you have children?

1. YES
2. NO

1.7.1 If yes, how many children? _____

1.8 Are you a member of any faith or religious grouping?

1. YES
2. NO

1.9 If yes, what is your religion?

1. Christian
2. African traditional
3. Muslim
4. Other, please specify _____

1.10.1 What is the highest level of schooling that you attended?

1. No Schooling
2. Primary School
3. Secondary School
4. Higher Education (University; Post-Matric Education)

1.10.2 What is the highest grade/year/certificate/diploma/degree you completed at that level:_____

1.11 Where do you live?

1. In a house on a farm/smallholding
2. In a wendy house/bungalow on someone else's plot
3. In a shack
4. In a flat or apartment
5. In a house (rented)
6. In a house (owned)
7. I live on the streets
8. Other, please specify _____

1.12 How would you describe your present employment situation?

1. Unemployed
2. Employed (have a steady job)
3. Occasional work (piece work, odd jobs)
4. Unpaid volunteer work
5. Other, please specify)_____

1.13 What is your income (before tax) each month?

1. No income
2. Amount per month R_____
3. Refuse to say

1.13.1 How do you get by financially (rent, food, health care, clothes, other living expenses) (Please choose all that apply to you and circle the corresponding number/s)

1. My own income
2. Government grant
3. Income of partner
4. Income of other family members
5. Friends help me out
6. Other, please specify _____

1.14 Do you have anyone else who depends on your income? (Please choose all that apply)

1. Children
2. Partner
3. Brother and/or sisters
4. Parents
5. Grandparents
6. Other family members
7. Other, please specify_____

1.15 Are you on a medical aid?

1. YES
2. NO

SECTION 2: SEXUAL ORIENTATION & GENDER

2.1 Were you born female?

1. YES
2. NO

2.2 Do you feel more sexually attracted to women or to men?

1. Only to women
2. More to women then to men
3. To women and men equally
4. More to men than to women
5. Only to men

2.3 How would you describe your sexual orientation?

1. Lesbian (only attracted to women)
2. Bisexual (attracted to both men and women)
3. Heterosexual (straight) (attracted to the opposite sex)
4. I don't identify with any of the above
5. Other , please specify_____

2.4 How do you see yourself in terms of your gender? *(In this study, gender refers to the social construction of the roles prescribed to men and women)*

1. I see myself as transgender
2. I see myself as a woman
3. I see myself and a man
4. Other, please specify_____

2.5 How many people in your family know that you are sexually attracted to persons of the same sex?

1. None of them
2. Some of them
3. All of them

2.6 How many people at your school, university, college know that you are sexually attracted to persons of the same sex?

1. None of them
2. Some of them
3. All of them

4. I am not at school, university, college

2.7 How many people at your workplace know that you are sexually attracted to persons of the same sex?

1. None of them
2. Some of them
3. All of them
4. I am unemployed

2.8 How many people in your home or household know that you are sexually attracted to persons of the same sex?

1. None of them
2. Some of them
3. All of them
4. I live alone

2.9 Below are some statements about how you could feel about being part of the general community where you currently are living. Please indicate whether you agree or disagree with these statements.	Agree	Agree Somewhat	Disagree	Disagree Somewhat
Where I live, people accept me	1	2	3	4
I feel misunderstood where I live	1	2	3	4
I am part of the community where I live	1	2	3	4
I feel like an outsider where I live	1	2	3	4

SECTION 3: SEXUAL PARTNERS AND RELATIONSHIPS

3.1 What is the sex of your current sexual partner(s)?

1. Male
2. Female
3. Both female and male
4. Intersex (people born sexual organs that are not clearly female or male)

3.2 What is your current relationship status?

1. Living together with a woman
2. Married to a woman
3. Single
4. Divorced / separated
5. Living together with a man
6. Married to a man
7. Widowed
8. In a relationship, but not living together
9. Other (specify): _____

3.3 In your relationship with your main partner, who makes the rules and decides what happens in the relationship	
3.3.1 I make the rules and decide what my partner does in the relationship	1
3.3.2 My partner makes the rules and decide what happens in the relationship	2
3.3.3 We both equally make decisions within the relationship	3
3.3.4 I am not currently in a relationship	4

Sex with Women

(Instruction for the participant: Please be as specific with numbers as far as possible: e.g., 30/35/23 and not 30+/35+-/23+-)

3.4 Have you ever had sex with a woman? *(By sex we mean any form of sexual practices listed in 3.9)*

1. YES
2. NO ***[GO TO 3.13]***

3.5 How old were you when you had sex with a <u>woman</u> for the first time?
Your age in years_____

3.6 How old was the woman you had sex with for the first time (if you don't remember her exact age was, please fill in her approximate age)?

Her age in years? _____

3.7 How many <u>women</u> have you <u>ever</u> had sex with? _____Number of Women

3.8 Have you had sex with women in the <u>last 6 months</u>?

1. YES _____(Please indicate the **number of women**)
2. NO ***[GO TO 3.13]***

3.9 Please indicate what sexual practices you engaged in with women during the last 6 months?

YES	NO	SEXUAL PRACTICES <u>WITH WOMEN</u> IN THE LAST 6 MONTHS
1	2	You rubbed your partners clitoris with your hand
1	2	Your partner rubbed your clitoris with her hand
1	2	You inserted your fingers into your partners vagina
1	2	Your partner inserted her fingers into your vagina
1	2	You inserted your fist (whole hand) into your partners vagina
1	2	Your partner inserted her fist (whole hand) into your vagina
1	2	You licked your partner clitoris and/or vagina with your tongue/mouth
1	2	Your partner licked your clitoris and/or vagina with her tongue
1	2	You inserted your fingers into your partners anus (butt)
1	2	You partner inserted her fingers into your anus (butt)
1	2	You inserted your fist (whole hand) into your partner's anus (butt)
1	2	You partner inserted her fist (whole hand) into your anus (butt)
YES	**NO**	**SEXUAL PRACTICES WITH WOMEN IN THE LAST 6 MONTHS**
1	2	You licked your partner's anus/butt with your tongue
1	2	Your partner licked your anus/butt with her tongue
1	2	You rubbed your breast against or into your partner's vagina
1	2	Your partner rubbed her breast against or into your vagina
1	2	You rubbed your vagina against your partner's vagina

1	2	You inserted a sex toy (dildo, vibrator, any other object) into your partner's vagina
1	2	Your partner inserted a sex toy (dildo, vibrator, any other object) into your vagina
1	2	You inserted a sex toy (dildo, vibrator, any other object) into your partner's anus (butt)
1	2	Your partner inserted a sex toy (dildo, vibrator, any other object) into your anus (butt)
1	2	You had sex with a woman while you or she had a period (menstruation)
1	2	Are there any other sexual activities that you have engaged in with another woman that are not named in the list above. If Yes, please explain: _____

3.10 In the last 6 months have you had consensual sex with a <u>woman</u> where you or her did things (cutting, biting, hitting, rough sex) that caused either you or her to bleed?

1. YES
2. NO

3.11 What are the approximate ages of your most recent <u>female</u> sexual partners in the last 6 months? (Record regular partner/s first)

1. Partner No. 1 Age in years_____
2. Partner No. 2 Age in years_____
3. Partner No. 3 Age in years_____
4. Partner No. 4 Age in years_____
5. Partner No. 5 Age in years_____

3.12 What is the sexual orientation of your most recent female sexual partners? (Record regular partner/s first)

Sexual partners in the last 6 months	Lesbian	Bisexual	Heterosexual/ Straight	Not Sure
Partner No.1	1	2	3	4
Partner No.2	1	2	3	4
Partner No.3	1	2	3	4
Partner No.4	1	2	3	4
Partner No.5	1	2	3	4

Sex with Men

3.13 Have you ever had sex with a man? *(By sex I mean any form of sexual contact including any of the sexual practices listed in section 3.17)*

1. YES
2. NO, I have never had sex with a man. ***[GO TO SECTION 4]***

3.14 How old were you when you had sex with a man for the first time?

Your age in years _____

3.15 How old was the man you had sex with for the first time (if you don't remember his exact age was, please fill in his approximate age)?

His age in years? _____

3.16 Have you had sex with a man in the last 6 months?

1. YES _____**(Please indicate the number of men)**
2. NO

3.17 Please indicate what sexual practices you engaged in with men during the last 6 months?

YES	NO	SEXUAL PRACTICES WITH MEN IN THE LAST 6 MONTHS
1	2	You rubbed your partners penis with your hand
1	2	Your partner rubbed and moved his penis between your thighs (thigh sex)
1	2	Your partner rubbed your clitoris and with his hand
1	2	Your partner inserted his fingers into your vagina

1	2	Your partner inserted his fist (whole hand) into your vagina
1	2	Your partner inserted his penis into your vagina
1	2	You sucked your partner penis with your tongue and mouth
1	2	Your partner licked your clitoris and/or vagina with his tongue
1	2	You inserted your fingers into your partners anus (butt)
1	2	Your partner inserted his fingers into your anus (butt)
1	2	You inserted your fist (whole hand) into your partner's anus (butt)
1	2	You partner inserted his fist (whole hand) into your anus (butt)
1	2	You licked your partner's anus/butt with your tongue
1	2	Your partner licked your anus/butt with his tongue
1	2	You rubbed your vagina against your partner's penis
1	2	You inserted a sex toy (dildo, vibrator, strap on, any other object) into your partner's anus (butt)
1	2	Your partner inserted a sex toy (dildo, vibrator, strap on, any other object) into your vagina
YES	**NO**	**SEXUAL PRACTICES WITH MEN IN THE LAST 6 MONTHS**
1	2	Your partner inserted a sex toy (dildo, vibrator, strap on, any other object) into your anus (butt)
1	2	You had sex with a man while you had your period (menstruation)
1	2	In the last 6 months are there any other sexual activities that you have engaged in with a man that are not named in the list above. If YES, please explain: inserted penis into anus

3.18 In the last 6 months have you had consensual sex with a man where you or him did things (such as cutting, biting, hitting, rough sex) that caused either you or him to bleed?

1. YES
2. NO

3.19 What are the approximate ages of your most recent male sexual partners in the last 6 months? (Record regular partner/s first)

1. Partner No. 1 Age in years_____
2. Partner No. 2 Age in years_____
3. Partner No. 3 Age in years_____
4. Partner No. 4 Age in years_____
5. Partner No. 5 Age in years_____

3.20 What is the sexual orientation of the your most recent male sexual partners? (record regular partner/s first)

Sexual partners in the last 6 months	Gay	Bisexual	Heterosexual/ Straight	Not Sure
Partner No.1	1	2	3	4
Partner No.2	1	2	3	4
Partner No.3	1	2	3	4
Partner No.4	1	2	3	4
Partner No.5	1	2	3	4

3.21 In the last 6 months have you had sex with more than one person at the same time?

1. YES, with more than one women
2. YES, with more than one man
3. YES, with both a man/men and a woman/women at the same time
4. NO

SECTION 4: HIV & STI PREVENTION

4.1In the last 6 months, during your sexual contact with **women**, did you do anything to prevent the possible transmission of HIV?

1. YES
2. NO
3. I don't know how to prevent the transmission of HIV when having sex with women

4.2 In the last 6 months, during your sexual contact with **women**, did you do anything to prevent the possible transmission of other sexually transmitted infections (STIs) such as Hepatitis B and C, Herpes, Gonorrhea, HPV, Chlamydia, Syphilis?

1. YES
2. NO

4.3 In the last 6 months, did you use any of the following when having sex with **women**?

	YES	NO	NOT SURE WHAT THIS IS
Dental Dams	1	2	3
Cling wrap	1	2	3
Latex gloves	1	2	3
Finger cots	1	2	3
Condoms on sex toys such as dildos or vibrators	1	2	3
Female condom/femidom	1	2	3
Other protective measures	1	2	3
If you have used any other measures to prevent HIV and STI transmission during sex with women, please explain what you used? _____			

4.4 During the last 6 months, how often have you used protection when having sex with a **woman**?

1. Every time
2. Almost every time
3. Sometimes
4. Never

4.5 If in the last 6 months you have not used protection during sex with one or more of your **female sexual partners**, what are your reasons for not using protection to prevent HIV and STI transmission? (*Please choose all the reasons that apply to you and circle the corresponding number. If you have reasons other than those mentioned below, please write them down in the space provided.)*

1. Protection against HIV and STI is not necessary for sex between women
2. My partner/s would not like it if I suggested using protection (e.g. condoms)
3. My partner refuses to use protection

4. Protective measures are unpleasant to use
5. I have never thought about it
6. Protective measures are difficult to get (not available or expensive)
7. I don't know of any protective measures that can be used in sex between women

4.6 In the last 6 months, did you do anything to prevent the possible transmission of HIV when having sex with a **man**?

1 YES

2 NO

3 I don't know how to prevent the transmission of HIV when having sex with men

4.7 In the last 6 months, during your sexual contact with men did you do anything to prevent the possible transmission of other sexually transmitted infections (STIs), such as Hepatitis B and C, Herpes, Gonorrhea, HPV, Chlamydia, Syphilis, when having sex with **men**?

1 YES

2 NO

4.8 In the last 6 months, did you use any of the following when having sex with **men**?

	YES	**NO**	**NOT SURE WHAT THIS IS**
Dental Dams	1	2	3
Cling wrap	1	2	3
Latex gloves	1	2	3
Finger cots	1	2	3
Condoms on sex toys such as dildos or vibrators	1	2	3
Female condom/femidom	1	2	3
Other protective measures	1	2	3
If you have used any other measures to prevent HIV and STI transmission during sex with men, please explain what you used? _____			

4.9 During the last 6 months, how often have you used protection during sex with men?

1 Almost every time

2 Sometimes

3 Never

4.10	**During the last 6 months:**	**YES**	**NO**
4.10.1	Have you had vaginal sex (penis in your vagina) with a man without using a condom?	1	2
4.10.2	Have you had anal sex with (penis in your anus) a man without using a condom?	1	2
4.10.3	Have you had performed oral sex (penis in your mouth) on a man without using a condom?	1	2

4.11 If in the last 6 months you have not used protection during sex with one or more of your **male sexual partners**, what are your reasons for not using protection to prevent HIV and STI transmission? (*Please choose all the reasons that apply to you and circle the corresponding number. If you have reasons other than those mentioned below, please write them down in the space provided.)*

1. I do not need to use protection
2. My male partner/s would not like it if I suggested using protection
3. Male sexual partner refused to use a condom
4. I wanted to fall pregnant
5. I did not plan to have sex with a man, so I did not think about using condoms
6. I was drunk or high
7. Other reasons, please specify_____

4.12 In the last 6 months, have you done anything to prevent pregnancy?

1. No
2. Yes, I used condoms
3. Yes, I am on contraceptives (e.g. the pill, the injection)
4. Yes, I used another method, please specify

_____

4.13 Have you ever had sex with a **man** mainly because you wanted to fall pregnant?

1. YES
2. NO

SECTION 5: HIV/AIDS AWARENESS

	YES	NO	DON'T KNOW
Can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission?	1	2	3
Can a person get HIV from mosquito bites?	1	2	3
Can a healthy-looking person have HIV?	1	2	3
Can people avoid transmission of HIV by having anal sex.	1	2	3
Can a person get HIV by sharing a meal with someone who is HIV infected?	1	2	3
Can women who have sex with other women and lesbian women transmit a sexually transmitted infection (STI) (syphilis, gonorrhea, herpes) during sex with each other?	1	2	3
Have you ever heard of the human papillomavirus (HPV)?	1	2	3

SECTION 6: SEXUAL HEALTH

6.1 Have you ever had a pap smear?

1. YES
2. NO

6.1.2 If YES, when last did you have a pap smear? Year_____

6.2 In the last 12 months have you been told by a medical doctor or nurse that you a sexually transmitted infection (STI) such as, Hepatitis B and C, Herpes, Gonorrhea, HPV, Chlamydia, Syphilis?

1. Yes I have received treatment
2. Yes, but it has not been treated

3. No
4. Don't know

The following questions are about HIV testing. Please note that the information you give will be kept completely anonymous and confidential

6.3 Do you know of a place close to your home where you can get an HIV test?

1 YES

2 NO

6.4 Have you ever had an HIV test?

1. YES
2. NO ***[Go to 6.10]***

6.5 If you have tested for HIV: How many times have you been tested for HIV?

_____

6.6 How long ago did you have your most recent HIV test?

1. Less than a year ago
2. Between 1-2 years ago
3. Between 2-3 years ago
4. Three or more years ago

6.7 What was the result of your most recent HIV test?

1. Negative
2. Positive
3. Don't know/never collected result
4. Rather not say

6.8 Where did you have your most recent HIV test?

1. Public hospital
2. Private hospital
3. Public clinic or doctor
4. Private clinic or doctor
5. Traditional healer
6. LoveLife clinic
7. Youth-Centre
8. HIV testing centre
9. Workplace
10. Other, please specify_____

6.9 What was your main reason for having your most recent HIV test? (Please choose only one)

1. I wanted to know my HIV status
2. My partner asked me to go for testing
3. I wanted to start a new sexual relationship
4. I wanted to get married
5. I applied for an insurance policy
6. I applied for a loan
7. My employer requested it
8. I was feeling sick
9. I was instructed by a health worker (nurse/doctor)
10. There was a HIV testing campaign at work
11. I found out that one of my sexual partners has HIV
12. I had unsafe sex with a man
13. I had unsafe sex with a woman
14. I was raped / forced to have sex against my will
15. Other reason, please specify_____

6.10 If you have never been tested for HIV, what are your reasons for not getting tested? (Please choose each reason that applies to you)

1. I do not know where to get tested
2. I do not think that I have HIV
3. I am not at risk for HIV
4. I trust my partner
5. I always use protection
6. I was afraid to find out that I might be HIV positive
7. I am not ready to have an HIV test
8. I was concerned about CONFIDENTIALITY
9. I was concerned about STIGMA, DISCRIMINATION or REJECTION
10. I was concerned about LOSING MY JOB
11. I am concerned about the STANDARD OF SERVICE
12. I haven't got around to it
13. Other, please specify_____

SECTION 7: SEX, MONEY AND FAVOURS

7.1 Have you ever had sex of any kind with another woman in exchange for any of the following things: *(please choose all that apply)*

1. Food
2. A place to stay
3. Clothes
4. Drugs / Alcohol
5. Transport
6. Money
7. No, I have never had sex with a woman for these reasons

7.2 In the last 12 months, have you had sex with a woman in return for food, clothes, a place to sleep, drugs, money, etc?

1. YES
2. NO

7.3 In the last 12 months, have you given another <u>woman</u> money, gifts, food, transport, drugs, or a place to stay in exchange for having sex with you?

1. YES
2. NO

7.4 Have you <u>ever</u> had sex of any kind with another <u>man</u> in exchange for any of the following things: *(please choose all that apply)*

1. Food
2. A place to stay
3. Clothes
4. Drugs / Alcohol
5. Transport
6. Money
7. No, I have never had sex with a man for these reasons

7.5 In the last 12 months, have you had sex with a <u>man</u> in return for food, clothes, a place to sleep, drugs, money, etc?

1. YES
2. NO

7.6 In the last 12 months, have you given man money, gifts, food, transport, drugs, or a place to stay in exchange for having sex with you?

1. YES
2. NO

SECTION 8: ALCOHOL USE

8.1 How often do you drink alcohol?

1

1. Never ***[GO TO SECTION 9]***
2. Once per month or less
3. Two to four times a month
4. Two to three times a week

5. Four or more times a week

8.2 Have you ever felt you should cut down on your drinking?

1. YES
2. NO

8.3 Have other people suggested that you cut down on your drinking?

1. YES BUT NOT IN THE LAST 12 MONTHS
2. YES DURING THE LAST 12 MONTHS
3. NO

8.4 Have you ever felt bad or guilty about your drinking?

1. YES
2. NO

8.5 How often do you have sex after drinking?

1. Always
2. Sometimes
3. Never

8.6 How often do you use protective measures (such as condoms and dental dams) in these instances?

1. Always
2. Sometimes
3. Never

8.7 Who do you have sex with in these instances?

1. Stable partner
2. Casual partner
3. Strangers
4. Other, please specify)_____

8.8 If you have sex with strangers when drink, are these strangers men or women or both.

1. Men
2. Women
3. Both men and women

SECTION 9: USE OF OTHER SUBSTANCES

9.1 During the last 6 months how often have you used any of the following drugs?

	No Times	Only Once	More than Once
Dagga (Cannabis, Hashish)	0	1	2
Cocaine	0	1	2
Tik	0	1	2
Crack	0	1	2
Mandrax	0	1	2
Heroin	0	1	2
Glue, Petrol or paint thinners	0	1	2
Other drugs, please specify_____	0	1	2

9.2 Have you ever used a needle to inject drugs into your body?

1. YES
2. NO ***[GO TO SECTION 10]***

9.2.1 IF YES: Have you used a needle to inject drugs into your body in the last 6 months?

1. YES
2. NO

9.3 During the last 6 months, have you injected drugs using a needle that had already been used by someone else?

1. YES
2. NO

SECTION 10– EXPERIENCES OF VIOLENCE WITH WOMEN

INSTRUCTION: I am going to ask you questions about violence in your community. Please remember that your name is not written anywhere and everything you write is confidential.

10.1 a) Has a woman or girl ever made you have sex by using force or threatening to harm you or someone close to you?

1 YES

2 NO ***[GO TO SECTION 11]***

10. 1 b) **IF YES** Has a woman or a girl done this in the last 12 months?

1 YES

2 NO

10.2 a) Has a woman or girl ever made you have oral sex by force or threat of force? Just so there is no mistake, by oral sex we mean that a woman or girl penetrated your vagina or anus with her mouth or forced you to penetrate her vagina or anus with your mouth.

1 YES

2 NO

10. 2 b) **IF YES** Has a woman or a girl done this in the last 12 months?

1 YES

2 NO

10.3 a) Has a woman or girl ever put fingers or objects in your vagina or anus against your will or by using force or threats?

1 YES

2 NO

10.3 b) **IF YES** Has a woman or a girl done this in the last 12 months?

2

1 YES

2 NO

10.4 If you ever had any of the above negative experiences with women or girls, were these women or girls you knew before this happened or were these women or girls strangers to you?

I knew the woman/girl	1
I did not know the woman/girl	2
There were women/girls that I knew and that I didn't know	3

10.5 How often would you say you have had these experiences with women or girls?

Seldom	1
A few times	2
Regularly	3
Often	4

10.6 Looking back, how severe would you say these experiences with women or girls were?

Not severe at all	1
Mildly severe	2
Somewhat severe	3
Very severe	4
Extremely severe	5

SECTION 11– EXPERIENCES OF VIOLENCE

WITH MEN

11.1a) Has a man or boy ever made you have sex by using force or threatening to harm you or someone close to you?

1 YES

2 NO ***[Go to 11.7]***

11.1 b) **IF YES** Has a man or a boy done this in the last 12 months?

1 YES

2 NO

11.2 a) Has a man or boy ever made you have oral sex by force or threat of force? Just so there is no mistake, by oral sex we mean that a man or boy put his penis in your mouth or penetrated your vagina or anus with his mouth.

1 YES

2 NO

11.2 b) **IF YES** Has a man or a boy done this in the last 12 months?

1 YES

2 NO

11.3a) Has a man or boy ever put fingers or objects in your vagina or anus against your will or by using force or threats?

3

1 YES

2 NO

11.3 b) **IF YES** Has a man or a boy done this in the last 12 months?

1 YES

2 NO

11.4 If you ever had any of the above negative experiences with men or boys, were these men or boys you knew before this happened or were these men or boys strangers to you?

I knew the man/boy	1
I did not know the man/boy	2
There were men/boys that I knew and that I didn't know	3

11.5 How often would you say you have had these experiences with men or boys?

Seldom	1
A few times	2
Regularly	3
Often	4

11.6 Looking back, how severe would you say these experiences with men or boys were?

Not severe at all	1
Mildly severe	2
Somewhat severe	3
Very severe	4
Extremely severe	6

11.7 Have you ever been locked-up in a police cell or prison?

1 YES

2 NO

11.8 Have you ever experienced any type of violence (verbal, physical, sexual abuse) from members of the police service?

1 YES

2 NO

11.9 Have you ever felt discriminated against by members of the police service because of your sexual orientation?

1 YES

2 NO

11.10 If you have been a victim of rape during the last 12 months, did you report the rape to the police.

1. Yes
2. No

11.11 If you have been raped during the last 12 months, did you take any antiretroviral (ARV) medication in order prevent the possible transmission of HIV?

1. YES
2. NO

11.12 If NO, what are your reasons for not taking ARVs after you had been raped?

1. I did not think about it.
2. I did not know where or how to get ARVs

3. I have never heard of ARV medication
4. I have heard of ARV's but I am not sure what ARVs are and what they do.
5. I belief that ARVs are harmful

SECTION 12 PERCEPTIONS OF RISK

12.1 If you think about your sexual experiences in the last 12 months, what do you think are the chances that you might have become infected with HIV?

No chance at all	1
A minor chance	2
A reasonable chance	3
A major chance	4

12.2 When you look at your drug use behaviour in the last 12 months, how do you assess the chances that you might have become infected with HIV?

No chance at all	1
A minor chance	2
A reasonable chance	3
A major chance	4

Thank you for completing this survey.

Check to be sure that you answered every question and filled out every page.

Be sure that you have not put your name anywhere on this questionnaire.

PLEASE HAND THE COMPLETED QUESTIONNAIRE BACK TO THE FIELDWORKER