

**University of Pretoria
Faculty of Health Sciences**

School of Health Systems and Public Health

Title: The health care experiences and perceived health needs of
adult black lesbian women in four Gauteng townships

Master in Public Health (MPH)

Author: Ntlotleng Mabena

Student number: 99034370

Supervisor: Prof Kirstie Rendall-Mkosi

Co-supervisor: Prof Elna McIntosh

Date: December 2014

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List of acronyms and abbreviations

AIDS	Acquired Immunodeficiency Syndrome
CBO	Community Based Organization
CDC	Center for Disease Control
FGD	Focus Group Discussions
GBV	Gender Based Violence
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
LGBT	Lesbian, Gay, Bisexuals, Transgender
MSM	Men who have sex with men
NGO	Non Governmental Organization
PEP	Post Exposure Prophylaxis
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
USA	United State of America
WSW	Women who have sex with women

The health care experiences and perceived health needs of adult black lesbian women in Gauteng townships.

Executive Summary

Aims and objectives: This study explored the health needs and health care experiences of black lesbians living in townships around Gauteng province in South Africa. The study also identified social factors that influence the health of black lesbians, as well as identifying the major barriers that prohibit lesbians from accessing health care services that they may need. Although heterosexual women were not the focus of this study, the study also looked to compare health care experiences and needs of lesbians with those of heterosexual women living in Gauteng townships.

Background: The progressive South African constitution grants all citizens protection against all forms of discrimination, including discrimination based on sexual orientation. Lesbians are a marginalized, vulnerable group of women, who often face many societal challenges, including homophobic attacks in their communities. Studies reporting the risk of HIV amongst lesbians and the role of violence in Southern Africa are increasing, however, little is known about the comprehensive health needs of this population.

Methods: A mixed method, cross sectional study was conducted. Data was collected between June 2013 and March 2014. Two focus group discussions were conducted with 22 lesbians from Johannesburg and Pretoria townships. The participants were recruited using the purposive sampling method. A survey was conducted with a total of 179 women (113 lesbians, 59 heterosexuals and 7 bisexuals). The bisexuals were excluded from the data analysis. Spontaneous information from survey participants was included in the qualitative data set. Survey participants were recruited using the snowballing sampling method. Although the two components of the study were sequential, the survey data collection was not in anyway influenced by

the focus group discussions. Data analysis for both study components commenced after all data was collected.

Results and findings: The qualitative data collection process proved to be insightful. Lesbians expressed difficulties they experienced when trying to access health services, particularly from public sector clinics. Negative health care provider attitudes and lack of clinical knowledge were cited by the lesbians as the main barriers to accessing care. The lesbians were significantly younger than the heterosexual participants ($p=0.000$). More lesbians than heterosexuals had no children ($p=0.000$). The lesbian participants had fewer breast examinations ($p=0.06$) and Pap smears ($p=0.000$) than their heterosexual counterparts. Fifty-two percent of lesbians currently have symptoms suggestive of depression and anxiety, as compared to 58% of heterosexuals ($p=0.4$). Almost 50% of lesbian participants use Marijuana, with 69% screening positive with the CAGE questionnaire, suggesting a possible alcohol problem. Whereas only 24% of heterosexuals use Marijuana and 39% screened positive with the CAGE questionnaire.

Conclusions: Considering the various methodological limitations, this study has shown that black lesbians living in Gauteng townships have health needs that are similar to heterosexual women living in townships. However, certain health needs, such as mental health and substance abuse amongst black lesbians, are currently not met by the health system. Most women in this study access primary health care from public sector clinics. However lesbians experience more barriers than heterosexuals. Negative health care worker attitudes towards lesbians are a major barrier, with some health care providers displaying overt homophobia towards lesbian patients. Health care workers who were not necessarily homophobic were perceived to not have adequate knowledge on meeting the health needs of lesbians. Health care provider sensitization and trainings are needed to better equip health care providers with the necessary skill needed to treat lesbian patients.

SECTION A

Research protocol

Title: The health care experiences and perceived health needs of adult black lesbian women in Gauteng townships.

Introduction

Women, in recent years have seen an increase in research of health issues related to them. These issues of concern include sexual and reproductive health and rights, chronic diseases, cancer and mental health, to mention a few.

Noticeably though, on this continuum of women's health, lesbian health has largely been left off the agenda. Lesbians are a subgroup of all women, and therefore also share many health risks and experiences in the health care system with women in general. However, the scope of their specific health concerns and problems needs to be better understood. Knowledge of areas in which the health of lesbians differs from that of other women may provide insight to improve the health of all women ultimately.

The term "women who have sex with women" describes sexual behaviour, while lesbian is a term that describes sexual identity. However, sexual identity does not necessarily predict sexual behaviour, most lesbians have a history of sexual intercourse with men^{1,2}. Women who have sex with women form a small but important group and may have specific health needs. A lack of awareness among healthcare professionals about these needs may lead to ill informed advice and missed opportunities for the prevention or treatment of illness^{2, 3}.

As South Africans, our constitution and legal framework protect against discrimination on the basis of sexual orientation (South African constitution, Bill of Rights), however, from many anecdotes, the reality is that LGBT persons are denied proper care and services, by being stigmatized and discriminated against, based on their sexual orientation². The disparities between the protective legal status for individuals in same-sex relationships and the reality on the ground with regards to societal attitudes and health service provision in South Africa is particularly worrying.

There is definitely a need for lesbian women's health needs to be explored and where possible, addressed. This has been highlighted by Fields (2001), emphasizing that there are certain risk factors that place lesbian women at risk of certain conditions, like cancer³. Furthermore, some first world countries, like the United States of America³ have addressed this neglected population to a limited extent, with formal national surveys having been conducted amongst their LGBT communities to establish their health needs.

A study conducted in the Western Cape has initiated the exploration of risks associated with sexually transmitted infections and HIV amongst lesbians, bisexual women, and women who have sex with women in four rural and peri-urban communities².

In general, the health needs of LGBT people are often not given priority, and therefore these health needs are often not provided for when planning public health services. Within the LGBT communities, gay men (also including men who have sex with men) have received the most attention and response from the health sector, mostly because of the HIV epidemic, which in most parts of the world, is considered a significant driver of the epidemic.

Various authors around the world have documented certain medical conditions, which are particularly common in lesbian women.

These include higher rates of breast cancer, substance abuse, and depression, just to name a few^{2, 3, 4}. Admittedly, these observations were made in countries and settings that differ greatly from the African context. This research looks to explore the kinds of medical conditions South African black lesbians are prone to, and risk factors that may impact on the health of this particular target population.

The aim of this research is to explore what the perceived health needs are, specifically for black lesbian women in Gauteng townships; to look at how black lesbian women perceive their own state of health and the factors that contribute to their ill-health. This information will be able to aide health service providers to be able to give their lesbian clients appropriate and relevant care, based on their needs.

Although some data exists about lesbian women's health needs in other parts of the world, such data is not readily available in South Africa, if at all it does exist. The existing data in other parts of the world could theoretically be extrapolated to the South African lesbian community; but this will not necessarily give a true reflection, as social conditions differ from country to country, and even from community to community, within the same country. Gender based violence for one, is an issue that is very rife in our settings, with rising rates of corrective rape being reported, especially amongst lesbian women living in townships².

This baseline research will not make any pre-existing assumptions, by focusing on an area, such as sexual and reproductive health or mental health. Even though these areas have been pointed out to be areas mostly affecting lesbian women in certain publications. This research seeks to take a snapshot of the perceived state of health of black lesbians living in townships around Gauteng province. The findings of this study may potentially launch further research possibilities to look into common health concerns of this target population more closely.

Additionally, this research will also explore barriers that exist, which in turn restrict access to health care services for black lesbian women living in Gauteng townships. The findings of this research will address, and will have the potential to influence accessibility of health care services for lesbian women, based on their specific health needs.

2. Literature review

It is generally accepted that women who self-identify as lesbians in the most part experience similar health issues as the average woman in the community they live in. It is also generally accepted that in principle, lesbian women should have access to health care services just as any other woman in society. The health needs of any population are often based on their physical health status, as well as social determinants⁵.

These social determinants of health will vary from place to place. Factors influencing health in lesbian women in Europe and America may not necessarily be the same as factors influencing the health of lesbian women on the African continent⁵. There is limited research on lesbian women health across the world, but the dearth of research in Africa is even worse, and very real. The lack of documented and published research both in South Africa and the rest of the continent, on health issues related to lesbian women and their health needs, has led to the reliance on literature from developed countries.

This literature review will focus on health themes that recurred in different settings and literature. These include issues around access^{1,2,3,4,6} and use of health care services^{7,8} by lesbian women, sexually transmitted diseases (STI's)^{1,9,10,11} including HIV; mental health and substance abuse^{4,12,13}, screening services^{4,6,7,14} and lastly the discussion of social factors, such as violence¹⁵, alcohol abuse¹⁶, and unemployment⁵ possibly influencing the health of lesbian women in different settings.

This review will include secondary sources as well as non-research literature, obtained through searching databases such as Pub-Med and Google scholar. The different databases were used, to enhance the breadth of the search, as there is limited validated information on this particular research topic. Search keywords included the following; Lesbian health, Women who have sex with women health, health needs of sexual minorities. All sources referred to will be appropriately referenced.

The data collection for this study will act as a primary source of information, and will be used to discuss findings, comparing to what was found in the literature review.

2.1 Access to health care

Various authors have addressed the issue of access to health care services, as well as usage of health care services by lesbian women. In a population-based data survey, conducted by Diamant et al (2000), in Los Angeles, it was found that Lesbian women were 'significantly more likely to have encountered

some difficulty receiving health care' than heterosexual women in the preceding year⁴. Furthermore, the study found that financial barriers of accessing health care services, such as prescription medication, mental health care and even medical care from a physician, were reported more by lesbian women than their heterosexual counterparts⁴. This finding was contradicted by further findings in the study, that there was no significant difference by sexual orientation for women having made a visit to a health care provider within the previous year. What is clear from further findings of this study, is that although Lesbian women do access health care services, some critical screening tests, such as Pap smears and clinical breast examinations were often not offered to Lesbian clients. This study further highlighted the fact that Lesbian women experienced greater barriers than heterosexual women in accessing needed health care. This was further echoed in findings of a similar type of study conducted by Heck et al⁶, in 2006, looking at data from a national health survey in the USA.

It also highlighted the importance of identifying these specific barriers, in order to determine what possible interventions need to be in place to increase access for this specific group of women.

Client-health care provider relationships and dynamics have been pointed out to be a crucial factor in lesbian women using health care services. Various authors reported negative experiences of lesbian women, and negative attitudes towards them from health care providers^{2,3}. Discrimination by health care providers, based on the patient's sexual orientation is also documented and reported^{2,3}. Within the literature, it was found that not all lesbian women who consult a health care provider feel comfortable to 'come-out' to the provider. This is mostly due to fear of being discriminated against, by the health care provider^{7,8}. Often, health care providers have 'unreflected assumptions of heterosexuality, and use heterosexist concepts^{6,7,8}, when dealing with patients. Although this may not necessarily affect the level of care received by the lesbian woman, often health care providers who did not know the patient's sexual orientation did not focus on areas of health that may be more relevant to lesbian women. Such risky health behaviours include

tobacco use, excessive alcohol consumption, mental health disorders, fertility options and violence^{4,8}.

2.2 Sexually Transmitted Infections and HIV

Local South African researchers, as well as anecdotal evidence suggests that lesbian women face multiple risks for STI's, including HIV². Historically, lesbian women have always been thought of being at low risk of acquiring HIV^{6,10} and other STI's, with very few cases of woman to woman transmission having been documented^{9,10}. These cases, however, have not always been proven to be exclusively due to sexual contact between women^{9,10}. More recently, several studies have reported the plausibility of vagina-to-vagina transmission of infections^{9,10,11}. Infections like trichomoniasis, human papilloma virus, bacterial vaginosis, and Chlamydia trachomatis have all been detected in women who have only reported having sex with women^{8,9}. In studies from the United Kingdom, the incidence and prevalence of sexually transmitted infections are lower in women who have sex with women than heterosexual women, but they are still at risk. Trichomoniasis has been transmitted sexually, supporting the hypothesis that sexually transmitted infections can be transferred between women through vaginal secretions. Transmission of syphilis by orogenital sex between women has also been described, and overall more than 10% of women with exclusively female partners have a history of a sexually transmitted infection in the USA¹. Bacterial vaginosis is a bacterial infection found more commonly in women who have sex with women than heterosexual women. It has been described to be found in up to half of women who have sex with women in USA¹. However, debates exist about the sexual transmissibility of the causative organism within female partnerships due to the similarity of vaginal flora in women in monogamous relationships.

Human immunodeficiency virus (HIV) has been isolated from vaginal secretions, cervical biopsies, and menstrual blood^{1,2}, and, although uncommon, female-to-female sexual transmission of HIV has been reported¹⁰. It is known that HIV vulnerability and risk of transmission are associated with

sexual practices where blood, vaginal secretions or semen come into contact with sensitive mucous membranes (CDC, 2009)¹⁷.

Recent findings in an unpublished research conducted in Gauteng, revealed that 9% of black lesbians and 5% of white lesbian women self-reported to be HIV positive¹⁸. Furthermore, the local study on the sexual practices of lesbian women revealed that 1% of the participants reported their partners to be HIV positive. Despite this fact, 40% of participants reported being not at risk of acquiring HIV, while 45% said they were 'too scared' to test, while 25% never tested before¹⁸. The major limitations of these unpublished studies were the small sample sizes and the fact that the findings could not be generalizable. The study participants also self-reported their HIV status; this is not necessarily a true reflection of the HIV prevalence amongst the study population. The figures above seem very low, but do certainly alert health care providers to the existing risk of HIV acquisition by lesbian women. In both the small studies conducted in Gauteng and Cape Town, it is clear that the majority of lesbian women in these studies did not see the need for safe sexual practices, due to the perceived low risk^{2,18}. Again, the above-mentioned figures highlight to health care practitioners the importance of discussing safer sexual practices with all women who report having sexual relations with only women. It has also been noted that high levels of sexual violence against women, and particularly hate crimes, dubbed corrective rape, against lesbian women increases the risk of HIV acquisition^{2,15}.

2.3 Mental health and substance abuse

Mental health problems are persistently cited by women who have sex with women as a notable health concern. Increased risk of suicide, deliberate self harm, depression, and anxiety disorder have been shown in several studies amongst this population^{1,12}. Research conducted in earlier years had suggested that Lesbian women, compared to heterosexual women, may be at increased risk of depression^{13, 19}. This notion however, has recently not been conclusive, especially considering the sampling concerns of previous studies, with some studies having sampled patients already receiving mental health services⁴. A fair explanation that may support the increased risk of depressive

symptoms in lesbian women may be associated with reported increased alcohol consumption in lesbian women, when compared with heterosexual women^{4,16}. The National survey of midlife development in the United States revealed a correlation between perceived discrimination on the basis of sexual orientation, and an increase in stress-sensitive psychiatric disorders, such as depressive, anxiety and substance dependant disorders¹³. Although dated, White and Levinson noted in an article written in 1995, that adolescent lesbian and gays completed suicides accounted for 30% of completed youth suicide. In light of the above, this research will use the widely used CAGE²⁰ questionnaire to screen study participants for alcohol concerns. The World Health Organization's Well Being Index-5 of 1998²¹ will be used to screen for depression.

2.4 Screening services

2.4.1 Cervical and breast screening:

An unfortunate perception exists among healthcare providers and lesbian women that they do not need regular cervical smears¹⁴. High-risk types of genital human papillomavirus are associated with developing high grade cervical intraepithelial neoplasia, and sexual intercourse with men is a powerful risk factor for cervical cancer. However, it is important to counter the erroneous assumption that women who have sex with women are not at risk of acquiring human papillomavirus. Around one in five women who have never had heterosexual intercourse have human papillomavirus^{1,14}. Cytological abnormality in women who have sex with women varies in prevalence between studies but ranges from inflammation to severe dyskaryosis¹⁴. Specifically the development of high grade cervical intraepithelial neoplasia with human papillomavirus type 16 after exclusive lesbian behaviour has been described¹. Therefore regular testing of cervical smears should be recommended to all women who have sex with women, regardless of their present or past sexual activities. Studies have also often revealed lower rates of lesbian women receiving pap-smear screening tests, and clinical breast examination. These findings have often been interpreted as

an indication of poor access to health care services⁴. This is despite the fact that there is a documented need for lesbian women to have regular cervical screening¹⁴. Many studies have shown that a majority of lesbians have had unprotected vaginal intercourse with male partners in the past and thus placing them at risk of being exposed to the HPV.^{2,14,18}. Literature has also highlighted the risk of lesbians of being diagnosed with breast cancer, particularly those who have never had children or used contraception. It is very important for lesbians to go for regular breast examination, as they grow older. This research will explore accessibility and usage of Pap-smear and breast examination services for black lesbian women living in Gauteng townships.

2.4.2 Diseases of lifestyle

A Massachusetts's survey on LGBT people indicated that the health profile of gays and lesbians was worse than their heterosexual counterparts²², with increased sexual assault, alcohol binge-drinking, substance abuse, depression, asthma and type 2 Diabetes^{22, 23}. Furthermore, lesbian women have been reported to be more likely to report cigarette smoking and a higher percentage reported as being overweight and obese²³. In various studies conducted, lesbian women have been found to have worse health behaviour than their heterosexual counterparts^{4,23}. Although some authors suggest that tobacco and excessive alcohol consumption is common amongst lesbian and bisexual women, more so, than in their heterosexual counterparts¹⁶; the credibility of these findings were often in question, as some of these convenient samples were drawn from places such as bars, pubs, or other entertainment events⁴. The study conducted by Diamant and colleagues (2000) compared health risk behaviour, specifically looking at alcohol and tobacco use, between homosexual and heterosexual women.

In this study, nearly a third of the lesbian women respondents reported current use of tobacco. Almost three quarters of the lesbian and bisexual women interviewed reported alcohol consumption, compared with only 50% of heterosexual women reporting alcohol consumption⁴.

The quantity and frequency of consumption was also greater for lesbian women, as compared to the heterosexual women, with more lesbian women consuming 3 or more drinks on almost daily basis^{4,16}. With regards to health status, in Diamant et al's study, their findings on the 5-point global assessment scale for health status were similar in both heterosexual and lesbian women. Cochran et al, when analyzing data from California quality of life survey, found that lesbian and bisexual women reported a greater variety of health conditions as compared to heterosexual women, but when distress levels were taken into account, the differences were no longer significant²⁴. This research will solicit alcohol, smoking and physical activity of respondents through using an administered questionnaire. Interpretation of these variables will be performed after analysis, following guidelines from other published studies, and will be appropriately linked to health risks described in literature.

2.5 Violence

Gender based violence is a social ill of great concern in South Africa. Hate crimes on the basis of sexual orientation, are common in communities, where lesbian women are often raped and assaulted, in an attempt to 'correct' their sexual orientation^{2,25}. The violence faced by these women has a great impact on their health. This impact may appear on various levels, ranging from physical disease, which may affect their sexual and reproductive health in the form of sexually transmitted infections and unwanted pregnancies²; physical injuries as well as mental conditions, such as anxiety and depression²⁵.

2.6 Social determinants of health in lesbian women

2.6.1 Unemployment and poverty

It is well documented, that lesbian women in South Africa living in poverty, and faced with unemployment, often resort to risky sexual behaviours with men, as a form of transactional sex. This places the lesbian women, and her female sexual partners at risk of HIV and other STI's^{2,15}.

2.6.2 Homophobia

Societal attitudes towards a non-conventional sexual orientation have an impact on the mental health of homosexual individuals. The process of disclosing one's sexual orientation has been described as very stressful. This, coupled with poor support structures available to support homosexuals, diminishes the individual's capacity to deal with homophobias, and may result in mental health conditions such as anxiety and emotional distress⁷. The US department of Justice (2002) also gave an indication that lesbians and gay men may be the most victimized group in that nation.

2.6.3 Alcohol and substance abuse

The high rate of alcohol consumption amongst lesbian women, increases their risky behaviour, and places them in vulnerable situations²⁵. This has been anecdotally reported to be a catalyst for violence, both amongst lesbian women themselves, and also by heterosexual men.

The rates of smoking and consumption of alcohol among women who have sex with women are higher than in heterosexual women, as mentioned above. They also tend to have a higher body mass index, lower parity, and poorer participation in health screening programmes¹. As mentioned elsewhere above, alcohol is a contributing factor to mental health conditions in LGBT persons. The impact of recreational drugs on this target group's health is currently unknown. This research seeks to first explore the extent of use of recreational drugs by black lesbian women living in Gauteng townships.

2.7 Research methodology in hard-to reach populations

Methodological challenges in LGBT research is well-documented, with these challenges ranging from accurately defining the target group, measuring and sampling respondents, as well as ethical considerations which need to be considered when researching vulnerable groups^{26, 27,28}. Lesbian women are considered to be a hidden population²⁷, making it difficult to know where

lesbian women could be found, and also making it difficult to have a sampling frame to work from. This then also results in various sampling issues. Without a defined sampling frame, it may be difficult to use probabilistic sampling strategies, such as randomized sampling^{27, 28}. Research relating to hidden populations often had to employ non-probabilistic sampling methods, such as snowballing or respondent driven sampling²³. Although these strategies assisted with increasing sample sizes, results from such studies were often not generalizable, due to lack of randomization. Newer sampling methods are being developed, in an attempt to increase randomization. One such method is random digit dialing²⁹ which has been found to increase randomization somewhat. This method should however be used with caution in South African settings; particularly in the target population of this study. The black lesbians living in townships may not be found in official phone directories, for various reasons.

3. Research question

What are the health care experiences and perceived health needs of adult black lesbian women in Gauteng townships?

4. Study aim

The aim of this study is to understand the health needs of black lesbian women, to explore their experiences of accessing health care services, and to make recommendations that would assist health care providers and policy makers to provide services which are appropriate and sensitive to the needs of lesbian women in townships in Gauteng (Pretoria and Johannesburg).

5. Objectives

- 5.1 To describe experiences of health services utilization and identify barriers to access to health care services for adult black lesbian women.

5.2 To identify self-reported health problems, risk factors, and level of access to, and utilization of health services needed.

5.3 To identify social factors influencing the health of adult black lesbian women.

5.4 To make a comparison of health care experiences between lesbian women and heterosexual women living in the same communities

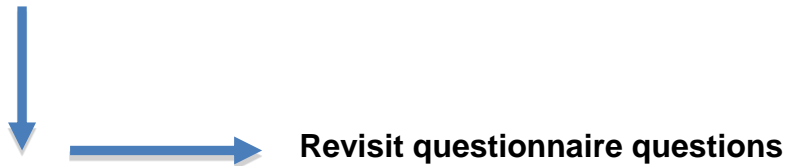
The following diagram on the next page outlines the methodology to be followed for this study.

Further explanation will follow in text.

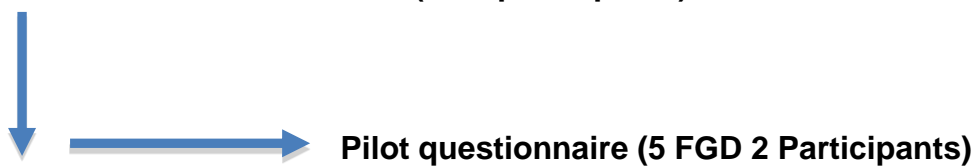
Figure 1: Schematic presentation of research methodology

PHASE 1 (Qualitative phase) Only lesbian women

FGD 1 (8-10 participants)



FGD 2 (8-10 participants)



FGD data consolidation



Lesbian women vs
heterosexual women

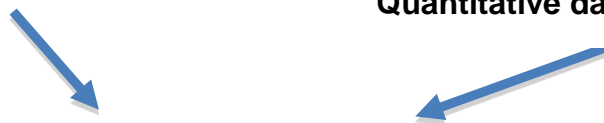
Administered questionnaire (100/100)

Questionnaire data collation

Quantitative data analysis

Qualitative data analysis

Reporting of findings and results



6. Methodology

The methodology described below, takes all the challenges mentioned in the literature review into consideration.

6.1 Defining the population

There is no standard definition of lesbian, however, having a clear definition of this subgroup of women is imperative, in order to be able to properly explore and understand the health implications of being a lesbian woman.

For the purposes of this study, the definition for lesbians is the following; 'women who have sex or primary emotional partnerships with women (Institute of `medicine) ³⁰.' This will include women who self-identify as lesbians, but will exclude those who identify as bisexuals or those who are attracted to both men and women.

6.2 Study design

A review of available literature addressing research in LGBT communities showed that a mixed method approach may enhance research findings.

The study was designed to be a cross-sectional mixed method study. It can be described as a sequential exploratory mixed method study ³¹, with the qualitative component of the research being more dominant than the quantitative component. Although the data collection for the qualitative component of the study preceded the quantitative data collection, the qualitative process did not in anyway influence the quantitative data collection process. Data analysis of both components was performed simultaneously at the end. Although each component of the study produced its own data set, with participants who took part in the qualitative component not included in the data set of the quantitative component, participants for both components of the research were recruited using the same strategy.

6.2.1 Participant recruitment strategy

Firstly, four fieldworkers were recruited from two lesbian community organizations. The fieldworkers were women who identified as lesbian and lived in Gauteng townships. They were chosen because they showed an interest in the research and were eager to assist with data collection. The fieldworkers underwent a half-day training on informing participants about the study objectives, facilitating a focus group discussion, administering the survey questionnaire and lastly on identifying distressed participants who may require acute counseling services and where to refer such participants. The fieldworkers volunteered their time to the study, but were provided with transport money and airtime by the researcher.

6.2.2 Qualitative research method

The qualitative research methods used were focus group discussions, as well as spontaneous interviews from survey participants.

i. Study population and settings

The qualitative component of this study only included lesbians living in 4 predetermined Gauteng townships. No heterosexual women were included in this data collection.

Inclusion criteria:

- Black lesbian women
- Individuals to be 18 years and older
- Residing in the following Gauteng province townships:
Mamelodi, Soshanguve, Katlehong and Soweto.

ii. Sampling method

The sampling method used for the two focus group discussions was purposive sampling, with 22 individuals in total being recruited. The fieldworkers invited the first 22 lesbians whose contact details were obtained from the 2 network organizations to participate in one of the two focus group discussions.

iii. Study setting

The first focus group took place in a Johannesburg office park, while the second took place at a residential area in Mamelodi. The study participants chose both venues.

iv. Measurements

An interview guide was used to facilitate the focus group discussions. The questions were guided by the literature review. The questions were developed in English, and were also asked in English and other vernacular languages depending on the mix of participants.

The domains covered in the interview guide included the following:

Focus Group Discussion interview guide domains
1. Experience living as a lesbian in Gauteng township
2. Health issues affecting women in township in general
3. Health issues affecting lesbians in townships
4. Barriers to access to health care services by lesbians in townships

Table 1: FGD interview guide domains

6.2.2.1 Data collection process

The focus group discussions were facilitated by two of the fieldworkers after each participant received explanation of the process and signed informed consent. The researcher was present during both focus group discussions, but did not take part in the discussions. The focus group discussions were recorded using a voice recorder, and the researcher also made field notes. To address the question of rigor for this study, the focus group discussions were facilitated in English. The questions were asked in English. However, participants were free to respond in English, an Nguni language or Sesotho. It is important to note that the researcher, who was present in both focus group discussions, but was not actively participating, is proficient in both Nguni and Sesotho languages.

Five focus group discussion participants, outside the FGD, shared additional information. They felt the information was important to share, but felt too shy to share within the group. The fieldworker captured this additional information in writing. This information was added to the qualitative data set.

6.2.2.2 Data management and analysis

The transcripts were translated into English, with the transcriber and translator being a research assistant who is also proficient in Nguni and Sesotho languages. The transcripts were checked by the researcher with the help of another research assistant, with experience with qualitative data collection and analysis, for accuracy. In addition data from the qualitative questions from the survey questionnaires, as well as the additional information from the spontaneous discussions, were typed to form part of the data set.

The data was coded and analyzed manually by two different individuals. Analytical categories were generated, from which themes and sub-themes were derived.

6.2.3 Quantitative research method

i. Study population and settings

Black lesbian women associated with lesbian networks in Gauteng townships were recruited for this part of the study.

This section of data collection included heterosexual women residing in the same communities as the lesbian women. The heterosexual women should be residing under similar circumstances, and of similar age group as the lesbian participants. The lesbian women participating in this section of research will be given an opportunity to recommend someone, which could be a sister, a cousin or a neighbour.

Interviews were held at participant's homes, others in the car on the side of the road, others during people's lunch breaks at work in the parking lot, some at places where lesbians gather to hang out. All interview venues were chosen by the participants.

ii. Inclusion criteria: Lesbian participants

- Black lesbian women
- Individuals to be 18 years and older
- Residing in Gauteng province townships

iii. Inclusion criteria: Heterosexual women participants

- Black heterosexual woman
- Individuals to be 18 years and older
- Residing in Gauteng (similar socio-economic status as lesbian referral)

iii. Sampling frame

LGBT populations are largely hidden in South Africa, with the national census not including this community as an independent indicator in their data collection tools. This leads to not knowing how many LGBT people there are in the country, let alone in different provinces.

For these reasons, and many other reasons not covered by the scope of this research, it remains difficult to have a sampling frame for lesbian women residing in Gauteng.

iv. Sampling method

The fieldworkers recruited lesbians by contacting eligible lesbians affiliated to two network organizations telephonically, after which an appointment was set with those participants who were interested in taking part in the study, for the administered questionnaire. The lesbians were recruited employing the non-probabilistic snowball sampling method, while the heterosexual participants were recruited by being nominated by a lesbian participant. An attempt was made to match heterosexuals to lesbians, in order to compare their health outcomes and experiences. Lesbian participants were asked to refer the researcher to a woman who identifies as heterosexual but who lives in similar conditions as themselves.

v. Sample size

The targeted sample size for the survey component was 200. The plan was to recruit 100 lesbians and 100 heterosexual women to take part in the survey.

6.2.3.1 Data collection instruments

The researcher designed an administered questionnaire following key health areas identified through the literature review.

Below is a table describing the various sections of the interviewer-administered questionnaire.

Section	Quantitative instrument question domains
Section 1	Demographic information
Section 2	Access to health care
Section 3	Screening health services
Section 4	Mental health and substance use
Section 5	Sexual and Reproductive health
Section 6	Social factors and violence

Table 2: Survey questionnaire domains

The domains covered by the questionnaires included sexual orientation, general demographics of age, employment status, relationship status, educational level and number of children. The other domains looked at issues of access to health care services, sexually transmitted infections including HIV, mental health, alcohol and substance abuse, screening for non communicable diseases, including screening for breast and cervical cancer. The last domain addresses other social determinants of health, and how they influence the health of women, particularly those who identify as lesbian. Some of these social determinants include violence in its many forms, unemployment, societal discrimination and stigma.

The administered questionnaire was piloted using lesbians and heterosexuals who did not meet the inclusion criteria of the study. All pilot questionnaires were not included in the data analysis.

6.2.3.1 Data collection process

The fieldworkers collected the administered questionnaire data during face-to-face interviews at venues chosen by the participants. Data collection took place between June 2013 and March 2014. The survey data collection was preceded by the two focus group discussions, but was not influenced by the outcome of the focus group discussions.

There were two sets of administered questionnaires. Both had the exact same content, but one set of 100 questionnaires were marked A and given a sequence number. This particular questionnaire was for those participants who self identified as lesbian, gay, bisexual or as a woman who has sex with women. The second batch of 100 were marked B and also given sequenced numbers. This second batch was used for participants who identified as heterosexual, and other.

In addition, 15 study participants felt a strong need to talk further about issues not addressed in the questionnaire. Their discussions will also be incorporated in the qualitative data analysis as information derived from spontaneous interviews.

6.2.4. Data management and analysis

i. Data entry:

Following data collection, the data was prepared for data entry, which included checking that all relevant sections have been completed, and data for entry belongs to people who meet the inclusion criteria discussed above.

ii. Data cleaning:

The process of entering the data in STATA 12 included data cleaning.

To address the question of rigor for this study, the focus group discussions were facilitated in English. The questions were asked in English. However, participants were free to respond in English, Nguni or Sesotho. It is important

to note that the researcher, who was present in both focus group discussions, but was not actively participating, is proficient in both Nguni and Sesotho languages. The transcripts were translated into English, with the transcriber and translator being a research assistant who is also proficient in Nguni and Sesotho languages. The transcripts were checked by the researcher with the help of another research assistant with experience with qualitative data collection and analysis for accuracy.

iii. Data analysis:

Data capturing, cleaning and analysis was conducted using STATA 12. Simple frequencies were computed, and comparative analysis for key variables between lesbians and heterosexuals was performed using the chi square test, and significance testing.

The focus group discussions were audio-recorded and then transcribed into English. The data was coded and analyzed manually, using texts, by two different individuals. Qualitative questions from the administered questionnaires, as well as the additional information from the spontaneous interviews during the survey were also coded and analyzed manually. Analytical categories were generated, from which themes and sub-themes were derived.

iv. Data storage:

All the records acquired during the study period, such as the completed questionnaires, informed consent forms, demographic and contact information, interview guides, focus group interview transcriptions and electronic files will be stored safely by the researchers where only the researchers and relevant individuals can access the information. This control will take place during the whole research process. The electronic records are kept on a password locked laptop. The hard drive used to backup the records is also kept in a lockable cupboard. The documents collected during the sessions were kept in a secure carry case whilst on site. These documents were then transferred to a lockable cupboard at the home of the researcher and held there until the analysis phase.

After completion of the study, data will be stored for 15 years in accordance with the rules of the University of Pretoria.

7. Ethical considerations

Prior to commencement of this study, permission from the Student Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria was granted. Letters of permission and support were sought from both organizations that provided the researcher with contact details of lesbians. A trusted known person affiliated to the organizations contacted the lesbian women, in order to inform them about the study and invite them to participate. To ensure the safety of the participants, interview times and venues were individually chosen by the study participants. Each research participant was issued with an informed consent form. The consent form stated the purpose of the study, the duration, risks, anonymity, benefits and compensation as well as a declaration that they are voluntarily participating in the study. Participants signed two copies and retained one copy for themselves. The consent forms will be stored in accordance with University of Pretoria rules. The study participants were given the opportunity to refuse to participate or may withdraw their participation at anytime. The study population is vulnerable, and requires protection against harassment and harm. Due to the sensitivity of some questions, participants in the FGDs were requested to keep the discussion confidential and respect one another's privacy, and not to discuss anything that was spoken about in the group, outside the group. This was important to emphasize as not all individuals were 'out' in the communities. All participants and facilitators made verbal commitments to uphold confidentiality and privacy of all group members.

Confidentiality and respect was also emphasized to the field workers, as they are known in the community and also personally know some of the study participants. The field workers were also trained to debrief participants after administering the questionnaire, and refer women appropriately for counseling and medical care. Lifeline number was given to all women who needed urgent counseling that was beyond the scope of the field workers. In some townships, women were referred to NGOs providing counseling and medical

care. Women in crises were referred to appropriate shelters. A psychologist was also made available to participants who needed therapy after the interviews, as some had never received counseling after experiencing violence.

8. Action plan and budget

Action	Responsible	Time	Budget	Action specification
Research Protocol	Ntlotleng and supervisor	To submit by May	none	
FGD preparation (Phase 1)	Ntlotleng	After approval from Ethics	R200	<ul style="list-style-type: none"> • Print FGD questionnaires (4 copies) • Print participant information leaflets (25 copies) • To secure voice recorder and batteries • To secure sticker labels for name tags • Notepad • Assistant researcher Participants • Obtain 15 names of participants (Mamelodi) • Obtain 15 names of participants (Katlhong) • Make phone calls to invite to FGD • Transport
(Phase 2) Administered questionnaires			R500 R1200	Print questionnaires (120 copies) Print participant information leaflets (120) Print informed consent forms

				(120) Transport
Data collection and transcription	Professional		R3000	On completion of data collection phase 1
Data entry	Ntlotleng			On completion of data collection phase 2
Data analysis (Quantitative) (Qualitative)	Statistician Ntlotleng and assistant researcher		R3000	On completion of data entry and cleaning
Report writing	Ntlotleng			On completion of data analysis
TOTAL			R7900	

Table 3: Action plan and budget

9. Reporting of the results

The study will be written up and submitted for journal peer-review and publication.

A presentation to share the study results will be made to the two organizations providing participants for the study. The constituents from the organizations will also be invited to the presentation.

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SECTION B

Journal Article

Title: Understanding Lesbian Health

Journal:

Culture, Health & Sexuality

Word count: 7401

Authors: Ntlotleng Mabena, MBcHB, MPH

University of Pretoria

31 Hastings Drive

Mulbarton, Johannesburg

2190

Cell: +27827076377

Email: Ntlotleng.mabena@yahoo.com

Kirstie Rendall-Mkosi

University of Pretoria,

South Africa

Email: Kirstie.Rendall-Mkosi@up.ac.za

Understanding Lesbian Health

Authors: Ntlotleng Mabena, Kirstie Rendall-Mkosi

University of Pretoria; School of Health Systems and Public Health

Abstract

The aim of this study was to understand the health care needs and experiences of black lesbians living in Gauteng townships. *Method:* This was a mixed-method cross-sectional study, with the qualitative component being dominant. Two focus group discussions were conducted with 22 lesbians from Johannesburg and Pretoria. Qualitative information from spontaneous discussions with survey participants was also included in the data set. *Findings:* Lesbian health needs range from mental health to sexual and reproductive health. Homophobia and interpersonal violence also contribute significantly to the physical and mental health of lesbians. Health care providers are seen as gatekeepers of health care and often act as barriers for lesbians accessing care. Sensitization of health care providers may increase access to care for lesbians by addressing health care provider attitudes. *Conclusion:* Lesbian health needs go beyond just sexual and reproductive health. Mental health and substance abuse are prominent unmet lesbian health needs. Both lesbians and health care providers need education about these needs.

Keywords: Lesbians; Health needs, South Africa

Introduction

Lesbians have been found to have more difficulty when accessing health care services (Diamante, 2000). The barriers that face lesbians range from financial barriers (Diamante, 2000), to overt discrimination and negative attitudes from health care providers (Fields 2001, Heck 2006). There are alarming disparities between the protective South African legal status of women in same sex relationships and what their actual lived realities are due

to societal attitudes, which in turn affect their experiences of health services. Certain health services have been withheld from lesbians because they are perceived by service providers not to appear as women. This finding was made by Heck (2006), with lesbians in the US, and Henderson (2011), in a study looking at lesbians in Cape Town, South Africa. Poteat (2013) describes 'hard core' lesbians in Lesotho who have to 'change' their dress code and appearance, in order to avoid ridicule while accessing contraceptive services from their local clinics. Lesbians have been denied cervical screening services, as it is often believed that women who have sex with women do not need such screenings as they are not at risk of acquiring cervical cancer (Rankow 1998). The health care system in Sub-Saharan Africa is generally described as unresponsive to the health needs of lesbians (Mathabeni 2013, Poteat 2013). Health care providers often have 'unreflected heterosexual assumptions' using heterosexist concepts when addressing patients (Heck, 2006). This places lesbians in uncomfortable situations, with some afraid to disclose their sexual orientation for fear of discrimination and ridicule.

Social determinants that affect the health of lesbians include societal attitudes (Reddy, 2008), unemployment and poverty (Albeida, 2009), violence and substance use (Sorenz, 1997, Mays 2001, Matebeni 2011). Lesbians in South Africa experience high rates of violence as a result of a homophobic society (Henderson 2011, Mkhize 2010). Stigma and discrimination have been described to have a significant role in the mental ill-health of lesbians. Stigma, driven by homophobia, devalues human beings and often results in social isolation (Gilman 2001, Massachusetts department of public health, 2009)).

The isolation alone places tremendous pressure on the individual, often resulting in increased risk of suicide, depression, anxiety and substance abuse (Sorensen 1997, Mays 2001). The phenomenon of corrective rape also compromises the health of lesbians. The rape may result in physical injuries, unwanted pregnancies and sexually transmitted infections including HIV. (Matebeni 2011, Henderson 2006, Gontek 2007). Unemployed lesbians have been described to engage in transactional sex with men, in order to support themselves and their partners. This is also a finding made by Matebeni

(2013). The negotiation powers in such sexual relationships are often skewed towards the paying client, placing lesbians at risk of acquiring STI's (Matebeni 2011, 2013). Gay men and lesbian women are reported to use and abuse alcohol and other substances at rates higher than the general population (Cabaj 2000, Hefferman 1998). These usually assist individuals in suppressing desires and needs, and facilitate disassociation, particularly for those individuals with internalized homophobia and poor social support structures (Kessler, 1999).

The main aim of the study was to understand the health needs and experiences of lesbians living in Gauteng townships, in order to make recommendations to health care providers and policy makers to ensure that the health system responds to these needs. The objectives were to assess the current health status, risk factors, social factors that influence the health of black lesbians living in Gauteng townships and those that act as barriers to accessing health care services.

Methodology

The study was designed to be a cross-sectional mixed method study. It can be described as a sequential exploratory mixed method study (Creswell, 2003), with the qualitative component of the research being more dominant than the quantitative component. This article will focus on the qualitative component of the study.

Study settings

This study was conducted in townships. These are lower socio-economic peri-urban areas where blacks were displaced to during the apartheid era in South Africa. The areas are often plagued with high rates of violence, crime and unemployment. Resources are often limited and have to be shared by many community members.

Participant recruitment

Firstly, four fieldworkers were selected from two lesbian community organizations in Gauteng. The fieldworkers were women who identified as lesbian and lived in Gauteng townships. They were chosen because they showed an interest in the research and were eager to assist with data collection. The fieldworkers underwent a half-day training on informing participants about the study objectives, the process of obtaining informed consent, facilitating a focus group discussion using the interview guide, and lastly on identifying distressed participants who may require acute counseling services and where to refer such participants. The fieldworkers volunteered their time to the study, but were provided with transport money and airtime by the researcher.

The sampling method used for the two focus group discussions was purposive sampling, with 22 individuals in total being recruited. The fieldworkers invited the first 22 lesbians whose contact details were obtained from the network organizations to participate in one of the two focus group discussions. Participants for the survey were recruited using the snowballing sampling method.

Inclusion criteria included women who identified as lesbian; age 18 years and older, living in a Gauteng township, and consenting to taking part in the study. Two focus group discussions were conducted. Qualitative data from the survey questionnaires was also analyzed with data from the focus group discussions and spontaneous discussions from survey participants.

Data collection tool and data collection process

An interview guide used to facilitate the focus group discussion included questions relating to the experience of living as a lesbian in a township, health issues affecting women in townships in general, as compared to lesbian women and barriers to access to health care services by lesbians in townships.

The first focus group took place in a Johannesburg office park, while the second took place at a residential area in Mamelodi. The focus group discussions were facilitated by two of the fieldworkers after each participant received explanation of the process and signed informed consent. Each focus group discussion lasted about 1 hour. The researcher was present during both focus group discussions, but did not take part in the discussions. The focus group discussions were recorded using a voice recorder, and the researcher also made field notes. To address the question of rigor for this study, the focus group discussions were facilitated in English. The questions were asked in English. However, participants were free to respond in English, an Nguni language or Sesotho. It is important to note that the researcher, who was present in both focus group discussions, is proficient in both Nguni and Sesotho languages.

Although in depth interviews were not part of the original protocol, 5 focus group discussion participants shared additional information outside the group discussions. The participants felt the information was important to share, but felt too shy to share within the group. The fieldworker captured this additional information in writing. This information was added to the qualitative data set.

Data management and analysis

The transcripts were translated into English, with the transcriber and translator being a research assistant who is also proficient in Nguni and Sesotho languages. The transcripts were checked by the researcher with the help of another research assistant, with experience with qualitative data collection and analysis, for accuracy. In addition, data from the qualitative questions from the survey questionnaires, as well as the additional information from the spontaneous discussions, were typed to form part of the data set. The data was coded and analyzed manually by two different individuals. Analytical categories were generated, from which themes and sub-themes were derived.

Ethical considerations

Due to the nature of the study participants, the researcher had to consider participant confidentiality and informed consent. Some participants were not openly 'out' as lesbians. Fieldworkers were trained to explain the study to participants, and obtain individual informed consent. Fieldworkers and participants signed confidentiality clauses to ensure that participant confidentiality is maintained. Provision was made in order to identify participants who were distressed and needed counseling. This study has received written approval from the Research ethics committee of the Faculty of Health Sciences at the University of Pretoria.

Findings

Participants' description

Out of the total of 22 participants, 12 were from Johannesburg and 10 were from Pretoria. The majority of the participants were in the 20s, while only two participants were aged 30 years and older. Eight participants were employed either fulltime or part time, 8 were unemployed and 6 were students. Only 8 participants have medical aid insurance. Four participants lived in informal housing. Three participants have at least one child.

Sexual identities and gender expressions

An initial question was posed to the study participants to inquire about their sexual orientation and gender expression, but also to enquire about what it means to be a lesbian. The participants almost always volunteered information about their own gender expression without being prompted. They would give examples of how their dress code or the way they speak affects how they are treated in communities.

There were varying views on the question of identifying as lesbian. Although all participants agreed that they are women who sleep with women, some participants stated clearly that they do not particularly like to identify as

lesbian, even though they are, because the lesbian label causes people to stigmatize them unnecessarily and treat them differently. One participant said:

'I don't want to be called lesbian. I'd rather be called a woman who does other women. I don't like the word lesbian. Period.'

The participants emphasized that they are women first before they are lesbian, and they should be treated as such. This was in particular reference to the treatment by health care providers. One respondent summarized it as follows:

'I for one see myself as any other woman. The only difference about me is that I sexually feel in a different way than other women. I prefer women....'

Others were glad to identify as lesbian, as this is not only their sexual orientation, but also their identity. They felt that being called lesbian is a sign of being recognized as different from any other woman. Two participant said the following:

'I feel different because people look at me differently. Even if I am hanging around with straight people, I feel like I am the only different (person).'

'I don't care if people call me a lesbian because I am happy about who I am, I love women.'

The general consensus though, between those with the varying opinions and those who identify as either a 'butch' or a 'femme', is that they are women and they are human. All citizens of South Africa have the same rights, and the right to health applies to everyone, irrespective of sexual orientation or gender expression.

Stigma, risky sexual behaviours and HIV testing

Study participants reported that some lesbians and women who have sex with women do sometimes have sex with men. The reasons for lesbians having

sex with men ranged from transactional sex to consensual sexual relationships. Participants explained that this behavior is often taboo, and not openly spoken about. There are strong societal expectations of how lesbians should relate sexually, therefore lesbians tend to hide their sexual encounters with men. This in itself is very risky, as negotiation powers are often skewed towards the male sex partner.

The behaviour of some lesbians was also described as a threat to their health sometimes. One participant mentioned that some 'butch' lesbians secretly sleep with taxi drivers for money so that they can support themselves and their girlfriends. This practice of transactional sex is often very hidden. One participant who hesitantly spoke about her own secret encounters with men, mentioned that she developed an STI and fears going to the clinic for treatment for fear of ridicule from health care providers, but also does not have money to see a private GP. One survey participant explained:

'Some of these butch lesbians have boyfriends. They behave like men during the day but at night they become women. We see them. They try to hide. But because we all know each other we see them.'

It was also mentioned that some butch lesbians' social behaviour also puts them at risk. They behave like boys in every way, and even hang out with guys in their neighbourhoods until the early hours of the morning, drinking and smoking together. This practice was described as being very dangerous, as they place themselves in vulnerable positions because they are still physically women, and are at risk of being raped. One survey participant said:

'If they forget that they are still biological females and behave like men knowing very well that they are not safe if they sit at street corners with the thugs. They make themselves targets.'

Butch lesbians explained that they are also afraid of going to local clinics to test for HIV. The main reason being afraid of being judged by the nurses at the facilities.

'We went for HIV test with my partner and we were told we cant do we cant do it (test) because we same sex.'

They prefer to either test at health campaigns that are conducted by non-governmental organizations, or private general practitioners.

Health needs

The participants raised a variety of health concerns and needs. Some of their needs are related to sexual behaviour and practices, while others are related to social factors, such as violence, alcohol abuse and lack of social support structures.

Sexual and reproductive health needs

The study participants highlighted that lack of information and awareness about safe sexual practices contributes to health problems encountered by lesbians. The study participants commonly reported vaginal discharges and sexually transmitted infections as presenting health problems at clinics. Some lesbians have received information regarding using protective equipment such as gloves, condoms with sex toys and dental dams for oro-genital sex. The information is largely received from LGBT organizations. The biggest challenge though, is that even though some lesbians have the information of how to protect themselves and their partners, the protective equipment is not available or accessible to lesbians.

The study participants explained that lesbian safe sex packs that contain the protective equipment mentioned above are mainly distributed by one organization based in Pretoria. This affects the accessibility of the products. One participant said the following:

'...The current challenge we are facing is that they aren't always available at the clinics. So if the government could ensure that safe sex packs are always available....'

Even though there were some lesbians who knew a lot about safe sex packs, and how to use the protective equipment, there were some lesbians who had never heard of these safe sex packs, nor have they ever received information regarding safer sexual practices and the risk of transmitting STI's and HIV amongst women who have sex with women. Those lesbians who know about safer sex packs often report not using the packs during sexual encounters. The reason given by the lesbian participants is that the pack contents are not user-friendly.

'Yes we know about the safe sex packs, but it is difficult to always use the dental dam when having sex with your partner. Those things slip off. Even the gloves we don't use because when you having gloves on during sex it feels like you are a doctor doing a sterile investigation.'

A number of lesbian participants reported using sex toys during intercourse, but were mostly unaware of the risk of HIV and other STI transmission from used sex toys.

The issue about accessing Pap smears, as mentioned elsewhere above, was also raised several times by the participants. Some participants knew to have Pap smears, while others knew nothing about Pap smears. This again, highlights the gap in information accessed by lesbians in township areas.

'For me I can hear you talking about Pap smear but I don't know what that is, I have never even thought of anything about it.'

The age at which the policy states when to access Pap smears was also a contentious issue. Some respondents mentioned that public clinic staff is not consistent with messages of when, and how often to have a Pap smear. One participant summarized as follows:

'On that part, it seems as health staff at the clinics did not undergo the same training because they provide us with different information regarding the same thing. Some tell that you need to do Pap smear every year and some say 5

years.....It seems as if they train in different countries. If that could be addressed perhaps it could bring change in accessing health care services.'

The effects of rape as a health need

Participants described rape as a phenomenon that affects lesbians in townships in various ways, including their health and well-being. Rape is a social ill that many lesbians experience as an act of hate and homophobia on the part of the perpetrator. Participants have described corrective rape as a rape that occurs in an attempt to correct sexual orientation.

Besides the rape encounter affecting the mental well being of individuals, it also causes a lot of physical health risks. One participant disclosed that she acquired HIV after being raped by several men in her neighbourhood. She further stated how the health system had failed her by not giving her adequate post rape care:

'My friend and I were walking our girlfriends home one evening, and on our way back some guys started harassing us verbally saying that why do we behave like boys when we know very well that we are girls. We got into a physical fight with the 2 guys and they beat us very bad. The next thing I know I was at the hospital, my body was painful everywhere. The doctors just did x-rays on me and discharged me with Brufen. They did not even check if I was raped or what. They just sent me home saying that I am fine. Next thing I know about 6 weeks later I discover I was pregnant. I went to test for everything, and that is when they found the HIV.'

Another participant explained that the health care system is not very supportive of rape survivors, stating that after the rape has occurred they do not receive appropriate supportive counseling. She also mentioned that some rape survivors have other physical gynaecological problems, which are not attended to by health care providers:

‘Sometimes the lesbians experience a lot of problems with their womb after the rape. When you go to the hospital they don’t help you. Or you are helped by a different doctor every time and you have to tell the story many times.’

Participants also highlighted that they are afraid to report rape both at the police and at health facilities, because of the ridicule and secondary victimization they experience from service providers.

Mental health needs

With regards to mental health, substance use and alcohol abuse, the three were often interlinked. Participants reported that they are often isolated by their families, receiving very little support from their families because they are lesbian. This causes a lot of strain on the mental well being of these unsupported lesbians. Other contributing factors, such as unemployment, coupled with the poor support structures result in many of these lesbians resorting to using alcohol excessively and smoking marijuana to be able to numb their emotions and cope with their realities. Below are comments from 3 participants:

‘I don’t feel love from my family, because of my sexuality. I will wake up in the night and never get my sleep back. This thing causes a lot of stress for me.’

‘I smoke weed everyday. It makes me forget about my problems, and also helps me sleep. I don’t sleep well at night.’

‘I drink. Actually I drink a lot. I think it might be a problem. But I drink every time I’m stressed. It helps me not to think too much.’

One survey participant mentioned that in her township, they see a lot of these young lesbians who smoke ‘nyaope.’ She indicated that these young lesbians who smoke nyaope are isolated from the general community, and also isolated from lesbian groups:

‘They have chosen to live their lives differently, and smoke nyaope. They have all dropped out of school. It is very difficult to reach them. I tried to

contact one of them for you to be able to interview, but they are very difficult to find. When you do find them they are too high to even speak sense, so it's useless.'

Only one respondent reported seeking medical help for a mental condition. She went to the local clinic several times because she had no appetite, no drive and mood feeling low with some suicidal thoughts. The clinic kept giving her multivitamins, but not referring her for further diagnosis and management. She eventually went to a private general practitioner, with the support of her close friend. She was then diagnosed with severe depression and was put on treatment. Although she is happy with the treatment from the doctor, she worries about the financial implications of receiving medication from the private doctor. She has lost confidence in the care provided by the local clinic.

Interpersonal violence

Violence also plays a significant role in the health and wellbeing of lesbians in this study. Not only do they experience violence in the form of rape or sexual assaults by men in their communities. The women also described the violence that exists amongst same-sex partners. The study participants mentioned incidences where they themselves are perpetrators of violence towards their partners, or are victims of violence by their partners. The violence ranges from verbal abuse, physical abuse and even sexual abuse:

'....I was beaten by my partner and find that by that time she is next to me and they see she is also a woman. And when they ask me why I don't open a case she says she was angry. So this thing takes us backwards in believing that GBV is only associated with opposite sex violence...We also have to look at the same way as heterosexual incidences but when you go and report her, there will be a lot of issues.'

'I was once raped by my ex-girlfriend, she forced herself on me, and I was admitted in hospital for 2 weeks after that.'

'I once had a partner who always knew she was HIV positive but never chose to tell me. So, at some stage I developed a rash down there. I am not saying the rash was because of her HIV status, but when I went to the clinic they encouraged me to get tested and that was when she then disclosed her HIV status but she was quiet about it all the time. So I feel its intimate partner violence because she hid it from me.'

Access to health care and information

Access to health care services has been a major featuring point in discussions with lesbian women. The women raised variously factors that hinder them from accessing proper health care services. Below, the various factors contributing as barriers to access have been grouped into sub-themes, and these will be discussed accordingly.

Health care worker related barriers to access

The study participants raised concerns about health care workers' attitudes towards homosexuals, especially if 'a girl is dressed like, and looks like a boy.' Three different study participants related stories of how health care providers would 'read the bible' to them in a consultation, condemning their sexual orientation. Several study participants explained that health care workers have their own prejudices, with some being outright homophobic, and this affects how they as lesbians are treated. One study participant described an incident she encountered at a local public health clinic. She had gone to the clinic because she had noticed a breast lump. When she arrived at the clinic, the receptionist asked her why she wanted to consult. This was very embarrassing and uncomfortable for her, as other people waiting in line were listening to the conversation with the receptionist. After mentioning that she has a breast lump, the receptionist started laughing loudly, and asked her if she was a girl or a boy. Once she was in the consulting room with a nurse, the nurse immediately noticed that she was a lesbian. The nurse did not even want to listen to why she was consulting, but instead took out a bible from her drawer, and started reading to her and condemning her sexuality.

Once a lesbian patient experiences negative and hostile attitudes from health care providers, they are inclined to not return to the health facility. The participants quoted below capture this sentiment:

‘The other problem I see that is facing lesbian women is that we don’t go and get tested for anything at all. It’s not like we don’t want to go, the problem is that when we go to access health services there are usually challenges and attitudes towards us which as a result we are scared to go and access health care services.’

‘I was at Bara and was asked about my partner and the nurse said to me so you are gay? Sorry we don’t help confused women. I had flu, I just needed medication.’

The study participants indicated that in some cases where staff attitudes were not necessarily homophobic, one find that health care providers themselves are not knowledgeable when it comes to health needs of homosexual patients. Some health care providers don’t have the necessary knowledge on the clinical approach to a lesbian client. For instance, one study participant said she went to the clinics requesting family planning services, but because she looks like a boy, the nurse attending to her denied her contraceptive services:

‘She said to me since I am a lesbian I don’t need family planning...there are condoms if I want to cheat with a man.’

Other lesbians related similar stories of being denied certain services because they disclosed that they are lesbian or they ‘looked like boys:’

‘The nurses always say I don’t need Pap smear because I do not sleep with men.’

Another study participant further echoed the disparities and unequal treatment received by lesbians in public clinics. She explained that she once went to the

local clinic with ‘stomach cramps.’ She said that next to her was another young woman of similar age to herself who also had the same complaint of ‘stomach cramps’:

‘The heterosexual girl next to me got a urine test, but I did not get the same test.’

This example shows that lesbian women do not necessarily get the same level of care as their heterosexual counterparts.

A need for training health care providers on the health needs of lesbians was echoed by many participants. One study participant said:

‘....our health providers are not educated enough in their field....they assume you can’t contract the STI’s from another woman, it means you slept with a man.’

Often times, when lesbian women present to the clinic with a vaginal discharge, the nurses usually tell them to bring their sex partner. As one participant indicated:

‘The clinic staff will tell you to bring along your partner, and if you bring another woman they will tell you they meant a boyfriend....if you tell them she is your partner...you wont get the right treatment anymore, they will throw the panado to your face, not even the antibiotic.’

The participants felt judged by health care providers, even before they could take a proper history and make an informed diagnosis. This is very demotivating for lesbians, and discourages them from accessing health care services at their local clinics.

Client-related barriers to access

Barriers to access to health care services are not only due to health-provider related factors. Lesbian women were described to be shy in discussing their

health problems, and health issues in general. This stems from poor knowledge of own health needs. For instance, lesbian women themselves also do not know that they still need to have Pap smears for cancer screening, even if they only have sex with other women. Furthermore, most lesbians also do not know what a Pap smear is, or why it is performed in the first place. Participants also noted that there are no confidential platforms where lesbians could ask confidential health questions. Public health facilities are not seen and experienced as confidential, and there is a lot of mistrust of health care providers due to previous negative experiences. Private doctors are also not always knowledgeable about lesbian issues either, and cost money for one to be able to access them. Fear of being ridiculed also prevents many lesbians from accessing health care services.

Another issue relating to the lesbian client raised by study participants is the fact that some lesbians, especially those that are 'butch', do not like to be touched, and also sometimes have "a fear of being touched." This poses a challenge to health care workers when wanting to examine them closely.

Places of health service access

The majority of study participants access health services at the local public clinics. A small number of participants indicated that they consult both the private general practitioners and the local clinic, depending on the severity of the illness. If they have serious symptoms they would rather pay a general practitioner to examine them thoroughly, but if it is a minor ailment, or a chronic condition, they would then go to the local clinic.

'When I feel that it's a light problem I go to the local clinic, then if it has to do with my operation because I have an operation, then I go to a private doctor because at the clinic they will only give you Panado but the doctor will make sure he diagnoses you and see where there is a problem.'

The above statements indicate that there is poor confidence in the management and care received from the public clinics. Some study

participants indicated that they prefer to pay for the service in order to receive 'better' care.

Other participants indicated that they avoid visiting a health facility because of previous negative encounters at clinics. When there is a need to be treated then they prefer to go directly to a pharmacy and purchase over-the-counter medication.

'It is due to the treatment at our local clinics. So I prefer to go to the chemist and explain how I feel and they'll give me medication. I know they will help me fast and not asking me many questions.'

A few participants indicated that they consult a traditional healer when they feel that the spirits are affecting their physical condition, and symptoms are persistent.

Recommendations from participants

Lesbians need to organize themselves and form advocacy groups that will go out to clinics and advocate for the proper treatment of all lesbians, regardless. This will address staff attitudes, and decrease the fear of lesbians to be ridiculed by health care providers.

'We as lesbians we need to stand up and challenge the negative attitudes in our local clinics. We know our rights, but sometimes we too scared to stand up for our rights.'

The participants also recommended that there be safe platforms for them to be able to ask health related question. This could be in the form of a website, a call centre or even a face book page. They also suggested that workshops be organized for lesbians to teach them about various health related topics. This will help lesbians understand their bodies better, and also know more about their health behaviours and needs.

‘We need workshops for us to learn about these things. Lots of lesbians are ignorant when it comes to things like these. We really need education about health.’

Another recommendation was that sensitization workshops are necessary for all public health care service providers, to teach them about sexuality and the health needs of the LGBT individuals. This may decrease the judgment lesbians receive from health care providers, and also assist them to receive appropriate care that meets their needs.

‘The staff at the clinics need to be trained again. It seems like they were not taught about lesbians in school, or maybe they are just ignorant and not interested to know.’

Discussion

South Africa’s constitution, unlike the legal statuses of other African countries, recognizes the rights to sexual orientation free of discrimination, however, the reality on the ground, as captured in this study with respect to public institutions such as health services fall far short of the progressive law. Lesbians living in Gauteng townships displayed varied health needs and experiences of the health care system. Lesbians in the study perceived themselves as being treated differently by health care providers when seeking health care. They describe their experiences as mostly negative. This, they believe, is based on their sexual orientation. They particularly highlighted that health care providers’ lack of knowledge in managing lesbians presenting with various health conditions discourages them from returning to those public facilities. The study revealed some health needs that have been largely hidden, and thus unaddressed by the health system. Some of these needs related to the mental health and well being of lesbians in townships.

Health care providers often have heteronormative assumptions, treating clients as if they are all involved in heterosexual relationships (Fields 2001, Diamante 2009). Although these assumptions do not necessarily affect the

quality of care received by lesbian patients, the health care provider may miss crucial insight in needs that are more prominent amongst lesbian patients, therefore missing to meet the actual needs of such patients.

Homophobia is a socially constructed idea that has an impact on the health of lesbians. Homophobia drives stigma and results in unfair discrimination based on a person's sexual orientation and gender expression (Massachusetts department of health, 2009). Health care providers are often governed by their own belief systems, and have also been described to discriminate against lesbian clients based on their sexual orientation. This was both a finding in this research and has also been previously reported in literature (Westerstahl 2002). Health care providers have also been seen to be gatekeepers of the healthcare system, posing as major barriers for lesbians accessing health care services they need.

Instead of treating the patient for their presenting problem, study participants described encounters with health care providers that are judgmental and unprofessional. Certain health services were withheld from lesbians because they are erroneously thought to be at low risk of certain conditions like HIV acquisition and cervical cancer. Rankow (1998) explains that some lesbian women have a history of having sex with men, either consensually or forcefully. Participants in this study also reported practices of having sex with men, mostly for financial reasons. Interestingly, this practice of having consensual sex with men by lesbians is often frowned upon too by other lesbians. This results in this practice being very stigmatized and therefore driven further underground, with women not accessing safe sex information and resources. Homophobia also results in lesbians experiencing high levels of violence, which affects both their physical health and their mental health (Mkhize, 2010). Lesbians often find themselves targeted for 'corrective rape' within their communities (Mkhize 2010, Matebeni 2011). Participants in this study described how rape affects their own health, with one participant reporting to have acquired HIV after being raped. They find themselves being victims of not only the rape, but also victims of an often-homophobic health and justice systems, with secondary victimization when attempting to report

these crimes (Mkhize, 2010). As part of coping mechanisms, lesbians often resort to excessive use of alcohol and the use of other substances (Kessler 1999, Gilman 2001), such as marijuana as reported by study participants in this research.

There are high levels of mental health concerns affecting this population. Study participants reported the excessive use of alcohol and Marijuana, with some lesbians reporting symptoms of depression and anxiety. Lesbian women have been reported to have higher levels of depression than their heterosexual counterparts (Mays, 2001). The reasons of this high use of substances is not very clear, with it being uncertain if the high stress levels cause them to use substances (Abbott 1998, Tallis 2009), or if the high use of the substances causing other mental health problems like depression and anxiety. This health need is largely not catered for, with very few lesbians having accessed health services to address these problems.

Lesbians experience various factors that put them at risk of acquiring sexually transmitted infections, including HIV (Matebeni, 2013, Sandford 2013). It becomes important for HIV programs to start addressing the risk of HIV acquisition by lesbians, and also to produce safe sex messages that are targeted at lesbians.

New approaches that discourage health care provider discrimination are urgently needed. Health care providers need to be sensitized on issues relating to gender identity and sexual orientation. Specific health needs of lesbians also need to be taught as part of health care worker training. These interventions will provide health care providers with the necessary skills and insight when dealing with lesbian patients.

This study has several limitations. The purposive sampling method for this study makes the findings not generalizable to lesbians from other townships. The information gathered from this study was self-reported, and possibilities of both under-or-over reporting by study participants remain. No focus group

discussions were conducted with heterosexual women hence the findings cannot be compared with experiences of heterosexual women.

Conclusion

This study has highlighted important health needs and experiences of black lesbians living in Gauteng townships. Some of the needs discussed, have largely been hidden within this population and have therefore not been appropriately addressed. Although the risk of HIV and other STIs is evident (Matebeni 2013, Poteat 2013), lesbian health needs go beyond just sexual and reproductive health needs. This study highlighted mental health and substance abuse needs by lesbians living in townships. Depression in this group often goes undiagnosed and untreated, and places the lesbians at risk of using alcohol and other substances excessively. Both health care providers and lesbians need education about the specific health needs of lesbians. Appropriate health promotion messages targeting lesbians are urgently needed. This research can form a basis of health areas needing to be addressed. Information brochures can be produced to educate both lesbians and health care providers regarding different health needs. Programs that have implemented health care provider sensitization trainings on gender identity and sexual orientation have mitigated against negative health care provider attitudes, and access to services has been improved (Ayala, 2010). These sensitization programs should be replicated and implemented on a larger scale, reaching as many public servants as possible. This particular study provides new knowledge in an important context, given the disparities between the law and lived experiences of black lesbians. LGBT advocacy and service organizations may find this new knowledge helpful in framing advocacy messages. Advocacy is strongly required in order to inflict changes at both societal and institutional levels.

Acknowledgement

The researcher would like to thank the Forum for Empowerment of Women and Open Closet for providing lesbian data bases; the fieldworkers and

participants who took part in the study; my supervisor Kirstie Rendall-Mkosi, co-supervisor Prof Elna McIntosh, the Centre for statistical Analysis and Research for data analysis support and the Centre for HIV/AIDS Prevention Studies for research support. There are no conflict of interests.

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SECTION C

Quantitative results and discussion

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1. Introduction

This section includes results from the quantitative component of this study. The key results will be presented in tables, followed by a detailed description of the findings in text. Some results will also be graphically presented, in order to highlight the difference in the findings.

The results section will be followed by a brief discussion that will compare the study findings to other findings in the literature, and recommendations will also be made. The discussion section will also make reference to the qualitative study findings presented in section B of this portfolio. The results presented below exclude the bisexual population, as this particular sample was too small.

2. Quantitative results

		Lesbian	Heterosexuals	P-value
Age	30 years or less	93 (82.3)	32 (54.2)	0.000
	More than 30 years	20 (17.7)	27 (45.8)	
Employment status	Part/full time	62 (54.9)	36 (61)	0.523
	Unemployed/Student	51 (45.1)	64 (39)	
No. of children	None	81 (71.7)	19 (32.2)	0.000
	1 or more	32 (28.3)	40 (67.8)	
Education	Matric and more	94 (83.3)	41 (69.7)	0.117
	Less than matric	19 (16.7)	18 (30.5)	

Table 4: Demographic profile of participants

		Lesbians	Heterosexuals	P-value
Access health care past 12 months	Private	53 (47.8)	22 (37.3)	0.543
	Public	55 (49.6)	37 (62.7)	
Access to medical aid	Yes	32 (28.3)	25 (42.4)	0.06
	No			
Current medical	Yes	31 (27.7)	17 (29.3)	0.8

condition	No			
Symptoms in past 6 months	Yes	49 (44.6)	33 (55.9)	0.158
	No			
Health status	Poor/fair	69 (66.4)	31 (52.6)	0.03
	Good/Excellent			
Breast examination	Never	89 (79.5)	37 (62.7)	0.06
	Ever	23 ()	22 ()	
Pap smear	Never	89 (79.5)	21 (35.6)	0.000
	Ever			
Treated for STI in past 12 mths	Yes	27 (24.3)	25 (43.1)	0.004
	No			
Tested for HIV in past 12 mths	Yes	75 (67.6)	44 (77.2)	0.165
	No			
Sexual Orientation disclosure to HCP	Never	52 (46.9)	57 (98.3)	0.000
	Sometimes/Always			

Table 5: Health behaviour and utilization

		Lesbians	Heterosexuals	P-value
Depression & Anxiety symp	Yes	58 (52.3)	33 (57.9)	0.4
	No			
Serious suicide thought/attempt	Yes	44 (40.7)	23 (38.98)	0.8
	No			
Alcohol problem (CAGE)	Yes	78 (69)	23 (38.98)	0.000
	No			
Marijuana use	Yes	54 (47.8)	14 (23.7)	0.002
	No			
Cigarette use	Yes	74 (65.6)	19 (32.2)	0.000
	No			
Raped in last 5 years	Yes	24 (21.4)	11 (18.97)	0.7
	No			
Abusive	Yes	48 (46.3)	20 (33.9)	0.035

relationship	No			
Physical fight	Yes	43 (41.75)	20 (30.3)	0.214
	No			

Table 6: Mental health and substance use

2.1 Response rate

A total of 200 administered questionnaires were prepared, and 200 potential participants were approached. There were 179 (response rate 89.5%) respondents. It proved to be difficult to recruit heterosexual women for this study, with many heterosexuals declining to take part in the study.

2.2 Demographic profile

The study methodology attempted to match lesbians with heterosexuals. There were a total of 179 women participated in the survey section of the study, where 112 were lesbians (57.3%), 6 bisexuals (8.4%), 59 were heterosexuals (33.2%). One woman identified as 'women who has sex with women' (1.1%). This woman was included in the lesbian data set. There were almost twice as many lesbian participants as the heterosexual participants. The bisexuals were excluded from the data analysis.

The figure below depicts the sexual orientation profile of the study participants.

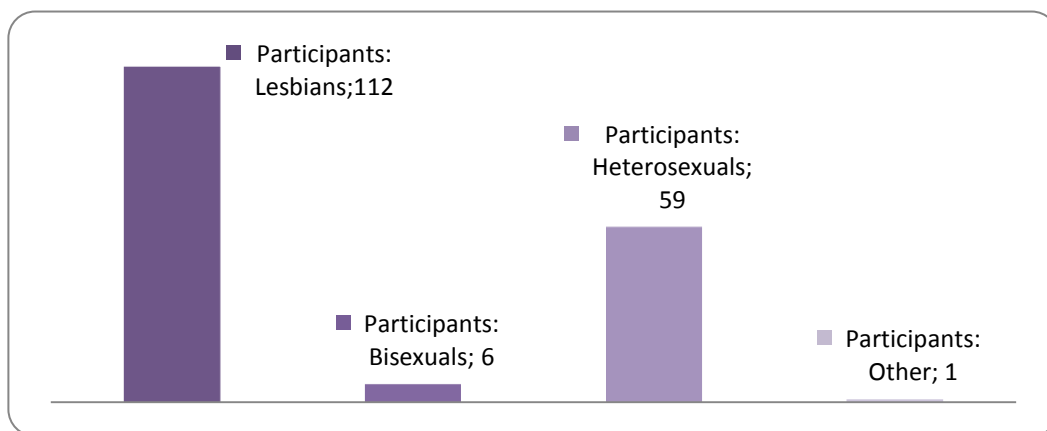


Figure 2: Total distribution of participants by sexual orientation

The women were recruited from a total of 13 townships in and around Gauteng province. The graph below shows the geographical distribution of all the study participants.

The chart below depicts the total distribution of all study participants who took part in the survey. These include all the lesbians, bisexuals and heterosexual women who were interviewed.

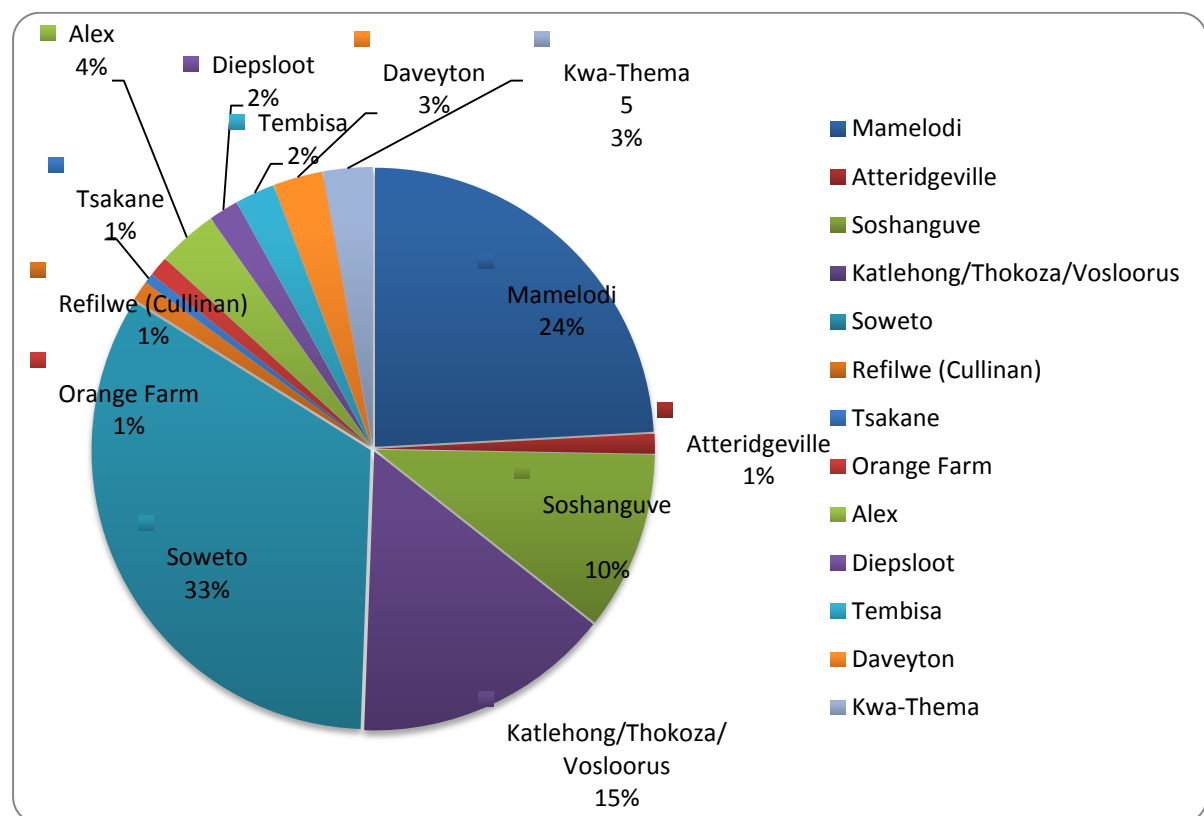


Figure 3: Geographical distribution of all study participants

Thirty-three percent of all study participants (n=58) are from Soweto in Johannesburg, while 24% (n=42) are from Mamelodi in Pretoria. Just over 20% of study participants are from Ekurhuleni.

Ten percent of the participants are from Soshanguve township in Pretoria. The rest of the townships represented 8% of participants in total.

There was a statistically significant difference between the ages of the lesbians and heterosexuals ($p=0.000$). The lesbian and bisexual participants

were generally younger than their heterosexual counterparts, with 82% (n=93) of lesbians being 30 years or younger. Only 54% of the heterosexual women were either 30 years or younger.

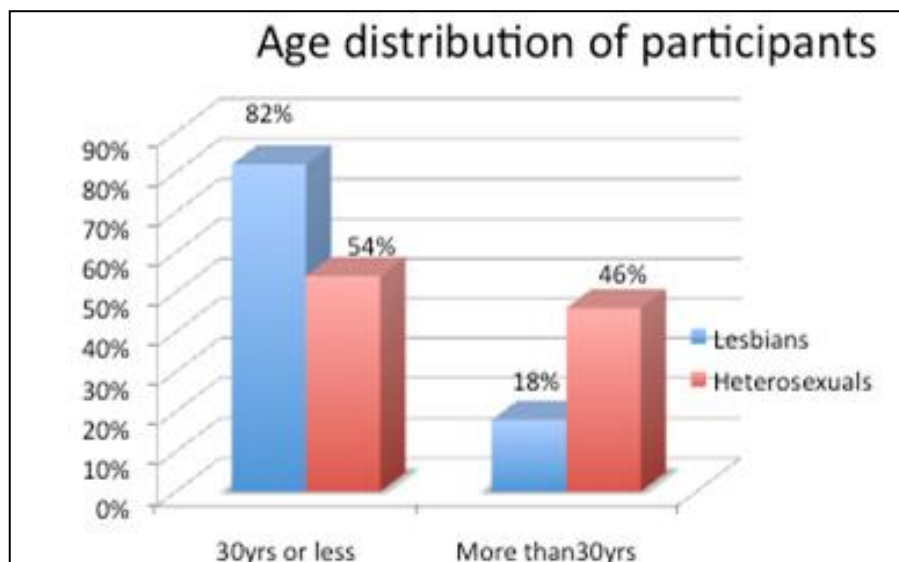


Figure 4: Age distribution of participants

Within the heterosexual group, 67.8% (n=40) women had at least one child, as compared to 28.4% (n= 32) of lesbians who had at least one child (p=0.000).

The majority of the study participants (83%% lesbians and 70% heterosexuals, $p>0.05$) had either a Grade 12 certificate as their highest qualification, or had post-matric qualifications.

Fifty-five percent of lesbian participants are employed either fulltime or part time; whereas 61% of the heterosexuals were either employed full time or part time ($p=0.117$). The unemployment rate amongst the lesbians was just under 25%, while amongst the heterosexuals was just above 30% ($p=0.523$). The unemployment figures exclude participants who reported to be students.

2.3 Access to health care

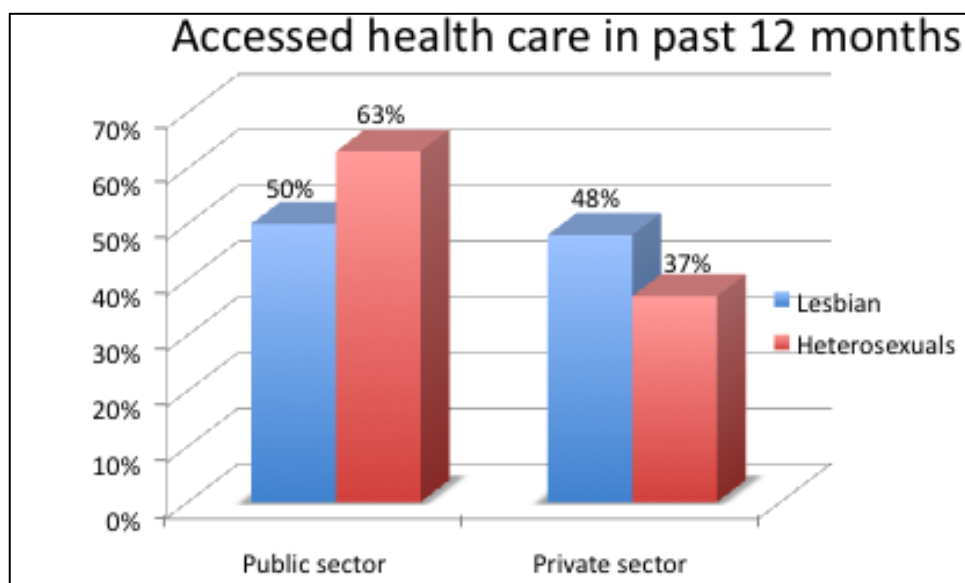


Figure 5: Accessed health care in past 12 months; Lesbians vs. Heterosexuals

When asked if they have access to medical aid insurance, 28.3% (n=32) of the lesbians responded yes, while in contrast, 42.4% (n=25) of the heterosexuals responded yes ($p=0.06$).

The majority of the study participants access primary health care from the public sector clinics (49.6% n=55 lesbians, 62.7% n=37 heterosexuals, $p=0.543$). Even though only 28% of the lesbians reported having access to medical aid insurance, 47.8% (n=53) lesbians reported to prefer accessing health care services from private general practitioners. The majority of these participants make out-of-pocket payments for the services. Two lesbian respondents reported to prefer to access primary health care services directly from a pharmacy, while only one lesbian participant reported accessing primary health care services from a traditional healer. No heterosexuals reported using any other type of health care service other than the public sector clinic or the private general practitioners.

Respondents were asked if they ever disclose their sexual orientation to the health care provider. Forty seven percent (n= 52) of lesbians said they never

disclose their sexual orientation, while 41% (n= 45) of lesbians saying that they only disclose their sexual orientation when it is appropriate for the consultation. Nearly all (98%, n= 57) the heterosexuals felt that it was not necessary to tell their health care provider that they are heterosexual.

2.4 Perceptions of health status needs

The majority of the study participants (72.3% lesbians vs. 70.1% heterosexuals) reported to have no medical conditions, although (44.6%, n=49) lesbians and (55.9%, n=33) heterosexuals reported having had symptoms requiring medical attention in the last 6 months.

Nearly 43% (n= 48) of lesbians reported never to have had a physical examination, as compared to 25% (n=15) of heterosexual women.

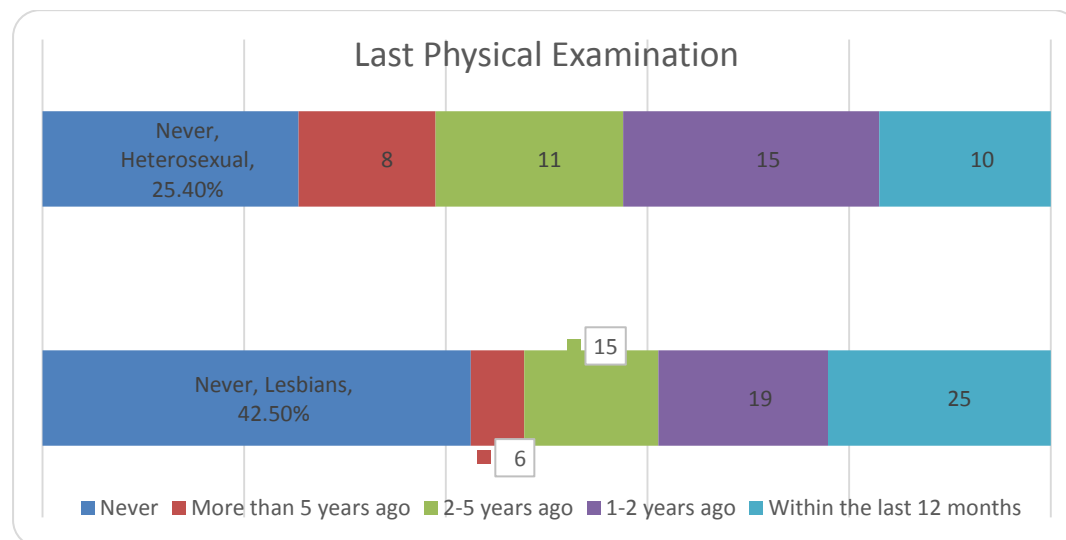


Figure 6: Last physical examination by sexual orientation

Respondents were asked how they perceived their own state of health, rating their own state of health from poor to excellent.

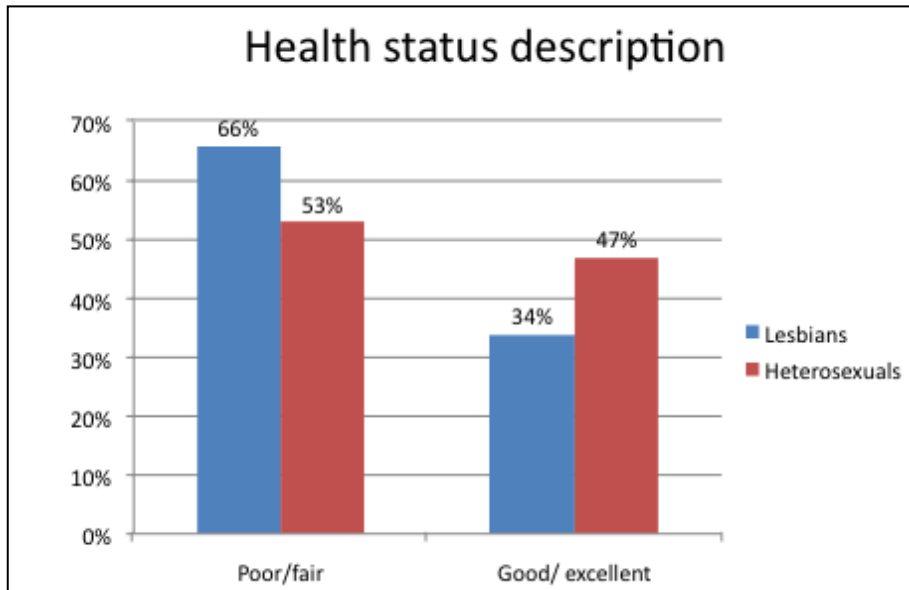


Figure 7: Self-description of health status by sexual orientation

The majority of the study participants reported their health as being fair or poor, with only 34% (n=35) of lesbians and 47% (n=28) heterosexuals rating their health status as good or excellent.

2.5 Cervical and breast cancer screening

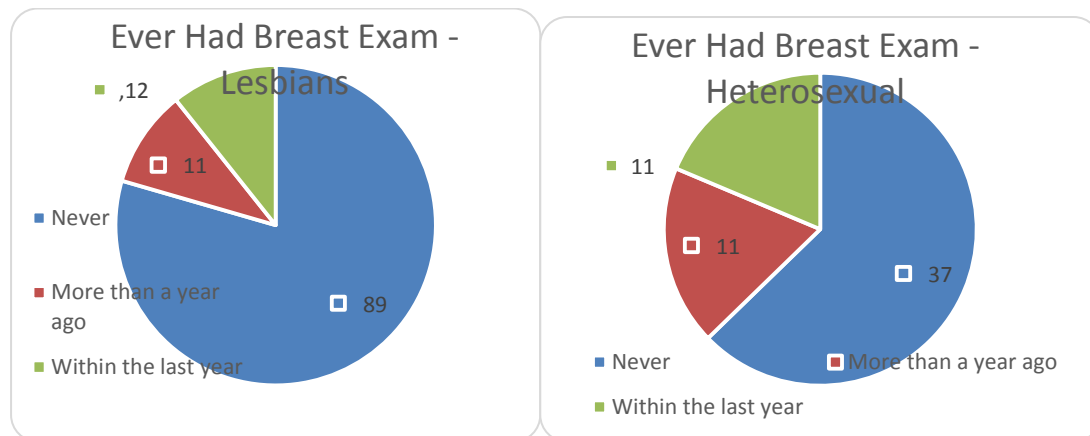


Figure 8: History of breast examination by sexual orientation

Although 18% (n=20) of lesbians and 22% (n=13) of heterosexual women reported to have had close relatives who had a history of breast cancer, the majority of the study participants have never had clinical screening for breast cancer. This finding was similar amongst lesbians, with almost 80% of them

never had been screened, as it was amongst heterosexuals, with 63% never have been screened for breast cancer ($p=0.06$).

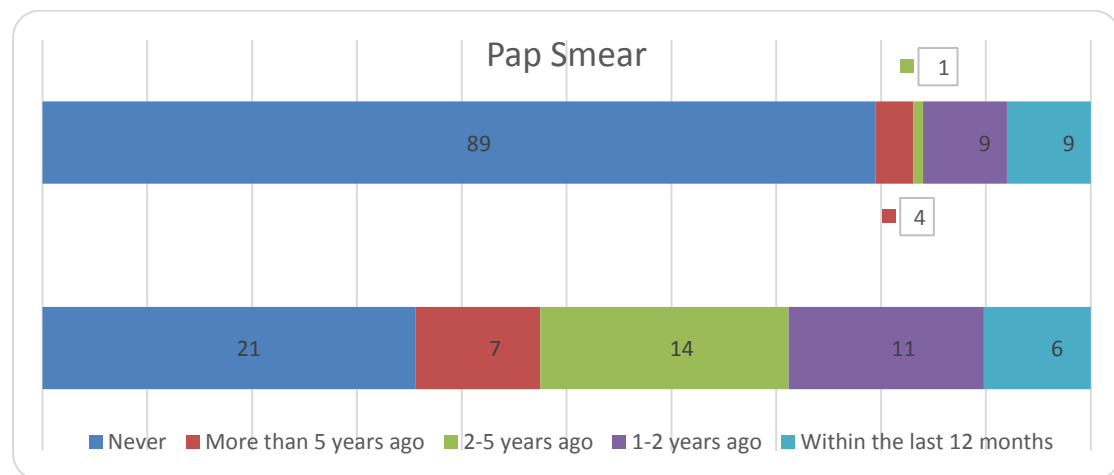


Figure 9: History of Pap smear examination by sexual orientation

There was a significant difference in the number of lesbians who have never had a Pap smear as compared to heterosexuals. Almost 80% ($n=89$) of lesbians reported never to have had a Pap smear, while only 36% ($n=21$) of heterosexual women have never had a Pap smear ($p=0.000$).

2.6 Sexually transmitted infections and HIV

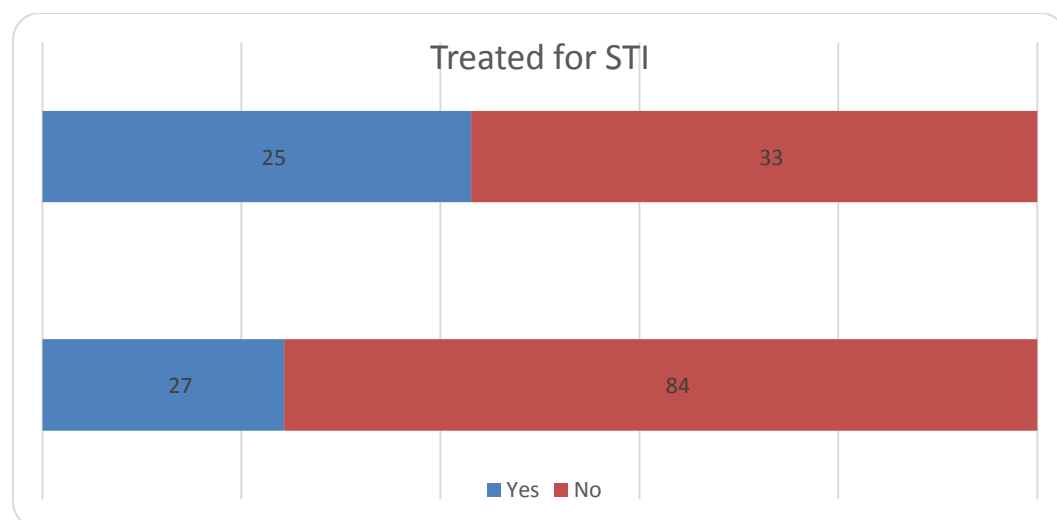


Figure 10: History of STI treatment in past 12 months by sexual orientation

Sexually transmitted infections (STI) were described as vaginal discharge or genital sores that were as a result of a sexual encounter and required medical

treatment. It must be noted however; that participants did not necessarily know how to differentiate a non-sexually transmitted discharge, such as vaginal thrush, from sexually transmitted discharges. When asked if they have been treated for STI in the last 12 months, 24% (n=27) of lesbians responded affirmatively, while 43% (n=25) of heterosexuals reported having been treated for an STI ($p=0.004$).

With regards to testing for HIV in the past 12 months, about 68% (n=75) lesbians reported to have tested for HIV, while 77% (n=44) of the heterosexuals have tested for HIV in the same period ($p=0.165$).

2.7 Mental health

A screening tool was used to screen respondents for symptoms of depression and anxiety. The responses were similar between the lesbian and heterosexual respondents ($p=0.4$). Fifty-two percent (n=58) of lesbians and 58% (n=33) of heterosexuals screened positive for symptoms of anxiety and or depression. Almost 18% (n=21) of lesbians did not respond to this question, while 22% (n=14) heterosexuals also did not respond.

Respondent were asked if they have ever considered committing suicide. The consideration could have been just seriously thinking about it and planning it, or even an attempted suicide. Again, the results of lesbians and heterosexuals were very similar, with about 41% (n=44) of the lesbians responding affirmatively and 39% (n=23) of the heterosexuals also responding affirmatively. Five lesbian respondents did not respond to this question. Forty one percent of lesbians had serious suicidal thoughts or attempt, while 39% of heterosexuals also either seriously considered suicide or attempted ($p=0.8$).

2.8 Alcohol and substance use

Respondents were also screened for alcohol dependence, using the CAGE-questionnaire. All respondents with at least two yes responses to the CAGE-

questionnaire were considered to have an alcohol problem. An alarming 69% (n=78) of lesbians were considered to have an alcohol problem, as compared to 39% (n=23) of the heterosexuals (p=0.000).

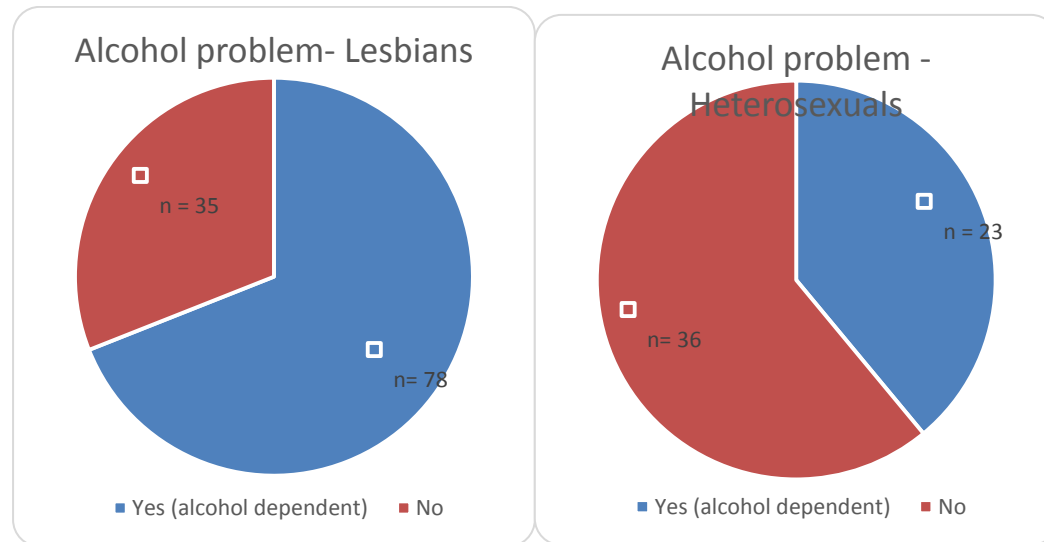


Figure 11: Alcohol problem by sexual orientation. Yes: screened positive with CAGE; No: screened negative with CAGE

The study participants reportedly used cigarettes, cannabis, and other drugs, which included nyaope, cocaine and ecstasy. Sixty-six percent of lesbians (n=74) reported smoking cigarettes, while only 32% (n=19) of heterosexuals reported smoking cigarettes (p=0.000). Almost half of the lesbian respondents (n=54) reported using marijuana, as compared to only 24% (n=14) of the heterosexual respondents (p=0.002). Twenty-one percent (n=24) of lesbians reported using other types of drugs, as compared to about 14% (n=8) of heterosexuals.

2.9 Violence

Both the lesbians and heterosexuals had high rates of rape, with 21% of lesbians and 19% of heterosexuals having experienced rape in the past 5 years (p=0.7). Forty six percent of lesbians reported to have been in an abusive relationship, while 34% of heterosexuals reported abusive relationships (p=0.03). The abuse in both groups ranged from verbal abuse to

sexual abuse. Forty two percent of lesbians reported to have been in a physical fight, compared to 34% of heterosexuals ($p=0.214$).

2.10 Cross tabulations for lesbian survey participants.

Depression and cigarettes	0.05
Depression and Marijuana	0.107
Depression and Alcohol	0.142
Multiple CP and STI treatment	0.536
unemployment and access public	0.000
Unemployment and Marijuana	0.000
Unemployment and alcohol	0.271
Rape and HIV test	0.018
2-5 females and HIV testing	0.778
1 male and HIV testing	0.782
Disclosure and denied health service	0.005
Abuse and physical violence	0.06
Last physical and breast exam	0.074
Last physical and pap smear	0.006
Serious suicide and Marijuana	0.002

Table 7: Chi Square and significant testing of key variables; Lesbians

Cross tabulations were performed for the lesbian group, where variables were tested using the chi square test. P-value of 0.05 was the used as the threshold of significance.

Depression was cross tabulated with the use of alcohol, cigarette use and Marijuana use. There was significant association only between depression and cigarette use ($p=0.05$). No significant association was found between depression and the use of alcohol, or the use of Marijuana. Employment status was tabulated against access to public health services. It was found that unemployed lesbians were more inclined to use public health services ($p=0.000$). Unemployment was also significantly associated with the use of Marijuana ($p=0.000$), but not with the use of alcohol.

3. Discussion

The focus of this research was to enquire about the health needs and health care experiences of black lesbians living in Gauteng townships. An attempt was made to compare lesbian health needs and experiences with the health needs of black heterosexual women living and working in similar conditions, as seen in other studies conducted in other countries ^{1, 2}. Considering the small sample sizes of especially the heterosexuals, and the sampling methods employed ³, it is pertinent to understand that these findings are by no means representative of all lesbian and heterosexual women living in the various townships around Gauteng Province. These findings can only be generalized amongst the study population that took part in this study.

The lesbian participants in this study were significantly younger than the heterosexual counterparts. This could have influenced some social and health care experiences of the different women in this study. For instance, because the heterosexuals were generally older, they were more likely to have children, than the younger lesbian participants. It should also be noted that the younger generation of women who identify as lesbian are often found to be more vocal and upfront, whereas the older women are more conservative and less vocal. This was seen in the focus group discussions, where the younger lesbians were more inclined to 'challenge' health care providers about information more than the older lesbian would.

3.1 Access to health care

The main focus of participants responses centered around access to health care services. Lesbian study participants were found to experience more barriers in accessing health care than their heterosexual counterpart. This finding was similar to findings in other studies conducted in earlier years in the US ^{1, 2}. In a study conducted on Lesotho lesbians in 2013, Poteat⁴ found that participants were denied certain health services due to their sexual orientation or gender expression. These experiences were also described by study participants in this current study. Although there are significant differences

with regards to how the law perceives sexual orientation between Lesotho and South Africa, health care experiences of lesbians are similar, with health care providers' attitudes influencing service experiences. The protective South African legal framework does not seem to improve the lived realities of lesbians in townships. Lesbian study participants reported poor access to health information relevant to lesbians. Matebeni (2013)⁵ reported similar findings in her study looking at health experiences of HIV positive women in four countries, including South Africa. Both the lesbian and heterosexual study participants reported accessing health care service primarily from public clinics. The private medical care is received primarily from general practitioners, but some participants preferred to go directly to a private pharmacy to purchase over the counter medication. General practitioners were generally trusted more than the public clinics if the individual experienced symptoms that they considered serious. The public sector clinics are mostly used for minor ailments and screening services. Although the majority of study participants reported having physical access to health facilities, it was commonly reported that health care providers acted as the biggest barrier to accessing appropriate care and services. Health care providers have also been found to act as barriers in other studies^{6, 7}. Lesbian participants in this study, and in other studies generally felt the health system is not particularly responsive to their health needs, and often discourages them from trying to access services^{5, 6, 8}. Negative attitudes of service providers, as similarly reported in other studies^{1, 6}, seemed to be a major barrier to care for those who identify as lesbian.

It is interesting that the heterosexual counterparts did not experience the same barriers of accessing health care services as their lesbian counterparts. This drives the message that our society and practices are often biased towards heteronormativity^{2, 8, 9}. This societal heterosexist attitude was also reported by a study conducted by the Triangle Project in Cape Town⁶, with service providers knowingly or unknowingly assuming that heterosexism is the 'norm', and anyone presenting with an identity or gender expression that is out of this 'norm' posing a challenge for them.

When asked if they disclose their sexual orientation, study participants varied in their responses. As expected, the heterosexual women did not see the need to specify their sexual orientation to their health care providers. The lesbians however, largely disclosed their sexual orientation only when it was necessary to do so in order to guide the health care provider to ask them appropriate questions. The issue of disclosing however placed some lesbian individuals in difficult positions^{8, 9}. Because of their sexual orientation, they were expected to behave in a particular way, even sexually. This meant that certain services were withheld from these individuals, as health care workers assumed that they are not at risk of certain health conditions, such as pregnancy, STI's and cervical cancer^{8, 10, 11}. Those lesbian individuals who were too shy to disclose their sexual orientation, mainly due to fear of being ridiculed were often subjected to hetero-centric questioning and interventions. Trust of health care providers plays a significant role in lesbians feeling comfortable in disclosing their sexual orientation. Lack of this trust discourages lesbians from accessing health care services. These findings are similar to findings by Diamant et al (2009)¹ in a study conducted in the USA.

3.2 HIV and other STI's

Various authors have also reported the plausibility of STI's amongst lesbians^{10, 12, 13}. Although heterosexual study participants experienced more sexually transmitted infections, a significant number of lesbians also reported having been treated for STI's within the past 12 months. Studies have suggested that lesbian women face multiple risks for acquiring STI's, including HIV^{5, 6}. These risks include sexual violence¹², transactional sex with men^{5, 14}, and unsafe sexual practices amongst women who have sex with women^{15, 16, 17, 18}. It is important for HIV programs to consider interventions and messages that are specifically targeted at this vulnerable group⁵.

3.3 Cervical and breast screening

Even though the literature expresses the importance and need for women who only have sex with women to have regular cervical screening^{11, 12}, this

information is not explicitly included in South African Sexual and Reproductive Health policy. Health care providers are unaware of the importance and need for these women to access cervical screening services, and often act as barriers themselves for lesbians to accessing this important screening service^{8, 9, 11}. The evidence in this study shows that heterosexual women access the Pap smears more than the lesbians. One confounding factor though in this particular study, is the fact that the lesbian cohort is generally younger than the heterosexual cohort. The South African national cervical screening recommends cervical screening from age 30 years¹⁹. As most participants in the lesbian cohort were less than 30 years of age, this could contribute to the low access rate of this service. Similarly, lesbians are often not provided with breast screening services, despite the fact that they may biologically be at an increased risk of presenting with breast cancer²⁰.

Their risk is increased by the fact that lesbians tend to have fewer children²⁰, and in most cases as highlighted by this study, no children at all. They are also less likely to use any form of contraceptives²⁰. This too increases their risk of developing breast cancer.

3.4 Mental health and substance use

Although this study's focus was not on mental health exclusively, and very superficial questions of screening for depression were asked, the responses to questions relating to symptoms of depression, alcohol abuse and substance use were concerning. A significant number of the lesbian participants reported symptoms of depression (52%), and an even larger number reported using alcohol excessively (69%), and drugs of abuse, particularly Marijuana (47.8%). Many lesbians reported using alcohol and substances to numb their feelings of stress. This finding was also reported in other studies, where lesbians were found to use alcohol and other substances more than their heterosexual counterparts^{7, 21, 22, 23}. The 'stress' reported was attributed to feelings of neglect by families, lack of social support structures, unemployment and relationship problems. Stigma and discrimination has been found to affect the mental well-being of lesbians^{24, 25}. Many study

participants reported that they have not sought medical help in any of this regard, mostly because they don't know where to access help, but also because they do not have trust in the local clinics from previous experiences. These findings are worrying, as most of these participants have not had access to mental health services, including assessment, diagnosis and management by trained health care providers.

The number of study participants who have reported ever having seriously thought of, or attempted suicide is alarming. Just over 40% of lesbians and 39% of heterosexuals reported to have seriously considered suicide or attempted suicide. These figures are high, but may not even be a true reflection of the mental health state of lesbians and heterosexual women in townships. Many women battle many social and economic struggles on a day-to-day basis. This alone may mask the true prevalence of mental health conditions amongst women who are forced to build resilience against social factors experienced everyday. Other studies in the US have found that lesbians have increased risk of suicide as compared to heterosexuals^{7, 22}. Although figures were high, the findings in this study did not find a statistically significant difference between the lesbians and heterosexuals. Efforts are needed to urgently address mental health needs of all women in general, but also of lesbians who experience high levels of stress due to stigma, discrimination and social isolation.

3.5 Perception of health status

Although the majority of the study participants (both lesbians and heterosexuals) reported their health status as being fair or good, very few participants actually have yearly physical examinations and screenings. Also, many study participants reported doing minimum exercise and being overweight. Smoking is also a major health risk factor amongst the lesbian cohort, with 66% of lesbians smoking cigarettes, as compared to only 32% of heterosexuals. This finding is consistent with findings in other studies^{1, 23, 26}.

Smoking, obesity and sedentary lifestyles places individuals at high risk for cardiovascular diseases such as hypertension and Diabetes Mellitus^{26, 27}. Interventions are needed to address social factors that impact on the health of this population group.

3.6 Social determinants of health

Both the lesbian and the heterosexual women experienced similar social factors that influence their health. The unemployment rate was similar in the two groups (45% in lesbian group) vs (39% in heterosexual group). Violence plays a very significant role in the health of all women in South Africa. Lesbians are often targeted victims of corrective rape^{5, 28, 29, 30}. Just over 21% of lesbians and 19% of heterosexuals study reported being raped in the past 5 years. Some women who reported ever being raped also reported that they did not report the incidence to the police station, or to a health facility. These women cited fear of secondary victimization as the main reason for not reporting these incidences²⁸. Others expressed that their families did not support them through the experiences, and therefore had no support to report the incidents. When asked about post exposure prophylaxis (PEP) for rape survivors, some study participants did not know what that was, and some had heard of it, but had never accessed it. Others knew about PEP, and have accessed it, but had never been followed up after the first consultation at the hospitals.

Intimate partner violence amongst lesbian couples was also reported, with some lesbians admitting to being perpetrators of this violence. A similar finding was made by Van Dyk³⁰ in a study looking at sexual experiences of lesbians in Tshwane, South Africa. The abuse experienced by lesbians in same-sex relations ranged from verbal abuse, emotional abuse, physical abuse and also sexual abuse. This is an uncharted area of violence that has not received much attention in the past. In this study, lesbians who reported being in physical fights, reported fighting with other lesbians (friends and girlfriends) and men in their communities. The physical fights mostly occurred with people they knew, and not just strangers.

4. Methodological considerations and study limitations

The limitations of this research begin with the sampling method. Individuals who identify as homosexual are very difficult to reach, and creative methods of finding study participants had to be employed. These sampling methods are statistically non-randomized sampling methods, posing a major challenge with the generalizability of findings.

Selection bias can also not be excluded, since recruited individuals are most likely more prone to be of the same age group, and background as the recruiters. Those individuals who were eligible for the study, who do not use social media platforms were unlikely to have been reached. Selection bias of the heterosexual control group also potentially exists.

These women were identified by lesbian participant, therefore heterosexual women who do not personally know lesbian women may not have been selected for this study. This too limits the generalizability of findings.

The questionnaire was developed in English, and the field workers had to be proficient in English and the locally spoken languages (Sesotho and Nguni), in order to administer the questionnaire effectively. However, study participants were not required to be proficient in English. The field workers translated questions that were not understood by participants into the various local languages. It is not known if the translation of some questions into the locally used languages reflected the sentiment of the original English question.

The study relied heavily on self-reported information. It is possible that participants withheld certain information from the field workers especially because some study participants were known to the field workers.

The interviewers for the administered questionnaires identified as lesbians, so the risk of the interviewer not being objective also exists. This was addressed by training the field workers on how to administer the questionnaire, while remaining consistent with all interviewees. Sometimes the conversations

would end up taking a direction of their own after the questionnaire was administered, and comments made outside the questionnaire were also documented.

The sample size for the study was very small therefore findings may not be a representation of all lesbian and heterosexual women in the townships. Attempts to match lesbians with heterosexual women proved challenging, with most heterosexual women declining to take part in the study as the focus was perceived to be mainly on lesbian women and other women who have sex with women.

5. Conclusion

This study sought to explore the health needs and health care experiences of black lesbians living in Gauteng townships. The findings indicate that lesbians do in fact have unique challenges when accessing health care services. Health care workers are seen to be the main barrier experienced by lesbians. Health care providers not only restrict access with their negative attitudes towards homosexual women, but their lack of adequate knowledge of health needs of this population also restricts lesbians from receiving appropriate care. Lesbians in this study perceived their general health to be good. However, on further interrogation, it became evident that certain health needs are not appropriately met by the health system. The high rates of mental health conditions, including alcohol and substance abuse are very alarming and need urgent public health interventions. The production of health promotion messages targeted specifically at these high priority health concerns is urgently required. These messages have to be targeted especially at lesbians. Homophobia plays a critical role, acting both as a risk factor and a barrier to accessing health care for lesbians. The high rates of rape influence the health of all women in South African townships, but lesbians face additional burdens of fear of secondary victimization and ridicule when accessing post-rape care services. Efforts are needed to up-skill health care workers on actual health needs of lesbians. Public service providers need sensitization workshops, to decrease prejudices. These sensitization

workshops should address issues relating to sexual orientation, gender identity and basic human rights. Sexual orientation does not predict sexual behaviour. Lesbians should not be denied services based on their sexual orientation or expected sexual behaviour. It is thus important to create awareness by developing appropriate public health messages that are targeted at key health issues affecting lesbians. The findings in this research should precipitate further research in order to understand the impact the various conditions have on lesbians, and to also determine appropriate interventions needed to address these health problems.

6. Reflexivity

Prior to commencement of the study, the researcher did not foresee the difficulty in reaching lesbian women in townships. The researcher also did not foresee that heterosexual women would be difficult to recruit. As a result, the intended geographical townships had to be extended to ensure that the study sample size is acceptable.

The matching attempt of lesbians to heterosexuals also did not materialize as planned. The study managed to recruit almost twice as many women who have sex with women as heterosexual study participants.

The decision to administer the questionnaire to study participants may have influenced the level of honesty from respondents. Many study participants answered the questionnaire in a particular way, but once the formal questionnaire was complete, they would then explain situations that contradicted their responses in the questionnaire. They also felt more comfortable to tell stories about their friends than themselves.

This study has personally assisted me to understand the health needs of lesbians better, and has encouraged me to continue advocating for the health and rights of these marginalized women. It also encouraged me to hear young women without much resources talk so passionately about their own health

and rights, and hearing of their personal efforts to mobilize and advocate for these rights, one problem at a time.

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APPENDICES

- 1. Focus group discussion interview guide**
- 2. Survey questionnaire**
- 3. Ethics approval**
- 4. Letters of permission**
- 5. Informed consent**
- 6. Author guidelines**

INFORMATION LEAFLET AND INFORMED CONSENT FOR NON-CLINICAL RESEARCH (FGD)

TITLE OF THE STUDY

Health care experiences and perceived health needs of adult black lesbian women in four Gauteng townships

Dear study participant

We invite you to voluntarily take part in a research study. This information leaflet will help you decide if you want to participate in the study or not. Before you agree to take part, you should fully understand what is involved. If you have questions that this leaflet does not fully explain, please do not hesitate to ask the investigator, Ntlotleng Mabena, or the interviewer, Kopo Lehobye.

THE NATURE AND PURPOSE OF THIS STUDY

This research study looks to explore the experiences lesbian women have had when accessing health care services. It also looks to identify common health problems, as well as health needs of black lesbian women currently living in Gauteng.

You as a study participant are a very important source of information for this research, regarding your health experiences and health needs as a lesbian women living in Gauteng.

EXPLANATION OF THE PROCEDURE TO BE FOLLOWED

This study involves two phases:

PHASE 1

This first phase will be conduction of two Focus Group Discussions with 10 lesbian participants in each discussion session. In the focus group discussion, an interviewer will follow an interview guide with a few questions. All the participants in the group will be given a chance to respond. The interviewer may ask follow up questions to obtain better clarity.

The group discussions will be voice recorded, and notes will be taken. However, to ensure that your real identity is protected at all times, all participants will wear name tags of pseudonyms they would like to be called during the discussion.

At the end of the group discussion, the interviewer may ask you to complete the questionnaire to be used in the second phase, as a pilot. This process should be used as an opportunity to highlight areas requiring deeper attention, or the removal of unnecessary questions.

Should you wish not to answer a particular question, you may request the interviewer to pass.

RISK AND DISCOMFORT

Some of the questions asked may cause some discomfort in some participants. We will have a psychologist/social worker present in the sessions, should any participant require further counseling.

The interview process will also take some of your time. The interview is expected to take a minimum of 1 hour, but not longer than 2 hours.

The questionnaire is expected to take no longer than 30 minutes of your time.

Please be advised that should any participant require any further professional services, like further counseling, following the focus group discussion, appropriate arrangements will be made by the researcher.

POSSIBLE BENEFITS OF THE STUDY

Although you will not directly benefit from the study, the results of the study will enable us to come up with appropriate health promotion messages directed to lesbian women. The results may also influence health policy in South Africa to provide better health care for all.

The results of the study will be published in a relevant journal, and constituents of the LGBT community will have access to the report through LGBT organizations.

WHAT ARE YOUR RIGHTS AND RESPONSIBILITIES AS A PARTICIPANT?

Your participation in this study is entirely voluntary. You can refuse to participate, or stop at any time during the interview without giving any reason. Your withdrawal will not affect you in anyway.

Furthermore, by taking part in this research, you have a responsibility to respect fellow participants and keep all discussions confidential. You will meet other people in the discussion group who you may or may not know. The discussions may reveal sensitive issues raised by any of the participants. It is of utmost importance that everything spoken about in the focus group discussion remains within the discussion group.

Ethical approval

This study has received written approval from the Research ethics committee of the Faculty of Health Sciences at the University of Pretoria. The study has also received written approval from the Forum of the Empowerment of women (FEW), and Open Closet. Copies of these approval letters are available should you wish to have one.

INFORMATION AND CONTACT PERSON

The contact person for this study is Ntlotleng Mabena, if you have any questions about the study, please contact her on 0827076377.

COMPENSATION

Your participation is voluntary.

We will provide study participants with small tokens of appreciation at the end of the session.

CONFIDENTIALITY

All information that you give will be kept strictly confidential. Once we have analyzed the information no one will be able to identify you. Research reports and articles in scientific journals will not include any information that may identify you.

CONSENT TO PARTICIPATE IN THIS STUDY

I confirm that the person asking my consent to take part in this study has told me about nature, process, risks, discomfort and benefits of this study. I have also received, read and understood the above written information (information leaflet and informed consent) regarding the study. I am aware that the results of this study, including personal details, will be anonymously processed into research reports. I am participating willingly. I have had the time to ask questions and I have no objections to participate in this study. I understand that there is no penalty should I wish to discontinue with the study and my withdrawal will not affect me in anyway.

I have received a signed copy of this informed consent agreement

Participant's name _____ (please print)

Participant's signature _____ Date _____

Investigator's name _____ (please print)

Investigator's signature _____ Date _____

Witness name _____ (please print)

Witness's signature _____ Date _____

Focus group discussion semi-structured interview questions

Target group: South African lesbian women

Study population: South African lesbian women, aged 18 years and above, residing in Gauteng province.

Interviewer name:

Recorder name:

Start time:

End time:

Ground Rules for the Focus Group

1. In focus groups there are a lot of different opinions. There are no right or wrong answers – just your own opinions. That's OK. This isn't school and I am not here to give the "right answers" because there are none. I just want to know what you think.
2. It's OK to react to each other's comments. Some of you may agree with each other and some of you may disagree.
3. Let's all try to respect each other's different cultural values, beliefs and opinions. Everyone is entitled to their own opinions so it is very important that everyone be heard.
4. Please talk one at a time so the group hears your opinions. We don't want to miss what you're saying. If people start side conversations with their neighbors we miss out on what's being shared.
5. All of your comments are confidential. What we say in this room stays in this room. Can everyone agree with that?
6. Your participation is voluntary. You can say "pass" on a questions that is uncomfortable for you if you like.
7. In order to ensure that we capture what the group says, we will be audio recording the discussion. We need your consent to do this. Group members will use numbers to introduce themselves or pseudonyms. No actual names will be used in the report to protect your anonymity and privacy.

Interview questions:

1. Interviewer introduces topic to group after consent has been received, and takes necessary questions.
2. What do you think are the most important health problems affecting women in your community?
3. What do you think are the most important health problems affecting you as a lesbian woman? And how do they differ from the general woman population, if they do differ?
4. Do you access health care services mostly for prevention or for cure of a specific ailment?
5. Where do you access health care services the most? And why?

6. Are there barriers of lesbian women accessing health care services in your community? If yes, describe.
7. If a clinic in your areas could do only one thing to help lesbian women in the community, what would that be?
8. Closing comments?

INFORMATION LEAFLET AND INFORMED CONSENT FOR NON-CLINICAL RESEARCH (Questionnaire)

TITLE OF THE STUDY

Health care experiences and perceived health needs of adult black lesbian women in Gauteng

Dear study participant

We invite you to voluntarily take part in a research study. This information leaflet will help you decide if you want to participate in the study or not. Before you agree to take part, you should fully understand what is involved. If you have questions that this leaflet does not fully explain, please do not hesitate to ask the investigator, Ntlotleng Mabena, or the interviewer, Kopo Lehobye.

THE NATURE AND PURPOSE OF THIS STUDY

This research study looks to explore the experiences lesbian women have had when accessing health care services. It also looks to identify common health problems, as well as health needs of black lesbian women currently living in Gauteng.

You as a study participant are a very important source of information for this research, regarding your health experiences and health needs as a lesbian women living in Gauteng.

EXPLANATION OF THE PROCEDURE TO BE FOLLOWED

The study will be conducted in the form of an administered questionnaire. An interviewer will have a questionnaire consisting of 25 questions, and will ask you the questions and record your responses on the questionnaire form.

Should you wish not to answer a particular question, you may request the interviewer to pass.

RISK AND DISCOMFORT

Some of the questions asked may cause some discomfort in some participants. You have the right to decline to answer any question you are not comfortable answering.

The questionnaire is expected to take no longer than 40 minutes of your time.

POSSIBLE BENEFITS OF THE STUDY

Although you will not directly benefit from the study, the results of the study will enable us to come up with appropriate health promotion messages directed to lesbian women. The results may also influence health policy in South Africa to provide better health care for all.

The results of the study will be published in a relevant journal, and constituents of the LGBT community will have access to the report through LGBT organizations.

WHAT ARE YOUR RIGHTS AND RESPONSIBILITIES AS A PARTICIPANT?

Your participation in this study is entirely voluntary. You can refuse to participate, or stop at any time during the interview without giving any reason. Your withdrawal will not affect you in anyway.

Furthermore, by taking part in this research, you have a responsibility to respect fellow participants and keep all discussions confidential.

Ethical approval

This study has received written approval from the Research ethics committee of the Faculty of Health Sciences at the University of Pretoria. The study has also received written approval from the Forum of the Empowerment of women (FEW), and Open Closet. Copies of these approval letters are available should you wish to have one.

INFORMATION AND CONTACT PERSON

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COMPENSATION

Your participation is voluntary.

CONFIDENTIALITY

All information that you give will be kept strictly confidential. Once we have analyzed the information no one will be able to identify you. Research reports and articles in scientific journals will not include any information that may identify you.

CONSENT TO PARTICIPATE IN THIS STUDY

I confirm that the person asking my consent to take part in this study has told me about nature, process, risks, discomfort and benefits of this study. I have also received, read and understood the above written information (information leaflet and informed consent) regarding the study. I am aware that the results of this study, including personal details, will be anonymously processed into research reports. I am participating willingly. I have had the time to ask questions and I have no objections to participate in this study. I understand that there is no penalty should I wish to discontinue with the study and my withdrawal will not affect me in anyway.

I have received a signed copy of this informed consent agreement

Participant's name _____ (please print)

Participant's signature _____ Date _____

Investigator's name _____ (please print)

Investigator's signature _____ Date _____

Witness name _____ (please print)

Witness's signature _____ Date _____

Questionnaire on the health needs of black lesbian women in Gauteng province

Study population: Black Lesbian women aged 18 years and above, residing in Gauteng province townships.

Section 1: Demographics

Q1. Where do you live? _____

Q2. How would you describe your sexual orientation?

- ☐ Lesbian
- ☐ Bisexual
- ☐ Heterosexual
- ☐ Other: Specify _____

Q3. How old are you?

- ☐ 18-24
- ☐ 25-30
- ☐ 31-40
- ☐ Above 40

Q4. How would you describe your relationship status currently?

- ☐ Single without sexual partner(s)
- ☐ Single with sexual partner(s)
- ☐ Married
- ☐ Living with partner
- ☐ Other: Specify _____

Q5. What is your highest qualification?

- ☐ Primary school level
- ☐ High school level
- ☐ Matric
- ☐ Degree/Diploma
- ☐ Postgraduate

Q6. Your employment status?

- ☐ Employed full time
- ☐ Employed part time
- ☐ Unemployed
- ☐ Student

Section 2: Access to health care

Q7. Medical cover/insurance

- ☐ Medical aid cover
- ☐ No medical aid

Q8. Where do you access your primary health care services from most?

- ☐ Private general practitioner
- ☐ Public sector clinic
- ☐ Traditional healer
- ☐ Other: Specify _____

Q9.1 In the past 6 months, have you had any symptom or illness requiring a health care service?

No ☐

Yes ☐

Specify illness/symptom _____

Q9.2. If answered yes, did you seek health care? (skip if answered no above)

No ☐

Yes ☐

Specify where _____

Q9.3 Where you satisfied with the service received? (skip if answered no above)

Yes ☐

No: ☐

Specify

People sometimes go for regular medical checkups or physical examination

Q10. When was your last physical examination?

- ☐ Never
- ☐ More than 5 years ago: where _____
- ☐ 2-5 years ago: where _____
- ☐ 1-2 years ago: where _____
- ☐ within the last year: where _____

Q11. Have you ever been denied health services based on your sexual orientation?

☐ Yes ☐ explanation: _____

☐ No ☐

Q12. When accessing health care, do you usually disclose your sexual orientation to the health care provider?

No ☐

Yes: ☐

If yes, please explain _____

Section 3: Screening health services

Q13. Do you consider your health to be:

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

Q14. How would you describe your weight?

- ☐ Very underweight
- ☐ Slightly underweight
- ☐ About the right weight
- ☐ Slightly overweight
- ☐ Very overweight

Q15. Do you exercise?

- ☐ Never
- ☐ Seldom Type: _____
- ☐ Once a week Type: _____
- ☐ 3-5 days a week Type: _____

Q16. CAGE screening questionnaire for alcohol (Tick all relevant answers)

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

Have people annoyed you by criticizing your drinking? ☐

Have you felt bad or guilty about your drinking? ☐

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? ☐

Q17.1. Have you ever had a Pap-smear?

No ☐

Yes ☐

Q17.2. If answered yes, when last did you have a Pap-smear? (skip if answered no above)

- ☐ Within the past 5 years where: _____
☐ More than 5 years ago where: _____

Q18. When last did you have a breast examination?

- ☐ Never
☐ More than a year ago Where? _____
☐ Within the last year Where? _____

Q19. Do you have any medical conditions you are receiving treatment for?

- ☐ Yes
 specify: _____

☐ No
☐ I don't know

Section 4: Mental health and substance use

Some people sometimes use recreational drugs.

Q20. In the last 30 days, which of the following have you used? (Tick all relevant boxes)

- ☐ Cigarette no. smoked per day: _____
☐ Marijuana how often: _____
☐ Nyaope how often: _____
☐ Ecstasy how often: _____
☐ Cocaine how often: _____
☐ Other drugs specify: _____

Q21. In the past year, have you been in an abusive relationship? (Tick all relevant)

- ☐ No
☐ Yes, emotionally abusive
☐ Yes, physically abusive
☐ Yes, sexually abusive

Q22. In the past year, have you experienced depressive symptoms like being sad more than usual or sleep disturbances?

☐ Yes: explanation _____

☐ No

☐ I don't know

Q23.

	Over the last 2 weeks	All of the time 5	Most of the time 4	More than half of the time 3	Less than half the time 2	Some of the time 1	At no time 0
1	I have felt cheerful and in good spirit						
2	I have felt calm and relaxed						
3	I have felt active and vigorous						
4	I wake up feeling fresh and rested						
5	My daily life has been filled with things that interest me						

Q24. In the past year, have you seriously considered to commit suicide?

☐ Yes explain: _____

☐ No

Section 5: Sexual reproductive health

Q25. In the last year, have you been treated for a sexually transmitted infection?

☐ Yes where: _____

☐ No

Q26. In the last year, have you tested for HIV?

☐ Yes where: _____ result: _____

☐ No

Q27. Have you receive information on how to have safer sex with your partner to protect against STIs and HIV?

☐ Yes explain: _____

☐ No

Section 6: Social factors and violence

Q28.1. In the past 5 years, have you been sexually assaulted?

- ☐ Yes
☐ No

Q28.2. If ticked yes, did you receive medical care? (skip if ticked no above)

☐ Yes: explain

☐ No: explain

Q29.1 In the last year, have you been involved in a physical fight?

☐ Yes explain:

☐ No

Q29.2 If yes, did you require medical treatment?



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26 March 2013

TO WHOM IT MAY CONCERN

**RE: SUPPORTING RESEARCH ON THE HEALTH NEEDS OF BLACK LESBIAN WOMEN IN
GAUTENG**

Open Closet Entertainment Solutions grants Dr Ntlotleng Mabena permission to use the data base on our facebook page, Friends of Open Closet, to randomly select members for the above research. Selected members will be informed of their rights as potential participants, anyone agreeing to take part in the study will sign a consent form indicating their agreement to be part of the research.

For more information please contact me on the numbers provided.

Sincerely yours

Dr MD Rakumakoe

Director: Open Closet Entertainment Solutions

083 2741577 (T) drrakumakoe@gmail.com



CONTACT DETAILS:

Tel: +27 11 403 1906/7
Fax: +27 11 403 1035

Email: info@few.org.za
Website: www.few.org.za

PHYSICAL ADDRESS:

6th Floor, Office 601, Heerengracht
87 Dekorte Street, Braamfontein, 2000

POSTAL ADDRESS:

P O Box 10204
2001

FORUM FOR THE EMPOWERMENT OF WOMEN

22 March 2013

TO WHOM IT MAY CONCERN

RE: SUPPORTING RESEARCH ON THE HEALTH NEEDS OF BALCK LESBIAN WOMEN IN GAUTENG

Forum for the Empowerment of Women (FEW) grants Dr Ntlotleng Mabena permission to use the data base of FEW to randomly select members for the above research. Selected members will be informed of their rights as potential participant, anyone agreeing to take part will sign a consent form indicating their agreement to be part of the research.

For any further clarity/ information on this letter, please contact me on the numbers provided.

Sincerely yours

Phindi Malaza
Programmes Coordinator
Forum for the Empowerment of Women
Defending Women, Advancing Rights
27 11 403 1906/7 (T)
27 11 403 1035 (F)
phindim@few.org.za
www.few.org.za

BOARD MEMBERS: Ntlotleng Mabena (Chairperson); Emily Craven (Deputy-Chairperson); Jessica Gamede (Treasurer); Sizakele Mokoena (Secretary); Laurie Adams; Sebenzile Nkambule;

Registration Number: 030-374-NPO

The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.

- FWA 00002567, Approved dd 22 May 2002 and Expires 20 Oct 2016.
- IRB 0000 2235 IORG0001762 Approved dd 13/04/2011 and Expires 13/04/2014.



UNIVERSITEIT VAN PRETORIA
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Faculty of Health Sciences Research Ethics Committee

12/06/2013

**Approval Notice
New Application**

Ethics Reference No.: 170/2013

Title: Title of Research Project: The Health Care Experiences And Perceived Health Needs Of Adult Black Lesbian Women In Four Gauteng Townships **Department:** School Of Health Systems And Public Health

Dear Dr Ntlotleng Mabena

The **New Application** for your research received on the 7/05/2013, was approved by the Faculty of Health Sciences Research Ethics Committee on the 29/05/2013.

Please note the following about your ethics approval:

- Ethics Approval is valid for 1year, till the end of May 2014.
- Please remember to use your protocol number (170/2013) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, or monitor the conduct of your research.

Ethics approval is subject to the following:

Standard Conditions:

- The ethics approval is conditional on the receipt of 6 monthly written Progress Reports, and
- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

We wish you the best with your research.

Yours sincerely

Dr R Sommers; MBChB; MMed (Int); MPharMed.

Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

- ♦ Tel: 012-3541330
- ♦ Fax: 012-3541367 Fax2Email: 0866515924
- ♦ E-Mail: manda@med.up.ac.za
- ♦ Web: www.healthethics-up.co.za
- ♦ H W Snyman Bld (South) Level 2-34
- ♦ Private Bag x 323, Arcadia, Pta, S.A., 0007

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Manuscript submission

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Manuscript preparation

1. General guidelines

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A typical manuscript will not exceed 7500 words including tables, references, captions, footnotes and endnotes. Manuscripts that greatly exceed this will be critically reviewed with respect to length. Authors should include a word count with their manuscript.

Manuscripts should be compiled in the following order: title page; abstract; keywords; main text; acknowledgements; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figure caption(s) (as a list).

[Abstracts](#) of 200 words are required for all manuscripts submitted.

Each manuscript should have 3 to 5 [keywords](#).

For all manuscripts non-discriminatory language is mandatory. Sexist, heterosexist, and racist terms should not be used.

Please avoid the use of acronyms like MSM (men who have sex with men) in your paper; such terms should be included in full.

Search engine optimization (SEO) is a means of making your article more visible to anyone who might be looking for it. Please consult our guidance [here](#).

Section headings should be concise.

All authors of a manuscript should include their full names, affiliations, postal addresses, telephone numbers and email addresses on the cover page of the manuscript. One author should be identified as the corresponding author. Please give the affiliation where the research was conducted. If any of the named co-authors moves affiliation during the peer review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after the manuscript is accepted. Please note that the email address of the corresponding author will normally be displayed in the article PDF (depending on the journal style) and the online article.

All persons who have a reasonable claim to authorship must be

named in the manuscript as co-authors; the corresponding author must be authorized by all co-authors to act as an agent on their behalf in all matters pertaining to publication of the manuscript, and the order of names should be agreed by all authors.

Biographical notes on contributors are not required for this journal.

Please supply all details required by any funding and grant-awarding bodies as an Acknowledgement on the title page of the manuscript, in a separate paragraph, as follows:

For single agency grants: "This work was supported by the [Funding Agency] under Grant [number xxxx]."

For multiple agency grants: "This work was supported by the [Funding Agency 1] under Grant [number xxxx]; [Funding Agency 2] under Grant [number xxxx]; and [Funding Agency 3] under Grant [number xxxx]."

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2. Style guidelines

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Please provide the highest quality figure format possible. Please be sure that all imported scanned material is scanned at the appropriate resolution: 1200 dpi for line art, 600 dpi for grayscale and 300 dpi for colour.

Figures must be saved separate to text. Please do not embed figures in the manuscript file.

Files should be saved as one of the following formats: TIFF (tagged image file format), PostScript or EPS (encapsulated PostScript), and should contain all the necessary font information and the source file of the application (e.g. CorelDraw/Mac, CorelDraw/PC).

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