



**UNIVERSITY OF CAPE TOWN**  
IYUNIVESITHI YASEKAPA • UNIVERSITEIT VAN KAAPSTAD

**TRENDS OF UTILISATION OF  
REPRODUCTIVE HEALTH SERVICES BY  
LESBIAN WOMEN IN CAPE TOWN**

03/10/2013

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## DECLARATION BY CANDIDATE

I, Dr Paversan Archary, hereby declare that the work contained herein is my original work, and work by others has been acknowledged as such.

This study was conducted whilst being a registrar in the Department of Obstetrics and Gynaecology at the University of Cape Town as required by the university in fulfilment of the requirements for the degree MMed (Obstetrics & Gynaecology).

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Date: 08. 10. 2013

## DECLARATION BY SUPERVISOR

The research undertaken by Dr Paversan Archary, and the presentation of this dissertation was supervised by Professor Petrus Steyn.

I am satisfied that this is Dr Archary's original work, and that this dissertation should be submitted in fulfilment of the requirements for the MMed (Obstetrics & Gynaecology) degree.

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Date: 08 / 10 / 2013

## ABSTRACT

**Background:** The Lesbian, Gay, Bisexual and Transgender (LGBT) community has historically been marginalised. Increased international awareness of the LGBT profile has led to the recognition that the medical profession has overlooked the health needs of lesbian women, with a resultant paucity of data regarding lesbian women's health risks.

International literature has shown that lesbians remain at risk of sexually transmitted infections and HIV; are at significant risk of mental health disorders; exhibit a high-risk profile for cardiovascular disease, diabetes, as well as cancer, and underutilise health care services due to experiences of homophobia. South African data is almost non-existent.

**Objective:** To explore Cape Town wsw's (women who have sex with women) experiences with, and trends of utilisation of Reproductive Healthcare Services.

**Study Design:** Cross Sectional Survey.

**Methods:** A sample of self-identified wsw was recruited using a snowball sampling method to complete an anonymous, self-administered online questionnaire during February 2013.

**Outcome Measures:** Predominantly descriptive, with an aim to validate the study questionnaire for the South African context.

**Results:** A total of 116 responses were analysed. The mean age of the population was 37years of age, with the majority identifying as lesbian. The population comprised predominantly of Caucasian, middle class suburban residents, with most having medical aid, and accessing private health care.

A significant proportion of respondents reported previous intercourse with a male sexual partner. Barrier contraception was not always used during intercourse with men and almost never during sex with women. There were a significant number of sexually transmitted infections in women with no previous male sexual partners. Most respondents considered themselves to be at low risk of contracting HIV, and at intermediate risk of cervical and breast cancer, and showed higher than average utilization of cervical screening practices for

this population, despite a general perception that screening is unnecessary in lesbian women.

A general trend towards disclosure of sexual orientation was noted; however users of private healthcare were significantly more likely to have disclosed their orientation to their physician than users of public and NGO services. Respondents held a preference for practitioners that were themselves gay/lesbian.

The study tool was validated for use in the South African context; however redundancy could not be formally excluded from the questionnaire.

**Conclusions:** Wsw from Cape Town experience internationally comparable exposures and risks of gynaecological problems. Further research is required to fully understand the healthcare needs of lesbian women living in lower socio-economic conditions.

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## ABBREVIATIONS

LGBT	Lesbian, Gay, Bisexual & Transgender
HIV	Human Immunodeficiency Virus
STI	Sexually Transmitted Infection
wsw	Women who have sex with women
HPV	Human Papillomavirus
HSV	Herpes Simplex Virus
BV	Bacterial Vaginosis
WHI	Women's Health Initiative Study
NGO	Non-Governmental Organisation
UCT	University of Cape Town
HREC	Human Research Ethics Committee
PMS	Pre Menstrual Syndrome



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## INTRODUCTION

The Lesbian, Gay, Bisexual and Transgender (LGBT) community has historically been marginalised. There is recognition that both clinical practice and the medical research establishment have largely ignored the health needs of LGBT individuals, and in particular, lesbian women.<sup>[1]</sup> Of all the sexual minorities, gay men have enjoyed the greatest response from the medical fraternity.<sup>[2]</sup> In the early 80's, there was a dramatic rise in LGBT publications in the medical literature.<sup>[3]</sup> The most significant proportion of this publication growth was attributable to the then newly discovered 'Gay Related Immune Deficiency', or GRID, as it was first known.<sup>[3]</sup> This early research regarding HIV and other STI transmission amongst gay men may have served to foster inaccurate perceptions of homosexuality, purporting that gays were the carriers of disease due to their sexual orientation.<sup>[2]</sup> Despite now changed perceptions, and seemingly increased awareness of the LGBT profile in the literature, research on lesbian healthcare remains scarce, and a paucity of data exists regarding lesbian women's health risks.<sup>[4]</sup> Much of the existing body of evidence is based on anecdotal experience and volunteer surveys.<sup>[1]</sup>

In the last few years, amid increasing international awareness of gay and lesbian rights, as well as high profile media attention given to the recognition and legalisation of same-sex marriage in many countries, the LGBT community has become more integrated into mainstream society. With ever increasing openness and disclosure of LGBT status, particularly during the medical consultation, our profession needs to keep up with, and satisfy the health requirements of this community.<sup>[6]</sup> The scarcity of literature in the field of LGBT health means that healthcare providers are themselves lacking accurate information regarding relevant health risks in this population, and particularly in the field of gynaecology.<sup>[9]</sup>

Prior to 1990, appreciation of lesbian health issues was lacking in terms of healthcare, particularly as research specifically aimed at lesbian health issues, was rare.<sup>[5]</sup> In addition, women's health research generally did not document sexual orientation as one of the variables when evaluating healthcare.<sup>[5]</sup>

Between 1990 and 2000, lesbian health research began to emerge as a major area of study.<sup>[5]</sup> The Institute of Medicine of the American National Academy of Sciences appointed a committee to review the research on lesbian health.<sup>[6]</sup> They subsequently released a report in 1999 outlining the many challenges to studying lesbian health, and made specific recommendations regarding areas for research attention.<sup>[1,6]</sup> They called for improved funding for research to increase knowledge of lesbian health and to improve access to healthcare services for lesbian women. Specific recommendations were made to improve research methodology, with the aim of understanding the lives of lesbian women, and the diversity among them.<sup>[6]</sup> They advocate researchers' inclusion of sexual orientation as part of the routine demographic information collected in all women's health research.<sup>[6]</sup>

The committee concede that health concerns, behaviour, risks and needs varies over the lifetime of lesbian women, with these concerns differing vastly between childhood and adolescence, early-to-mid adulthood and late adulthood. Accordingly, they make recommendations for specific research in each of these age brackets in order to improve understanding of lesbian health issues.<sup>[6]</sup>

## **REVIEW OF THE LITERATURE**

Lesbian health research to date can be categorised into these main areas of study:

- The doctor-patient relationship
- Routine care and gynaecological screening
- Sexually transmitted infections
- Mental health
- Alcohol, smoking and other substance abuse
- Other health care issues
- Parenting

## 1. The Doctor- Patient Relationship

Most early researchers who explored the client-provider relationship found that lesbians in general had negative experiences in health care encounters.<sup>[5]</sup> Only a minority of physicians are ever aware of having lesbian patients, with even fewer ever asking about sexual orientation during consultation.<sup>[7, 15]</sup> The general consensus was that caregivers held a prejudiced view towards lesbian clients, being disparaging and ignorant towards them.<sup>[5]</sup> Reports of 'lesbianism being a disease; immoral; disgusting and unnatural' were a common finding amongst health care providers.<sup>[5]</sup>

The majority of lesbian patients reported experiences of health care providers making derogatory comments about lesbians, and consequently felt that their treatment had been negatively affected.<sup>[5]</sup> More subtly, mainstream heterosexual norms are communicated subconsciously and enforced by way of heterosexist language and grammar use by professionals.<sup>[8, 15]</sup> This influences patterns of health seeking behaviour negatively by reducing access to health services, and by promoting mistrust and reticence within the healthcare provider-patient relationship.<sup>[8, 15]</sup>

Researchers consistently demonstrated negative attitudes and discomfort of providers, as well as fear of prejudice if lesbian status was disclosed to their health care provider.<sup>[5]</sup> Consequently, many surveys found that lesbians were reluctant to disclose their sexual identity,<sup>[5]</sup> many by not challenging the healthcare providers assumption of heterosexism.<sup>[8]</sup> When asked what effect disclosure would have on their care, 38% said it would hinder, 31% thought no effect, whilst only 22% thought it would improve care.<sup>[7]</sup>

Much of the work on the client-provider relationship was conducted prior to 1990, during a very conservative period when LGBT rights were not prominent, and would probably account for the unforgiving attitudes expressed.

A number of articles were published in response to the above reports with the aim of informing and sensitizing health care providers to issues of lesbian health.<sup>[5]</sup> Unfortunately most of these recommendations could not be based on any form of evidence<sup>[1,5,8]</sup> as none previously existed, and thus had little if any impact.

## 2. Routine Care and Gynaecological Screening

### Cancer risk factors

Lesbian women have above average prevalence of breast and gynaecologic cancers.<sup>[10]</sup> It is proposed that as a group, lesbians have a higher incidence of behavioural and lifestyle related factors that are known to be linked to the development of cancer of the breast, colon, endometrium and ovary.<sup>[1]</sup> Lesbians are less likely to have ever been pregnant or have given birth to a child.<sup>[6]</sup> Fewer pregnancies mean prolonged uninterrupted oestrogen levels, which increases risk of ovarian, uterine and breast cancers.<sup>[4]</sup> The increased prevalence of risk factors for ovarian cancer has been demonstrated in a retrospective medical record review.<sup>[11]</sup>

### Cervical atypia

Early studies showed that rates of cervical atypia were lower in lesbian women than in women in general, however this rate could be clearly correlated with the number of male partners in their lifetime.<sup>[5]</sup> A large percentage of lesbian women have had previous heterosexual experiences in their lifetime.<sup>[9]</sup> A sample of 6935 lesbians across America reported a 77.3% incidence of having had one or more male sexual partners in their lifetime, with a 5.7% incidence of having had a male partner in the preceding year.<sup>[13]</sup> Lesbians with more than 6 male partners were more likely to have had a STI at some point in their lives.<sup>[13]</sup> Furthermore there is some research to suggest that STI's including HPV may be transmitted between women.<sup>[1, 13, 14]</sup> High risk human papillomavirus DNA test positivity, as well as cases of cervical intraepithelial neoplasia have been reported in women with no prior history of heterosexual intercourse.<sup>[14]</sup>

### Cervical Screening

Lesbian women do not access preventive screening services because of the negative experiences already described.<sup>[1, 5, 8, 14, 15]</sup> They abstain from, or underutilise health care due to real or perceived homophobia.<sup>[8]</sup> Early literature suggests that the minority reported having annual physical examinations, with most only seeking care when problems arose.<sup>[5]</sup> An American cross sectional community based survey of 1010 self-identified lesbians from demonstrated that lesbian women were less likely to have had a pap smear within the

preceding 2 years.<sup>[16]</sup> This would suggest that lesbian women display avoidance of, and reduced health seeking behaviours,<sup>[4]</sup> and consequently miss opportunities for routine screening and detection of cervical lesions at earlier, more treatable stages.<sup>[10]</sup> This is compounded by the fact that many healthcare providers, as well as lesbians, may perceive this to be a low risk group, and therefore be less likely to recommend them for screening. <sup>[4, 5, 8,9]</sup>

A study undertaken in the American state of Delaware, exploring lesbian women's knowledge about HPV found that disclosure of sexual preference to healthcare provider was associated with increased odds of not knowing about woman to woman transmission of HPV, suggesting that physician inexperience or discomfort may still prejudice the provider-patient relationship.<sup>[4]</sup> There was no difference in the knowledge of the association between HPV and cancer risk. College and further education was not shown to increase knowledge regarding HPV infection.<sup>[4]</sup> Valanis et al, in their analysis of data collected during the Women's Health Initiative studies, showed that higher socioeconomic and educational status did not reduce prevalence of modifiable risk factors gynaecologic cancers.<sup>[10]</sup>

A review of manuscripts researching cervical cancer screening demonstrates varying results, all of which suggest lower than recommended cervical screening rates.<sup>[1, 5]</sup> Diamant, Schuster, & Lever report 54% of 6935 self-identified American lesbians having had a pap smear in the preceding year, and 71% within the previous two years.<sup>[17]</sup> These studies are again difficult to interpret as there is no heterosexual control group with which to compare rates.<sup>[5]</sup> The 1998 consensus recommendation of the American College of Obstetricians and Gynaecologists is that all women that are or have been sexually active should have an annual pap smear, and that after three consecutive normal annual smears, further screening should be done based on evaluation of individual risk factors.<sup>[1]</sup>

In many countries, screening programmes and primary health care interventions for women are coupled to reproductive health, and young heterosexual women make their primary contact with the healthcare system through antenatal care and childbirth, or because of contraceptive requirements.<sup>[4]</sup> Lesbians are significantly less likely to make use of family planning or contraceptive services, and as such, miss the cues that trigger routine gynaecologic screening.<sup>[9]</sup>

### Breast Cancer risk and screening

Lesbian women have a significantly higher risk of developing breast cancer than their matched heterosexual sisters.<sup>[18]</sup> The difference was attributed to lesbian women's lower likelihood of ever having been pregnant, as well as a significantly higher incidence of breast biopsies in this population.<sup>[18]</sup>

Studies conducted in the USA have demonstrated similar to fairly high rates of mammography screening amongst lesbian women.<sup>[1, 5, 10]</sup> This could possibly be attributed to increased awareness of breast cancer risks amongst women in the developed world.

### 3. Sexually transmitted infections

Rates of bacterial vaginosis (BV) are quoted as being approximately twice that of heterosexual women.<sup>[1, 19]</sup> There is a high concordance for the presence or absence of the infection between monogamous partners, suggesting the possibility of sexual transmission between women.<sup>[20]</sup> BV risk was associated with increasing numbers of female partners.<sup>[1, 8]</sup> Prevalence of candida vulvovaginitis is similar between lesbian and heterosexual women,<sup>[1]</sup> with the risk of acquiring the infection increasing with numbers of female partners.<sup>[1, 8]</sup>

There are reports of trichomoniasis in women with no history of previous heterosexual intercourse, whilst gonorrhoea, chlamydia and syphilis have never been reported in lesbian women without history of heterosexual intercourse. The risk of transmission between female partners is considered to be negligible.<sup>[1]</sup> There are also reports of genital herpes infection in women that have never had heterosexual intercourse.<sup>[21]</sup> Herpes simplex virus (HSV) Type 1 was associated with increasing numbers of female partners, whilst HSV 2 was associated with heterosexual contact.<sup>[22]</sup>

HPV subtypes 6 and 11 which are responsible for most condylomata have been demonstrated amongst lesbians including a small number that had never engaged in heterosexual intercourse.<sup>[23]</sup> The same researcher found positive high risk HPV DNA tests in women who had exclusively homosexual intercourse in the last year.<sup>[14]</sup>

Hepatitis C was found to be more common in lesbian women, with risk factors for this infection including sexual contact with a homo/bisexual man or a partner that used intravenous drugs.<sup>[1]</sup>

Low rates of HIV infection were reported, with all infections having occurred through intravenous drug use or heterosexual intercourse (particularly with homosexual men).<sup>[1,5]</sup> HIV transmission risk between females is unknown, but thought to be low, as female to female transmission should theoretically be the least efficient way to transmit the virus.<sup>[1]</sup> Despite a few possible cases of transmission documented in the literature<sup>[24]</sup>, a prospective 6 month follow-up of serodiscordant lesbian couples reported no seroconversion.<sup>[25]</sup>

#### 4. Mental Health

Lesbians were found to be frequent users of mental health services. Counselling was sought for feelings of sadness or depression, family problems, relationship problems, and generalised stress or anxiety.<sup>[5]</sup> Actual rates of depression and anxiety disorders vary widely, with a global understanding that lesbian women are at high risk of mental illness. Lesbians have a two-fold lifetime risk of developing at least two mental health diagnoses.<sup>[1, 8]</sup> A significant proportion of the sample had made at least one suicide attempt, with at least half of these having been made before the age of eighteen.<sup>[5]</sup> Risk factors for suicide include teenage or adolescent age group, not being 'out' and experiences of bullying and discrimination.<sup>[8]</sup>

#### 5. Alcohol, Smoking and other Substance Use

There are mixed reports of rates of alcohol use amongst lesbians.<sup>[5, 8]</sup> More recent studies, however seem to point toward lower or similar rates of alcohol abuse compared to heterosexual women, but reports that drinking rates of lesbians do not decline with age as for women in general.<sup>[5]</sup>

#### 6. Other health problems

There is growing evidence that lesbians in general share a profile of risk factors that may predispose to cardiovascular disease, diabetes, breast, colon, endometrial and ovarian cancer.<sup>[1, 4, 10, 26]</sup> These risk factors include high rates of tobacco and alcohol use, coupled



with higher rates of obesity<sup>[9, 10, 16]</sup>; lower rates of parity and breastfeeding; and less use of oral contraceptives<sup>[1, 9, 10]</sup>

### The WHI Study

Analysis of a lesbian subsample of the Women's Health Initiative study found lower rates of pap smear and mammography screening, a higher prevalence of obesity, smoking, and alcohol use; higher rates of depression, and lower intake of fruit and vegetables.<sup>[10]</sup> Breast cancer was reported more often in the lesbian and bisexual group, although the trend was not significant. Cervical cancer was commonest amongst bisexual women, whilst lifetime lesbians reported the highest rates of colorectal cancer.<sup>[10]</sup> Adult and lifetime lesbians reported more myocardial infarctions, the same rate of hypertension and fewer strokes than bisexual or heterosexual women.<sup>[10]</sup> This is one of the largest sample sizes of lesbian women to date (573 self-identified lesbians) but is still deemed to be a small sample epidemiologically.<sup>[1]</sup>

### Nurses' Health study

The Nurses' Health Study II followed a prospective cohort of 116 671 registered nurses, and with analysis of 694 lesbian responses, demonstrated significantly elevated prevalence of several risk factors that may affect current or future health status.<sup>[26]</sup> Significantly higher rates of nulliparity and significantly elevated alcohol intake were deemed to be key risk factors for the development of breast cancer.<sup>[26]</sup> High rates of obesity and smoking were linked to risk of cardiovascular disease in keeping with the findings of the WHI study group.

## 7. Parenting

Many lesbian women raise children that are the product of previous heterosexual relationships, and an increasing number want to start families within their lesbian relationships.<sup>[1]</sup> Some may pursue adoption or assisted reproductive techniques through a medical facility.<sup>[1, 8]</sup> There is no evidence to suggest difference in parenting style, emotional adjustment, or sexual orientation of the children between straight and homosexual families.<sup>[1]</sup>

Lesbians who become pregnant have been shown to be model parents. All obtained prenatal care before 16 weeks of gestation, with the vast majority attending childbirth classes and breastfeeding for at least six months.<sup>[1]</sup>

### The South African Context

The studies quoted above were conducted in Europe, America and Australia, which are considered to be developed nations with reasonably well developed and accessible health care systems. The South African experience is unique in its own right, with many different social aspects contributing to accessibility and acceptability of health care.

The foundations of LGBT equality are based on democratic values and a constitution that enshrines the principles of human dignity, equality and social justice.<sup>[28]</sup> The gay rights clause of the South African Constitution, which was the first of its kind in the world, explicitly prohibits discrimination on the basis of sexual orientation.<sup>[27, 28]</sup> It is because of this that the South African Constitution is renowned, and held in high regard as being one of the most progressive constitutions in the world with a bill of rights second to none.

In stark contrast to this constitutional guarantee of freedom and human rights for all is the fact that homophobic victimisation is endemic in South Africa.<sup>[28]</sup> LGBT individuals continue to be denied cultural recognition and are subject to shaming, harassment and violence.<sup>[27]</sup> Violence against women is rife, with particularly vicious attacks being directed at lesbian women in particular.<sup>[27]</sup> Physical violence, coupled with alarming reports of 'Corrective Rape' make it extremely dangerous for young women to be openly lesbian in the townships.<sup>[27, 28]</sup> This brutality is legitimized by statements from other African leaders including presidents of Zimbabwe, Namibia, Zambia, Nigeria and Uganda labelling homosexuality as 'unafican, unnatural, and a western import'.<sup>[27]</sup>

A comparison of findings from American and South African anti-gay violence victimisation surveys revealed that while South Africans were less likely to experience verbal abuse and bullying than their American counterparts, they were more prone to being physically assaulted and were significantly more likely to be sexually assaulted.<sup>[28]</sup>

Violence is not experienced equally across class, race, and gender lines in the general South African population.<sup>[28]</sup> It is noted that women from lower socio-economic levels are far more

susceptible to gender based violence such as rape and domestic violence.<sup>[28]</sup> The same may hold true for lesbian women.

Whereas the studies quoted in the introduction speak of a real or perceived prejudice as a barrier to appropriate health care for lesbians, in South Africa, this prejudice would also be experienced in the form of physical violence and sexual assault.

A report published by OUT LGBT showed that 9% of lesbians self-reported to being HIV positive.<sup>[2]</sup> With such high prevalence of HIV in South Africa, coupled with high prevalence of sexual assault and gender based violence, this rate may very well be far higher than international HIV prevalence of Lesbian women.

Another determinant of health care, unique to South Africa, is socio-economic class. Poor health is strongly associated with low socio-economic position, with growing evidence that social inequalities play a role in poor health outcomes.<sup>[29]</sup> With tangible boundaries between social classes, there is a vast discrepancy between accessibility, acceptability and quality of care available across socio-economic class lines. Mid to upper class citizens with financial resources are able to seek medical care with practitioners that are 'gay friendly'.

The public health system is fraught with issues of accessibility, large patient loads, exhaustion of resources, which may well transcend issues of sexual orientation. It is likely that social class, rather than sexual orientation is the major determinant of acceptability of health care services to lesbians in South Africa.

The Western Cape and the City of Cape Town in particular, are well suited to testing this hypothesis. Whilst the City of Cape Town promotes itself as the most cosmopolitan and 'gay friendly' city in South Africa, the stark contrast between social classes is clearly evident.

Presently, a monthly women's health clinic in the city, run by a non-governmental organisation called the Triangle Project, is the only dedicated lesbian healthcare clinic for women in Cape Town. This service offers pap smears, HIV and STI counselling and testing services, as well as a general medical clinic.

## STUDY GOALS AND OBJECTIVES

The objective of the study was to explore lesbian, bisexual and wsw (women who have sex with women) women's experiences with, and trends of utilisation of Reproductive Healthcare Services within the Cape Town area.

This should provide insight into local acceptability and accessibility of reproductive healthcare services available to women who have sex with women in Cape Town, as well as contributing to an international body of evidence regarding Lesbian Reproductive Health.

It was anticipated that this information would be used to evaluate the need for, and to advocate for dedicated lesbian/bisexual/wsw healthcare services that are structurally integrated into the City's existing healthcare system. A more integrated 'lesbian health clinic' would have multiple benefits for patient care as well as to serve as a platform for further medical research.

An integrated clinic would result in easier access to the mainstream healthcare service if major disease is detected. It would also serve to de-stigmatise the lesbian status both for healthcare providers as well as the community, propagating a culture of acceptance towards homosexuality at large, within the city and its townships.

A formal lesbian health clinic, with an established client base may serve as a population base for further important research into lesbian health in all sub-specialties of gynaecology. The template for this approach has already shown to be effective in terms of many important studies conducted via NGO run clinics and support groups for homosexual people in Cape Town. Examples include the work done by the Triangle Project, as well as the Health 4 Men organisation which have contributed significantly to LGBT health research.

Further research into Lesbian Health issues should provide much needed information that will serve to identify areas for focused intervention in terms of health education and primary prevention.

## METHODOLOGY

A cross section of self-identified lesbian, bisexual or wsw women from the Cape Town Metro were recruited to complete an anonymous, self-administered online or written questionnaire. The questionnaire included questions on several topics including sexual orientation, medical and gynaecological history, current health practices and screening.

### Sampling

Sampling was by Non Probability Purposive Sampling. The Snowballing strategy of sampling was utilised.<sup>[30]</sup> A primary sample frame was purposively selected to include diverse individuals of varying race, social class, and demographics. This primary framework was developed from prominent individuals within Cape Town's lesbian community. Such individuals were identified through existing social groups and community organisations recognised through listings in the lesbian and gay media.

Each participant voluntarily nominated or identified other lesbian/bisexual/wsw women that were known to them, to participate in the study. These in turn referred other women to participate, and so on until the target sample size was obtained.

Nominated women were referred to the investigators (as opposed to the investigators being referred to the women). The nominated women then at will, accessed the survey online, as a self-identified lesbian/bisexual/wsw, voluntarily participating in the study. This ensured that the individual's sexuality was not disclosed without her consent in the process of recruitment.

Awareness regarding the survey was created by use of poster and flyer advertisements in prominent lesbian venues. (Addendum 4)

The study instrument was a self-administered, structured questionnaire comprising open and closed ended questions, as well as Likert Scales. The instrument comprised of 85 questions, and assessed the following:

- Participant background & Demographics
- General Health
- Utilization of health services (general)
- Sexual History
- Gynaecological history
- Utilisation of Reproductive health services (gynaecology)
  - a. Cervical Screening
  - b. Sexually transmitted infections
  - c. Contraception use and knowledge
  - d. Parenting consideration and assisted reproduction
  - e. Breast Self-Examination
  - f. Hormone Replacement use
- Experiences of healthcare
- Experiences of discrimination
- Existing knowledge of lesbian health issues
- Perception of risk

Likert Scales were utilized to assess the following domains:

1. Access to care
2. Physician Relations
3. Physician Technical (the physicians skills/ability to assess and deal with lesbian healthcare issues)
4. Surgery/ Clinical Environment

## 5. Reception Staff Attitudes

## 6. Stigmatization

The instrument was derived from the Stonewall Questionnaire, which is a validated questionnaire that was used in the Stonewall Survey of 2008 undertaken in the United Kingdom.<sup>[31]</sup> It was modified to satisfy the objectives of this study, as well as the local context. It was tested for validity and reliability within the local context, and included a link to a purposefully designed web page on Lesbian Health information, as well as useful contact numbers of gay-friendly health and support services within Cape Town.

The instrument was made available to participants in the three main languages used in Cape Town (English, Afrikaans and isiXhosa).

The instrument was primarily available for completion in an online format via the SurveyMonkey Online Questionnaire and Survey Software Service. It was also available for completion in the traditional paper format by participants that did not have access to email or internet.

### Reliability and validity

The reliability and validity of the questionnaire was assessed in two stages.

During the protocol development phase of the study, the validity or meaningfulness of the questionnaire was determined by pre-testing the questionnaire with wsw consultants known to the investigators.

During the data analysis phase of the study, further psychometric testing for the different domains and internal consistency was done, using Chronbachs Alpha Coefficient.

### Research site

The study was limited to women residing within the Cape Town Metro district, who access health care within its public or private healthcare referral structures. Responses were screened, and those originating from outside the Cape Town area were automatically excluded from analysis.

### Study population

The study included women self-identified as either lesbian, bisexual or wsw. Exclusively heterosexual, transgender women, and men were automatically excluded by the survey software.

#### Inclusion criteria

- Any wsw legally competent to consent, willing to participate, and permanently living in Cape Town, accessing reproductive healthcare services within its referral structures (public or private).

#### Exclusion criteria

- Age less than 18
- Transgender or Intersex individuals
- Exclusively Heterosexual
- Permanently residing outside of Cape Town
- Previous completion of the questionnaire (having already been referred by another participant)

### Sample size

The baseline population of wsw women in Cape Town is unknown. It was therefore not possible to perform any form of power calculation for this study. As such, an arbitrary number of 100 wsw women was chosen as a target sample size. As this was very preliminary research, the investigators felt that this number would have been adequate to have sufficiently achieved the goals of the study, as well as validated the tool in the South African context.



## Data collection

The survey was open for completion between February and March 2013. A covering letter explaining the scope of the study, its aims, and a link to the online survey was distributed to LGBT community organizations, support groups, social groups, and prominent members of the LGBT community in Cape Town.

Leaflets containing the online link as well as investigators' contact details were distributed to members of community organizations and NGOs during LGBT community events held in the run up to the Gay Pride event held during that same month. Specific effort was made to include organisations working with lesbian women from socioeconomically disadvantaged backgrounds.

Data were primarily collected via an online questionnaire using the SurveyMonkey Online Questionnaire and Survey Software Service. The use of an online survey was chosen as it would facilitate the greatest ease of access to the participants whilst maintaining a strong degree of anonymity and privacy. Participants were able to complete the questionnaire at their own convenience, at a location and time that best suited them. Furthermore, recruitment of participants in terms of the snowball method of sampling was simplified by the sharing of an online link between participants which took the new participant directly into the SurveyMonkey website for completion of the questionnaire.

Traditional paper format questionnaires and consent forms were to have been delivered to, and collected from participants without internet access either in person by the investigators, or by post. These would have subsequently been captured verbatim onto the online version by investigators.

Afrikaans and isiXhosa responses were translated into English by the translation service originally used to translate the instrument, and thereafter captured in English on the online format as above.

Data collection took place for a period of up to six months, or until the minimum target sample size had been reached. The minimum sample size was reached within a period of about ten days; however data collection was continued with the consent of the Human Research Ethics Committee of the Faculty of Health Sciences.

## Ethical Considerations

Participation was completely voluntary, and strict confidentiality was maintained with regard to participant's identities at all times. No identification information or contact details' of participants was collected during the study.

The SurveyMonkey Service has a strict and comprehensive security policy. Access to data collected was limited only to the primary investigator, using server identification and data encryption software technology. Internet Protocol (IP) or email addresses were not collected by the survey software. During the period of data collection, research data were stored and accessed electronically via SurveyMonkey internet servers in the USA. Once data collection was completed, all data were transferred, stored and accessed electronically in the Department of Obstetrics and Gynaecology. Subsequent termination of the SurveyMonkey account resulted in permanent deletion of all data stored in the US.

The referral of contacts to participate in the study was completely voluntary. Declining to provide further participants in terms of the snowball method of sampling did not preclude participation in the study.

Informed consent was a pre-requisite for participation in the study. A covering letter and information leaflet providing information, together with contact details for further information was provided to participants. On the online survey, by clicking the 'next' tab, the participant implied informed consent to participate in the survey. (Appendix)

Ethical approval was granted by the UCT Human Research Ethics Committee prior to commencement of data collection. (HREC/REF: 538/2012) (Appendix)

## Statistical analysis

Data was captured directly by the SurveyMonkey Software and was exported to Microsoft Excel. Data was then analysed using SPSS (Statistical Package for the Social Sciences) version 19, and STATA version 13 software packages.

Categorical data were compared using Pearsons Chi Squared and Fishers Exact Tests. A p-value of less than 0.05 was regarded as statistically significant. Likert responses underwent statistical analysis with Chronbachs Alpha coefficient and factor analysis. Item to total

correlation was not possible in all instances due to there being too few responses in certain domains.

### Problems Anticipated

#### Participation

Reluctance to participate and disclose lesbian status was an anticipated problem. International experience (in the WHI study) has shown that lesbian women are likely to participate in health surveys<sup>[6]</sup>. The few studies undertaken in South Africa have shown otherwise. Many South African researchers have expressed difficulty in finding willing participants within the lesbian population.

The online survey format was specifically chosen to help provide anonymity, and thus alleviate this problem.

#### Sampling bias

The snowball method of sampling is known to predispose to sampling bias. As sampling occurred along known, existing social networks, it was anticipated that naturally, demographically non-representative sampling pathways would be created. Furthermore, the possibility of crossing pathways and repeated resampling of individuals occurring was anticipated. Sampling frameworks were intentionally created across diverse networks at their starting points in a deliberate attempt to overcome this problem. This would have ensured that fundamentally diverse sampling pathways were taken, ensuring a representative and varied overall sample.

#### Recall and response bias

Surveys of sexual health are inevitably vulnerable to inaccuracies such as recall and response bias. Furthermore, questions about sexual behaviour are liable to subtle variation in interpretation by respondents depending on what is considered to be 'intercourse' or 'a partner'.<sup>[12]</sup>

The extremely personal nature of certain questions may have elicited a poor response due to embarrassment and shame, and thus were open to response bias. The closed ended

structure of the questionnaire with predetermined response categories was also likely to underrepresent the true diversity of sexual history and practice.

#### Budget

The costs of the study were carried primarily by the principal investigators, with application for re-imbusement from the Department of Obstetrics and Gynaecology Registrar Research Fund. No external funding for the study was sought.

#### Implication for further research

This survey is preliminary research in South Africa, and it is hoped that it will form a basis towards the identification of areas for, and inspiration of further research into Lesbian Reproductive Health.

## RESULTS

One hundred and forty seven responses were received exclusively via the online survey software. After screening, thirty one responses were omitted from analysis by application of the inclusion and exclusion criteria as specified in the study protocol: fourteen responses from exclusively heterosexual women and three male respondents were automatically excluded by the survey software. A further fourteen were excluded after screening as these originated from outside of the Greater Cape Town Metropolitan Area.

A total of 116 responses were analysed using SPSS (v.19) and STATA (v.13) statistical analysis packages. Results were predominantly univariate and descriptive, and are presented as number of responses (n) and percentages of total. Multivariate analysis was performed to establish associations between variables; however reliable analysis was not possible in certain instances due to there being too few responses for that particular variable. Pearson's Chi Squared and Fishers Exact Tests were used where appropriate to establish statistical significance. The study was powered primarily to be able to validate the study questionnaire, and as such the minimum of 100 responses was deemed to have been an acceptable sample size at the time of completion of data collection.

Internal consistency was assessed using Chronbach's Alpha Coefficient. It was not possible to calculate Chronbach's Alpha for each of the different domains as there were too few responses in some of the individual domains. Factor analysis was also performed in order to elucidate the presence of redundancy within the questionnaire.

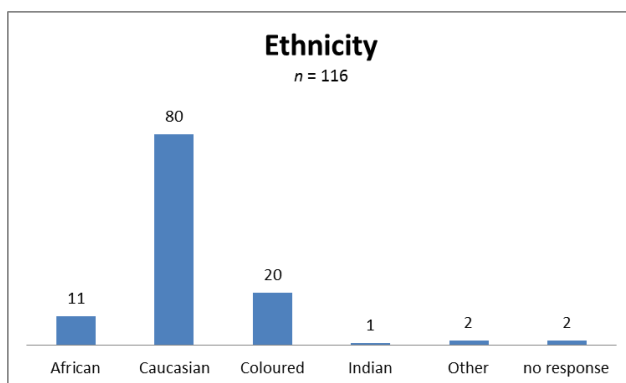
### Descriptive Statistics

The mean age of our population (n = 116) was 37 (18 - 65) years. Eighty-three percent identified themselves as being lesbian whilst 12% identified as bisexual. The study populations' demographic characteristics are summarized in table 1 on page 28.

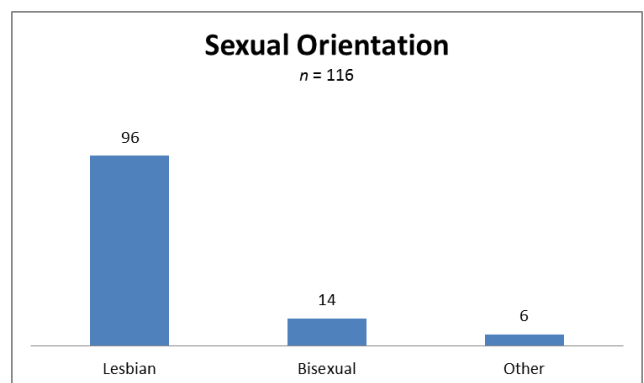
DEMOGRAPHIC DATA <span style="float: right;">(n = 11)</span>					
Age <span style="float: right;">(years)</span>					
37 (18 – 65)					
Ethnicity <span style="float: right;">n (%)</span>					
African	Caucasian	Coloured	Indian	Other*	No Response
11 (9)	80 (69)	20 (17)	1 (1)	2 (2)	2 (2)
Sexual Orientation <span style="float: right;">n (%)</span>					
Lesbian	Bisexual	Other*			
96 (83)	14 (12)	6 (5)			
Highest Level of Education <span style="float: right;">n (%)</span>					
High School	Passed Matric	Undergrad	Postgrad		
2 (2)	34 (29)	45 (39)	35 (30)		
Type Of Area Residing In <span style="float: right;">n (%)</span>					
Residential	Township	Industrial	Rural		No Response
108 (93)	2 (2)	4 (3)	1 (1)		1 (1)
Employment <span style="float: right;">n (%)</span>					
Full Time	Part Time	Unemployed	Retired	Student	No response
84 (72)	9 (8)	4 (3)	2 (2)	15 (13)	2 (2)
Monthly Personal Income <span style="float: right;">n (%)</span>					
1 - 5000	5 - 10000	10 – 20 000	20 – 30 000	> 30 000	No Response
10 (9)	21 (18)	20 (17)	26 (22)	34 (29)	5 (4)
<i>*Other Ethnicity</i>		<i>White African; Human; South African; Mixed Race</i>			
<i>*Other Sexual Orientation</i>		<i>Bi-Curious; Queer; Pansexual;</i> <i>Woman who is currently connecting with other women;</i> <i>Queer and gender questioning;</i> <i>Physically attracted to both genders but emotionally and mentally attracted to women</i>			

**Table 1: Demographic Data**

The population was comprised predominantly of Caucasian, middle class suburban residents (Figure 1). All respondents had received formal education, with 29% having completed high school. Sixty-nine percent had accessed tertiary education, and 72% were engaged in full time employment, with the majority (91%) earning in excess of at least R10 000 per month.



**Figure 1: Ethnicity**



**Figure 2: Sexual Orientation**

Eighty respondents (69%) had medical aid, which allowed access to private health care. Only about 10% of our population sampled accessed public or NGO (Non-Governmental Organisation) based primary and reproductive healthcare.

The majority of the sample population was self-identified as lesbian, with 12% identifying as bisexual (Figure 2, page 28). Sixty-nine percent of respondents were currently involved in a monogamous homosexual relationship and reported having had sex with only women in the last year. A similar number (64%) confirmed sex with only women in the last five years.

At least 20% of the population sampled reported having had sex with both women and men in the last five years.

Seventy six percent of respondents had a sexual experience with a male sexual partner in their lifetimes, with 54% reporting more than two lifetime male sexual partners.

Barrier contraceptive use during intercourse with both men and women is illustrated in table 2 below. With more than 75% of our study population admitting to having at least one lifetime male partner, it is striking that barrier contraception is not always used during intercourse with men; and almost never during sex with women.

BARRIER CONTRACEPTIVE USE					
Barrier Contraceptive Use with Women					<i>n= 116 (%)</i>
Never	Mostly	Sometimes	Always		No Response
89 (78)	3 (3)	8 (7)	1 (1)		15 (13)
Barrier Contraceptive Use with Men					<i>n= 54 (%)</i>
Never	Mostly	Sometimes	Always		No Response
8 (15)	8 (15)	3 (6)	20 (37)		15 (28)

**Table 2: Use of barrier contraceptives**

Fifty four percent admitted to having smoked cigarettes in their lifetime, with only 25% currently smoking.

Sixty-nine percent consumed alcohol, with an average use of alcohol on 2 days per week. Marijuana (33%) was the most commonly used substance of abuse.

Mean body mass index (BMI) was in the overweight range (28kg/m<sup>2</sup>). We did not enquire for history of pre-existing chronic medical conditions.

Twenty eight percent of respondents sampled reported having been previously pregnant, and had therefore made contact with the reproductive healthcare service with their pregnancy related care. Fifteen percent had vaginal delivery of a child, whilst 5% had a previous caesarean section.

Sixty one percent of respondents had ever had a cervical cytology (pap smear) test (Figure 3), 42% of which was in the last three years (Figure 4). The commonest reason given for not having the test was fear of the procedure. This reason for lack of screening may not be exclusive to lesbian women. However it is important to note that a significant proportion of respondents and/or their healthcare workers (38% in total) believed that they did not require smears as they were not at risk of cervical atypia as a result of their sexual practices.

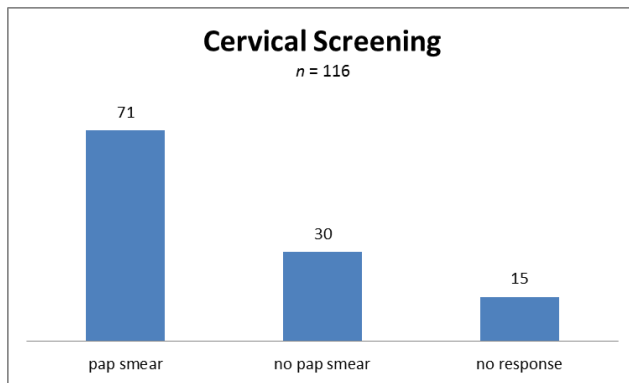


Figure 3: Utilisation of Cervical Screening (Pap Smears)

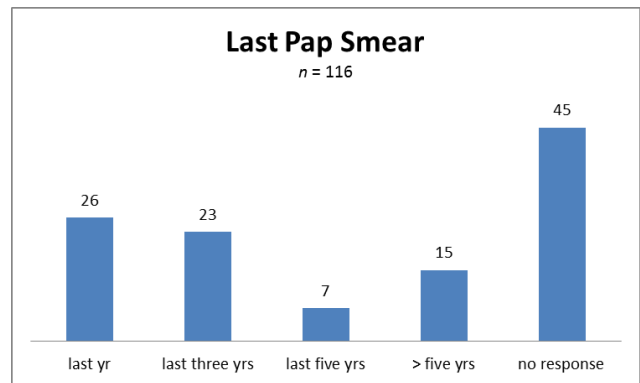


Figure 4: Timing of last cervical cytology test

Thirteen percent had previously received treatment for a sexually transmitted infection. Almost three quarters of the sample (72%) had tested for HIV infection previously. The main motivation for being tested was the importance of knowing one's status. One respondent was HIV positive and on antiretroviral therapy.

Half of the population sampled had ever used a family planning method. The commonest method used being the oral contraceptive pill (55%) (Figure 5, page 31). The most frequent reason for using the method was to avoid pregnancy, followed by cycle regulation and relief of dysmenorrhoea and pre-menstrual syndrome (PMS) symptoms respectively (Figure 6, page 31).

Six percent used family planning methods with the intention of inducing a state of amenorrhoea. One respondent admitted to having been denied access to contraception as a



direct result of her sexual orientation. Eleven percent of respondents admitted to the use of barrier contraception during sex with women, whilst a similar 7% reported never using barrier contraception during intercourse with men (Table 2, page 29).

As 69% of respondents ever had one or more lifetime male sexual partners this small proportion that have unprotected sex with men become significant in that they are very likely to have unprotected intercourse with other women.

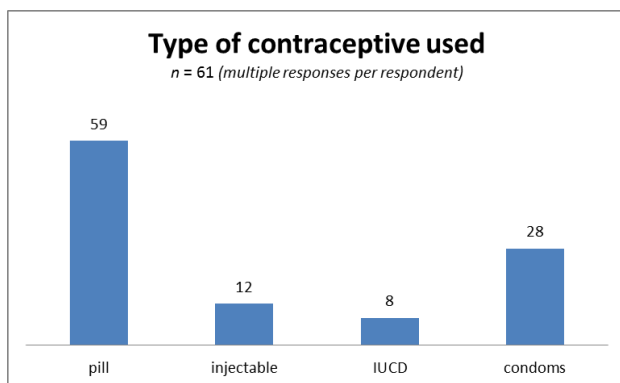


Figure 5: Type of contraceptive used

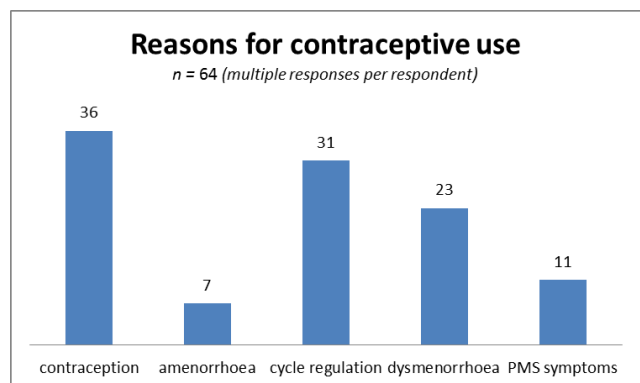


Figure 6: Main reasons for contraceptive use

Fifty three percent checked their breasts regularly for lumps, and 32% previously had a mammogram. Three respondents reported a diagnosis of breast cancer.

Eleven respondents confirmed having experienced some form of sexual assault/harassment in their lifetime.

Lesbian health knowledge regarding STI and HIV transmission, cervical cancer, and the need for cervical screening was assessed in a Likert scale format. Respondents demonstrated a good understanding and knowledge as depicted in the heat map shown below (Table 3).

Rate the following statements according to your understanding of lesbian/bisexual health.					
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Lesbian/bisexual women are not at risk of contracting sexually transmitted infections.	1	2	2	40	45
Lesbian/bisexual women are less likely to develop cervical cancer than straight women.	2	17	19	28	24
Lesbian women don't need to have pap smears.	1	4	5	30	48
HIV infection cannot be transmitted from one woman to another.	2	2	3	39	43

Table 3: Lesbian Health knowledge

## Multivariate Analysis

Results were analysed for the presence of associations between variables. Three main themes were explored:

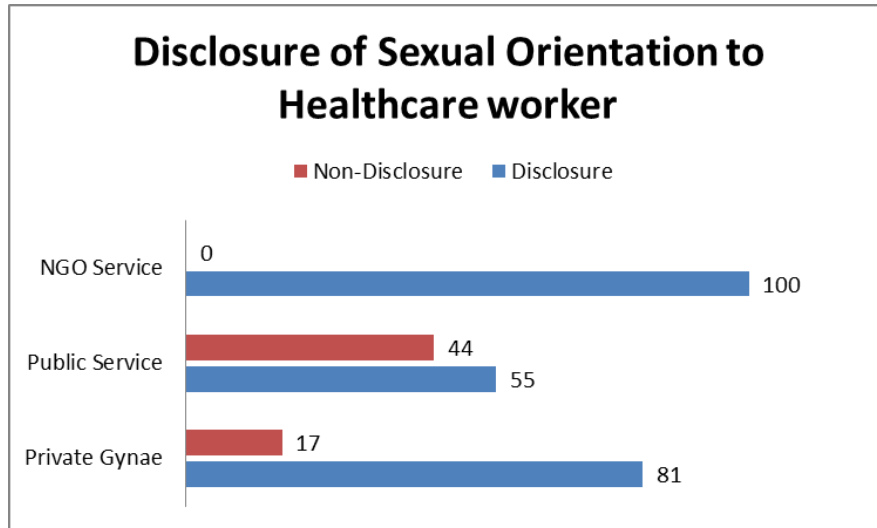
1. Disclosure of sexual orientation to healthcare practitioners and experiences with regard to reproductive health care appropriateness.
2. Perceived risk of HIV infection, breast and cervical cancer.
3. Influence of type of sexual exposure on incidence of sexually transmitted infections, abnormal cervical cytology result, and cervical cancer.

### 1a. Disclosure of sexual orientation to Reproductive Healthcare Practitioners

Of the 116 responses received, 69% reported being frankly open about their sexuality to their medical practitioner. The most frequent reason for non-disclosure was that sexual preference was not felt to be medically relevant. A significant proportion of respondents also felt scared to, or did not trust their doctor enough to disclose their sexual orientation. Some reasons given for non-disclosure included previously being treated poorly by a gynaecologist after disclosing, and a feeling that the practitioner did not have the knowledge of how to deal with issues regarding lesbian healthcare.

Only 20% felt that disclosing sexual orientation would improve their quality of care whilst most felt that it would not affect the quality of care they would receive. Less than 10% of respondents felt that disclosure would hinder the quality of care they received.

A general trend towards disclosure was noted within each of the three subtypes of reproductive healthcare service used. More respondents in each subclass of reproductive healthcare service disclosed their sexuality to their practitioner than not. Figure 7 on page 33 demonstrates this trend.



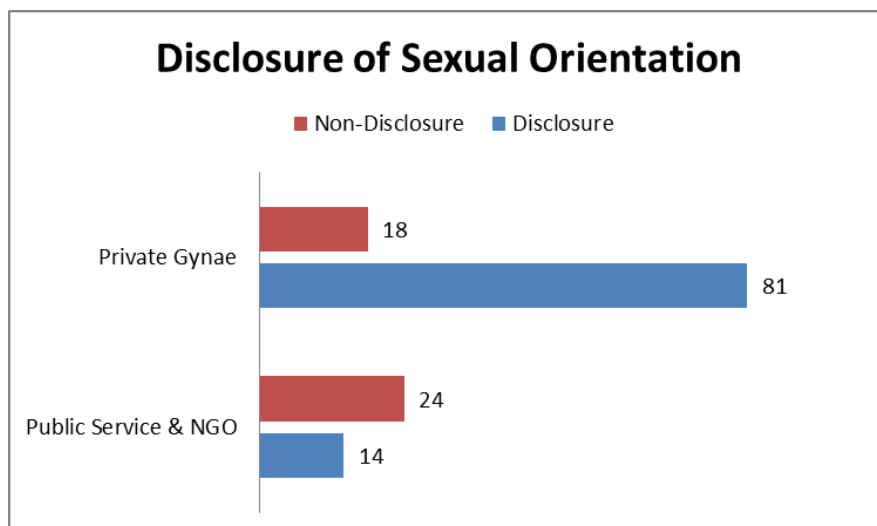
Type of Service	n
Private Gynaecologist	95
Public Service	9
NGO Service	2

**Figure 7: Trends of disclosure of orientation to healthcare worker**

A statistically significant association was observed between attendance of private gynaecologists and disclosure of sexual orientation (  $n = 95$  (79%);  $p < 0.001$ ).

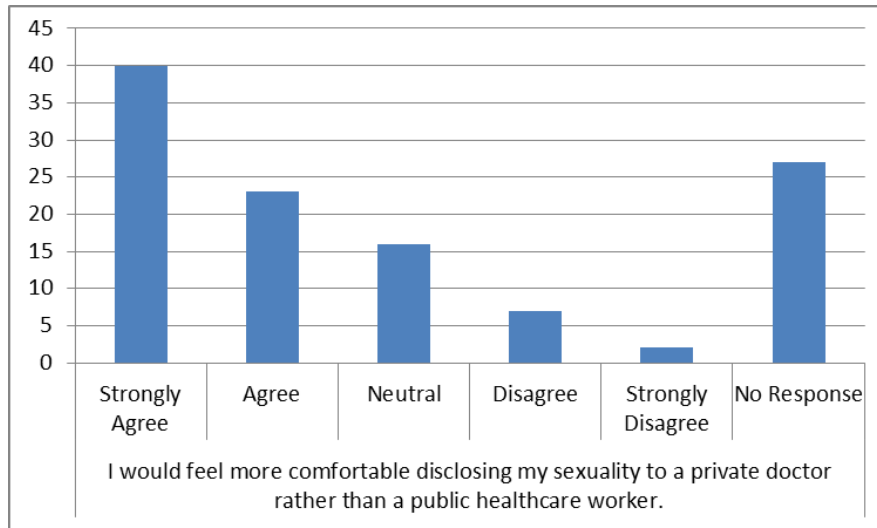
Users of private sector healthcare reported significantly more disclosures than nondisclosures (81% vs 17%); and were 67% more likely to have disclosed their orientation to their physician than users of public and NGO services combined (Figure 8).

There were however significantly more users of private gynaecologists than any other type of service within this study which may bias the results.



**Figure 8: Disclosure of sexual orientation: Private vs Public & NGO Service**

Respondents reported that they would be more inclined to disclose their sexual orientation to a private practitioner rather than a public service healthcare worker in the future (Figure 9).



**Figure 9: Likelihood of disclosure to healthcare worker**

There was no significant association identified with regard to feelings of homophobic discrimination between users of public, private, and NGO services.

1b. Experiences of Reproductive Healthcare Appropriateness

Respondents were asked to comment in an open ended fashion on their positive and negative experiences with reproductive health care. A common theme observed amongst positive experiences, was the use of gynaecologists that are known to be gay and or lesbian. The use of a clinician from within the community contributed to a sense of acceptance and comfort within the consultation, facilitating disclosure of orientation and open discussion of risks and issues with their clinician.

We were privileged to receive a response from a lesbian private practitioner who outlined her own feelings regarding reproductive healthcare, as well as the steps that she has taken to ensure that her practice is an open and supportive environment that endeavours to empower women in general to take ownership of their reproductive healthcare.

She writes: *‘As a gynaecologist I am privileged in not having to expose myself to woman unfriendly services and believe that, instead, I am able to control the healthcare I expect and access. My own patients fill in online questionnaires which directly address and make it clear that sexual activity is not defined as heterosexual. This creates a safe non-judgmental space and openness. Once this is created and experienced women generally claim their healthcare space and experience and are able to control their healthcare environment elsewhere.’*

The common theme amongst the negative responses related to experiences of being treated poorly or harshly by doctors that were not as accepting of homosexual orientation, or ignorant of health risks specific to lesbian women.

An open ended response described services at state hospitals being *‘disempowering and outdated’*. This respondent went on to describe her experience of public sector staff as being *‘unempathetic, unskilled and judgemental when it comes to lesbians’*.

Figure 10 on page 37 describes the Likert-type responses regarding respondents’ experiences of health care in the last year. Responses are categorised according to the six domains explored within the questionnaire.

LIKERT SCALE DOMAINS
Access to care
Physician Relations
Physician Technical
Surgery/ Clinical Environment
Reception Staff Attitudes
Stigmatisation

**Table 4: Likert Scale Domains**

Respondents generally experienced good physician relations, with most agreeing that physicians respect confidentiality, and acknowledge their orientation after coming out to them.

The ‘Physician Technical’ domain was generally rated favourably. This domain assessed if healthcare workers did not automatically assume heterosexuality, provided ample opportunity for respondents to disclose orientation during the consultation, gave advice that was orientation specific, and did not ask inappropriate questions or make inappropriate comments about respondents’ orientation.

The 'Clinical Environment' and 'Access to Care' domains were rated poorly in that respondents felt that the surgery and clinical environment did not provide relevant lesbian health information, and was generally not openly welcoming to homosexual women.

The 'Stigmatisation' and 'Reception Staff' domains were rated well with respondents generally not feeling stigmatised by healthcare workers and associated clinic staff members.

With regard to the following statements, use the scale to rate how much they apply to your experiences in the last year.						
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	No Response
<b>Physician Relations</b>						
My healthcare provider respected my right to confidentiality.	62	13	12	1	0	28
My healthcare provider acknowledged my lesbian/bisexual status after I had come out to him/her.	46	10	26	3	1	30
<b>Physician Technical</b>						
My healthcare provider gave me advice that took into account that I am lesbian/bisexual.	34	15	28	4	5	30
The healthcare worker did not ask any inappropriate questions about my orientation.	38	25	17	3	3	30
The healthcare worker did not make any inappropriate comments.	41	21	15	4	4	31
The healthcare worker assumed that i was heterosexual.	27	19	19	9	10	32
There was no opportunity for me to discuss my sexual orientation.	14	12	25	17	15	33
<b>Surgery/Clinical Environment</b>						
The surgery/clinic is gay/lesbian friendly (relevant posters and/or health information is freely displayed).	8	7	31	21	18	31
The surgery/clinic has a non-discriminatory policy that is clearly displayed and adhered to.	13	11	34	11	12	35
<b>Access to Care</b>						
The practice/dinic environment was not welcoming to me as a lesbian/bisexual woman.	5	4	32	17	26	32
<b>Stigmatisation</b>						
The healthcare worker reacted badly when i came out to him/her.	5	1	23	21	35	31
<b>Reception Staff Attitude</b>						
I had overheard homophobic comments made by the healthcare worker/ other clinic staff.	4	3	11	27	37	34
The reception staff were unfriendly and hostile towards me when they found out that I was lesbian/ bisexual.	3	0	28	18	34	32
<b>Question</b>	<b>Strongly Agree</b>	<b>Agree</b>	<b>Neutral</b>	<b>Disagree</b>	<b>Strongly Disagree</b>	<b>No Response</b>

Figure 10: Likert Type Responses

2a. Perceived Risk of HIV, Cervical and Breast Cancer

Respondents were asked to rate how they perceived their chances of contracting HIV, cervical cancer and breast cancer. A scale of 1 to 10 was used, with 1 being lowest risk and 10 being highest possible perceived risk.

Most respondents considered themselves to be at low risk of contracting HIV, and at intermediate risk of cervical and breast cancer. Perceived risk of each of breast cancer, HIV and cervical cancer is depicted in figures 11 – 13 below. Respondents considered themselves at higher risk of developing cervical or breast cancer, than contracting HIV (Figure 14).

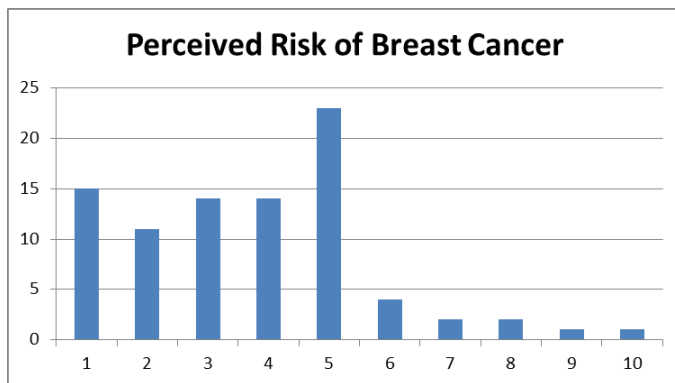


Figure 11: Perceived Risk of Breast Cancer

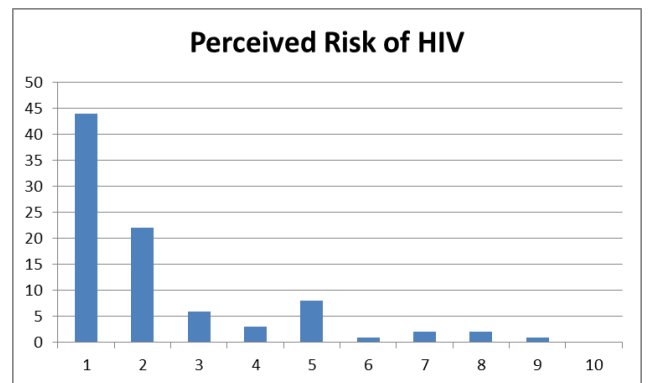


Figure 12: Perceived risk of HIV

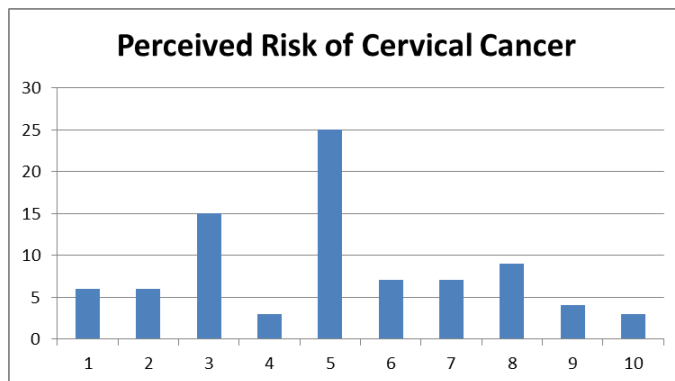


Figure 13: Perceived Risk of Cervical Cancer

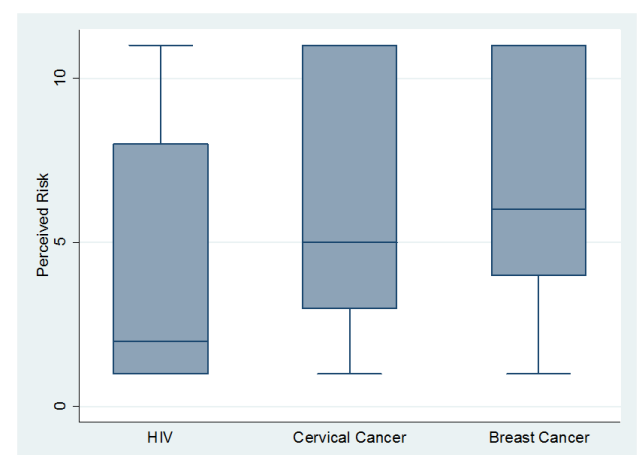
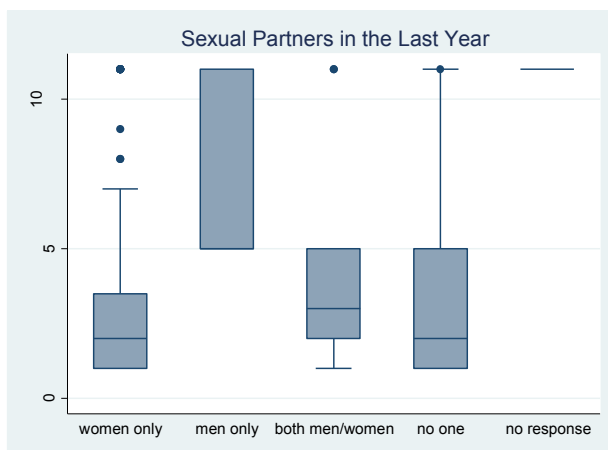


Figure 14: Comparison of risk perception

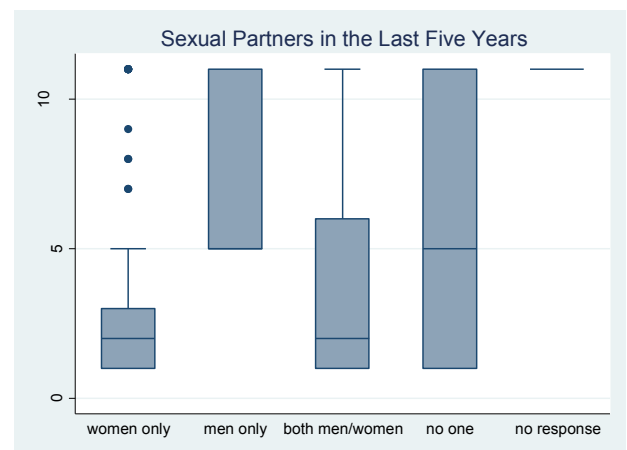


The perceived risk of HIV infection was compared to the respondents' past history of sexual contact with men in the last year, last five years and to lifetime number of male sexual partners respectively. There was a statistically significant association between the perceived risk of HIV infection across all subtypes of sexual contact involving male sexual partners.

Respondents with only male sexual partners in the last year perceived themselves at higher risk of HIV infection than respondents with only female, both male and female, or no sexual partners in the last year. Respondents with only female sexual partners in the last five years considered themselves at lower risk of HIV infection than respondents with only male, both male and female, and with no partners in the last five years.

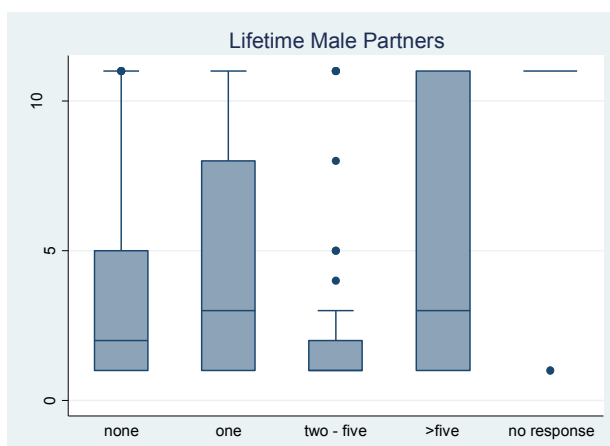


**Figure 15: Perceived Risk of HIV by type of sexual partner in the last year**



**Figure 16: perceived risk of HIV by type of sexual partner in the last five years**

Respondents with two to five lifetime male partners considered themselves to be at significantly lower risk of HIV infection than respondents with no male partners, one male partner, or more than five lifetime male partners. (Figures 15 – 17).



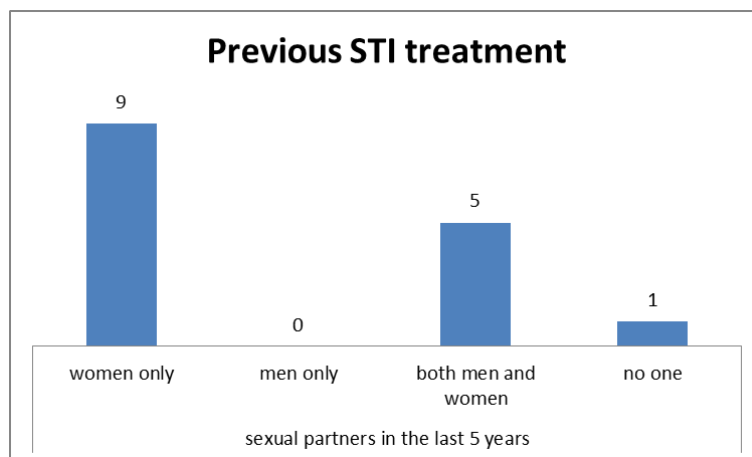
**Figure 17: Perceived risk of HIV by number of lifetime male partners**

2b. Sexually Transmitted Infections, Abnormal Cervical Smear, Cervical Cancer

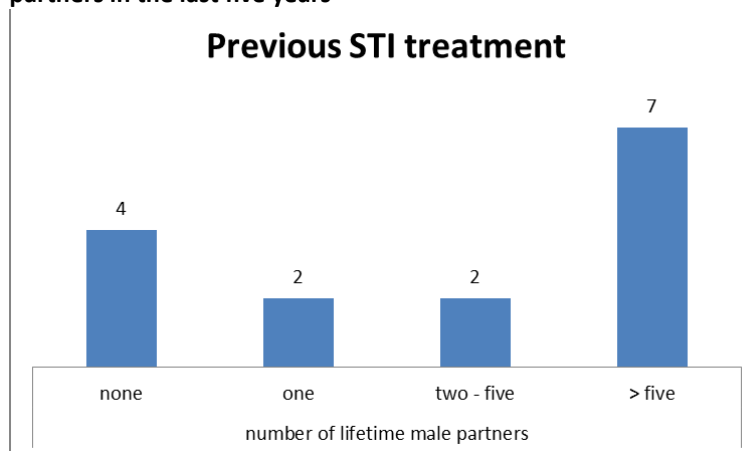
A positive history of being treated for a sexually transmitted infection (STI) was compared to type of sexual exposure in the last year, last five years, and the lifetime number of male sexual partners. Fifteen respondents reported a history of previous STI treatment.

A statistically significant association was revealed between the types of sexual contact, lifetime number of male sexual partners, and treatment for sexually transmitted infections [ $n = 15$ ;  $p < 0.001$ ].

Previous STI treatment was more common in respondents with only female partners in the last five years (Figure 18), and with more than five male partners in their lifetime (Figure 19). There was a significant number of STI's in women with no previous male sexual partners.



**Figure 18: History of previous STI treatment by type of sexual partners in the last five years**



**Figure 19: History of previous STI treatment by number of lifetime male sexual partners**

There was no association between the sexual exposures and abnormal cervical cytology result or cervical cancer. There were far too few respondents with abnormal pap smears or cervical cancer in each of those subgroups to make a reliable comparison.

### Internal Consistency

The questionnaire used in the study was validated as a tool for use in the South African context. The questionnaire was assessed for internal consistency using Chronbach's Alpha coefficient. The Likert- type responses were used to calculate the reliability coefficient. Chronbach's Alpha was used as the preferred measure of internal consistency as it is easy to apply to a single administration of the test.

In general, an alpha value greater than 0.7 is considered to be a marker of acceptable internal consistency for questionnaires, whilst a value greater than 0.9 may indicate redundancies within the instrument.

A reliability coefficient of 0.9736 was calculated for the Likert- Type responses of our questionnaire. It was not possible to perform the calculation of alpha value for each of the different domains independently as there were too few responses to some of the questions for that particular domain. While the total sample size considered was sufficient to calculate an alpha value overall, it was insufficient to perform the calculation for each domain, particularly as some were only tested by only one question.

A factor analysis was performed on the same responses, with the factor loadings being plotted below. Figure 20, page 42 shows a sharp drop followed by a plateau of the curve after the 5<sup>th</sup> eigenvalue indicating that the factors plotted thereafter may be redundant, and not contributing further. Figure 21 on page 42, shows a clear distinction between the factor loadings between the first six and last five variables. This indicates that there may be some redundancy within the overall Likert descriptives, however formal re-evaluation of the alpha value for each domain is still required.

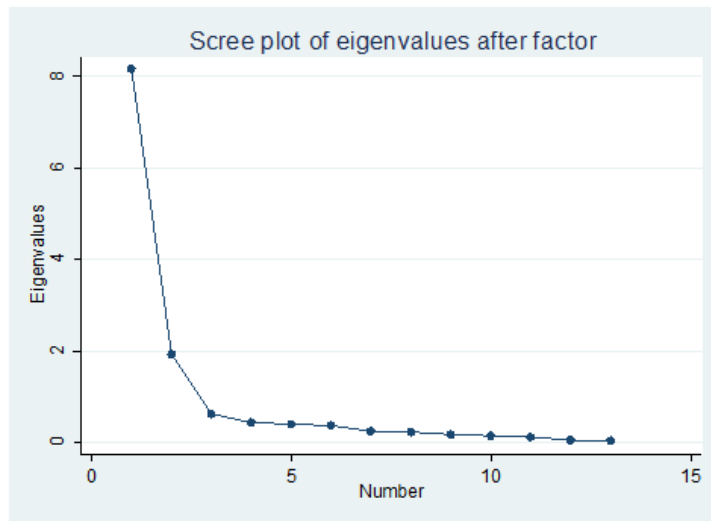


Figure 20: Scree Plot of eigenvalues after factor analysis

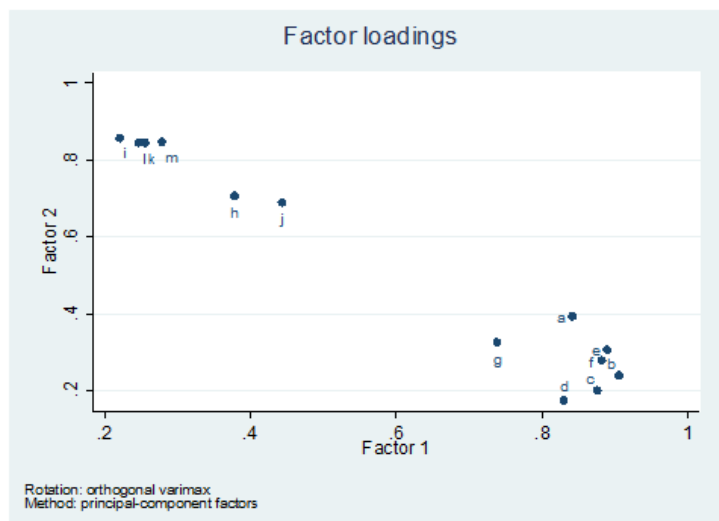


Figure 21: Factor Loadings after factor analysis

## DISCUSSION

The population we sampled represented a very specific demographic of the Cape Town lesbian population. The study population was comprised predominantly of middle class, well-educated, employed suburban women. The demographics of the population sampled are in keeping with the fact that all responses were received via an online format. Bias towards the sampling of this population was anticipated during the sampling process; however, the measures to counter these had proved ineffective. This included promoting the questionnaire in a non-electronic format in lower socio-economic areas where access to computers and internet was expected to be difficult. Despite this, there were no requests received for paper questionnaires. Seven responses were received from these areas using the online survey software.

Even with this skewed population, the study nonetheless provides insight into the reproductive healthcare needs of women who have sex with women (wsw) in Cape Town, as well as their health seeking behaviours, and experiences. To our knowledge, this is the first study of its kind looking specifically at the reproductive healthcare practices of wsw in the South African context.

It was not surprising to find that since most of our respondents belonged to a well-educated and employed middle class that had access to medical aid; they therefore made use of private healthcare services. Respondents were, as a result of their socio-economic situation able to choose their healthcare service providers. While many had previous negative experiences of some form of homophobic discrimination within the healthcare setting, they had the economic freedom to seek out more suitable and acceptable service providers. As our population had the means to 'shop around' for acceptable service providers, it is quite likely that they may choose 'gay friendly' services on the recommendation of friends.

One respondent acknowledged her privileged socio-economic status which afforded such a degree of service, and questioned whether the same holds true for women in less advantaged situations.

A common thread that tied together the open ended responses was the preference of practitioners that are themselves gay/lesbian. Our population showed an inclination towards attending gay/lesbian practitioners. Respondents felt more comfortable disclosing sexuality to them, and discussing issues related to lesbian health with these practitioners.

The respondents generally expressed their willingness to disclose their sexuality to their reproductive healthcare provider. Only a small proportion of the sample population believed that disclosure would negatively impact on the quality of healthcare they would receive. This is in contrast to international literature indicating that lesbian women are reluctant to disclose sexual orientation within the medical consultation.<sup>[5]</sup> It must be noted however, that the study population comprised a remarkably select demographic of lesbian women that (possibly due to their socio economic status) are proud of, and are able to claim, and openly express their orientation socially.

It was clear that the respondents felt more comfortable disclosing to a private rather than a public service practitioner. While it may be true that private healthcare practitioners may spend more time engaging with their patients on a more personal level, it may certainly be perceived as an indictment on the public healthcare system, or at least the LGBT communities' perception of it.

It would be prudent to establish whether this general perception is actually the result of first-hand experience, and if any of our population had ever made use of public reproductive healthcare services previously.

It is furthermore very difficult to personify state provided reproductive health care as being directly homophobic and discriminatory to lesbian women, or just being detached and impersonal to women in general. While lesbian women may interpret their experience as being discriminatory, a comparison would have to be made to heterosexual women's experiences of the state reproductive healthcare services in order to establish this. Such a comparison would be extremely difficult to make given the considerable emotional and cultural differences involved in making such judgements.

It was interesting to note that healthcare related homophobic discrimination was experienced equally between both users of public and private healthcare services alike. This

may hint that public and private services may actually be comparable in terms of skill and expertise (or lack thereof), with public healthcare service providers that provide quality and acceptable care to wsw.

The sample population also represented a mature and established group of individuals in terms of sexual activity. Most were currently in a sexual relationship with a single female partner. As much as 40% of our sample was cohabitating with their female partner at the time of the questionnaire. As evidenced by their type of sexual activity in the previous year, it may be inferred that a significant proportion of our study sample were in stable long term relationships. It could be argued that a stable population such as this would in any case be more comfortable enough with their sexuality to disclose even if they had been seeing public service practitioners.

In comparing the types of sexual partners in the previous year to that of the previous five years, a distinct difference was noted between the number of respondents that had both male and female partners in the two time periods, as well as those that had no sexual partners in the two time periods. The number of respondents with both male and female partners dropped from 23 in the last five years to just 9 in the last year, and the number of respondents with no sexual partners increased from 3 in the last five years to 11 in the last year. This lends support to the notion that our population is a more settled and stable one, and that the sexual activity may have evolved from one of more frequent contact and experimentation with multiple partners of both sexes (and therefore high risk) to a more conservative (low risk) state of pure homosexuality or asexuality whilst maintaining a lesbian self-identity. Such a transition may be in keeping with the change in self-acceptance of one's sexuality with age and maturity.

It may be considered from the above information that the women in the sample underwent an evolution in their pattern of sexual activity. While the study population considered itself to be predominantly homosexual and monogamous, the women have in the past five years, engaged in heterosexual behaviour (either in experimentation or otherwise). This could perhaps be considered characteristic of the process involved in coming to terms with one's sexuality before settling into stable long term partnerships. The large proportion of the study population in monogamous relationships (39%) indicates a stable population that may

be more comfortable with its orientation, and therefore be more open to participating in surveys of this nature. This may have contributed to the skewed population observed in this sample.

The pattern of lesbian women having previous male sexual encounters is well documented in the literature<sup>[9]</sup>, yet remains contrary to the general perception of sexual practices of lesbian women. The medical fraternity generally maintains a perception of exclusive homosexuality by wsw, and therefore considers them not to be at risk of sexually transmitted infections and associated gynaecological problems.<sup>[4, 5, 8, 9]</sup> It is this discrepancy between the perceived and actual risk that puts lesbian women at the greatest danger, as they are overlooked by health education and screening programmes entirely.

Our study confirms previous findings that wsw are at risk of STI infection, HIV infection, and cervical atypia<sup>[1, 13, 14]</sup>, and therefore require surveillance and monitoring. Risk factors for development of these conditions have been defined as previous heterosexual intercourse as well as having more than six lifetime male sexual partners.<sup>[13]</sup> At least 76% of our population had a previous sexual experience with a male partner and about 23% had more than five lifetime male sexual partners. A concerning trend was noted was that a significant number of women did not use barrier contraception with either women or men. This places even the small proportion of women that had no lifetime male sexual partners at significant risk of STIs. While the absolute number is small, a significant proportion of our population that had a previous STI were women with no previous male sexual partner.

Our population showed good participation in cervical and breast cancer screening programmes. Seventy percent of our population had ever had a pap smear, 32% of which had been done in the previous three years. Diamant, Schuster, & Lever report 54% of 6935 self-identified lesbians having had a pap smear in the preceding year, and 71% within the previous two years.<sup>[17]</sup> It is very difficult to compare these screening rates as the screening policy of South Africa varies greatly from international recommendations for cervical screening. Private healthcare screening rates were estimated using data from one of South Africa's largest medical aids, Discovery Health. This study estimated private cervical screening by pap smear to be about 23.1% for the Western Cape with a national rate of about 16.7%.<sup>[32]</sup>



Sixty one percent of our population claimed to have regularly checked their breasts for lumps with 31% having had a recent mammogram. Provincial and national rates of mammography taken from the same Discovery Health study are estimated to be 16.1%, and 13% respectively. <sup>[32]</sup>

The high rate of uptake of screening services may be due to a combination of factors. Our population is well educated, and well informed regarding the risk factors for cervical and breast cancer. This heightened awareness translates into a higher perceived risk of developing these conditions. It has been proposed that this same mechanism has resulted in increased breast cancer screening amongst lesbian women internationally.<sup>[1, 5, 10]</sup> Their predominant use of private reproductive healthcare services would allow them easy access to screening services outside of the limitations of national and provincial screening protocols.

Our population demonstrated high use of hormonal contraceptive methods with about 60% having used a contraceptive method previously. While there are many known benefits to the use of hormonal contraception besides preventing unwanted pregnancy, the commonest reason given for its use was in fact preventing pregnancy. This contradicts the conventional view that wsw do not require contraceptive services. Our population clearly considered themselves to be at risk of pregnancy. Some may argue that in a country like South Africa where sexual assault, and in particular, the targeted assault of lesbian women and 'corrective rape' is so prevalent, the provision of contraception should be an important aspect of lesbian health care. <sup>[27, 28]</sup>

We were able to confirm internal consistency of the study questionnaire. With an appropriate alpha cronbach value calculated, we were able to validate the questionnaire for use in the local, albeit middle-class, well-educated context. With such a high reliability index, the possibility of redundancy may certainly exist within the questionnaire; however our small sample size precluded formal factor analysis, and establishment of those factors that were non-contributory and which therefore that could be excluded.

The snowball sampling method with the online survey tool worked well for this study in terms of obtaining responses from the middle-class and computer literate population, however, it resulted in the skewed population that was sampled. Other studies aimed at

lesbian women from lower socio-economic circumstances have used a more targeted approach, using focus groups, interviews, and administered questionnaires for data collection. These methods, although more time consuming have not been hugely successful in obtaining data from this hard to access, and most at risk population. Due to the high incidence of homophobic victimisation directed against lesbian women in the townships, these women are less likely to openly disclose their orientation at the risk of being raped or murdered.

## CONCLUSIONS

It is evident from our study that Capetonian lesbian women experience comparable exposures and risk of gynaecological problems as published in the international literature. South African women may however experience the added dynamic of socio-economic class distinction between accesses to private or public healthcare. With perceived discrepancies between the acceptability of healthcare between the two types of service, the women in our sample population have made use of their economic freedom to overcome these discrepancies. Further studies, including women from lower socio-economic groups would be required to test the notion that socio-economic status rather than sexual orientation is the major determinant of access to acceptable care.

We accept the shortcomings of the study; in particular, the skewed population sampled, as well as the relatively small sample size that precluded certain data analyses. Despite these shortcomings, the study population nevertheless represents the largest group of lesbian women to have been sampled in South Africa to date, and provides insight into the reproductive healthcare needs, as well as the reproductive health seeking behaviours of wsw in Cape Town.

Much of the existing research into lesbian health in South Africa thus far has focused on women from lower socio-economic status, and as such, our study population represents a novel and previously untapped resource for further work in this emerging field. Further research is required to assess these needs formally, and we are confident that our instrument could be used to fulfil this need. We see our study as a pilot study for a much larger and possibly nation-wide study possibly using both the snowball sampling method as well as focussed targeting of women from lower socio-economic areas.

Notwithstanding the idea that Lesbian Health is a distinct entity of reproductive healthcare and should be treated as such, it is the opinion of the authors that Lesbian Health is in fact Women's Health. All women are afforded equal right to acceptable reproductive healthcare, and should have access to the same. It is the responsibility of the medical profession to make itself cognisant of the risks of lesbian women and to afford them the appropriate advice and standards of care accordingly.

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## ADDENDA

Participant Information Leaflet and Consent

### **TRENDS OF UTILISATION OF REPRODUCTIVE HEALTH SERVICES BY LESBIAN WOMEN IN CAPE TOWN**

A friend of yours has already contributed to this survey, and thinks that you may also be eligible to join in.

#### What's the survey about?

If you're lesbian, bisexual or simply a woman who has sex with women, we would like you to tell us about your sexual, reproductive health and wellbeing

#### Completing the survey

The survey is completely anonymous and confidential and will take you about 20 minutes to fill out. Some of the questions in the survey are quite personal. We have asked them so that we can understand your experiences fully, so please answer honestly. You may choose to opt out at any time.

The survey is being conducted by the Reproductive Medicine Unit of the Department of Obstetrics and Gynaecology at the University of Cape Town and has been approved by the Human Research Ethics Committee of the Faculty of Health Sciences of the University of Cape Town.

This leaflet will give you further information about why the study is being done, what will happen during the study and any risks and benefits involved in the study. Please read it carefully.

If you would like any further information, please feel free to contact us, and we will gladly answer any query you may have.

## RESEARCHERS

Dr Paversan Archary

Professor Petrus Steyn

## WHY IS THIS STUDY BEING DONE?

Historically, the specific health needs of Lesbian, Gay, and Bisexual people have been largely overlooked. In current years, LGBT individuals are living more openly and freely, and as a result, the medical field is beginning to realise its shortfall in terms of knowledge on the specific health needs of LGBT people.

Not much is known about the reproductive health of lesbian women, and most of what is already known is based on data collected overseas, and may not be relevant to the South African context.

This survey will give us an idea of the factors influencing, as well as the specific reproductive health requirements of lesbian women, so that doctors can be better equipped to help lesbian women in the future, and to develop appropriate services.

The aim of this survey is to ensure that your healthcare needs and experiences will be better appreciated, rather than ignored. This is the first survey of its kind in Cape Town, and by taking part you'll be helping us understand your specific healthcare needs, and help us tailor healthcare services to better serve you.

We are hoping that the information collected from this survey will assist with the planning and provision of acceptable, 'gay friendly' reproductive healthcare services within the health system.

## STUDY PARTICIPANTS

- Any woman older than the age of 18 who has sex with women, and identifies herself as Lesbian, Gay or Bisexual, is invited to participate in the survey.
- Participation in the study is entirely voluntary and completely anonymous.
- We will ask you to complete a questionnaire either online, or on paper. This should take about 20 minutes and may be done at a time and in a language that is most convenient to you.



- Once you have completed the questionnaire, we request that you ask your friends to also participate.
- You may share the contact page with them or simply email them the link to the online survey.

## RISKS

- This study involves a questionnaire and will not pose any risk to you.
- You will not incur any costs by being part of the study.

## BENEFITS

- You may not benefit directly from taking the study but your participation will assist us in helping other lesbian/bisexual women in future.
- There is no financial reward for taking part in the study.

## CONFIDENTIALITY

- The questionnaire will be completed in a private area, at your own convenience.
- Your identity will not be used on the response, or on the database, and your participation will be completely anonymous.
- If you choose to participate via the online survey, your email or computers Internet Protocol (IP) address will **NOT** be logged or collected in any way by the investigators.
- During the period of data collection, all the research data will be stored and accessed via secure internet servers located in the USA. During this limited time, this data may be subject to US Federal Law regarding access to online information. Once the data collection has been completed, this data will then be transferred, stored and accessed electronically in the Department of Obstetrics and Gynaecology at the University of Cape Town. All information stored in the USA will then be permanently deleted. Your identity would in no way form part of this data. The privacy policy of our internet service provider may be reviewed at: <http://www.surveymonkey.com/mp/policy/privacy-policy/#respondents>
- Only the investigators will have access to the completed questionnaires, and research data.

- You will be asked to sign a consent form for yourself. If you are participating in the online survey, clicking the 'agree' tab and proceeding to complete the survey will be taken as informed consent.
- This research forms part of work towards a higher degree and will be submitted for examination within the University of Cape Town. The results of the study will be published in the medical literature. You will not be identified in any of these documents.

## CONTACT INFORMATION

If you have any questions, comments or queries regarding the study, or if you have been referred by a friend and are interested in participating in this survey, please feel free to contact us at [lesbianhealthsurvey2013@gmail.com](mailto:lesbianhealthsurvey2013@gmail.com).

Alternately, you can contact Dr P Archary at 082 827 5605, or Dr T Spence at 072 409 4318 for more information.

For more information regarding your rights as a research participant, you may contact the UCT Faculty of Health Sciences Human Research Ethics Committee at 021 406 6338.

Thanks for your time, we really do value your contribution.

## INFORMED CONSENT

I willingly agree to take part in this research survey that is being conducted by the Reproductive Medicine Unit of the Department of Obstetrics and Gynaecology at the University of Cape Town. This study has been approved by the Research Ethics Committee of the Faculty of Health Sciences at the University of Cape Town.

The purpose of this study is to gain insight to the reproductive health of lesbian and bisexual women in Cape Town, and to determine if this is in keeping with international literature to date. Such information is critical in terms of identifying factors influencing access to, and acceptability of reproductive healthcare services within the city. Furthermore it will be valuable in increasing current knowledge on lesbian health issues, and hopefully contribute to better healthcare in the future.

I understand I shall need to complete an anonymous questionnaire either online, or on paper, in one of three languages of my choice (English/ Afrikaans/isiXhosa). My participation is entirely voluntary and I may withdraw at any time. Declining to complete the questionnaire will not prejudice me in any way from receiving future health care. Participation in the study

poses no risk to me, and I understand that I may not benefit directly from this study and that there is no financial reward for my participation, but that the information collected in this survey may benefit other lesbian/bisexual women in the future.

I understand that confidentiality will be maintained and I will not be identifiable in any of the databases or manuscripts subsequently produced for publication. I have been given adequate opportunity to ask questions about the study and have been provided with an information leaflet about the study and contact details of persons whom I may contact to answer questions. I understand that the results of the survey will be published in the medical literature.

By clicking next, I confirm that I have read and understand the above terms and conditions, and agree to participate in the survey.

## Questionnaire

### A: Getting to know you

1. Are you?
  - Male
  - Female
  
2. How would you describe yourself?
  - Lesbian
  - Bisexual
  - Other: I would describe myself as: \_\_\_\_\_
  
3. How old are you?
  - \_\_\_\_\_ years old.
  
4. What is your postal code?
  - \_\_\_\_\_
  
5. Do you have a female partner at the moment?
  - No
  - Yes, one female partner.
  - Yes, more than one female partner.
  
6. Do you have a male partner at the moment?
  - No
  - Yes, one male partner.
  - Yes, more than one male partner.
  
7. What is the highest level of education you have achieved?
  - Primary school
  - Secondary school, but not till matric
  - Passed matric/grade 12
  - Undergraduate degree/diploma
  - Postgraduate degree

8. Are you employed?

- In full-time work
- In part time work
- Unemployed
- Retired
- Student

9. Who do you live with? (tick as many as may apply)

- On my own
  - Female partner
  - Male partner
  - Children
  - Parents
  - Friends
  - Shared accommodation
  - Other, please say what:
- 

10. If you live with children, they are: (tick as many as may apply)

- My biological children
  - My non-biological children (*eg nieces/nephews*)
  - My partners children (*eg from his/her previous relationships*)
  - My foster/ adopted children
  - Other, please say what:
- 

11. What kind of area do you live in?

- Industrial area
- Residential suburb
- Township
- Informal settlement
- Rural area

12. Do you have a medical aid?

- No
- Yes

13. What is your ethnic group?

- African
- Caucasian
- Coloured
- Indian
- Other: Please say

what: \_\_\_\_\_

14. What is your occupation?

- Modern professional occupations (*eg: nurse, teacher, physiotherapist*)
- Clerical/intermediate occupations (*eg: secretary, PA, admin clerks*)
- Senior managers/ administrators (*eg: finance manager/executive*)
- Technical and craft occupations (*eg: motor mechanic, plumber, electrician*)
- Self-employed (*eg: small business owner*)
- Semi routine, manual and service occupations (*eg: machine operator, security guard, farm worker*)
- None (*unemployed*)
- Routine manual and service occupations (*eg: driver, cleaner, porter, packer*)
- Middle or junior managers (*eg: office/ retail/ restaurant manager*)
- Traditional professional occupations (*eg: lawyer, civil engineer, medical practitioner*)
- Other: Please say what:

\_\_\_\_\_

15. What is the monthly income of your household?

- R1 – R5 000
- R5 000 – 10 000
- R10 000 – 20 000
- R20 000 – 30 000
- >30 001

**B: General Health**

16. How much do you weigh?

- \_\_\_\_\_ Kilograms.

17. How tall are you?

- \_\_\_\_\_ Centimetres.

18. Do you have any disability that limits your activities or the work you can do?

- No
- Yes. Please say what: \_\_\_\_\_

19. How would you describe your general state of health?

- Excellent
- Good
- Fair
- Poor

20. How do you usually access **primary/general** health care? (tick as many as may apply)

- Private doctor
- Public clinics or hospitals
- NGO based clinic

21. How do you usually access **reproductive** healthcare services? (tick as many as may apply)

- Private doctor
- Public clinic or hospital
- NGO clinic

22. Have you ever disclosed your sexuality to your healthcare provider?

- Yes
- No

23. If not, why? (tick as many as may apply)

- I'm scared that I will be discriminated against
- I feel ashamed/unsure/embarrassed about my sexuality
- I don't trust my healthcare professional enough to come out to him/her
- I don't feel comfortable coming out to anyone just yet
- I don't think that disclosing my sexuality is important medically
- Other: Please say why:

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24. Have you ever smoked cigarettes?

- No
- Yes

25. Do you currently smoke cigarettes?

- No
- Yes, how many per day? \_\_\_\_\_ cigarettes.

26. Do you consume alcohol?

- No
- Yes

27. On an average week, how many days do you usually consume an alcoholic drink?

- 1 day
- 2 days
- 3 days
- 4 days
- 5 days
- 6 days
- 7 days

28. On an average drinking day in the last week, how many of the following alcoholic drinks did you consume?

- Beer/Ciders \_\_\_\_\_ bottles/glasses
- Wine \_\_\_\_\_ glasses
- Spirits \_\_\_\_\_ shots

29. Have you ever used any of these drugs in the last year? (tick as many as may apply)

- Marijuana /Weed
- Ecstasy/ E
- Chrystal Methamphetamine / TIK
- Cocaine/Coke
- LSD /Acid
- Amphetamine/Speed
- Heroin
- Poppers
- Viagra/ Cialis/ Levitra
- Benzodiazepines (off prescription)
- Others. Please say what: \_\_\_\_\_



## C: Sexual History

30. In the last year, have you had sex with?

- Women only
- Men only
- Both women and men
- No one

31. In the last five years, have you had sex with?

- Women only
- Men only
- Both women and men
- No one

32. In your lifetime, how many male sexual partners have you ever had?

- None
- One
- Between two and five
- More than five

33. Do you use barrier contraception during sex with women? (e.g. female condoms/dental dams)

- No, never
- Yes, most times
- Yes, sometimes
- Yes, always.

34. Do you use barrier contraception during sex with men? (e.g. condoms)

- No, never
- Yes, most times
- Yes, sometimes
- Yes, always.
- Not applicable

**D: Gynaecological History**

35. Have you ever been pregnant?

- No
- Yes

36. Have you ever experienced labour and/or childbirth? (tick as many as may apply)

- No
- Yes, vaginal delivery
- Yes, emergency caesarean section
- Yes, elective caesarean section

37. Have you ever had a pap smear?

- Yes
- No

38. If yes, when last did you have one?

- In the last year
- In the last three years
- In the last five years
- More than five years ago

39. If not, why not? (tick as many as may apply)

- I'm scared to
- I'm too busy
- I don't think that I need one
- I've been told by my healthcare provider that I don't need one
- I wanted one, but was refused one because of my sexuality
- Other. Please say why: \_\_\_\_\_

40. Have you ever been treated for a Sexually Transmitted Infection (STI) or vaginal condition?

- Yes
- No

41. Have you ever had an HIV test?

- Yes
- No

42. If yes,

- How often do you get tested?
  - At least twice per year
  - Once a year
  - Every few years
  
- And why? (tick as many as may apply)
  - I think I need one
  - It's important to know ones status
  - It's part of my routine checkup
  - For insurance purposes
  - My partner insisted that I get tested

43. If no, why not?

- I don't think I need one
- I'm scared to be tested
- I'm too busy to go for a test
- Other, please say why

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44. What is your current HIV status?

- I don't know
- Negative
- Positive

45. If you are HIV positive, are you using antiretroviral treatment?

- Yes
- No

46. Have you ever used a family planning (contraceptive) method?

- Yes
- No

47. What method have you used? (tick as many as may apply)

- The pill
- Injection
- IUCD (loop)
- Condoms
- Other: Please say what \_\_\_\_\_

48. What was the main reason you used contraception? (tick as many as may apply)

- Contraception (to avoid pregnancy)
- To take away my periods
- To regulate my cycle
- To help with my period pain
- To help with my PMS symptoms

49. Have you ever been denied contraception because of your sexual orientation?

- Yes
- No

50. Which of the following family planning methods do you know about/ have heard of in the past? (tick as many as may apply)

- The Progesterone-only Pill (Minipill)
- The Combined Oral Contraceptive Pill (COC)
- Injectable contraception (Depot)
- Implant
- Intra-uterine Contraceptive Device (IUCD/loop)
- Intrauterine System (IUS/Mirena)
- Sterilisation (male/female)
- Diaphragm/Cap
- Condoms (male/female)
- Emergency Contraception

51. Have you ever considered having a child within a lesbian/bisexual relationship?

- No
- Yes

52. If yes, would you consider Artificial Insemination or other Assisted Reproductive Techniques?

- Yes
- No

53. Do you regularly examine your breasts for lumps?

- Yes
- No

54. Have you ever had a mammogram?

- Yes
- No

55. Have you ever used Hormone Replacement Therapy?

- Yes
- No

56. Have you ever been diagnosed with any one of these gynaecological conditions?

- Abnormal pap smear
- Cervical Cancer
- Endometrial (womb) Cancer
- Ovarian Cancer
- Breast Cancer

57. Have you ever been the victim of sexual assault, rape or physical violence as a direct result of your sexuality?

- No
- Yes

58. What are your experiences of reproductive health care in general?

- Positive, please describe

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- Negative, please describe

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59. Do you feel that disclosing your sexual orientation to your healthcare provider would improve or hinder the quality of care you would receive?

- Improve
- Not affect
- Hinder

60. Have you ever had an experience where you were discriminated against (in the healthcare setting) because of your sexual orientation?

- No
- Yes, please describe

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**With regard to the following statements, use the scale to rate how much the statements below apply to your experiences with healthcare services in the last year.**

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
61. My healthcare provider respected my right to confidentiality.	☺ ☺	☺	☹	☹	☹ ☹
62. My healthcare provider acknowledged my lesbian/bisexual status after I had come out to him/her.					
63. My healthcare provider gave me advice that took into account that I am lesbian/bisexual.					
64. The surgery/clinic is lesbian/bisexual friendly (posters of same sex couples and/or relevant health information, etc.)					
65. The healthcare worker did not ask any inappropriate questions about my orientation.					
66. The healthcare worker did not make any inappropriate comments.					
67. The surgery/clinic has a non-discriminatory policy that is clearly displayed and adhered to.					
68. The practice/clinic environment was not welcoming to me as a lesbian/bisexual woman.					
69. The healthcare worker reacted badly when I came out to him/her.					
70. The healthcare worker ignored it when I came out to him/her.					
71. The healthcare worker assumed that I was heterosexual.					
72. There was no opportunity for me to discuss my sexual orientation.					

73. I had overheard homophobic comments made by the healthcare worker/ other staff.					
74. The reception staff was unfriendly and hostile towards me when they found out I was lesbian/bisexual.					

**Rate the following statements according to what you understand regarding lesbian/bisexual women's health.**

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
75. Lesbian/bisexual women are less at risk of contracting sexually transmitted infections than straight women are.					
76. Lesbian/bisexual women are less likely to develop cervical cancer than straight women.					
77. Lesbian women don't need to have pap smears.					
78. HIV infection cannot be transmitted from one woman to another.					
79. Reproductive healthcare services in the city generally don't cater to the specific needs of lesbian/bisexual women.					
80. I would be more comfortable attending a Gay-Friendly/ dedicated Lesbian Health Clinic.					
81. I would be more comfortable attending a Gynaecologist/Reproductive Healthcare worker that was also gay.					
82. I would feel more comfortable disclosing my sexuality to a private doctor rather than a public healthcare worker.					



**On a scale of 1 – 10, state what you think YOUR OWN risk (chances) of the following problems are, where 1 is the least likely, and 10 is most likely**

83. What do you think your risk of getting HIV is?



84. What do you think your risk of developing Cervical Cancer is?



85. What do you think your risk of developing Breast Cancer is?



## more information..

### Pap Smears

It is a common myth that lesbian women don't need pap smears. This isn't true, and in fact, ALL women who are sexually active require pap smears. This includes lesbian and bisexual women.

Pap smears are necessary to detect abnormal cells on the mouth of the womb, so that they can be treated before they lead to cancer. Cervical cancer is the commonest cancer affecting women in Africa, and is easily curable if detected early.

In South Africa, a woman may get a free pap smear at any local clinic or hospital every ten years from the age of 30. The international recommendation is that a woman has a pap smear about every three years or so. Women that are HIV positive must have more frequent pap smears.

For more information regarding cervical cancer visit: [www.cansa.org.za](http://www.cansa.org.za)

Alternately, email [info@cansa.org.za](mailto:info@cansa.org.za) or phone the CANSA Toll Free Call Centre at 0800 22 66 22.

### STI Testing

Another myth is that lesbian women are 'immune' to sexually transmitted infections and HIV. Lesbian and bisexual women can in fact be affected by infections such as thrush, BV, Chlamydia and Syphilis. Local clinics don't routinely test for these infections, but can easily treat them with a short course of antibiotics. Always remember to get your partner tested as well, or you'll just get re-infected the next time you sleep together.

Although the chances of spread of HIV from one woman to another is quite low, HIV can certainly be transmitted between women. Voluntary Counselling and Testing for HIV is available at most local clinics and hospitals, and is free of charge. Knowing your status will enable you to make healthy choices for both you and your loved ones.

Call the AIDS helpline on 0800 012 322 or visit the [www.karabo.org.za](http://www.karabo.org.za) for information about the nearest government VCT/HCT centre, or for more information.

### Breast Examination

Studies done overseas have suggested that Lesbian women stand a much greater chance of getting breast cancer. Smoking and an unhealthy diet can further increase the chances. Regular breast examination can save your life. Check your breasts regularly (self-examination is good enough) and report any abnormal lumps, redness or discharge to your doctor immediately.

Check out [www.cansa.org.za](http://www.cansa.org.za) for more information about breast cancer. Alternately, email [info@cansa.org.za](mailto:info@cansa.org.za) or phone the CANSA Toll Free Call Centre at 0800 22 66 22.

### Smoking, Drug and Alcohol use

The use of cigarettes, alcohol and other drugs, all have a detrimental effect on ones health. It's never too late to quit, but this is often easier said than done! Get the help and support of those around you, and contact these organisations for some expert assistance:

National Council against Smoking: [www.againstsmoking.co.za](http://www.againstsmoking.co.za)

011 720 3145 (quit line)

Cape Town Drug Counselling Centre: [www.drugcentre.org.za](http://www.drugcentre.org.za)

071 447 8076

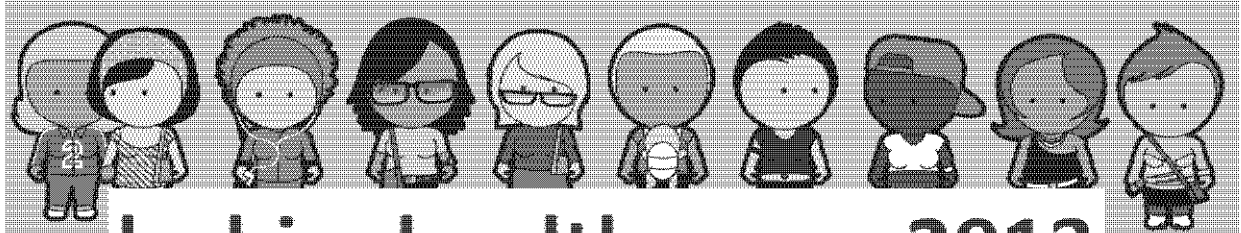
### Rape and physical violence

The unfortunate reality of life in South Africa as a lesbian woman is the threat of corrective rape, physical assault and violence. This is thought to be far more common in the townships.

A non-profit organisation estimates that about 10 lesbian women are raped or assaulted each week as a direct consequence of their sexual orientation. If you are the victim of rape or physical violence in any of the townships around Cape Town, you can contact the Euleki Sizwe Organisation for support.

Ndumile Funda can be contacted at 074 307 4056. Alternately get hold of The Triangle Project for more information on support services at 021 712 6699.

If you are able to give off some of your free time, why not volunteer your services to these organisations.



# lesbianhealthsurvey2013

have your say about the state of reproductive  
healthcare available to wsw in cape town

If you're lesbian, bisexual or simply a woman who sleeps with women, we would like you to tell us about your reproductive health and wellbeing.

Not much is known about the health of lesbian and bisexual women. Sometimes the doctors get it right. Sometimes they don't.

The aim of this survey is to ensure that your healthcare needs and experiences will be better appreciated, rather than ignored.

By taking part, you'll be helping us understand your specific healthcare needs, and help us tailor healthcare services to better serve you.

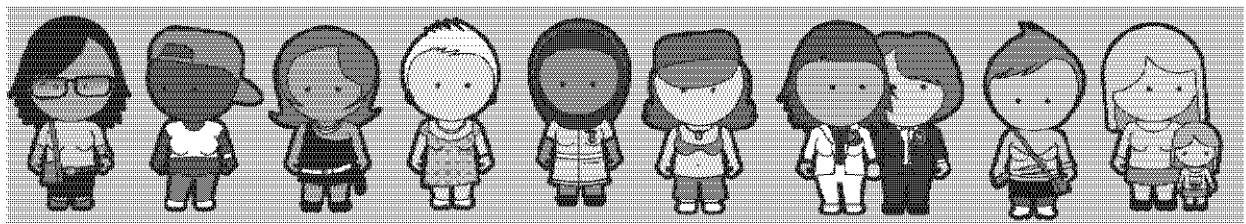
The survey is completely anonymous and confidential and will take you about 20 minutes to fill out.

The survey may be accessed online at:

<https://www.surveymonkey.com/s/lesbianhealthsurvey2013>

If you have any questions or queries, or cannot access the online survey, contact Paversan Archary at 082 827 5605 or mail us at [lesbianhealthsurvey2013@gmail.com](mailto:lesbianhealthsurvey2013@gmail.com)

Thanks for taking part, we really do value your contribution.



UNIVERSITY OF CAPE TOWN



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29 January 2013

HREC REF: 538/2012

Dr P Archary  
c/o Prof P Steyn  
Obstetrics & Gynaecology  
H-Floor  
OMB

Dear Dr Archary

**PROJECT TITLE: TRENDS OF UTILISATION OF REPRODUCTIVE HEALTH SERVICES BY LESBIAN WOMEN IN CAPE TOWN**

Thank you for addressing the issues raised by the committee.

It is a pleasure to inform you that the HREC has **formally approved** the above mentioned study.

**Approval is granted for one year till the 15 February 2014.**

Please submit a progress form, using the standardised Annual Report Form, if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

**Please quote the REC. REF in all your correspondence.**

Yours sincerely

**PROFESSOR M BLOCKMAN**  
**CHAIRPERSON, HSF HUMAN ETHICS**

Federal Wide Assurance Number: FWA00001637  
Institutional Review Board (IRB) number: IRB00001938

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