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Health risks for women who have sex with women, in particular in relation to HIV/AIDS

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Abstract: Due to the persistent myth that women in same-sex relations are not so much at risk of infection with sexually transmitted diseases (STI's), they are less likely to seek health care than heterosexual people or men who have sex with men (MSM). Stigma and marginalisation are gendered phenomena that lead to feelings of guilt and shame. These may make women susceptible to health risks, and to silence on critical matters related to the risk of infection. Health care providers lack knowledge about the specific health needs of women who have sex with women (WSW). Without attention to the wider and multiple issues of marginalisation, economic deprivation and stigma, a narrow focus on health concerns and safe sex practices only is bound to fail.

Keywords: health services; sexually transmitted disease (STI); women who have sex with women (WSW); homophobia; HIV/AIDS

Riesgos para la salud de mujeres que tienen sexo con mujeres, en particular con relación al VIH/SIDA

Resumen: Debido al persistente mito de que las mujeres que tienen relaciones sexuales con mujeres no están tan expuestas a infecciones de transmisión sexual (ITS), estas tienden a procurar servicios de salud en menor medida que las personas heterosexuales o los hombres que tienen sexo con hombres (HSH). El estigma y la marginalización son fenómenos atravesados por el género que producen sentimientos de culpa y vergüenza. Estos pueden tornar a las mujeres susceptibles a riesgos para su salud y silenciar cuestiones críticas relacionadas con el riesgo de infección. Los agentes de salud carecen de conocimientos acerca de las necesidades específicas de las mujeres que tienen sexo con mujeres. Sin prestar atención a la marginalización, la carencia económica y el estigma, un foco restringido a la salud y el sexo seguro sólo puede fracasar.

Palabras clave: servicios de salud; infecciones de transmisión sexual (STI); mujeres que tienen sexo con mujeres; homofobia; VIH/SIDA

Riscos para a saúde de mulheres que praticam sexo com mulheres, em particular em relação ao HIV/AIDS

Resumo: Devido ao persistente mito de que as mulheres que têm relações sexuais com mulheres não estão tão expostas a infecções de transmissão sexual (ITS), estas tendem a procurar serviços de saúde em menor medida do que as pessoas heterossexuais ou os homens que praticam sexo com homens (HSH). O estigma e a marginalização são fenômenos atravessados pelo gênero que produzem sentimentos de culpa e vergonha. Estes podem tornar as mulheres suscetíveis a riscos para a sua saúde e silenciar questões críticas relacionadas ao risco de infecção. Os agentes de saúde carecem de conhecimentos a respeito das necessidades específicas das mulheres que praticam sexo com mulheres. Sem dar atenção à marginalização, à carência econômica e ao estigma, um foco restrito à saúde e ao sexo seguro só pode fracassar.

Palavras-chave: serviços de saúde; infecções de transmissão sexual (ITS); mulheres que praticam sexo com mulheres; homofobia; HIV/AIDS

Introduction

There is a persistent myth that women in same-sex relations are not so much at risk of infection with sexually transmitted diseases (STI's), such as HIV, as men who have sex with men. This is compounded by the belief that if women who are having sex with women (WSW) are infected it is mainly because of heterosexual contacts or because of intravenous drug use. I will discuss both assumptions and stress that stigma and marginalisation are gendered phenomena that lead to feelings of guilt and shame that may make women susceptible to other health risks, and to silences on critical matters related to the dangers of infection. I will also briefly discuss the role of health personnel.

First, a note on terminology: the female-bodied persons that are the topic of discussion here display such a broad range of behaviours and identities that it is difficult to find a label that encompasses all those aspects. What concept can do justice to the fluid, complex, contingent population that is the topic of this article? The boundaries of this group are constantly shifting, as they are being defined and redefined in constant processes of in- and exclusion, both by the heteronormative majority as by the marginalised non-normative female-bodied persons themselves. The term WSW is coming in vogue now, following the commonly used term MSM. The advantage of the term is that it focuses on sexual practices. But what to do with women who identify as lesbian but have sex with men or don't have sex at all? Or with women who are in a same-sex relations but deny that their loving has a sexual aspect? Another problem is that both the concepts MSM and WSW that emerged in its slipstream are problematic, as they conflate sex and gender and invisibilize intersex, transsexual and transgender people.

It is thus preferable to discuss sexual acts that carry more or less risk than to name and focus the relationships within which the act is performed. However, for the sake of brevity in this article, I will use both WSW and 'women's same-sex relations.' That concept again may exclude those who are in a heterosexual relation and have occasional sex with a woman partner. Thus here I will use both terms interchangeably, aware of their limitations. I will use the term 'lesbian' only for women who identify themselves as such.

Although most women in the 'global South' who are in same-sex relations live in societies that marginalize and abject them, it is important to realize that in certain historical and cultural constructs women were (and still are) able to carve out a niche in which

their relationships with other women were/are accepted to a more or lesser degree.¹ In general, these women did/do not identify as lesbian; in some cases we do not know whether their relationships were/are actually sexual. This may by the way tell more about the inhibitions and carelessness of their researchers, who failed to ask the relevant questions (Wieringa, 2005b).

Ironically, the rise of modern middle class rights-based lesbian groups shatters the silence behind which some women could hide, and exposes the same-sex sexuality of their relations. This may lead to ostracism and violence. Willingly or unwillingly, they are drawn into the orbit of the rights-based groups. The present-day situation, as far as women in same-sex relations is concerned, is then complex. There are multiple forms in which women live their desires, which are divided by class, religion, ethnicity, legal system, political culture, and gender regime. Present-day discourses on WSW are rather inadequate to capture this wide variety of practices, desires and identities. There are some excellent case studies, such as those by Blackwood (1999), Wekker (2006), Lai (2007), Sinnott (2004) and others. There are also a few compilations of accounts by members of activist groups such as Reinfelder (1996) and Rosenbloom (1996), and a few anthologies, such as Blackwood and Wieringa (1999), Wieringa, Blackwood & Bhaiya (2007).

Another debate which has gained much currency over the past decade is the one about the global queer movement. As I have argued elsewhere (2004) the term 'queer' encompasses a rather unilinear and homogenizing discourse that, originating on a generally white, western and mostly male point of view, fails to recognize the great diversity of sexual cultures. I have warned that global queer discourse may become the latest form of sexual imperialism, as the authors generally take Anglo-American realities as their basis and tend to ignore local sexual cultures. They posit a unilinear development, 'from the West to the Rest', as Wekker (2006) argues. Authors like Adam et al., who speak of 'national imprints of a global movement' (1999: 368), or Altman, who posits 'the apparent globalization of postmodern, gay identities' (1996), assume an ongoing process of 'global queering', in which behaviours and identities are spreading from Amsterdam, New York and Sydney to the global South. These authors seriously underestimate the persistence of local gender regimes. Their hegemonic discourse marginalizes non-western, non-urban settings.

Apart from its ethnocentrism, global queer discourse ignores the differences between the experiences of male-bodied and female-bodied persons in same-sex relations. Gender issues, women's economic deprivation and, in general, the 'patriarchal dividend'

¹ In this article I will use South and West not as geographical terms but as concepts indicating a particular economic, social and cultural reality. Thus 'West' refers to the developed world and includes for instance Australia, while 'South' or 'global South' refers to the less developed world (in economic terms).

discussed by Connell (1995 and 2001) cannot be simply dismissed (Wieringa & Blackwood 2007). Women's and men's trajectories in relation to heteronormativities are vastly different. Ignoring this gender component is, I would argue, yet another attempt to depoliticize the power of feminist discourse.

Health risks

I will base my analysis of health risks for WSW both on secondary sources, mostly evidence-based research on western women and on recent fieldwork with Women having Sex with Women (WSW), in Southern Africa in (2003), and in Jakarta, Indonesia (2002 and 2004).²

The silence on health concerns of WSW in the western world is considerable. A review article by McNair (2005) indicates gaps both in the literature and in (socio)medical practices regarding health needs and the responses of medical providers. If in the western world health providers find it difficult to respond adequately to the need for information and help on the prevention of STI's, including HIV infection, and on issues related to relationships and trauma healing, these problems are exacerbated in many countries in the global South, as I will illustrate below.

McNair explored two persistent myths around WSW. The first is that WSW are rather immune to the transmission of STI's if they don't engage in other risky activities such as drug use or sex with men. The second is that the prevalence of partner abuse is low. Yet data reviewed by McNair indicate that the prevalence of STI's among WSW in the West is as high as that of heterosexual women. As UNAIDS reports, women comprise about half of all people living with HIV worldwide (www.unaids.org 2004). Although data on STI's cannot be directly extrapolated from data on HIV, the sources reviewed by McNair indicate that WSW are at risk for both STI's and for HIV infection. This may partly be due to a (past) history of sex with men or to substance abuse, but various forms of sexual activities that WSW engage in also carry risks of transmission of infections such as HSV (Herpes Simplex Virus, in oral to genital contact), the transmission of blood-borne viruses, candida, and bacterial vaginosis.

Yet, as McNair found, WSW have little knowledge of such risks, and when they have

² In both cases life stories of WSW were collected. In Southern Africa the interviewees were nine young self-identified lesbians of six countries, who each collected 3- 5 life stories in 2003. In Jakarta I conducted the interviews myself in two periods of fieldwork in 2003 and 2004, working with a community of butch/femme identified women whom I have known for over 20 years. The Africa material has been published (Morgan & Wieringa 2005), while the Jakarta interviews are under analysis.

it, they show lower levels of protection. Regarding cytology for cervical cancer, the rates of which are as high for heterosexual women as for WSW, the screening rate is much lower for WSW. Thus the myth that WSW are immune to infection of STI's and HIV leads to lower levels of awareness of such risks, and to lower levels of protection.

As the assumption of vulnerability guides current surveillance categories of HIV infection, it is important to take a closer look at the WSW invulnerability myth. As Dworkin (2005) found, based on 2002 US data, heterosexual contact accounts for approximately 60% of identifiable cause of HIV/AIDS transmission among women. However, she argues, cases of possible female-to-female transmission are conveniently ignored or classified under heterosexual transmission. The current HIV research in the US does not inquire about women's same-sex contacts. Bisexual women are commonly classified as being infected through their heterosexual contacts. Although the CDC (Centres for Disease Control) report cited by Dworkin lists vaginal secretions and vaginal blood as potentially infectious, and mucous membrane (e.g. oral, vaginal, penile) exposure to these secretions has the potential to lead to HIV infection, information about whether the woman had sex with women is missing in half of the case reports (Dworkin 2005:620.)

Yet WSW engage in various risky practices such as tribadism, where women rub the wettest part of their genitals together, or oral sex with women who ejaculate (Ramos 1997 and Darling et.al. 1990, quoted in Dworkin 2005:620). Sharing sex toys without cleaning them between partners, as well as cunnilingus without a protecting barrier, are also risky practices. Health care providers who are unfamiliar with these practices or uncomfortable to discuss them may not ask the relevant questions, and thus fail to diagnose possible female-to-female transmission (Arend 2005).

There are other relevant other issues regarding situations in which WSW may be at risk. Fethers e.a. (2000) found that WSW are more likely than non-WSW to report sexual contact with a homosexual or bisexual man (quoted in Dworkin 2005:619; an interesting question is whether this contact can be classified as 'heterosexual'). In general it is found that women identified as lesbian tend to have more sexual partners. A survey found that lesbians averaged more male sexual partners than heterosexual or bisexual women during one given year (2.4, compared to 2.2 for bisexual women, and 1.5 for heterosexual women), and reported the highest prevalence of intercourse with bisexual men (London 2006: 54). Factors that increase the prevalence of risky behaviour include drinking, drug use, and poverty. The correlation between sexual minority status and drug use is significant. Young et al. reported that sexual minority women are more than twice as likely to be HIV-infected as other injectors. Studies in the US consistently found that poor, lesbian women of color have the highest HIV prevalence among women in the country (Arend 2005, Dworkin 2005, Young e.a. 2005).

All these studies, most of them conducted in the West, disrupt the myth that WSW are the category at lowest risk of STI and HIV infection. The invisibility of WSW in HIV

discourse means that they are ignored by researchers and health providers, as well as by AIDS activists, while they are less likely to practice safe sex (see also Dolan 2005).

Qualitative findings

Qualitative research can shed more light on the processes behind the statistics. In my own research in southern Africa and in Indonesia I found that the women engaging in same-sex relations hardly engage in protective behaviour, except when they know their partner is infected with HIV (South Africa).³ The women interviewed reported no health-seeking behaviour in relation to STI's. They knew there were no services available for them, feared the stigmatizing conduct of medical personnel and very few reported ever having gone to a doctor or a clinic for STI care or prevention services, apart from HIV testing. Younger, higher educated women might seek information on the internet. However, their online activity was mostly in the search for partners or guidelines about sexual practices. In any case, as reported by McNair, they were seldom able to find information on these matters in the Internet.

Apart from sexual practice, other issues are at play as regards to the risk of infection by HIV and other STI's for WSW. Those are homophobia, violence, and the desire to get children. All these are gendered phenomena and manifest themselves differently in various contexts. Compounded by economic deprivation, limited education (many butch-identified women leave school early, as they refuse to wear school uniforms), as well as the ignorance or hostility of health providers, it is clear that WSW are faced with multiple health risks in an often hostile environment. When out (publicly identified as homosexual), lesbian women face various risks, including physical violence and rape. Butch women may be raped as a punishment for their transgression, femme women in order to 'teach them a lesson'. One Namibian interviewee, referring to being in a relationship with a woman, said there are good and bad things about it: the good thing is, according to her, that you don't get diseases, the bad thing is male aggression.

One negative thing is men in the community are watching our kind of people, because you don't want relationships with men and are together with a woman. They think I must rape that woman, or if men have Aids rape me and give me the disease as well, or think men did not stay in a good way with lesbian women so I have to do this to get them. ...

They think women pretend to be men because other men did not treat them

³ Yet in South Africa the risks of being infected are high, and lesbian women are particularly vulnerable due to punitive rape (Nel & Judge 2008, Morgan & Wieringa 2005).

well - so I will get her so she will stop that thing. The benefit is that I think that one is protected from diseases (Khaxas & Wieringa 2005:136).

Homophobia-related trauma

Probably the most vulnerable period for a lesbian woman in the West is when, as a young woman, she discovers her attraction to other women. Services available to them are few, also in the West. although many of them access the web for information and support. Confronting peers at school, parents and society may cause great stress, also in a country such as Holland where lesbian and gay marriage are legal. In many countries in the global South this is exacerbated by overt expressions of homophobia. The interviews I conducted with women in same sex relations in Jakarta revealed that almost all of them had experienced great distress, ranging from loneliness to physical abuse. Ironically, the few women who escaped such censorship were the ones who, already at an early age, expressed such convincing forms of masculine behaviour that they were accepted by their parents as such.

In the Africa project, a woman from the Ovambo group in Northern Namibia tells the following story:

... if someone should find out that I am gay, all right, they will get together...then they will bring you, put you in the middle and ask you questions. If you don't answer according to the question that was asked, then they will ground you...You will be tied to a tree, all right? You know? You will stay like that for 3-4 days. Just like that. You will eat or drink nothing...They take it that when they untie you, you will tell the truth about why you are doing it. Because they say a man may not sleep with a man and a woman may not sleep with a woman. But for us that have those feelings, we will never understand it... (Isaacks & Morgan 2005:89).

Another interviewee tells of the extreme loneliness she experienced because of the community response to her feelings towards other girls:

Rejection, harassment. Not physically but verbally. A lot at school, high school... Even at home in my location people would call me lesbian, you know. That's why I pulled away from people and stayed always on my own. You know, weekends, the youth in my location would go clubbing. I'd rather go to town and sit at the museum just to get away from the people. (Isaacks & Morgan 2005:90/91)

Homophobia and religion

Post-colonial authorities and religious leaders are in general vehemently op-

posed to same-sex relations, particularly in Africa. In Jakarta I found that most femme women found it easier to relate to Islamic teachings than the butch women I interviewed. This leads butch-identified women to harbour internalised feelings of guilt and self-hatred. Likewise the Christian church condemns women's same sex relations, also in the Damara culture (Namibia), where in the past women's friendship bonds were institutionalised (Wieringa 2005b). One of our respondents didn't accept the homophobia she was confronted with, and fought back. Being an active church member, she felt hurt by the hostility she experienced from a church leader.

God who has made this creation must provide help. ...I told him [the preacher] that in his congregation there are people like that and I am also of that kind, but I don't want to publicise myself before the people (Khaxas and Wieringa 2005:140-1).

This was an effective intervention; the priest stopped his homophobic behaviour. Other Damara respondents also related their confrontations with church leaders, in which they met with similar success. This example shows that when women in same-sex relations are strong enough to confront the homophobia in their surroundings, they may be able to create a more tolerant discourse. However, they receive no help from social workers or community leaders for that task, having to find the strength themselves, or in a lesbian support group.

Homophobic responses vary whether they are directed towards MSM or to WSW. In Indonesia, effeminate men have a certain niche in society, as waria or banci (Atmojo 1987, Koeswinarno 2004).⁴ Masculine women don't have such a niche, though they may be accepted on the condition that their sexuality is never brought to public scrutiny (Wieringa 2005a). A few years ago the Ardhanary Institute, a lesbian advocacy group that includes butch women and their femme partners among its members, was set up in Jakarta. Since then, other lesbian rights groups have become active.

Violence

WSW suffer from various forms of violence, ranging from community vio-

⁴ Waria comes from the Indonesian words wanita (woman) and pria (man); it means a male-bodied person who behaves like a woman and usually has sex with other men. Banci is a Javanese word originally referred both to male-bodied and female-bodied transgender. It is currently used mostly for male-bodied persons.

lence, rape and incest, but also from relational violence. Almost all the lesbian-identified women in South Africa we interviewed had experiences with male aggression, whether incest or rape. Health services are hardly available to WSW who experience violence. Women in same-sex relations both in Africa and in Indonesia generally mistrust the health providers in their countries, due to negative experiences with them. In Indonesia, for instance, it is still common for WSW to be sent for psychiatric treatment due to their sexual orientation. Only one of our African narrators reported having gone to a therapist who was sensitive to the issue; while all the others dealt with their traumas on their own. This loneliness and rejection is also common in Jakarta.

In extreme cases women are driven to suicide. One of our Namibian informants left her native town because her mother feared she might be driven to commit suicide because of the social stigma attached to her way of living. She knew a young woman who had actually committed suicide.

...when I was operated the first time there was a girl, she came to the hospital three times one after another. She suffered from headaches, and while she had headache the parents of the girl would say "this man.... this man....," ... and she could not take it any longer and wrote a letter, one to the pastor and the other one to the police and one for the parents that she cannot change the fact that she loves women, that it is better if she takes her own life so she can die and no longer be in the way of the parents. When she was there the doctors asked her whether they would tell her parents about the fact that there is something male in her, because when she came to the hospital she told the doctors about those things. Her headache was only when she was at home because she was not at peace... so she had a disease of not being at peace. The parents were brought from their home town with their travel paid by the state and the doctors told them whatever they told them. They were adult enough to understand but in the train on their way back they said "it's because of this man that we went to Windhoek and that because of this man....," everyone in that compartment was told. When they got to Luderitz the girl wrote the letters I mentioned before and hanged herself... (silence). The letter was read at her funeral and the parents while they could not change anything regret what they have done (Khaxas & Wieringa 2005:132).

In this case doctors tried to intervene, but what exactly they did is unclear, and in the end their intervention was ineffective, perhaps counter productive. This may be due to a lack of empathy or knowledge about the extent of the homophobia in the community.

Getting pregnant

Women are under great pressure to marry a man. In many countries in Africa they must provide their fathers with lobola (bride-price) and grandchildren. Also in Indonesia, women are supposed to have children. Yet trying to get pregnant is precisely a sexual practice that carries a high risk of HIV and other STI infection. Most of the women's same-sex couples interviewed in both research projects expressed the desire to have children. Only in one case (Jakarta) was a child adopted. Often the femme partners had already brought children to the relationship, and in several cases children were born during the relationship. This created, however, a number of contradictions. Neither in Southern Africa nor in Indonesia was it possible to access artificial insemination services. Younger, higher educated lesbian women are able to find the necessary information on the internet, but for that option was not available to our interviewees. Pregnancies sometimes were not planned at all. As McNair (2005) also found, WSW are ambiguous in their relation to contraception services. They are not used to making love while using contraceptives, so they often forget to use them in occasional heterosexual contacts as well.

One of our narrators reflected on her lover's pregnancy:

What made her vulnerable was that in the time she was with me she never used contraceptives or never even considered it. So obviously she walked into the other relationship with that mentality and then she fell pregnant... (Isaacks & Morgan 105:104).

Due to lack of information and lack of attention to issues of women in same-sex relations on behalf of health providers, it is difficult for WSW to know how to get pregnant with the least risk. Also, as is the case for heterosexual women, negotiating safe sex with male partners is often difficult, also in cases where one of the partners is HIV-positive.⁵

Health care providers' attitudes

The hetero-sexism and homophobia of health care and other personnel who provide care for HIV/AIDS patients and WSW in general, has serious effects. That is especially the case with women from the lower income brackets, whose

5 Irwan Hidayana, of the Amsterdam School of Social Science Research - ASSR, is conducting a research project on this topic in West Java.

knowledge about bio-medical aspects is – at best – vague. One of our respondents once stayed in hospital for three months on what at first appeared to be an ovary infection. The lengthy excerpt from her story below illustrates about the arrogance of medical personnel and the helplessness of the lower class women subjected to their interventions.

I became ill with my ovaries and then my stomach swelled up, and when I got there for examination they said it was possibly a pregnancy, but I knew that all these years I had never slept with men, how could I become pregnant? I told the doctors that I was not pregnant, that I didn't have a man and that it was impossible. They asked "How come that you don't have a man?" I don't know how old my daughter was by then. I told them to operate on me because I was in so much pain... All the women who were with me in the hospital were discharged and I was alone all by myself. I was now healthy - why was I still in the hospital? Then they would say "We are looking for something, we are looking for something ..." and I would say "What is it that you are looking for and which you don't find?" ...I stayed there for three months, they were examining me and examining me but they discharged me without telling me anything. I went back to the hospital when I had a continued headache, and when they got my file they were examining the old mysterious disease. I asked a German doctor "What is going on with me, my head is sore but you don't care about that and you are only interested in the operation that has already been done - what is the problem? ...they showed me films, they did not say what they were looking for. They showed me films of men who are sleeping with other men, and they could not understand that I did not have any interest in those things... of men with men and women with women... While I did not know what was going on in my life they showed those things to me, when they were supposed to tell me what was precisely going on in my life. When I asked about that... They told me that my hormones were not good and the head is sore continuously and so on so on, and that this would only be corrected when I am operated on. And I said "What precisely would I be operated on?" They asked me why I don't have relationship with men and I said I did not come to the hospital to find men - I came because I have pain - "If there is any reason why I should have relationship with men then you should tell me." At that time I was with Alwina and every time they met her they would ask "Is this your sister?" and later I told them "She's my woman" and then they said "This is what we found in you, something is not right with you, it's impossible why a young person like you doesn't have relationships with men and why you have only one child." I said it wasn't my problem and that it also was not their problem and that they should only help me with my headache and the pain in the stomach. They said they could operate on me because the headache was continuing... When I was to be operated I

was supposed to leave Namibia, and go and stay in a country in which the people don't know me. I said leave it and let me die if necessary.

...the doctors said that male hormones are strong in my body and when I asked why it is like that they said that in some people, male hormones are strong in a woman and an examination shows whether it can be changed or not, and I said "Let this be, I am okay, I have relationships with women and I don't have a problem." (Khaxas & Wieringa 2005:165/6).

Dolan (2005) and McNair (2005), among others, likewise report that health care providers do not always have appropriate information themselves. Coupled with the lack of respect shown to their patients as evidenced in the above narrative, this may lead women with same-sex desires to avoid approaching medical personnel.

Conclusion

WSW in the global South have specific health needs which are different from both heterosexual women's and MSM's. These relate to issues such as vulnerability to STI transmission, as well as to the context of socio-medical care. The findings of the two research projects discussed in this article demonstrate that the health needs of WSW are seldom met, and in a partial manner. The myth that women in same-sex relations are at lower risk of STI and HIV infection cause health providers to ignore the specificity of WSW sexual practices, and prevents women in same-sex relations from taking their health needs seriously. This is compounded by lack of information, economic deprivation, homophobia, marginalisation and other socio-cultural factors. Based on secondary sources on WSW health needs in the global West, and on the data gathered in our life-story interviews with women from Jakarta and southern Africa, we have concluded that most health providers have neither enough knowledge about the specific health needs of WSW, nor empathy with their problems. Even in cases where they show some sympathy, their efforts are often dramatically misdirected, which points to a lack of communicative skills.

There is also a serious gap in research methods. Women in same-sex relations are often not asked the relevant questions about sexual practices. This is compounded by the fact that women in same-sex relations are not easily reached by the sampling methods used in MSM research. WSW are not visible in the public space as much in the ways and to the extent that MSM are. Researchers have to adapt their research methods to fit WSW's social patterns.

The only assistance WSW get comes from some lesbian human rights organi-

zations, but their funding is limited, and their knowledge and skills are far from sufficient. The myth that WSW do not engage in risky sexual behaviour means that lesbian groups have fallen outside the funding for HIV/AIDS projects. Lesbian rights groups need more training and more funds to provide sufficient services to the WSW they work with. They also need help to reach out to other networks of women living in same-sex relations. Those groups are the ones WSW turn to first and often the only ones they can trust.

As the prevalence of HIV-infections is not an isolated phenomenon, prevention must take into account the complexity of the WSW experience. Without attention to the wider and multiple issues of marginalisation, economic deprivation and stigma, a narrow focus on health concerns and safe sex practices is only bound to fail.

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