Sexual practices, identities and health among women who have sex with women in Lesotho - a mixed-methods study

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Despite the high prevalence of HIV and STIs among women in Africa and the growing literature on HIV and STIs among women who have sex with women, research on the sexual health of women who have sex with women in Africa is scant. This study used mixed methods to describe sexual identity, practices and health among women who have sex with women in Lesotho. Most respondents (48%) described themselves as lesbian, 29% as bisexual and 23% as heterosexual. Almost half (45%) had disclosed their same-sex attraction to family, but only 25% had done so with healthcare workers. A total of 8% reported having HIV. Self-reported HIV was associated with having three or more male partners, having male and female partners at the same time and having a history of STIs. Gender norms, the criminalisation of homosexuality, varied knowledge of, and access to, safer-sex strategies, and mixed experiences of HIV/STI testing and sexual healthcare provided social and structural contexts for HIV- and STI-related vulnerability.

Keywords: African sexuality; HIV/AIDS; sexually transmitted infections; women who have sex with women; homosexuality

Introduction

Lesotho is a small, low-income, mountainous kingdom completely surrounded by South Africa (MOHSW and ICF Macro 2010). Health services challenges in Lesotho include limited coverage of cervical cancer screening as well as the need to further integrate sexual and reproductive health with HIV services (MOHSW and ICF Macro 2010; MOHSW, UNFPA, and European Union 2012; Mwase et al. 2010).

On its website, the International Lesbian, Gay, Bisexual, Trans and Intersex Association (http://ilga.org) states that ‘Intentional sexual relationships per anum between two human males’ is illegal in Lesotho. The Lesotho penal code is silent about female same-sex practices. However, as in other places in southern Africa, lesbian-identified women are subject to social prejudice and discrimination (Bonthuys and Erlank 2012; Lorway 2006; Ntabe 2010). Despite this stigma, anthropologists have documented a historic and widespread rural practice of ritual recognition of erotic friendships between women as recently as the 1950s (Gay 1986; Kendall 1998). More recently, anthropologists have described sexually intimate ‘mummy-baby’ relationships between young women in southern Africa that replace or accompany heterosexual bonds prior to marriage (Kendall 1998, 231).
At 23%, adult HIV prevalence in Lesotho is one of the highest in the world and even higher among women, at 27% (Lesotho National AIDS Commission 2012). While access to testing for sexually transmitted infections (STIs) is low, 4% of adults in Lesotho report diagnosis with an STI and 15% of adult women report symptoms of an STI (MOHSW and ICF Macro 2010). Despite the disproportionate burden of HIV/STIs among women in Africa, women who have sex with women are often assumed to be ‘low risk’ and have historically been excluded from public health discourse on HIV and STIs (Dworkin 2005; Logie et al. 2012; Logie and Gibson 2013; Power, McNair, and Carr 2009; Richardson 2000).

Data from several countries indicate that women who have sex with women engage in sexual practices that can increase their vulnerability to HIV and STIs (Gorgos and Marrazzo 2011; Lee and Hahm 2012; Mora and Monteiro 2010; Muzny et al. 2011; Schick et al. 2012; Singh, Fine, and Marrazzo 2011; Wang et al. 2012), including unprotected vaginal and anal intercourse, multiple partners, genital rubbing and sex while intoxicated, and some may be susceptible to HIV and STIs from both female and male partners. Some studies suggest that women who have both male and female partners may be more vulnerable to HIV and STIs than women with exclusively male or female partners (Bauer, Jairam, and Baidooobonso 2010; Steele et al. 2009; Xu, Sternberg, and Markowitz 2010).

Despite the high prevalence of HIV and STIs in Africa and the growing literature on HIV and STIs among women who have sex with women, we found few studies of HIV and STIs among women who have sex with women in Africa (Cloete, Sanger, and Simbayi 2011; Matebeni et al. 2013; Sandfort et al. 2013). Matebeni and colleagues (2013) conducted qualitative interviews with 24 African lesbians with HIV in South Africa, Zimbabwe and Namibia who encouraged health services to be more responsive their needs. Cloete, Sanger and Simbayi (2011) presented quantitative data from 72 HIV-positive women who have sex with women in South Africa, demonstrating that same-sex desire was no protection from HIV. Sandfort et al. (2013) explored HIV testing and sexual practices among 591 women who have sex with women in Botswana, Namibia, South Africa and Zimbabwe. Self-reported HIV prevalence was almost 10% and forced sex emerged as an important risk factor.

These studies begin to build evidence for addressing HIV among women who have sex with women in four African countries. However, gaps remain in understanding the sexual health and practices of women who have sex with women in other African countries. To address this gap, we analysed data from a study among sexual minorities in Lesotho. We sought to describe sexual identity and sexual practices among women who have sex with women, and to determine the prevalence and correlates of STIs and HIV in this population.

Methods

Study design

A community-based participatory approach was taken in this mixed-method, cross-sectional study. The Matrix Support Group, a lesbian, gay, bisexual and transgender organisation in Lesotho, partnered with academic researchers in the design, data collection and analysis. This analysis includes data from women who had sex with women, regardless of sexual or gender identity.

Study population and sample

Eligibility criteria included being 18 years of age or older, born female and reporting a history of sexual contact with a woman in the previous 12 months. Participation required
the ability to understand and provide informed consent in either Sesotho or English. A total of 250 women completed the structured questionnaire.

Focus group discussions (FGDs) were held with a subset of women who completed the questionnaire. Six to eight people participated in each of three focus groups for a total of 21 FGD participants. One FGD took place in each of three cities, Maseru (the capital), Mafeteng and Maputsoe. The FGD in Maseru was intentionally limited to married women who have sex with women in order to provide a safe space for this more hidden population to participate without experiencing the stigma known to exist between married and unmarried women who have sex with women. The other two focus groups were open to all women who met the eligibility criteria, regardless of marital status.

Ethics approval and funding
Ethics approval was received from the Ministry of Health and Social Welfare in Lesotho as well as the Institutional Review Board at The Johns Hopkins School of Public Health. This study was a joint initiative between the offices of UNAIDS and UNDP in Lesotho. The UNDP provided financial support and UNAIDS provided technical and project management support.

Study accrual
Accrual took place from October to November 2009 in four urban centres in Lesotho (Maseru, Mafeteng, Hlotse and Maputsoe). Fifteen initial participants recruited subsequent participants via network-referral (Penrod et al. 2003). The initial participants came from the Matrix Support Group and functioned as the study interviewers. They were chosen based on motivation and ability to articulate clearly the purpose of the study to their peers. One of these participants also served as facilitator for the FGDs.

To minimise bias, the initial participants completed the study questionnaire before the two-day training that included the purpose of the research, design of the research project, human subjects protection, interviewing methods and data integrity. Initial participants recruited 10–15 members of their social network. Each new participant then recruited others until the desired sample size was achieved. In addition to a salary, each interviewer received 45 Maloti (6.50 USD) per interview to cover the costs of transportation and refreshments for the participants. Verbal consent was obtained from each individual prior to taking part in any research activities. Following the provision of consent, each participant completed a structured interview using the study questionnaire. Those who expressed interest and met criteria were scheduled to attend a FGD. Focus group participants were remunerated with 20 maloti (3.00 USD) to cover transportation.

Data collection
A structured survey instrument containing 45 questions was developed in consultation with community members, the National AIDS Commission, the Ministry of Health, UNAIDS and the UNDP. Domains covered demographics, relationship patterns, sexual practices, self-reported HIV status and STI history. The instrument was piloted with leaders of Matrix and adapted based on feedback. Trained members of the local community of same-sex attracted women conducted face-to-face interviews in Sesotho. Each interview lasted approximately 30 minutes and collected no personally identifiable information.
The FGDs were conducted using a field guide developed in consultation with community members. Domains included sexual identity, sexual practices, relationship patterns and social context for women who have sex with women in Lesotho. All FGDs were facilitated by the same trained group facilitator, chosen based on her trusted role in the community. Each focus group lasted 60–90 minutes, with an average duration of 75 minutes.

**Statistical analysis**
Quantitative data were analysed using Stata 11 (StataCorp, College Station, TX). Means, ranges and frequencies were calculated for demographic and sexual health variables. Bivariate analyses included two-sample tests for differences in proportions, $\chi^2$ tests of independence, and logistic regression assessing the relationship between covariates and outcomes of interest. Case-wise deletion was used to handle missing data. Variables that were significantly ($p < 0.05$) associated with the outcome of interest were reported by presenting odds ratios (OR) with 95% confidence intervals (CIs).

**Qualitative analysis**
Focus-group discussions were conducted in Sesotho, then transcribed and translated into English by a bilingual native Sesotho speaker who was part of the research team. Using thematic analysis (Braun and Clarke 2006) two separate researchers coded each transcript into topical categories to facilitate the identification of key themes. Memos were used to summarise codes and describe themes. These memos were compared and discussed between the two coders and a final list of salient codes and themes was created. Pseudonyms and ages have been provided for all quotes.

**Results**

**Demographic factors**
As presented in Table 1, the mean age of participants was 24 (range 18–52) with 34% of the sample older than 25. Most participants were ethnic Basotho (98%), one-third were currently employed and nearly three-quarters lived in an urban centre. Sixty-four percent of the sample had received tertiary or vocational school education. Forty-eight percent of the participants identified as lesbian or homosexual, with the remainder self-reporting as bisexual (29%) or heterosexual/straight (20%). Five participants (2.5%) identified as transgender. Twenty-six percent of the sample had ever been married. Over 40% had disclosed their same-sex attractions at least one family member, whereas only 25% had disclosed their same-sex behaviour to at least one healthcare worker. In total, 50% of the sample had disclosed their same-sex behaviour to either a healthcare worker or a family member.

**Qualitative results – key themes**

**Sexual identity and relationships**

*Family expectations of marriage.* Participants described how socio-cultural gender norms reinforced family expectations of marriage:

I don’t have children because I don’t really have the desire for a man, but then because of the pressures of culture you can end up falling in that trap. Living free means that if honestly I
love you, I should have the right to tell you that I love you. I am forced to live the life that isn’t mine, that a woman has to be married to a man. (Lebohang, 24 years, Maseru)

In some cases, this expectation was grounded in traditions where families would benefit financially from their daughter’s marriage:

Parents still expect that as time goes by their daughter will get married. In earlier times I could see that my mother now was raising me well, raising me for the benefit that in future her money that she spend for me to go to school, I will refund by means of me getting married and she would get cows. (Matsheliso, 30 years, Maputsoe)

Another participant reinforced this idea that family expectations of marriage led her to hide her identity:

My father will ask me exactly, ‘Are you a spinster? When exactly will you get married?’ It makes me feel as if I owe him something, maybe there’s something he’s expecting, so sometimes it puts fear in you that you’re afraid to tell parents the truth of what you are, you live your life undercover so that they don’t end up knowing. (Matelile, 27 years, Maputsoe)

Others discussed how the topic was avoided, even if their family knew about their same-sex sexual behaviour. For example, a participant who was caught in a same-sex encounter by her mother stated:

my mother hasn’t said anything, she just looks at me, it makes me wonder – is she trying to ignore the situation, or is it because she doesn’t want to talk about those things? (Lipuo, 29 years, Maputsoe)

Family expectations that daughters would marry men presented barriers to disclosing and engaging in same-sex relationships. When families did find out about their same-sex relationships, there was reluctance to discuss this issue and provide support.
Gender normative clothing. Experiencing pressure to wear feminine clothing was discussed as problematic by several participants across all focus groups. Participants were distressed by the expectations of family and community members: ‘in the community they infringe on me because they’ll say I must wear a dress’ (Sello, 27 years, Mafeteng) and ‘there’s nothing I dislike more than wearing a dress!’ (Lebohang, 24 years, Maseru). These participants said that wearing masculine clothing led to questions over their gender: ‘they definitely ask, actually is she a girl or boy? They all ask “if she’s a girl why doesn’t she wear a dress?”’ (Limpoh, 24 years, Maputsoe). These questions were perceived as constrictive: ‘I’m not free; because you see everywhere I pass I’m sure they’re saying “is this a girl or a boy?”’ (Lipuo, 29 years, Maputsoe). This social pressure at times impacted treatment by family members: ‘Let me tell you, last week my mother said she’d like to see my breasts’ (Matelile, 27 years, Maputsoe). In response, another participant said that the mother’s request could have been due to social pressure: ‘Maybe someone must have come to her mother and said “are you sure your child has breasts?”’ (Mpho, 23 years, Maputsoe).

Participants said that pressure to wear women’s clothes was exacerbated in church. A participant navigated these expectations by choosing a church service where she would be more accepted: ‘at the 10 am mass, you’ll hear them saying you should cover your heads, wear dresses, so I go to the 9 am because nobody cares’ (Matelile, 27 years, Maputsoe). These narratives highlight the distress caused by the convergence of social and family expectations to conform to gender norms through wearing typically feminine clothing.

Sexual relationships, practices and identities. Participants placed great value on committed partnerships and discussed a fluidity of sexual roles and practices. Having a loving relationship was described as fulfilling: ‘I feel good when I’m with my girlfriend you know? That is everything’s all right as long as she’s there and I can see her, I’m satisfied’ (Bongani, 20 years, Mafeteng), ‘You feel content with all your days as long as you’re with the person you love’ (Malineo, 35 years, Maseru). While participants in all FGDs valued partnership, discussions about the meaning of sexual relationships and identities differed in the FGD with married women who have sex with women compared to the other FGDs.

Participants in the FGDs that were open to unmarried women discussed having greater satisfaction if same-sex marriage were legalised and if their parents would support them marrying a female partner. These narratives indicated that same-sex marriage would allow them freedom to express their sexuality in ways that that they did not currently have:

My expectation honestly is that I want to see myself married to the person I love, living happily, and living openly not sneaking around in the country … I want it to get to a point where the situation will be like that I can get married with my person in broad daylight with people watching. (Matsheliso, 30 years, Maputsoe)

This account highlighted how social and legal validation of same-sex marriage would impact freedom in daily life. Another participant articulated: ‘If my parents can agree that I marry my girlfriend, that’s the day I’ll be satisfied’ (Pulane, 18 years, Mafeteng). Others corroborated that same-sex marriage was indicative of freedom: ‘we don’t have that freedom to date, be in love and get married’ (Mpho, 23 years, Maputsoe). Another participant discussed the notion that same-sex marriage would contribute to social acceptance: ‘when everyone sees her they shouldn’t always be pointing fingers or asking questions, they should understand that they are a person and her person’ (Mamello, 26 years, Maputsoe).
Sentiments expressed in FGDs with unmarried women who have sex with women revealed lower acceptance towards bisexual women than lesbians: ‘You know a person who’ll be dating girls and boys? I really can’t be comfortable around a person like that’ (Bongani, 20 years, Mafeteng). Other participants agreed and differentiated themselves from bisexuals: ‘I only date girls’ (Mathabiso, 21 years, Mafeteng), ‘Yes the bisexuals we don’t know what they’re doing cause we’re actually lesbians, we’re hardcore lesbians!’ (Refioe, 22 years, Mafeteng). These participants’ narratives also suggested a fluidity of sexual roles and female partners: ‘I actually date ladies and butch ones’ (Mathabiso, 21 years, Mafeteng) and ‘I penetrate, I get penetrated, I do all those roles!’ (Itumeleng, 30 years, Mafeteng). The changeability of sexual roles was perceived as exciting: ‘I like someone who’s unpredictable, who sometimes you’ll see all butch and sometimes, you’re not sure exactly what’s going on’ (Refioe, 22 years, Mafeteng).

Participants in the married focus group described how some women who have sex with women did not want to be labeled as lesbian stating: ‘She’s bi’ (Mathabo, 23 years, Maseru) and ‘She doesn’t want to identify herself as a lesbian.’ (Lebohang, 24 years, Maseru). Participants in this focus group discussed their attraction to both men and women:

It’s all the same to me, whether at this time if I love you because I say you’re a woman, and I love him because I say he’s a man, you see, it all depends on who I’m with at the time, so it’s never been a problem. (Puleng, 24 years, Maseru)

At times, husbands provided space for their partners to engage in same-sex relationships: ‘even if I am this lady’s baby [girlfriend] when I arrive at her home, her husband gives us some space knowing that the baby is visiting’ (Lineo, 28 years, Maseru). Another participant articulated feeling satisfied by being in relationships with men and women:

I live with my husband but it’s totally complete when I’ve met with a woman. I don’t even dream that tomorrow a man can be gone and I’m left with a woman only, or that a woman can be gone and I’m left with a man. No, I’m good as it is. (Mathabo, 23 years, Maseru)

Participants discussed strategies to navigate how they approached other women when they did not know if she was interested in women. Fear of rejection or negative consequences often deterred participants from approaching a woman: ‘I’ve never told anyone that I love them, never asked anyone out’ (Puleng, 24 years, Maseru), ‘I haven’t asked a chick out’ (Pulane, 18 years, Mafeteng). One participant described how she would assess clothing and words to guess if a woman would be interested in her: ‘it takes someone [with] guts, because when a person is standing there, you might be able to see that she could be the type, only to find its just attire or even language’ (Palesa, 33 years, Maseru). Others described presenting a hypothetical situation to a woman they were interested in to test her reaction:

I’ve noticed with women who date other women is that when they go to ask someone out, you first start by asking the person what they would do if a girl asked them out. Yes then sometimes you’ll hear this person saying ‘Oh my! A girl asks another girl out!’ They like to get people’s opinions, so that they can hear which way this person is leaning, if she says yes, well it’s on. (Mpho, 23 years, Maputsoe)

Safer-sex practices and HIV/STI testing

Participants demonstrated concerns regarding HIV and STI transmission and knowledge about HIV and STIs. However, they also described limited access to safer-sex materials and mixed experiences accessing HIV/STI testing services. A participant articulated fear of being sexually active: ‘when there is enough protective gear in the country, that’s when
I’ll do [sex]! Honestly I’m scared: diseases, STIs, pubic lice and so on’ (Thato, 25 years, Maputsoe). This sentiment was corroborated by another participant:

I think the first thing is to, needless whether you fall with the lesbians or bisexuals, protect yourself because if somebody’s married she has a husband on the side, she’s not sure how the other partner is living right, it can bring you something and you pass it on. (Palesa, 33 years, Maseru)

When asked about safer-sex practices, a participant described condoms, gloves and lubricant: ‘where you’re using the dildos, that’s where you can use a condom, but where you’re using fingers then you can use gloves, and also use with lubricants’ (Sello, 27 years, Mafeteng). Another participant added to this: ‘we can put them on our hands, we shouldn’t use them many times, you use it on one person and then throw it away, and with another you use a clean one’ (Itumeleng, 30 years, Mafeteng). Others described avoiding sexual activity if they had cuts on their hands: ‘we have to check for injuries on our hands’ (Mpho, 23 years, Maputsoe) and keeping their nails short: ‘if you have long nails you can cause her injury’ (Lipuo, 29 years, Maputsoe). Participants also discussed limiting the number of sex partners to reduce HIV and STI risk: ‘we should also avoid having many partners’ (Mpho, 23 years, Maputsoe), ‘there’s a person you’re dating, it should be just you two’ (Limpoh, 24 years, Maputsoe). Others described limited access to safer-sex materials: ‘they are not there here in Lesotho, sexual protection’ (Rethabile, 29 years, Maseru). This resulted in participants not practising safer sex: ‘we do it, we just see. I’ve never used anything, anything!’ (Mateboho, 24 years, Maseru). Another participant asked: ‘why don’t they invent something that can be used for women protect themselves on the mouth?’ (Lineo, 28 years, Maseru) suggesting limited knowledge of, and access to, dental dams.

Although participants reported utilising HIV/STI testing services, they had mixed feelings about their treatment by healthcare providers (HCPs). A participant reported: ‘those questions they ask us are embarrassing’ (Itumeleng, 30 years, Mafeteng). Another recommended a lesbian, gay, bisexual and transgender-specific clinic: ‘if there were to be a clinic for gays only then we’d feel protected’ (Refioe, 22 years, Mafeteng). A different participant reported positive experiences accessing sexual healthcare: ‘he [doctor] actually asked for my opinion and said it’s good for me cause without knowing that as a woman I can have an infection from the other woman, he was so understanding’ (Limpoh, 24 years, Maputsoe). Other participants described how limited knowledge of women who have sex with women among HCPs presented barriers to testing:

Maybe if you talk to someone from health department they can be able to sensitise others who don’t know that there are people like this, we have to see that maybe they also get health services because so far they haven’t showed the existence of people like us. (Sello, 27 years, Mafeteng)

Participants discussed strategies to reduce stigma when going to an HCP: ‘when I know that I’ll be injected I won’t wear boxer shorts that I’m wearing now, I’ll try to find something a bit more girlish; some things that we use to hide ourselves’ (Limpoh, 24 years, Maputsoe).

These qualitative findings demonstrate a complex constellation of factors that shape sexual identity, including gender norms, valuing partnership and a fluidity of sexual practices and relationships. Varied knowledge of, and access to, safer-sex strategies and mixed experiences of HIV/STI testing and sexual healthcare emerged as key to understanding social and structural contexts of HIV and STI vulnerability among participants.
Table 2. HIV knowledge and sexual and reproductive health characteristics of women who have sex with women in Lesotho.

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Received any information about preventing HIV infection from</td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>38.7 (87/225)</td>
</tr>
<tr>
<td>Men</td>
<td>74.4 (177/238)</td>
</tr>
<tr>
<td>Know that anal sex has greater chance of transmitting HIV than other forms of sex</td>
<td>6.3 (15/240)</td>
</tr>
</tbody>
</table>

Sexual health

<table>
<thead>
<tr>
<th>Self-reported HIV prevalence</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Those HIV-positive, being treated</td>
<td>7.7 (16/208)</td>
</tr>
<tr>
<td>Those HIV-positive, being treated with medication at clinic</td>
<td>33.3 (5/15)</td>
</tr>
<tr>
<td>Have regular male partner</td>
<td>43.0 (95/221)</td>
</tr>
<tr>
<td>Have regular female partner</td>
<td>75.8 (166/219)</td>
</tr>
<tr>
<td>In last 6 months:</td>
<td></td>
</tr>
<tr>
<td>Had both male and female partners</td>
<td>26.3 (52/198)</td>
</tr>
<tr>
<td>Active bisexuality (not regular partners)</td>
<td>40.0 (62/155)</td>
</tr>
<tr>
<td>Number of male partners in last 12 months</td>
<td>87.8 (165/188)</td>
</tr>
<tr>
<td>3 or greater</td>
<td>12.2 (23/188)</td>
</tr>
<tr>
<td>Number of female partners in last 12 months</td>
<td>79.1 (159/201)</td>
</tr>
<tr>
<td>3 or greater</td>
<td>20.9 (42/201)</td>
</tr>
<tr>
<td>Safer sex*</td>
<td></td>
</tr>
<tr>
<td>With men at last sex</td>
<td>48.0 (49/102)</td>
</tr>
<tr>
<td>With women at last sex</td>
<td>13.4 (21/157)</td>
</tr>
<tr>
<td>With both men and women at last sex</td>
<td>5.2 (4/77)</td>
</tr>
<tr>
<td>Easy condom access</td>
<td>47.7 (114/239)</td>
</tr>
<tr>
<td>Pap smear in last 2 years</td>
<td>11.9 (22/185)</td>
</tr>
<tr>
<td>In last 12 months:</td>
<td></td>
</tr>
<tr>
<td>Were tested for HIV</td>
<td>63.0 (148/235)</td>
</tr>
<tr>
<td>Experience symptoms of STI</td>
<td>12.4 (24/194)</td>
</tr>
<tr>
<td>Diagnosed with STI at clinic</td>
<td>4.0 (9/222)</td>
</tr>
</tbody>
</table>

*Safer sex was defined as use of a condom with male partners and use of a latex dam with female partners.

Quantitative results

As illustrated in Table 2, 76% of the women who have sex with women who completed structured interviews had a regular female partner and 43% reported having a regular male partner (e.g. husband, boyfriend). Twenty-six percent of women who have sex with women reported both a regular female partner and a regular male partner and 40% reported both male and female sexual partners in the previous 12 months. A total of 12% of all women reported three or more male sexual partners in the last year and 21% reported three or more female partners.

Forty-eight percent of the respondents reported using condoms with their last casual or regular male sexual partner, 13% reported using dental dams with their last casual or regular female sexual partner. Only 5% of women reported use of latex barriers (condoms or dental dams) at last sex with both men and women. Access to condoms was mixed, with about half reporting easy access to condoms. However, one-quarter reported having no access to condoms when they were needed. The majority (74%) had received some information about preventing heterosexual HIV and STI transmission, but only 38% had
received any information about HIV and STI prevention during sex with women. Less than 10% of respondents knew that anal sex presented the highest risk for sexual transmission of HIV. Almost half of respondents reported that oral, anal and vaginal sex all carried equal risk.

Sixty-three percent of the respondents had received an HIV test in the past year and slightly fewer than 8% self-reported being HIV-positive. Thirty-three percent of HIV-positive women reported that they were being treated for HIV, of which four out of five were being treated with medicine at a clinic. One out of eight women in the full sample had experienced symptoms of an STI (e.g. vaginal discharge, sores on or around the vagina) and 4% reported having been diagnosed with an STI. About 12% reported having had a Papanicolaou test within the preceding two years.

In the bivariate analyses presented in Table 3, self-reported HIV infection among study participants was significantly associated with having concurrent male and female regular partners (OR 2.9, 95% CI 1.0–8.7), having three or more male partners (OR 4.8, 95% CI 1.3–17.8), having been diagnosed with an STI (OR 22.3, 95% CI 4.7–105.5, p < 0.01), having had symptoms of an STI (OR 12.4, 95% CI 3.6–42.4), and, having had a pap smear in the last two years (OR 5.7, 95% CI 1.5–21.8) and ever being married (OR 4.4, 95% CI: 1.5, 12.7). Older age (OR 4.7, CI 1.8, 12.2) and having three or more male partners (OR 3.5, CI 1.1, 11.3) were both associated with being diagnosed with an STI at a clinic.

**Discussion**

To our knowledge, this is the first study to characterise sexual identity, behaviours and sexual health among women who have sex with women in Lesotho. Qualitative findings highlight how gender norms and stigma against homosexuality shape the lived experiences of women who have sex with women in Lesotho, in particular the limits on freedom to express themselves and live openly in same-sex relationships. While participants described fear, and knowledge, of HIV and STI transmission, they discussed limited access to safer-sex materials and reported mixed experiences accessing sexual health

<table>
<thead>
<tr>
<th>HIV status</th>
<th>OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concurrent male and female regular partners</td>
<td>2.9 (1.0, 8.7)</td>
</tr>
<tr>
<td>Have 3 or more male partners</td>
<td>4.8, (1.3, 17.8)</td>
</tr>
<tr>
<td>Ever been married</td>
<td>4.4 (1.5, 12.7)</td>
</tr>
<tr>
<td>Diagnosed with STI at clinic</td>
<td>22.3, (4.7, 105.5)</td>
</tr>
<tr>
<td>Experienced symptoms of STI</td>
<td>12.4, (3.6, 42.4)</td>
</tr>
<tr>
<td>Had pap smear in last 2 years</td>
<td>5.7, (1.5, 21.8)</td>
</tr>
<tr>
<td>Disclosed same-sex practices to health worker</td>
<td>12.1 (3.7, 40.0)</td>
</tr>
</tbody>
</table>

**Sexually transmitted infections**

<table>
<thead>
<tr>
<th>Age 25 years and older</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosed with STI at clinic</td>
<td>4.7 (1.8, 12.2)</td>
</tr>
<tr>
<td>Experienced symptoms of STI</td>
<td>14.1 (1.7, 117.1)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Have 3 or more male partners</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosed with STI at clinic</td>
<td>3.5 (1.1, 11.3)</td>
</tr>
<tr>
<td>Experienced symptoms of STI</td>
<td>5.8 (1.3, 26.4)</td>
</tr>
</tbody>
</table>
services, where they often felt healthcare providers were unprepared to work with them and at times discriminatory. Pressure to marry men and produce children, lack of opportunities to marry female partners, healthcare providers who were unprepared to address their sexual health needs, and lack of access to appropriate safer-sex commodities all influence women who have sex with women’s ability to protect themselves from HIV and STIs. These findings are consistent with other studies that have described the social and structural contexts of HIV and STI vulnerability among sexual and gender minorities (Baral et al. 2009; De Santis 2009; Kazatchkine 2011; Parker, Easton, and Klein 2000).

The quantitative data confirm that women who have sex with women are vulnerable to HIV and STIs. As expected, women who had been diagnosed with or who had symptoms of an STI were more likely to report HIV compared to others. Women with higher numbers of male partners were more likely to have been diagnosed with or had symptoms of an STI. Self-identity as a lesbian was not associated with a lower likelihood of HIV or STIs, highlighting the importance of behaviour rather than identity in vulnerability to HIV and STIs. Nearly half of the women sampled had male partners. As described in previous studies among women who have sex with women in low-income settings (Cloete, Sanger, and Simbayi 2011; Lenke and Piehl 2009), these data highlight how identity-based risk categories for HIV render women who have sex with women invisible and obscure the importance of considering the range of sexual behaviours among women who have sex with women, including sex with male partners.

Having both a male and female current regular partner or having a higher number of male sexual partners in the preceding 12 months was significantly associated with self-reported HIV status. Unfortunately, this data do not allow a distinction between short-term serial monogamy and longer-term concurrent relationships. The difference may be important for developing interventions, since the social incentives for each may differ (Mah and Maughan-Brown 2013).

Despite vulnerability to HIV and STIs, more than 25% of the women had never received information about how to prevent HIV and STI transmission with male partners and 61% had never received information on HIV and STI transmission with female partners. Even in the face of well-known associations between the presence of STIs and increased risk for HIV, women who had received an STI diagnosis were not more likely to have been given information on HIV and STI prevention. This suggests that clinicians missed an important opportunity to provide prevention information to women who were clearly susceptible.

These missed opportunities make it unsurprising that condom use with men was not consistent and use of latex barriers during sex with women was uncommon among women who have sex with women. Given that much of the risk for women who have sex with women is associated with male partners, it is critical to note that less than half of the respondents reported using condoms with their last regular or casual male partner. Furthermore, 25% of the respondents reported having no access to condoms when needed. Condom access was much better in urban centres and, in turn, condoms were used more frequently by women residing in cities. This corroborates previous literature describing increased access to HIV-prevention services in urban compared to rural areas (Papo et al. 2011) and underscores the importance of enhancing access to safer-sex information and commodities outside of urban centres.

Studies in higher-income countries have found that women who have sex with women are less likely to access healthcare, including STI and HIV screening as well as pap smear screening (Charlton et al. 2011; Kerker, Mostashari, and Thorpe 2006; Marrazzo 2004; Marrazzo et al. 2001; McIntyre, Szewchuk, and Munro 2010). In this study, HIV testing
and receipt of pap smears served as markers of access to health services. Sixty-three percent of women reported having been tested for HIV in the last year and this was highly associated with positive HIV status. Similarly, HIV infection was more common among those who reported having had pap smears. Hence, both markers of access to health care were associated with self-reported HIV status. This association raises the question of how many women are unaware of their HIV status because of infrequent access to healthcare or access to suboptimal care.

Consistent with studies that critique the notion of high- or low-risk behaviour (Pinto et al. 2005), the participants in this study reported a combination of intersecting and overlapping factors that increased their vulnerability to HIV. A growing body of literature highlights the structural factors that increase HIV vulnerability among sexual minorities (Baral et al. 2009, 2011; Logie et al. 2012; Poteat et al. 2011). Our findings indicate that structural barriers such as social stigma, inadequate access to health services and inadequate sexual health information from healthcare providers limit the ability of women who have sex with women in Lesotho to adequately protect themselves from HIV and STIs. Studies among men who have sex with men have demonstrated the need to address multiple levels of HIV- and STI-related vulnerability (Fay et al. 2011; van Griensven et al. 2009). Likewise, effective interventions for women who have sex with women need to address the layers of marginalisation that increase their vulnerability to HIV and STIs.

**Limitations**

Limited resources and the constraints of working with a small community-based organisation in difficult social environments restricted the scale and scope of this study. While FGDs provided an opportunity to examine the lived experience of women who have sex with women in Lesotho, it is possible that participants were unwilling to share socially unacceptable views or experiences in a group setting. The cross-sectional nature of the data precludes making causal inferences, and the use of non-probability sampling limits the generalisability of the results. Missing data was common for questions about sexuality and STIs, suggesting participants were hesitant to respond to sensitive questions during face-to-face interviews. The use of anonymous methods may have resulted in less missing data. Limited sample size precluded multivariable analyses to assess independent predictors of self-reported HIV status.

While transgender identity and same-sex sexual orientation are not mutually exclusive, the structure of the quantitative survey instrument required respondents to select only one of the following options: lesbian/homosexual, bisexual, straight/heterosexual or transgender. Therefore, we have no information on the sexual orientation of the five respondents who identified as transgender. As noted by Parker (2009) in a recent review of sexuality research, ‘... notions of gender, and of gender identity, have increasingly been called into question. What it is to be male or female, masculine or feminine, in different social and cultural contexts may vary greatly and gender identity is clearly not reducible to any underlying biological dichotomy’ (257). Indeed, the first author has conducted unpublished qualitative research among transgender adults who felt comfortable identifying as both lesbians and as transgender men.

**Conclusion**

Women who have sex with women in Lesotho are vulnerable to HIV and STIs. Gender norms and sexual stigma as well as limited access to appropriate safer-sex commodities
and prevention information serve to increase their vulnerability. This community-led research project was able to provide insights into the sexual lives and health of women who have sex with women in Lesotho. Results suggest that addressing social and structural factors, such as acceptance of same-sex sexuality and healthcare provider knowledge, would be useful bases for comprehensive HIV and STI prevention, treatment and care services for sexual minority women in Lesotho.

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References


Résumé
Malgré la forte prévalence du VIH et des IST parmi les femmes en Afrique et le nombre croissant de publications sur ces infections parmi les femmes qui ont des rapports avec les femmes, les recherches sur la santé sexuelle chez ces dernières en Afrique sont limitées. Cette étude a employé diverses méthodes pour décrire l’identité, les pratiques et la santé sexuelles chez les femmes qui ont des rapports avec des femmes au Lesotho. La plupart des répondantes (48%) se sont définies comme lesbiennes, 29% comme bisexuelles et 23% comme hétérosexuelles. Presque la moitié (45%) des participantes avaient révélé à leur famille leur attirance pour le même sexe, mais seulement 25% l’avaient fait auprès de soignants. Huit pour cent d’entre elles ont déclaré être infectées par le VIH. L’auto-déclaration de séropositivité au VIH s’est révélée associée à ≥ 3 partenaires masculins, à la possibilité d’un multi-partenariat à la fois avec des hommes et avec des femmes, et à une histoire d’IST. Les normes de genre, la pénalisation de l’homosexualité, les connaissances sur les méthodes de sexe à moindre risque et l’accès à ces méthodes, et des expériences mixtes de dépistage du VIH et des IST et de soins de santé sexuelle ont souligné les contextes sociaux et structurels de la vulnérabilité de ces femmes au VIH et aux IST.

Resumen
En África, a pesar de la alta prevalencia del vih y de las its (infecciones transmitidas sexualmente) entre las mujeres y del creciente número de estudios sobre vih e its entre mujeres que tienen sexo con
mujeres, son escasas las investigaciones respecto a la salud sexual de estas últimas. El presente estudio utilizó métodos diversos con el fin de describir la identidad sexual, las prácticas y la salud de mujeres que tienen sexo con mujeres en Lesoto. La mayor parte de las participantes (48%) se identificó como lesbiana, 29% como bisexual y 23% como heterosexual. Asimismo, cerca de la mitad de las mismas (45%) había revelado su atracción homosexual a su familia, pero sólo 25% lo había hecho ante trabajadores de salud. Ocho por ciento reportó tener vih. El auto-reportarse como seropositiva se asoció con tener ≥ 3 parejas hombres, con tener parejas hombres y mujeres al mismo tiempo y con tener antecedentes de its. Las normas de género, la criminalización de la homosexualidad, los diversos conocimientos de prácticas sexuales seguras, y el acceso a ellas, así como las diversas experiencias de someterse a exámenes de vih/its y el nivel de atención de la salud sexual, constituyen factores que proveen contextos sociales y estructurales en torno a la vulnerabilidad relacionada con el vih y las its.