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"La Solución es la Tijera" (The Solution is Scissors): Sexual Health Programme Oriented to Lesbian and Bisexual Women

Diana Marcela Palma* & Linda Teresa Orcasita

Pontificia Universidad Javeriana, Cali, Colômbia

ABSTRACT – There is little inclusion of lesbian and bisexual women in the health promoting agenda. However, the risks in their sexual practices have been scientifically recognized. This article aims to present the main results from the "*La Solución es la Tijera*" (The Solution is Scissors) programme, geared at LB women from Cali, Colombia. 23 women between 18 and 25 years old (X021.5; DS=1.78) participated in this study. The programme evaluation was conducted with a pre-post design, using mixed methodologies. Significant changes were found in the level of knowledge and the attitudes towards HIV. Likewise, the participants reported a strengthening in their identity, an empowerment in their sexuality and knowledge about sexual and reproductive rights.

KEYWORDS: sexual health, lesbian and bisexual women, psychosocial intervention, sexuality, STIs, HIV

"La Solución es la Tijera": Programa de Salud Sexual para Mujeres Lesbianas y Bisexuales

RESUMEN – La inclusión de las mujeres lesbianas y bisexuales en las agendas de promoción de la salud sexual es escasa. Sin embargo, los riesgos en sus prácticas sexuales han sido reconocidos científicamente. Este artículo presenta los resultados principales del programa de intervención "La solución es la tijera" dirigido a mujeres LB jóvenes de Cali, Colombia. Participaron 23 mujeres entre los 18 y los 25 años de edad (X= 21.7; DS=1.78). La evaluación se realizó de manera pre- post a través de una metodología mixta. Se encontró un cambio significativo en los niveles de conocimientos y las actitudes frente al VIH. Asimismo, se reportó el fortalecimiento de la identidad, el empoderamiento en su sexualidad y los conocimientos sobre derechos sexuales y reproductivos.

PALABRA CLAVE: salud sexual, mujeres lesbianas y bisexuales, intervención psicosocial, sexualidad, ITS, VIH

"La Solución es la Tijera": Programa de Saúde Sexual Orientado a Mulheres Lésbicas e Bissexuais

RESUMO – A inclusão das mulheres lésbicas e bissexuais na agenda de promoção de saúde é escassa. No entanto, os riscos existentes em suas práticas sexuais foram cientificamente reconhecidos. Este artigo pretende apresentar os principais resultados do programa "La Solución es la Tijera" orientado para mulheres lésbicas e bissexuais de Cali, na Colômbia. Vinte e três mulheres entre 18 e 25 anos de idade (X = 21,7; DS = 1,78) participaram deste estudo. A avaliação do programa foi realizada com um design de pre-post, usando metodologias mistas. Foram encontradas alterações significativas nos níveis de conhecimento e atitudes em relação a HIV. Da mesma forma, relatou-se reforço em sua identidade e empoderamento em sua sexualidade e conhecimento sobre direitos sexuais e reprodutivos.

PALAVRAS-CHAVE saúde sexual, mulheres lésbicas e bissexuais, intervenção psicossocial, sexualidade, ISTs

* Email: dianapalma-23@hotmail.com

The HIV epidemic is taking on a younger and more feminine face; of the 36.9 million people who currently live with the virus, 40% of them are young people between the ages of 15 and 24 years old (Joint United Nations Programme on HIV / AIDS [UNAIDS], 2014) and 50% of them are female (UNAIDS, 2010).

Even though the transmission of HIV and other sexually transmitted diseases (STIs) between two women has been scientifically proven (Fethers, Marks, Mindel, & Estcourt, 2000; Kwakwa & Ghobrial, 2003; Marrazzo et al., 2002), lesbian and bisexual women (LB) have been historically absent from the discourse of prevention and research in sexual health (Logie, 2015). It wasn't until 2011 that UNAIDS (2011) indicated the need to include this population in the agenda aimed at HIV prevention; aspects like: the perception of low risk, held by many health workers and actors with decision making power, prejudices towards homosexuality and hetero-normative language that are prevalent in prevention programmes have left this population out of the discussion. According to Richardson (2000), this lack of consideration of LB women as an at-risk group has extended beyond HIV and into the field of general health care.

The aforementioned has caused a global lack of awareness about the number of LB women affected by HIV (Logie, 2015; Palma, Múnevar, & Orcasita, 2014). Nevertheless, studies like that of Teti and Bowleg (2011) confirm the existence of LB women living with this disease who represent 3% of the cases in the United States. It is worth noting that this figure corresponds to around 7000 people and ignores the cases where sexual orientation was not asked about, or where the woman decided not to reveal it (Morrow, 1996; Teti & Bowleg, 2011). This lack of systematization of the data has hindered, to a large degree, the efforts and resources allocated to this population (Logie, 2015)

The World Health Organization (WHO, 2006) emphasised that sexual health does not refer simply to the absence of disease, but implies a positive and respectful experience of sexuality; this includes the experiences of eroticism and pleasure. In this sense, it is a priority to create sexual health programmes that positively include the sexual orientation of these women, and consider each aspect of their identity. These programmes have ignored the diversity of women's sexuality under the false assumption of their universal heterosexuality (Logie & Gibson, 2013). Moreover, they have violated the right to health of the LB population in terms of their ability to participate on equal terms, without being discriminated against, and with equal access to health care programmes (Fish & Bewley, 2010).

There is a lack of literature that takes on the topics related to LB women's sexual health. However, multiple studies from Latin America and on a global scale have signalled a significant disparity in the level of knowledge about HIV, STIs, and their possible preventions within the population (Mora & Monteiro, 2010; Power, McNair, & Carr, 2009; Profamilia, Grupo de Estudios de Género, Sexualidad y Salud en América Latina, & Centro Latinoamericano de Sexualidad y Derechos Humaos, 2007). Likewise, very low rates of use of preventative measures like condoms, latex gloves or latex barriers have been observed (Muzny, Harbison, Pembleton, Hook, & Austin, 2013; Towen et al., 2013). As described by Uribe, Orcasity and Vergara (2010), attitudes towards HIV and towards the use of preventative measures are linked to knowledge and to the social stereotypes of the disease, therefore, they affect risk perception and shape motivations related to self-care.

Even though authors like Bell, Ompad and Sherman (2006) and Fethers et al. (2000) have pointed out the prevalence of STIs in LB women, compared with heterosexual women, they report taking HIV tests or other blood and gynaecological tests with less frequency. In countries like Colombia, this situation is more visible in the research conducted by *Colombia Diversa* (2010), which reports that Colombian LB women prefer to hide their sexual orientation from health care centres for fear of rejection or of receiving inadequate attention. This reduces the number of women who take pap smears and gets in the way of the timely detection of numerous problems, like cervical cancer.

As mentioned before, there is a disparity in the level of knowledge related to sexual health. However, it must be acknowledged that this is the product of social, political and cultural factors that hamper access to education and to health care. Likewise, the programmes that take on this topic are scarce, but some have been implemented in countries like the United States and Canada (Logie, Lacombe-Duncan, Weaver, Navia, & Este, 2015; Marrazzo, Thomas, & Ringwood, 2011; Morrow, 1996). This indicates the pressing need in Latin America to make efforts that take into consideration the needs and experiences of LB women in these countries.

In general, the topics that have been included in prevention programmes oriented towards LB women have emphasized understanding of unsafe sexual practices and preventative measures (Marrazzo et al., 2011; Morrow, 1996; Stevens, 1994). However, Logie et al. (2014) indicate the need for the inclusion of other intra and inter-subjective, communitarian and structural aspects, like self-esteem, attitudes towards HIV, internal stigmatization, the negotiation of preventative practices, social support and access to health care.

For example, recent studies of the LB population have described the link between family support and the functioning of this support network for depression, the use of psychoactive substances and unsafe sexual behaviours (Rothman, Sullivan, Keyes, & Boehmer, 2012). Likewise, the link between stigmatization, discrimination and exposure to HIV has been made by Poteat et al. (2015) in a sample of African LB women. These studies demonstrate the importance of including these topics in the programmes oriented towards this population.

Consequently, due to the particularities of the LB women's population in their exposure to risk and the apparent resistance to their inclusion in prevention programmes, the objective of this article is to present the main results of the intervention programme "*La Solución es la Tijera*" (The Solution is Scissors), aimed at young LB women in Cali, Colombia, from a psychosocial perspective.

METHOD

Design

This intervention utilized a pre-post design, and made use of contributions from two theoretical models. The first is the theory of gender and power from Wingood and DiClemente (2000) that emphasises the social and biological factors that create vulnerability in women. These power and gender-based hierarchies permeate their relationships, access to health care, public policy and medical discourse. Consequently, the main thrust of HIV prevention at a behavioural and social level aims at helping the subjects to modify their intra and inter-personal risk factors, improve their knowledge, perception of norms and beliefs, improve access to health care and education, negotiate protection, recognize abuse, be it physical or an abuse of authority, review the social expectations related to gender and to generate reflection about the manner in which bonds are constructed with other people. The second theory that was used was the model for social change put forth by Montero (2003) whose aim is to strengthen individuals or communities through participation, the creation of critical awareness, empowerment, politicisation, the possibility of self-management, the development of individual skills and of social identity. These factors allow for the development of resources that can be used to transform their context and take charge of their own lives in an engaged, aware and critical manner.

Participants

The participants in this programme were 23 LB women between 18 and 25 years of age (X= 21.7; SD= 1.78). 69.6% defined themselves as homosexual and 30.4 % as bisexual. 78.3% were from the middle social class, 8.7% were from a higher social class, and 13.0% were from a lower social class. The participants were recruited by means of an open invitation made in public and private universities in the city, using an informative strategy within each campus and promoting the invitation through social networks.

To be eligible to participate the following criteria were taken into account: (a) that they self-identified as lesbian or bisexual women; (b) that they were between 18 and 25 years old; and (c) that they were currently studying in a university in the city since this programme is part of a larger research project related to sexual and preventative practices among university students in Cali, Colombia.

Instruments

This programme included the use of qualitative and quantitative evaluative instruments. In order to collect the quantitative data, a questionnaire was designed to measure the knowledge, attitudes and sexual practices of LB women. The questionnaire was revised by three expert judges before being applied, and included sections with the following validated instruments: (a) the complete version of the family functioning questionnaire (APGAR) was used to measure family support. The rating of this instrument suggests that scores between 0 and 3 correspond to low functioning family situations; scores between 4 and 6, moderate, and 7 to 10, high (De la Revilla et al., 1991), and (b) the section of knowledge, attitudes and sexual practices with regards to HIV, from the HIV risk assessment questionnaire designed by Morrow (1996) for this specific population. This instrument measures the knowledge variable through 31 items that inquire about information related to the virus, its transmission and methods of prevention. Answer options correspond to categories like "true", "false" or "I don't know". For the total score, the minimum and maximum values were divided into a scale with three equal ranges. Scores between 0 and 10 were categorised as low knowledge; from 11 to 21, middle; and from 22 to 31, high. Likewise, attitudes were measured through 14 items with options that included options like "agree", "disagree", and "I don't know". For scoring, three ranges were established; scores from 0 to 4 corresponded to negative attitudes; 5 to 9, neutral; and from 10 to 14, positive. Additionally, questions were designed to explore the perception of spaces where discrimination takes place, the revealing of sexual orientation and HIV testing.

All of the questionnaires were applied at the beginning and the end of the programme to observe the changes in the categories of analysis that were addressed through the programme's content. In order to observe the relationships between qualitative variables, the test was applied, and for quantitative variables, the non-parametric test by Wilcoxon was applied.

The qualitative evaluation was carried out in two focal groups, one at the beginning of the programme and one at the end. These groups compiled the participants' expectations and the most significant lessons. They also explored which were the most successful activities, their applicability or the contributions to their daily lives, and they evaluated

topics that were part of the programme. Both focal groups took place after filling out the questionnaire; they lasted approximately an hour and audio recordings were made. All of the programme's participants took part in the focus groups. In addition, an individual written strategy was employed using a logbook in which each participant kept a record of their reflections, doubts, and lessons learned from each session in the programme. A facilitator provided feedback and observed each participant's process on an individual level. These descriptions were also included in the data that was used to evaluate the programme. The data collected from the logbooks and focus groups was analysed through topical analysis according to the following categories: identity, sexuality, rights and successful aspects of the programme.

Programme

"*La Solución es la Tijera*" (The Solution is Scissors) is a sexual health programme aimed at the LB population whose objective was to promote a healthy and pleasurable experience of their sexuality through the strengthening of self-care practices and the recognition of sexual and reproductive rights. It was based on participative methodologies that grant an active role to the participants as designers and agents of knowledge by means of activities like group discussions, dramatizations, theatre, sculpting with clay, among others (Molina & Romero, 2004). This programme was carried out in six weekly sessions that were four hours each (24 hours of intervention). Attendance was taken for the group. Table 1 shows the main topics of the programme and its modules.

Procedure

Table 2 sets out the phases through which the programme was executed, this procedure corresponds to the phases indicated by Blanco and Rodriguez (2007) for the implementation of psychological interventions.

Table 1. *Description of the programme "La solución es la tijera"*

	Name of Session	Topics addressed
Module 1 Sexuality is not just about sex	1. At the starting line	Concepts, dimensions and functions of sexuality
	2. This is me – I like this!	Social stereotypes about bodies, love and intimacy of LB women. Self image, self concept and self-esteem. The body, erotica and pleasure dimension.
	3. When I decide to speak up	Social support and community resources, coping strategies for revealing your sexual orientation, strategies for disclosure in the context of health, mechanisms for demanding your right to health.
Module 2 In my sexual practices, I'M the one who chooses	4. What HIV has to do with me	Perception of risk. Knowledge about HIV and other STIs. Knowledge of risky sexual practices and ways of prevention. HIV testing and organisations, centres, places of sexual health care.
	5. To love ME is to take care of US	Contraceptive methods. Communication styles. Communication in couples and negotiation of sexual practices.
	6. From the closet to full recognition of my sexual and reproductive rights.	Citizen rights and sexual and reproductive rights. Legislative advances for the LGBT population in Colombia. Ways of demanding and protecting citizens' rights.

Table 2. *Implementation phases of the programme*

Phase	Description
1. Literature review.	Search for research on health and national and international public policies of intervention and action with the population
Interviews with experts.	Interviews with health service providers from disciplines such as psychology, medicine, gynaecology and public health to identify their recommendations and perceived needs for the development of the programme. Interviews with women of the LB community about their sexual health intervention needs.
2. Initial proposal design	Review of intervention guides developed by national and international organisations Reconstruction of the modules and thematic areas from a previous pilot exercise and interviews with different agents.
3. Announcement	Design of the programme image, adjusted to the language of the population and for dissemination
4. Baseline	Signing of informed consent form and application of a questionnaire
5. Programme Implementation	Review and adjustment of the thematic areas of the programme in light of the needs found in the questionnaire and in the initial focus group. Monitoring and follow-up of each session through group evaluation and log-taking. Support of professionals from other areas such as medicine, nursing and law.
6. Final evaluation of the process	Application of the instrument Evaluation of significant learning and aspects to improve in future implementation.

Throughout the programme, the ethical guidelines from the Ministry of Health's Resolution 008430 were taken into account, in which scientific, technical and administrative norms for health studies are established, like Law 1090 from the Congress of the Republic of Colombia, which regulates ethical and professional practices of psychologists. Moreover, the results of the qualitative component are presented using pseudonyms to protect the identities of the participants.

RESULTS

Sexual and Preventative Practices

It was found that the average age for beginning sexual relations amongst participants was 15.5 years old (SD=2.4). Likewise, the average number of sexual partners was 4.95 (SD=2.6) including men and women. Specifically, 62.5% had had sex with men and had an average of 3.0 (SD=2.0) sexual partners; 91.3% had had sex with women and had an average of 4.09 (SD=2.7) sexual partners. 31.8% of the women reported to have experienced situations of sexual abuse at least once. Additionally, engaging in sexual acts under the influence of alcohol and other psychoactive substances and sharing toys without washing is described in table 3.

Table 3 also describes a low rate of preventative measures taken in oral-genital sex, and a low rate of condom

Table 3. *Sexual practices and use of preventative measures*

Sexual practices			**Use of preventative measures**		
Use of sex toys	10 (45.5%)			Women	Men
Exchange of sex toys without washing	6 (46.2%)		Condom	18.2%	30.8%
Experience of sexual abuse	7 (31.8%)		Latex barrier	4.8%	0.0%
Sexual relations under the effect of alcohol	19 (86.4%)		Latex gloves	4.8%	0.0%
Sexual relations under the effect of psychoactive substances	15 (68.2%)				
	vaginal	**anal**	**Reasons for non-use**	**Pre (%)**	**Post (%)**
Given oral sex WITHOUT protection	21(95.5%)	3 (13.6%)	I am in a long-standing, stable relationship with only one person	50.0%	57.9%
Given oral sex WITH protection	1 (4.5%)	1 (4.5%)	I don't think HIV is something that will affect me	13.6%	0.0%
Received oral sex WITHOUT protection	21 (95.5%)	5 (22.7%)	I don't think I can contract any sexually transmitted infection	9.1%	0.0%
Received oral sex WITH protection	1 (4.5%)	0%	I don't have any preventative methods to hand when the opportunity for sexual relations presents itself	54.5%	42.1%
Use of receptive sex toy WITHOUT a condom	4 (18.2%)	0%	There are no preventative methods designed for homosexual women*	36.4%	0.0%
Use of receptive sex toy WITH a condom	4 (18.2%)	3 (13.6%)	I don't know where to buy preventative methods**	52.4%	5.3%
Use of penetrative sex toy WITHOUT a condom	1 (4.3%)	0%	Gay women do not need to care for ourselves in terms of HIV.	9.1%	0.0%
Use of penetrative sex toy WITH a condom	4 (18.2%)	1 (4.5%)	I don't know how to use protective methods properly***	54.5%	0.0%
Receptive digital penetration WITHOUT a condom	23 (100%)	3 (13.6%)	I don't think either I or my partner are at risk in terms of HIV	13.6%	0.0%
Receptive digital penetration WITH a condom	3 (13.6%)	2 (9.5%)	I think using barrier methods reduce pleasure	13.6%	0.0%
Insertive digital penetration WITHOUT a condom	22 (100%)	0%	I feel that even if I ask my partner to practice safe sex, she/he won't do it*	0.0%	26.3%
Insertive digital penetration WITH a condom	2 (9.1%)	0%	I can't afford to buy condoms or other protective methods	13.6%	10.5%
Penile penetration WITHOUT a condom	7 (31.8%)	1 (4.5%)			
Penile penetration WITH a condom	11 (50%)	2 (9.5%)			

*(P=0.001) ** (P=0.003) ***(P=0.000)

and latex barriers used with women. Furthermore, only 30.8% of those who had had sex with a man used condoms regularly (see table 3).

The major reasons for not using preventative measures are highlighted, monogamous relationships and not having preventative measures easily accessible were significant. The evaluation carried out after the programme found significant changes in knowledge of preventative methods for LB women and their adequate forms of use. Similarly, the number of people who felt that their partner would not use these methods increased. Regarding the testing, it was found that 34.8% of the women had taken the HIV test (see table 3).

Knowledge of HIV

The pretest found that 21.7% of the participants had middle level understanding and 78.3% had high understanding. In the post-test, 100% of the participants scored in the high understanding range. Through the Wilcoxon test, differences were found between both measurements (Z=-6.120; p=0.000). The significant changes were grouped into the items that measured manners of transmission and unsafe sexual practices for HIV, understanding of epidemiological data for LB women and forms of treatment (see table 4).

Table 4. *Knowledge about HIV*

Item	pre-test (%)			post-test (%)		
	F	T	DK	F	T	DK
You can tell if a person has HIV just by looking at them	82.6	4.4	13.0	100	0.0	0.0
Anal sexual relations are high risk for transmitting HIV	8.7	69.6	21.7	0.0	95.7	4.3
Oral sex does not represent a risk for transmitting HIV * (P=0.022)	65.2	8.7	26.1	95.7	4.3	0.0
A person can be exposed to HIV from just one sexual encounter	0.0	91.3	8.7	0.0	100	0.0
You can avoid getting HIV by practicing sport regularly	78.3	0.0	21.7	91.3	0.0	8.7
When you have sexual relations with the same partner during a long-term relationship, it is not necessary to keep using a condom	82.6	8.7	8.7	91.3	8.7	0.0
Taking a bath after sex reduces the possibility of getting HIV* (P= 0.016)	69.6	4.3	26.1	100.0	0.0	0.0
When engaging in oral sex, not ingesting your partner's bodily fluids helps to prevent HIV* (p= 0.002)	39.1	17.4	43.5	69.6	30.4	00
People who contract HIV show symptoms immediately or soon after* (P=0.034)	56.5	8.7	34.8	82.6	13.0	4.3
Reducing the number of sexual partners prevents HIV	47.8	34.8	17.4	65.3	30.4	4.3
HIV is not transmitted between homosexual women	91.3	0.0	8.7	100	0.0	0.0
In the world, cases of homosexual women with HIV have been found* (P=0.001)	0.0	43.5	56.5	4.3	91.4	4.3
A homosexual women can only get HIV by having sexual relations with a man	78.3	4.3	17.4	100	0.0	0.0
Sharing a toothbrush can facilitate the transmission of HIV* (P=0.000)	47.8	4.4	47.8	13.0	87.0	0.0
Pre-ejaculatory fluids can contain HIV* (P=0.000)	0.0	34.8	65.2	0.0	100	0.0
Injectable drug users are at risk of HIV when sharing needles	0.0	95.7	4.3	0.0	100	0.0
Vaginal sexual relations are high risk for the transmission of HIV*(P=0.001)	13.0	43.5	43.5	13.0	87.0	0.0
Only homosexual men are at risk of getting HIV	95.7	4.3	0.0	100	0.0	0.0
Women who exclusively practice homosexual relations are not at risk of getting HIV	91.3	0.0	8.7	87.0	4.3	8.7
Sharing kitchen or bathroom utensils with a person who is living with HIV represents a risk of getting HIV	56.5	17.4	26.1	56.5	39.2	4.3
HIV can be transmitted by a mosquito bite* (P=0.004)	60.9	4.3	34.8	100	0.0	0.0
A negative result on an HIV test can occur even when a person has the virus* (P=0.004)	0.0	47.8	52.2	8.7	82.6	8.7
The HIV virus can be transmitted from a sneeze* (P=0.002)	65.2	0.0	34.8	100	0.0	0.0
Donating blood does not represent a risk of HIV to the donor	39.2	30.4	30.4	43.5	43.5	13
Mutual masturbation does not lead to increased risk unless the person has wounds or scratches* (P=0.004)	8.7	52.2	39.1	22.7	77.3	0.0
People who got HIV through injecting drugs can transmit it through sexual relations* (P=0.054)	0.0	82.6	17.4	0.0	100	0.0
Only men transmit HIV	87.0	0.0	13.0	95.7	4.3	0.0
Currently there is no cure for HIV (P=0.001)	13.0	43.5	43.5	8.7	91.3	0.0
Exchanging sex toys increases the possibility of getting HIV* (P= 0.001)	21.7	43.5	34.8	95.7	4.3	0.0
The HIV virus can be transmitted through breast milk* (P=0.00)	13.0	30.4	56.6	4.3	95.7	0.0

Level Of Knowledge	Pre	Post
Low	0%	0%
Medium	21.7%	0%
High	78.3%	100%

F= false, T= true, DK= don't know. (Z=-6.120 P=0.000)

Attitudes About HIV

The pretest found that 34.8% of the participants held positive attitudes that favoured their self-care; the post-test found that these attitudes were found in 60.9% of the women. The Wilcoxon test found differences between both measurements (Z=-5.646; p=0.000). The most representative changes occurred in items that measured risk perception and the perception of existing methods geared toward the sexual practices of LB women (see table 5).

Disclosure of Sexual Orientation and Family Functioning

69.6% of the participants had disclosed their orientation to their mothers, of those women, 62.4% received positive support and 37.6% regular or poor support. 39.1% of them had told their fathers about their sexual orientation. According to the APGAR family scores, 52.2% of the women belonged to high functioning families. However, only 34.8% looked to their families for support when they had a problem; in general, their friends provided them with support (see table 6).

Experiences with Violence and Discrimination

73.3% of the participants reported having experienced discrimination and 8.7% had been physically assaulted as a result of their sexual orientation. Spaces shared with family and public spaces were where violence occurred, 43.5% and 68.6% respectively. The pre and post-tests showed a significant increase in the perception of discrimination in health centres (45.5; P=0.000) (see table 7).

Table 5. *Attitudes towards HIV*

Item	Pre-			Post-		
	D	A	DK	D	A	DK
I would reject sitting near someone who has HIV	82.6	8.7	8.7	82.6	4.3	13.0
I'm not the type of person who could get HIV (P=0.008)	52.2	4.3	43.5	87.0	8.7	4.3
People with HIV should be isolated to guarantee the safety of others	95.7	0.0	4.3	100	0.0	0.0
I would feel comfortable sharing a bathroom with someone who has HIV	26.1	43.5	30.4	34.8	39.1	26.1
I think I could get HIV	8.7	65.2	26.1	13.0	73.9	13.0
I am able to tell my partner if I have had sex with a bisexual person	13.0	82.6	4.3	8.7	91.3	0.0
Stopping during the sexual act to put on a condom makes the sex less enjoyable	60.9	17.4	21.7	69.6	13.0	17.4
I think it is really important to use condoms every time you have sex	4.3	82.6	13.0	0.0	91.3	8.7
I insist that my sexual partner uses a condom	52.2	30.4	17.4	30.4	60.9	8.7
I am able to tell my partner that I have had sex with men	8.7	82.6	8.7	100	0.0	0.0
I think only homosexual men need to worry about HIV	87.0	8.7	4.3	100	0.0	0.0
I think homosexual women should get laboratory tests done to identify an STI	91.3	0.0	8.7	100	0.0	0.0
I think that preventative methods adapted for our sexual practices do not exist for homosexual women (p=0.002)	8.7	65.2	26.1	47.8	52.2	0.0
Healthcare workers generally treat people with HIV well	13.0	0.0	87.0	30.4	4.3	65.2
Types Of Attitudes*	**Pre-**	**Post-**				
Negative	0.0	0.0				
Neutral	65.2	39.1				
Positive	34.8	60.9				

D= Disagree, A= Agree, DK= Don't know. *(Z=-5.646, P=0.000).

Table 6. *Level of familial behaviour and disclosure*

Familial behaviour	**Low**	**Moderate**	**High**
Level	2(8.7%)	9 (39.1)	12(52.2%)
Who do you most often approach for help?	Family (34.8%)	Friends (60.9%)	Others (4.3%)
Sexual orientation disclosure	**Perceived support**		
Person (%)	*Good*	*Regular*	*Bad*	*Indifferent*
Mother (69.6%)	10 (62.4%)	3(18.8%)	3(18.8%)	0
Father (39.1%)	4 (44.5%)	3(33.3%)	1(11.1%)	1(11.1%)
Friends (100%)	20(87.0%)	2 (8.7%)	0	1 (4.3%)
Extended family (34.8%)	5 (62.5%)	1(12.5%)	1(12.5)	1(12.5%)
Others (34.8)	9 (100%)	0	0	0

Table 7. *Discriminatory spaces*

Place	% pre	% post	Place	% pre	% post
Family	10 (43.5%)	10 (43.5%)	Shopping Centre	6 (26.1%)	7 (30.4%)
Friends	0	2 (8.7%)	Public Transport	5 (21.7%)	8 (34.8%)
School	7 (30.4%)	5 (21.7%)	Health Centre *	0	10 (43.5%)
University	5(21.7%)	7(30.4%)	Public Spaces	11 (47.8%)	16 (69.6%)

*(P=0.000)

Qualitative Component

The focal groups explored the most significant lessons learned in the programme. The participants indicated three general points: a strengthening of their identity, an empowerment of their sexuality and their understanding of their sexual and reproductive rights. These points will be further examined below:

The first point identified by the participants was that the programme allowed a strengthening of their identity as LB women. They felt that the programme allowed them to connect with other women in different ways from the connections made in other LGBT friendly spaces in the city of Cali. These other spaces are generally nightclubs and bars where the main activities are drinking alcohol and "partying". Additionally, some of the stereotypes surrounding the identity of LB women were recognized and discussed. These included lifestyles, sexuality and gender roles. This created the possibility of considering other, more authentic, manners of being in the world.

> *I had never really felt lesbian. I think that connecting in this way is more comfortable than, 'Ahh! Let's march and wave our flags all over the place,' and that type of lesbian stereotype. But here, we really think about what we are doing with our bodies. This group breaks all the stereotypes in the world, and one person is not like any other. That was what most brought us together. The possibility to be ourselves.* (Camila, 19 years old)

Moreover, the group became a support network where the women could talk about the process of disclosing their sexual orientation, which was identified as a process of "struggle" for their identity that could be guided, facilitated and re-signified through this network. The following testimonies demonstrate how this network created coping strategies and support for those who had not disclosed their sexual orientation. It also allowed those women who had already gone through this process to recognise the positive effects and re-signify painful experiences.

> *Sharing our experiences and the situations that we face in society and with our families was an interesting exercise for the girls who haven't come out of the closet yet; they can know that we've all gone through the same thing, that we all felt that they weren't going to love us anymore, but that in the end, we got through it and here we are, facing difficulties bravely and knowing that we are worth a lot.* (Julieta, 21 years old)

> *To know that other people's experiences were tempestuous, but that they're living calm, happy lives now, in a certain way, gives me courage and helps me understand some of the ways I can face this moment that I know is going to change my life and how I get along with my family.* (Lina, 20 years old)

Regarding sexuality, it was appreciated that the programme, more than simply providing knowledge, allowed for the possibility of reflecting on sexuality from a holistic perspective including gender roles, sexual identity, pleasure and eroticism. These aspects were recognized as the backbone of sexuality, and the participants indicated the importance of negotiation with their partners during their sexual practices. In terms of understanding, most of the participants were not knowledgeable of unsafe sexual practices regarding HIV and other STIs, nor did they know how they could prevent these in their relationships with other women. Generally, they reported that their LB friends were unaware of this information as well, and they highlighted the fact that this new information provided them with the tools to become replicators of knowledge.

> *I've spoken with a friend, and she said to me, 'Girl, what do you mean, latex barriers? You mean like condoms?' And I told her, 'You prefer to get a disease?' I think a lot of women think like that, or don't know how to take care of themselves, but this is a space where we can understand, and can tell other women that it's something they need to start doing.* (Juliana, 20 years old)

> *I found a group of women with whom I have a lot of similarities and differences, and that is really valuable for me. I connected with myself, with what I like and what I don't like, and I learned that I have to keep working on health and on myself. I learned the value that I give my sexuality, how it protects me, how I make it stronger and how I enjoy it.*
> (Clara, 23 years old)

In terms of rights, the participants noted that in addition to the session aimed at addressing this issue, the general activities had empowered them to demand better health care and to identify certain forms of discrimination that had become naturalised on a day to day basis. Additionally, this social awareness enabled them to reflect on the political

importance of influencing other spaces in the LGBT community and other discussion environments.

> *Coming to this programme is a political action - being a politician isn't just about showing up at a voting box - it's about making decisions within society, so coming* [*to the programme*] *was an act of consciousness, it is a way of behaving in society and of continuing to transmit a message to other people ... not only did we learn things about sexual care, but I also feel that we learned about citizenship and how to stand up for our rights.* (Luisa, 25 years old)

Furthermore, from the focus groups, the aspects of the programme that were considered positive are: (a) the creation of a space for freedom of expression that enabled the discussion of intimate topics about sexuality, life as a couple, and relationships with others; (b) the possibility of sharing experiences and seeing oneself reflected in the stories of the others; (c) that the themes and sessions were logically and coherently sequenced; (d) the multidimensional approach to sexuality; (e) the programme facilitator was of the same age and sexual orientation; (f) that their support networks were strengthened and they identified community resources in their city; (g) knowledge of sexual and citizen's rights and their enforceability; and (h) the use of participatory dynamics that enabled the participants to create bonds of support and affection.

DISCUSSION

In this sexual health programme, in which 23 women between the ages of 18 and 25 participated, changes were reported in the pre and post-tests in the variables of knowledge and attitudes towards HIV.

With regard to knowledge, it was found that the participants had some general knowledge about the virus. This may have been acquired during their process at school as the participants correspond to a sample with access to higher education. However, there was a lack of knowledge about specific practices that put them at risk, about epidemiological data on LB women and about available means of prevention. This disparity between general knowledge of STIs and knowledge of unsafe sexual practices and specific preventive methods for LB women has been reported in other investigations (Muzny et al., 2013). Similarly, these results contribute to the findings of multiple global and Latin American studies that point to a gap in knowledge about HIV and other STIs in LB women (Mora & Monteiro, 2010, Power et al., 2009, Profamilia et al., 2007).

The gap arises out of limitations in access to education and healthcare for this population because agents such as families, schools and healthcare professionals are not necessarily trained to provide this specialized information. A manifestation of this low level of sensitisation is shown in the percentages of discrimination that participants perceived from the afore-mentioned agents. Bearing this in mind, through the process of programme implementation, in the subsequent evaluation, an increase in perceived discrimination from health centres was found. This may indicate that there are forms of discrimination and violence that have become naturalized due to the stereotypes and social guidelines of "socially accepted" sexuality. Thus, the care provided to this population may be affected. Additionally, while 60% of the participants indicate that their friends are their greatest source of social support, the qualitative data enables us to observe that these sources also suffer from a lack of knowledge in the area of sexual health.

In terms of attitudes, an increase in positive attitudes that enable self-care with regard to HIV was found. In particular, the qualitative data allows us to understand that the LB woman's relationships centre on a notion of self-care and couple care that ultimately facilitates a desire for protection in sexual health. This desire to improve their sexual practices and reflect on their sexuality can be derived, according to Teti and Bowleg (2011), from the protective nature of LB women's relationships. However, the quantitative data found that the percentage of women who reported that they would not use protection increased significantly where there was a probability that their partner would not approve it. This increase may be attributed to the fact that after the participants gained knowledge about preventive practices and the need for their use, they asked themselves how it would be to include these "new" forms of self-care that had not been used before, and perceived difficulty in including these practices in their life as a couple.

This indicates that including activities that provide tools for improving these communication processes and, furthermore, to propose programmes that couples can attend together, are very important. Being able to reach couples is a key point for intervention in the population because other programmes have also shown an increase in knowledge and improved attitudes but there are still gaps in the negotiation issue (Logie et al., 2015).

In relation to sexual practices, it was found that, on average, 4.95 couples were reported, including men and women. However, a considerable percentage of the women had had sex with men, in addition to reporting that they did not make constant use of the condom in their relationships with men. This situation, in epidemiological terms, constitutes a profile that substantially exposes LB women with this sexual history to risk. Therefore, it is necessary to understand this type of logic and address it within the

prevention programmes designed for this purpose (Lindley & Walsemann, 2013).

Another high-risk practice for the acquisition of STIs in LB women is the exchange of sex toys. According to Power et al. (2009) due to the universal prevention discourses that focus on penetration, LB women are more likely to use condoms in these practices. However, they point out that even so, the percentages are very low. In this programme, a high rate of exchange of sex toys without hygiene or use of condom was found. Likewise, a low percentage of the use of the latex barrier was found. These percentages reflect the Latin American findings of the low use of preventive measures in LB women, with rates of less than 30% (Colombia Diversa, 2010, Mora & Monteiro, 2010, Pinto, 2004).

In the same vein, another risk factor for the sexual health of the LB women population is the high consumption rates of alcohol and psychoactive substances that have been described worldwide (Lindley & Walsemann, 2013). The results of this investigation are similar because a high percentage of the participants reported having sexual relations under the effects of alcohol and/or psychoactive substances. Relationships mediated by this type of consumption could impede self-care and negotiation of practices.

On the other hand, authors such as Logie (2015) believe that a phenomenon that increases the vulnerability of this population to STIs is the experience of sexual abuse due to their sexual orientation. While this phenomenon is still invisible at a worldwide level, rates reach as high as 34% and 43% in research carried out in countries such as the United States (Lindley & Walsemann, 2013, Rothman, Exner, & Baughman 2011). In this programme, similar results were found as 31.8% of the participants reported having been victims of sexual abuse.

The foregoing demonstrates the challenge faced by sexual health programmes aimed at this population because of the need to address various interwoven factors that contribute to vulnerability and that are specific to this population group: the search for sensation, the perception of risk, the exploration of sexual identity, the lack of specific knowledge and the risk of sexual abuse. These factors transcend purely biomedical views that place this population at low risk, and demonstrate that there are social and structural influences that increase the risk of LB women to HIV and other STIs (Lindley & Walsemann, 2013; Logie, 2015).

This programme has some limitations that should be taken into account. First, the study sample consisted of 23 participants who mostly belonged to the middle class and had access to higher education. In light of this, it is necessary to point out that the levels of knowledge regarding sexual health may be higher than a non-school-based sample. Therefore, it is recommended that the further studies and intervention efforts be carried out with participants of different ethnic origins and different socioeconomic levels. Also, there was no control group to verify that the changes reported in the questionnaire were due exclusively to the activities carried out within the programme. A further limitation of the study was the time lapse between the end of the programme and the post-evaluation, since it was carried out immediately at the end of the programme. This prevents verification and measurement of long-term changes in sexual and preventive practices.

In line with reports by the participants in the focus group and what has been found in previous research with the population, it is recommended that future programmes take into account the following aspects: (a) provide suitable information, adjusted to the sexual practices of LB women in relation to HIV and other STIs (Lindley, Friedman, & Struble, 2012; Power et al., 2009; Rhodes et al., 2014); (b) strive for the empowerment of women and promote political awareness to improve awareness of rights (Morrow, 1996, Teti & Bowleg, 2011); (c) provide information on how to access resources and social support networks (Rhodes et al., 2014); (d) the programme should become a safe space where participants can find support and talk freely about their day-to-day reality (Rhodes et al., 2014; Teti & Bowleg, 2011); and (e) work on the distrust of the population towards health service providers and provide tools to help them reveal their sexual orientation within these spaces (Morrow, 1996).

To conclude, this sexual health programme targeting LB women in the city of Cali, Colombia was an important opportunity for reflection and will contribute towards building a proposal that will address the needs of this population group. In general, significant changes were found in levels of knowledge and attitudes towards HIV and other STIs. The qualitative data contributed towards an understanding that in programmes directed towards this population it is vitally important, in addition to the informational component, to address issues that allow for identity strengthening and acceptance, the importance of citizens' rights and sexual and reproductive rights, as well as reflections on sexuality and the role this plays in each participant's life. Zimmerman, Darnell, Rhew, Lee and Kaysen (2015) point out that these processes where one can interact and relate to other LB women play an important role in protecting oneself against discrimination and resignifying its effects, accepting sexual orientation and developing identity, within a group that provides positive social support. This type of programme that focuses on the positive resources of the population could have an impact on mental health and sexual and reproductive health (Gahagan & Colpitts, 2016). This is why multiple efforts are required to include these in prevention programmes in Latin America, where gender roles are represented and assigned which have an impact on LB women's access to health and education.

REFERENCES

Bell, A. V., Ompad, D., & Sherman, S. G. (2006). Sexual and drug risk behaviors among women who have sex with women. *American Journal of Public Health, 96*(6), 1066-1072. doi: 10.2105/AJPH.2004.061077

Blanco, A., & Rodríguez, J. (2007). *Intervención psicosocial*. España: Pearson Educación.

Colombia Diversa. (2010). *Provisión de servicios afirmativos de salud para personas LGTB (Lesbianas, Gays, Bisexuales y Transgeneristas).* Bogotá: Colombia Diversa.

De la Revilla, L., Bailón, E., Luna, J. D., Delgado, A., Prados, M. A., & Fleitas, L. (1991). Validación de una escala de apoyo social funcional para uso en la consulta del médico de familia. *Atención Primaria, 8*(9), 688-691.

Fethers, K., Marks, C., Mindel, A., & Estcourt, C. (2000). Sexually transmitted infections and risk behaviors in woman who have sex with woman. *Sexually Transmitted Infections, 76*, 345-349.

Fish, J., & Bewley, S. (2010). Using human rights-based approaches to conceptualise lesbian and bisexual women's health inequalities. *Health and Social Care in the Community, 18*(4), 355–362. doi: 10.1111/j.1365-2524.2009.00902.x

Gahagan, J., & Colpitts, E. (2016). Understanding and measuring LGBTQ pathways to health: a scoping review of strengths-based health promotion approaches in LGBTQ health research. *Journal of Homosexuality, 4,* 1-27. doi: 10.1080/00918369.2016.1172893

Joint United Nations Programme on HIV/AIDS. (2010). *UNAIDS Report on The Global AIDS Epidemic.* Retrieved from http://www.unaids.org/globalreport/Global_report.htm

Joint United Nations Programme on HIV/AIDS. (2011). *Woman who have sex with woman, in all their diversity: putting their needs and right on the HIV agenda. Community innovation: achieving sexual and reproductive health and rights for women and girls through the HIV response.* Retrieved from http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/07/20110719_Community%20innovation.pdf

Joint United Nations Programme on HIV/AIDS (2014). *2014 Global Statistics*. Retrieved from http://www.unaids.org/sites/default/files/media_asset/20150714_FS_MDG6_Report_en.pdf

Kwakwa, H. A., & Ghobrial, M. W. (2003). Female-to-female transmission of human immunodeficiency virus. *Clinical Infectious Diseases, 3*(3) e40– e41.

Lindley, L., Friedman, D., & Struble, C. (2012). Becoming visible: Assessing the availability of online sexual health information for lesbians. *Health Promotion Practice, 13*(4), 472– 480. doi: 10.1177/1524839910390314

Lindley, L., & Walsemann, K. (2013). Invisible and at risk: STDs among young adult sexual minority women in the United States. *Perspectives on Sexual Health, 45*(2), 66-73. doi: 10.1363/4506613

Logie, C. (2015). (Where) do queer women belong? Theorizing intersectional and compulsory heterosexism in HIV research. *Critical Public Health, 25*(5), 527-538. doi: 10.1080/09581596.2014.938612

Logie, C., & Gibson, M. (2013). A mark that is no mark? Queer women and violence in HIV discourse. *Culture, Health & Sexuality, 15*(1), 29–43. http://dx.doi.org/10.1080/13691058.2012.738430

Logie, C., Lacombe-Duncan, A., Weaver, J., Navia, D., & Este, D. (2015). A pilot study of a group-based HIV and STI prevention intervention for lesbian, bisexual, queer, and other women who have sex with women in Canada. *AIDS patient care and STDs*, *29*(6), 321-328. doi: 10.1089/apc.2014.0355

Logie, C., Navia, D., Rwigema, M., Tharao, W., Este, D., & Loufty, M. (2014). A group based HIV and sexually transmitted infections prevention intervention for lesbian, bisexual, queer and other women who have sex with women in Calgary and Toronto, Canada: Study protocol for a non-randomised cohort pilot study. *BMJ Open, 4*. doi doi:10.1136/bmjopen-2014-005190

Marrazzo, J. M., Koutsky, L. A., Eschenbach, D. A., Agnew, K., Stine, K., & Hillier, S. L. (2002). Characterization of vaginal flora and bacterial vaginosis in women who have sex with women. *Journal of Infectious Diseases, 185*(9), 1307–1313.

Marrazzo, J., Thomas, K., & Ringwood, K. (2011). A behavioural intervention to reduce persistence of bacterial vaginosis among women who report sex with women: results of a randomised trial. *Sexually Transmitted Infections, 87*(5), 399-405. doi: 10.1136/sti.2011.049213

Molina, M. L., & Romero, M. C. (2004). *Modelos de intervención asistencias, socioeducativa y terapéutico en el trabajo social*. San José: Editorial Universidad de Costa Rica.

Montero, M. (2003). El fortalecimiento en la comunidad. In *Teoría y práctica de la psicología comunitaria: La tensión entre la comunidad y la sociedade* (pp. 59-92). Buenos Aires: Editorial Paidós.

Mora, C., & Monteiro, S. (2010). Vulnerability to STIs/HIV: Sociability and the life trajectories of young women who have sex with woman in Rio de Janeiro. *Culture, Health & Sexuality, 12*(1), 115-124. doi: 10.1080/13691050903180471.

Morrow, K. M. (1996). *Culture-Specific HIV/STD prevention programming for lesbian and bisexual women* (Doctoral Thesis). Western Michigan University, Michigan.

Muzny, C., Harbison, C., Pembleton, E., Hook, E., & Austin, E. (2013). Misperceptions regarding protective barrier method use for safer sex among African-American women who have sex with women. *Sexual Health, 10*(2), 138-41. doi: 10.1071/SH12106

Palma, D. M., Munévar, J., & Orcasita, L. T. (2014). Percepción de riesgo frente al VIH/Sida en mujeres homosexuales: retos y desafíos actuales desde la investigación. In E. Soriano, A. González & V. Cala (Eds.), *Retos actuales de educación y salud* (vol. 2). Almería: Editorial Universidad de Almería.

Pinto V. M. (2004). *Aspectos epidemiológicos das doenças sexualmente transmissíveis em mulheres que fazem sexo com mulheres* (Doctoral Thesis). Universidade de São Paulo, Brasil.

Profamilia, Grupo de Estudios de Género, Sexualidad y Salud en América Latina, & Centro Latinoamericano de Sexualidad y Derechos Humanos. (2007). *Encuesta LGBT: Sexualidad y derechos. Participantes de la marcha de la ciudadanía LGBT de Bogotá, 2007*. Retrieved from: http://www.profamilia.org.co/images/stories/afiches/encuestas-investigaciones/encuesta-lgbt-2009.pdf

Poteat, T., Logie, C., Adams, D., Mothopeng, T., Lebona, J., Letsie, P., & Baral, S. (2015). Stigma, sexual health, and human rights among women who have sex with women in Lesotho. *Reproductive Health Matters, 23*(46), 107-116. doi: 10.1016/j.rhm.2015.11.020

Power, J., McNair, R., & Carr, S. (2009). Absent sexual scripts: Lesbian and bisexual women's knowledge, attitudes and action regarding safer sex and sexual health information. *Culture, Health & Sexuality, 11*(1), 67–81. doi: 10.1080/13691050802541674

Rhodes, S., Alonzo, J., Mann, L., Downs, M., Simán, F., Andrade, M., … Bachmann, L. (2014). Novel approaches to HIV prevention and sexual health promotion among Guatemalan gay and bisexual men, MSM and transgender persons. *AIDS Education & Prevention, 24*(4), 345-361. doi: 10.1521/aeap.2014.26.4.345

Richardson, D. (2000). The social construction of immunity: HIV risk perception and prevention among lesbians and bisexual women. *Culture, Health & Sexuality, 2*(1), 33-49.

Rothman, E. F, Exner, D., & Baughman, A. L. (2011). The prevalence of sexual assault against people who identify as gay, lesbian or bisexual in the United States: A systematic review. *Trauma, Violence & Abuse, 12*(2), 55–66.

Rothman E. F., Sullivan, M., Keyes, S., & Boehmer U. (2012). Parents' supportive reactions to sexual orientation disclosure associated with better health: Results from a population-based survey of LGB adults in Massachusetts. *Journal of Homosexuality, 59*(2), 186-200. doi: 10.1080/00918369.2012.648878

Rowen, T., Breyer, B., Lin, T., Li, C., Robertson, P., & Shindel, A. (2013). Use of barrier protection for sexual activity among women who have sex with women. *International Journal of Gynecology and Obstetrics, 120*(1), 42–45. doi: 10.1016/j.ijgo.2012.08.011

Stevens, P. (1994). HIV prevention education for lesbian and bisexual women: A cultural analysis of a community intervention. *Social Science & Medicine, 39*(11), 1565-1578.

Teti, M., & Bowleg, L. (2011). Shattering the myth of invulnerability: Exploring the prevention needs of sexual minority women living with HIV/AIDS. *Journal of Gay & Lesbian Social Services, 23*(1), 69-88. doi: 10.1080/10538720.2010.538009

Uribe, A. F., Orcasita, L. T., & Vergara, T. (2010). Factores de riesgo para la infección por VIH/Sida en adolescentes y jóvenes colombianos. *Acta Colombiana de Psicología, 31*(1): 11-24.

Wingood, G., & DiClemente, R. (2000). Application of the theory of gender and power to examine HIV-related exposures, risk factors, and effective interventions for women. *Health Education & Behavior, 27*(5), 539-565.

World Health Organization. (2006). *Defining sexual health: Report of a technical consultation on sexual health.* Retrieved from http://www.who.int/reproductivehealth/publications/sexual_health/defining_sexual_health.pdf

Zimmerman, L., Darnell, D., Rhew, I., Lee, C., & Kaysen, D. (2015). Resilience in community: a social ecological development model for young adult sexual minority women. *American Journal of Community Psychology, 55*(1-2), 179–190. doi: 10.1007/s10464-015-9702-6

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