# ACKNOWLEDGING DIVERSITY: QUESTIONING AUTHORITY

## *A Report on the Findings of the Women Who Have Sex with Women Survey*

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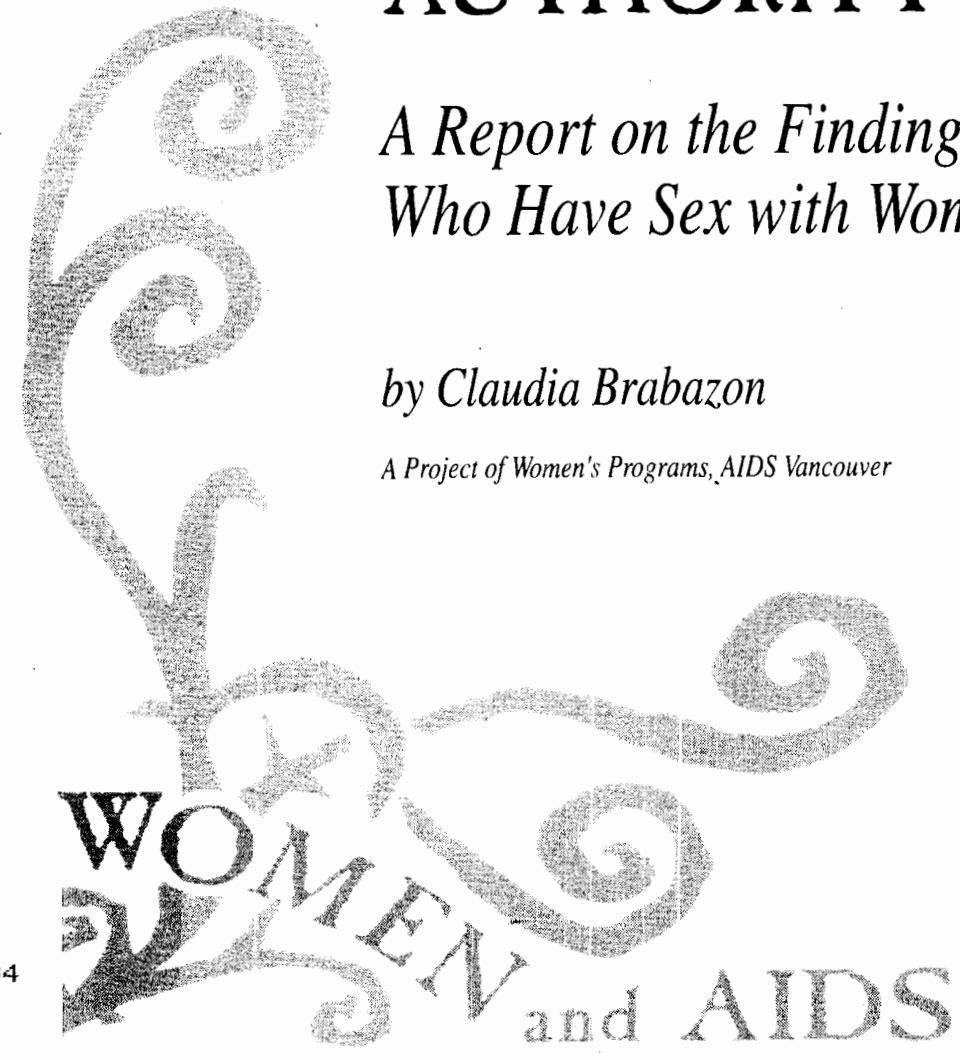

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This survey could not have taken place without the collaboration and participation of a number of people:

First and foremost, thanks must go to the 158 women who completed the survey. A special thanks must also go to the 79 women who wrote comments in the margins of the survey, and thus added a personal, individual component to the research. Their added contribution demonstrates the eagerness of women who have sex with women to be asked about issues relate to HIV transmission that affect their lives.

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A special word of thanks must also go to the Women's Programs volunteers who distributed and collected the surveys, coded, and entered the data.

Thank you all.

Claudia

# SUMMARY OF FINDINGS

This report summarizes the data gathered in a pilot survey of 158 women who have sex with women in Vancouver in the fall of 1992.

- 88% of the women surveyed have been sexually active with women in the past year. 60% of the women surveyed reported having exclusively female partners over the past five years, while 40% said that they had sex with men during this time.
- 91% of the women surveyed had performed oral sex on another woman and 92% reported having oral sex performed on them in the past five years. 88% of these women said they never used protection for oral sex.
- 49% of the women surveyed had been penetrated vaginally with a sex toy. 32% always used protection (washing or using condoms on toys before sharing), 19% used protection sometimes, and 49% never used protection. 80% of the women surveyed had not shared sex toys anally. Among the 20% who had shared toys anally, 42% always used protection, 38% did so sometimes, and 19% never used protection.
- Among the 40% of respondents who had engaged in vaginal intercourse with a man in the past five years, 30% said that they had always used condoms, 47% said they sometimes used condoms, and 23% said they never used condoms. Among the 20% who had engaged in anal sex with men, 35% reported always using condoms, 30% reported using condoms sometimes, and 35% reported never using condoms.
- Of the women who reported having vaginal or anal intercourse with male partners in the past year, 15% were lesbian–identified, and 85% identified as bisexual. Among those who reported having intercourse with a male partner in the past 5 years, 56% identified as lesbians and 44% said they were bisexual.
- 97% of the women surveyed identified sharing unclean needles as a high risk activity. 92% identified unprotected anal sex as a high risk activity. 87% identified unprotected vaginal intercourse as high risk, and 85% said that performing unprotected oral sex on a woman is a minimal/low risk activity if she is not menstruating. 63% identified sharing sex toys as a high risk activity.
- When asked about other low risk activities, 46% believed sucking a man's penis was low risk, and 27% believed that this was low risk if the ejaculate was swallowed. 73% believed vaginal penetration with hands or fingers was low risk, and 54% thought this would be low risk if the anus was penetrated.
- In their written comments, women revealed their own definitions and understandings of safer sex. Among these were: the monogamous, long–term relationship as a form of safer sex, HIV testing with new partners, and using latex barriers with male partners, new partners, or all partners. Reasons for adopting some form of safer sex practice included fear of dying, increased self– esteem and respect for others, and already having STDs or other health problems.

- Most women surveyed felt that they had enough information about HIV transmission/ prevention, and did not consider themselves at risk for HIV infection. There was no relationship between having enough information about HIV transmission and self-reported behaviour change among the women surveyed.
- The women surveyed had most often received information about HIV transmission/ prevention through pamphlets, gay and lesbian media or mainstream media. Many had also learned through friends or through knowing someone living with HIV. When asked how they would like to learn about HIV/AIDS, most women selected methods of information provision that did not require direct contact with another person, such as mainstream media, and gay and lesbian media. When asked where they would most like to go to obtain information, most selected lectures, women's centres, and Women's Programs at AIDS Vancouver. The women surveyed indicated that they wanted more information targeting women who have sex with women from all possible sources.

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# I. BACKGROUND

NO MATTER HOW WE IDENTIFY OURSELVES, AS LESBIANS, BISEXUALS, QUEERS, DYKES, WOMEN LOVING WOMEN, WE ARE AN ADDENDUM IN AIDS RESEARCH.

Throughout history, we have faced the challenges of sexism and heterosexism, sometimes compounded by racism and classism. Pervading our existence has also been the challenge of invisibility. We are the unseen, the uncounted, the unheard. In patriarchal societies throughout the world, the health concerns of women in general have long been a low priority for research and public health initiatives, unless the health and welfare of our children is also perceived to be in jeopardy. Even in the context of an international health crisis like AIDS, often without children or male partners, women who have sex with women become the marginalized among the marginalized. We are left alone to speculate about whether we are at risk, what we should do, and how and if we should protect ourselves.

Women who have sex with women have been receiving conflicting messages about the risk of HIV transmission associated with their sexual practices since the AIDS pandemic began. These conflicting messages come not only from the public health establishment, but from women who care about other women and women's health. We are told that there have been no documented cases of woman to woman transmission, that there have been a few cases of woman to woman transmission, and most recently, that all cases of woman to woman transmission have been discredited[1]. The result of these conflicting messages has been widespread confusion about the risks of sex between women and what we need to do to protect ourselves. Seldom have AIDS education messages acknowledged other sources of potential risk for women who have sex with women, such as having unprotected sex with men or sharing unclean needles. The so-called "dam debate" (whether or not lesbians should use latex barriers for oral sex) continues.

At present, little is known about the mechanics of woman to woman transmission of HIV. Does it happen? How does it happen? And with what frequency? That lesbians are living with HIV/AIDS or that lesbians have died of complications of AIDS is certain. According to the most recent information, these women may not have contracted HIV through unprotected sex with other women [2]. Some became infected through transfusions, others shared unclean needles, and some had unprotected sex with men; yet all are sexually active with other women.

Information about how lesbians get HIV other than by having unprotected sex with women is often marginalized or viewed as detracting from concerns about "real" lesbians or the "real" threat of woman to woman transmission. Woman to woman transmission is not impossible, but it does seem to be much less common than transmission through unprotected vaginal or anal intercourse or sharing unclean needles; nonetheless there is a reluctance to talk about these issues. Instead, the focus of AIDS education for women who have sex with women has been oral sex, considered a low risk activity according to Canadian AIDS Society Guidelines [3].

Oral sex is not all that women do with each other sexually, nor for some is it a principle component of their erotic life. According to the results of this survey, mutual masturbation, tribadism (rubbing your genitals against someones body, often the genital area), and sharing sex toys are some of the activities common to women who have sex with women, and could carry higher risks, but discussion of these behaviours is absent from the literature.

If some women who have sex with women also have unprotected sex with men, or if women who have sex with women also share unclean needles, they are at risk for HIV infection. Thus, in the survey, we asked women about the sex they have with other women, but we also included questions about sexual history with male partners, and about injection drug use. While these questions, particularly the ones about men, were controversial and not always appreciated, as one woman wrote, *"I thought this was supposed to be a survey about women who have sex with women,"* only one person did not complete the survey because it included questions about sex with men.

Disagreement exists among AIDS educators about what safer sex guidelines should be for women who have sex with women, and how they should be presented. According to Camlin [4] a campaign from the Terrence Higgins Trust (THT) in London was adversely received at the VIII International Conference on AIDS because it acknowledged that oral sex is low risk for HIV transmission, suggesting that lesbians "ditch the dams." The Gay Men's Health Crisis (GMHC) in New York recently released a pamphlet for lesbians detailing all manner of safer sex, from gloves to dams to plastic wrap, and describing a plethora of sexual activities which included menstrual blood and rituals involving cutting. The target audience for this campaign is given "reasons to be obedient" in adhering to the guidelines. The tone of this campaign could be just as offensive or alienating to some women as the "do nothing" approach of the THT poster. Despite their respective mass appeal, both examples illustrate the huge schism that exists amongst AIDS educators over this issue. The GMHC campaign also illustrates the barriers to education which can emerge when women are targeted as a single unified group for AIDS education messages.

The AIDS Committee of Toronto responds to the controversy over the safety of performing oral sex on women by encouraging more research on the concentration of HIV in vaginal secretions and the mouth as an entry point for HIV, so that the messages provided by AIDS educators about the risk of performing oral sex on women can be rooted in fact rather than speculation [5]. Some educators are comfortable suggesting that performing oral sex on a woman is a low risk activity for transmitting HIV. Other educators are less certain about the risks of performing oral sex on a woman, emphasizing the added risks associated with sores or bleeding gums, or if menstrual blood is present.

Without clear information about risks for women who have sex with women, safer sex becomes a matter of individual discretion, rather than an informed choice. We cannot identify a distinct community that includes all women who have sex with women that share a common culture, language or tradition. Differences in ethnicity, social class, and sexual practices creates distinct groups of lesbians, bisexual women, and others who do not identify with these labels. Socialization may occur between or

among members of these groups to various degrees. Other women who have sex with women may not identify with any group, whether they are in a relationship with a woman, a man, or not in a relationship at all.

Early in the AIDS epidemic, some education initiatives for North American women were modeled after programs targeting gay and bisexual men, and some continue to follow this pattern. Amongst those responsible for program development in Vancouver, there has been a growing recognition of many barriers to education and behaviour change that develop when education strategies developed for men's communities are adapted for women. The first problem with this style of program development is that women who have sex with women do not form a single "community" the way that many gay men do; thus, they cannot be targeted as a community for AIDS education. Women who have sex with women form various sub–groups including those who are lesbian, bisexual, gay, and/or involved in leather/ s&m activities. Some women may not identify with any such group. Other women may have sex with women and not acknowledge their sexual practices to themselves or others. All these women have different needs for AIDS education and support.

LITTLE IS KNOWN, EXCEPT ANECDOTALLY, ABOUT THE MEANING OF COMMUNITY WHEN APPLIED TO WOMEN WHO HAVE SEX WITH WOMEN.

# II. THE SURVEY

THIS SURVEY IS A FIRST ATTEMPT TO RESPOND TO THE VAST ARRAY OF UNANSWERED QUESTIONS WHICH EXIST ABOUT WOMEN WHO HAVE SEX WITH WOMEN IN THE CONTEXT OF HIV/AIDS IN CANADA.

The purpose of the survey was to answer some basic questions about the risk situations that women who have sex with women are experiencing. Among these initial questions were: how/if women who have sex with women identify themselves? What are our sexual practices? What is our knowledge of the risks of HIV infection and what are the risks in our lives? How have we learned about HIV transmission and how would we like to learn?

The survey reveals some interesting trends about how we are living and loving each other in the era of AIDS. The findings clearly indicate that women who have sex with women have sex creatively and regularly. Many of us have strong opinions about issues related to our identity, our sexuality, sexual practices and HIV/AIDS. In general, the response of the women surveyed indicates that this kind of inquiry is long overdue. Women were eager to express their opinions and begin to share what they know, think, and feel about sexuality and HIV/AIDS. Half of all respondents went so far as to write additional information about themselves and their practices "outside the lines" of the questionnaire. These unsolicited comments, suggestions, stories, objections, and words of encouragement are compelling. They make a substantial contribution to developing an understanding of how women are experiencing other women and themselves in the second decade of AIDS. The voices of the women who wrote to us in the margins are integrated into the survey results, just as they were woven into the survey itself, and create a kind of built-in context for interpreting the findings.

The findings of this survey indicate that women who have sex with women have been exposed to risk for HIV infection in the past five years through vaginal and anal intercourse in which male partners did not use condoms, sharing sex toys without washing, and to a lesser extent, through sharing unclean needles. These findings are consistent with the results of two surveys of lesbian and bisexual women conducted by the San Francisco Health Department released in October 1993 [6]. Both these studies involved over 400 women. The results demonstrated a high incidence of injection drug use and unprotected sex with men, many of whom were gay or bisexual, leading the Assistant Chief of Prevention of the San Francisco Department of Health AIDS office to caution, "service providers should not assume that their lesbian clients are only having sex with women and should help them feel comfortable enough to talk about their behaviours and address the subsequent risks for HIV infection. [7]"

A small pilot study such as this cannot provide definitive answers to all the questions that exist about women who have sex with women. The results of this study can stimulate discussion and lead to the development of programs that reflect women's educational needs. Through its advertisement, distribution and publication of findings, the survey serves the additional function of increasing community awareness about AIDS as an issue for women who have sex with women.

# III. METHODOLOGY

## 1. SURVEY DEVELOPMENT AND DISTRIBUTION

The content of the final version of the Women's survey was developed through extensive collaboration amongst the coordinators of Women's Programs at AIDS Vancouver, and the project researcher. Preliminary interviews were conducted with key communicators, all of whom relate sexually to other women, to identify the principle issues which needed to be addressed. At the time the survey was developed, two other organizations were constructing surveys for the lesbian community: the Gay Men's Health Crisis (New York), and the San Francisco Health Department. Both these organizations and the principal researchers were contacted and made aware of the Vancouver research. A copy of the San Francisco survey was obtained after the Vancouver survey was distributed. The existing AIDS literature and educational materials were examined for the few articles and studies reporting on lesbians and AIDS. Input from this variety of sources was used to construct a preliminary set of questions which were edited and expanded to create a draft version of the survey.

Questions for the survey were developed from a core set of topics such as respondent characteristics (age, identity, ethnicity, HIV status etc.), sex partners in the past year, sexual activity in the past five years, use of risk–reducing methods by women and their partners, and knowledge of risk associated with various activities. These topics derived from interviews conducted with women who identified as relating to other women sexually, and who had knowledge and experience in working with groups of women who have sex with women in Vancouver. These key communicators included staff members at AIDS Vancouver, the Vancouver Lesbian Connection, the AIDS Committee of Toronto, and the Vancouver Health Department who were lesbian, gay and bisexual–identified. The core set of topics derived from these interviews were drafted into a preliminary set of questions which were re–worded and re– worked into a draft version of the survey. Care was taken to use wording which was as inclusive and simple as possible. The final set of questions were derived from a consensus among Women's Program staff and interview participants.

The draft version of the survey was distributed to a sample of 25 women for their comments. Several minor editorial changes were made to the test version of the survey based on the results of the trial run. Specifically, women wanted the opportunity to say that they used "none" of the services of Vancouver AIDS service organizations, and that "none" of the reasons for using injection drugs applied to them. Consequently, these response categories were added. Others suggested that some women insert sex toys orally, as well as vaginally and anally, so this category was included in the final version. None of the women who completed the test survey advocated changing the basic tone or content in any way.

The final version of the survey was a four page document consisting of a series of multiple choice questions and nominal response categories. The survey was divided into sections about sexual activity, injection drug use, understandings of risk,

perceived knowledge and risk, current safer sex practices, talking about sex, sources of information about AIDS, and preferred ways of learning about HIV prevention. The complete text of the *Women who have Sex with Women Survey* is printed in Appendix A.

The survey was distributed in Vancouver by a team of Women's Programs volunteers. A total of 900 surveys were distributed to women's centres, bars, clubs, restaurants, bookstores, and gay and lesbian centres. Women were also given surveys and asked to distribute them among their friends. Completed surveys were returned by respondents to the place where they were obtained or to AIDS Vancouver. The AIDS Vancouver helpline telephone number was printed on every survey with instructions about how to get more information about HIV/AIDS. This information also accompanied each survey as a separate insert. Although the survey was advertised in the local gay newspaper and on community radio, respondents were not given any rewards or incentives to complete it. A total of 158 unspoiled, completed surveys were returned, constituting a response rate of 18%, which is relatively high for a "self–selecting" sample.

## 2. DATA ANALYSIS AND INTERPRETATION OF FINDINGS

Little is known, except anecdotally, about the meaning of community when applied to women who have sex with women. It is questionable whether such a community of women sharing a common culture, language or tradition even exists. We can identify some groups of women who have sex with women who are lesbian or bisexual–identified, but even within these groups distinctions exist based on ethnicity, class, and sexual practices. These distinctions within groups can often be the basis of socialization, rather than identity within a larger "community." Beyond these more visible groups exist other women who have sex with women who do not fit into any pre–existing categories and may not identify themselves using the labels of lesbian, gay, dyke, or bisexual. These women may be in relationships with female or male partners; they may not be in a relationship at all.

Because we do not know where all or even most women who have sex with women live, where they work or socialize, establishing a sampling frame for research on women who have sex with women becomes challenging, if not impossible. As a community, women who have sex with women are invisible and as such are difficult to find and difficult to study. This survey was distributed at the bars, restaurants, women's centres and gay and lesbian centres where women who have sex with women were known to go. When one speaks about "lesbians" and a "women's community" in Vancouver, one is usually speaking of this group. There is no way of determining what proportion of women who have sex with women frequent these establishments.

In interpreting the results of this survey, care must be taken not to generalize the findings to a larger population of women who have sex with women in Vancouver. Questions about income and level of education were not asked for two reasons. First, because we cannot identify a population of women who have sex with women with a known level of income, geographic location and level of education, information about

these variables obtained from a small self- selecting sample has little meaning. Second, assessments of income and education are value- laden, and for women, often correlated with childrearing, partner's income, and related to the devaluing of women's work, women's knowledge, and women's education in our society. Priority was given to asking about income and education in a way that would give respondents and researchers a context in which to interpret this information meaningfully and with as little bias as possible. This would have meant asking several other questions which were beyond the scope of a small pilot study. The absence of this information limits the generalizing of findings and limits the types of analytic comparisons that can be made.

The survey data were analyzed using a combination of statistical analysis and thematic analysis procedures. Responses to each survey question were described using frequency distributions, and correlations between nominal categories were produced using Statview. Responses to question 19, "In the space below, please tell us what has caused your sex practices to change? (if applicable)," were analyzed for relevant issues and themes using standard thematic analysis procedures [8]. Although the unsolicited comments written on the surveys could not be analyzed as part of the data, those comments made most often are included in the report to help clarify and contextualize the responses participants gave.

THE SURVEY REVEALS SOME INTERESTING TRENDS ABOUT HOW WE ARE LIVING AND LOVING EACH OTHER IN THE ERA OF AIDS. THE FINDINGS CLEARLY INDICATE THAT WOMEN WHO HAVE SEX WITH WOMEN HAVE SEX CREATIVELY AND REGULARLY. MANY OF US HAVE STRONG OPINIONS ABOUT ISSUES RELATED TO OUR IDENTITY, OUR SEXUALITY, SEXUAL PRACTICES AND HIV/AIDS.

# IV. RESULTS

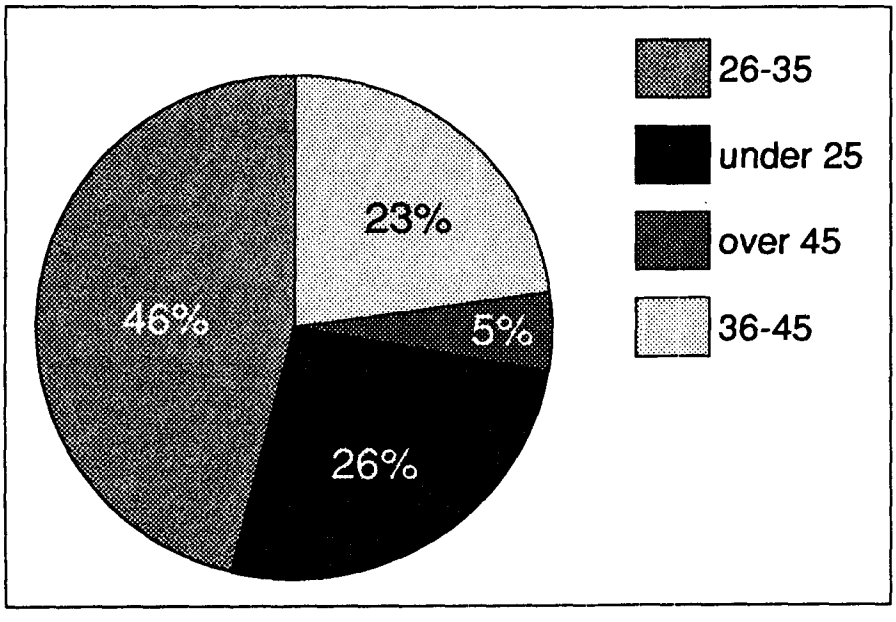
## 1. WHO RESPONDED

One hundred-fifty-eight women in Vancouver completed the survey. 46% of respondents were between 26 and 35. Twenty five percent were 25 or under, and 22% were between 36 and 45. Less than five percent were over 45 (see figure 1).

The survey was available at gay and lesbian centres, women's bookstores, bars and restaurants so it is possible that a considerable portion of respondents could be the lesbians and bisexual women who frequent these establishments. 75% percent of all respondents identified as lesbians. 17% were bisexual. 20% of women who described themselves as lesbians also used other labels to describe themselves such as queer or gay. Some respondents noted on the survey that "dyke" was not one of the options, and 5% of respondents indicated that they preferred this label. It is possible that if "dyke" had been included as a response category, more women would have selected it. Five self-described heterosexual women completed the survey. Only the responses of the two heterosexual women who reported having sex with women were included. Two women provided more unique alternatives: one woman called herself a *"loner"* and another said she was *"a gay man trapped in a lesbian's body."* 12% of all respondents had children.

76% of all participants were white women of North American and European origin. The remaining 24% were a mix of First Nations, Asian, Black, Jewish, and mixed ethnic ancestry. Several respondents wrote comments about the use of *"outdated"* racial categories rather than more accurate and politically correct ethnic terms.

**FIGURE 1: AGE OF RESPONDENTS**



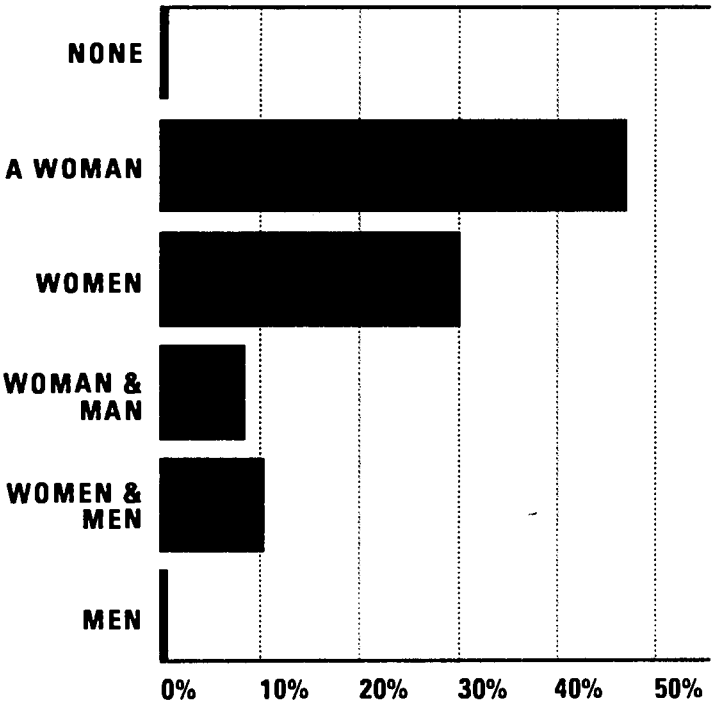
49% of the women surveyed said that they had taken the HIV antibody test. 57% (10 more women than reported having been tested) said that they were HIV negative, two women (1%) said that they were HIV positive, and the remaining 62 (41%) said that they did not know their HIV status, including some of the women who reported having been tested. Several women indicated that they had been tested when they had donated blood. Both of the women who identified as HIV positive said that they had AIDS. One of these women reported using the services of the Vancouver Persons with AIDS Society (PWA). 5% of survey respondents indicated that they had received AIDS education from Safe Company[1]. 89% of the women surveyed said that they did not use the services of any AIDS organizations. The remaining 6% said that they had used the services of AIDS Vancouver.

## 2. WHO WE DO IT WITH

We asked respondents to tell us who they had been sexually active with in the past year (see figure 2). As Figure 2 demonstrates, 88% of respondents have been sexually active with other women in the past year. For 20%, sexual activity also included some male partners. 4% of these women were lesbians—14% of the lesbians who completed the survey.

73% of respondents reported having sex with women only in the past year. Three women reported that they were *"taking a break"* from all sexual activity while they struggled to deal with childhood sexual abuse. 73% of women who have sex with women are masturbating. Of those who did not report masturbating in the past year, all had female partners only during this time.

**FIGURE 2**
**SEXUAL ACTIVITY IN THE PAST YEAR BY PARTNER'S GENDER**



# 3. WHAT WE DO

Respondents were given a list of sexual behaviours and asked to indicate in which of these behaviours they had engaged during the past five years, the gender of their partner, and whether they practiced safer sex when doing the activity "always," "sometimes," or "never." One women made a distinction between using protection for sexual activities with her male "spouse" and her female "lovers." With her spouse she reported never having practiced safer sex; with her lovers she reported practicing safer sex "sometimes." This distinction between practices with a regular partner as opposed to new or casual partners is a pervasive theme in the comments written by the women surveyed:

The survey should distinguish between monogamous/long-term relationships and non-monogamous type encounters for better accuracy.

> *Please note that I have safe sex with anyone who I don't know their HIV status in the last three months or any of their partners i.e. I don't use latex with my life partner. I think these questions need to take into account non-monogamous relationships.*

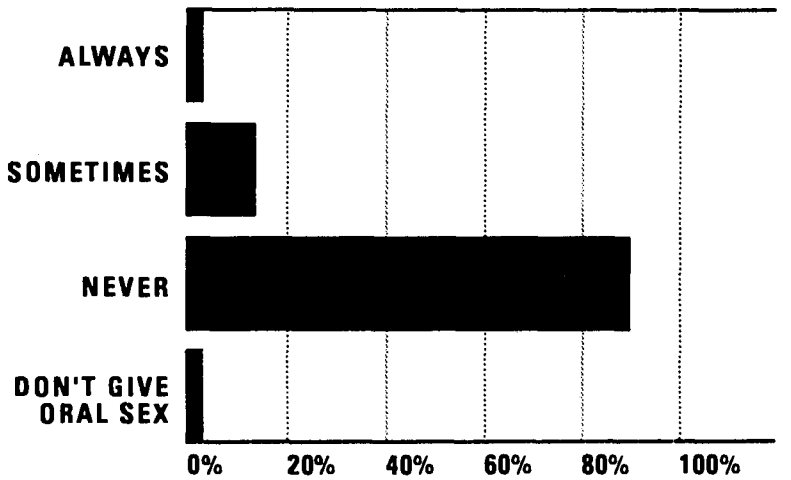
One woman did not complete any of the questions about sexual activities, writing instead, *"abstinence from the above, not from love and affection."*

## *Oral Sex*

Licking or sucking a woman's clitoris, vagina, and/or labia was the sexual activity engaged in most often by survey respondents. 91% of the women surveyed had performed oral sex on another woman in the past five years. 68% reported performing oral sex on women exclusively. 23% said they had "gone down on" both men and women, while only eight percent reported having oral sex with men only. Two women had not performed oral sex on a partner of either gender in the past five years.

88% of the women surveyed said that they had never used protection (i.e. a latex barrier) when performing oral sex on a woman. Two women out of 139 (2%) said they always use protection when performing oral sex on other women, while 14% said that they sometimes used protection (see figure 3).

**FIGURE 3**
**USE OF LATEX BARRIERS**
**WHEN PERFORMING ORAL SEX ON A WOMAN**



None of the women who performed oral sex on men said they always used protection. 14% reported having used protection sometimes when giving oral sex to their partners, both male and female.

30% said that they had performed "rimming" (licking the anus) on their partners. Of those who engaged in this activity with men (5 women), none had ever used protection. Of those who had rimmed other women, 6% said they always used protection, and 27% said they did so sometimes. The remaining 67% said that they had never used protection for this activity.

## *Hands/Fists*

108 women (73%) report that they put their hands/fists in their partners' vaginas. 40 women (17%) said that they had not engaged in this practice in the past five years. Of the women who do not engage in this activity, a few had concerns (*"is this possible?" "painful?"*). More women reported always using protection for manual penetration and fisting (10%) than did so for either giving or receiving oral sex. 22% said that they sometimes used protection for manual penetration. 67% said that they had never used protection for this activity.

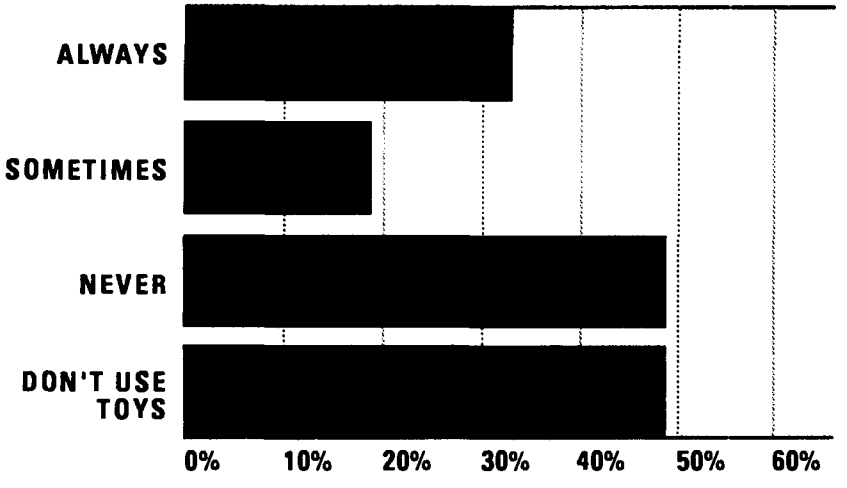
38% reported practicing anal fisting with their partners. 62% said that they had not engaged in this behaviour. 19% reported having engaged in this behaviour with men only or men and women. None of those who had fisted with men had used any type of protection even sometimes. 16% said that they always used protection for this activity with women, and 26% said that they did so sometimes. 58% said that they had never used protection for anal penetration.

## *Toys*

51% of the women surveyed said they had used sex toys with their partners. The remaining 49% had not. The women who used toys (dildos, vibrators, etc.) indicated that toys were used to penetrate both themselves and their partners vaginally. 90% of those using sex toys are doing so with female partners.

32% of the women who are penetrated vaginally with sex toys always use

**FIGURE 4a**
**SEX TOYS: USE OF PROTECTION***
**FOR VAGINAL PENETRATION**



protection (washing or using condoms on toys before sharing), 19% use protection sometimes, and 49% never use protection (see figure 4a).

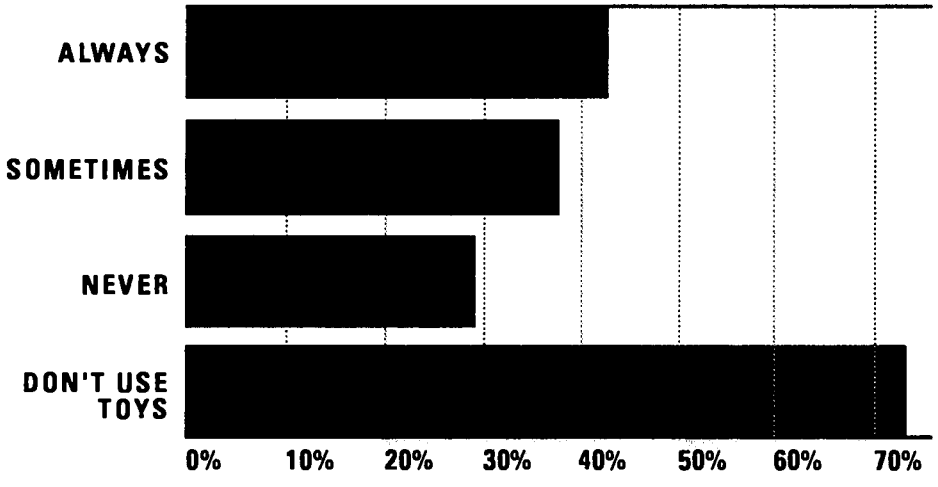
20% said they had been penetrated with a toy anally. 26% of the women surveyed report having penetrated their partners in this manner. 74% of those using toys for anal penetration are doing so with other women, while 26% are doing so with men.

Of those women who had been penetrated anally with a sex toy, 42% always use protection with their female partners, 38% report using protection sometimes, and 19% never use protection (see figure 4b).

One woman reported always using protection when penetrating her male partners anally. Of the remaining 8 women who report penetrating men with dildos and vibrators, 50% said they sometimes used protection, the other half said that they never did so.

When we tested the survey in the community, several women suggested that we include oral penetration in the sex toy category. This activity was practiced by 20% of the women surveyed. The same percentage reported putting dildos and vibrators in their partners' mouths as reported licking or sucking their partners' toys. The percentages of women using protection for sharing toys orally are less than those sharing vaginally or anally. 29% report always using protection, 29% report sometimes using protection, and the remaining 42% report that protection is never used. Two women report putting toys in the mouths of their male partners without protection, and two report having men put toys in their mouths, again without protection.

**FIGURE 4b**
**SEX TOYS: USE OF PROTECTION***
**FOR ANAL PENETRATION**



## *Sex with Men*

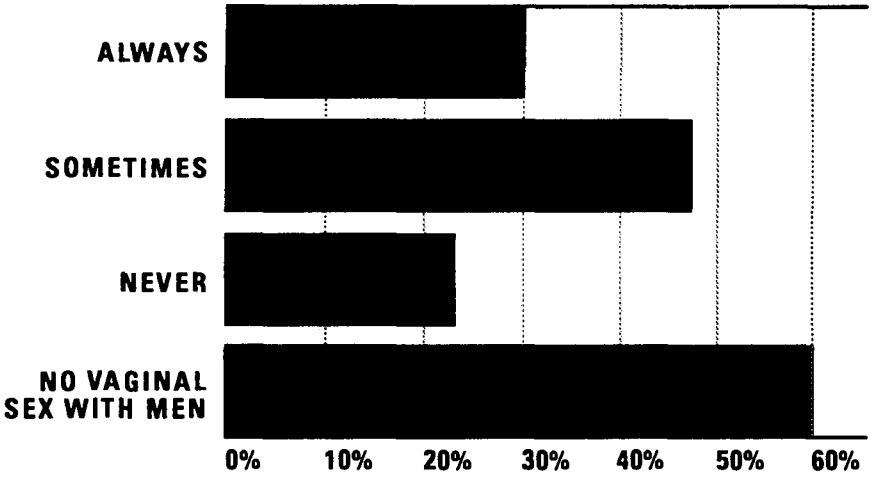
Including questions about having sex with men in a survey of women who have sex with women generated a great deal of interest amongst some survey respondents, to say the least. Those women who reported having had sex with men completed these questions without comment. Among those women who had never had sex with men, or stopped having sex with men, some wrote a variety of unsolicited but nonetheless articulate replies to these questions. Often, women who objected to seeing the word "penis" in print in a survey about their sexual behaviour simply took ownership of the survey and blackened it out, or replaced it with "her dildo." A few women wrote "not applicable" next to the entire category or crossed all the "penis questions" out. Some drew an arrow referring us to the title of the survey. 25% of those surveyed ignored the "penis questions" altogether.

While these comments do not constitute the majority of responses, the attitudes expressed by these women are strong and prohibitive, and as such could make it difficult for women who have sex with women to talk about the sex they have with men and the risks they are exposed to if the sex is unprotected.

40% of the women surveyed said they had participated in vaginal intercourse with a man in the last five years, as some pointed out, prior to becoming sexually active with women only. 56% of the women who had vaginal intercourse with men in the past five years identified as lesbians. 44% said they were bisexual.

30% of the women who had engaged in vaginal intercourse said their male partners had always used condoms. 47% said their partners sometimes did so, and 23% said their partners never used condoms. (see figure 5a).

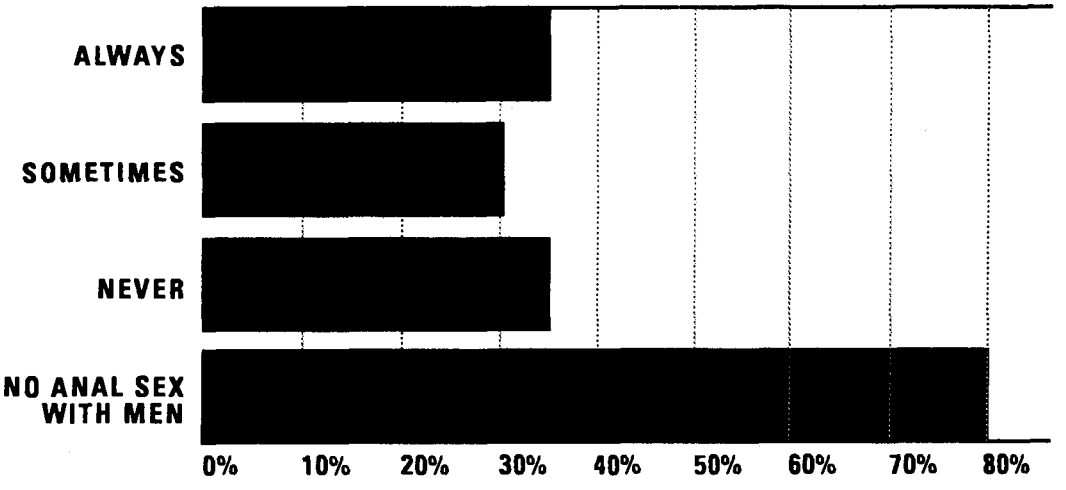
**FIGURE 5a**
**USE OF CONDOMS BY MALE PARTNERS FOR VAGINAL INTERCOURSE***




*The first three columns refer to the 40% who reported having vaginal sex in the past five years.

20% of the women surveyed said they had been penetrated anally by a man. Amongst these women, 35% said their partners always used condoms, 30% said they used condoms sometimes, and 35% said condoms were never used (see figure 5b).

**FIGURE 5b**
**USE OF CONDOMS BY MALE PARTNERS FOR ANAL INTERCOURSE***




*The first three columns refer to the 20% who reported having anal sex in the past five years.

## *Sharing Unclean Needles*

When asked in question 11 of the survey if they had shared unclean needles within the past five years, only two women reported having done so. Question 13 asked women to "Check those activities in which you [they] have shared unclean needles. In answer to this question, 8 women reported having used recreational drugs, two said that they had used steroids and one woman specified an activity not listed, *"sharing illegal drugs more than for recreation."* Nearly all women surveyed (97%) believed that sharing needles is high risk. The remaining three percent said that the practice of sharing needles constituted "some" risk for women.

## *Other*

The survey did not include questions about the frequency of digital penetration or mutual masturbation, as one woman wrote, *"you forgot my favourite thing, mutual masturbation."* Because mutual masturbation is a safer sex behaviour, it would be useful to know its frequency in women who have sex with women. Several other women distinguished between manual and digital penetration by changing the word "hand" to "finger(s)" in both the anal and vaginal categories before responding. Others wrote, *"what about fingers?"* Tribadism (rubbing your genitals against someones body, often the genital area) was also not part of the survey, as indicated by three respondents who added it *"tribadism, with a woman, never with protection."*

# 4. UNDERSTANDING HIV TRANSMISSION

To assess understandings about the risk of HIV transmission associated with various unprotected sexual activities, women were asked to determine whether a particular behaviour was "high risk," "some risk," "no risk," or whether they didn't feel they had enough information to make this judgment ("don't know"). Quite a few women found questions about the risk of "sucking a man's penis" or "swallowing his cum" out of place or offensive in a survey of women who have sex with women. These respondents expressed their objections in a number of ways. Most either crossed out the category or wrote "not applicable" beside it. A few used more colourful phrases. Next to the category, "sucking a man's penis is..." more than a few wrote "*gross*," "*yuk*," and "*NOT!*" Others merely created a new category, "*I don't care.*"

Again a distinction between behaviour within a monogamous relationship and behaviour with a new partner was made: "*same partner 11 years, both healthy, both monogamous. Re: sex today with new partners I believe...*" Some women asked for better and more complete information about risks for women:

Because of the way the research has been done around women, "I don't know" is probably the most accurate answer in all cases.

*Re: oral sex with women. We require more information on this issue!*

The women who responded to the survey most often associated a high risk of HIV transmission with unprotected vaginal intercourse (87%) and unprotected anal intercourse (92%) with a man, and with injection drug use in which needles are shared without cleaning (97%). 63% of women surveyed identified sharing sex toys with a female partner as high risk, 23% less than the number that identified unprotected vaginal intercourse as high risk.

There was a tendency among survey respondents to identify all activities with a male partner as high risk. 59% believed that sucking a man's penis was high risk, although this is considered a low/minimal risk activity according to the Canadian AIDS Society safer sex guidelines. 69% indicated that sucking a man's penis and swallowing his cum was high risk. 85% believed that performing unprotected oral sex on a woman who is not menstruating would be low risk. 31% felt that performing oral sex on a menstruating woman would be a low risk activity.

Table 1 shows the consistency of women's assessments of risk with current Canadian AIDS Society Guidelines. Canadian AIDS Society Guidelines are not absolutes, and are constantly changing as more information about risk emerges. It is possible that some of the discrepancies between responses given by the women surveyed and Canadian AIDS Society Guidelines could be an artifice of the survey design. Making a distinction between "licking a woman's genitals" and "licking a woman's genitals when she has her period" implies by the mere fact of the distinction, that a difference exists. This same distinction was made in the survey between "sucking a man's penis" and sucking and swallowing, again, implying a difference. Such implied differences can create real differences in how people respond particularly when the similar response categories immediately follow each other, as they do in this

survey. Thus, it is possible that those women who were not sure about the risk of oral sex while menstruating or swallowing ejaculate simply guessed that these activities were higher risk based on how these questions were asked.

**TABLE 1:**
**CONSISTENCY OF RISK REPORTED FOR VARIOUS SEXUAL ACTIVITIES WITH CURRENT CAS GUIDELINES.**

| ACTIVITY | CAS GUIDELINES | CONSISTENCY WITH CAS GUIDELINES (Percent) |
|---|---|---|
| licking a woman's clitoris, labia, vagina | minimal risk | 85% |
| licking a woman's genitals when she has her period | low risk | 31% |
| manual penetration—vagina | minimal risk | 73% |
| manual penetration—anus | minimal risk | 54% |
| sharing sex toys | high risk | 63% |
| having a man's penis in your vagina | high risk | 87% |
| having a man's penis in your anus | high risk | 92% |
| sucking a man's penis | low risk | 46% |
| sucking a man's penis and swallowing his cum | low risk | 27% |

# WHAT HAS CAUSED YOUR SEX PRACTICES TO CHANGE?

This question was the only question in the survey which allowed women an opportunity to express themselves. Thus, many women not only used the space to talk about reasons why their sex practices had changes, but also to describe why they had not changed or how they felt about AIDS or sexuality in general. The themes which emerged fall into two categories: reasons for changes in practice, and specific changes in practice.

## *I don't want to die...*

Ten women wrote that "fear of death" or "I don't want to die" was their motivation for changing their sexual practices. For some, the fear was associated with AIDS specifically, for others the concern had become a large and lingering unspecified "fear:"

> *If and when I do enter another relationship, and even if we are both currently checked out and are HIV– we shall most certainly observe safe i.e. protected sex at all times.*

> *I want to have sex more often with more women but am fearful – I realize this is self–destructive but fear is a powerful motivation*

## *Self–esteem and respect for others...*

> *As a sexually active adult, I feel I need to respect my own health as well as those with whom I am intimate.*

> *Even though I've known about safer sex practices for at least 2 years, I was completely in denial that I could get it. I didn't want to think about it. It wasn't until I started doing healing work around issues of child sexual abuse that I started to care about myself and what happened to me. It was then that I decided to commit to some form of safer sex. In other words, I think it had a lot to do with gaining some self–esteem and overcoming my own fatalism. I've often wondered if this is true of a lot of women in general. As an urban white lesbian I had the information available to me and still I wasn't practicing.*

As these comments illustrate, a connection is made between building self–esteem and valuing oneself and feeling able to negotiate or practice safer sex. Caring about one's own life is also connected with caring for one's partner or "want[ing] to be sexually responsible for both myself and my partners." An HIV positive woman wrote, "I do not want to pass the virus to my partner." One woman raised the issue of trust, saying "The only person I can trust 100% to take care of myself is myself."

## *I already have STDs or other health problems...*

For some women, changing sexual practices was motivated by contracting an STD:

> *I have HIV.*

> *I already have one sexually transmitted disease – genital herpes – I don't want another.*

For one woman, having another chronic disease impacted on her behaviour and could not be separated from a variety of other concerns:

> *Fear, maturity, friends who are HIV+, friends who died from complications of AIDS, have 2 gay family members with AIDS, have a chronic disease called systemic lupus erythematosus and a lowered immune system – AIDS would kill me very quickly, responsibility, too busy to get sick, in a period of celibacy to do intense therapy for ritual abuse.*

## *Safer sex is for male partners...*

The results of the survey indicate that women who have sex with women are less likely to practice safer sex with their male partners than they are with other women, despite their knowledge that the risks are higher. When asked if their practices had changed, several women wrote that they were more likely now to practice safer sex with male partners:

> *I am a 20 year old woman who has sex with men and women. I use safe sex practices with men but not with women. My sexual education occurred during the era of the AIDS plague, so I have never been sexually active outside the context of AIDS awareness.*

> *I will always use a condom when having intercourse with a man because I've heard a lot about condom use and it makes sense to me that HIV can be transmitted by unprotected intercourse*

> *I have always used condoms with male partners, so that hasn't changed. I would not have considered barriers necessary with women without AIDS being an issue. If I were to participate in high risk activities, I would seriously consider risks and probably choose safest protection. I have considered having sex with a gay male friend. Protection would be mandatory. I don't know if I would choose not to if he had tested +. Perhaps I would consider non–penetrative sex, no fluid contact. Undecided. Is sex worth a known risk?*

## *Safer sex is for new partners...*

For other women, the gender of their partner is less important than whether this is their regular partner or someone new in determining whether they practice safer sex. in these cases, getting a new sex partner was associated with adopting safer sex practices:

> *If I were to change partners now, I would change my sexual behaviour. If I were to have a male partner, I would insist on condom use. I would have and insist on my partner, male or female, have an AIDS test before sexual activity.*

*I know that with a new partner who I don't yet know very well it is advisable to use latex for all sexual activities.*

One woman pointed to the paucity of information about risks for lesbians in changing her practices in the opposite direction:

*Information on how little research is available for women about lesbian sex and straight sex has made me swing from wanting to be extra–cautious to more relaxed but aware enough to think about what is safer for me. I would use latex more if there was more proof that women's vaginal juices are a source of infection rather than merely a possible but as yet unknown source of transmission for lesbians and bisexual women.*

## *Safer sex is for everyone...*

A small group of women said that they now would practice safer sex all the time with everyone. These women had all been sexually active with men:

*Have stopped being sexual with men in the last four years but may want to start again. Use of condoms unquestionable now! Want to have other sexual partners besides my primary partner – want to practice using dental dams, gloves, condoms with her too.*

*Now I never have intercourse without a condom. One of my partners, a man, is HIV+, and we've learned to have sex, well, creatively, and rarely have intercourse. One thing I have to say...we need to be honest that oral sex in most circumstances has little/no risk. People are less willing to adapt to safe sex if they think all the fun stuff has to go. People need to learn creative ways of cumming!*

## *Having a monogamous long–term relationship is a form of safer sex...*

The theme of the monogamous, usually long–term relationship as a kind of safer sex practice was prevalent throughout the survey. In some cases at the beginning of a relationship both partners have an HIV antibody test, and if both test negative, they will not use protection for any sexual activities. Many survey respondents are vested in the belief that practicing monogamy reduces their risk of contracting HIV:

*I had been in a monogamous relationship. Now I'm single and dating so it is important to be as safe as possible if I have multiple partners.*

*Because of my last sexual partner's age (much older than me) no history of needle use, and monogamy during 2 1/2 years together I did not feel it necessary given our history and sexual practices to use protection for oral sex. I hope this adds to the content of my answers. Thank you for this opportunity to give you feedback.*

Some of these women also emphasized the importance of knowing the sexual history of their partners in determining whether safer sex practices are used.

### *Perceived Risk*

58% of women surveyed do not believe that they are at risk of contracting HIV. 19% sometimes think they are at risk, and 17% believe they are at risk. The majority of these women (61%) think that they have enough information about HIV transmission and prevention; the other 39% do not. A few women wrote "what's enough?" on the survey.

The women surveyed were asked whether having information about HIV/AIDS had changed their practices. Women were very divided in their responses. 36% said that their practices had changed. The same percentage (36%) said that their practices had not changed. 27% said that their practices had changed sometimes. Most of the women surveyed (46%) did not think they were at risk for HIV infection. 31% said they sometimes felt they were at risk, and 20% said that they believed that they were at risk. No relationship exists between having enough information about HIV transmission and prevention and change in practices. Likewise, perceived risk is not related to behaviour change.

## 5. AIDS EDUCATION AND PREVENTION

Women reported having learned about HIV/AIDS from a variety of sources. Pamphlets (77%) and gay and lesbian media (74%) were the sources of information mentioned most often. 68% had heard about HIV/AIDS through straight media. 66% reported learning about HIV/AIDS through friends. 51% reported gaining their knowledge from someone living with HIV. 41% said they had gotten information from women's centres. Lectures and workshops were a source of information for 39% of women surveyed. 36% reported having received information when they had an HIV antibody test. Of existing AIDS service organizations, 32% said they had gotten information through AIDS Vancouver, 27% through Women's Programs at AIDS Vancouver, and 22% through the Vancouver PWA Society. 22% had gotten information about HIV/AIDS from their doctor, 7% had learned through family members, and 17% said they had learned through school.

The women surveyed were asked to indicate where they would like to learn more about women and AIDS. Lectures (44%), women's centres (58%), doctor's offices (55%), and gay and lesbian centres (53%) were selected most often. 41% said they would like to learn through Women's Programs at AIDS Vancouver. Respondents were also asked to indicate the form in which they would prefer this information to be presented. Women showed a preference for information that did not require person to person contact such as campaigns from mainstream media, gay and lesbian media, and pamphlets. Women also indicated that they wanted more information from all the sources indicated.

# V. DISCUSSION

## MORE QUESTIONS...

The present survey constitutes a beginning of work which needs to be done with women who have sex with women. Still relatively little is known about women who have sex with women as a community. Do lesbians, dykes, and gay women have a sense of belonging to one community? Is it the gay community? The lesbian community? The women's community? What about bisexual women? Leather women? Injection drug users? How do women fit in? Future surveys should include these and other questions about relevant demographic information, such as income, education, occupation, ethnicity, and medical markers of exposure to HIV like other STDs, and pregnancy. AIDS education programmes must begin to address issues of community and identity to be effective in preventing HIV infection and promoting health. These interventions should also consider the impact of women's economic situations, education/literacy, and histories of sexual abuse, violence, and addiction in constraining women's ability to make choices or to be aware that choices exist.

Like any other group in society, lesbians are not a homogeneous group with respect to socioeconomic status, belief systems, and as this survey demonstrates, sexual practices. Acknowledging diversity means more work for AIDS researchers and educators in developing and designing programs, for example, a campaign aimed leather/s&m women may not be appropriate for groups of women who do not engage in these practices. If members of a target group are clearly divided in their ways of conceptualizing and having sex, to do otherwise would seem less than effective, if not less than responsible.

Subsequent surveys of women's sexual practices should include questions about mutual masturbation, tribadism, and digital penetration—popular practices among the women surveyed. Further research must be done to accurately assess the risks of sexual activities in which both partners are women so that correct, clear information can be given to women about the risks in their lives.

That 158 women took the time and effort to complete and return a four page survey, when offered little incentive to do so, suggests that this type of inquiry is long overdue. That half of these women took the additional time to write their feelings about the survey, their own sexuality, and HIV/AIDS in the margins of a survey suggests that many of these women want to talk in greater depth about how AIDS is affecting their lives and their sexuality. This could be accomplished through interviews or focus group discussions beginning with a small number of key informants using a snowball sampling frame. Such a qualitative inquiry could answer questions about the context of community in which women have sex with women, use drugs, and have sex with men.

The written response, both solicited and unsolicited can provide a rich source of information about the attitudes and practices of women who have sex with women. The anonymity of putting pen on page rather than a face to face encounter with an individual or group yielded many compelling personal disclosures. Further research with all groups should consider the worth of incorporating an open-ended written

question and answer format to elicit responses which reflect more of the private and personal processes of thought and feeling which comprise the individual erotic and psychic life. This research is clearly biased towards those who are literate. Alternative ways of obtaining this type of information from women who do not fall into this category should also be developed.

## WHAT WE HAVE LEARNED

The survey results affirm that women do have sex with women and themselves in a variety of ways. Most women are sexual with themselves. Throughout the survey, women reported engaging in a wider range of sexual activities with female partners than with men. While oral sex was the most popular activity amongst women, half the respondents said that they had used vibrators and dildos in their sex play, for oral, vaginal, and anal penetration. Manual and digital penetration is engaged in by most women (73%). This figure does not include those who practice mutual masturbation. Sex with women, for those surveyed, is not exclusively or some cases predominantly about oral sex, but includes sharing toys, mutual and self–stimulation, manual and digital penetration, deep kissing, and tribadism.

The results of this survey strongly suggest that future AIDS education initiatives should pay increased attention to all the ways we are sexual with each other. This means expanding the focus of AIDS education for women who have sex with women to include information about reducing risks associated with sharing sex toys, sharing unclean needles, and unprotected sex with men, as well as oral sex. This change in emphasis is particularly important if we can accept existing epidemiological evidence and current Canadian AIDS Society guidelines which state that performing oral sex on a woman or penetrating her manually is a low risk activity, whether she is menstruating or not.

Among the range of sexual activities that women can engage in with each other, sharing sex toys without cleaning them is high risk. The risks of mutual masturbation and tribadism are uncertain. Information about these activities must be acknowledged and incorporated in AIDS education messages, just as risks of oral sex, anal sex, rimming (licking the anus/around the anus), frottage (two men rubbing their bodies together to point of climax), and mutual masturbation have been included in prevention messages for gay and bisexual men for the past decade.

The results of this survey demonstrate that most women who have sex with women have received and retained information about high risk behaviours which involve sex with men or injection drug use. More uncertainty exists about risks associated with sexual activities in which the partner is another woman, and about the various lower risk activities. This is not surprising given the controversy which exists over risks for women in general and women having sex with women in particular. Women are entitled to know the actual concentration of HIV in all female body fluids, but particularly in vaginal secretions and menstrual blood so that we can take assessment of risk for women beyond the realm of speculation.

The survey results clearly demonstrate that while women who have sex with women understand that unprotected vaginal and anal intercourse are high risk activities for HIV transmission, their male partners are not wearing condoms for these activities. Only 30% report that condoms are always used for vaginal intercourse. This means that the remaining 70% of the women who had sex with men in the past five years (40% of those surveyed) have had at least one incident of unprotected vaginal intercourse. 23% of these women report that their male partners never wore condoms.

20% report having been penetrated anally by a man in the past five years. 35% said their partners always wore condoms. This means that among the women who engaged in anal intercourse, 65% have had at least one incident in which the sex was unprotected. For 35% of these women, all incidents of anal intercourse were unprotected. These findings demonstrate that women who have sex with women have engaged in activities which put them at risk for HIV infection. These findings also show that having knowledge of high risk activities does not make women willing or able to have their male partners adopt safer practices.

Future research should assess the frequency and consistency with which condoms are used for vaginal and anal intercourse by men when they have sex with women. The results of this survey add to a growing body of evidence that women are unable or unwilling to get their male partners to wear condoms, regardless of their sexual orientation, age, ethnicity, or socioeconomic status. If this is indeed the case, more energy and attention may need to be focused on convincing men that they need to practice safer sex with their female partners, if prevention efforts are to become more effective.

The results of this research also suggest that having correct information about HIV transmission and prevention is not related to perceived risk. For years, women who have sex with women have been told that they cannot get AIDS, and specifically that "lesbians and bisexual women do not constitute a risk group." Behaviours place people at risk for HIV infection, not the labels they use to identify themselves and each other. For many years, public health education has provided information about risk and incidence of HIV infection among so- called "risk-groups" (heterosexual, bisexual, homosexual, injection drug using, prostitutes). This reporting process fails to identify the specific behaviours which place individuals at risk such as sharing unclean needles, having unprotected vaginal or anal intercourse, or sharing sex toys without cleaning them. Women who have sex with women have never been included in these statistics, even if they engage in high risk activities. This emphasis on risk groups may have contributed to a denial of risk among women who have sex with women even if they engage in high risk activities. The absence of any mention of women who have sex with women in these statistics might lead some to think, "this has nothing to do with me, women who have sex with women don't get AIDS."

Most of the women surveyed had been exposed to some AIDS education information. This information was not simply absorbed, but was thought about, discussed and critically evaluated by many of the women surveyed. The women who completed the survey seemed to question the authority of the information they had been given about what activities might place them at risk, and how they should protect

themselves, recognizing that much of what they had been told was unclear or grounded in speculation. This suggests that future AIDS education for women who have sex with women needs to be honest about what is known about risk and incorporate women's understandings of safer sex.

65% of the women who answered this survey reported that having information about HIV transmission and prevention has changed their practices at least sometimes. These changes are important to them, as evidenced in their compelling replies to the question which asked what had caused their practices to change. However, relatively few had started using latex for oral sex or condoms for anal or vaginal intercourse. While these changes were important to the women surveyed, they are not part of the latex–based, conventional forms of safer sex, and are worth reviewing.

Women reported that their changes in practice were motivated primarily by self–esteem and respect for others, having already developed an STD or other health problem, and the fear of dying of AIDS. In the context of powerful and compelling motivations to change behaviour, women described a new type of safer sex. These women defined a safer sex centred more on practicing safer sex with male partners or new partners of either gender. The most prevalent theme throughout is the idea that serial monogamy, particularly when accompanied by regular HIV antibody tests is a valid form of safer sex. Changes which women described involved decisions which are within women's control, much more than changes which involved negotiating condom use.

Most existing AIDS education campaigns focus on risk behaviours and latex, and advocate 100% compliance with these guidelines 100% of the time with everyone. Safer sex for the women surveyed is an issue about people first and latex second, if at all. Despite having information about risk, these women are choosing to/being forced to/have no alternative but to live with some risk. We do not have methods of preventing HIV infection within our control, so we try to make sense of risk, live with risk, and reduce risk according to the means available in our experience.

Presently, women use methods of risk reduction that have meaning in relation to our lives and relationships. We need accurate information about how effective these methods are, and how much risk they reduce, so we can make our own best risk reduction decisions. All women need risk reduction methods that are as effective as condoms and are in our control. Working together we can develop ways of supporting each other as we try to change our behaviour to include more safer sex practices more of the time.

# VI. RECOMMENDATIONS

Do not assume that women do not have any risk for HIV infection. In particular, do not assume that women who have sex with women are not or have not been sexually active with men. Provide women with a safe and comfortable atmosphere in which to discuss their risks without fear of judgment, recrimination, or loss of identity.

* Acknowledge and incorporate in all resources targeting women (regardless of sexual orientation) the range of risk activities in which women may engage. This range of activities includes having sex with women and men, using sex toys, sharing needles, having vaginal or anal intercourse, oral sex, mutual masturbation, and s/m activities.

* Assess the risk of sexual activities unique to women who have sex with women. These would include tribadism (women rubbing genitals together), mutual clitoral/vaginal masturbation, and sharing sex toys vaginally or anally.

* Provide women who have sex with women with the information and support they need to assess their own risk, and provide them with a safe atmosphere in which to tell their stories and discuss how they are at risk. Create a non–judgmental atmosphere for women to assess risk so women can make informed decisions about how much risk they live with, and to begin to take steps to reduce their risks.

* Give women information about risk reduction methods which are within their control, even if these methods are not technically as effective as the ones we do not control. Condoms are not effective if they are not used correctly and consistently. Diaphragms, contraceptive sponges, and spermicides can be used by women properly and consistently without the cooperation or knowledge of their partners.

• Develop an effective method of HIV prevention that can be used by women without the knowledge or consent of their partners.

• Acknowledge that women may choose to or are forced to live with risk. Resources need to model non–judgmental, non–blaming attitudes about risk realities for women.

* Do not focus AIDS education for women who have sex with women exclusively on oral sex. Acknowledge in AIDS education messages that performing unprotected oral sex on a woman is considered a minimal risk activity for HIV transmission. Women must also be made aware of situations in which risk of infection through oral sex may increase (eg. sores/cuts in the mouth, presence of other STDs, menstrual blood).

* Determine the concentration of HIV in women's body fluids, especially menstrual blood and vaginal fluid.

• AIDS education resources should address the role that violence and abuse (either from past experiences or present events), alcohol and drugs may play in contributing to our risks.

* Acknowledge that men can be part of sex or part of our sexual history as women who have sex with women whether they are partners, ex–partners, semen donors, or perpetrators of sexual abuse or assault.

* Separate initiatives must be developed to target men who have sex with women with AIDS prevention/education messages.

* Health care professionals and educators should provide women with information about how to maintain good vaginal health and ensure that vaginal health is maintained through regular PAP tests and vaginal exams.

* Shift public health emphasis from reporting statistics on incidence of HIV infection amongst various risk groups to reporting incidence of infection associated with specific behaviours.

* Conduct a larger more detailed survey of women who have sex with women to generalize and corroborate the findings of this small pilot study. Design and conduct a survey of women of all sexual orientations about their attitudes and practices related to HIV transmission.

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