First, service

Relationships, sex and health among lesbian and bisexual women

Laurie Henderson
Sigma Research, London

David Reid
Sigma Research, London

Ford Hickson
Sigma Research, London

Susie McLean
National AIDS Trust, London

Jacqui Cross
The Lesbian and Gay Foundation, Manchester

Peter Weatherburn
Sigma Research, London

Original Research Report

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Questionnaire design: Ford Hickson, Laurie Henderson, Peter Weatherburn, Susie McLean.

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©Sigma Research
Faculty of Humanities & Social Sciences
University of Portsmouth
Eurolink Business Centre
49 Effra Road
London SW2 1BZ
020-7737 6223
www.sigmaresearch.org.uk

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Contents

1.	**Introduction**	**1**
1.1	Why we did it	1
1.2	How many lesbians or bisexual women are there?	2
2.	**Methods and demographics**	**3**
2.1	Survey 1: Sexual Health for All	3
2.2	Survey 2: The Lesbian & Bisexual Women's Sex Survey	3
2.3	Description of samples	4
2.3.1	Region of residence	4
2.3.2	Age	5
2.3.3	Preferred term for sexuality	5
2.3.4	Ethnicity & country of birth	6
2.3.5	Current partnerships	6
2.3.6	Household living arrangements	7
3.	**Sexual Behaviour**	**8**
3.1	Gender of partners	8
3.1.1	Age and gender of partners	8
3.1.2	Sexuality and gender of partners	9
3.1.3	Household living arrangements and gender of partners	9
3.2	Casual and regular sexual partners	9
3.3	Length of time known partner prior to first sex	10
3.4	Length of time since sex with someone other than partner	10
3.5	Sources of new sexual partners	10
3.6	Frequency of sex	11
3.7	Summary	11
4.	**Sexual values and needs**	**12**
4.1	Health concerns	12
4.2	Sexual values	12
4.3	Needs for a satisfying sex life	13

4.3.1 Age and sexual dissatisfaction 14
4.3.2 Sexuality and sexual dissatisfaction 15
4.3.3 Relationship length and sexual dissatisfaction 15
4.3.4 Household living arrangements and sexual dissatisfaction 15
4.3.5 Gender of partner and sexual dissatisfaction 15
4.4 Needs for maintaining a relationship 15
4.5 Needs for sexual activity 16
4.6 Need to be able to demonstrate affection 17
4.7 Desire for children 18
4.8 Need for information about available interventions 18

5. Knowledge and experience of sexual health services 20
5.1 Access to interventions 20
5.2 Past sources of sexual health information 20
5.3 Seeking interventions 21
5.4 Are interventions tailored? 21
5.5 Quality of service received 22
5.6 Where services need to improve 23
5.7 Summary 23

6. Summary and implications 24
6.1 Recruitment 24
6.2 Demographic profile 24
6.3 Sexual behaviour 24
6.4 Sexual values and needs 25
6.5 Sexual problems 25
6.6 Sexual health information need 26
6.7 Use of sexual health services 26
6.8 Conclusion 27

References 28

1 Introduction

1.1 WHY WE DID IT

The UK's first *National Strategy for Sexual Health and HIV* (Department of Health, 2001) does not mention the word lesbian and no reference is made to women who have sex with other women. The omission is symbolic of the invisibility of lesbian and bisexual women in sexual health services in this country. Given the predominance of the medical model of sexual health, this is not surprising. In this model, sexual health is conceptualised as the absence of sexually transmitted infections and unwanted conception; two forms of sexual harm most commonly arising from sex with men, and to which, consequently, lesbians are considered less likely to be subject. Although some lesbians do acquire STIs (through sex with either women or men) and some conceive, in the medical model lesbians are the most sexually healthy adult sub-population.

However, infections and unintended conceptions are not the only hazards that can arise from sex, and they are not the only sources of sexual distress. Enforced celibacy, absence of sexual fulfilment, unequal and abusive sexual relationships, difficult and painful sex, relationship disruption, and feelings of low self-worth and sexual disgust can all cause extensive unhappiness and poor mental or physical health. Little is known about the relative value people place on freedom from these harms compared with freedom from STIs and unwanted conception. Even less is known of their prevalence in different adult populations. Although we had been interested in doing a survey about sex between women for some time, the dominance of the medical model in sexual health means very little research funding is available in this area.

The two surveys reported here arise from two areas of interest around lesbian sexuality and health. The first was (ironically) undertaken to inform the *National Strategy for Sexual Health* (prior to its merger with the *National HIV Strategy*). Sigma Research, The Lesbian and Gay Foundation (LGF) and the National AIDS Trust (NAT) were commissioned by the Department of Health to conduct a community recruited survey among lesbians, gay men and bisexual men and women to better understand their sexual health needs. Access to services and health promotion were two areas of special concern to the Department. The key aims of the investigation were to describe, firstly, the major obstacles to sexual health for lesbian, gay and bisexual people and, second, those people's preferences and priorities for State funding to address their sexual health needs.

The second survey was commissioned by a television production company which was making a documentary about lesbians' and gay men's experience of domestic violence. A set of questions about this topic was embedded within the sexual behaviour survey. The domestic violence data are not reported here as it was commissioned on the understanding that no data would be published until the television programme had been made and broadcast. This has not yet happened. Here we report the sexual health data from that survey other than the questions about domestic violence.

This report looks at sexual behaviour among lesbian and bisexual women, what value women place on aspects of sex and the harm that can be associated with it, and women's experiences of services designed to address sexual health needs.

1.2 HOW MANY LESBIANS OR BISEXUAL WOMEN ARE THERE?

In 1990, the first *National Survey of Sexual Attitudes and Lifestyles* (Johnson *et al.,* 1994) interviewed a demographically representative sample of 10,492 women living in the UK about their sexual behaviour. In the previous year, 13.6% had no sexual partners, 86.0% had male partners only, 0.2% had both male and female partners and 0.2% had female partners only. Overall, 0.4% said they had sex with a woman in the last year, rising to 0.8% in the last five years and 1.8% ever (Johnson *et al*., 1994, p.209).

Findings from the second *National Survey* which took place in 2000 have recently been reported (Johnson, Mercer, Erens *et al*., 2001). The second survey found a considerably higher prevalence of sex between women compared to the first. Overall some 2.6% of women had sex with another woman in the preceding 5 years (compared with 0.8% in 1990) and 4.9% had ever had a female partner (compared with 1.8% in 1990).

The authors of the *National Survey* suggest that "..some of the differences between the 1990 and 2000 surveys probably result from new computer-assisted interviewing methods which help people to report their sex lives more accurately, and to a more tolerant and accepting society which makes it easier for people to answer questions candidly." However, a methodological paper from the same team has shown no differences in reporting of sensitive sexual information between computer-assisted and pen-and-paper methods (Johnson, Copas, Erens *et al.,* 2001). It is certainly possible that bigotry and discrimination against lesbians and bisexual women has declined in the last ten years and this may make homosexually active women less likely to conceal their behaviour from researchers. If this is the case, we should still treat these figures as minimum estimates for the prevalence of sex between women, given that a fair and equitable society for lesbians is still some way off.

2. Methods and demographics

This document reports on the results of two separate surveys of lesbian and bisexual women conducted at different times. Copies of both questionnaires are available to download from Sigma's website.

2.1 SURVEY 1: SEXUAL HEALTH FOR ALL

This survey was for lesbians, gay men and bisexuals. For women, the inclusion criteria was: 16 years or older *and* resident in England and either: homosexually active in last five years, *and/or* lesbian, gay or bisexual identity. The target sample size was 500 women (and 500 men). Only the women's responses are reported here. A short, self-completion questionnaire was used (two sides of a single sheet of A4) covering demographics; sexual and general health needs; obstacles to sexual health; and experiences of sexual health services. The forms were distributed through a number of settings, outlined below.

- *Community groups*: a letter and 25 copies of the form were sent to both women only and mixed community groups requesting they distribute them to members. Addresses of groups were taken from *Gay Times* and *Diva* magazines. Groups listing telephone numbers only (n=42) were telephoned and asked for a postal address. Packs were sent to a total of 164 groups (including 60 women only groups). The letter requested they call Sigma if additional copies were needed. Two groups requested an additional 200 forms each.
- *Mailing lists*: a letter and single questionnaire were sent to 1,500 members of The Lesbian and Gay Foundation mailing list and 400 women on the mailing list of the Manchester-based Lesbian Community Project.
- *The Lesbian and Gay Foundation Founder's Fete*: attenders were invited to participate from a stall during the launch event of LGF.
- *Hand-to-hand in women's bars*: in bars and other social spaces in London (on five evenings by Sigma team) and in Manchester (on two days/evenings by LGF team), recruiters made personal requests to individuals to self-complete on the spot and return the form to a sealed box. In Manchester the forms were also left in racks in approximately 75 to 100 bars, clubs, shops and other places where lesbians meet, socialise and receive services.
- *In women's bookstores*: in three bookstores in London, forms were left in information racks.

The following table shows the numbers of forms returned and excluded.

SURVEY 1	No. of forms (%)
Forms returned	515
No evidence of sex with women or lesbian or bisexual identity	16 (3.1%)
Resident outside England	2 (0.4%)
Total exclusions	**18 (3.5%)**
Sample size	497

2.2 SURVEY 2: THE LESBIAN & BISEXUAL WOMEN'S SEX SURVEY

The inclusion criteria for this survey differed slightly: 16 years or older *and* resident in **the UK** *and* either: homosexually active in last **twelve months**, and/or lesbian, gay or bisexual identity.

Women were recruited on-the-spot at two free, community based events (*Leeds HydeOut! 2000* and *Brighton Pride 2000*) and a commercial ticketed lesbian, gay and bisexual event (*London Mardi Gras 2000*). Of the final sample, over half (57%) were recruited at London Mardi Gras, the remainder being split between Leeds Hydeout and Brighton Pride (22% each). A short, self-completion questionnaire (two sides of a single sheet of A4) was offered on a clip-board with a pen attached. Forms were returned to sealed boxes.

SURVEY 2	Leeds	Brighton	London	No. of forms (%)
Forms returned	**429**	**455**	**1179**	**2063**
No evidence of sex with women or lesbian or bisexual identity	14	31	70	115 (5.6%)
Resident outside the UK	0	7	17	24 (1.2%)
Less than 25% complete	3	5	4	12 (0.6%)
Male	0	1	0	1 (0.0%)
Total exclusions	**17**	**44**	**91**	**152 (7.4%)**
Sample size	**412**	**411**	**1088**	**1911**

There are a number of factors that probably led to the small differences in the proportion of exclusions between the samples. First, the exclusion criteria was slightly different as Survey 1 specified that women must have been homosexually active in the last five years, while Survey 2 specified in the last year. More women will have qualified on the five year criteria. Second, the pride-type events used in Survey 2 will probably have attracted a larger proportion of non-qualifying women attending with friends or for the music (in the case of London) than the community groups and bar recruitment of Survey 1. Also these pride-type events probably attract a larger proportion of tourists and other visitors than everyday bars and community groups.

2.3 DESCRIPTION OF SAMPLES

All of the women in both samples either (a) identified as lesbian or bisexual, and/or (b) had sex with another woman in the last year (Survey 2) or last five years (Survey 1). Sexual behaviour is reported in Chapter 3. This section describes the two samples using six variables: region of residence; age; preferred term for sexuality; ethnicity & country of birth; current partnerships; household living arrangements.

2.3.1 Region of residence

The sites used for recruitment obviously effect the geographic distribution of the samples. The following table shows the proportion living in each of the NHS regional health authorities (England population from NHS Executive, Finance and Performance Directorate, mid-1999 projections).

NHS region of residence	% of Survey 1 (n=482)	% of Survey 2 (n=1893)	% of both surveys (n=2375)	% of England only sample	% of total population of England	Sample difference from total population
London	72.8	29.3	38.1	38.8	14.5	+24.3
Eastern	4.6	10.9	9.6	9.8	10.9	- 1.1
South East	2.1	22.5	18.4	18.7	17.4	+1.3
South West	1.7	3.4	3.0	3.1	9.9	-6.8
West Midlands	1.2	2.3	2.1	2.1	10.8	-8.7
Trent	3.1	7.4	6.6	6.7	10.4	-3.7
North West	12.9	7.1	8.3	8.4	13.3	-4.9
Northern & Yorkshire	1.7	14.9	12.2	12.4	12.8	-0.4
Wales	–	1.6	1.3			
Scotland	–	0.5	0.4			
Northern Ireland	–	0.1	0.04			

The first survey recruited only women who lived in England. Three quarters of these lived in London and half of the remainder lived in the North West. The second sample is more geographically dispersed with less than a third living in London and the next most common regions being the South East and Northern & Yorkshire.

If we compare the geographic distribution of our sample to that of all women in the UK, Wales, Scotland and Northern Ireland were clearly under-represented due to recruitment procedures. The final two columns in the table above show the proportion of the England sample living in each region and the proportion of the total population of England that live in each region. (Males and females are equally distributed across the country.) We can see that, compared to the population of England our sample were much more likely to live in London and less likely to live everywhere else (particularly the West Midlands and the South West) except the South East. This is likely to be due to a sampling artefact.

2.3.2 Age

Figure 3.2 shows the distribution of ages in the two surveys. Although the age profiles are similar, the women in Survey 1 (recruited in bars and social groups) had a narrower age range and were significantly older than those in Survey 2 (recruited pride events).

Overall the average (median) age of all respondents was 31 (mean 31.8, standard deviation 8.6). Survey 1 respondents were slightly older on average (mean 32.9, median 32) than Survey 2 respondents (mean 31.5, median 30).

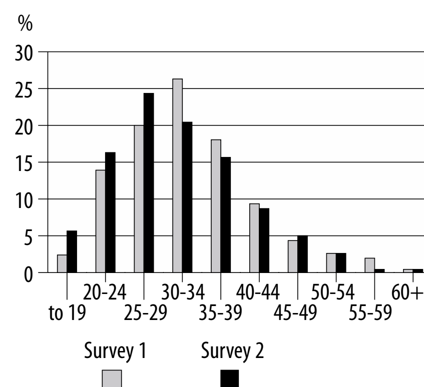

Figure 2.3.2: Age groups across the surveys

2.3.3 Preferred term for sexuality

Women were asked *What term do you usually use to describe yourself sexually?* in both surveys but the range of responses offered differed slightly. The following table shows the proportions giving each response in the two surveys.

Preferred term	**% in Survey 1** (n=496)	**% in Survey 2** (n=1905)	**% in total** (n=2401)
Lesbian	67.5	56.3	58.6
Gay	14.3	17.8	17.1
Bisexual	10.7	8.3	8.8
Dyke	*not offered*	9.9	7.9
I don't usually use a term/any other term	7.5	7.7	7.7

The most common preferred term in both surveys was *lesbian* followed by *gay*. When *dyke* was offered in Survey 2 this was indicated by a significant minority of women. Fewer women used *bisexual* or did not usually use a term.

For comparison to other data through the rest of the report we merge shared variables between the two samples. To overcome small numbers we grouped women who indicated *dyke* with those who indicated *lesbian*. In addition we group those who indicated *any other term* or *no term* together. This gives us four sexual identity categories.

Age and preferred term for sexuality

The proportion of women in each sexuality category by age group is shown in the following table.

Preferred term	**% in total** (n=2388)	**% by age group**				
		<20 (n=121)	**20s** (n=940)	**30s** (n=905)	**40s** (n=333)	**50+** (n=89)
Lesbian/dyke (n=1587)	66.5	62.0	61.6	68.7	73.6	74.2
Gay (n=410)	17.2	10.7	18.8	17.5	15.0	13.5
Bisexual (n=209)	8.8	20.7	10.9	6.5	5.4	5.6
No/any other term (n=370)	7.6	6.6	8.7	7.3	6.0	6.7

Lesbian was the preferred term at all ages, although it was less popular among younger women. The term *gay* was most common among those in their 20s and 30s. Women under 20 were much more likely than older women to identify as *bisexual*.

2.3.4 Ethnicity & country of birth

The two surveys recruited in different parts of the England and consist of women living in different areas so we might expect their ethnic profile to vary. This was the case.

Ethnic group		**% in Survey 1** (n=493)		**% in Survey 2** (n=1909)		**% in total** (n=2402)	
White	**British**	88.9	65.7	93.5	78.1	92.5	75.5
	Irish		5.1		7.4		6.9
	other		18.1		8.0		10.1
Black/ Black British	**Caribbean**	3.6	1.2	2.3	1.5	2.6	1.5
	African		0.4		0.3		0.3
	other		2.0		0.5		0.8
Asian/ Asian British	**Indian**	3.0	1.6	1.1	0.6	1.5	0.8
	Pakistani		0.2		0.2		0.2
	other		1.2		0.3		0.5
Chinese			0.6		0.1		0.2
Mixed ethnicity			3.0		2.3		2.4
All other groups			0.8		0.9		0.9

In both surveys, the majority of women were White British. A much higher proportion of Survey 1 lived in London (72%) than Survey 2 (29%) and the proportion of women from other ethnic groups was higher in the first survey, reflecting the greater ethnic diversity in London's population. In Survey 2, women were also asked their country of birth. The box shows their responses grouped by continents.

Country of birth in Survey 2 (n=1864)	%
United Kingdom	87.9
Other European country	5.8
African country	1.6
Asian country	0.8
Oceanic country	2.0
North American country	1.8
South American country	0.1

2.3.5 Current partnerships

Women were asked whether they had a regular sexual partner or relationship and the gender of their regular partners.

Do you have a regular partner?	% in Survey 1 (n=490)	% in Survey 2 (n=1872)	% in total (n=2362)
No regular partner	31.2	23.1	24.8
Female partner(s) only	62.2	73.1	70.8
Both female(s) and male(s)	2.4	0.7	1.1
Male partner(s) only	4.1	3.1	3.3

Overall 70% of women had a current regular female sexual partner. Women in Survey 1 were more likely to be single or to have a male partner than those in Survey 2. Conversely, women in Survey 2 were more likely to have a regular female partner. These differences may be attributed to the different recruitment methodology for each survey.

Women in Survey 2 were also asked how long they and their partner had been together. The average (median) length of these primary relationships with women was two years with a range from 1 month to 26 years. (As these rates are current, this should not be confused with the average length of relationships by the time they cease). The average (median) length of primary relationships with men was almost identical at two years with a range from 1 month to 27 years.

Age and current relationships

Women under 20 years of age were significantly less likely to have any current relationships compared to those that were older. This may be due to the fact that younger women are in the early stages of their sexual career and have not had the opportunity or desire to develop regular relationships. Indeed, the probability of having a regular female partner increased with increasing age.

It is interesting to note that the likelihood of having a relationship with a male partner diminishes with increasing age.

Preferred term for sexuality and current relationships

Unsurprisingly, those who identified as lesbian, dyke, or gay were most likely to be in a relationship with female. Furthermore, women who identified as bisexual were most likely to have a current relationship with a man or have no current relationships. They were also least likely to have a current female partner. Preferred terms for sexuality are strongly related with the gender of current regular partners.

2.3.6 Household living arrangements

The following table shows that almost a quarter (23.6%) of all women lived alone, but almost twice this many (45.5%) lived with a female sexual partner.

Who do you live with? (can choose more than one)	**% in Survey 1** (n=497)	**% in Survey 2** (n=1901)	**% in total** (n=2396)
Live alone	31.9	21.5	23.6
Female partner	32.6	48.8	45.5
Friends	18.3	11.6	13.1
Parents	3.8	9.5	8.5
Children	4.6	8.5	7.8
Other family members	4.4	3.6	3.4
Other	5.8	3.2	3.5
Male partner	3.4	2.2	2.4

To provide a clearer picture of household living arrangements, we collapsed all family (parents, children, siblings, other family) into one category. Overall, almost half lived with a female partner, a quarter lived alone and almost a third lived with either friends, family or a male partner.

Who do you live with?	**% in Survey 1** (n=475)	**% in Survey 2** (n=1856)	**% in total** (n=2332)
Live alone	33.3	22.0	24.2
Live with any female partner	34.1	49.9	46.7
Not with female partner but with any family/friends or male partner	32.6	28.1	29.1

In the 1990 NSSAL study (Johnson *et al*., 1994) there were 40 women who had sex with another woman in the last five years (p.209) and 11 of these (28%) who were cohabiting with a same sex partner (p.211). This figure is substantially lower than those provided by our surveys.

3 Sexual behaviour

This chapter looks at the gender and quantity of women's sexual partners, and patterns of sexual behaviour among them. We look at how common regular and casual sexual partners are, how often women have sex and where they meet new partners.

3.1 GENDER OF PARTNERS

In *NSSAL* (Johnson, *et al*., 1994, p.209) half the women who had sex with a woman in the last year also had sex with a man. The current samples are predominantly exclusively homosexually active women. Overall, in the last year 81.9% had sex only with women, 10.9% had sex with both men and women and 1.8% had sex only with men. The remaining 5.4% had not had any sexual partners in the last year. (Approximately 3% of women in both surveys gave insufficient information to allocate the gender of their sexual partners in the previous year.)

Figure 3.1 presents the gender of women's sexual partners in the last year for Surveys 1 and 2 separately, as well as for the last five years in Survey 1.

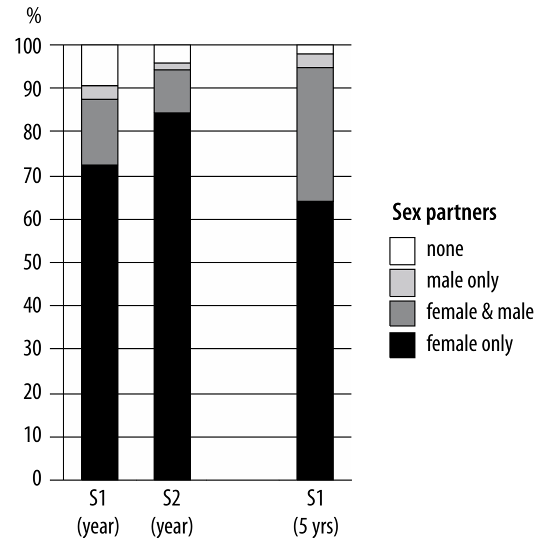

Figure 3.1: Gender of sexual partners in the last year and five years (n=482, 1844, 1844)

Due to the inclusion criteria more women in Survey 1 had no sexual partners (9.5%, compared with 5.6% in Survey 2). Also, a larger proportion in Survey 1 had sex with men in the preceding year (18.0% compared with 11.2%).

With an increasing time-frame, more women have sex with men. In Survey 1, over a five year period, just over a third (34%) had sex with men.

3.1.1 Age and gender of partners

Sexual activity, especially with men, declines with increasing age. Figure 3.1.1 shows the gender of women's sexual partners over the age range. Women who had no sexual partners in the last year were, as a group, significantly older than those who did have sex. However, 88% of the women aged 50 or over had sex in the last year.

Among sexually active women, those who had sex with men were significantly younger than those who had sex with only women. Among the under 20s (n=115), 24% had sex with both men and women and another 3% with only men, compared to less than 5% of those over 50 who had both male and female partners.

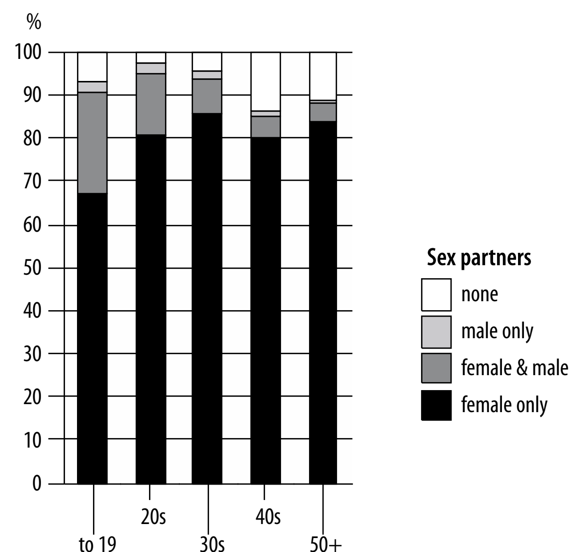

Figure 3.1.1: Gender of sexual partners in the last year by age group (n=115, 912, 879, 320, 87)

3.1.2 Sexuality and gender of partners

The gender of respondents sexual partners were clearly related to their sexual identity. Figure 3.1.2 shows the gender of sexual partners among groups of women using the same term for their sexuality.

There was no significant difference between the groups in the proportion with no sexual partners. Bisexual women were much more likely to have sex with men than were lesbians, gay women or dykes. Women who used no term or any other term to describe themselves sexually were next most likely to have sex with men.

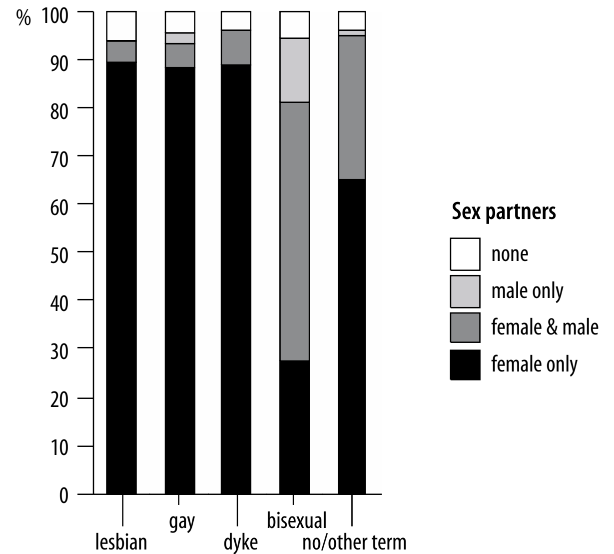

Figure 3.1.2: Gender of sexual partners in the last year by term used for sexuality (n=1353, 400, 181, 207, 178)

3.1.3 Household living arrangements and gender of partners

Figure 3.1.3 shows the relationship between household living arrangements and gender of sexual partners.

Of those reporting living with a female partner, the vast majority (97%) had exclusively female sexual partners and none reported having sex with men only. Conversely 19% (10/54) of women living with a male partner had not had sex with a man in the last year.

Women who lived alone were most likely to have had no sexual partners in the last year, although they were in the minority.

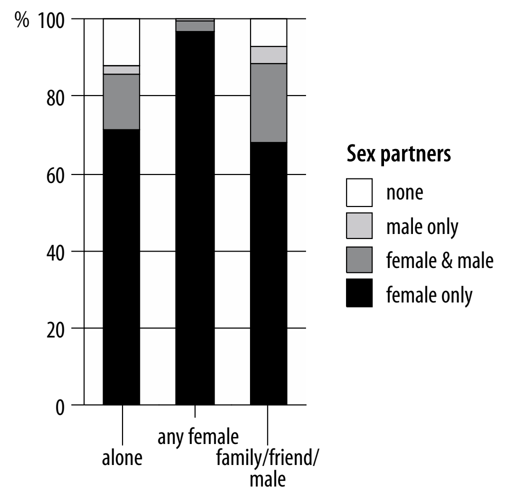

Figure 3.1.3: Gender of sexual partners in the last year by living arrangements (n=539, 1070, 647)

3.2 CASUAL AND REGULAR SEXUAL PARTNERS

Both surveys asked how many female and male sexual partners women had sex with in the previous year. The average (median) number of female partners for those who had any was 1 (mean 2.6, range 1 – 1000). One sixth of women (16.2%) had sex with three or more women. The average (median) number of male partners for those who had any was also 1 (mean 11.9, range 1 – 1200).

Survey 2 also asked the number of casual female and male partners women had in the previous year. Almost a quarter (23.9%) had a casual female partner, the average (median) number of casual female partners was 1.

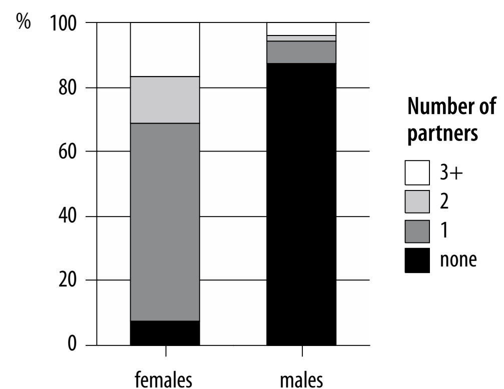

Figure 3.2: Sexual partner numbers (n=2378, 2329)

Just over 10% of women had a male sexual partner in the previous year (11.3%) and 6.9% had a casual male partner. The average (median) number for both regular and casual male partners was one.

The vast majority of women had a female sexual partner in the preceding year and a minority had a male partner. Amongst those who had either a male or female partner, the majority had one partner only.

3.3 LENGTH OF TIME KNOWN PARTNER PRIOR TO FIRST SEX

Many women in relationships with a female knew their partner for a considerable period of time before they became sexual partners. In Survey 2, women who were currently in a regular sexual relationship were asked how long they had known their current partner before they first had sex. They were given options of *years, months, weeks, days, hours or minutes*.

One in five women in a relationship (19%) had known their partner for *years* before they became sexual partners. A further 27% had known them for *months*, while 20% had known them for *days* before first sex. A minority (13%) had met their partner on the day they first had sex with them.

Figure 3.3: Length of time known regular partner prior to first sex (n=1412)

3.4 LENGTH OF TIME SINCE SEX WITH SOMEONE OTHER THAN PARTNER

In Survey 2, an open-ended question, How long has it been since you had sex with someone other than your main partner was asked of all women in relationships (81.9% of those who reported a current relationship responded). The average (median) length of time since sex with someone other than their partner was two years. Since we also know the length of time of the current relationship, we were able to gauge whether that relationship had been monogamous or not. The majority of (80.5%) were in relationships which had been monogamous (at least on the respondents side) since their inception.

3.5 SOURCES OF NEW SEXUAL PARTNERS

In Survey 2, women were asked where they had met any new female sexual partners in the preceding year. They were given the option I've not met any new sexual partners in the last year or to tick as many as applied of eight possible places to meet partners. An *other* option was also provided. Half (50.6%) had met a new sexual partner in the last year (missing data for 5.0%). The following table shows where those women had met their new female sexual partners.

The most commonly used place for meeting new partners (used by 46%) was pubs and clubs. After that, partners meet in a wide variety of locations. Those who ticked the other category (10%) specified university, coffee shops, holidays, through relatives and at festivals.

Of those women who reported having met any new sexual partners (n=919)	**Total**
In a pub/club	45.9%
Work	16.3%
Regular social groups	13.6%
Through friends	11.3%
At a private party	9.6%
On the Internet	8.1%
Through personal ads	7.4%
Sex clubs	2.0%
Saunas	0.9%

3.6 FREQUENCY OF SEX

Survey 2 asked how many times women had sex with female partners in the preceding month. They were then asked whether, for them, that amount was *too little, too much* or *about right*.

Of those responding, 25% had no sex in the last month, 10% had sex once, 13% twice, 8% three times, 8% four times, 19% five times, 19% between five and eleven times and 19% twelve times or more (missing data for 22%). On average (median) women had sex with female partners four times in the last month (mean 9.6, range 1 to 100).

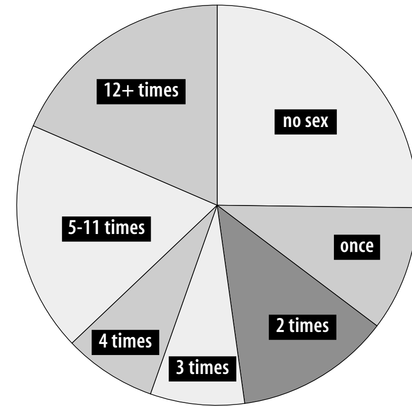

Figure 3.6: Number of times had sex with a female partner (n=1495)

Over half the women (52%) said the amount of sex they had was *too little*, almost half (47%) said it was *about right* and only a very small number (1%) said it was *too much*. The following table shows the proportion of women having different quantities of sex among those who felt it was too little, about right or too much.

% for whom that amount of sex was...	Number of different times sex with a women in the previous month No sex (n=377)	once or twice (n=338)	3 or 4 (n=225)	5 to 11 (n=278)	12+ (n=277)
Too little	85.0	69.2	55.5	43.4	25.7
About right	13.8	29.3	44.1	56.3	73.2
Too much	1.3	1.5	0.5	0.4	1.1

Having too much sex was equally uncommon irrespective of how much sex women had. However, those who had sex more frequently were more likely to say the amount of sex they had was about right. The less sex women had, the greater the likelihood that they reported that the amount of sex they had was too little.

3.7 SUMMARY

Compared with other populations, lesbians and bisexual women have a relatively low rate of partner change and concurrent relationships. This accords with the assumed low incidence of STIs among these women. However, over half the women felt the amount of sex they were having was too little. What is 'good' for those concerned with STI rates may be 'bad' for the population itself.

Clearly, some women do have larger numbers of partners and half the women had a new partner in the last year. The potential for STI transmission is real. Sexual health services for women must therefore be able to provide an equitable service to women who have sex with women and/or identify as lesbian, gay or bisexual.

4 Sexual values and sexual health needs

If sexual health is thought of as the foundation for a safe and satisfying sex life, what constitutes 'satisfying' should not be taken for granted. In the previous section we found that behaving in a way that reduced the probability of STIs did not equate with sexual satisfaction. In this chapter we explore in more detail what it is about sex that women value and what is lacking when it is not satisfying.

4.1 HEALTH CONCERNS

To locate sexual health within women's range of concerns about health and well being, in Survey 1 we asked *What are your three biggest health concerns?* Just over 80% gave one health concern, 67% gave a second, and 48% gave a third. That 20% of women cited no health concerns indicates that health is not uppermost in everyone's mind nor at the top of everyone's agenda. However, responses to these surveys suggest that health, in particular sexual health, is clearly a major area of interest and concern to lesbians and bisexual women. The concerns women gave were coded into six broad areas.

Health concern (n=406)	**% citing that concern**
Cancer	69.0
Other sexually transmitted infections	42.8
HIV and AIDS	25.1
Heart disease	17.5
Mental health/stress/depression	14.4
Weight	7.6

Cancer was the most commonly cited health concern as it is among many populations in Britain. A quarter of women who reported cancer specified breast cancer but the majority did not distinguish a specific type (see section 4.8).

In the context of a sexual health survey we might expect concern about sexually transmitted infections to be high and in this case almost half (42.8%) cited these a one of their top three health concerns. A more detailed description of need in this area would be useful. A quarter (25.1%) reported concern about HIV and AIDS. A recent paper suggests lesbian's perceptions of their own risk of acquiring HIV is realistically low (Ferguson & Frankis, 2001) but our finding may reflect women responding to the question with regard to their friends and the threat posed to their communities rather than themselves. Heart disease, mental health and weight problems were also areas of concern for large numbers of women.

Each of these health problems can interfere with sexual functioning, satisfaction and safety, but we would not equate sexual health with the absence of all of them. To explore in more detail the possible meaning of sexual health for lesbians and bisexual women, we asked a number of open-ended and closed questions.

4.2 SEXUAL VALUES

Both surveys asked what women most valued in their sex life using two slightly different open-ended questions. Survey 1 asked *What do you value most in your sex life?* (79% responded) and Survey 2 asked *What do you value most about having sex with women?* (80% responded). Responses were analysed and a coding frame of five main themes emerged. The table below shows the proportion of women indicating each theme and examples of each.

S1: What do you value most in your sex life? *S2: What do you value most about having sex with women?*	% responders citing theme, multiple response possible		
	Survey 1 (n = 393)	**Survey 2** (n = 1524)	**Examples of responses**
Emotional relationship with sexual partner/s	70.5	62.5	• Affection • A stable partner • Being with someone I care about • Closeness • Commitment • Communication • Connection • Companionship • Compatibility • Equality • Friendship • Honesty • Intimacy • Love and respect • My girlfriend • My partner • Openness • Stability • Trust • Understanding
The sex itself	36.4	44.2	• A true orgasm! • Being sexually active • Climax for both partners! • Clitoral stimulation • Great sex • Having lots of it • My multiple orgasms • Oral sex • Passion • Pleasure • Variety of positions • Wonderful sex • Ecstasy • Dirty sex • Sensual • Hot sticky sex
Safety, comfort & security	6.4	2.0	• Being safe • Comfort • Feeling secure with someone • Opportunity to be totally relaxed and in a sharing environment • Not being harassed • Safety • Security • Feeling safe and loved • No violence • Safe, secure and intimate • Knowing and trusting my partner
Freedom of expression	3.3	6.4	• Independence • Diversity • Freedom to choose • Freedom to express myself and be who I am • Able to be myself without being self-conscious
Physical characteristics of partner	1.5	10.6	• Breasts • Gorgeous clits! • Lovely bottom • Curve of a woman's body • Cleavage • Great bodies • Long tongues and short fingernails

It is clear that asking specifically about the value of 'sex with women' led more respondents to focus on the physical aspects of sex or the physical characteristics of partners. There were similar proportions of women in both surveys valuing the emotional relationships they have with their partners, as well as sex in itself.

4.3 NEEDS FOR A SATISFYING SEX LIFE

Both surveys also asked women if they were 'happy' with their sex lives. About two-thirds reported being happy with their sex life.

	S1: Are you happy with your sex life? (n = 482)	**S 2: Are you currently happy with your sex life?** (n = 1792)	**% of total** (n =2274)
No	29.3	38.8	36.8
Yes	70.7	61.2	63.2

The proportions who answered *no* to these questions (37% overall) is smaller than the proportion of women who said the amount of sex they had was *too little* (52%). This suggests that while some women have less sex than they would like, they are not unhappy about this. However, not having enough sex was the major source of sexual unhappiness.

In Survey 1 women who responded *no* to *Are you happy with your sex life?* were asked *Why not?* Most only gave one reason for their unhappiness and these are presented in the table below, which also shows the proportion of women citing that reason first.

Survey 1 (n =134)	% cited first	Examples of responses
Not having any sex	29.9	• No sex with girlfriend anymore • Not getting any • What sex life?
Wanting more sex	30.6	• Could happen more often • Don't get enough • Irregular and infrequent
Wanting a relationship	14.2	• Cannot find decent reliable partner • I'm looking for a relationship • Would like to feel close and intimate with one person
Problems in relationship/s	11.2	• I'm with the wrong girl • Seeking sex outside the relationship covertly and feel guilt about this • Sexual breakdown between me and my partner
Health problems interfere with sex	5.2	• I lack stamina due to being asthmatic • I rarely have sex because of my severe pain and heart condition.
Low or absent sex drive	5.2	• Currently too tired a lot of the time to really enjoy it – also affected by menopausal changes • Have no libido most of the time
Worry about HIV/safer sex	1.5	• Lack of safe sex info for Hep C+ lesbians
All other reasons	3.8	• I am always drunk when I have sex • I don't fancy her that much • Don't feel as confident as I would like

Dissatisfaction was most commonly caused by not having any sex or not having enough (each first mentioned by almost a third). Similarly, wanting a relationship, or a better relationship, was mentioned by about a sixth of women.

The reasons for being unhappy with one's sex life that emerged from this question were used to develop a closed ended question in Survey 2. Women who said *no* to the question *Are you currently happy with your sex life?* were then asked *Why are you not happy with your sex life?* and provided with ten responses, asked to tick as many as applied and asked for *other* reasons. Responses are shown in the table below.

Why are you not happy with your sex life? (n =752)	% of those not happy
I'm not having any sex/any sex at all	37.8
I'd like more sex with my current regular partner	31.0
I'd like more female sexual partners	17.7
I'd like more male sexual partners	2.0
I have problems in my relationship/s	9.7
My partners' sex drive is too low	10.6
I've got a low or absent sex drive/I worry my sex drive is too low	9.0
My health problems interfere with sex	5.9
My partners health problems interfere with sex	3.5
I have problems having orgasms during sex	4.3
Stress/exhaustion/too busy	3.2
Long distance relationship problems	2.3
All other reasons	1.6

The primary reasons for dissatisfaction were not having any sex at all or not having enough sex with current partners. Other causes of sexual dissatisfaction are suffered by a significant minority of women. Relationship problems were indicated by one in ten.

The following sections look at the variation in these causes of sexual ill-health among different groups of women.

4.3.1 Age and sexual dissatisfaction

In both samples, overall sexual dissatisfaction increased with increasing age. While almost all problems were found at all ages, some were more common in particular age groups. In Survey 2 younger women were most likely to want more female sexual partners while those in their 20s and 30s were most likely to indicate they were unhappy because of having no sex at all. Older women were most likely to feel their sex drive was too low and to want more sex with a partner they already had. Interestingly, health problems interfering with sex did not notably vary across the age range.

Clearly, interventions intending to increase sexual well-being should attend to the differences in need for them across the age range.

4.3.2 Sexuality and sexual dissatisfaction

In both surveys, unhappiness with their current sex life was more common among *bisexual* women (50% were unhappy) compared with *lesbians/dykes* (35%) and *gay* women (36%). In survey 2 *bisexual* women were significantly more likely to want more female partners and more male partners but no other problem significantly varied by sexuality. This may suggest lack of sexual variety is a more common source of dissatisfaction among *bisexuals* than too little sex.

4.3.3 Relationship length and sexual dissatisfaction

Amongst those in a relationship, the satisfaction with sex life declines with increasing length (Figure 4.3.3). Those who had recently entered a relationship (within the last year) were least likely to be unhappy and the proportion of women dissatisfied increased with increasing length of relationship. However, women in longer term relationships were more likely to be happy than single women.

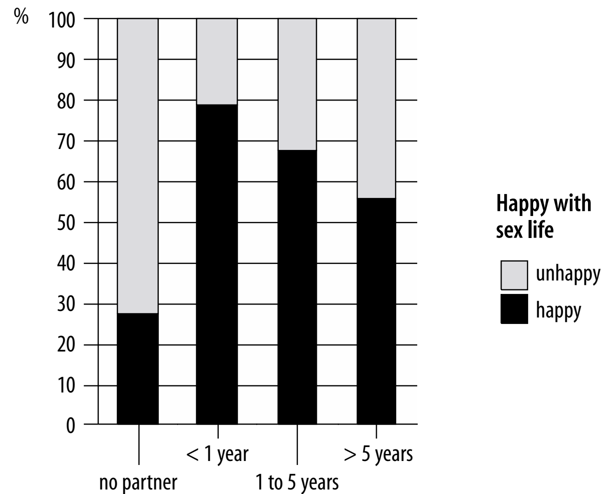

Figure 4.3.3: Satisfaction with sex life and length of time in relationship (n=1737)

4.3.4 Household and sexual dissatisfaction

Perhaps unsurprisingly fewer women who live with their female sexual partner (26%) were dissatisfied with their sex lives than those who lived alone (49%) or with friends, family or male partners (45%). Among women who did not live with a female partner, living with a male partner was not associated with sexual dissatisfaction. Similarly, single women were most likely to be unhappy (68%) followed by those with a male regular partner (42%). Women with a current female partner were the least likely to be unhappy (25%).

4.3.5 Gender of partner and sexual dissatisfaction

We also looked at the relationship between gender of partners and unhappiness with sex life. In line with preceding findings, those who had no partners in the last year were most likely to be unhappy (74%), followed by those who had sex with men only (60%) and who had sex with both men and women (43%). Women who had sex exclusively with women reported the lowest level of dissatisfaction with their sex lives (32%).

From these surveys, sexual relationships are central to sexual satisfaction. This suggests that interventions hoping to increase the sexual well-being of lesbians and bisexual women may find considerable gain in supporting women to establish and maintain relationships.

4.4 NEEDS FOR A MAINTAINING A RELATIONSHIP

In survey 2 we asked those women with a current regular partner the open-ended question *What would make your relationship better?* Over three quarters (77.5%, n=1116) of women in a current relationship responded. Almost a third (30.1%) believed that their relationship was 'perfect the way it is'. The rest cited a wide range of ways in which their relationships might be improved. Again, thematic content analysis was used and is reported in the table below. Each theme shows the proportion of women in a relationship citing it, and gives a selection of typical responses.

What would make your relationship better?	% of those in relationships (n = 772)	Examples of responses
More and/or better sex	17.7	• Sex out of the bedroom • More sexual adventure • Want plenty more sex • A full sexual relationship with my partner • Group sex • Sex with toys • Kinky sex
To have more money	14.6	• Financial security • Having an independent income • Less stress about money • Loads of dosh • Money to buy a house • No money hassles • Winning the lottery! • Being rich!
Changing my partner	12.3	• More respect from my partner • My girlfriend should let her hair down more • If she was more romantic • If my partner was not so angry all the time • If she didn't cheat on me • If she could commit • If she liked Man. United
Equal legal and social rights	11.5	• A less bigoted society • Acceptance by the rest of society • Being able to marry • Being treated as a regular couple • Citizenship for my US girlfriend • If we could be openly affectionate in public • Freedom and equal rights • Full social and political acceptance of gay lifestyles • Deletion of Section 28
More time together	11.3	• Being able to spend more time together • More quality time together • More time alone together • Time with each other and no kids
Living closer together	7.8	• If I could live in the same town as my girlfriend • If only we could live together • If we were allowed to live in the same country
Less work and more fun	7.4	• More time off to have fun with partner • More free time to enjoy ourselves • No work and more holidays • Opportunities for more fun
Better communication between us	7.1	• Better at communicating our feelings • Less misunderstandings • If we could talk to each other more • More communication about sex
Other	9.2	• More gay & lesbian friends • More social events for women • A gay health clinic • Don't know • Children • More time alone • Counselling • HRT • Dining out more

A wide variety of suggested improvements to current relationships were specified. Most commonly mentioned was more or better sex, indicating that a relationship is not, in itself, a key to a happy sex life. Significant though were socio-economic factors such as money and equality. The low cost of implementing equal rights legislation suggests this would be a very cost effective way of increasing the sexual health of lesbians and bisexual women (as well as bisexual men and gay men).

4.5 NEEDS FOR SEXUAL ACTIVITY

In survey 1, we provided a series of statements about possible problems associated with sexual activity. They were asked to indicate their experiences in the last year. We were interested in the attributable risk associated with various causes of sexual ill-health. We can think of each of these as being things we need to be free of in order to have a safe and satisfying sex life.

Thinking about your experiences last year ...	% of responders
I was anxious or stressed during sex (% always or sometimes, n=446)	30.9
I felt bad about the sex I had (% always or sometimes, n=441)	19.5
I agreed to sex when I didn't want it (% yes, n=444)	18.7
I have had physical problems during sex (% yes, n=447)	14.8
I picked up a sexually transmitted infection (% yes or maybe, n=447)	6.3
I passed on a sexually transmitted infection (% yes or maybe, n=445)	4.5
In the last year, have you been forced to have sex when you didn't want it? (% yes, n=484)	4.1

Anxiety and stress during sex were the most commonly indicated problems with almost a third experiencing it in the last year. Feeling bad about the sex they had was experienced by one in five, as had agreeing to sex they did not want.

Women who indicated they had sex they did not want were asked how many times this had happened. Answers ranged from 1 to 10 with the median being twice in the last year. One woman in twenty-five said *yes* to a more direct statement about forced sex. Again, women who reported having experienced forced sex were asked how many times that had happened in the last year. This

ranged was 1 to 5 with one woman reporting 50 times. The median was twice in the last year. All these findings suggest that while not as common as other problems, abuse among women who have sex with women occurs and services intended for victims of sexual abuse and assault must be able to provide an equitable and sensitive service to lesbians and bisexual women.

One in eight women indicated physical problems with sex. They were asked the open-ended question *What problems?* Responses were analysed and six general themes emerged. These are presented below with examples drawn from the respondents' own words.

What physical problems?	**% of those with physical problems** (n=64)	**Examples of responses**
Pain/discomfort	34.4	• Pain • Painful orgasms • Lower abdominal pain • Severe pain in womb
Psychological	18.8	• Stress • Anxiety • Not interested • No enjoyment • Can't relax • Worry too much
Orgasm problems	17.2	• Unable to orgasm • Cannot come • No climax
Non-sexual health problems	15.6	• Being too tired to have sex • Cramps in legs • RSI in right hand • Chest tightness • Hip pain
Genital problems	7.8	• Vaginismus • Thrush • Bleeding after digital penetration • Dry vagina • Cervical spasms
Partner's problem	6.3	• Partner is not sexual • Partner's gone off me

Clearly, lesbians and bisexual women can and do suffer from the same range of causes of sexual ill-health as other sexually active groups. The vast majority of physical problems can be treated, cured or managed with clinical and psychological care. Providers of these services must be able to appropriately deal with women who have sex with women who present with these problems.

4.6 NEED TO BE ABLE TO DEMONSTRATE AFFECTION

It is clear that close sexual relationships are very important for large numbers of lesbians and bisexual women. Survey 1 asked women whether they had **ever** *avoided same sex affection in public due to fear of the consequences* (11.7 % missing), while Survey 2 asked the same question about the last year. Overall, 47.6% in survey 1 reported that they had ever avoided same sex affection in public, while only slightly less (43.3%) had done so in Survey 2. This suggests that the avoidance of same sex affection is an everyday occurrence for many women.

We found no associations between avoiding affection in public and sexual identity or age. There was, however, a significant relationship with household living arrangements, current relationship status and the gender of sexual partners in the previous year. Those most likely to avoid expressing public affection are those who live with a female partner and/or have a regular female partner and/or had sex with a female partner in the previous year. This is probably because these women have more opportunity to both display affection and feel the need to avoid it in public.

In Survey 2, women who had avoided same sex affection in public were asked what they feared would happen if they did not. These responses were analysed and the following five general themes emerged. Respondents could give more than one response.

What were you afraid of happening?	% of those avoiding affection (n=608)	Examples of responses
Physical assault	39.5	• Getting beaten up • Violence • Assault • Being punched • Getting bottled • Getting my head kicked in • Battered
Verbal abuse	32.9	• Taunts • Insults • Harassment • Ridicule • Shouted at • Screaming
Negative reactions from onlookers	19.9	• Staring • Gawking • Criticisms • Disapproval • Intimidating looks and comments • Being judged • Anger
Unspecified abuse	13.5	• Narrow minded people • Public abuse • Conflict • Being bullied • Complaints • Homophobic attitudes • Victimised
Discrimination from employer or neighbours	13.2	• Job loss • Scared of being outed at work • Don't want my children taunted or bullied due to neighbours finding out

These data are similar to those from gay men (Hickson *et al.,* 2001), 51.9% of whom had avoided same sex affection in public in the last year. The proportion of men and women who reported fear of verbal abuse was similar (31.0% of men compared to 32.9% of women). Although fear of physical assault was a major concern for men and women, it was less common (39.5%) among women than men (57.8%).

A recent survey from ID research of gay men and lesbians found that females tend to be more confident in holding a partner's hand or kissing a same sex partner in public, although … *a majority of gays and lesbians would not consider displaying these obvious signs of affection* (Pink Paper, 2001). They also reported that 27% of men and 18% of women had been physically assaulted in the previous 5 years. The fear of homophobic verbal and physical assault and the knowledge that it happens can be extremely effective as a inhibitor of affection in public between same sex couples.

4.7 DESIRE FOR CHILDREN

In Survey 1, we assessed the extent of future desire for children. One in ten women (9.9%) indicated they were already a parent. A later question asked whether they would like to have children at some point in the future (only 2.5% did not respond). A large proportion (29.8%) indicated *yes* with a similar number (27.9%) indicating *maybe*.

Clearly, sex with women is not incompatible with a desire for children nor concerns about conception, delivery and parenting. Interventions intended to address these needs should be provide equitable levels of service to lesbians and bisexual women.

4.8 NEED FOR INFORMATION ABOUT AVAILABLE INTERVENTIONS

To benefit from interventions women need to know about their existence generally, and specifically their availability locally. In Survey 1 we asked respondents *Do you know where your nearest NHS sexual health clinic is?* and found that over half (56.1%) were unaware of the location of their nearest clinic. Clearly, in terms of access to GUM based services, knowledge of their existence is the first priority.

Also in Survey 1, we asked directly which of a range of sexual health interventions women felt they would like to know more about. The proportion indicating each intervention is shown in the table below.

Which of the following sexual health services would you like more information about? (n = 486, multiple answers possible)	% wanting more information
Breast examination	57.1
Cervical cancer screening	52.7
Relationship counselling	29.8
Fertility, pregnancy, insemination	24.1
Screening for sexually transmitted infections	22.1
HIV testing	15.7
Dating services	8.5

Given that cancer was the most common health concern, it is no surprise that interventions for early diagnosis of breast and cervical cancer were most commonly cited. More than half of women want to know more about the availability of such services, which suggests that service providers need to consider the appropriateness of their information and advice to this target group.

About a quarter of women wanted to know more about the availability of relationship counselling (29.8%); services relating to contraception and fertility (24.1%); and about screening for sexually transmitted infections (22.1%). Somewhat less, at a sixth (15.7%), wanted to know more about HIV testing services.

The common desire for children is reflected in a quarter of women wanting to know more about interventions concerned with fertility, pregnancy, insemination, and the centrality of strong relationships in the interest in counselling.

5 Knowledge and experience of sexual health interventions

The previous chapter outlined the range of sexual health needs expressed by women who have sex with women, and gave an indication of the extent to which each need is currently unmet. The chapter described considerable capacity to benefit from interventions among these women. In this chapter we report on a series of questions asking women about their past experience of such sexual health interventions.

5.1 ACCESS TO INTERVENTIONS

Firstly, to give an indication of women's own perceptions of their ease of access to sexual health information and services, in Survey 1, we gave four statements and asked women to indicate if they agreed or disagreed with each.

Statements	% who agreed
It's hard finding information about sexual health which is relevant to me. (n=456)	58.8
Being lesbian/ gay/ bisexual means I have less access to sexual health services. (n=421)	45.8
I often find I've got no one to talk to about my sex and love life. (n=456)	32.9
I've had bad experiences in sexual health services because of my sexuality. (n=425)	25.2

It is apparent that many women find it difficult to access appropriate and relevant sexual health information and services because of their sexuality and sexual behaviour. Past 'bad experiences' set up obstacles and disinclinations to use services where they were known about. It is also clear that many women felt sexual health services' inability to respond to their sexuality was the main cause of their bad experience of such services.

5.2 PAST SOURCES OF SEXUAL HEALTH INFORMATION

While acknowledging problems with access to information, we asked the open-ended question *Where would you say you have got most of your sexual health information from in the past?* (77.7% responded). Multiple answers were possible and many women cited more than one source. Responses were analysed and seven main sources identified.

The most frequently cited source was the gay and lesbian press. The UK has a fairly lively lesbian and gay press and some lesbian-specific publications. These clearly play a pivotal role in sexual health information provision that can be supported and developed. Equally important were peer and social networks, indicating the importance of informal education routes. Both these sources were twice as commonly cited as health services. We should be careful not to confuse where women have got their information from with where they would prefer to get it from. However, the routes by which women do get information should be supported and encouraged.

Where would you say you have got most of your sexual health information from in the past? (N=386, multiple responses possible)	% of responders mentioning source
Lesbian & gay newspapers and magazines	50.5
Friends, family & peers	45.9
Health services	24.1
Community organisations	13.0
Self	13.0
Lesbian & gay scene	3.1
In formal education	2.8

5.3 SEEKING INTERVENTIONS

Again in Survey 1 we asked *When was the last time you sought any kind of advice or help about your sex life or sexual health?* The table below presents this data.

When was the LAST TIME you sought any kind of advice or help about your sex life or sexual health? (n = 486)	%
Never	49.8
Over five years ago	9.5
In the last five years	19.3
In the last year	16.0
In the last month	5.3

Half (49.8%) had never sought advice or help, which concurs with Farquhar *et al.* (2001) who found that 65% of lesbians had never attended a GUM or sexual health clinic.

However, almost half of those who had attended had done so in the last year. All women who had ever sought advice or help were asked what that was about. These open-ended responses were analysed and categorised into five key areas, outlined below.

What were you seeking advice or help about? (n = 227) (more than one response possible)	**% of those who sought advice**
STI's, testing and information (not HIV)	40.1
Cancer, pap smears, breast screening	29.1
Sex, safer sex, sexual response and physical sexual problems	14.1
HIV and testing	12.3
Psychological issues, relationships and sexuality	7.9

The range of services sought reflect the range of health concerns women expressed, and the range of interventions they wanted to know more about. Most commonly, women were seeking advice and information on sexually transmitted infections and/or testing for such infections.

Almost a third of women had required advice on cancer and testing for breast cancer and human papilloma virus causing cervical cancer. Advice was also sought about sexual practices, sexual responses and physical sexual problems. Least commonly sought was advice about psychological issues, relationships and sexuality despite these areas being indicated as the largest causes of sexual unhappiness.

Where did you go for advice or help? (n=246) (more than one answer possible)	%
GUM/STD/HIV/sexual health clinic	50.0
GP/family doctor	37.4
Charitable advice agency (eg LGB switchboard)	5.3
Private clinic/doctor	4.1
Other	13.4

Those who had sought advice were asked which services they had attended and given five options including an *other* option.

Women had most commonly used statutory clinical services such as sexual health clinics and general practitioners. A small proportion had used charitable advice agencies, family planning, private clinics and counsellors. Of those 33 women who reported receiving help elsewhere 8 reported help from a counsellor/psychologist/therapist, 5 from a hospital clinic, 4 from friends, 3 from a family planning or Brook Advisory clinic, 3 from a women's health clinic, 2 from a marriage guidance clinic (Relate), and one each from Boots, Student health, child support unit, herbalist, Shape and a youth group. Two did not specify where else they got help. This illustrates the potential range of sources of advice and information women draw on.

5.4 ARE INTERVENTIONS TAILORED?

Sexual history taking is now expected to be done in a wide range of service settings and knowledge of sexual practices is crucial for appropriate diagnostic procedures for STIs. However, over half (55.9%) of the women who had sought an sexual health intervention (n=227, missing 5.0%) said that their sexuality was not raised during the intervention. While sexuality was more likely to have been discussed in GUM/STD/HIV or sexual health clinics (it had in 58% of cases) it was far less common in primary care settings such as General Practitioners (GPs) (raised in only 25% of cases). This suggest

that many GPs simply assume women to be heterosexual. While in many interventions sexual behaviour may not have been appropriate to discuss, these findings raise concern about the equity of service lesbians and bisexual women receive.

Many lesbians do not feel safe disclosing their sexual identity in health service contexts and it appears that often neither they nor their medical practitioner initiate discussion of their sexual practices (Farquhar *et al*., 2001; Carr *et al*., 1999; Fethers *et al*., 2000).

5.5 QUALITY OF SERVICE RECEIVED

To obtain an idea of the quality of service provided, those accessing an intervention were asked to agree or disagree with five generic statements about service quality. The statements are given in the table below, as well as the proportion indicating poor quality service for all interventions together, and those received in primary care and GUM separately (square brackets reverse a statement to show the proportion of unmet need).

Thinking about that service, indicate whether you disagree or agree with the following statements:		% agreeing
It did not feel safe enough to discuss my sexuality properly	All sources of help & advice (n=226)	39.4
	GP/family doctor (n=87)	54.0
	GUM/STD/HIV/sexual health clinic (n=113)	31.0
The staff [did not] listened carefully to what I said	All sources of help & advice (n=231)	18.6
	GP/family doctor (n = 87)	27.6
	GUM/STD/HIV/sexual health clinic (n=120)	10.8
I was [not] treated with courtesy and respect	All sources of help & advice (n= 231)	16.0
	GP/family doctor (n=86)	20.9
	GUM/STD/HIV/sexual health clinic (n=118)	11.0
The staff [did not] seem to know their job well	All sources of help & advice (n=225)	13.3
	GP/family doctor (n=84)	16.7
	GUM/STD/HIV/sexual health clinic (118)	10.2
I would [not] recommend that service to other people	All sources of help & advice (n = 217)	24.4
	GP/family doctor (n=80)	41.3
	GUM/STD/HIV/sexual health clinic (n=116)	12.1

Women were least satisfied with services received from their General Practitioners. The majority (54.0%) did not feel safe enough to discuss their sexuality with a GP and a significant proportion reported that GPs did not listen carefully to what they said, did not treat them with courtesy and respect, and had not seemed to know their job well. Compared to other sexual health services, the GPs seen were also least likely to be recommended to others. More than one in three women who consulted their GP about a sexual health issue would not recommend that intervention to others.

Less widespread but perhaps more worrying given their assumed specialism, was dissatisfaction with interventions received in GUM and sexual health clinics. A third of the women who had used these settings felt wary of discussing their sexuality. Not being personally attended to, being treated with disrespect, receiving poor interventions and consequently being unwilling to recommend that service was the experience of about one in ten women who sought sexual health services.

Clearly, there are serious implications for the ability of some primary care and GUM services to deliver acceptable and appropriate sexual health interventions to lesbians and bisexual women. This is not to say these services are incapable of doing so, but this will not spontaneously happen. Explicit investment in services and training of providers is necessary to deliver an equitable standard of sexual health service provision.

5.6 WHERE SERVICES NEED TO IMPROVE

Respondents who had ever sought help or advice (n=244) were asked the open-ended question *How could that service have been made better for you?* (55.3% responded, 44.7% did not). Most suggested one change. Responses were analysed and six themes emerged as outlined in the table below.

Of those responding (n=141), 16.3% said that the service they had used was excellent and could not be improved. Those who had used a GUM/STI clinic were more likely to say the service was good (22.6%, n=62) than were those who had used their GP (11.6%, n=43).

How could that service have been made better for you?	**% of those suggesting improvements**	**Examples of responses** (n=118)
Increase staff ability to address needs of lesbian, gay and bisexual clients	41.5	• Assumed I was straight • Increased awareness and understanding of health issues as they relate to lesbians • Instead of assuming contraception is needed, the question could be phrased 'do you have any need for contraception and if so, are you using it?'
Better attitude of staff towards lesbian, gay and bisexual people	22.9	• Change their mentality • For the nurse to have not been so patronising about my sexuality • Lesbian friendly
Increase accessibility	15.3	• Available more hours in the day (after 9–5) • Earlier appointments • Made more public, found out about clinic through friend • Shorter waiting time for appointment
Improved facilities	8.5	• It could have been in private instead of across the counter • Special waiting rooms for women separate from men • A less clinical atmosphere
Choice of staff	6.8	• Would prefer lesbian GP • Employ gay/lesbian personnel • More women in the job!
Other	5.1	• By not calling out my name, a number would have been better • Combined with natural health stuff • Get rid of that metal thing they use for cervical tests and invent something new! How old is that design?

The most common area of need for improvement was in the attitude and approach of the people delivering the service. Not doing so meant a failure to properly address the needs of their lesbian and bisexual female clients. Homophobia, the lack of understanding of diverse sexualities and the assumption of heterosexuality all contribute to exclusion and poor services for lesbians and bisexual women.

Together, fear of the negative consequences of disclosure, a general mistrust towards sexual health services and discomfort with the assumption of heterosexuality (Farquhar *et al.,* 2001; Butler *et al.,* 2001) all result in a reluctance among many women to access medical advice and/or treatment, and thus problems may remain untreated.

5.7 SUMMARY

The surveys give a picture of relatively poor access to sexual health interventions and a relatively poor quality of service when they are accessed. This suggests considerable capacity for improvements in interventions at relatively little cost. A major cause of inequality in sexual health service provision could be addressed by improving the equity of service provision experienced by lesbians and bisexual women.

6. Summary and implications

6.1 RECRUITMENT

We successfully recruited two large samples of lesbian and other homosexually active women from community sources. Women were very interested in our work and appreciated our efforts. Sexual health is an area of interest and concern to these women and further research is feasible.

6.2 DEMOGRAPHIC PROFILE

The samples were biased towards England, in particular towards London. However, few differences between women living in the capital and those living elsewhere were observed. We tentatively feel these findings are geographically generalisable.

As with community recruited samples of gay men, these samples are biased towards women in the 20s and 30s. Further research on how sexual health needs change with increasing age would be very valuable.

Lesbian was women's most commonly preferred term at all ages, although a variety of terms were used. A significant minority (6%) used no term to describe themselves sexually. While services for homosexually active women may advertise themselves as 'lesbian and bisexual women's services' individual consultations should be sensitive to the variety of terms (including no term) women use to describe themselves.

The predominance of White British women in these samples precludes any observations on ethnic group differences in women's sexual health needs. Further research on the validity of these findings in minority ethnic groups is needed. It is worth noting however, that sexual needs varied considerably *within* the White British women. We should also expect great variation *within* any other ethnic group. It is possible that the women within any one ethnic group are more diverse than they are, as a group, different from other ethnic groups. Again more research is needed to examine the impact of ethnicity on sexual health and sexuality.

The majority of women were, at the time of the survey, in a relationship with another woman and almost half lived with a female partner. This underlines the importance of services acknowledging the context in which women's sexual behaviour takes place, and the potential sources of support they can draw on.

6.3 SEXUAL BEHAVIOUR

The majority of women in both surveys had sex with women only. While two-thirds of the bisexual identified women had sex with a man in the last year, less than 5% of the lesbians had. Sex with men also became less common with increasing age. These findings suggest the need for service providers to recognise that lesbian, dyke or gay identity does not preclude sex with men. We reiterate the need for more research on how to understand how sexual health needs change with increasing age.

Very few women had large numbers of sexual partners. The average number in the last year was one (both for female and male partners). This suggests a relatively small potential for STI transmission. However, about half the women had met a new sexual partner in the last year. Pubs and clubs were by far the most common way women met, with smaller numbers meeting through work, social groups, friends, at private parties, personal ads or through use of the internet.

Among those with a current regular partner, most had known their partner for some time prior to their first having sex. Again, this suggests less potential for sexual harm among this group than among groups whose primary sexual activity involves men. Further, in contrast with gay men, where open relationships appear the rule rather than the exception, 80% of women's relationship were monogamous (they had not had sex anyone else during their relationship). Extra-relational sex became more common with increasing length of relationships.

Although almost half the women indicated the amount of sex they were having was right for them, over half said it was too little. Very few women indicated they were having more sex than they wanted. Absence of sexual opportunities was more of a problem for these women than STI acquisition.

6.4 SEXUAL VALUES AND NEEDS

Sexual health featured strongly in these women's health concerns. When asked for their three biggest health concerns the most common response was cancer, followed by sexually transmitted infections. That HIV was also a common answer suggests women were concerned about health needs in their community and not just themselves. Another relatively common concern was mental health, in particular stress and anxiety.

For these women, the most valued aspect of sex was the emotional relationship they had with their sexual partners. Many also mentioned the physical side of sex. Fewer cited the physical characteristics of partners, safety, comfort, security and freedom of expression.

Over a third of women were currently *un*happy with their sex life. Women in recently formed relationships (under a year) were happier with their sex life, and dissatisfaction increased with increasing length of relationship. This may well be due to the decrease in sexual activity within relationships with increasing length. However, single women were most likely to be unhappy with their sex life.

The most common reason for sexual unhappiness was having too little sex (either having no sex, wanting a regular relationship, wanting more sex with the regular partner they had, or wanting more female sexual partners). Some felt that a low libido was a problem for themselves and/or their partners. Other significant causes of sexual dissatisfaction included relationship problems and poor health which interfers with sex. Smaller proportions of women reported lacking sexual confidence, having problems related to orgasms or being too stressed or tired for sex. These observations underline the need for an understanding of sexual health beyond freedom from infection and conception.

Among those currently in a relationship, a third felt their relationship could not be improved. Others suggested improvements, most commonly: more sex, more money, changing their partner in some way, legal equality with heterosexual partnerships, less discrimination and stigma, more time together, living together or near each other, less work and more fun, and better communication. Clearly there is not one single thing that would improve all women's relationships. However, the predominance of sexual issues suggests considerable sexual health gain could be achieved through addressing these needs. The concerns with social inequality also suggest that the sexual (and relational) health needs should be addressed at a national policy level.

6.5 SEXUAL PROBLEMS

Women were asked about the problems they had with sex in the last year. The most common negative experiences were psychosocial. These included feeling anxious or stressed during sex, feeling bad about the sex they had and agreeing to sex when they did not want it. Less common but still significant were physical problems including pain or discomfort, impeded orgasms and involvement in STI transmission. One in twenty-five women had been forced to have sex they did not want in the last year.

Given the importance they place on emotional relationships between sexual partners and freedom of expression, it is very significant that half of these women had avoided same sex affection in public. They had done so primarily to avoid physical assault and verbal abuse, general negative reactions from onlookers and discrimination from employers or friends and family which they felt would result from being seen to display same sex affection. This suggests that the climate of legal and social discrimination is a major obstacle to sexual health for lesbians and bisexual women and points towards societal and community level interventions.

6.6 SEXUAL HEALTH INFORMATION NEED

The draft *National Strategy for Sexual Health and HIV* (Department of Health, 2001) stresses the importance of access to appropriate sexual health information for everyone. Many of the women surveyed find it hard to access relevant sexual health information and services because of their sexuality. Almost 60% said it was hard finding information and over half were unaware of the location of their nearest sexual health clinic.

Women most commonly wanted information on breast and cervical cancer services. Information about relationship counselling services was also commonly requested. While ten per cent had children about a third would like children in the future. Consequently information about fertility and insemination services was another area of unmet need.

Less common, but still considerable, was unmet information need around diagnosis and treatment of sexually transmitted infections (including HIV). The complete invisibility of lesbians (and same sex activity between women) in the *National Strategy for Sexual Health and HIV* illustrates the obstacles faced by lesbians in this area.

The limited contribution of health services to these women's sexual health is reflected in the fact that half had found sexual health information from the lesbian and gay media but only a quarter cited health services as a significant source of such information.

6.7 USE OF SEXUAL HEALTH SERVICES

Half of the women had never sought advice or help about their sex lives or sexual health. Of those who had, the most commonly sought advice was about STI's, cancer, HIV and psycho-social issues around relationships and sexuality.

Half had sought help from GUM/sexual health clinics, slightly fewer from their GP, and a small proportion from charitable agencies or a private clinic or doctor. Others had seen counsellors, psychologists, gone to hospital clinics, family planning clinics etc.

Sensitive sexual history taking is now judged an element of good practice of any sexual health service, including those provided by GPs. However, among the women who had sought sexual health advice or help, over half had not been asked about their sexuality or their sexual practice. GP's were the least likely to ask about sexuality with only a quarter doing so, but even 40% of women seeking GUM consultations had not had their sexuality raised. Clearly there is extensive need among sexual health service providers for basic awareness and understanding about sex between women and the need to ask about sexuality and sexual practices.

Those who had used services were asked to agree or disagree with statements related to service quality. Responses indicate considerable need for improvement. Of those who had sought any service, 40% did not feel safe enough to discuss their sexuality (54% of those using GP services and 31% using GUM services). A fifth (19%) thought that the staff listened carefully to what they said (28% using their GP, 11% using GUM) and 16% felt that they were treated with courtesy and respect (21% using GP services and 11% using GUM services only). Overall, a quarter of women would **not** recommend the service they had used to another woman. This rose to 40% among those using GP

services (compared with 12% of those using GUM services). Clearly, primary care has a long way to go before it will be able to provide equitable and appropriate sexual health services to lesbians and bisexual women.

Those who had previously sought help or advice were asked how the service could have been improved. Most commonly they suggested an increase in staff ability to address needs of lesbian and bisexual clients or a better attitude towards lesbians, gay men and bisexual people.

6.8 CONCLUSION

While lesbian (and to a lesser extent bisexual women) are probably less likely to be subject to STIs and unwanted conceptions, a non-medicalised understanding of sexual health indicates considerable unmet need among these women, particularly around creating and sustaining sexual relationships. Lesbians need access to all sexual health services that any other woman requires. Currently the ability to deliver a tailored service in a *sensitive, appropriate and equitable* manner appears to be woefully lacking among service providers, particularly in primary care settings.

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