

HIV Risk Perception in Young Homosexual Women from Cali, Colombia

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ABSTRACT

Risk perception is a cognitive process that allows people to organize information and assess their exposure to a hazard. Therefore, this study aimed to describe the risk perception towards HIV in young homosexual women from Cali, Colombia. Six homosexual women participated in this research, which has a qualitative narrative design. Data was collected using semi-structured interviews and analyzed through Thematic Analysis. The findings indicate that women have low knowledge about HIV and the use of preventive methods was not reported. It was found that their beliefs about HIV have been built on their interaction with peers and health service providers. These results provide an initial understanding of how and why to develop comprehensive prevention strategies for this population.

Keywords: HIV; Youth; Risk perception; Homosexual women; Health Access.

Percepção de risco de VIH em mulheres homossexuais jovens de Cali, Colômbia

RESUMO

A percepção de risco é um processo cognitivo que permite organizar e avaliar a exposição a uma ameaça. Portanto, o objetivo deste estudo é descrever a percepção de risco para o HIV de um grupo de mulheres homossexuais de Cali, na Colômbia. Desta pesquisa, com desenho narrativo, participaram seis mulheres homossexuais. Os dados foram coletados através de entrevistas semiestruturadas e analisados por meio de uma análise temática. Os resultados indicam que as mulheres têm um baixo nível de conhecimento sobre o HIV e o uso de medidas preventivas não foi relatado. Verificou-se que suas crenças sobre o HIV foram construídas em interação com seus pares e seus provedores de serviços de saúde. Esses resultados fornecem uma compreensão inicial de como e por que estratégias adequadas de intervenção devem ser desenvolvidas para essa população.

Palavras-chave: HIV; Juventude; Percepção de risco; Mulheres homossexuais; Acesso à saúde.

Percepción de riesgo frente al VIH en mujeres homosexuales jóvenes de Cali, Colombia

RESUMEN

La percepción de riesgo es un proceso cognitivo que permite organizar y evaluar la exposición a una amenaza. Por tanto, el objetivo de este estudio es describir la percepción de riesgo frente al VIH de un grupo de mujeres homosexuales de Cali, Colombia. En esta investigación, con diseño narrativo, participaron seis mujeres homosexuales. Los datos fueron recogidos usando entrevistas semi estructuradas y analizados a través de un análisis temático. Los resultados indican que las mujeres tienen un bajo nivel de conocimientos sobre VIH y no se reportó el uso de medidas preventivas. Se encontró que sus creencias sobre el VIH se habían construido en la interacción con sus pares y sus proveedores de servicios de salud. Estos resultados proveen una comprensión inicial de cómo y porqué se deben desarrollar estrategias de intervención adecuadas para esta población.

Palabras clave: SIDA; Juventud; Percepción de riesgo; Mujeres homosexuales; Acceso a la Salud.

Introduction

Around 36.9 million people in the world live with HIV, and in 2014, 60% of all new infections in young people corresponded to young women between and 24 years old. (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2014). Additionally, Cambiar a UNAIDS (2017) reported that women represented 51% of the people affected globally.

Orza (2011), in a report from UNAIDS, has declared that lesbian, transgender and other WSW (women who have sex with women) have been historically and socially invisible in the HIV prevention and research agenda due to a low-risk perception of the population; prejudices toward homosexuality and heteronormative approaches surrounding the design and implementation of prevention programs. Furthermore, there are few communication tools about sexual health designed for them (Sandfort et al., 2013) even when there is scientific evidence that homosexual women are at risk for Sexually Transmitted Infections (STIs) Orza (2011) and studies show its prevalence is not significantly lower in this group than in heterosexual women (which are between 10–20%) (McNair, 2005).

Thus, it is a global health priority to include homosexual women in the HIV prevention agenda, in order to ensure their rights to health, not only in terms of accessing health care but also receiving accurate information and participating equally in health care programs (Fish & Bewley, 2010). However, it represents a major challenge in countries such as Colombia where lesbian, gay, bisexual, transgender and intersexual (LGBTI) rights are still in public debate (Jaime, 2013).

In Colombia, 98.5% of the cases acquired the virus through sexual transmission and 32% of the diagnosed people were between 15 and 29 years old (Ministerio de Salud

y Protección Social [MinSalud], 2014). The rates of HIV in women are increasing, for 2010 they represented a ratio of 2:7 when compared to men and they represent 26.9% of the people living with HIV (United Nations Fund for Population Activities [UNFPA], 2012). Likewise, the department of Valle del Cauca, of which Cali is the capital city, presents the second highest number of cases between 1983-2010, with a total of 14.848 (MinSalud, 2012).

Several actions to reduce the HIV incidence are being developed by the Ministry of Health because it is considered a relevant health issue (MinSalud, 2015). According to this entity, these efforts should be directed to all the populations without discrimination by gender, ethnic, sexual orientation or any other means (MinSalud, 2013). However, specific public policies and intervention strategies on HIV prevention and care for homosexual women were not found, and even when the affected population had been described according to their age, gender, transmission pathway and location (MinSalud, 2012), the statistics of homosexual women living with HIV are not identified in any report yet.

The prevalence of STIs in the female homosexual population has been reported by Bauer and Welles (2001), Bell, Ompad, & Sherman (2006) and Fethers, Marks, Mindel, & Estcourt (2000), while low rates of gynecologic and serological testing are also described. Colombia Diversa (2010) reported that Colombian women prefer to hide their sexual orientation in health services out of fear. This generates inadequate health care and low rate of Pap testing, increasing the risk of untimely detection of possible irregularities, such as cervical cancer.

In regard to the risky sexual practices in this population, studies in the United States, Lindley, Nicholson, Kerby and Lu (2003) described that the most common sexual practices performed by this population were oral sex, mutual masturbation, vaginal penetration and the use of sex toys. According to Dolan and Davis (2003) homosexual women were at risk in these practices when they shared sex toys, performed oral or vaginal sex without protection (condoms, dental dams, latex gloves) or during their partners menstrual period, had oral-anal contact, performed tribadism (direct contact of the two vaginal surfaces) and fisting (inserting the hand into the vagina) without using latex barriers.

In a study conducted in South Africa with 391 undergraduate women, homosexual women reported a higher level of alcohol and substance consumption in comparison to heterosexual women. That consumption was also related to a higher number of sexual partners (Hoque, 2011). Correspondingly, in other continents such as North America and Oceania, it was found that the female homosexual population had a major number of sexual partners and higher substances consumption, including intravenous drug abuse. This situation potentially exposes them to HIV transmission (Bell et al., 2006; Fethers et al., 2000; Goodenow, Szalacha, Robin, & Westheimer, 2008; Matarazzo, Coffey, & Bingham, 2005; Saewyc et al., 2006).

Moreover, in regard to their perceptions, studies have found that homosexual women tend to value the idea of love and confidence in their relationships over the use of preventive methods (Degges-White, 2012; Monteiro, Cecchetto, Vargas, & Mora, 2010; Ronson, Milhausen, & Wood; 2012). However, Pinto (2004), in Brasil, concluded that the low use of preventive methods in this population was a consequence of a lack of knowledge about them, low HIV risk perception and excessive mutual confidence in their romantic relationships. The lack of knowledge about HIV in this group, including general information and preventive strategies, have been reported as a major gap for HIV prevention practices around the world (Matarazzo et al., 2005; Mora & Monteiro, 2010; Asociación Probienestar de la Familia Colombiana [Profamilia] , 2007).

The studies conducted in the female homosexual population have exclusively focused on the description of their sexual and preventive practices and little is known about their risk perception towards HIV. In psychology, risk perception is considered to be a cognitive process in which a person organizes a value judgment from different information sources such as personal history, characteristics of the context, beliefs, attitudes, motivations and stereotypes (Pastor, 2000). With regard to the stereotypes, they could be understood as beliefs and action patterns that could be shared collectively and their main function is to allow differentiating between situations and identifying certain threats (Gómez, 2007).

As suggested by García del Castillo (2012) risk perception has been studied in relation to health issues because it is a principal predictor to risk exposure. But it is still necessary to build conceptual and empirical research that allows us to understand risk perception beyond the traditional models that only emphasize the cognitive aspect of this process without considering its social context. Therefore, it is relevant to design qualitative studies approaching the HIV risk perception from a psychosocial perspective in order to explore how it is constructed.

The main objective of this study was to describe the risk perception towards HIV in a group of young homosexual women from Cali, Colombia. This study was oriented to young people due to the rates of HIV in this population and the specific characteristics of their developmental stage which include the exploration of identity and pleasure (Arnett, 2008; Zuckerman, 1979).

Method

Design

This exploratory study, part of a larger research describing sexual practices in young university students from Cali, Colombia, was based on a qualitative methodology that analyzed how women construct their perception about HIV through their spoken narrative (Bonilla-Castro & Rodríguez Sehk, 1997; D'Aloisio, 2009). The study was focused on a narrative design, which describes and analyses the participant's perspectives about HIV, recognizing the importance of social context in its comprehension (Willig, 2013).

To achieve the general objective, this study focused on identifying participant's knowledge, attitudes and stereotypes towards HIV; detailing their sexual and preventive practices, and identifying their perceived resources and difficulties to perform preventive practices.

The participants of this study were six women between 18 and 25 years old that identified themselves as homosexual. In this article, the term "homosexual women" was used because the participants felt that the word "lesbian" was not a positive description of their identity. This could be a particular characteristic of the context in which this research was conducted.

The inclusion criteria was: (a) reported having sexual activity; (b) reported having homosexual relationships for a minimum of three years; (c) that identified themselves as homosexual women for a minimum of three years; (d) did not present cognitive or physical impairments that prevent them from having a clear narrative. This was ensured by the direct questioning of the medical history.

Procedures

The sample was selected in a non-probabilistic way, using the "snowball strategy" or key informants contact. The reason for using this sample strategy and sample size

is because in the context where this study occurred, this population corresponds to a hard-to-reach group that has not been easily studied in the city Uribe Castro, 2012) Likewise, given the scope of the study and the nature of the topic, in which information can be easily provided by the participants; the specific characteristics of the sample and their capacity to provide quality information; and the study design, in which retrieving in-depth data was procured, it is believed that this sample holds enough information power to provide an initial exploratory understanding to this understudied topic (Morse, 2000).

Prior to data collection, participants were informed about their voluntary participation and were provided with information about the study. They also signed a consent form and choose a pseudonym to identify themselves and protect their identity.

For data collection, two semi-structured interviews were designed, reviewed by experts and used. The first one aimed to explore sociodemographic information of the participants and their knowledge and attitudes toward HIV. The second one explored their sexual practices, including preventive practices and perceived resources. These interviews had an average duration of one hour each, were audio recorded and transcribed for the analysis process. They were conducted in Spanish and translated by an English native speaker for this report.

The Department of Social Sciences approved the instruments and procedures of this research in accordance with the 008439 Resolution that establishes the scientific, technical and administrative norms for health research in Colombia (Ministerio de Salud, 1993).

Analysis

Data treatment was made through a thematic analysis that allowed identifying core ideas in the narratives and experiences (Mieles Barrera, Tonon, & Alvarado Salgado, 2012). The information was systematized by main categories and subcategories that were built from a literature review. The main categories of this study were: information about HIV, HIV stereotypes, attitudes toward HIV, sexual practices, prevention practices, perceived resources for prevention and perceived difficulties for prevention.

Data was coded by using the ATLAS.ti. Software. The technique for double coding data of consensual qualitative research (CQR) was used as a strategy of analysis. This codification strategy allows generating a consensus between two or more researchers and reduces their possible biases in order to capture the complexity of the phenomena (Hill et al., 2005). CQR was a useful tool to face the divergences and potentiate the convergences between our multidisciplinary research group. This group was formed by psychologists, nurses and sociologists who were involved in the discussion of the results.

Results

Knowledge about HIV

The most common idea in the participants' narratives was that HIV was a mortal disease. As evidenced in the discourse below, the information about the virus was a mix of truth and misinformation:

[HIV] is a sexually transmitted disease... There is one person that has the virus and puts it in other person and activates it depending on I don't know what, a strange thing, and well, there isn't a cure for AIDS. The truth is that I don't have a lot of information about it (Valentina, 22 years old).

In regard to the HIV transmission pathways, participants identified that sexual transmission was the primary one. They associated anal sex as the riskiest sexual practice, but they did not identify risk in oral sex. Therefore, the transmission was mainly associated to penetrative practices in a heterosexual relationship: *"HIV is transmitted by sexual relationships. I mean by the transference of fluids between a woman and a man in penetration"* (Sara, 23 years old).

Concerning the chances of transmission between two women, some participants reported that it was impossible and others declared not having enough information about it. One of the primary ideas that explain those statements was that the virus can only be transmitted if one of the women has had previous sexual relationships with men: *"I think it may be possible...For example, if two girls have never had sex with boys it is not possible, but if one of them has been with a boy and the boy had HIV and he transmitted the virus to her, then it is possible"* (Julieta, 19 years old).

The internet was identified as the most common source of information about HIV. They preferred to use it because: (a) it was easily accessible; (b) there was no exposure to peers, family or health services professionals that could judge them; or (c) they were able to read about similar experiences of people that share their sexual orientation.

HIV Stereotypes

Participants believed that HIV was identifiable by physical aspects of a person such as thinness, paleness and hives. Also, they reported that transmission was only possible in "promiscuous" people, sex workers, psychoactive substances users and homosexual men.

Their idea of invulnerability was marked by these factors: (a) they did not know any person living with HIV, including cases of other homosexual women; (b) the lack of information about the possible transmission pathways according to their sexual orientation; (c) the belief that HIV was only transmitted by heterosexual and homosexual men and (d) the consideration that their own sexual practices were not risky. In the discourse below, Paula expressed those ideas assuming herself as part of a particular social group with shared beliefs about HIV:

"We don't know anything about HIV in homosexual women so we preferred to believe that just happens in homosexual men or in heterosexual men. I think that is why we feel invulnerable" (Paula, 20 years old).

Also, women reported not feeling vulnerable to HIV because: (a) most of them had stable relationships; (b) they or their partners had not had sexual relationships with men, and those who have worn protection. In addition, one participant reported the perception that HIV it has been socially "normalized" by the whole population:

"I think that some years ago there were more cases of HIV, but now it is normal or common. You don't see it in the news like: in some country, there is some number of people with HIV. No, now it is normal" (Valentina, 22 years old).

It was also reported that in university settings and bars there were stereotyped behaviours and action patterns that shaped their sexual practices and identity exploration. Those places allowed them to meet people with the same sexual orientation and who were also consuming psychoactive substances, mostly alcohol. Bars and clubs for the LGBTI community were frequented by the participants because: (a) it provided a community feeling for being surrounded by people with common characteristics; (b) it provided a feeling of security for being less judged than in other public places, because they generated the sensation of being surrounded by people they knew; (c) they also had the opportunity to meet new

people, and (d) generated identity as homosexual women. For these reasons, they would feel freer to explore their identity and sexuality with people they have met in those spaces.

"In gay bars, I see girls like me. I mean that they have short hair or they aren't very feminine. In a heterosexual place, you see that girls go in high heels, wear makeup... but in gay bars, I can go with my sneakers and everybody knows it's normal" (Paula, 20 years old).

Attitudes toward HIV

Participants associated negative consequences in their social and emotional life to the risk of HIV transmission. However, some of them perceived that risk could be controlled or avoided. While others reported assuming sexual practices without having second thoughts: *"Risk is knowing you are going to do something with bad consequences. But it is like: I'm going to do this and this can happen. But I just do it anyway"* (Paula, 20 years old).

Additionally, none of the participants reported knowing any person living with HIV. Some of them reported that if their partner were diagnosed with HIV, they would continue having sex with her only if the transmission was not related with infidelity with a man. This idea was associated with the meaning that women had about love and confidence in their relationships: *"First of all, I'd ask her how she got infected because you can get HIV by having heterosexual relationships and if she was not infected by a man and it was by some other way, everything between us could continue normally"* (Carla, 18 years old).

It is interesting that one participant pointed that she would not judge a person living with HIV because of her identification with a minority population group:

"I would treat a person with HIV normally, I think that I'm not able to judge them because I'm not a normal person, you know... being homosexual makes me think that I can't judge someone for being different because I'm aware of how harmful it is" (Valentina, 22 years old).

Sexual practices

It was found that the most common sexual practices were oral sex, finger-vagina penetration, mutual masturbation and tribadism. Anal sex, fisting and group practices were not reported because they were associated with pain and danger. Only one of the participants reported the exchange of sexual toys. The reasons for not using them in their sexual relationship were (a) feeling discomfort with penetrative practices; (b) disliking the phallic shape of the toy, and (c) perceiving them as a non-hygienic object.

Sexual practices under the effects of alcohol were reported. They perceived that it increased their sensations and provided a sensation of renouncing control. Also, participants reported that alcohol consumption facilitates the decision of having sex:

"Alcohol affects so many things. I think that you are more aware of every feeling, and everything is more sensitive. When you are touched you feel a lot of things... I think that having sex under its effect is better" (Valentina, 22 years old).

Half of the participants reported having sexual practices with men under the effects of alcohol. These practices also occurred in their process of acceptance and disclosure of the sexual orientation. In the following discourse, a participant narrates her encounter with a man: *"Like three years ago, after a party, we went out and we were so drunk and we kissed and he got horny and we sat on the stairs and we began to masturbate each other and I did oral sex on him"* (Carla, 18 years old).

Preventive practices

None of the participants identified the preventive methods that can be used by homosexual women in their practices: *"I don't know what protection can be used in homosexual relationships. I have no idea because that is a topic that it is not talked about often. There is no information about it"* (Paula, 20 years old).

Likewise, no participant has used preventive methods in their sexual relationships with other women. The principal reason for this non-use was the lack of information about them: *"I don't use protection because I haven't had sex with men. I mean, if I do it with a man I would never do it without a condom... But with girls, I haven't used one. I don't even know what kind of protection I can wear in homosexual relationships"* (Carla, 18 years old).

Other motives for not using preventive methods were associated with the sensory and physical assessment of the texture and odor. And they were also related to the emotional bond with their partners: *"Some people say that you don't feel anything if you wear a condom. Maybe I would feel the same with a woman. They also say that you can hurt your partner if she doesn't lubricate, that would be uncomfortable for her. That's why I wouldn't use it"* (Carla, 18 years old).

Other reasons for not using preventive methods were related to the affective bond with a partner, such as (a) not perceiving the necessity of using them because they trusted and loved their partner; (b) being afraid of hurting themselves or their partners with the use of preventive methods; (c) perceiving that they should not use any protection because they did not have sex with men.

Different prevention strategies such as having good hygiene previous to sexual relationships to prevent vaginal infections, having an exclusive sexual partner and knowing a person in different aspects of their life were also identified.

Perceived resources and barriers for prevention

Other social aspects could be helpful to analyze HIV risk perception and risky practices. According to perceived social support, it was identified that their families provided material support principally. However, it was also reported that emotional support into the family was exclusively related to academics and sports, neglecting subjects such as sexual orientation and sexuality:

I can count on my parents for everything except something related to my homosexuality because they get really upset. I can't tell my mom something that happened with my girlfriend, like: -hey mom, I had a fight with my girlfriend-. No, I can't tell her those things (Carla, 18 years old).

It was also found that friends and partners were a significant emotional support and accompanied them through their sexual orientation disclosure. Some participants reported that if it were not for them they would feel lonely.

Another explored social support network was health providers and institutions. Only half of the participants had had a cytology or Pap test, even if they were affiliated with health services. They also reported receiving inadequate service when they went to a health professional for two reasons: (a) the professionals did not perform the test they requested because they did not perceive them to be at risk and (b) they did not provide information according to their particular needs and sexual orientation. The following discourse evidences those ideas:

I went to a health institution and I said: -I want to take the HIV test- and they took me to another room and started to ask me a lot of questions such as -have you been at risk?-

and I said -Do I have to be at risk get tested?- and he said -yes because if you haven't it is not necessary that you get tested- (Sara, 23 years old).

However, none of the participants had been tested for HIV for two reasons (a) they did not perceive the need because they had a stable relationship or (b) the test was denied for the health providers because they did not consider them to be at risk:

I went to a doctor once because I wanted to check my sexual health, and I told him that I was gay. I said: -I'm gay and I have never been with a man- and he said -but the girls you've been with have had sex with boys-, and I said - yes. Then he said: -have you done this or this practice?- and I said -no. Then he said -you don't need to be tested- (Julieta, 19 years old).

The participants also described political and social barriers to access to preventive methods such as (a) the lack of information and interventions addressing sexual health in homosexual women and (b) the difficult access to preventive methods on the market:

The primary difficulty is the lack of information and education. In schools, they should say -hey, you have to wear protection with boys and girls-. I know it's difficult but society should give more information to homosexual people and maybe we could use preventive methods because that's the reason for my lack of information and my friend's lack of information, because no one has ever spoken to us and said -you, homosexual women, are in risk to that and that when you have sexual relationships- (Paula, 20 years old).

Discussion

This study responded to the need of conducting research on HIV and homosexual women in Latin America (Palma & Orcasita, 2017). It aimed to describe the risk perception towards HIV in a group of young homosexual women from Cali, Colombia. In the first place, the findings suggest an important gap related to HIV information in the sample. Those results were consistent with the national reality described by *Profamilia* (2011), who reported that young women between 15 and 24 years old have low levels of information about the virus. However, *Profamilia's* report is generalized to the female women population and was not analyzed by sexual orientation. The inclusion of specific data on HIV in homosexual women remains a challenge for governmental and non-governmental institutions in charge of promoting sexual health.

Additionally, participants had no knowledge about HIV preventive methods. This was also reported globally by authors such as Mora and Monteiro (2010), Dolan and Davis (2003) and Matarazzo et al. (2005) who found low levels of knowledge about prevention in homosexual women. However, one of the most important findings of this research was that even when any preventive practice against HIV was found in the sample, it was identified that they performed different self-care strategies related to personal hygiene and monogamy, suggesting that they had significant resources that could be potentiated in future intervention programs addressing sexual and reproductive health.

Similarly to findings reported by Mora (2009), the risk perception of the participants was associated with the belief that only specific social groups were vulnerable, such as sex workers or homosexual men. Moreover, they believed HIV had visible signs which could increase their risk if the decision of performing preventive practices is based on the stereotyped physical sequel of HIV.

It was found that these particular beliefs and ideas were shared and socially built through the interaction with peers and other social groups. They were even perpetuated by health providers. This means that the perceived invulnerability of homosexual women is also rooted in social institutions because due to the lack of information and public policies provided by them, the female homosexual community remains invisible.

These results have significant implications for providing health care to this population as inadequate beliefs and/or homophobic ideas in health services providers shaped the attention offered to participants. In this case, the barriers in the medical attention for homosexual women were related to (a) non-registration of HIV cases, (b) indirect questioning by medical professionals due to a heteronormative assumption of sexuality and (c) the lack of comprehensive guidelines for medical care.

The barriers in medical attention in the LGBT community have been highlighted by the social movements in Colombia (Colombia Diversa, 2010; Jaime, 2013) and in order to respond to this challenges, these struggles need to be studied nationally to make evidence-based decisions in the proposal of comprehensive public policies for this population.

The participant's attitudes toward HIV were mediated by their information about HIV transmission pathways and distant experiences with HIV cases. That information made them think that they could not be infected, thus they considered themselves not to be at risk. Uribe, Orcasita, & Vergara Vélez (2010), show that due to the diagnosis stigma and little information about HIV, people have a highly unfavorable attitude toward HIV diagnosed population. However, as reported by one participant, the favorable attitude in the sample can be explained by the identification of homosexual women with another social group that has been socially stigmatized, and they avoid discriminating against people that have lived similar situations.

Also, a favorable attitude towards the possible diagnosis of their partner was found, and most of the participants would continue having sexual relationships with them. These findings could be related to lack of knowledge about specific risky homo-erotic practices. A significant idea of fidelity and love was also found in their narratives, and it has been widely described by multiple authors as a characteristic of female homosexual relationships (Degges-White 2012; Tangmunkongvorakul et al., 2011). These results could be explained by Salazar's et al. (2006) and Granados-Cosme, Torres-Cruz, & Delgado-Sánchez's (2009) findings about the influence of stigma and discrimination in performance of safer sex strategies in Latin-America homosexual men, because their partners become a principal source of support and help them to face the consequences of sexual orientation disclosure. Therefore, it is mandatory to address the social and cultural aspects that shape risk assessment and prevention in the Latin-American LGBTI community.

Additionally, an unfavorable attitude towards condom use was found as it was believed it interferes with pleasure. The study found a low-use of safer sex strategies that have been described in previous research on this population (Lindley et al., 2003; Matarazzo et al., 2005; Profamilia, 2007). Women in this study reported that latex barriers limited their sexual practices, had a disgusting odor or were not designed according to their bodies and genital anatomy. Also, this non-use was due to the confidence and love they felt for their partner.

It is also necessary to point out that no participant has ever been tested for HIV nor received a regular cytology. This may be explained by the low-risk perception in the population and in the health service providers that do not perform the tests when the participants requested. This may explain the reasons behind the low performance of diagnostic and serological tests in the population (Colombia Diversa, 2010; Curmi, Peters, & Salamonson, 2014; Sandfort, Baumann, Matebeni, Reddy, &

Southey-Swartz, 2013). However, it should not be ignored that one of the principal tasks in global health is characterizing the affected people and expanding HIV testing (World Health Organization [WHO], 2014), therefore designing strategies to include this one in the HIV prevention and health promotion agenda is urgent.

In this work, a diagram that allows comprehending the construction of HIV risk perception is suggested. It was built from the approaches of García del Castillo (2012), who describes that risk has an individual and collective level and the approaches of Sevilla Peñuela (2008), who studied the frames of actions and meanings that underlie any risk. The frames of action are composed of the physical, chemical and biological aspects of an action and the frames of meaning are the values, representations or symbolizations built in interaction with culture and society.

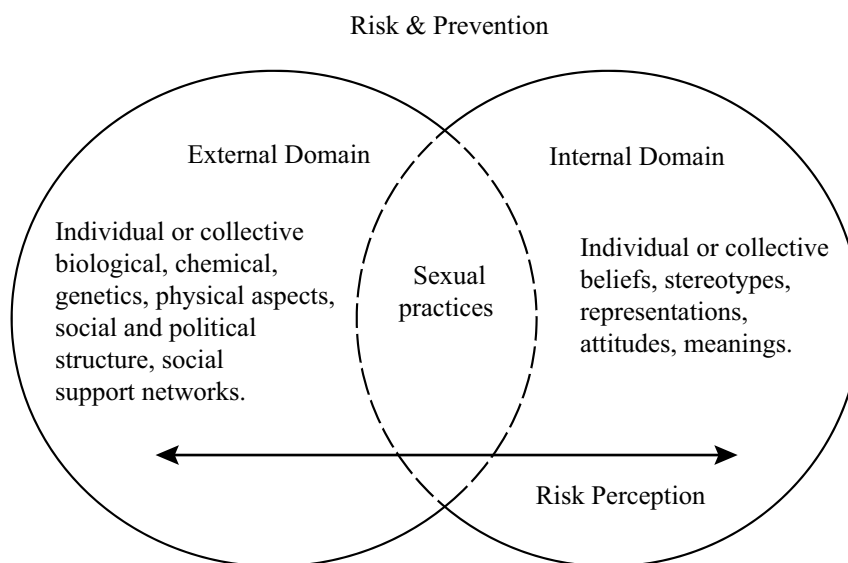


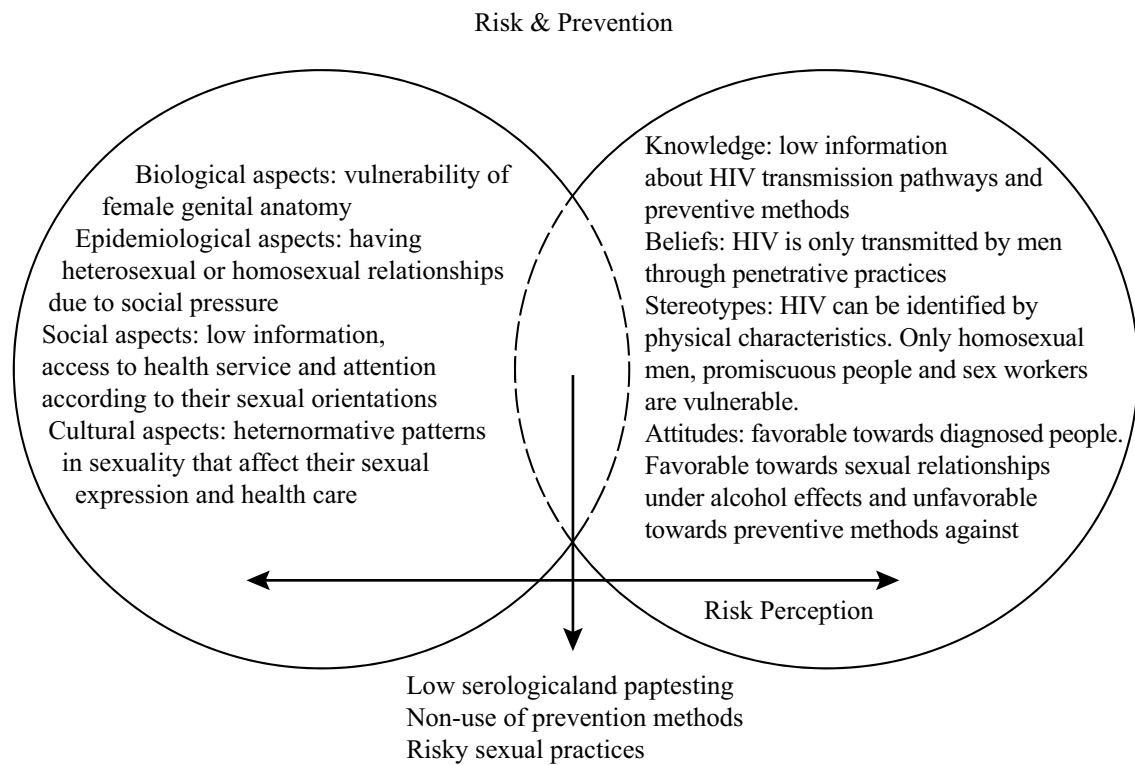
Figure name: diagram built based on García del Castillo (2012) and Sevilla (2008)

Figure 1 shows that in the external domains of risk there are indicators such as biological, genetics or chemical aspects that create vulnerability for an individual or a collective. They are considered external because they are an autonomous process. However, the socioeconomic and political structure can also increase or decrease the risk. On the other hand, the internal domain contains those beliefs, representations, and meanings whereby the risk is perceived.

The proposed diagram could be considered as a navigation tool in further research or programs addressing HIV prevention in the population. It goes beyond the assumption that HIV risk perception is an individual cognitive process, and it is finally the person who processes the information and act, and emphasizes contextual and social aspects because it is considered that through the interaction with groups of peers, family and other social institutions, individuals build what they consider risky (Slovic, 1987).

In this research, it was evident that the participants' risk perception was configured by meanings built in their interaction within the context and it was rooted not only in a subjective level but also in their social groups and health service providers, therefore this perception was individual but also collective. It is finally in the intersection between the external and internal domains where their sexual practices occur

and, depending on the risk perception, prevention strategies are performed. Figure 2 describes the principal findings of this research.



Insert figure 2 model of HIV risk perception for homosexual women.

As can be seen in Figure 2, the external domain contains biological, epidemiological, social and cultural characteristics that configure HIV risk in this group of women. This risk can be individual because of the personal difficulties for prevention that expose them to HIV, as well as individual characteristics that impede their access to health and education such as gender and sexual orientation. Although the biological aspects were not measured in this study, they were retrieved from a literature review about women's vulnerability in the HIV epidemic (Herrera & Campero, 2002).

However, the external domain is also shared collectively. For example, women in the study have no access to accurate sexual education and information regardless of their level of schooling and affiliation to health service. Also, more than half of them reported to not receiving adequate medical care due to social and cultural aspects that configured the representations about sexuality in health providers. Therefore, participants built their HIV risk perception according to the messages received from them. These findings suggest that risk perception also can be studied by considering the structural characteristics and not only on the subjectivity as suggested initially by García del Castillo (2012) and Padlog (2009).

As mentioned, in the interaction between the internal and external domains, the HIV risk perception was built in communication with a society that has cultural and political characteristics that shape access to health and education because there are underlying gender norms that permeate such access.

According to Richardson (2000), the perception of "invulnerability" in homosexual women may have been created by their invisibility in the epidemic and by the perpetuation of misconceptions about their sexual practices and risk through several social agents, even when research has demonstrated situations that increase their vulnerability such as marginality, stigma, rape and access barriers to health and education (Palma & Orcasita. 2017).

The limitation of this study was the impossibility of generalizing the results due to the sample size. Further quantitative and qualitative research must review and test the suggested diagram on a larger scale to be able to understand this phenomenon. However, it was an initial attempt to highlight key topics to be considered in further efforts, because the participant's narratives and experiences can teach us how to build programs addressing HIV that include them.

This research suggests that the inclusion of homosexual women on the national HIV agenda must be emphasized. With this aim health services institutions in Colombia should: (a) train their professionals on affirmative forms of attention to the LGBTI population; (b) establish protocols for recording information that will promote a national registry of homosexual women who have been diagnosed with HIV, because one of the main factors of the invisibility of the epidemic within them is that there is a underreporting of these data and (c) create care guidelines for homosexual women in health services.

In order to face these challenges, a collective work from different community, public and private actor is required from various interdisciplinary perspectives. These agents must recognize the demands of the LGBT social movements in the country for a collective construction of public policies for equal health and education access, especially their right to receive comprehensive sexual education at schools; and the protection of their civil, sexual and reproductive rights.

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