# HIV and Intimate Partner Violence in Same-Sex Female Relationships: A Comprehensive Report on the Intersection of IPV, Mental Health, and HIV Risk Among Women Who Have Sex with Women

**The Hong Kong Aids Prevention Society**

**Executive Summary**

Women who have sex with women (WSW), including lesbian and bisexual women, represent a profoundly understudied and marginalized population in HIV research and public health services, particularly in Hong Kong. This comprehensive report examines the critical intersection of intimate partner violence (IPV), mental health, and HIV risk among WSW—a population rendered nearly invisible in Hong Kong's HIV prevention landscape. Evidence demonstrates that WSW face comparable or elevated rates of IPV relative to heterosexual women, experience significant mental health disparities driven by minority stress, and contrary to pervasive misconceptions, are not at zero risk for HIV infection. The convergence of these factors creates a syndemic that profoundly compromises the health and wellbeing of WSW. This report synthesizes current research evidence, identifies critical gaps in Hong Kong's service provision, and provides evidence-based recommendations for addressing the complex healthcare needs of this marginalized population.

## 1. Introduction and Background

### 1.1 Defining the Population

Women who have sex with women (WSW) encompass a diverse population including women who identify as lesbian, bisexual, queer, or who engage in same-sex sexual behavior regardless of identity label. The heterogeneity of this population presents both

methodological challenges for research and practical challenges for service delivery. Sexual orientation identity does not necessarily predict sexual behavior, and many WSW have histories of sexual contact with men, engage in bisexual behavior, or may have fluid sexual orientations over their lifetime. This complexity is particularly relevant when assessing HIV risk and IPV experiences, as risk behaviors and violence exposure may vary significantly across this diverse population.

Research on WSW health has historically been limited, with most LGBTQ+ health research focusing predominantly on men who have sex with men (MSM) in the context of HIV/AIDS. Sexual minority women, particularly those in same-sex relationships, have been systematically excluded from mainstream health research and prevention programs. This exclusion stems from several factors including heteronormative assumptions in healthcare, misconceptions about disease risk among WSW, and the relatively smaller size of this population compared to other key populations in HIV epidemiology.

### 1.2 The Hong Kong Context: A Nearly Invisible Population

In Hong Kong, WSW represent an almost entirely invisible population in HIV surveillance, prevention services, and research initiatives. The territory's HIV programs have traditionally focused on MSM, people who inject drugs, and sex workers, with minimal attention to sexual minority women. Cultural factors compound this invisibility, as traditional Chinese family values emphasizing heterosexual marriage and procreation create additional layers of stigma for sexual minorities. The intersection of Confucian cultural norms, family expectations, and societal stigma renders many WSW in Hong Kong reluctant to disclose their sexual orientation to healthcare providers, limiting their access to appropriate sexual health services.

Hong Kong's HIV prevention infrastructure, while relatively well-developed for certain key populations, lacks WSW-specific programming, culturally competent services for sexual minority women, or even basic data collection on sexual orientation among women presenting for HIV testing or sexual health services. This absence of targeted services occurs despite evidence from other regions demonstrating significant health disparities affecting WSW populations.

### 1.3 Rationale and Scope of This Report

This report addresses a critical gap in Hong Kong's public health response by systematically examining the intersection of IPV, mental health, and HIV risk among WSW. The rationale for this comprehensive analysis includes: (1) documenting evidence of HIV risk among WSW to dispel dangerous misconceptions about "zero risk"; (2) synthesizing research on IPV prevalence and dynamics in same-sex female relationships; (3) examining mental health consequences at the intersection of minority stress, IPV exposure, and HIV vulnerability; and (4) identifying barriers to healthcare access and proposing evidence-based interventions tailored to this population's needs.

The synthesis of these interconnected health issues through a syndemicframework—recognizing how IPV, mental health problems, substance use, and HIV risk mutually reinforce one another in contexts of social marginalization—provides a more complete understanding of WSW health than examining these issues in isolation.

## 2. HIV Risk Among Women Who Have Sex with Women

### 2.1 Challenging the "Zero Risk" Misconception

A pervasive and dangerous misconception exists among both WSW themselves and healthcare providers that women who exclusively have sex with women face no risk of HIV infection. This belief has profoundly negative consequences, leading to reduced HIV testing rates, inadequate sexual health counseling, and delayed diagnosis among WSW who do acquire HIV. Historical data from HIV surveillance has reinforced this misconception by categorizing HIV-positive WSW as "heterosexual contact" cases if they reported any history of sex with men, thereby rendering female-to-female transmission invisible in epidemiological data.

Research demonstrates that while female-to-female sexual transmission of HIV is less efficient than certain other routes, it is biologically plausible and has been documented. Multiple case reports and studies have identified HIV-positive WSW with no other identified risk factors, suggesting female-to-female transmission as the likely route of infection. Kennedy and colleagues' early assessment noted that the biological risk of female-to-female transmission, while not fully characterized, should not be discounted,

particularly given behaviors such as digital-vaginal contact during menstruation, sharing of sex toys, and presence of co-existing sexually transmitted infections (STIs) that increase viral shedding and susceptibility.

### 2.2 Documented Transmission Pathways and Behavioral Risk Factors

Several pathways contribute to HIV risk among WSW. Contrary to assumptions of exclusive same-sex behavior, nearly half of WSW report lifetime histories of sex with men. In a Southern African study of 591 lesbian and bisexual women, 47.2% reported ever having consensual heterosexual sex, 18.6% engaged in transactional sex with men, and 31.1% experienced forced sex by men. These findings illustrate that many WSW are behaviorally bisexual or have histories of sexual contact with men, creating clear routes for HIV acquisition.

Among WSW, specific sexual practices may facilitate HIV transmission between female partners. Sexual contact during menstruation, when cervicovaginal viral loads may be elevated, presents increased risk. Sharing of sex toys without barriers or adequate cleaning between partners can transfer infected cervicovaginal fluids. Traumatic sexual practices resulting in tissue damage or bleeding create opportunities for viral transmission. The presence of untreated STIs, particularly those causing genital ulceration such as herpes simplex virus, significantly increases HIV susceptibility and transmission risk.

Injection drug use represents another important risk factor among some WSW populations. Studies from diverse geographic regions have documented substance use disparities affecting sexual minority women, with injection drug use occurring at elevated rates among some WSW subgroups compared to heterosexual women. Needle sharing and injection practices create direct bloodborne transmission routes independent of sexual behavior.

Research on sexual transmission risk has also examined bacterial vaginosis (BV), which is highly prevalent among WSW and can be transmitted between female partners. While BV itself is not an STI, it substantially increases HIV susceptibility by disrupting the protective vaginal microbiota. Marrazzo and colleagues found that BV was present in 25% of WSW studied, with concordant BV status observed in 95% of partnered women, suggesting

partner-to-partner transmission of BV-associated bacteria and potentially increased HIV vulnerability in both partners.

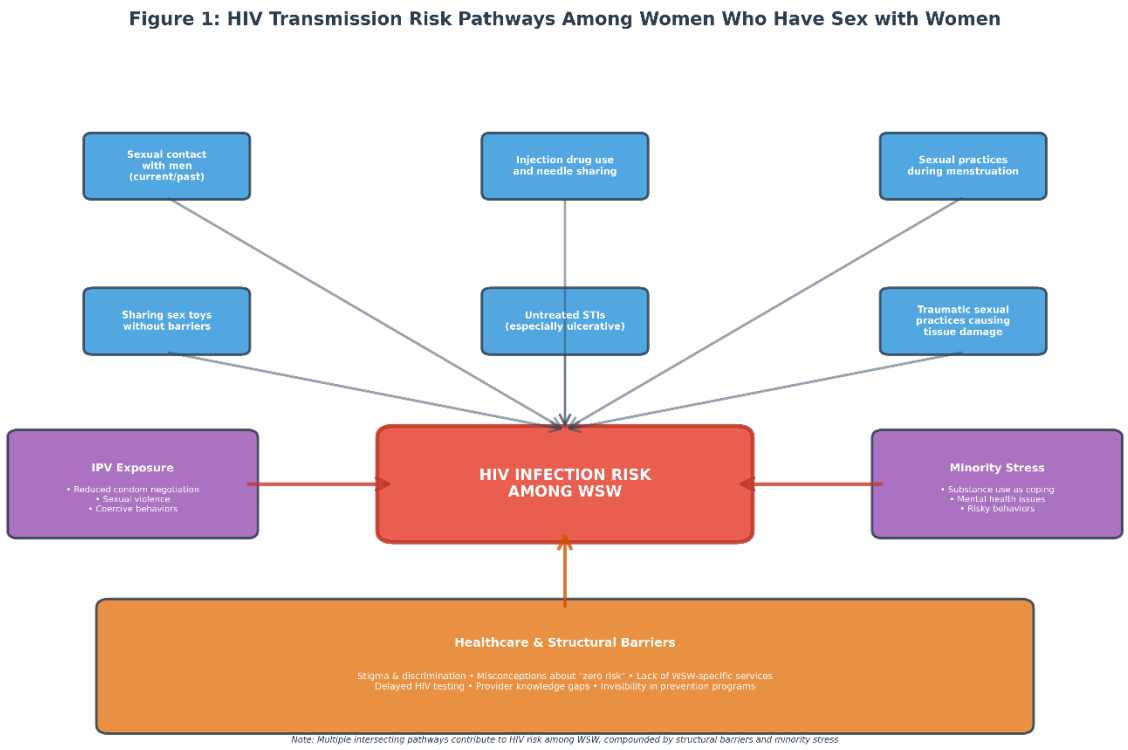
### 2.3 HIV Prevalence Data and Testing Patterns

HIV prevalence data specific to WSW populations remain limited due to small sample sizes, challenges in population definition, and historical exclusion from surveillance systems. However, available data challenge assumptions of negligible HIV burden. In a Southern African study by Sandfort and colleagues, among 591 lesbian and bisexual women who had been tested for HIV, 9.6% self-reported living with HIV/AIDS. Critically, the sole independent predictor of self-reported HIV-positive status in this population was having experienced forced sex—by men, by women, or both—highlighting the intersection of sexual violence and HIV risk.

HIV testing rates among WSW are suboptimal in many settings. One study of lesbian and bisexual women in Seattle found that only 78.3% had ever been tested for HIV, and women who engaged exclusively in same-sex behavior were significantly less likely to be tested despite potentially having other risk factors. This pattern reflects both provider failure to assess risk comprehensively and women's own perceptions of invulnerability. Low awareness of HIV risk translates into delayed testing, missed prevention opportunities, and potentially delayed treatment initiation for those who acquire HIV.

McNair's comprehensive review of STI risks among WSW concluded that STI prevalence among WSW is at least as high as among heterosexual women, and potentially higher in some subgroups. Risk factors for both STIs and HIV among WSW include higher numbers of lifetime partners, minimal use of protective barriers, low levels of STI knowledge, and importantly, experiences of marginalization leading to poorer mental health and abuse that can influence risk-taking behaviors including substance use.

*Figure 1: HIV Risk Pathways Among Women Who Have Sex with Women*




## 3. Intimate Partner Violence in Same-Sex Female Relationships

### 3.1 Prevalence and Patterns of IPV Among WSW

Intimate partner violence affects women in same-sex relationships at rates that challenge the persistent myth that IPV is exclusively or predominantly a heterosexual problem. Research demonstrates that IPV prevalence among lesbian, gay, and bisexual (LGB) individuals is comparable to or exceeds that observed in heterosexual populations. Despite this reality, IPV in same-sex relationships has received far less research attention, policy focus, and service development than heterosexual IPV.

Studies examining IPV among WSW reveal concerning prevalence rates. Meta-analytic findings indicate that approximately 42.5% of sexual and gender minority (SGM) individuals in general have experienced lifetime intimate partner violence, with 43.4% experiencing sexual and gender minority-specific violence. Among WSW specifically,

prevalence rates vary by study methodology and population, but consistently demonstrate that IPV affects a substantial minority of women in same-sex relationships.

Research comparing IPV rates across sexual orientation groups shows mixed findings regarding relative risk. Some studies find comparable rates between lesbian/bisexual women and heterosexual women, while others document elevated rates among sexual minority women. A systematic review by Falluji and colleagues synthesizing recent research on IPV among sexual minority women in same-sex relationships found that SMW are more likely to experience IPV in their lifetime compared to heterosexual women and men, gay men, and bisexual men. This elevated risk may reflect intersecting vulnerabilities including minority stress, experiences of discrimination, internalized homophobia, and barriers to help-seeking specific to same-sex relationships.

### 3.2 Types and Dynamics of IPV in Same-Sex Relationships

IPV in same-sex female relationships encompasses the same forms of abuse observed in heterosexual relationships: physical violence, sexual violence, psychological/emotional abuse, and coercive control. However, same-sex IPV also includes unique manifestations related to sexual orientation and gender identity. Abusive partners may threaten to "out" their victim to family, employers, or community—a form of coercive control particularly potent in contexts where disclosure of sexual orientation could result in discrimination, family rejection, or employment loss.

The dynamics of power and control in same-sex relationships differ from heterosexual IPV models that center on patriarchal gender hierarchies. In same-sex relationships, power differentials may derive from factors such as differences in "outness," economic resources, social capital within LGBTQ+ communities, immigration status, or parental status in relationships involving children. Some abusive partners exploit myths about same-sex IPV—such as the belief that IPV is "mutual" in same-sex couples or that women cannot truly be abusive—to minimize their behavior or manipulate help-seeking.

Physical violence in same-sex female relationships may be misperceived by outsiders, including law enforcement and service providers, as "mutual combat" rather than IPV, particularly when both partners are female and gender-based size differentials are less

pronounced than in many heterosexual relationships. This misperception can result in inappropriate dual arrests or failure to identify the primary aggressor, leaving victims without protection and potentially criminalizing their self-defensive behaviors.

Sexual violence within same-sex female relationships remains particularly understudied and under-recognized. The persistent societal belief that "real" sexual assault requires penile penetration renders female-perpetrated sexual violence invisible and unacknowledged. WSW who experience sexual coercion or assault by female partners face particular challenges having their experiences validated and accessing appropriate support services.

Psychological abuse and coercive control are reported at high rates among WSW experiencing IPV. Controlling behaviors may include isolating partners from LGBTQ+ community spaces, monitoring communications, economic control, and leveraging minority stress by convincing partners that no one will believe or support them due to their sexual orientation.

### 3.3 Minority Stress and Its Role in IPV Vulnerability

Minority stress theory provides a crucial framework for understanding elevated IPV risk and its consequences among WSW. This theoretical model posits that sexual minority individuals experience chronic stress stemming from stigma, prejudice, and discrimination, which occurs across multiple ecological levels: societal stigma and discrimination (distal stressors), anticipated rejection and concealment of sexual orientation, and internalized homophobia (proximal stressors). These minority stressors are associated with adverse mental health outcomes and may increase both perpetration and victimization of IPV.

Research on minority stress among WSW demonstrates associations between experiences of discrimination, internalized homonegativity, and various health outcomes including depression, anxiety, substance use, and relationship problems. In the context of IPV, minority stress may operate through several pathways. Chronic stress exposure may contribute to relationship conflict and violence. Internalized stigma may reduce self-worth, making it difficult for victims to recognize abuse or believe they deserve better treatment.

Fear of discrimination may deter help-seeking, as victims worry about homophobic responses from law enforcement or service providers.

The intersection of minority stress and IPV creates particularly potent health risks. Studies document that WSW who experience both sexual minority-specific violence and intimate partner violence show higher rates of psychological distress, depression, and PTSD symptoms compared to those experiencing only one form of violence. This synergistic effect highlights how multiple marginalized identities and experiences of violence compound one another.

### 3.4 Barriers to IPV Disclosure and Help-Seeking

WSW experiencing IPV face unique barriers to disclosure and help-seeking that contribute to underreporting and delayed intervention. The relative invisibility of same-sex IPV in public discourse creates an environment where victims may not recognize their experiences as abuse or may feel isolated in their victimization. Services for IPV survivors have historically been designed for heterosexual women, and many service providers lack training on dynamics specific to same-sex IPV.

Fear of homophobic responses from law enforcement, legal systems, and social services represents a major deterrent to help-seeking. WSW may have previous negative experiences with discriminatory treatment or may anticipate such treatment based on community narratives. In some jurisdictions, laws and policies do not adequately protect same-sex couples, creating legal barriers to accessing protective orders or other legal remedies.

Community-level factors also influence help-seeking patterns. Small, interconnected LGBTQ+ communities may make confidentiality challenging, particularly if both partners are known in community spaces. Victims may fear community ostracism or being labeled as disrupting community cohesion by speaking about IPV. Some WSW report that abusive partners leverage their community connections to isolate victims or discredit them within LGBTQ+ social networks.

Lack of economic resources creates additional barriers, as WSW face wage discrimination and employment barriers that may make it difficult to achieve financial independence from

abusive partners. Housing discrimination against same-sex couples may limit options for safe housing away from abusive partners.

***Table 1: Comparative IPV Prevalence Across Sexual Orientation Groups***

| Population Group | Lifetime IPV Prevalence | Study Citation | Sexual/Gender Minorities (Overall) | 42.5-43.4% |
|---|---|---|---|---|
| (Harper et al., 2021) | Lesbian/Bisexual Women | 32-51% (varies by study) | (Falluji et al., 2024; Sandfort et al., 2013) | Heterosexual Women |
| ~25-35% | (White et al., 2023) | Gay Men | Variable, generally comparable | (Buller et al., 2014) |

## 4. Mental Health Consequences at the Intersection

### 4.1 Mental Health Disparities Among Sexual Minority Women

Sexual minority women, including lesbian and bisexual women, experience elevated rates of mental health problems compared to heterosexual women, a disparity documented across multiple countries and study designs. A comprehensive meta-analysis of population-based studies found that lesbian and gay individuals had significantly higher odds of depression (OR 1.97), anxiety disorders (OR 2.41), and alcohol use disorders (OR 2.70) compared to heterosexuals. Bisexual individuals showed even higher odds of depression (OR 2.21) and suicidality (OR 4.81) compared to heterosexuals.

These mental health disparities are not attributable to sexual orientation per se, but rather to minority stress—the chronic stress resulting from stigma, discrimination, and prejudice faced by sexual minorities. Distal stressors include experiences of discrimination, harassment, and violence based on sexual orientation. Proximal stressors include internalized homophobia, expectations of rejection, and concealment of sexual identity. Both categories of stressors have been linked to adverse mental health outcomes including depression, anxiety, post-traumatic stress disorder (PTSD), substance use disorders, and suicidality.

Research specific to WSW populations confirms elevated prevalence of depression and anxiety. Studies examining mental health among lesbian, gay, bisexual, and transgender (LGBT) populations in various contexts consistently find that sexual minority women report higher rates of psychological distress than heterosexual women. These disparities persist even when controlling for demographic factors and other health-related variables, suggesting that minority stress and associated social determinants play causal roles in producing mental health inequities.

### 4.2 Mental Health Impacts of IPV Among WSW

The mental health consequences of IPV are well-established in general populations, with robust evidence linking IPV exposure to depression, PTSD, anxiety disorders, substance use, and suicidality. Meta-analytic findings demonstrate that IPV exposure is associated with 2-3 times increased odds of depression and PTSD, with effect sizes varying by type and severity of violence. These mental health impacts persist long after violence ends, with longitudinal studies showing that IPV survivors continue to experience elevated symptoms of depression and PTSD years post-separation.

Among WSW, the mental health impacts of IPV occur against a backdrop of pre-existing mental health disparities driven by minority stress. This creates a synergistic or syndemic relationship where minority stress, IPV, and mental health problems mutually reinforce one another. Women experiencing both sexual minority stigma and intimate partner violence show particularly elevated rates of psychological distress compared to those experiencing either stressor alone.

Research examining mental health among sexual and gender minority populations in Western Kenya found that 42.5% of participants reported lifetime IPV, 43.4% reported sexual and gender minority-based violence, and notably, many had experienced both. The study documented high rates of clinically significant psychological distress (11.7%), PTSD symptoms (53.2%), and depressive symptoms (26.1%) among this population. While this study included both MSM and sexual minority women, it illustrates the high burden of trauma-related mental health problems affecting SGM populations experiencing violence.

### 4.3 Depression, PTSD, and Anxiety: Prevalence and Clinical Significance

Depression represents one of the most common mental health outcomes associated with both minority stress and IPV exposure. Among WSW experiencing IPV, rates of clinically significant depression are substantially elevated. A systematic review and meta-analysis examining mental health outcomes among women experiencing IPV found that those exposed to IPV had 2.04-3.14 times the odds of depression compared to non-exposed women. Among IPV survivors, depression manifests not only as sadness but also as hopelessness, anhedonia, disrupted sleep and appetite, concentration difficulties, and in severe cases, suicidal ideation.

The intersection of IPV and minority stress appears to produce particularly severe depressive symptoms. Studies of sexual minority populations report that experiences of discrimination and stigma predict depression even after controlling for other risk factors. When IPV occurs in this context, it represents an additional severe interpersonal stressor compounding existing vulnerabilities. Some research suggests that sexual minority women experiencing IPV may face unique forms of psychological abuse that exploit minority stress, such as partners who reinforce internalized homophobia or convince victims that their sexual orientation makes them undeserving of help.

Post-traumatic stress disorder (PTSD) is another prominent mental health consequence of IPV. Meta-analytic evidence indicates that IPV exposure increases odds of PTSD by 2.15-2.66 times compared to non-exposed women. PTSD following IPV is characterized by re-experiencing symptoms (intrusive memories, nightmares), avoidance of trauma reminders, negative alterations in cognitions and mood, and hyperarousal. The chronic, repeated nature of IPV exposure may produce complex PTSD presentations with additional symptoms of emotional dysregulation, negative self-concept, and difficulties in relationships.

Among WSW, PTSD following IPV may be compounded by previous trauma exposures common in sexual minority populations, including childhood abuse, experiences of discrimination and hate crimes, and family rejection related to sexual orientation disclosure. Research on cumulative trauma burden demonstrates that multiple trauma exposures have

synergistic effects on PTSD risk, with individuals experiencing multiple forms of violence showing particularly high PTSD prevalence.

Anxiety disorders, including generalized anxiety disorder, panic disorder, and social anxiety, are also elevated among both sexual minorities and IPV survivors. The combination of minority stress and IPV creates a state of chronic hypervigilance where individuals must monitor both for potential violence from intimate partners and for potential discrimination or harassment in broader social contexts. This chronic state of threat perception contributes to sustained anxiety symptoms.

### 4.4 Substance Use and Self-Harm

Substance use represents both a risk factor for and consequence of IPV, creating bidirectional relationships. Among sexual minority women, elevated rates of alcohol use and drug use compared to heterosexual women are well-documented. Research indicates that lesbian, gay, and bisexual individuals show approximately 2-4 times higher rates of substance use disorders compared to heterosexual individuals, with some studies finding particularly elevated risk among bisexual individuals.

IPV exposure further increases substance use risk. Women experiencing IPV may use substances as a coping mechanism for trauma symptoms, to manage chronic pain from injuries, or due to coercive substance use initiated by abusive partners. The relationship between IPV and substance use is complex and bidirectional, with substance use also increasing vulnerability to IPV victimization through multiple pathways including impaired judgment, financial dependencies, and partner selection.

Suicidality—including suicidal ideation, suicide attempts, and completed suicide—is dramatically elevated among both sexual minorities and IPV survivors. Meta-analytic evidence demonstrates that sexual minority individuals have significantly elevated odds of suicidal ideation and attempts compared to heterosexual individuals, with particularly high risk among bisexual individuals and younger sexual minorities. Among women experiencing IPV, suicidality is 2.17-5.52 times more likely than among non-abused women.

The intersection of sexual minority status, IPV exposure, and mental health problems creates particularly elevated suicide risk. Research among sexual minority youth in China found that those with same-sex or both-sex romantic attractions had significantly elevated risk of both suicidal ideation and suicide attempts compared to peers with opposite-sex attractions only, with both-sex attracted individuals showing the highest risk. When IPV occurs in contexts of minority stress, hopelessness, social isolation, and limited support resources, suicide risk becomes a critical clinical concern requiring urgent intervention.

Self-harm behaviors, including non-suicidal self-injury, are also elevated among sexual minority populations and trauma survivors. These behaviors may serve emotional regulation functions for individuals struggling with intense negative emotions stemming from both minority stress and IPV trauma.

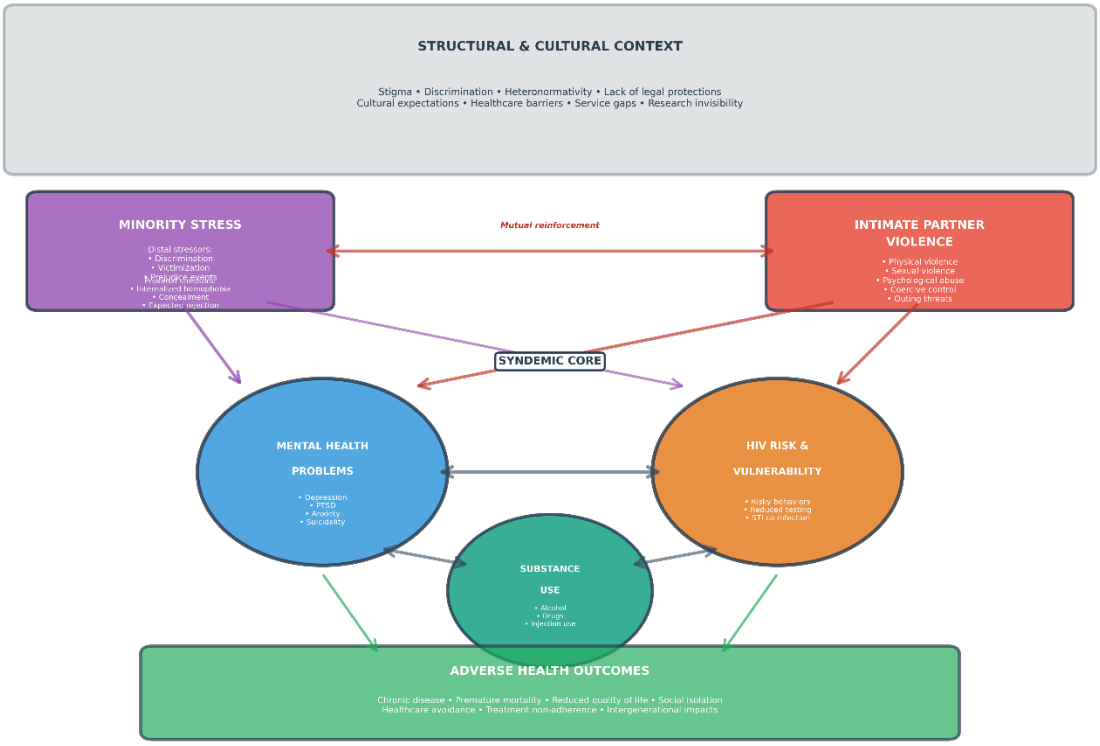
### 4.5 The Minority Stress Model and Syndemics Framework

Understanding mental health among WSW experiencing IPV requires application of theoretical frameworks that account for multiple, interacting health threats in contexts of social marginalization. The minority stress model, developed by Meyer, posits that sexual minority individuals experience chronic stress from both distal stressors (discrimination, violence, prejudice) and proximal stressors (internalized homophobia, expectations of rejection, concealment). These stressors contribute to mental health disparities through multiple pathways including direct psychological impacts of stress, reduced social support, and maladaptive coping behaviors.

The syndemics framework extends this understanding by recognizing that certain health problems tend to cluster together in marginalized populations, with each condition exacerbating the others. In the context of WSW health, IPV, mental health problems, substance use, and HIV risk represent co-occurring and mutually reinforcing conditions. IPV contributes to mental health problems and substance use; mental health problems and substance use increase vulnerability to IPV and HIV; HIV diagnosis may precipitate mental health decline and relationship stress that could include IPV. This syndemic clustering occurs in contexts of social marginalization including poverty, discrimination, and limited access to healthcare.

Interventions addressing any single component of this syndemic while ignoring others are likely to show limited effectiveness. Comprehensive, integrated interventions that simultaneously address IPV, mental health, substance use, and HIV risk while also confronting minority stress and discrimination represent the most promising approach for improving health outcomes among WSW.

**Figure 2: Syndemics Framework - Intersection of Minority Stress, IPV, Mental Health, and HIV Risk Among Women Who Have Sex with Women**




## 5. Barriers to Healthcare Access and Service Utilization

### 5.1 Healthcare Stigma and Discrimination

Sexual minority women face substantial barriers to accessing culturally competent, affirming healthcare. Stigma and discrimination within healthcare settings represent major deterrents to care-seeking. Research across multiple countries documents that LGBTQ+ individuals frequently experience discrimination from healthcare providers, ranging from subtle microaggressions to overt refusal of care. Among transgender and gender-nonconforming individuals participating in HIV Prevention Trials Network studies in sub-

Saharan Africa, 45.3% reported one or more healthcare-related stigma experiences, with 36.3% reporting fear of seeking healthcare services and 29.2% avoiding services because of fear their MSM/transgender status would be discovered.

For WSW specifically, healthcare encounters are often characterized by heteronormative assumptions that render their sexual orientation invisible. Providers may assume that female patients have male partners, use language that excludes same-sex relationships, or fail to ask about relevant sexual health risks because they assume WSW face no STI or HIV risk. These heteronormative practices communicate to WSW that they are not welcome or understood, deterring future care-seeking.

Disclosure of sexual orientation to healthcare providers is associated with improved health outcomes, yet many WSW choose not to disclose due to previous negative experiences or anticipated discrimination. Studies examining disclosure rates find that only 50-70% of sexual minority individuals disclose their orientation to healthcare providers, with lower disclosure rates among those in rural areas, ethnic minorities, and those with lower educational attainment. Non-disclosure prevents providers from offering appropriate sexual health counseling, IPV screening tailored to same-sex relationships, or mental health support for minority stress.

### 5.2 Lack of WSW-Specific Services and Provider Knowledge Gaps

Healthcare providers receive minimal training on sexual minority health, and even less on the specific health needs of WSW. Many providers lack knowledge about HIV transmission routes relevant to WSW, appropriate sexual health counseling for this population, or dynamics of IPV in same-sex relationships. This knowledge gap leads to provision of inaccurate information, failure to screen for relevant health risks, and inability to provide affirming care.

Services for IPV survivors are predominantly designed for heterosexual women experiencing violence from male partners. Shelter policies may exclude male children over certain ages, creating barriers for lesbian mothers. Service providers in IPV agencies may lack training on same-sex IPV dynamics, potentially leading to victim-blaming, inappropriate dual-victim identification, or failure to understand unique aspects of coercive

control in same-sex relationships. Some WSW report that IPV service providers expressed discomfort or made homophobic comments, deterring them from seeking further assistance.

HIV prevention and testing services similarly reflect heteronormative assumptions. Prevention messaging focuses almost exclusively on penile-vaginal or penile-anal intercourse, with virtually no public health messaging addressing HIV risk for WSW. Testing services may not ask appropriate sexual history questions to assess WSW-specific risks. Pre-exposure prophylaxis (PrEP) programs, while expanding rapidly for MSM, rarely consider WSW as potential PrEP candidates, even for those with specific risk factors such as injection drug use or sex with HIV-positive partners.

Mental health services, while generally more affirming of sexual diversity than some other healthcare sectors, often lack integration with sexual health services, IPV services, or substance use treatment. This fragmentation means that WSW with complex, intersecting health needs must navigate multiple disconnected service systems, each potentially requiring separate disclosure of sexual orientation and trauma histories.

### 5.3 Invisibility in Research and Policy

WSW remain largely invisible in HIV research, prevention policy, and surveillance systems. Most HIV research among sexual minorities focuses on MSM, reflecting both the greater HIV burden in MSM populations and historical prioritization of this population in research funding. When WSW are included in sexual minority health research, sample sizes are often too small for meaningful subgroup analyses, or WSW are combined with other populations in ways that obscure their specific needs.

This invisibility in research translates to invisibility in policy and service planning. HIV prevention strategies identify key populations for targeted interventions—typically MSM, sex workers, and people who inject drugs—but rarely include WSW even when evidence suggests specific subgroups face elevated risk. Public health messaging about HIV prevention does not address WSW, reinforcing misconceptions about zero risk.

IPV policies and services similarly fail to adequately address same-sex IPV. Legal frameworks in many jurisdictions were designed to address male violence against female intimate partners, with language explicitly gendered in ways that exclude same-sex couples.

Protection order laws may not cover same-sex partners, or may require victims to navigate legal systems ill-equipped to understand same-sex relationship dynamics.

Research priorities have historically neglected the intersection of IPV, mental health, and HIV risk among WSW. The few studies addressing this population are predominantly from Western, high-income countries, particularly the United States. Research from Asia, including Hong Kong and other Chinese populations, is virtually nonexistent. This geographic gap reflects broader patterns of LGBT health research concentration in North America and Western Europe, leaving major knowledge gaps about sexual minority health in other global regions.

### 5.4 Hong Kong-Specific Barriers

In Hong Kong, the barriers faced by WSW are compounded by cultural and structural factors specific to the local context. Traditional Chinese family structures emphasize heterosexual marriage, procreation, and filial piety, creating intense pressure on individuals to conform to heterosexual norms. For women, additional cultural expectations around femininity, caregiving, and family loyalty may make same-sex relationships particularly stigmatized.

Hong Kong lacks comprehensive anti-discrimination protections based on sexual orientation. While the government has gradually increased recognition of LGBT issues, legal protections remain limited. Same-sex couples cannot marry and receive no legal recognition of their relationships, creating vulnerabilities in multiple domains including housing, healthcare decision-making, and child custody. For WSW experiencing IPV, this lack of legal relationship recognition means they cannot access legal protections available to married heterosexual women.

Healthcare services in Hong Kong generally lack cultural competence regarding sexual minority health. Medical and nursing curricula provide minimal education on LGBT health, and continuing education opportunities on this topic are limited. While some private clinics and NGO-operated services provide LGBT-friendly care, these services are not universally accessible due to cost or geographic barriers. Public healthcare services, which serve the

majority of Hong Kong residents, vary widely in their competence and sensitivity toward sexual minority patients.

HIV prevention and testing services in Hong Kong focus heavily on MSM, with specialized clinics and outreach programs targeting this population. No comparable services exist for WSW. Public health messaging about HIV emphasizes heterosexual transmission and MSM transmission, with no recognition of potential risks for WSW. Testing recommendations do not include WSW as a key population warranting regular screening.

Research on LGBT health in Hong Kong is limited, with most existing research focusing on MSM and HIV. Studies on lesbian and bisexual women's health are virtually absent from Hong Kong's scientific literature. This research gap means that policymakers and service providers lack even basic descriptive data on WSW population size, health needs, or service utilization patterns in Hong Kong.

Cultural factors influencing help-seeking include strong emphases on family privacy, face-saving, and avoiding bringing shame to one's family. For WSW experiencing IPV, these cultural values may create additional barriers to disclosure, as seeking help could require revealing sexual orientation to family or authorities and potentially bringing family shame. Collectivist cultural values emphasizing group harmony over individual needs may make it particularly difficult for WSW to prioritize their own safety and wellbeing over maintaining family relationships or community cohesion.

***Table 2: Multi-Level Barriers to Healthcare Access for WSW***

| Level | Barrier Type | Specific Examples |
|---|---|---|
| **Individual** | Internalized stigma | Shame about sexual orientation; belief that abuse is "normal" in lesbian relationships |
| **Individual** | Lack of knowledge | Unawareness of HIV risk; not recognizing IPV in same-sex context |
| **Interpersonal** | Provider discrimination | Heteronormative assumptions; refusal of care; inappropriate responses |

| Level | Barrier Type | Specific Examples |
|---|---|---|
| **Interpersonal** | Family/social rejection | Fear of outing; family pressure for heterosexual conformity |
| **Organizational** | Service design | IPV services designed for heterosexual women; lack of WSW-specific programs |
| **Organizational** | Provider training gaps | Minimal LGBT health education; no same-sex IPV training |
| **Structural** | Legal barriers | No same-sex relationship recognition; inadequate anti-discrimination laws |
| **Structural** | Research invisibility | Excluded from studies; no local data to inform services |
| **Cultural** | Heteronormativity | Assumptions that all women have male partners; stigma against same-sex relationships |
| **Cultural** | Traditional values | Family expectations; emphasis on marriage and procreation |

## 6. Interventions and Recommendations

### 6.1 Evidence-Based Interventions for IPV Among WSW

Effective interventions addressing IPV among WSW must be trauma-informed, culturally specific, and recognize the unique dynamics of violence in same-sex relationships. While evidence-based interventions for heterosexual IPV provide some transferable principles, adaptations are necessary to address minority stress, same-sex relationship dynamics, and specific barriers facing WSW.

Psychotherapeutic interventions showing promise include trauma-focused cognitive-behavioral therapy adapted for sexual minority populations. A randomized controlled trial testing interpersonal psychotherapy delivered by non-specialists for HIV-positive Kenyan women affected by gender-based violence demonstrated significant reductions in both depression and PTSD, with 3-month outcomes showing intervention participants had

markedly lower odds of meeting diagnostic criteria for these conditions. While this study focused on heterosexual women, the intervention principles—addressing trauma, interpersonal relationships, and social functioning—are applicable to WSW with appropriate adaptations for same-sex relationship contexts and minority stress.

Narrative exposure therapy has demonstrated efficacy for IPV survivors experiencing PTSD. A randomized controlled trial among Iranian women exposed to ongoing intimate partner violence found that narrative exposure therapy produced significantly greater symptom reduction in PTSD, depression, and perceived stress compared to standard counseling. Again, while conducted with heterosexual women, this intervention could be adapted for WSW by incorporating attention to minority stress narratives and same-sex relationship dynamics.

Minority stress-focused interventions specifically tailored for sexual minority women show promise for addressing the compounding effects of minority stress and IPV trauma. A transdiagnostic minority stress intervention (EQuIP) designed for sexual minority women demonstrated significant reductions in depression and anxiety, with moderate effect sizes. Such interventions address both universal cognitive-behavioral processes underlying mental health problems and minority stress-specific processes including internalized stigma, expectations of rejection, and concealment stress. Integrating IPV-focused components into minority stress interventions may provide comprehensive care addressing multiple intersecting vulnerabilities.

Advocacy and case management services for IPV survivors provide critical support for safety planning, accessing legal protections, securing housing, and navigating service systems. For WSW, advocacy services must address specific needs including support for coming out to authorities or service providers, navigation of legal systems that may not recognize same-sex relationships, and connection to LGBTQ+-affirming resources. Advocates require training on same-sex IPV dynamics, minority stress, and strategies for addressing homophobia in systems that WSW must engage.

### 6.2 Trauma-Informed and Culturally Competent Care Approaches

Trauma-informed care principles provide an essential foundation for serving WSW affected by IPV and other forms of violence. Trauma-informed approaches recognize the widespread impact of trauma, understand potential paths for recovery, integrate knowledge about trauma into policies and practices, and actively resist re-traumatization. For WSW, trauma-informed care must recognize both IPV trauma and minority stress-related traumas including discrimination, family rejection, and hate crimes.

Cultural competence specific to sexual minority populations requires several core elements. Providers must understand diversity within WSW populations, recognizing differences by race/ethnicity, socioeconomic status, immigration status, and other intersecting identities. They must be knowledgeable about minority stress and its health impacts, able to discuss sexual orientation and relationship dynamics comfortably, and aware of their own biases and assumptions. Training programs for healthcare providers, IPV advocates, and mental health professionals should incorporate content on LGBT health, same-sex IPV, and culturally responsive practices.

Healthcare settings can signal inclusivity through environmental cues such as non-discrimination policies explicitly protecting sexual minorities, intake forms that allow for same-sex partner identification, and visible symbols of LGBTQ+ affirmation such as rainbow flags or safe space stickers. These signals communicate that WSW patients are welcome and that disclosure is safe, increasing likelihood that patients will discuss relevant health risks.

Creating LGBTQ+-specific services or programs within larger agencies can provide safer spaces for WSW to access care. Such services concentrate LGBT-competent providers, create peer support opportunities, and signal organizational commitment to serving this population. However, LGBT-specific services alone are insufficient—competence must be developed across all service sectors to ensure WSW receive affirming care regardless of entry point.

Peer support programs can be particularly valuable for WSW experiencing IPV. Connecting survivors with peers who have navigated similar experiences provides

validation, hope, and practical knowledge about resources. For WSW, who may feel isolated due to the combination of same-sex relationship stigma and IPV stigma, peer connections can be especially meaningful. Peer support programs must ensure facilitators are trained in trauma-informed practices and appropriate boundaries to protect both peers and participants.

### 6.3 HIV Prevention and Testing Services for WSW

HIV prevention messaging must explicitly include WSW and address behaviors specific to this population. Public health campaigns should dispel myths about "zero risk," educate about transmission routes relevant to WSW (including menstrual contact, sex toy sharing, and risks associated with bisexual behavior or histories of sex with men), and promote regular HIV testing as part of comprehensive sexual health. Messages must avoid heteronormative language and imagery, instead using inclusive language and diverse representation.

Testing recommendations should incorporate sexual orientation-specific guidance. While routine HIV testing is recommended for all sexually active adults regardless of sexual orientation, providers should assess specific risks for WSW including history of sex with men, injection drug use, having partners with unknown HIV status or known HIV-positive status, and presence of STIs that increase susceptibility. Providers must ask sexual history questions that do not assume heterosexuality and probe for relevant risks without judgment.

Pre-exposure prophylaxis (PrEP) programs should consider WSW as potential candidates based on individual risk assessment rather than categorical exclusion. WSW who inject drugs, have HIV-positive partners, or engage in bisexual behaviors may benefit from PrEP. Provider education about PrEP candidacy should explicitly include WSW scenarios.

Sexual health services for WSW should address both HIV and other STIs, provide information about barrier methods (dental dams, gloves, condom use on sex toys), and offer comprehensive reproductive health services recognizing that many WSW may desire pregnancy and parenting. Services should integrate IPV screening, mental health screening, and substance use assessment given high co-occurrence of these issues.

### 6.4 Mental Health Services and Integration

Mental health services for WSW should be integrated with sexual health, IPV, and substance use services to provide holistic care addressing intersecting needs. Screening for depression, anxiety, PTSD, and suicidality should be routine in all services serving WSW, with clear pathways for mental health referral and treatment. Screening tools should be validated for sexual minority populations and administered in ways that acknowledge minority stress contexts.

Evidence-based psychotherapies should be adapted to address minority stress alongside other therapeutic targets. Cognitive-behavioral therapy, for example, can incorporate attention to internalized homophobia, discrimination experiences, and their cognitive and emotional impacts. Interpersonal therapy can address challenges in relationships stemming from minority stress, family rejection, or same-sex relationship dynamics. Trauma therapies should recognize multiple trauma types including IPV, discrimination, family rejection, and hate crimes.

Substance use treatment for WSW should recognize elevated substance use rates in sexual minority populations and address both substance use and underlying contributors including minority stress and trauma. Integrated treatment addressing co-occurring mental health and substance use disorders shows better outcomes than sequential or parallel treatment. LGBTQ+-specific substance use treatment programs provide environments where sexual orientation can be openly addressed as relevant to recovery.

Suicide prevention for sexual minority populations must be prioritized given elevated risk. Crisis services, including telephone and text-based hotlines, should be trained in LGBT-competent crisis intervention. Safety planning with suicidal WSW should account for minority stress, IPV, and social isolation as risk factors, and should strengthen protective factors including LGBTQ+ community connection and affirming social support.

### 6.5 Policy and Structural Interventions

Policy changes are essential for creating environments supporting WSW health. Anti-discrimination laws explicitly protecting sexual orientation and gender identity in employment, housing, and public accommodations reduce minority stress and its health

consequences. Legal recognition of same-sex relationships through marriage equality or registered partnerships provides relationship protections relevant to property rights, healthcare decision-making, and IPV legal remedies.

IPV legislation should explicitly include same-sex couples to ensure equal access to protective orders, criminal prosecution of offenders, and IPV victim services. Law enforcement training on same-sex IPV dynamics can improve responses to WSW seeking police assistance. Judicial education ensures fair handling of IPV cases involving same-sex couples.

Healthcare policies should mandate cultural competence training on LGBT health for all licensed healthcare providers. Accreditation standards for medical schools, nursing programs, and continuing education should require LGBT health content. Insurance policies should prohibit discrimination based on sexual orientation and ensure coverage for IPV-related services, mental health care, and HIV prevention including PrEP.

Research funding priorities should explicitly include sexual minority populations, with specific attention to WSW given current knowledge gaps. Funding mechanisms should encourage intersectional research examining multiple minority identities and health issues. Population-based health surveys should collect sexual orientation data to enable population-level surveillance of health disparities. HIV surveillance systems should collect data on female-to-female transmission to improve understanding of this transmission route.

## 6.6 Recommendations for Hong Kong

For Hong Kong specifically, several priority actions would improve health services and outcomes for WSW:

### *6.6.1 Population Data Collection and Surveillance*

**Recommendation 1: Implement routine collection of sexual orientation data in health surveys and surveillance systems.** Population-based health surveys such as the Population Health Survey and Behavioural Risk Factor Survey should incorporate validated measures of sexual orientation including identity, behavior, and attraction. This multi-dimensional approach recognizes that sexual orientation encompasses more than

identity labels and captures the diversity of WSW experiences. Data should be collected using best-practice methods that ensure confidentiality and include options for those who prefer not to disclose.

HIV surveillance systems must be reformed to capture female-to-female transmission routes. Current classification systems that default HIV-positive WSW to "heterosexual contact" categories render this population invisible in epidemiological data. Surveillance forms should include detailed sexual history questions allowing for identification of women who have sex exclusively with women, behaviorally bisexual women, and women with various patterns of sexual contact. This data is essential for understanding HIV epidemiology among WSW and planning appropriate prevention services.

**Recommendation 2: Conduct a baseline population health assessment of WSW in Hong Kong.** A comprehensive mixed-methods study should be undertaken to characterize the WSW population in Hong Kong, document health status across multiple domains (sexual health, mental health, chronic disease, substance use), assess service utilization patterns, identify barriers to care, and document experiences of discrimination and minority stress. This baseline assessment should employ multiple recruitment methods including venue-based sampling, online recruitment through LGBTQ+ networks, and respondent-driven sampling to reach diverse subgroups of WSW including those who may not identify with LGBTQ+ community spaces.

Such population assessments have proven valuable in other contexts for establishing the evidence base needed to advocate for resources and services. The assessment should be conducted in partnership with LGBTQ+ community organizations to ensure cultural appropriateness, community buy-in, and ethical conduct of research with this marginalized population.

### *6.6.2 Healthcare Provider Training and Service Development*

**Recommendation 3: Mandate LGBT health competency training for all healthcare providers.** Medical schools, nursing programs, and other health professional training programs in Hong Kong should incorporate comprehensive LGBT health content into their curricula. This training should cover sexual orientation and gender identity terminology,

minority stress and its health impacts, specific health risks and needs of sexual minority populations including WSW, strategies for creating welcoming clinical environments, and skills for taking inclusive sexual histories. Training should move beyond basic cultural sensitivity to develop actual clinical competence in addressing LGBT health needs.

Continuing education requirements for licensed healthcare professionals should include LGBT health content to ensure that practicing providers develop competencies. The Hong Kong Medical Council, Nursing Council, and other regulatory bodies should establish expectations for cultural competence that explicitly include sexual orientation and gender identity. Training programs should be evaluated for effectiveness in improving provider knowledge, attitudes, and clinical practices using validated assessment tools.

**Recommendation 4: Establish WSW-inclusive sexual health services.** Existing sexual health clinics, including Social Hygiene Service clinics operated by the Department of Health, should be equipped to serve WSW through provider training, modification of intake forms and assessment protocols to be inclusive of same-sex relationships, provision of relevant educational materials addressing sexual health for WSW, and creation of welcoming environments through visible LGBTQ+-affirming signaling. Staff should be trained to take sexual histories that do not assume heterosexuality, assess HIV and STI risks specific to WSW, and provide appropriate counseling on barrier methods for female-to-female sexual contact.

Consideration should be given to establishing dedicated LGBTQ+ sexual health services, following models from other jurisdictions where LGBTQ+-specific clinics have demonstrated success in reaching sexual minority populations and providing comprehensive, integrated care. Such services could be pilot-tested in areas with higher concentrations of LGBTQ+ residents or integrated into existing community health centers serving diverse populations.

**Recommendation 5: Develop trauma-informed IPV services accessible to WSW.** IPV service providers including shelter programs, hotlines, counseling services, and advocacy organizations must be trained on same-sex IPV dynamics and equipped to serve WSW experiencing violence. Training should address unique aspects of IPV in same-sex

relationships, outing as a form of coercive control, minority stress as a contextual factor, barriers WSW face in help-seeking, and strategies for creating affirming, effective services. Service policies should be reviewed and modified to ensure they do not exclude or create barriers for WSW, such as policies that inadvertently assume heterosexual relationship structures.

Following evidence-based trauma-informed care principles, services should recognize that WSW experiencing IPV may have experienced multiple forms of trauma including discrimination, family rejection, and hate crimes in addition to IPV. Assessment should screen for complex trauma, and treatment should address the full range of trauma exposures. Collaboration between IPV services and LGBTQ+ community organizations can facilitate development of culturally responsive programming and improve community trust in services.

#### *6.6.3 Mental Health Service Enhancement*

**Recommendation 6: Integrate minority stress-focused interventions into mental health services.** Mental health providers should be trained in minority stress theory and evidence-based interventions that address minority stress alongside mental health symptoms. Interventions such as EQuIP (Empowering Queer Identities in Psychotherapy) that specifically target minority stress processes including internalized stigma, expectations of rejection, and concealment should be adapted for the Hong Kong context and implemented in clinical settings. Culturally adapted versions should account for Chinese cultural values, family dynamics, and Hong Kong-specific social contexts while maintaining core intervention components.

Mental health screening should be routine in all services serving WSW, including sexual health clinics, IPV services, and primary care settings. Screening should assess not only for depression and anxiety but also for PTSD, suicidality, and substance use given elevated rates of these conditions among sexual minorities. Validated screening instruments should be used, with consideration of their psychometric properties in sexual minority populations and Chinese cultural contexts.

**Recommendation 7: Establish peer support programs for WSW.** Peer support has demonstrated effectiveness for various health conditions and may be particularly valuable for WSW who often experience isolation due to the intersection of gender, sexual orientation, and cultural minority status. Peer support programs could address various focuses including general mental health and wellbeing, IPV recovery, HIV prevention and living with HIV, substance use recovery, and navigation of coming out processes. Peers should receive structured training in trauma-informed approaches, boundaries, active listening, resource navigation, and recognition of when professional referral is needed.

### *6.6.4 HIV Prevention and Testing Services*

**Recommendation 8: Include WSW in HIV prevention messaging and programs.** Public health campaigns addressing HIV prevention should explicitly include WSW, dispel myths about "zero risk," and provide accurate information about transmission routes relevant to this population. Messaging should address both female-to-female sexual transmission risks and risks associated with bisexual behavior or histories of sex with men. Materials should use inclusive language and imagery representing diverse sexual orientations and relationship structures.

Pre-exposure prophylaxis (PrEP) programs should consider WSW as potential candidates based on individual risk assessment. While overall HIV incidence among WSW may be lower than some other key populations, individual WSW with specific risk factors including serodiscordant relationships, injection drug use, or sex work may benefit from PrEP. Provider education and PrEP eligibility guidelines should explicitly address WSW scenarios to ensure providers consider PrEP appropriately for this population.

**Recommendation 9: Promote routine HIV testing among WSW through targeted outreach.** HIV testing programs should actively reach WSW through community venues, online platforms, and partnerships with LGBTQ+ organizations. Testing services should be offered in welcoming, affirming environments with staff trained to serve sexual minority populations. Self-testing programs may be particularly appealing to WSW concerned about confidentiality or previous negative experiences with healthcare providers. Distribution of

HIV self-test kits through LGBTQ+ community organizations, online ordering platforms, and vending machines in LGBTQ+-frequented venues can increase testing access.

Testing should be accompanied by comprehensive sexual health counseling that addresses risks specific to WSW, provides information about barrier methods for female-to-female sexual contact, screens for IPV, and connects individuals to mental health and other support services as needed. Linkage to care for those testing positive must be ensured through robust referral systems and navigation support.

### *6.6.5 Policy and Legal Reforms*

**Recommendation 10: Enact comprehensive anti-discrimination legislation protecting sexual orientation and gender identity.** Hong Kong lacks comprehensive anti-discrimination protections for LGBTQ+ individuals. Legislation should prohibit discrimination based on sexual orientation and gender identity in employment, housing, education, healthcare, and public accommodations. Such legal protections reduce minority stress by providing recourse for discrimination, signaling societal acceptance, and creating safer environments for disclosure of sexual orientation. Evidence from jurisdictions that have enacted such protections demonstrates positive impacts on mental health outcomes among sexual minorities.

Legal protections are particularly important in healthcare contexts, where discrimination can create life-threatening barriers to care. Anti-discrimination laws should explicitly prohibit healthcare providers from refusing care based on sexual orientation or gender identity and should provide mechanisms for reporting and addressing discrimination when it occurs.

**Recommendation 11: Establish legal recognition of same-sex relationships.** Legal recognition through marriage equality or civil partnerships would provide important protections relevant to health and wellbeing. Relationship recognition enables partner involvement in healthcare decision-making, access to family leave for caregiving, joint health insurance coverage, and legal remedies in cases of IPV including protective orders and property protections upon relationship dissolution. Research demonstrates that marriage equality is associated with reductions in suicide attempts among sexual minority

youth and improvements in mental health among sexual minority adults, likely operating through multiple pathways including reduced stigma, increased social support, and tangible legal protections.

**Recommendation 12: Reform IPV laws and policies to explicitly include same-sex couples.** Domestic violence legislation should use gender-neutral language ensuring that protections extend to same-sex relationships. Police, prosecutors, and judicial officers should receive training on same-sex IPV dynamics to ensure appropriate responses when WSW seek legal protections. Protective order procedures should be accessible to same-sex couples with the same expedited processes available to opposite-sex couples.

### *6.6.6 Research Priorities and Funding*

**Recommendation 13: Establish dedicated research funding for sexual minority health in Hong Kong.** Government research funding bodies including the Health and Medical Research Fund and the Research Grants Council should prioritize sexual minority health research and create funding mechanisms specifically supporting this research area. Priority topics should include: prevalence of IPV among WSW in Hong Kong and its health consequences; HIV and STI risk behaviors and transmission dynamics among WSW; mental health disparities and minority stress among sexual minority women; effectiveness of interventions addressing the IPV-mental health-HIV syndemic; healthcare access barriers and facilitators; and intersectionality examining how sexual orientation interacts with other marginalized identities including ethnicity, socioeconomic status, and immigration status.

Research should employ rigorous methodologies including longitudinal designs to examine temporal relationships between minority stress, IPV, mental health, and HIV risk. Intervention research should test culturally adapted evidence-based interventions and novel approaches addressing the specific context of WSW in Hong Kong. Community-based participatory research approaches should be encouraged to ensure research is responsive to community-identified priorities and conducted in ethical partnership with affected communities.

**Recommendation 14: Support academic-community partnerships for research and program development.** Partnerships between academic researchers and LGBTQ+ community organizations can enhance research quality, ensure cultural appropriateness, facilitate participant recruitment, and promote rapid translation of findings into practice. Universities should recognize community-engaged research in promotion and tenure decisions, and funding mechanisms should support partnership development and community organization capacity building. Such partnerships have proven effective in other contexts for conducting research with hard-to-reach populations and developing interventions that are both evidence-based and community-responsive.

### *6.6.7 Community Engagement and Empowerment*

**Recommendation 15: Support LGBTQ+ community organizations providing health services and advocacy.** Community-based organizations play critical roles in reaching sexual minority populations, providing culturally responsive services, advocating for policy changes, and building community resilience. Government funding should support LGBTQ+ organizations to expand health programming including peer support, mental health services, sexual health education and testing, IPV prevention and response, and substance use support. Sustainable funding models should be established rather than short-term project grants to enable organizations to build capacity and retain skilled staff.

Organizations should be supported to develop data collection and evaluation capacity to document service utilization, assess outcomes, and contribute to the evidence base for effective interventions. Technical assistance and training should be made available to community organizations to strengthen program design, implementation, and evaluation.

**Recommendation 16: Engage WSW community members in service planning and policy development.** Meaningful engagement of WSW as stakeholders in decisions affecting their health is essential for developing responsive, effective services and policies. Advisory committees including WSW community members should inform policy development in HIV prevention, IPV services, mental health programs, and healthcare quality improvement initiatives. Service providers should seek regular feedback from

WSW clients about service experiences and incorporate this feedback into quality improvement.

Capacity building programs should support WSW to participate effectively in advocacy, policy engagement, and service planning. This includes training in policy analysis, public speaking, media engagement, and coalition building. Compensation should be provided for community members contributing their time and expertise to planning and advisory processes, recognizing the valuable knowledge they bring.

### *6.6.8 Monitoring and Evaluation*

**Recommendation 17: Establish indicators and targets for reducing health disparities affecting WSW.** Hong Kong's health system should adopt specific, measurable indicators related to sexual minority health including: rates of HIV testing among WSW; rates of mental health service utilization; IPV screening rates in healthcare settings; provider training completion rates; and patient experience measures assessing discrimination and cultural competence. Baseline data should be collected and targets established for improvement over defined timeframes. Regular monitoring and public reporting of progress toward targets creates accountability and maintains focus on disparity reduction.

Evaluation should assess not only service implementation but also health outcomes including changes in HIV incidence, mental health outcomes, IPV victimization rates, and quality of life among WSW populations. Evaluation findings should be disseminated to policymakers, service providers, and communities and used for continuous quality improvement.

**Recommendation 18: Conduct regular community health needs assessments.** Periodic needs assessments engaging WSW communities can identify emerging health concerns, assess evolving service needs, and evaluate whether existing services are meeting community needs. Assessments should examine diverse subgroups within WSW populations including attention to intersectionality and the experiences of multiply marginalized individuals such as WSW who are ethnic minorities, low-income, living with disabilities, or immigrants.

### *6.6.9 Cross-Sector Collaboration*

**Recommendation 19: Establish an inter-departmental task force on sexual minority health.** Addressing health disparities affecting WSW requires coordination across multiple government sectors including health, social welfare, education, justice, and housing. A formal task force with representatives from relevant departments, community organizations, healthcare providers, and researchers could coordinate policy development, align resources, identify gaps and redundancies, and monitor progress. The task force should have clear mandates, dedicated resources, and accountability for achieving specific outcomes.

Such cross-sector collaboration has proven effective in other jurisdictions for addressing complex health issues requiring integrated responses. For WSW experiencing IPV, for example, effective response requires coordination between healthcare providers, IPV services, law enforcement, housing services, and legal aid—coordination that is enhanced through formalized collaborative structures.

**Recommendation 20: Integrate sexual minority health into existing public health initiatives.** Rather than creating entirely separate systems for sexual minority health, integration into existing public health frameworks ensures sustainability and broad reach. Mental health promotion campaigns should include sexual minority-specific content; chronic disease prevention programs should address elevated risks among sexual minorities; and healthy relationship education should include same-sex relationships. This integrated approach normalizes sexual minority health as a routine component of public health while still allowing for targeted interventions addressing specific disparities.

# 7. Conclusion

Women who have sex with women in Hong Kong represent a profoundly marginalized population facing significant but largely unrecognized health challenges at the intersection of intimate partner violence, mental health, and HIV risk. This report has synthesized evidence demonstrating that WSW are not at “zero risk” for HIV, experience rates of intimate partner violence comparable to or exceeding those in other populations, and face substantial mental health disparities driven by minority stress and compounded by violence

exposure. The convergence of these health threats in contexts of social marginalization, discrimination, and healthcare barriers creates a syndemic with severe consequences for individual wellbeing and population health.

Hong Kong's current health system renders WSW nearly invisible through the absence of targeted services, lack of provider training on sexual minority health, failure to collect relevant data, and insufficient legal protections against discrimination. This invisibility is not benign—it translates directly into delayed HIV diagnosis, inadequate responses to intimate partner violence, untreated mental health problems, and preventable morbidity and mortality.

Addressing these disparities requires comprehensive, multi-level interventions spanning individual clinical care, organizational service development, policy reform, and structural change to reduce stigma and discrimination. The recommendations outlined in this report provide a roadmap for action grounded in evidence from diverse global contexts while acknowledging the specific cultural and structural context of Hong Kong. Implementation of these recommendations would represent a significant advancement in health equity and a fulfillment of Hong Kong's commitment to the health and wellbeing of all its residents.

Critical next steps include: establishing baseline data on WSW population health through rigorous research; developing provider training programs on sexual minority health and same-sex IPV; creating welcoming, culturally competent services across healthcare, mental health, and IPV service sectors; enacting legal protections against discrimination; and engaging WSW communities as partners in service planning and policy development.

The near-complete absence of research on WSW health in Hong Kong represents both a challenge and an opportunity. While lack of local data creates difficulties for evidence-based planning, it also means that even modest investments in research and service development can yield significant knowledge gains and service improvements. Research from other contexts provides a strong foundation of evidence about effective interventions, yet cultural adaptation and local evaluation remain essential for ensuring relevance and effectiveness in Hong Kong's specific context.

Ultimately, improving health outcomes for WSW is a matter of health equity and human rights. Sexual minority women deserve access to healthcare that recognizes their specific needs, relationships that are free from violence, legal protections ensuring their safety and dignity, and social environments that support rather than undermine their mental health and wellbeing. Creating systems that support WSW health requires commitment from policymakers, healthcare leaders, service providers, researchers, and communities. This report provides evidence to motivate such commitment and concrete recommendations to guide action.

The time has come for Hong Kong to recognize and address the health needs of women who have sex with women. Doing so will not only improve outcomes for this specific population but will also strengthen Hong Kong's health system more broadly by advancing cultural competence, reducing health disparities, and fulfilling commitments to health equity for all.

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