# PERSPECTIVES FROM SUB-SAHARAN AND SOUTHERN AFRICA



**There is a politics called public health politics, which gets you published in prestigious journals and in those journals you would use phrases like MSM: 'MSM venues', 'township MSM', 'younger MSM', 'MSM who have both male and female partners' and 'MSM who bridge with women'. That is the language of those journals and good luck to you in your future careers when you publish in them. But is that the language that does justice to the realities here in South Africa? I have no doubt it is the language that does justice to some realities in the USA although actually among real American men I talked to, it doesn't do much justice to their realities. It does justice to academic careers. And I really wonder what South Africa, southern Africa and Africa in general deserves. Does it deserve the frames, the tropes, the illusions of the North, of America, of Europe, perhaps of the south of Australia? Or does it actually deserve respect and the kinds of language and conceptual struggles that might allow us all to be surprised?** ***Peter Aggleton, conference delegate***

**People who participate in research should get their information back. Once we signed agreements with researchers stating that the study findings would make their way back to us. One of the researchers sent an electronic version via the internet – a 150-page document to people who have hotmail addresses…to people who access the internet from internet cafes where they pay per half hour and anything between R1 and R2.50 a page. So now people have received the information, but there is nothing they can do with it. In fact they can't even open the document properly, forget about read it. The other thing is that the information is written…by an academic. The language is such that people can do very little with it.**

**And so what we do now is agree on how the information is going to make its way back. That researchers promise to come back to us…that they do a little presentation. And if there are too many people, then they train people…to go out and do that presentation to others. But get the information out so that it has meaning and so that people can really benefit from** ***Ian Swartz, conference delegate***



CHAPTER TEN

# What we know about same-sex practising people and HIV in Africa

Cary Alan Johnson



By the mid-1980s, AIDS in Africa was being referred to as a 'heterosexual epidemic', in contrast to the association of the disease in other parts of the world with gay men (and later with other marginalised groups, such as Haitians, intravenous drug users, and haemophiliacs). Early African male AIDS patients claimed that they had never engaged in sex with other men, and the world was eager to believe them. The facile acceptance of these claims was, I argue, the product of a racist belief in the hypersexuality (and, furthermore, the hyper-*heteronormative* sexuality) of African men.

The construction of a universally heterosexual African HIV/AIDS epidemic has led to a 'sloppy and ideological science', according to historian Marc Epprecht (2004). Scientists and policy-makers have been slow to acknowledge the possibility that same-sex male transmission is playing an important role in HIV transmission in Africa and have put little effort into understanding the links between hetero- and homosexual HIV transmission.

In March 2005, Cáceres et al. (2005) reviewed 561 studies on HIV and men who have sex with men in non-Western settings. Of these, 224 focused on Latin America and 235 on Asia, with only eight addressing same-sex transmission in Africa. The paucity of research on HIV and same-sex practices in Africa is the result of a multiplicity of factors that include:

- The hesitancy of those who engage in same-sex practices to expose themselves to potentially judgemental researchers;
- Resistance by African research review panels to approve research on homosexuality;
- A general unwillingness among otherwise rigorous scientists to address same-sex transmission due to their discomfort with homosexuality;
- Homophobic stigma faced by HIV researchers themselves when addressing issues of homosexuality;
- Denial of the frequency of same-sex behaviour in Africa;
- The misconception that same-sex practising women face no significant HIV-related health threats.

Opportunities for collecting data on homosexual behaviour and attitudes toward homosexuality are consistently neglected. While behavioural surveillance surveys are conducted throughout Africa by governments and their partners – mainly non-

governmental organisations, UN agencies, and academic institutions – in order to collect data for public health and economic development programmes, these studies have avoided including questions related to same-sex conduct. The 2001 study Sexual Behaviour of Young People in Botswana (SIAPAC 2001), conducted by UNICEF, UNAIDS, Population Services International, the government of Botswana, and the African Youth Alliance of Botswana, provides a large and useful database for public health enquiries, but asked not a single question on the issue of homosexuality. The behavioural survey conducted by the National AIDS Control Programme of Tanzania and UNAIDS, designed to 'track trends in HIV/AIDS-related knowledge, attitudes, and behaviors in subpopulations at particular risk of HIV infection', failed to ask about behaviour, identity, or attitudes related to same-sex desire (Tungaraza n.d.). These examples represent lost opportunities to broaden our knowledge of sexual behaviour and attitudes among young people in Africa.

Similarly, the Guttmacher Institute (2006) asked more than 20 000 young people from four African countries questions related to sexuality, family life and health, but failed to ask a single question that might have provided data about same-sex behaviour. While Guttmacher researchers asked important questions about (heterosexual) anal sex, they and their local partners felt that their respondents were too young to be questioned about sexual orientation. If questions related to same-sex identity and behaviour are never asked, there will never be any relevant data collected, and claims that homosexuality doesn't exist in Africa will continue unchallenged.

Scholars who undertake research on non-heteronormative sexuality may face derision and 'gay-baiting', defined as the practice of using ideas or prejudices about someone's sexuality to intimidate or silence them (Rothschild 2005). Researchers at the universities of Nairobi in Kenya and Cheikh Anta Diop in Senegal experienced significant stigma while conducting research on men who have sex with men (MSM). One of the leading researchers on the topic, Dr Amadou Moreau of the Population Council in Senegal, reported that 'because homosexuality is so stigmatized, as a researcher I am stigmatized as well, by family, friends, and community'.

## Some of the key studies

### Behavioural research

The Horizons Program was the first international NGO to recognise that the HIV-related vulnerabilities of MSM in Africa deserved serious attention. Horizons is a USAID-funded programme, implemented by a consortium of organisations including the Population Council, International Center for Research on Women, International HIV/AIDS Alliance, Program for Appropriate Technology in Health, Tulane University, Family Health International, and Johns Hopkins University. Horizons has produced two ground-breaking studies on MSM in Africa, based on research conducted in Dakar, Senegal, in 2002, and in Nairobi, Kenya, in 2005. These

studies have provided important information about stigma, violence, identity, secrecy, and sexual practices among MSM, particularly younger men in urban settings.

Horizons collaborated with a number of local partners, including government agencies, academic institutions and organisations of MSM, creating a broad base of interest and support for this work at the country level. The Senegal research was conducted in collaboration with Cheikh Anta Diop University and the Senegalese National AIDS Control Programme. The Kenya research was undertaken in partnership with the University of Nairobi Institute of African Studies.

In March 2004, a study was conducted by the Ghana National AIDS Control Programme, using questionnaires completed by 156 MSM in the greater Accra area as an assessment tool with which to guide future programming (Attipoe 2004). In Uganda, Semugoma (2005) conducted ethnographic research to identify the health needs of same-sex practising men and women. In 2003, the University of California at San Francisco's (UCSF) Center for AIDS Prevention Studies (CAPS), in collaboration with Makerere University in Kampala, conducted research with more than 300 MSM in Uganda, but the results have yet to be made public. A participatory community assessment was conducted in Algeria, Morocco and Tunisia between September 2005 and June 2006 in which 193 MSM engaged in an analysis of their HIV-related needs and situations and proposed a number of solutions (International HIV/AIDS Alliance 2005). This research was conducted by three African AIDS service organisations, including the Association de Lutte Contre le SIDA (Morocco) in collaboration with the International HIV/AIDS Alliance. OUT LGBT Well-being (OUT) in Gauteng, South Africa, has answered critical questions about the attitudes and sexual health of same-sex practising men and women in South Africa in their reports *Research Findings on the Sexual Practices of Young Gay Men in South Africa* (OUT 2005), and *Gay and Lesbian People's Experience of the Health Care Sector in Gauteng* (OUT n.d.). The UCSF CAPS (Lane et al. 2006) and OUT (Wells & Polders 2005) in South Africa have both conducted important research on the uptake of voluntary counselling and testing by lesbian, gay, bisexual and transgendered (LGBT) people.

Understanding how LGBT people perceive their access to healthcare is an important aspect of designing effective sexual health interventions. The health-seeking behaviour of African LGBTs is described in OUT's (n.d.) *Gay and Lesbian People's Experience of the Health Care Sector in Gauteng* and by Ehlers et al. (2001) in *The Well-being of Gays, Lesbians and Bisexuals in Botswana*. In the latter, data from 47 questionnaires completed by gay, lesbian and bisexual respondents in Botswana were analysed in order to examine issues related to treatment at healthcare facilities, alcohol and drug use, and perceived HIV risk.

Researchers have begun to examine the sexual aspects of various homosocial situations and settings, such as among mineworkers, prisoners, soldiers, boys living on the streets, and in the context of certain initiation rituals. Additional research is

needed in order to understand this previously hidden male–male sexual behaviour, and the levels of HIV-related risk. Many of the men involved may unwittingly become what Semugoma (2005) refers to as 'amplifying populations' with regard to the spread of HIV in the larger community.

Sadly, the marginalisation that many same-sex practising people experience in their daily lives is reflected in research related to the impact of HIV on their lives (and again in the implementation of HIV/AIDS programmes based on that research). While African MSM were involved in the research that has been conducted in Ghana, Nigeria, Kenya and Senegal, they mainly functioned as research assistants, brought in to provide 'access to MSM communities'. They played little role in conceptualising the research, developing the research instruments or, ultimately, in analysing the results.

This has led to bias and misinterpretation of data. To cite but one example, the author of this chapter was told by the non-LGBT director of a West African research team that most of the MSM whom he had interviewed during a pre-project assessment had engaged in their first homosexual experience with a foreigner. When the author examined the data together with the researcher, it became clear that less than one-third of the respondents reported an initial homosexual encounter with an expatriate. The researcher's bias had caused him to read his own perception, that homosexuality was externally imposed, onto the data, despite evidence to the contrary.[1]

There are few openly gay or lesbian African social scientists or biomedical specialists involved in AIDS research, and most African LGBT organisations lack the capacity to conduct robust scientific research without technical assistance. LGBT communities express great appreciation for the efforts of non-LGBT researchers, without whom even this small amount of data would not exist. Nevertheless, researchers must find creative, meaningful ways of involving same-sex practising men and women in the design, analysis, dissemination and implementation of scientific research.

## Seroprevalence research

Abdoulaye Wade, chief of the STI/AIDS Level Two Division at the Senegalese Ministry of Health, conducted the first seroprevalence study of same-sex practising men in Africa in 2005 (Wade et al. 2005). The research protocol consisted of the implementation of a questionnaire, physical examination, and detection of HIV through serum samples of MSM in five Senegalese cities. Of 442 respondents, Wade et al. found HIV infection serology in the blood samples of 96 (21.5 per cent). By comparison, the overall seroprevalence rate for adult males in Senegal is 0.2 per cent while the seroprevalence rate for female sex workers is 27.1 per cent (UNAIDS 2006).

Similarly, unofficial results from seroprevalence studies of MSM conducted by the HIV Vaccine Initiative in Kenya suggest a seroprevalence rate of 40 per cent or higher, while the general seroprevalence rate for Kenya is 6.1 per cent among adults aged 15 to 49.[2] A behavioural and seroprevalence survey among MSM in Ghana has

revealed similar early results.[3] Tim Lane of CAPS interprets this data to suggest that seroprevalence among MSM could also be much higher than that of the general population in the higher seroprevalence countries of southern Africa, for which no same-sex specific HIV surveillance has been conducted. According to Lane, 'We should not be surprised if we see 40 or 50 per cent of MSM infected in countries like South Africa and Zimbabwe.'[4]

All of the available HIV seroprevalence data for women who have sex with women in Africa is self-reported, and therefore is likely to be under-represented. In a survey of 123 women who identified as lesbian in Tshwane (formerly Pretoria), South Africa, 9 per cent of black and 5 per cent of white women reported that they were HIV-positive. In a 2002 study conducted by the Human Sciences Research Council in South Africa, 13 per cent of lesbian women (15–49 years of age) self-reported a positive HIV test result (cited in Wells & Polders 2005: 2). While this rate is lower than seroprevalence rates for heterosexual South African women, it still represents a substantial number of people for whom there currently exist no targeted HIV prevention, treatment or care services.

One caution is necessary when interpreting the research that has been conducted on same-sex practising men and women in Africa: the use of 'snowball' (non-random) sampling relies on respondents to recruit peers for participation in the research, who in turn recruit their peers, and so on. This technique may lead to an overly homogenised sample and a potential skewing of the data in ways that random sampling can avoid. Instances of unprotected sex, violence and sex work, for example, are likely to be higher among a cohort of MSM who are young, urban and economically marginalised, than in the larger population of MSM.

As of 2007, seroprevalence research was being conducted among MSM by LGBT groups in five southern African countries, with technical assistance from Johns Hopkins University and funding from the Open Society Institute. This research should provide governments, donors and NGOs with irrefutable proof of the need to increase prevention, treatment and care projects specifically targeting gay and bisexual African men.

## What the available research indicates about HIV and same-sex practices in Africa

Though limited in scope, depth and duration, the research that has been conducted has revealed some consistent findings that provide critical information for understanding homosexualities in Africa and for launching effective HIV interventions. Some of the more salient results are discussed below.

Most African MSM have also engaged in sexual relations with women. Among MSM interviewed in Dakar and Nairobi, 88 per cent and 69 per cent respectively

had had sexual relations with a woman at least once in their lives. Of those respondents in Nairobi who had had sex with a woman, 20 per cent had engaged in heterosexual vaginal sex in the last month.

MSM harbour some significant misperceptions that may increase vulnerability to HIV infections. These include the false beliefs that HIV and sexually transmitted infections (STIs) cannot be transmitted through anal sex or through sex between men; or that only the receptive partner in anal intercourse is at risk of contracting STIs; and that washing the genitals and anus with disinfectants after unprotected sex is an effective way of preventing STI and HIV transmission (International HIV/AIDS Alliance 2005).

Economic exchange plays a role in sex among the men surveyed. Two-thirds of the men interviewed in Senegal and 52 per cent of those in Kenya had 'received money' in exchange for sex with other men during the last 12 months. Twenty-nine per cent of the respondents in Kenya also reported paying for sex. No comparisons were made, however, with economic exchange among heterosexuals.

Condom use is inconsistent among MSM. Fewer than 60 per cent of same-sex practising men surveyed in Kenya reported using condoms 'always' during anal sex. In Senegal, only 23 per cent of the sample reported condom use during insertive anal sex and 14 per cent during receptive anal sex. Even fewer MSM consistently used condoms in their heterosexual encounters.

Contrary to the belief that same-sex behaviour is taught to Africans by Westerners, most respondents engaged in their first homosexual experience with another African male, mainly fellow students, neighbours or extended family members (Semugoma 2005). Fewer than 3 per cent of respondents in Kenya and less than one-third in Mali had had their first homosexual experience with a foreigner or tourist. The first homosexual experience occurred on average at age 15 years in Senegal, and 17 years in Kenya.

In research conducted in South Africa by OUT, sexual abuse of both lesbians and gay men was common. The perpetrators of this violence include police officers, neighbours, schoolmates and family members.

## HIV vulnerabilities of women who have sex with women

The myth that sexual activity between women poses no risk for HIV transmission exists among healthcare professionals as well as among many women who have sex with women (WSW), themselves. HIV has been isolated in vaginal secretions, cervical biopsies, menstrual blood and breast milk (Hughes & Evans 2003). Sexual practices, such as digital-vaginal or digital-anal contact, as well as sex with shared penetrative toys, may well serve as a means for transmission of HIV-infected cervicovaginal secretions (Marrazzo 2004).

The details surrounding the first case of female-to-female transmission were released only in February 2003 in the journal *Clinical Infectious Diseases*.[5] In this case, a 20-year-old woman with no additional risk factors other than her sexual relationship with a female partner tested positive for HIV; the infecting strain matched that of her partner. The route of transmission was determined to most likely have come from the use of sex toys (Kwakwa & Ghobrial 2003).

The lengthy delay in the verification of the first case of female-to-female transmission, and the lack of subsequent research on this transmission vector, highlights the need for additional research on the HIV risks tied to sex between women and increased sensitivity in the conduct of such research. Same-sex practising women participating in HIV research may not self-identify as lesbian or bisexual, and many studies fail to even ask female participants about their involvement in same-sex practices. In most studies, if a woman has engaged in other behaviours considered to be higher risk behaviours, the fact that she also engages in same-sex behaviour will be subsumed and ignored, therefore contributing to the invisibility of same-sex female transmission. The US Centers for Disease Control and Prevention (CDC 2006) reported that of the 246 461 cases of women found to be HIV seropositive up to December 2004, information on whether the women had had sex with women was missing in more than 60 per cent of the case reports.

In addition to the biosexual risk of HIV transmission between women, various social factors also increase exposure to HIV and challenge women's efforts to protect themselves from infection. Many WSW are pressured or forced into arranged marriages to fulfil perceived responsibility to family and/or to 'cure' homosexual behaviour. While same-sex oriented men are also forced into heterosexual marriages, women have far less ability to negotiate sex, and particularly to refuse unprotected sex. Same-sex practising and gender non-conforming women are also subjected to 'corrective' rape and other forms of sexual abuse, which in their violence and brutality pose a disproportionate risk for HIV transmission. Some same-sex attracted women may also choose relationships with men at various points in their lives as a result of economic necessity or sexual and/or romantic desire. Other risk factors for same-sex practising women include the effects of alcohol and drug abuse, including intravenous drug use, which is a very real concern for many women who lead lives characterised by marginalisation and discrimination.

According to Alicia Heath-Toby of the Lesbian AIDS Project at Gay Men's Health Crisis in New York, the information, technology, and research capabilities for studies on female-to-female transmission exist today, but obstacles such as government homophobia still stand in the way. No African women's organisations are addressing the issue of female–female transmission of HIV and, with the exception of efforts by a few LGBT groups, no prevention programming for lesbians is under way. As a result, WSW may be the most 'at risk' group of all, not due to biological susceptibility, but to sheer neglect.

## The impact on HIV/AIDS programming of minimal research on same-sex practising people

HIV prevention programmes for MSM are under way in most Asian countries, many with US government funding. Efforts to prevent HIV transmission among MSM are under way in Bangladesh, Cambodia, Vietnam, Thailand, Hong Kong, India, Indonesia and China, through the combined efforts of local LGBT groups and international NGOs, such as the Naz Foundation, Family Health International, and the International HIV/AIDS Alliance.

In September 2006, the Naz Foundation hosted a conference for organisations throughout the region engaged in work with same-sex practising men. According to Kevin Frost, Vice President for Clinical Research and Prevention Programs at the American Foundation for AIDS Research (AmFar), having good epidemiology about the impact of HIV on MSM in Asia was essential to overcoming resistance and to obtaining increased funding for programs to address same-sex transmission. AmFar manages a clearing house for HIV prevention work among MSM for organisations working in the Greater Mekong Region of Southeast Asia. Similarly, programmes for MSM in Latin America have been functioning with both national and international assistance since the early 1990s.

The failure to undertake research on HIV and same-sex practising people in Africa – particularly the lack of seroprevalence data – has undercut efforts to advocate for targeted programming. AIDS policy, planning and resource allocation is driven by statistics. While a human rights framework upholds the right of every individual to equal access to healthcare and health-related information, governments are often forced into action only when it can be proven that a statistically significant number of people in a social group are affected and in need of targeted attention. Given the continued criminalisation of consensual same-sex acts, and the absence of compassion within various African national discourses for gay men and lesbians, clear seroprevalence data are needed to effectively advocate for an increase in HIV-related services.

## Working with what we've got

There are still important gaps in our knowledge of HIV and same-sex practices in Africa. We need more seroprevalence data on both men and women, as well as answers to many unanswered questions. Are female condoms and microbiocides important tools in HIV prevention among same-sex practising men? What role is sexual violence playing in HIV transmission among same-sex practising men and women? Are there cultural differences in the sexual behaviour of same-sex practising men and women throughout the African continent that impact on HIV vulnerability? Are same-sex practising men and women playing a significant role in HIV-orphan care that could be scaled up for the benefit of affected communities?

The few HIV interventions for same-sex practising people currently under way in countries like Ghana, Senegal and Kenya would provide a rich and useful set of information if they were properly reviewed and evaluated. Best practices can also be drawn from HIV interventions targeting gay men and lesbians of African descent in other parts of the world. Work with South Asian and Latin American same-sex practising communities may also provide relevant strategies. While additional research on Africa is essential, this research gap cannot be used to justify a failure on the part of African governments and international donors to provide services to respond to the HIV-related needs of same-sex practising people.

## Acknowledgement

This chapter first appeared as Chapter 2 in *Off the map: How HIV/AIDS programming is failing same sex practicing people in Africa,* by Cary Alan Johnson, published by the IGLHRC, New York in 2007. It is reproduced here with minor amendments with kind permission from the IGLHRC.

## Notes

1 Gay men who have been subjects of HIV research also complain that insufficient effort is made to make the results of the research available to the community.

2 International Gay and Lesbian Human Rights Commission (IGLHRC) interview with staff of International HIV Vaccine Initiative, Mombasa, Kenya, 15 June 2006.

3 IGLHRC interview with Anonymous, 11 November 2006.

4 IGLHRC interview with Tim Lane, PhD, University of California San Francisco Center for AIDS Prevention Studies, 25 May 2006.

5 Other cases of female-to-female transmission had been reported in the past – as early as 1984 – but attributions of these cases were based on the absence of a history of alternative risks for HIV infection, and seem not to have been fully accepted as evidence by the medical community. For a history of case studies, see K Morrow 'Say It! Women get AIDS! HIV among lesbians', *Selfhelp Magazine* 28 May1998. www.selfhelpmagazine.com/articles/glb/womenhiv.html.

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