

SA AIDS 2009 MSM Satellite Conference
Research and Advocacy: Sharing the strength, bridging the gap
30 - 31 March 2009
Durban, South Africa

OFFICIAL SATELLITE PROCEEDINGS

Executive Summary

For several years now, researchers and advocates working with African MSM have convened at conferences and symposia around the world building supportive relationships. The SA AIDS 2009 MSM Satellite Conference was the next step in this process. Over 35 participants from four African nations, the US, the UK, and the EU - 21 of whom gave oral presentations – were brought together for the 1.5 day meeting making it a huge success! We were able to move previous discussions into concrete collaborations and actions.

Included in the presentations were research outputs that, unfortunately, underscored what we already know to be a very difficult situation. Among MSM in South Africa, Kenya, and Malawi there are documented high-risk sexual behaviours; limited access to water-based lube; low knowledge of HIV; fatalistic views of HIV, sickness, and death; barriers to accessing care, HIV testing, ARVs, and support; vulnerability to homophobia and sexual violence; a lack of general security; and the most vulnerable among us being least connected to and supported by resourced gay communities. Researchers challenged us by asking; How do we reach more representative samples? Is diversity enough? How can we better recruit high-risk MSM to both research projects as well as delivery services? How are we measuring bisexuality? And what does it mean in terms of the intersection of disparate HIV epidemics? And what is the role of government in both the conduct of research as well as the translation of its outputs?

LGBT advocates, service providers, and support organizations outlined plans to mainstream LGBT-sensitive and specific healthcare into general health systems, with sex-positive and holistic care packages. There was a call to better understand the populations we work with; creating an LGBT sexual health training manual for clinicians; recognizing the role of religion in identity formation; and the almost complete lack of current bi- and trans-specific research and programming. They also underscored the need for more and better resourced safe-spaces and spoke out against sexual violence targeting LGBT folk. Outside of South Africa, the paramount issue was an urgent need de-criminalize homosexuality.

When it came to developing advocacy tools and funding strategies, we learned that we need to anticipate research outcomes in advance and prepare targeted advocacy packages for specific audiences, such as government and religious leaders. We need to use the data we have now well and leverage it to secure funds to collect more and better data, while at the same time becoming the “champions” that donors seek in meeting their funding goals. Especially in this time of global financial downturn, we must keep in mind that donors have obligations too, and focus on value for money with quality research projects and evidence-based interventions.

Throughout the satellite, participants expressed a need for more communication and open dialogue between researchers and advocate groups alike in order to develop a single framework with which to approach research and programme goals, as well as solicit donor funds. Standardized definitions used consistently in all research protocols are in acute need in order to make data outputs

comparable across sites. We recognized a need to work towards security for all LGBT folk and included government at all levels in the discussion, but also hold them accountable. We must develop a more streamlined approach to both research and service delivery asking; Who is suited to do the job best? Programme expansion must be informed by sound scientific research and guided by rigorous M&E, a perfect opportunity for LGBT research-advocate partnership. And lastly, in order to meet the burden of proof required for large-scale dedicated funds, we must be more flexible in our programme development and roll-out, adopting a step-wise approach with concrete and measurable objectives such as; collecting UNGAS indicators; distributing water-based lubricant; and developing and providing LGBT-sensitive and specific healthcare training.

DAY 1

Zane Green, Conference Facilitator – Welcome/Introductions

What do each of us want to take away from this meeting?

Linda-Gail Bekker, Desmond Tutu HIV Foundation – Welcome/Introductions

There is a new critical mass in interest and information stemming from the data collected on MSM to this date. What are our roles now? It is now time to build on the impetus of this work and ask more specific questions, join a larger, global HIV community. We need to understand MSM communities better, understand MSM at the individual level - what drives risky behaviour. I hope that this satellite will be the first step in our collective movement forward on this critical issue.

Maaza Seyoum, IAVI – Welcome/Introductions

I am here on behalf of IAVI and represent a more social science realm. We at IAVI see MSM as a key risk group contributing greatly to the future of vaccine research here in South Africa and around the globe. Our main hope with funding this satellite conference is to build support networks between LGBT advocates and researchers working with MSM populations to prevent new HIV infections among this group.

Key Note Address

Mandeep Dhaliwal, UNDP - MSM in Southern Africa...*intersections of policy, human rights, and public health*

This is the first MSM satellite event preceding the SA AIDS Conference, an accomplishment to be proud of, and I hope the first of many more to come. I am a physician, receiving my training in Canada, as well as a community activist with special interests in women and sexual minorities. Men who have sex with men (MSM) continue to be a largely misunderstood and overlooked population, particularly in the African context. This very fact calls for the need for more nuanced policy and programming for people who cross many different demographics and/or identities such as MSMW, trans MSM, MSM sex workers, MSM injection drug users, etc. We must also look at the drivers of HIV in MSM communities. What are the impacts of homosexual criminalization, violence, stigma, and institutional homophobia? To what extent is the epidemic hidden? Shrouded in criminalization, stigma, and rights abrogation? We must include MSM in national HIV prevalence data collection, include MSM-specific questions in population based surveys, monitor and expand access to prevention, treatment, care and support programs, repeal sodomy laws, and protect human rights. More donor and community engagement is needed than ever before. It is paramount to keep the pressure up and make more effective use of available funds by focusing on areas of greatest risk and by scaling up evidence-based programs and services.

Panel 1 - New MSM/HIV Research

Laetitia Rispel, Witswatersrand University – The Johannesburg/eThekweni Men’s Study (JEMS): Lessons learnt and future pointers

Our aim was to assess current HIV prevalence, available prevention programs and treatment services for MSM, as well as to measure the uptake of these programs and services in order to make recommendations to the National Strategic HIV/AIDS Plan (NSP). We found highly racialized sexual networks, and found it difficult to obtain a representative sample. Outcomes from this work highlight the need for government to take responsibility and promote ongoing surveillance to inform a targeted response.

Sibongile Dladla, PHRU – RDS prevalence study in Soweto, South Africa

Our study results show that many MSM in Soweto do not know their HIV status and are not testing for HIV consistently. Many MSM included in this research project perceive stigma as a barrier to accessing treatment through government ARV clinics.

Eduard Sanders (Given by Allan Muhaari), KEMRI-Wellcome Trust Programme – High incidence cohort in Kilifi, Kenya

This presentation is based on a Kenyan study working with both high risk men and women. We found that MSM are interested in participating in research programs, but that community engagement and service provision go hand-in-hand. The decline in HIV prevalence by recruitment year suggests a somewhat lower risk for HIV among MSM newly enrolled into the cohort. However, we also found a low perception of risk among MSM, low rates of correct and consistent condom and lube use, and a high HIV incidence over time.

Earl Burrell, Desmond Tutu HIV Foundation – New HIV Prevention Research: The Cape Town PrEP Studies

Few HIV prevention methods are currently available. Those that are available rely exclusively on behaviour change, and have not been effective in curbing the HIV epidemic at the population level. Chemoprophylaxis is a proven concept in the prevention of malaria, TB, and HIV transmitted from mother-to-child. The Cape Town PrEP study is part of a global initiative called the iPrEx study that seeks to measure the safety and efficacy of once-daily Truvada® in preventing HIV infection among high-risk MSM.

Juan Nel, UNISA - Levels of empowerment and emerging LGBT communities in South Africa

We conducted three community-based studies on gender empowerment with just short of 3,000 total participants. Most questionnaires were self-administered and focused on health, well-being, discrimination, and victimization. Stress from homophobia or heterosexism among MSM can cause susceptibility to more serious health issues. Our research concludes that vulnerability to homophobia cuts across all race/class groups.

Panel 2 - Research Challenges

Vasu Reddy, HSRC - IS AIDS A DEATH SENTENCE? Preliminary outcomes of a survey among Tshwane’s MSM

This project measured attitudes about the question "Is AIDS a death sentence?" among 300 MSM in Tshwane. A third of those who participated agreed that it is. Those men who agreed felt less positive about being gay, identify less with the gay community, were generally less informed, test for HIV less often, have more unprotected sex, and participate in transactional sex more often compared to those men who did not agree.

Helen Struthers, PHRU - Diversity, Definitions, and Directions

Studies conducted among MSM in South Africa to date indicate that there is a high percentage of men who are having sex with both men and women. But how are researchers defining bisexuality? How do we ensure that we are capturing a representative sample? There is a need to integrate ethnographic, sociological, and anthropological research with prevalence studies conducted in South Africa. Researchers must agree on definitions and use them consistently so that comparisons can be made across studies and cities.

Earl Burrell, Desmond Tutu HIV Foundation - Recruiting High-Risk MSM for a HIV Prevention Clinical Trial in Cape Town, South Africa

This presentation will overview some of the challenges we have come across recruiting for an HIV prevention clinical trial in Cape Town. We are running multiple recruitment strategies simultaneously throughout the greater Cape Town area. These strategies can be broken down generally into an advertising campaign that includes SMS cell phone technology, venue-based fieldwork, referrals from clinics, participants, private physicians, and passive Internet recruitment on gumtree.co.za. Our most productive recruitment methods are fieldwork at LGBT events and referral networks. With a more targeted SMS campaign, we hope to reduce the number of pre-screening failures we currently have.

Carol Metcalf, HSRC - "Eish, but the whites are scarce!": JEMS research challenges

This presentation will cover the challenges we have come across in describing HIV prevalence and behaviour of MSM in Johannesburg & Durban. In our study, challenges included ethical issues such as confidentiality and incentivizing; finding an accessible and discrete site location; staff selection; accessing a representative sample; recruitment chains failing to take off; low uptake of VCT; and RDS bias in data analysis. It may be that researchers working with MSM in RSA need to rely on a diverse sample rather than a representative sample in future prevalence studies.

Allan Muhaari, KEMRI-Wellcome Trust Programme - Experiences of Working with MSM in Mombassa

The MSM community in Mombassa is large and diverse. We work with sex workers, people living with HIV/AIDS, support groups, and a CAB. Our greatest challenges in working with MSM is that our outreach workers encounter harassment from the authorities on an almost daily basis. In Mombassa, gay people are referred to as *Shoka*. It has been quoted that "you cannot be a real shoka unless you've been beaten up so many times." In addition, challenges include dealing with "triple" stigma, condom negotiation with partners, lack of access to ART and support, mental health services, 'positive prevention', and family pressures. Within the health system, we struggle with provider attitudes and ignorance about MSM sexual health issues, absence of national prevention messaging, and few points of health care access that are safe for MSM. There is an urgent need for education and services targeted to MSM, and for advocacy within MSM communities to address these challenges.

Discussion 2 – Identifying Common Challenges and Brainstorming Solutions

There is a need to agree on and use consistent definitions in our work as researchers in order to have comparable study results across projects and across cities in South Africa and beyond.

There is a need to build in space and time into research proposals so that results can be disseminated to stakeholders and the communities we work with, as well as translated into useful programs and services.

When recruiting population samples we need to know what we are after. Should results be generalizable to a broader MSM community? Should they reflect those who would be willing and able to up-take services?

We need to recognize that LGBT rights in South Africa are not trickling down. There are huge gaps in security and safety among South African MSM of low socio-economic status.

There is a strong argument to make to government that even though MSM constitute a relatively small number of HIV/AIDS cases in South Africa, the MSM community as a whole is disproportionately burdened by HIV/AIDS and requires dedicated funds that reflect this.

There is a funding – data cycle where fund dedication is contingent upon evidence born through solid research data, but research data collection requires funds.

We have strength in our ability to share programmatic success with government to meet the burden of proof required for dedicated funds.

Panel 3 - LGBT Programme Overview

Dawie Nel, OUT - Service Delivery to Vulnerable Groups

OUT provides health service provisions, advocacy, and outreach to LGBT people in Gauteng. Our research includes identifying levels of empowerment, HIV risks, minority stress, and a programmatic needs assessment. Our health services include HIV prevention through barrier methods, life-skills workshops, counseling, and clinic services for the treatment and management of HIV. In terms of health mainstreaming, we are looking at how to integrate LGBT services in to the general health system by teaching health professionals to be accepting of and sensitive to the needs of LGBT clientele.

Malrow Valentine, Triangle Project - Multidimensional approach to MSM sex and its impact on risk behaviour

The Triangle Project in Cape Town provides health & support services, community engagement, training, and advocacy to and for LGBT people in South Africa. We recognize that this network is highly diverse in respect to sexual identities, gender identities, race, class, language, religion, urban/peri-urban, sexual behavior, and health status. We have a huge concern around sexual violence, underscored by the sheer number of violent acts reported and exacerbated by the lack of LGBT-friendly support and care services.

Kevin Rebe, Health4Men - Health4Men: A Clinical Service for MSM in Cape Town

The Health4Men project is funded by PHRU with support from PEPFAR, and consists of a Green Point drop-in VCT centre and the Ivan Toms Centre for Men's Health in Woodstock which is part of a Department of Health Community Hospital. We are currently involved in community education and social marketing. We are trying to create a "foot print" within the gay village because it is an easy access point for gay clients. The majority of our clients are white (79%) and have high rates of HIV and STIs. Our social marketing media campaign, "Play Nice", is geared towards Green Point-based MSM. It is trying to be progressive for a medical service and is based on gay stereotypes. Focus groups that we have conducted in the Cape Flats and black townships have shown that this messaging campaign and underlying stereotypes do not translate geographically.

Gift Trapence, Centre for the Development of People - An Overview of MSM Programs In Malawi

It is difficult to implement MSM programmes in an environment where homosexuality is criminalized. The government denied the existence of gay people in Malawi in 2005. Despite these difficulties, we have been able to measure HIV prevalence among MSM at 21.4%, and found that it is much higher than in the general population. Additionally, 95% of MSM surveyed were unaware of their status. Our sexual health programme provides LGBT people in Malawi with education and information on condoms and lubricants. However, there is a problem with importing lubricant into Malawi because of confiscation and harassment by customs officials and the police. We have a resource centre at our offices so that programme members can access literature on human rights, sexual health, and social welfare. Our ultimate aim is to provide a safe space for LGBT people. Our challenges include covering operating expenses, a lack of a national programme, and homosexual criminalization in Malawi.

Discussion 3 – Shared Programmatic Experiences

There is a need and interest in RSA to expand programmes regionally.

There seems to be a blurred line between research and service delivery, with traditionally research-focused organizations conducting service delivery, and traditionally service delivery-focused organizations conducting research. Is this useful and/or effective? It may be useful to think about where limited resources should be allocated and who has the expertise to provide the best outcomes.

There seems to be a trend in RSA that black gay men are participating to research that then is used to inform programmes with uptake from largely white gay men. How useful is this? Do we understand why? How can we conduct research and provide services to all MSM?

National or regional programmes will cost huge amounts of money. What is the scale of these endeavours? What is the endgame? What is it based on? And is it evidence-based?

There is a clear need for readily available water-based lubricant, for all African MSM. Sourcing supplies from RSA is convenient as opposed to the US or Europe, but requires import/export duties and is subject to confiscation and harassment by in-county officials.

Training is needed for all programme expansion. Currently there is a dearth of proven LGBT training programmes in Africa. Possible partners in developing future tools include New Start and IAVI. But what is the role of government in this process?

Monitoring and evaluation will also be required to programme roll-out and scale-up. What is the role of research organizations in this process? To what extent or scale will they be able to provide this kind of support?

We all need to think strategically in what and how we conduct our work. Collecting UNGAS indicators for the UN is an intelligent and efficient step towards national and regional advocacy.

Panel 4 - LGBT Programme Needs Assessment

Nonhlanhla Mkhize, Durban Lesbian and Gay Community and Health Centre – Drop-in LGBT centre in Durban

The Durban Lesbian and Gay Community and Health Centre has looked at perceptions of LGBT people towards available services and asked "Is the government responding well to our needs?". We found that many practitioners' homophobia prevented the delivery of proper care because they denied gay sex as legitimate sex. The resulting poor services can be attributed to a lack of understanding of LGBT people and their sexual health needs. We are currently interested in research that will facilitate healthy change in people's lives through programmes, research that is enabling, and that can be used as an advocacy tool.

Pepe Hendricks, The Inner Circle - HIV and Muslim MSM

The mission of The Inner Circle is to transform society into one of inclusivity of different faiths around gender and sexual diversity. We look at Koranic scripture through the lens of human rights and focus on peer education and training. A research project conducted by TIC found that queer Muslims were more monogamous than their heterosexual Muslim peers, but that they face significant stigma and discrimination from within the general Muslim community and that religion acts as a strong cultural factor in their identity formation. TIC is in need of further financial support to engage with queer Muslims and provided services.

Caroline Bowley, Gender Dynamix - An Assessment of Male to Female Transgender Person's Needs who are MSM in South Africa

One of the greatest challenges faced by Gender Dynamix is cataloguing trans-friendly or trans-specific medical services in RSA. Currently, no resources are available that document what kind of services are available. We are also interested in documenting how many people in RSA are applying for gender reassignment surgery. This would give us some idea as to how many people in RSA identify as trans. Some of our challenges include finding employment options for trans-identified people, and developing trans-specific medical training manuals. We are requesting partnership within the broader LGBT community to assist us with some in-house projects. In return, we are able to offer counsel on how best to approach and include the trans community in your own work.

Wiseman Chibwezo, Centre for the Development of People - Sexual Reproductive Health and MSM in Malawi

Prior to 2005, there was a considerable taboo around anal sex. Some progress has been made, although there is still a long way to go to diffuse fear and stigma around homosexuality in Malawi. MSM here are often victims of blackmail as homosexuality is still illegal in Malawi. Our challenges include the criminalization of homosexuality, cultural and religious acceptability, lack of sexual

health services, biased media coverage, outing of LGBT people, fear, and a total lack of local funding. There is a large knowledge gap on HIV transmission, no access to safe lubricants, unfriendly sexual health services, and little known about MSM networks. Despite these challenges, we were able to complete a survey measuring HIV prevalence and sexual risk behaviours among MSM here. We have used these results to justify HIV interventions for MSM, and have provided a somewhat safe space for MSM to hold discussions. We have learned that it is possible to work with MSM in Malawi, that MSM exist in rural areas, and that families of MSM are secretly supportive.

Discussion 4 – Facilitating the Attainment of Programme Goals

There seems to be much lip-service paid to trans issues, while a real need exists for trans awareness and education within the LGBT community and the general population, dialogue with funders around trans-specific research and programme needs, and specialization of current research and programmes to be inclusive of trans people – especially trans-specific medical training.

Bisexuality is something that has touched on in many of the presentations, but is something that remains elusive and difficult to define. There is a need for a uniform definition that is consistently used.

There is a huge need for a research-based platform of service delivery. How do we translate research outcomes into service when there is already such a deficit in service provision? There is a need to invest the time and resources into translating specific pieces of research data into concrete implementation plans

DAY 2

Panel 5 – Advocacy

Sam Avertt, amfAR - Integrating Research Outcomes into Advocacy (agitating for a better world)

How do we integrate everything we have heard into concrete advocacy and follow up? What outcomes can we anticipate?: better descriptions of MSM populations and definitions, better understanding of current HIV interventions, potentially new interventions. Who needs this data?: funders, agencies, policy makers, and service providers. How do we communicate research outcomes into advocacy tools?: Web, print materials, presentations, reports, etc. Having a hypothesis of how change happens can be used as a model to work towards this change. We need to aim towards a synthesis of these broad questions. What MSM research outcomes should we anticipate? Who are the constituencies for these research outcomes? What is their usefulness in advocacy? What might be some of our potential advocacy approaches?

Ian Swartz, OSISA - Research as advocacy tool: making the evidence work for us

There is much needed research being done in incredibly challenging settings throughout Southern Africa that is yielding valuable information. How do you use the information you receive from this research to engage government? We must look at the finer differences within the LGBT community or else we will overlook vulnerable populations. Certain research terms are not applicable within certain populations (MSM, gay, lesbian, etc), and we must understand where these differences in language originate. Advocacy is about packaging. We need to use the information from research in an accessible way depending on the populations we are working with. Media use will differ from the minister of health versus the communities we work with; keeping in mind that we need to provide information to advocates in such a way as that it will be useful to them. Some say that you can not engage with government, however this is untrue given the huge size of government as an organization. There is always someone who can link you with the individual you are trying to work with. This doesn't have to be a formal setting, but could be as simple as chatting over coffee. When engaging with homophobic governments, even having them ignore a law is a huge step. One baby step at a time is the way forward. We need to work towards developing and strengthening alliances between organizations in order to move forward. It is incredibly important to use research as a tool to speak with religious leaders. Nowhere in Southern Africa are you going to affect change efficiently without the buy in from religious leaders.

Discussion 5 - Strategizing Advocacy and Dissemination Plans

We need to think more clearly about how we package our research outputs into advocacy tools. What does the data really say? How can we use both the general media and the pink media to advocate for our cause? And without sensationalism? There is a clear need to build relationships and move forward with media as a partner. We also need to include funders at every step of this process. Funders should be considered partners that develop strategies together that find overlap across goals and emphasize that. This needs to be done without losing sight of the organizations original goal, but with transparency and frank discussion. In Southern Africa there is a clear need for a single framework to guide the future of both research and programme development.

Questions for Advocacy:

What MSM research outcomes should we anticipate?
Biomedical results like PrEP and additional Microbicide results
Better prevalence data and understanding of MSM sexual networks

Who are the constituencies for these research outcomes and for use of research in advocacy?
Service providers in other areas able to assist in the development of effective interventions
More researcher to further develop avenues for intervention deployment, etc.

What might be some of our potential advocacy approaches and questions?
With positive PrEP result, what do we do to implement it?
Move to better understand MSM networks in order to fully understand how to deliver PrEP
What do positive Microbicide results mean for MSM (and women who have anal sex)?
Should we look to rectal Microbicide clinical trials?

Panel 6 - Resource Identification

Tim Mah, USAID - Resources for HIV Prevention for MSM

PEPFAR priorities include community-based approaches for behaviour change, condom distribution and correct use, promoting VCT, STI screening, and promoting male circumcision. USAID funding doesn't follow population lines and we must therefore look at different ways of getting MSM projects funded. Funding "champions" can be individuals within non-government or government organizations. Funding mechanisms include umbrella grants, AIDSTAR I: service delivery, AIDSTAR II: capacity building, etc. All grants are given out centrally in-country and must be accessed by organizations themselves. There is much data, but we can always use more, and use what we have now better. Minimum packages of services are locally defined, and almost all epidemic prevention programmes have to have a minimum package. Quality of intervention is critical, while scaling up has not always proved the best option.

Andy Seale, UNAIDS - Resources, tools, and strategic considerations for funding strategies for MSM and LGBTI programmes and services

We have reached a critical mass of data and are now able to have an international movement that can be taken seriously. However there is global financial pressure on ALL HIV treatment and prevention programs and this is important to keep in mind; organizations need to demonstrate value for money, revisit targeted plans, and use evidence-based approaches. In the Southern Africa context, homophobia and stigma keep most LGBT folk in the closet. UNAIDS and UNDP have recently formed a regional collaboration in the form of a desk study to determine and pull together documents that make the case for the MSM agenda to more hetero-normative authorities. This will include regional dialogue, publications, policy briefs, etc. The Global Fund now has a strong focus on prioritizing gender and sexual minorities issues. Within bilateral donor support, we are close to finalizing a UNAIDS action framework that lays out universal access to care for MSM and trans populations. Within mainstream AIDS advocacy, the UN Special Envoy for AIDS in Africa has been slow, but it can still come around. Other tools include the SMUG e-list, Epprecht, Marc (2008) Heterosexual Africa?, and The history of an Idea from the Age of Exploration to the Age of AIDS.

Sam Avertt, amfAR - Negotiate safely with your funders: Three observations

Do no harm – manage and avoid polarizing conversations and politics, but also avoid backlash in building the bridges and agendas and bring people together.

Funding across fields – opportunities for Human Rights funders to see what health and HIV/AIDS funders can bring to the table. We can encourage a common platform of funding.

Dating – Within each of these organizations are real people (technical people or people who think they have technical expertise). We need to build relationships with them, engaging them as champions, and keep them interested. Storytelling and keeping things relevant are crucial.

Discussion 6 - Developing a Funding Strategy

We need to think of our donors as partners. Not only in the context of funding, but in strategizing and facilitating work. There is an excitement around telling community stories, finding organization champions, and collateral benefits that we need to highlight. We need to use funds from one donor to leverage even larger funds from another, build strong programmes on strong foundations. We need to keep in mind that donors answer to someone as well, and measurable impact is important. How are we changing lives? How are we conducting M&E and reporting back?

There is a need in RSA for our interventions to be scaled-up. At some level this will have to include government as a partner in order to effectively distribute MSM health service nationally, but how can we manage to fund something so large? We must start with models of change and develop methods for integration into the health system, then sell this to donors as evidence-based interventions that are accessible, appropriate, effective, and adequate for MSM-specific health care needs. These projects can be expanded to include psychosocial services which - weighs heavily on sexual health – if we can adequately measure the impact of such programs. The burden is on us.

In the interim, we need write up models of mainstreaming into health systems and develop pilot up-scaling programmes. But we need to be flexible and implement programmes piecemeal. With a staged approach, each new round of programme implementation can build evidence to secure the next stage of funding. This will also allow for self reflection. What is the impact we have? How could we enhance what we are doing? What are the outputs we are measuring for success? Are they appropriate? This requires a strategy founded on baseline surveys and interviews. The best way to do this is to partner with a combination of organizations with experience in research and service delivery from across the country.

What we need:

- Programmatic advances that include GCP for community programs and rigorous M&E
 - A thorough LGBT-sensitive HIV VCT training manual that highlights the mental health aspects of HIV among MSM.
 - Thoughtful partnerships and joint proposals for funding programmatic research and health delivery with national or regional scope
 - Training and mentorship in grant writing and dedicated staff to write and manage grants
 - Advocating for a better funded health system in general, so that it becomes possible to mainstream LGBT-specific health services
-