REPORT

KP Connect LGBTI/MSM Learning and Sharing Event 1 (LSE1)

Birchwood Hotel, Johannesburg

21 – 24 July 2015

Report by Pernille Madsen & Katie McDonald
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Introduction

This report provides a summary of the KP Connect MSM/LGBTI Learning and Sharing Event (LSE) process and content. It will be accompanied by a thematic synthesis report to be finalised in September/October 2015, which explores emerging themes, gaps and opportunities going forward.

KP Connect

The KP Connect Programme (also known as ARP 3 phase 2) aims to create a more enabling environment for HIV and health programming with key populations in Africa. It is implemented in 10 countries in Africa: Botswana, Burundi, Côte d’Ivoire, Kenya, Senegal, South Africa, Tanzania, Uganda, Zambia, and Zimbabwe; and has three objectives:

- To improve the technical capacity of LOs to promote Key Populations (KP) access to HIV, health and rights services;
- To increase the engagement of national policy makers in KP issues; and
- To improve processes for regional knowledge sharing and learning by LOs.

The programme is implemented by the International HIV/AIDS Alliance partly through a Capacity Building Unit set up by the Alliance Linking Organisation (LO) in Namibia, Positive Vibes, to coordinate all technical assistance to other participating LOs. It is a 4 year programme, running from 2014 to 2017, but builds on more than 10 years of programming experience in Africa and extends the work done in previous iterations of the ARP, with an increased emphasis on key populations.

Learning and Sharing Event – MSM/LGBTI

KP Connect hosted a Learning and Sharing Event (LSE) in Johannesburg from 21 to 24 July 2015. The central theme of the event was HIV programming for Men who have Sex with Men (MSM) and the broader Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) community. The event was attended by KP Connect participating LOs, partner organisations and other guests with expertise in the area (See Appendix 1 for a complete list of participants). The event was an opportunity to learn and share from our collective knowledge and experience.

The LSE was structured over three-and-a-half days and included plenary sessions, parallel sessions, market place sessions and solutions exchange sessions, as well as time for country group processing.

- In the plenary sessions all participants gathered in the main venue.
- There were 6 sets of parallel sessions across three breakaway rooms (e.g. during the first parallel session, the following topics ran simultaneously: 1A - Gender Violence and Vulnerability; 1B - Safety and Security; and 1C - Changing Family attitudes to MSM). Participants were encouraged to attend as many parallel sessions as possible per country in order to get as much out of the LSE as possible.
- In the market place session participants had the opportunity to set up stalls in which they shared information about their countries and organisations and learned more about others’ contexts and areas of expertise. In general, the stalls included information such as: basic country information, the organisation’s purpose, key strategies, areas of innovation and success, and any challenges the organisation seems to be facing. Please see Figure 1 for a collection of photos from this session (depicted here sharing their work are ABS, ANSCI, KANCO and LEGABIBO).
- On Day 1 of the LSE, the participants were asked to team up in their country groups and write down some goals for the Event (from a country perspective) and some issues/challenges they would like addressed (from an individual perspective). In the solutions exchange, the participants were split up
into three groups – each group worked with questions drawn from the participants’ issues/challenges. Please see pages 11-12 for more information about the solutions exchange process.

- Over the course of each day, participants were given time to reconvene in their respective country groups, in order to process the information gleaned from the day and discuss emerging insights, implications and opportunities for in-country programming. In this way, content was connected to practice.

A facilitator, a documenter and two interpreters were allocated to each of the parallel sessions. Because of the bilingual nature of the group (English and French) interpretation played an important role in this Event. Consecutive interpretation was used in most parallel sessions while simultaneous interpretation (using a booth) was used in plenaries. Three professional interpreters augmented by five volunteer interpreters from the Alliance and KP Connect made this possible.

It was made clear that the participants’ knowledge and experience were the main resources in the room and all were encouraged to be open, courteous and respectful, to interact with both English and French Speaking participants, and to work on building relationships that last beyond the Event.

Specific ground rules were established by participants at the outset:

- To share experiences more than opinions;
- To respect diversity (participants are from different realities and contexts);
- To be courteous and encourage learning;
- To be tolerant and accepting of questions;
- To mix it up and go beyond our comfort zones (i.e. to interact with participants from outside our country groups);
- To create a sharing network between all participants after the event;
- To manage the pace of presentations for translation; and
- To be open, yet discreet (respect that this is a safe space to share experiences).

**Expected LSE1 Outcomes**

By the end of the Event participating LOs and implementing partners (IPs) will have:

- Been introduced to a range of relevant experience, knowledge and practice-based learning by peers and resource people;
- Processed this material at individual and country-group level (at several points during the event) to draw out:
  - exciting new ideas;
  - their own insights; and
  - intentions for change or development in their own organisations, programmes and contexts;
- Planned to explore and/or implement 2-3 key changes/approaches/practices in the coming 6 months; and
- Identified one or two key peer resources (personnel from other LOs/IPs) to support this exploration/implementation.
Figure 1 – Market Place Session
Country Level Goals

The country level goals are represented in Figure 2 above. This exercise was the first step in the Expectation/Intentions and Solutions Sought session. All the following country level goals were generated and are collated into the following Table 1.

Table 1 – Country Level Goals

<table>
<thead>
<tr>
<th>Country</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alliance Secretariat</td>
<td>1. More spontaneous sharing between organisations and programmes.</td>
</tr>
<tr>
<td></td>
<td>2. Greater sense of shared purpose – mass behind the movement.</td>
</tr>
<tr>
<td></td>
<td>4. A better understanding of what enables and hinders KP programming in the specific country contexts.</td>
</tr>
<tr>
<td>Botswana</td>
<td>1. To learn how safety and security of our constituency-KPs can be integrated within the M&amp;E framework and system.</td>
</tr>
<tr>
<td>Burundi</td>
<td>1. Ensure that mechanisms and processes are put in place that enhance/facilitate a legal and political framework that integrates Sexual Health and Reproductive Rights and HIV for the LGBTI community.</td>
</tr>
<tr>
<td></td>
<td>2. Promote quality of services offered to the LGBTI community.</td>
</tr>
<tr>
<td>Cote D’Ivoire</td>
<td>1. Include transgender groups in programmes (approaches and activities).</td>
</tr>
<tr>
<td></td>
<td>2. Innovative experiences to improve KP programmes.</td>
</tr>
<tr>
<td></td>
<td>3. Strengthen ties with other LOs (horizontal learning).</td>
</tr>
<tr>
<td>Kenya</td>
<td>1. To share, learn from others and strengthen our implementation.</td>
</tr>
<tr>
<td>MENA</td>
<td>1. New ideas for our MSM programme through the sharing of experiences.</td>
</tr>
</tbody>
</table>
2. Establish new connections for further collaborations.
3. Strengthen our rights programming.
4. Identify innovations for MENA 2.0.

<table>
<thead>
<tr>
<th>Country</th>
<th>Goals</th>
</tr>
</thead>
</table>
| Namibia   | 1. Learn about various best practice/models that look at advocacy interventions.  
2. Movement Solidarity: How to create tolerance and acceptance of differences and finding/discovering smart/strategic ways to achieve common goals/interests.
| Senegal   | 1. Learn from experiences from countries that have a good practice regarding gender and human rights.  
2. Better comprehension of LGBTI concept and implications thereof (of having and using such a concept).  
3. Work experiences and cooperation with religious groups. |
| South Africa | 1. How to better think ‘out of the box’ in relation to KP identities.  
2. Addressing challenges reaching out to (hidden) MSM with information for HIV testing services as we attempt to reach the 90 90 90 target.  
3. Addressing the needs of the L and the BTI within MSM / KP programming.  
4. Gaining experience/learning for greater effectiveness in my work in bridging from personal experience, self-awareness and acceptance to useful, effective work with community in the broadest sense.  
5. More knowledge about safety and security measures. |
| Tanzania  | 1. Learning and shaping experiences on best practices regarding KP/LGBTI programs.  
2. Finding solutions / best practices on how to handle media in terms of data.  
3. Creating and strengthening KP/LGBTI Networks. |
| Uganda    | 1. Creation of spaces/relationships at decision making positions for LGBTI/MSM.  
2. Innovations around reaching out to KPs without compromising their security and increased discrimination. |
| Zambia    | 1. To learn from peer organisations how they have programmed around key populations (LGBTI).  
2. To understand the needs, opportunities and challenges faced by KPs.  
3. Identify opportunities for networking. |
| Zimbabwe  | 1. Cross learning from other organisations around programming and advocacy.  
2. Any opportunities for learning beyond this space. |
## Participant Issues and Challenges

The following exercise was step 2 of the Expectations/intentions session and informed the Solutions Exchange sessions. Participants individually wrote down practical issues and challenges from their work that they would like addressed or engaged with during LSE1.

*Table 2 – Participants Issues/Challenges*

<table>
<thead>
<tr>
<th>Participant Organisations</th>
<th>Issues/Challenges</th>
</tr>
</thead>
</table>
| **Alliance Secretariat**  | 1. How to overcome duplication in order to a) to better synergise and b) within programmes  
2. Understand and respect diversity of realities of countries we are working with  
3. A network created for communication / resource – sharing / collaboration between partners  
4. How to better understand what our partners are doing so as to better represent and share this work and learning within the Alliance global family |
| **Botswana**               | 1. How do we retain volunteers and peer educators? |
| BONELA                    | 1. Promote/enhance the quality of health and legal services offered to the LGBTI community  
2. To be able to influence my country to change laws criminalising LGBTI |
| LEGABIBO                  | 1. Involve religious leaders and media in KP programmes  
2. Increase/strengthen the fight against stigma towards LGBTI in health care settings  
3. Involvement of community leaders (religious, ‘traditional’) in KP programmes  
4. Media approaches in KP programmes |
| **Burundi**               | 1. How to reduce stigma towards KP services by communities  
2. How to mainstream KP services in Government facilities  
3. How do we ensure essential commodities are available at public health facilities |
| **Côte d’Ivoire**         | 1. Involve religious leaders and media in KP programmes  
2. Increase/strengthen the fight against stigma towards LGBTI in health care settings  
3. Involvement of community leaders (religious, ‘traditional’) in KP programmes  
4. Media approaches in KP programmes |
| **Kenya**                 | 1. How to deal with arrests by the police/new ideas to deal with the police |
| KANCO                     | 1. Safety and Security  
2. Movement politics  
| **MENA**                  | 1. How to deal with arrests by the police/new ideas to deal with the police |
| **Namibia**               | 1. Stigma and human rights: other countries’ experiences that have overcome the issue  
2. Make a few small changes to some of the terminology that is stigmatising  
3. Weak utilisation of information and communication technologies in the response  
4. Availability of data about LGBTI  
5. Promotion of community expertise about LGBTI interventions  
6. How do we reduce stigma towards LGBTI/MSM people |
| **Senegal**               | 1. Stigma and human rights: other countries’ experiences that have overcome the issue  
2. Make a few small changes to some of the terminology that is stigmatising  
3. Weak utilisation of information and communication technologies in the response  
4. Availability of data about LGBTI  
5. Promotion of community expertise about LGBTI interventions  
6. How do we reduce stigma towards LGBTI/MSM people |
7. How do we use unique identifier codes rather than names in prevention activities

| **South Africa** | 1. Where is the discourse /programmes regarding WSW  
2. Lack of HIV programming for trans women  
3. Harmful cultural practice e.g. cultural circumcision among trans women  
4. How do we practically address and tackle the language divide (English and French)? So many valuable learnings exist in each context. We need practical ways to share, learn, and collaborate – to build practice.  
5. Lack of coordinating mechanisms between civil society and policy makers  
6. Disproportionate distribution of resources (Funding) for ‘key’ populations  
7. Move towards ‘transsexuality’ has neglected primary healthcare  
8. Dangerous risk behaviours especially among trans sex workers  
9. Why is a lot of the advocacy around Transgender issues firmly rooted in total surgical intervention? Where is the space for medical intervention only (for example hormone treatment)?  

**Alliance Centre of Practice**  
ALN  
SHE  
COC  
AMSHER  
H4M  
*Not all of the above contributed to the following challenges*

| **Tanzania** | 1. Media intimidation towards KPs/LGBTIs  
2. KPs / LGBTI Programs implementation is hostile legal environment  
3. Hostile legal environments for LGBTI  
4. Lack of community awareness of the LGBTI issues  
5. Political interests interrupt to LGBTI issues  
6. How to find a solution to a case of media harassment

**TACOSODE**  
SANA

| **Uganda** | 1. Would like to find solutions to the health challenges faced by LGBTIQs  
2. How to improve safety & security of staff and clients in KP programming  
3. How to engage hostile Governments and advocate for inclusion of KPs in national HIV response  
4. Beyond projects how do we create sustainable programmes

**CHAU**  
UYDEL

| **Zambia** | 1. Working round a hostile environment to mobilise and increase access to services for KP  
2. How to engage hostile Governments and advocate for inclusion of KPs in national HIV response  
3. How do we explain the genealogy of MSM versus LGBT

**SAT Zambia**
Solutions Exchange

The solutions exchange session led by Gavin Reid (SHARP Programme, the Alliance), utilises a model that shifts the conversation from a problems-saturated approach to one which is more solution-focused.

The procedure:
1. Presenter shares the problem and what attempts have been made to address this so far (5-10 minutes).
2. Group notes what they appreciate about what has been tried so far (5 minutes).
3. Group offers possible (brief) solutions (not more than 90 seconds per solution; total 10 minutes).
4. Presenter makes notes and at the end comments on what she/he found most useful (5 minutes).

First Solutions Exchange Session - Wednesday (22nd July)

The following issues were selected and focused on for the first solutions exchange. Participants split into small groups to address the questions.

Martin: Working round a hostile environment to mobilise and increase access to services for KP.
Franck: To be able to influence my country to change laws criminalising LGBTI.
David: How to improve safety & security of staff and clients in KP programming.
Zundu: How to find a solution to a case of media harassment.
Sophie: How to reduce stigma towards KPs by communities.
Dennis: How to mainstream KP services in Government facilities.
Rabih: How to deal with arrests by the police/new ideas to deal with the police.
Zoonadi: How to engage hostile Governments and advocate for inclusion of KPs in national HIV response.

Second Solutions Exchange Session – Thursday (23rd July)

The following issues were selected and focused on for the second solutions exchange. Participants split into small groups to address the questions.

Jackie: How do we advocate for LGBTI/MSM population estimates?
Victor: How do we ensure essential commodities are available at public health facilities?
Massogui: How do we reduce stigma towards LGBTI/MSM people?
Lucile: How do we involve religious leaders in KP Programming?
Rodgers (Botswana): How do we retain volunteers and peer educators?
Magath: How do we use UIC rather than names in prevention activities?
Rodgers (Uganda): Beyond projects how do we create sustainable programmes?
Shaun: How do we ensure better coherence and avoid duplication in KP programming?
Zoonadi: How do we explain the genealogy of MSM versus LGBT?
Tana: How do we engage with the media around KP issues?
Solutions for Engaging Media

The following highlights an example of the outcomes of one of the solutions exchange sessions, which focused on engaging with the media (Tana’s challenge from the second solutions exchange).

Participants generated a number of practical solutions, such as:

- It is important to approach the media gradually – invest in building relationships. If you can take a proactive, rather than a reactive approach, this is preferable.
- Make sure everyone in your organisation is aware of the message you want to promote, can talk with authority about the work being done, and be consistent. The media often take advantage where they see gaps.
- Find champions in the media who are promoting human rights.
- Meet editors one to one – have a meeting with them in their offices before inviting their staff to a training.
- Invite the media to events – provide freebies (t-shirts, food/drink). Let them know there will be ‘known’ speakers from the community (in the areas of HIV, health, LGBTI or whatever issue you want to address).
- Find the time of day that works best for them – often this is in the morning (e.g. breakfast meetings).
- Invite KPs to provide first-hand testimonies on the effect of negative media attention.
- Prepare media packs with information about your work, your organisation and a transcription of any speech made. This makes it harder to misquote you.
- Develop a media strategy in your organisation, rather than engaging in isolated activities.
- It is a good idea to have someone on the board who is a journalist/media person, or form a media advisory committee in your organisation.
- If a negative article is written about LGBTI, write a response offering an alternative position and get it published in one of the competitor’s papers. Play their game!
- Write a monthly newsletter and distribute it among donors, media etc...
- Get well known by a particular newspaper so that during their ‘dry’ periods, they can contact you for stories.
- In training, focus on language. What language is stigmatising, and what language is not.
- Use your advertising spend strategically – do not give it to media houses whose response to KP and other important issues is not constructive.
Content Summary
This section provides a brief summary of the presentations and subsequent discussion. Original materials are available in the LSE resource pack, and should be referred to for more detail on each session.

Plenary: Framing the Context; MSM/LGBT organising in Africa
Presented by Kene Esom (ED), AMSHeR, South Africa

Summary

Epidemiological: UNAIDS has reported progress in the fight against AIDS, such as reduction in new HIV infections; decline in AIDS related mortality rate; and increase in PLHIV whom receive anti-retroviral therapy. However despite this progress, the epidemic continues to disproportionately affect sub-Saharan Africa.

Legislative: Over 30 Member States of the African Union (AU) criminalise same-sex relationships in some way. This exposes these populations to targeted harassment, violence and marginalisation from health care and other services. Strengthened law enforcements and criminal penalties against sex between have been seen in recent years, which have resulted in increased harassment and prosecution based on sexual orientation and gender identities. HIV outreach workers and service providers have reported heightened challenges in reaching this population. A health needs assessment conducted by 15 LGBTI organisations (Namibia, South Africa, Lesotho, Swaziland, Mozambique, Zimbabwe, Zambia and Malawi) reaching over 2,500 LGBTI people in 27 locations confirm:
- LGBT people have low uptake of HIV/STI testing
- Limited knowledge on safer sex practices
- Misconceptions about risk and risk-behaviours
- Difficulty accessing commodities such as dental dams, condoms and lubricants
- Limited ability to negotiate the use of protection (particularly in transactional sex)
- Some people reported denied health services and human rights abuse
- Delayed health seeking behaviour due to fear of stigma / negative attitudes from healthcare workers

Socio-political: The role of religion and culture of driving homophobic discrimination and violence in many African countries cannot be over-emphasised. According to The Pew Research Centre’s 2013 LGBT Survey, there is far less acceptance of homosexuality in countries where religion is central to people’s lives. Religious rhetoric plays a vital role in conversations around the enactment of homophobic legislations and policies. Homophobia and transphobia has become a major campaign tool of politicking and electioneering, and violence against LGBT persons increase in election season.

MSM/LGBT Organising Response: There has been an increase in MSM/LGBT organisations in African countries, and increased interactions with government department, judicial activity and improved country level coordination among MSM/LGBT organisation, HIV/Human rights CSO-partners, development agencies and donors. However, the forces opposing the cause are also getting better organised, more coordinated and significantly well resourced. Therefore, we must acknowledge this and sustain our progress by learning from each other, developing stronger partnerships and finding innovative ways of addressing discrimination based on sexual orientation and gender identity and advance access to quality health services.

AMSHeR’s five guiding philosophies:

1. Human rights-based approach to health – Focus on addressing marginalisation, exclusion and discrimination in healthcare.
2. Intersectionality – Approach requires consideration of multiple realities or range of factors that enhance/hinder the ability of MSM/LGBT persons to access their rights when planning, implementing interventions and carrying out advocacy work.
3. Incremental approach – Using effective context-specific strategies to achieve realistic outcomes.
4. Empowerment model – Reinforcing autonomy and agency of African MSM/LGBT individuals and communities through the promotion of partnerships and strategies rather than using charity models that perpetuate dependency.


We must demand accountability at four levels:

1. **The State as primary duty-bearer**: Demanding mechanisms that enforce human rights; protection against sexual and gender based violence; privacy and confidentiality of clients’ medical and personal information; testing, treatment and clinical research in consensual.

2. **The Media**: Hate speeches and any advocacy of hatred that constitutes incitement to discrimination, hostility or violence are prohibited by international law and the State has a responsibility to prevent these and punish perpetuators.

3. **Religious and Cultural Institutions**: Violence, stigma and discrimination will remain rife and ending HIV will remain an illusion, if religious and cultural institutions do not change their messaging.

4. **Donors and Development Partners**: Responsible funding models should reinforce autonomy and agency of African MSM/LGBT persons and communities. Contingency planning should be incorporated as a part of grant arrangements and core support (OD and internal systems strengthening) should be prioritised. Make donors and development partners allies of the MSM/LGBT community and encourage them to value positive narrative and capacity building.

**Discussion**

- In many countries legal status/registration will be an aspiration for many years to come. Non-registered partners should not be excluded but we should find different ways of working with partners whom do not have legal status.
- We must understand that there is a difference between ignorance and homophobia and be careful not to close doors by labelling people as homophobic (often victims of gender based violence go to religious leaders for advice because they do not trust authorities).
- The use of language must be considered and this must be a shared responsibility. The term *phobia* relates to fear and avoidance, whereas *prejudice* captures the fact that it is a ‘mental position’ rather than a ‘disease’.
- In regards to creating better partnerships, we must breach the gap between Anglophone and Francophone countries (e.g. translating material and websites).
- Media must be used to move populations towards tolerance and make it clear that human rights and HIV/LGBT affairs are not separate issues.

**Innovations, Insights and Implications**

Criminalisation not only drives MSM underground making them an invisible and even harder-to-reach population, but it also foreclosed the discussion on anal sex among heterosexual partners, thus making it impossible to determine their contribution to the HIV epidemic. AMSHeR’s five guiding philosophies should be incorporated across all areas of MSM/LGBT work and must be taken into consideration when dealing with the State, the media, religious and cultural institutions and donors and development partners. There has been progress in MSM/LGBT response across Africa, however the forces opposing the cause are also getting stronger and we must therefore sustain our progress by learning from each other, developing stronger partnerships and finding innovative ways of addressing discrimination.
1A - Gender Violence and vulnerability: Who is at risk and who is 'key' to the response?

*Presented by Dr Johanna Kehler, AIDS Legal Network (ALN), South Africa*

**Summary**

Gender violence in the context of HIV has long been recognised as an integral part of peoples’ realities and risks to HIV exposure, transmission and related rights abuses. At the same time, there is growing recognition of the risks of gender violence and other rights abuses in the response to HIV – thus impacting on the extent to which people are in the position to claim agency, exercise rights and benefit from competent services free from violence, discrimination and coercion. Yet, despite this knowledge, many programmes and interventions do not effectively respond to the multiplicity of risks to and facets of gender violence and other rights abuses.

**Discussion**

This interactive session explored both the obvious and not so obvious risks and vulnerabilities of ‘LGBTI/MSM’ communities to gender violence in the context of and response to HIV. A number of questions were posed to the participants, including:

- Who is at risk of gender violence?
- When you think of sexual and gender based violence (GBV) in the context of HIV, who do you seeing doing what to whom?
- Who are we leaving behind and why?
- What does this have to do with HIV risk and vulnerability?
- Is the refusal of services a form of gender violence?
- To what extent are programmes and interventions affirming agency, protecting rights, and ensuring that services are ‘safe’?

This discussion highlighted the links between gender, power and agency with the context of HIV. Regardless of sexual or gender orientation or identity, gender is linked to power; service providers makes assumptions/decisions based on how gender is presented.

In most countries, the medical curriculum is written from a heteronormative perspective, which does not take into account the needs of people who do not confirm to this perspective. As such, targeted services have arisen to bridge the gap. However, targeted services raise a number of other potential risks and vulnerabilities. First people have to identify themselves, disclose their status and then be seen leaving the medical centre that is known to cater for MSM. This begs the question - why would people use such services when it puts them at risk? And should we rather be aiming to get to a position where targeted services are not necessary? The lack of appropriate services for MSM/LGBTI people is not a medical issue, it is a social one. We need to escape the heteronormative perspective.

This is where we don’t necessarily have a clear understanding of how our programmes can actually perpetuate violence. Pressure to disclose gender identity, sexual orientation or HIV status can be a violation. If an individual does not want to disclose, they shouldn’t have to. That is the problem with targeted services – disclosure is not necessarily a conscious choice, as it is an entry point to services, and can compound risks. Yet in many contexts, targeted services are the option available.

This prompted further discussion about what our programmes should be aiming for and how to navigate the system so that we can both access funding for targeted services and at the same time disrupt some of the problematic elements associated with such services and/or promote a more integrated approach that challenges the prevailing heteronormative medical infrastructure.
This was followed by a robust discussion regarding the politics of disclosure, with some participants contending that disclosure can be an empowering act for the individual and is the basis for LGBTI rights – as the presence of LGBTI people becomes a normalised part of society. Indeed, it was highlighted that many men and women across Africa are actively claiming an LGBTI identity (as opposed to MSM or Women who have Sex with Women [WSW]). Agency was identified as the key element for disclosure to be empowering.

The session also encouraged participants to rethink how we define problems, solutions and beneficiaries within our programmes. Focusing on MSM/LGBTI can problematize these groups, yet they are not the problem, the problem is the prejudiced attitudes and behaviours which render them vulnerable.

**Innovation, Insights and Implications**

This session prompted some critical rethinking of some of the ways in which we conceptualise GBV, risk and vulnerability within the context of HIV. In doing so, it prompted participants to consider the extent to which MSM/LGBTI programmes actually promote the agency of individuals; and highlighted how the provision of targeted services for MSM can actually perpetuate violence and undermine confidentiality by exposing people to unintentional safety and security risks.
1B - Safety and Security: Practical Approaches
Presented by Gavin Reid, SHARP, Brighton

Summary

In order to frame the discussion around safety and security, Victor Digolo, from MAAYGO (Men Against AIDS Youth Group), presented a case study. MAAYGO targets 14-29 year olds and is a participating organisation in the SHARP Programme. As per the case study, a group of people were arrested for ‘illegally promoting homosexuality’ and for ‘illegal possession of sexual material’ during an investigation carried out by NASCOP (the National AIDS Control of Kenya).

In response to this event, MAAYGO moved their office to a safer location and initiated sensitivity forums with the local village chiefs and community gatekeepers. The community members (police, youth, elders, etc.) were sensitised and became familiar with MAAYGO’s work. The staff met with the Police Provincial Officer and presented evidence on how law enforcement agencies’ harassment of MSM and Community Based Organisations (CBOs) present barriers to the national HIV response. Since February 2015 MAAYGO has a support group for police officers living with HIV, which includes training and sensitisation of fellow officers. Organisations like MAAYGO do the training in Kenya and COC provides the training manuals. The police now provide security for MAAYGO outreach services in the Nyaza Province.

A number of practical steps for organisations were outlined:
1. Nominate a safety and security point person in the organisation
2. Identify decision-maker/making process for different types of incidents
3. Make a phone tree for all staff and outreach workers
4. Develop an agreement with a lawyer/law firm
5. Issue all staff and community outreach workers with organisation IDs.
6. When working with young key populations, staff should be informed/trained around the countries’ laws when providing services to children and young people. (e.g. parental consent, etc.)
7. Map where you are working – identify safe zones
8. All staff need to know the ICE (in case of emergency) numbers
9. All staff and community outreach workers need to read the organisational security policies.
10. Safety and security discussions must be held on a regular basis.
11. Log all incidents and follow them up
12. Careful use of social media (tagging, adding locations, etc.)
13. All staff must be have clarity about the work they do (consistency in language)

The handout for this session: How to plan for safety and security when implementing activities with key populations had more extensive information and recommendations in cases of high risk threshold; safety and security in the office; in the field; safety of clients; and safety and security organisational checklist.

Discussion

ANCS and ANSCI shared similar examples of working with the police after their implementing partner’s offices had been raided.
The main questions that emerged from the discussion were:

- Does the Alliance have measures in place on the ground? How do we mitigate the threat?
- Do we have a common understanding of the work that we do, in order to convey one message? Is there a need to ‘rehearse’ with LO staff and IPs what to do, is it clear to all? Can we describe our work in a coherent manner?
- How do we protect our constituents, taking into account that confidentiality is key in the work we do (e.g. attendance registers)?
- We need to create contingency measures for monitoring/research visits; and discuss in staff meetings, what the potential issues are; what to do if our office is targeted.

There was some debate amongst organisations about the use of gay service providers, e.g. taxi drivers, journalists, plumbers, etc. and the risks of creating a ‘ghetto’.

There was also discussion around the relationship between violence, security, mental health and accumulative trauma. The World Health Organisation’s (WHO) minimum standards for comprehensive services package was suggested as a useful resource material.

Furthermore, it was commented that as all organisations are legally registered, it is important to engage with the right people in government rather than view them as an immutable institution.

**Innovations, Insights and Implications**

As seen in the above case study, sensitising police is vital for the general safety and security of the organisations, the individuals and the clients. Sensitisation however, should focus on the health care perspective rather than the human rights perspective. The impact of presenting evidence on how harassment, stigma and discrimination present barriers to HIV response cannot be underestimated. This will lead to better understanding of the role of LGBT/MSM organisations within the community and law enforcement, and better cooperation.

It was highlighted that the importance of working with youth groups below the age of 18 (‘mature minors’), whom are afraid of coming out is vital in order to educate them before they get infected with HIV. The legal age of consent is 18 years in Kenya, but the national health policy makes it possible to provide services and to work with mature minors (between the ages of 14 and 18).

It is important that we are alert to how we transmit the message. Careful consideration of marketing and means of communication is vital, i.e. how the material (condoms, lubricants, information pamphlets, etc.) is packaged, what content is shared on social media (organisation’s page and the employees private page), etc. It is recommended to always travel with a trusted local partner when needing to carry materials (e.g. condoms, lubricants and information) for distribution.

LGBT/MSM organisations should work in partnerships and build coalitions that support an enabling environment. This not only involves the police, but organisations should also consider things like having lawyers on retainer contracts, having security cameras at offices sponsored by companies, have contingency budgets in place for medical services or temporary relocation for example, and organisations should keep in mind that there must be a way of accessing the budget after hours.
1C - Changing Family Attitudes to MSM
Presented by George Ngolo, TACOSODE, Tanzania

Summary

HIV prevalence rate amongst MSM in Tanzania is 25% according to THMIS (The HIV and Malaria indicator Survey). KP acts are criminalised.

TACOSODE’s Intervention in rejection Model Summary:
1. Identify parents/guardians and assess their attitudes (inform local government if the child seems to be in danger)
2. Invite them to parent-to-parent discussion (simultaneous group counselling with the kids)
3. Individual counselling with parent & child
4. Parent Reflection (i.e. acceptance or rejection)
5. Family reunion
6. Social worker follow-ups
7. Give parents a voice (i.e. action plan for community sensitization).

Figure 3 – Intervention in rejection Model

The key to success: Creating partnership with parents, allowing sharing among parents and engagement with the child. The parents that change their attitude become role models; creating a multiplying effect.

The Challenge: Counsellors get kicked out of parents’ homes for ‘promoting homosexuality’.
Discussion

The question of whether this is a universal model that could be applied to other situations was posed (i.e. whether it could be used with children under the legal age; MSM adults, transgender, and LGBT mothers instead of LGBT children, etc.). Tools, methodologies and manuals are needed to assess parents’ attitudes. The model was originally meant for LGBTI groups, and the programme has reached about 50 parents over a period of three years. The age group is typically between 15 and 25.

We must keep in mind that we must take different contexts into consideration when implementing a model. Bram Langen (COC) gave an example of the GOGO model used in Cape Town, where grandmothers are targeted, rather than the parents, which is an example of using different cultural contexts when carrying out and planning interventions.

One participant shared his experience of having run away from home after being threatened by his father as a fifteen year old and having engaged in sex work for over 10 years. He explained that young people in this situation suffer a total lack of self-confidence which leads to an unsafe lifestyle such as the inability to negotiate condom usage.

It is extremely important to have well-trained counsellors, and the counsellors in the programme are typically parents whom have changed their attitudes towards MSM and have undergone life skills and LIL0 (Looking In Looking Out) training and learnt how to live and communicate with their children.

There were questions around how the programme goes about getting parents and children together (parent-child communication can be particularly challenging in African contexts) and whether authorities are involved. The programme seeks to get the counsellor involved from the start. The counsellor will first of all get consent form the child to involve the parent, and will then get permission from the parent to have a conversation with them — and the counsellor then gets consent from the parent to involve the child in the counselling. Persistency is needed as the counsellor will often get turned down by the parents.

The question of whether this model is effective for a change in the community was discussed. Often the parents will change their attitude but will be pressured by the community to ‘change’ their children (the way they are, the way they dress, etc.) Parents are often manageable however the community is often a much more complex component of attitude change.

Rabih Maher (MENA) mentioned a campaign done in Lebanon that distributed a booklet called ‘We love them but’ to parents and school teachers.

Innovation, Insights and Implications

The main issues within the programme involve safety and security issues when engaging and confronting parents, family members, authorities and community members; whether it is possible/necessary to intervene in families before the children get rejected; and having to use ‘KP’ rather than ‘LGBTI’ due to the criminalisation of LGBTI in Tanzania.

Counselling and peer to peer (parent to parent) discussions help win over the parents and allow them to change their perceptions towards MSM. Engaging parents and family is the key to solve rejection issues and to create a better environment and using parents as role models to speak out for LGBT issues within the community.
2A - Regional Advocacy for the Rights of LGBTI people – East Africa

Presented by Bram Langen, COC, The Netherlands

Summary

The East Africa Advocacy Program has been running since 2013. It aims to move away from ad hoc advocacy efforts and towards a more coordinated and structured approach to regional level advocacy. The programme represents a collaboration between nine LGBT organisations in Uganda, Tanzania, Kenya and Burundi as well as UHAI-EASHRI (East African Sexual Health and Rights Initiative) and COC Netherlands. Participating LGBT organisations are provided with training and support to engage with regional policy makers and participate in the African Commission on Human and People’s Rights (ACHPR), which meets twice annually. This includes training on regional advocacy and strategy meetings before ACHPR, mentoring during ACHPR, and in-country feedback to other LGBT organisations after ACHPR.

Since the program’s inception, the ACHPR has made a landmark resolution against violence based on sexual orientation or gender identity, which can be used for national level advocacy purposes. This is the first time the African Commission has engaged with LGBTI issues.

Discussion

Session participants raised a number of important questions, including:

How does grassroots advocacy link to the regional and international levels?

The program tries to see how to connect these different levels. LGBT organisations meet before participating in the ACHPR, to discuss issues and create an agenda and strategy to take to the commission. As such, the agenda is developed by local LGBT organisations commission by commission, although we might need to consider a broader strategy with 3 year goals to tie these efforts together. The outcome of each ACHPR meeting is then fed back to community organisations to discuss implications at a national level.

When the African Commission adopts a resolution, what are the consequences on the ground? And how can we use those resolutions at a country level?

ACHPR resolutions, the African Charter and the International Declaration of Human Rights can be used for ‘rights’ advocacy at a national level. Although the resolution against violence based on sexual orientation or gender identity was a significant win, it did not contain a built in follow up mechanism for national compliance. As such, we need to keep engaging the Commission to ensure that it comes back on to the Agenda.

What was the reaction of the African Commission to you as Dutch organisation?

The COC has never attended the ACHPR, rather they support other organisations to attend. Indeed one of the key learnings of the program is that things can only be changed within a country by people within that country. It cannot come from outside because outsiders do not suffer the consequences of change.

What about other regions within Africa? Are they represented at the commission?

The Commissioners are from different countries. In the process of selecting, they ensure there is a spread. The list of current commissioners is available on the website: http://www.achpr.org/about/.
One participant in the LSE, who had also participated in the Regional Advocacy programme highlighted how the program has helped them learn to engage with regional and national bodies and the media:

“The advocacy training has helped us to know how to engage with these people. We were facing media harassment. 16 people from the municipality came to close down our office because they heard we were promoting LGBTI and we were on the TV and radio. We weren’t afraid because we were confident, we have the advocacy knowledge. We sat down with them [the people from the municipality] for 4 hours. They left understanding our work and agreed to let us continue.”

Innovation, Insights and Implications

The session highlighted the importance of a structured and coordinated approach to advocacy and for mechanisms to ensure local representation and engagement at the regional level. However, there are still challenges and gaps in our understanding of the linkages between and local, national, regional and international level advocacy. Multi-level linkages and coordination can enable success at one level to be utilised and leveraged for success at other levels. However, the ways in which particular human rights resolutions and documents can be used at different levels may need to be made more explicit. Furthermore, there may be a need to articulate overarching regional level advocacy goals, whilst still allowing for locally driven agendas.

Whilst there is still a long way to go, changes are actually happening extremely fast. Decriminalisation and social acceptance of LGBT people in the Netherlands and other parts of Europe took decades. Although it may seem as though there is a lot of resistance, the pace of change may actually be causing some of the tensions. We should be proud of the changes that are happening.
2B – LGBT advocacy through events and protests: How was it done in Lebanon?

Presented by Rabih Maher, HELEM, Lebanon

Summary

Helem means Dream in Arabic and is also an Arabic acronym for ‘Lebanese Protection for Lesbians, Gays, Bisexuals and Transgenders’.

Based in Beirut, Helem is the first LGBTI organisation in the Arab world (founded in 2004), and the only legally registered LGBTI organisation in the MENA family. When Helem applied for registration, they were not given a ‘yes’ or ‘no’ response before the deadline and as such, were automatically considered registered.

Helem lobbies with regional and international organisations for the rights of LGBTI. Helem also has its own website and produces a regular online newsletter publication.

First of all it is important to understand the Lebanese context and the conservative society in which Helem operates. While Lebanese law does not explicitly criminalise homosexuality, Article 534 of the penal code, which prohibits ‘sexual intercourse contrary to the order of nature’ (punishable by up to a year in prison and recorded in personal criminal record) has often been used to prosecute LGBT people. This Article has also been an obstacle for LGBTI to access health services.

Anal testing was until recently part of police investigative procedures to determine suspects’ sexual behaviour. In 2012 a number of men were arrested during an anti-gay raid on Beirut’s Plaza Cinema, and were subjected to anal testing. Helem started a campaign against the invasive procedure, motivating the Lebanese Medical Association to ban and brand it medically useless. Through dedicated collaboration with civil society and journalists, public protests led to the abolishment of anal testing which the police and doctors were performing to ‘prove’ same sex sexual acts. The general prosecutor issued a circular calling for the halting of such exams (dubbed ‘tests of shame’ by activists). These tests have no evidentiary value and have only served to humiliate the detained. Doctors are now banned from conducting the exam, and doctors performing these tests risk having their permits revoked.

While Lebanon remains far from being an LGBTI-friendly country, activists have been able to log a few wins. For example, in 2009 and 2014 legal precedents were set in the fight to abolish Article 534. In both cases, Judges have acquitted defendants charged under 534.

In addition to its advocacy and campaigning work, Helem offers a number of services, including legal, social and medical support to members of the LGBT community, a VCT centre, and an outreach programme supported by the Alliance.

Helem has had a huge impact on raising awareness and correcting misconceptions about homosexuality. Helem has over the years developed relationships with journalists and the private media, and as a result of workshops, the language used in the (private) media to talk about homosexuality has changed over the past 10 years. Support from Lebanese public figures has also been on the rise in recent years. Furthermore, Helem is currently working on a booklet targeting transgender people, and Helem (in cooperation with the UNHCR) is now looking into ways of supporting 1 million Syrian refugees living in camps, who have limited or no access to ARVs.
Innovation, Insights and Implications
Helem has contributed to a number of changes in Lebanon and is confident that persistent and consistent community-based work will prove fruitful in the future. Critical to their success to date is the use of public events to raise awareness, partnering with private media, innovate marketing, documenting human rights violations and utilising resources effectively.

Public events, such as IDAHOT (International Day Against Homophobia, Transphobia and Biphobia) on May 17 each year, provide Helem a platform for advocacy and visibility. Celebration of the work and achievements through public events is an excellent opportunity to meet with the media, allies and other human right groups. The LOs present are not actively involved or engaged with any IDAHOT activities. The main purpose of the May 17 mobilisations is to raise awareness of violence, discrimination, and repression of LGBT communities worldwide which in turn provides an opportunity to take action and engage in dialogue with the media, policymakers, public opinion, and the wider civil society.

Partnering with private media is vital and in the case of Helem has led to a change in language used when relating to the LGBTI community.

Innovation in marketing is also important for campaigning. The use of creative and relevant material for advocacy work will prove successful. Organisations should make use of the resources and skills that partners and donors are able to provide – for example to get good graphic designers to put together materials for a more sophisticated look. Likewise, human rights violations against LGBTI people must be documented for advocacy work/campaigns.
2C – I am MSM: The implications of HIV healthcare strategies for securing the rights of sexual minorities

Presented by Warren Banks, Positive Vibes (on behalf of Robert Common, Alliance Secretariat)

Summary

This session was introduced with a brief background on the term MSM, followed by an intense discussion. Please see the Resource Pack for a summary of the main points from Ross Reeve and Robert Common’s paper.

Some of the main questions arising from the paper ‘I am MSM’ were:
- Has the problem with the ‘MSM’ label become the lack of representation from other groups of same sex attracted men – because the current ‘MSM community’ is dominated by gay men?
- How does this affect service strategies that are mainly dominated by those who are openly gay?
- How does one reach the entire MSM population when the ‘non-gay-identifying men’ are discriminated against and frowned upon by ‘gay-identifying-men’?
- New phraseology is already appearing in debates, including ‘hidden MSM’ and ‘hard-to-reach MSM’. Are these men who identify as gay or are they men who practice masti (sexual play between boys or without significant implications to the sense of self) and do not wish to engage with LGBT dominated and tailored services?

Discussion

There was considerable animosity towards the terms ‘MSM’ in the group. Some of the key discussion points were as follows:
- Many gay men do not want to be identified as MSM due to the focus on the sexual act rather than on the human being in relationship with another.
- Construing ‘MSM’ as a public health term could be seen as disingenuous: the public health issue is not MSM, but the fact that having unprotected anal sex increases the risk of HIV transmission. Why not focus on anal sex rather than ‘MSM’ – after all heterosexual couples have anal sex too, and not all gay men engage in this practice.
- The term MSM has done damage to the gay identity. It has increased stigma due to the fact that it has turned MSM into bisexual in the eyes of the society. They should therefore be able to ‘leave their gay side behind’ and become a ‘real man’.
- Jean Marie (ANCS) mentioned in Senegal for example, the term ‘goorjiguen’. This term described a traditionally sanctioned role and goorjiguen were seen mainly as actors or performers and as people with social standing and importance – in this light, ‘being gay’ attracted little or no social stigma. When the term MSM appeared, gay men became ‘perverted’ as religious leaders took advantage of the term to stigmatise and criminalise them.
- The term MSM is also a way of turning the discussion into a public health led discussion rather than a human rights led discussion.

On the other hand, for some men, ‘MSM’ is a transitional term and allows them to own a part of their sexual lives without claiming a fully gay identity. Quite often these men come out as gay later on. Some participants argued that MSM is a legitimate descriptor of the behaviour, meaning that the risks of unprotected anal sex are captured in the term.
Innovations, insights and implications

The term MSM has limitations and the overall consensus in this group, was that it has increased stigma rather than reducing it.

At the same time, it was acknowledged that the category ‘MSM’ does provide us with leverage in environments hostile to recognising the existence and rights of LGBTI people. Major donors require that this group be addressed in public health efforts aimed at reducing HIV, and so, even hostile states generally accept the need to work with MSM. And in the process, some of the short term needs of gay men are met. At the same time, some argue that the term allows such states, individuals and institutions to continue to perpetuate the idea that homosexual relationships are not real and meaningful, and therefore do not deserve to be seen as fully human partnerships. Should we accept the term in order to get things done in the short-term?

The term MSM makes human rights based advocacy more difficult, but at the same time the term itself is the outcome of advocacy. It would be valuable to engage in research on the impact of the term on men’s health outcomes (access to services) and on the human rights status of such men. Martin (SAT Zambia) noted that gay men are more at risk of getting HIV than MSM – if we could get data on this it might help us argue for a change in the language.

Should a new, more ‘all encompassing’ term must be found to better express this identity? Due to the sexual connotation of the term it is not that helpful with regards to fighting stigma – MSM confronts people not with full human relationships (including sexuality), but with a simple sexual act. Jean Marie (ANCS) prefers the term MLM (Men Loving Men). Franck-Arnaud (ANCSI) emphasised the need for a term that relates to social justice and not just public health.

The consensus was to advocate for further discussion about what the term MSM has become in a rapidly evolving HIV response and what that means for the broader Human Rights discussion. The unthinking use of the term may do more harm than good to long term struggles for social justice and human rights.
Plenary: The Future of Combination Approaches  
*Presented by Casper Erichsen, Positive Vibes, Namibia*

**Summary**

This session provided an overview of historical trends in HIV responses and implications for what this might mean going forward. In brief, understanding of and responses to HIV in the 1980’s was dominated by fear, death and dying; in the 1990’s highly moralistic prevention messages prevailed (ABC); in the 2000’s the focus was on community empowerment and PLHIV rights – the message that ‘HIV is just a virus – you haven’t done anything wrong’, aimed to counter the downward spiral of exclusion and heavy self stigma. This proved much more effective than the bio-medical approach.

Then 2004 became a watershed moment when ARVs became more accessible and Governments began rolling out treatment. By 2010 indicators started to drop and new ideas started to emerge, ‘the apocalypse was averted’. The idea of combination prevention emerged (using bio-medical, social, and structural approaches).

In 2011, UNAIDS developed the Strategic Investment Framework – which portrayed a road map for the future. Using an evidence-based approach, six areas were identified that have worked and are likely to continue to work (including addressing KPs). These are underpinned by a number of critical enablers such as political commitment, community mobilisation, and stigma reduction.

There was a great sense of optimism in 2012 as the end of AIDS was in sight. We were at a tipping point and just needed smart investments. However, at the same time, there was emerging donor fatigue as other issues vied for global attention. The financial crisis saw greater austerity measures. There was a lot of investment in the BRICS counties and many low income countries moved to middle income status. As a result of these trends, funding dried up in HIV prevalent countries, particularly Southern Africa.

Currently there is a heavy focus on treatment, under the 90 90 90 slogan, that is, 90% tested, treated and virally suppressed. KPs are still part of the core programme but only in relation to treatment.

In Namibia and South Africa (as well as many other countries) prevalence has decreased but incidence rates are starting to rise again, and prevention funding has reduced drastically, with the emphasis instead on treatment. However, treatment benefits may be offset by reductions in behavioural/structural initiatives - so they need to work together. The test and treatment approach is not enough. It needs to be supported by the combination approach.

**Discussion**

A number of questions were posed to the audience including:

- Where will funding come from in the future for human rights and structural efforts?; and
- What if the models are wrong?

Discussion centred around the significance of the involvement of PLHIV and the establishment of the GIPA principle in 1994, which reinforced that patients were part of the response and decision making; the false dichotomy between prevention and treatment; and challenges for prevention work within the current funding environment.
Prevention and treatment should not be framed as a dichotomy; indeed treatment must include structural engagement and community engagement. Combination approaches are what works. The challenge is that the money is not following towards the combination approach. Most CSOs in Namibia don’t know where their funding will come from post global fund. There is panic at the moment and we are losing the language that started GIPA and moving back to a patient /client terminology. But with crisis comes opportunity, CSOs have been forced to have a conversation with each other. There is an argument to be made to Government that since the donors have left, it is up to them. However, Government will never pay for structural work – so there is still an argument for international donors to make sure human rights gains are not lost. Those conversations are being had.

As Massogui Thiandoume from ANCS in Senegal commented:

“treatment is very important, we must do everything possible so that those who need treatment have access to it - but we also need to make sure prevention reaches every single person in our countries. We are trying to adopt economists’ models but I’m not recognising the civil society I knew 10 years ago. That civil society was fighting and claiming things on behalf of communities. If we continue like this the global movement will collapse. Those who come up with the models will come back to us in 10 years’ time and say we made a mistake – the model is not working. As community actors we need to impose ourselves in the global environment so our achievements are not lost. We are all worried because we are being asked to achieve very important results but with three times less budget than before. So this is an appeal that we need to act, to move. The civil society that I know, does not necessary agree with everything - we need to question those slogans and be aware that we represent communities and we have a voice in decision making.”

Casper concluded with the following take home thoughts - ending AIDS cannot be done as simply as the slogan suggests but the response must be complex. The investment framework was brilliant and could have worked; the new 90 90 90 slogan can work too – but what about people’s rights – that was the big battle that was fought and won with GIPA. We can’t reach the tipping point without people. No country is anywhere near that point. What is going to get us there? We mustn’t accept that because combination approaches are not part of the conversation that we can’t talk about it. We must engage with the slogans and not forget the lessons from the past.

Innovation, Insights and Implications

The session highlighted that we have a long history of HIV responses to draw on about that works and what doesn’t. History shows that combination approaches that incorporate prevention, rights, civil society and PLHIV work. Yet the gains of the past are at risk of being lost. Civil society needs to fight for inclusion of prevention and social/structural approaches into the current treatment mantra. Civil society has more to offer beyond technical delivery agencies.
Summary

As the Alliance Centre’s of Practice are in the conceptual stage, this session was designed to inform participants of current thinking around the role of the Alliance Centre’s of Practice and to generate ideas from participants about how that role could be further shaped and refined to support LOs globally. The session was replicated twice during the course of the LSE so that all participants would have an opportunity to attend.

The Alliance Centre’s of Practice are part of a strategy within the Alliance to move the idea of distributed leadership going forward. This strategy has started in other ways – e.g. through the Technical Assistance Hubs (6 globally; providing TA to programmes in a variety of areas). The Hubs have already demonstrated an ability to provide such technical support that Secretariat would have previously provided. The Hubs are regionally-based and sell services to support themselves.

The formation of the Centres represents a second stage of this strategy: they aim to bring together, clarify and focus thematic expertise where the action is.

There are four Centres globally:
- New Delhi (India) – adolescents and health
- Kiev (Ukraine) – harm reduction and Hepatitis C
- Cape Town (SA) and Dakar (Senegal) – KP focused

The Centres aim to identify, develop and popularise:
- Learning and knowledge
- Practices and methodologies
- Influence and advocacy

Differentiating Hubs and Centres:
The Centres will provide thought leadership and therefore act as a form of think tank or facilitators whereas the hubs play the role of implementing these as a type of consultants.

The Technical Support Hubs are Regional – they aim to address practical capacity gaps in the region where they work. They often do this in a short-term and focused way through consultancies. The Centres, on the other hand, are global and focused on particular thematic areas of expertise (e.g. KPs). KP-focused centres are situated in sub-Saharan Africa as it is the epicentre of the epidemic.

Hosting LOs and Centres:
The Centre Directors (i.e. Flavian Rhode; Massougi Thiandoum) are still currently employees of their LOs as they are in the start-up phase. The vision is that the Cape Town Centre will become a place that reflects (not contains) the expertise of Southern and East Africa. Ultimately, the Centre needs to account to LOs because LOs are its primary sources of learning and its primary target/clients.

It makes financial sense for the Centres to access admin and other support from their hosting LOs. However, over time the Centres will grow beyond their hosts to establish stronger relationships with other LOs and with the Secretariat. As we go forward we need to work in ways that make this inclusion and autonomy clear. We want to find ways of showcasing and connecting others to thought leadership and effective practice in Southern, East and West Africa.
The role of the Secretariat:
The Secretariat is supporting the start-up of the Centres and helping to developing some commonality and links between them so that they ultimately form a global whole. In this sense, they are currently the main investor in the Alliance Centres.

Clarifying the actual work/function of the Centre

The Centre’s role is not to take LOs ideas and content and exclude the innovating LO from the process. Rather it is more about packaging, translating and facilitating processes of learning and transfer of ideas and practice. Those with expertise would remain involved in and be credited during the process. The figure below attempts to illustrate the process or the Centre’s Role simply:

One of the values added here is that the function of supporting the translation from one cultural/country context to another would be part of the Centre’s function. In many cases the work would be around drawing out the underlying programming/design principles that inform effective practice in a particular field; clearly this work would need to be done with the practitioners from LOs.

Discussion

The participants were given four questions which they were asked to answer. The questions were:

1. When we reflect on our work with HIV and/or LGBTI/MSM what are we most proud of?
2. In our HIV and/or LGBTI work, where is our strongest expertise? What do we have to share?
3. In our work with HIV and/or LGBTI what would we most like to learn to strengthen our programming?
4. ‘We only need to know two things: What we know, and what we don’t know...’ (Alan Ragi) What are you wondering about/wanting to know these days in relation to HIV and LGBTI programming and responses?

Participant responses from each session are presented in the table below and emerging issues are subsequently summarised.

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<thead>
<tr>
<th>Session 3A</th>
<th>Session 6A</th>
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<tbody>
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<td>1. When we reflect on our work with HIV and/or LGBTI/MSM what are we most proud of?</td>
<td>1. What LILO does for LGBTI individuals – healing, hope, connection, relationship, self-value.</td>
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<td>• Development of a true leadership</td>
<td>• LILO KP – shifting attitudes, opening space for thought and connection</td>
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<td>• Pioneering – being the first to carry out interventions targeting KPs before everyone else comes on board</td>
<td>• The active inclusion of LGBTI at all levels of project development.</td>
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<tr>
<td>• Our participatory engagement methodology with LGBTI CBOs; our work on knowledge generation regionally; capacity strengthening of budding CBOs.</td>
<td>• The KP populations representation in the council of administration in ANSCI</td>
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<tr>
<td>• Progress on engagement with GRN on LGBTI matters</td>
<td>• LGBTI/MSM adhering to HIV treatment</td>
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<td>• Capacitating stakeholders for inclusivity of LGBTI in</td>
<td>• LGBTI/MSM participating in HIV forums</td>
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<td>• LGBTI/MSM role models speaking out.</td>
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HIV strategies (NSF/AIDS Impact Surveys – IBBSS)
- Mentoring and housing LGBTI organisations
- Development of education and communication aids (manuals, etc.)
- Establishment of a functional referral system for healthcare services
- Partnerships with government and other CSOs in programming for LGBTI

- The people we work with – i.e. beneficiaries, IPs, LO’s

2. In our HIV and/or LGBTI work, where is our strongest expertise? What do we have to share?

- Localised programme design and delivery
- Prevention through ICT
- Evidence based interventions for informed policy advocacy work/engagement
- Movement building/diversity trainings/knowledge generation
- Advocacy within a hostile environment
- Programming and mobilisation of MSM
- Capacity building
- Human rights
- HIV prevention, care, support and treatment
- Policy and law
- Policy analysis and policy briefs; drafting of bills
- Advocacy and policy makers engagement
- Utilisation of the media as an advocacy and awareness raising tool
- Organisational development (systems strengthening/internal organisational policies)

- Experience designing and managing multi-country programmes.
- Putting people at the heart of the programme.
- Curriculum development experience – building process into structure/providing structure for process
- Advocacy
- Working with refugees LGBTI in hostile environments
- The nocturnal clinic approach to KPs
- Involving KPs from other countries into our programmes.

3. In our work with HIV and/or LGBTI what would we most like to learn to strengthen our programming?

- Not working in silos – how to have more engagement and collaborative linkages with other IPs, donors, etc. Coordination.
- Hostile operating environment should not derail us from our focus, but give us impetus to improve what we are doing (‘kaizen’)
- Improve capacity building for LGBTI in advocacy
- To document and publish what we have learnt and experienced
- Accountability/self-reflection
- Innovation/efficiency

- Uptake of HIV treatment, care and support
- Tracking of KPs
- Messaging on PDHP
- Demonstrating impact on interventions around uptake of services leading to improved health outcomes
- How to work with global/regional networks
- What else do PLHIV need now?
- How can we nurture and support innovation – also in working with family, culture, religion.
- Creating space for communities to share experience, and to inform global and regional guidelines.
4. ‘We only need to know two things: What we know, and what we don’t know…’ (Alan Ragi) What are you wondering about/wanting to know these days in relation to HIV and LGBTI programming and responses?

| Discussions on moving combination prevention to the next level (so sexual harm reduction for example) |
| Interface between community persons (LGBTI CBOs)/donors/stakeholders on promotion of a solely biomedical model for intervention (this includes treatment as prevention) option... |
| The place of LGBTI programming in the context of Sustainable Development Goals (SDGs) |
| Global, regional and national resource basket |
| Strengthening ‘participatory approaches’ |
| At what point are organisations’ capacity truly built without consultants making themselves relevant/securing jobs – what are the checklists? |
| How does one master the art of sharing what they have learnt? |
| Why are we so ‘bad’ at expressing/capturing what we know. |
| National and international discourse |
| How do we really get bi-directional sharing of info, tools, knowledge, expertise, people’s time. |
| How to capitalise on the whole range of technology. |
| Most NGO/CBO supporting work with LGBTI/ MSM around HIV |
| Why HIV prevalence is still so high when so many funds are being put into it. |
| Learning and gathering can show us what we don’t realise |

Innovation, Insights and implications

The emerging issues that seems to emerge from the session and participant reflections, include:

- Leadership, participation, capacity building and advocacy (both as strength and as needs). Everyone has a different view on capacity building and it seems to be a common practice emerging but what does it entail? Investigation around this is needed.
- Expertise is how we connect and link people with something to learn with people who have something to share. It’s not only about programming, but also about what makes for an effective organisation.
- We experienced that some people knew exactly what they do, but couldn’t communicate it, so it is important to take the time to reflect and document some of the successes/accomplishments we are proud of.
- People need to better reflect what is valuable and speak with authority about the work that they do in a clear and focused way, the Alliance Centre can help with this.
- We seem to be moving forward in a fractured way (each organisation is progressing in their own way and format). Organisations need to make progress together in a more harmonic way.
- Everyone has something valuable to share and by getting rid of competition we create a road to success.
- Need for focus on strategy rather than the process.
3B – Health4Men: Positioning to influence change in government policy and practice  
Presented by Glenn de Swardt, Health4Men, Anova Health, South Africa

Summary

Health4Men (H4M) is a project of Anova Health. Today they have receive their own funding (through a grant from the Elton John AIDS Foundation). UNAIDS and PEPFAR also got involved. H4M’s work is embedded in the public health sector treating MSM. The department of health staff have been trained and monitored by H4M.

H4M’s progress to date: Global Fund - 150% of target reached. PEPFAR/UNAIDS – 98% of target reached.

MSM Background: Homo-prejudice remains common in SA in spite of our human-rights based liberal Constitution and Bill of Rights. 60% of MSM do not use condoms consistently.

H4M Model:

- H4M developed ‘Sex Positive Paradigm’: making people feel good about themselves and their sex lives, which makes them more likely to take better care of themselves. H4M started using sexual connotations in marketing (male to male sex).
- They focused on STIs rather than HIV messaging which attracted more MSM.
- Sensitising nurses is usually not enough so nurses receive training and mentoring to reach the level of competence required.
- H4M Model cascade*:
  1. Sensitisation (attitude)
  2. Medical training (knowledge)
  3. Mentoring (skill)
  4. Technical assistance (monitoring)
*Time period for the cascade roll-out: One day for psycho social and one day for bio medical training. Three months for mentoring, and a survey carried out at the end.
- Community engagement and media was used to reach the MSM community to attract them to the clinic.
- MSM competent Health Worker will: not assume men only have sex with women; take an appropriate history; identify men who may be MSM (emphasis on behaviour and NOT identity); when appropriate, conduct anal and other examinations; provide appropriate prevention messaging.

Lessons learned:

- Offer solutions to authorities rather than approaching them as victims.
- Focus on MSM as opposed to broad LGBTI focus.
- Clear health focus (department of health not interested in human rights)
- Use your country’s NSP (national strategic plan) where possible. (i.e. 90 90 90)
- Identify and utilise ‘champions’ (doctor, etc.)
- Know your target group (where are they, what do they do, etc.)
- Be aware of limited resources – all interventions must be time and resource efficient.
- Use prejudice to get nurses attention and get them involved (they have all experiences prejudice/racism as some point). Remind them of the ethical aspect of having being prejudiced.
- Involve & train all staff – not only clinicians
- Use Monitoring and Evaluation – use this to impact to donors. (Donor support is essential, and they need to see results.)
- Have technical expertise.
- Confidentiality (no need to expose MSM people in journals, etc.)
- Clinics can attract many through word of mouth. (i.e. reputation management)
- Training health workers must be accompanied by community engagement

Innovation, Insights and implications

1. Innovation is one of the keys to success when advocating and fundraising.
2. A combination of a bio medical training as well as a psycho social training is key to developing MSM competence care.
3. According to H4M, the department of health (DOH) looks for tangible results when making decisions and therefore one must approach the DOH with a public health oriented focus rather than a human rights approach.
4. H4M’s branding has created a much more social enterprise character rather than a ‘victimised’ NGO.
5. Through the use of the ‘Sex Positive Paradigm’ there has been seen a growing confidence and pride within the MSM community which in turn has also lead to more responsible behaviour. Not only had this approach attracted MSM but also attracted staff to the training sessions (training all staff is a challenge resource-wise, and ‘on-the-ground’ employees cannot be forced to attend, however through the use of innovative marketing; more staff would attend without raising costs).
6. H4M also found that the use of STIs rather HIV messaging attracted more MSM people.
3C - Transforming the Health service delivery system in Zimbabwe

Presented by Samuel Matiskure, GALZ, Zimbabwe

Summary

In response to the high HIV prevalence rates amongst MSM and WSW in Zimbabwe, GALZ recognised the need to identify and train more healthcare workers who could provide healthcare services for the LGBTI community. As such, GALZ approached 50 health care providers to ask if they would be willing to provide such services; 35 of these expressed interest and subsequently participated in a sensitisation training program around how they engage with the LGBTI community.

Many of the doctors were afraid because GALZ has a reputation as confrontational and fighting with the government. They were worried about being arrested. In order to address their concerns, GALZ drew on core national documents (such as the Zimbabwe National Strategic Plan 2011-2015, which states KPs are a target group for HIV programming and the Zimbabwe Constitution, which articulates universal health care) to demonstrate the doctors were not working outside the mandate of the government.

The ANOVA Health4Men Curriculum was the basis for the training, which was delivered by an ANOVA Health4Men Doctor with vast experience of providing health care series to MSM. In this way, the training was conducted on a peer-to-peer basis. GALZ also trained a number of doctors from Zimbabwe Doctors for Human Rights to train other doctors. In addition to training doctors, the project focused on a mix of health care providers to address the various entry points, such as pharmacists, nurses, technicians, etc.

Discussion

The session evoked a lot of discussion and emotion. Participants were very inspired by what GALZ has managed to achieve in Zimbabwe despite the many challenges and restrictive environment. Core questions were as follows:

Q: What about trans-health and gender affirming care? Many organisations talk about LBT women but they are really talking about Lesbians and Bisexual women. Trans men are included by default because they were born women yet they would not be comfortable in women’s spaces. For health care services we need to know the physiological differences for as long as you are in one body you need to address those issues.

A: The trans movement is just emerging in Zimbabwe. In 2011 GALZ started to explore what it really means to be LGBTI, and realised that a number of people who were thought to be gay actually identified as trans, because it was easier. GALZ now has a trans desk to deal with trans and intersex issues. It is up to them to drive the agenda.

The project trained health gave workers on LGBTI not just MSM and included mental health aspects, not just physical health.

Q: What is the plan for ongoing training and education? Once off training does not necessarily build the level of competence you require. How do you ensure compliance in the absence of a supportive policy framework?

A: GALZ works with a number of partners who provide pro bono care to the LGBTI community. Zimbabwe Doctors for Human Rights has also found their own resources to continue training other doctors. Compliance is via peer educators.
Q: How are you motivating the health care workers?

A: Health care workers get points for attending trainings. That is one motivation for doctors. We work with John Hopkins University. They have a high profile so that appeals to the doctors.

Q: Is there any scope to work at the school level?

A: It is very difficult to get into government education systems, in order to change the medical curriculum. However, there are various levels to access youth, for example through the student unions. GALZ works with a number of different institutions.

Q: How do you measure positive outcomes and use it for advocacy?

A: GALZ uses pre and post-test evaluations, follow up surveys and mystery clients to see how doctors are progressing and get feedback. From there we make improvement recommendations.

Q: What about sustainability and the longevity of programs in hostile environment?

A: GALZ did not want to create specific sites for LGBTI but is rather promoting an integrated system care system. If there is only one clinic and it gets raided it is a problem.

Innovation, Insights and Implications

This project highlighted an innovative approach to transforming health service delivery systems in Zimbabwe. Rather than aim to revise the national medical curriculum, which would be met with great resistance, the project approached and sensitised individual doctors and health care providers to ensure appropriate services for the LGBTI community. This demonstrates that there are ways around even the most insurmountable problems. Although revising the curriculum is still on the agenda and needs to be addressed in the long run, incremental change is still possible in the interim and this change can be used gather the evidence that is necessary for raising awareness and long term advocacy.

The project also highlighted the value of sometimes staying in the background. Making doctors themselves the face of the project and utilising a peer to peer approach allowed GALZ to leverage off the influence and respect that doctor’s hold amongst other doctors and the community.

Whilst it is one step at a time, the project also highlighted the need to be bold. When asked what they would do differently if they could start again, Sylvester from GALZ highlighted:

“If you want to make a change and you are paralysed by fear, it does a disservice to you. If we had started this 25 years ago we would be so much further ahead now”.

4A – ANCS: MSM interventions in a hostile environment

Presented by Massogui Thiandoume, ANCS

Summary

ANCS (Alliance Nationale Contre le SIDA) started in 1994. In Senegal the religious environment criminalises homosexuality, and same-sex relations are penalised. In 2002, two MSM associations were officially recognised within the framework of HIV/AIDS interventions.

Studies show that 0.7% of the general population of Senegal is HIV positive. 18.5% of sex workers and 21.8% of MSM are HIV positive in Senegal.

ANCS became the principal recipient of the Global Fund for 2005 and 2006. The PEC (Prise en Charge Medical des MSM) was instituted by the Ministry of Health in Senegal, and went from 9 MSM intervention sites in 2005 to 43 sites in 2013.

In 2008, a group of nine MSM people were arrested while doing sensitisation work, and charged with nine years of imprisonment. By the time ANCS staff arrived to see them, they were told it was too late. They had already been judged and charged over the weekend. Senegalese law, however, states that no arrests can be made between 8pm and 8am (neither are warrants to enter people’s houses permitted to be given). Nevertheless, KPs get arrested between these times because many do not know the law or their rights.

France got involved, and local Senegalese religious authorities (a few imams, Muslim associations and male politicians known for their fundamentalist stances) framed the French intervention as ‘promoting homosexuality’, ‘homosexuality being Western’ and homosexuality being ‘forced on the Senegalese people’, etc. This foreign intervention complicated the situation. Facts were manipulated and homosexuality was constructed as a ‘novelty’ and ‘menace’. Nevertheless, France still has influence in Senegal, and an informal ‘crisis’ committee was formed to release the nine men. However, the Senegalese government did not release them before the elections for fear of how the opposition would use this against the government.

ANCS continued to lobby, hand in hand with the Global Fund and civil society. The Technical Committee (Ministry of Health) asked ANCS for evidence that MSM (and KPs more broadly) are most hardly hit by HIV amongst the population. Advocacy has since been at the centre of their intervention, and they also work closely with religious groups:

“We realised it was better to have them work with us, than against us. There can be no justification for allowing institutionalised violence against some members of society simply on the grounds of prejudice. Failing to act while people live in fear and constant danger is a threat to both the rights of individuals and to public health.” (Massogui Thiandoume, ANCS).

“Religious groups have a lot of power in Senegal. It is important to consider them as partners” (Paul Sagna, The Alliance).

ANCS also embarked on a series of interventions focusing on capacity strengthening, leadership training and organisation development. They support a KP network that is recognised at national level (Jean-Marie is the Secretary General of this network).
Discussion

Discussion centred around police engagement and crisis response.

Jean Marie’s approach to engaging with the police is to be open and honest (both about being gay and HIV positive). In Senegal 18% of MSM have been abused and/or raped by the police. There was interest from participants in more information on ANCS’s work with the police and religious groups, and whether this cycle of work is continuous.

Access to funding during a crisis is a challenge in many countries. There is a need for a rapid response mechanism for crisis situations. Participants were interested in knowing more about the ‘crisis committee’ in Senegal.

There is a need to ‘improve’ laws that are against human rights. For example, there is a pre-colonial law from 1979 against ‘prostitution’. The laws are simply dormant. The topic is very sensitive because there is a risk of religious groups and government forcefully engaging to protect these laws. ANCS is positioned as an HIV/AIDS organisation, not a Human Rights organisation, so this is a big challenge.

ANCS built a strong network and partnerships mainly through their civil society capacity strengthening work. However, there is a need for better and more coordinated communication between actors working in similar areas of intervention. Learning should be shared around how to bring partners on board, how to help build and support coalitions, in a context where our programmes are on average 2 – 3 years old.

Senegal is very complex as far as gender is concerned. For example, some lesbians prefer to be identified as a sex worker rather than as a lesbian (unfortunately, there was no time to take this discussion further).

Innovations, Insights and Implications

Strengthening the capacity of MSM strengthens their response to HIV and AIDS.

KP groups are diverse and often enter into conflict with each other, but networks should insist on embracing diversity and representation.

Documenting and follow up on cases of human right violations is key, however ‘small’ they may seem. In Senegal, there was an example of a sex worker who was evicted by her landlord. When she refused to move, the case was taken to the media and she was exposed and arrested.

Organisations should have rapid response mechanisms in place for crisis situation (to access funding for example).

It is important to build a network with partners and civil society, and there is a need for improved communication between these and the LGBT organisations and learnings need to be shared between them. It is also important to consider religious groups as partners, and work with them.
**Summary**

H4M deploys a variety of strategies to successfully engage with different communities and different community needs. The use of technology (including mobile technology) to target MSM is key.

Indicators/key markers that accentuate sexual risk amongst MSM, include: age, socio-economic status, stigma, psycho-social affective status (e.g. homophobia, depression, lack of self-efficacy), location, mobility, etc.

H4M’s quantitative and qualitative research found that depression and self-efficacy are the two strongest indicators as to whether or not men engage in safe sex or not. This demonstrates that homophobia must be tackled as it has a direct effect on depression and self-efficacy, which in turn affect men’s risk taking during sex.

**Mobile Technology:**

- Site: H4M.mobi
  - Mobile messaging/marketing is easy, cheap, and quick. Making the information mobile makes it easier and safer to transmit (no pamphlets needed); 92% of internet users in SA own a smart phone – and over half of them have at least 1GB data each month. The mobile site gives information on where it is accessed from and is therefore able to geographically pinpoint MSM.
  - Site provides ‘passive’ information (e.g. health topics) as well as ‘interactive’ information (e.g. Q&A with health providers.)
  - Software: Site is ‘data light’ as internet is very slow in many parts of the country. It is code dynamic making it able to adapt to show different versions according to how advanced the phone is. It has a caching system, whereby, the domain details are stored on the device which reduces loading time after it has loaded the first time.
  - The site also includes SEO (search engine optimiser) results: 75% of site viewers come through word-of-mouth and only 25% through other site referrals (links through twitter, facebook, etc.)
  - Translating the mobile sites was important, and very challenging. (e.g. ‘lubricant’ is ‘oil’ in Swahili and therefore translating water-based lubricant and oil-based lubricant was impossible. New words were created.)
  - Contradicting research: Recent research showed that mobile phone technology is a ‘double edged sword’ as it increases sexual risk. (e.g. by connecting MSM and making them find and speak to each other). This type of research should be engaged with and not ignored. *We the Brave* campaign does exactly this.

**We the Brave (Elton John AIDS Foundation):**

- Unifying all the components into a campaign (technology, psycho-social indicators, word-of-mouth, etc.)
- Site: WeTheBrave.co.za
- The campaign has left graphic images behind and made the campaign completely word based (e.g. ‘I AM #BraveEnough’) in order not to scare away people who don’t identify with the images.
- Example: ‘We’re brave enough to chat up a smash in a shebeen. So we’re definitely brave enough to chat to a nurse in a clinic’. This banner would appear in a shebeen.
- Other examples can appear in Men’s Health magazine (not necessarily only gay magazines) and appear on the door of the bathroom, so they appear in different contexts and settings. This shows the integrated marketing approach used.
Discussion

We must keep in mind that graphics can be useful (e.g. when translating information in order to make sure the meaning is not lost). Regarding SMS messaging there can be social and legislative aspects that hinder people from signing up or accessing this service (using code wording when providing SMS services; ‘time to take your meds’ could be any type of daily activity like ‘time to walk your dog’ for people whom have not disclosed their infection). In countries where laws prohibit MSM information sites, nothing hinders them from accessing sites such as the above based in South Africa.

Innovations, Insights and implications

Research and marketing: Using a combined research approach (qualitative and quantitative) to target MSM is vital. Research shows that the two key markers (depression and self-efficacy) are more likely to indicate whether the MSM person engages in safe sex or not. Therefore homophobia must be tackled in order to promote safe sex. The use of an integrated marketing approach will increase the success of the campaign. The campaign should be carried out across various contexts and settings and through various media. Word-of-mouth should not be underestimated.

Mobile Technology: Usage of mobile technology hugely increases MSM accessibility. Various technological aspects are key to making mobile sites successful (e.g. user friendliness and software advances of the site). This also gives you information about viewers (such as geographical location) in order to pinpoint MSM people.

Targeting MSM: By making the marketing approach completely word-based, you eliminate the risk of scaring away MSM that do not identify with the graphic images that may be used. Also, it was found that more MSM were attracted by using STI (sexually transmitted infection) rather than HIV messaging.
4C - Innovations in Peer Education in Tunisia

Presented by Issam Grittli, ATL, Tunisia

Summary

This session highlighted the experiences of Issam Grittli, who was approached by a peer educator in 2005. Inspired by their courage, Issam himself became a peer educator in 2006 and got involved in the fight against HIV amongst MSM. Issam went from a beneficiary to a trainer.

In Tunisia, peer educators focus on strengthening prevention packages and supporting sustainability of the programmes. A combination of approaches are used – behavioural (participatory needs assessments, distribution of sexual and reproductive health [SRH] materials, community spaces), bio-medical (distribution of condoms and lubricants, HIV testing and counselling, referrals) and structural (targeting police, NGOs, media etc. about issues including stigma and rights).

One activity of peer educators is virtual prevention using social networks – this is one way to reach ‘hidden’ MSM. They also undertake a number of artistic activities such as dance, theatre, musicotherapy, painting and culinary art. These are opportunities to exchange ideas, role play and learn new skills. ATL peer educators also created a web radio addressing topics such as discrimination, homophobia, and sexual health etc.

Discussion

Participants were particularly interested in a number of innovative activities run by peer educators in Tunisia, including the legal clinics, web radio, invisible theatre, musicotherapy, and culinary therapy; as well as the motivation, recruitment and retention of peer educators.

Legal clinics involve collecting acts of violence from doctors or police. There are 15 lawyers/judges who volunteer and highlight the complaints. The role of peer educators is to make the service known by informing people that there is a legal clinic in order to strengthen the fight again HIV.

The web radio was created by a peer educator. It is informal and specifically for the MSM population. It is like virtual prevention. The sessions are facilitated by peer educators and include topics such as public health, stigmatisation and HIV prevention. There are over 100 listeners. Because it is online, it doesn’t cost anything to set up or run. The web radio is promoted through social media and word of mouth. The station can only be accessed online as these issues cannot be discussed on public radio.

Invisible theatre involves going in to a public space and start acting out a story, watching people’s reactions and explaining about HIV. This is done in spaces that are frequented by MSM and is a part of the sensitisation campaign. It is a type of prevention work in the street. Because these are community spaces reserved to MSM, they are confidential so there are some measures to preserve safety. There have not been any problems with police.

Musicotherapy offers a pleasant space to exchange ideas and feel comfortable. It enables people to express themselves differently, to feel more self-confident. It is a type of privileged expression.

Culinary therapy activities are financed by peer educators, they bring the ingredients. The association only offers the space and electricity. PLHIV can then sell their items.
With regards to motivating and retaining peer educators – ATL provides training and support. Peer educators attend all meetings and are involved at all levels, including developing new programmes. This is sufficient as a motivation. They are not remunerated. There are criteria for peer educators and a charter so everything is voluntary. ATL gives spaces that can be managed by peer educators themselves. This is what interests them.

**Innovation, Insights and Implications**

Many of the activities implemented by peer educators were seen as highly innovative, particularly the web radio. This was something that no one had considered using before. Similarly, participants felt they had much to learn from ATL’s experience with motivating and retaining peer educators. This was an area where all participants reported challenges. One strategy for addressing this was to provide incentives to at least cover out of pocket expenses, such as transport and offset opportunity costs. This requires incorporating a budget for peer educators into resource mobilisation efforts. However, it was also highlighted that retention is not just about incentivising, peer educators need to be supported in the work. They need training, supervision, role definition, recognition, appreciation and psycho-social support to help overcome the stress, depression and burnout that they can face. This appears to be a fundamental issue as they are the face and driving force behind many programmes. They know the field and how to reach the target group. In many contexts, volunteers are looking for remuneration and if they find something better they will move on. When this happens it is incredibly disruptive to program implementation, yet donors do not want to fund additional human resources.
5A – HIV Programming for transgender women

Presented by Leigh Ann, SHE, South Africa

Summary

SHE Background: Leigh Ann describes SHE’s journey as being ‘Over the mountain and around the bend’. Influencing policy making such as the Commission for gender equality (over the mountain) and engaging the community (around the bend). Historically, transgender Men often led the discussion on the transgender movement and therefore the Transgender Women felt the need to change the way that they engage in advocacy. SHE (Social, Health and Empowerment) is a regional collective of transgender women that identify with female issues, empowerment and creating a voice for transgender women.

Studies:
- Transgender women are incorporated into MSM research and surveys, therefore it is impossible to get correct data on Transgender Women.
- International research shows that transgender women have 49 times more chance of contracting HIV, and that HIV prevalence is 19% among transgender women worldwide (note: One must beware of international data when applied to Africa).
- 44% of transgender women in South Africa experience harassment and do not report it (according to Transilience Report).
- SWEAT data shows that there are approximately 4000-7000 transgender sex workers in South Africa.

Challenges:
Prejudice from family, intimate partners, community members etc. (i.e. cut off from inheritance, family rejection, homelessness, suffering psychological and physical violence) leads Transgender Women into sex work as it will acknowledge their ‘female’ side. They also have difficulty finding a legitimate job being a woman and owning a male ID. Sex work is criminalised so when Transgender Women are put in a male cell, this often leads to sexual violence and HIV transmission.

The major issue with interventions is retention in care and adherence to drugs, and SHE has found that using gender affirming care (psychological screening and referral to public healthcare for hormone replacement therapy) will lead to better retention of HIV infected transgender women. The programme also offers HCT (HIV counselling and testing) on-the-go.

Successful community efforts:
1. Support groups
2. Miss Trans Diva beauty pageants used to recruit transgender women and offer on-the-spot HIV testing and referral to ongoing care.
3. Trans Film Festival
4. Human Rights awareness dialogues with trans women and communities in which they live.
5. Arts and Culture Program: ‘Isini Sami Sesami’ (My gender is my gender!)
Innovations, Insights and Implications

Stigma: Self-identification is vital in the initial steps of interventions with transgender women. Much of the stigma towards transgender women often comes from within the LGBTI community and therefore community engagement is vital. Capacitation for transgender women should have transgender leading their own programmes, in order not to create community engagement problems.

Research: Research remains a major issue and as long as transgender women are not in a sub group of their own it will be difficult to implement any type of intervention without the correct research data. The research results prove inaccurate epidemiological data for both transgender Women and MSM, which in turn proves disproportionate allocation of resources to interventions in transgender groups. Research programmes (such as SANAC) should engage and consult directly with transgender women and the community. Research, programming and interventions should keep in mind that transgender women are not one homogenous group and must take unique needs and intersectional vulnerabilities into consideration (e.g. urban outreach, race, class, literacy levels, etc.). Inclusion of cultural elements should also be taken into consideration (e.g. beauty pageants and arts programmes). Cultural barriers such as cultural circumcision should also be taken into consideration in these phases.

Retention and care: The use of gender affirming care leads to better retention of transgender women. Through care and retention, we are also able to eliminate/decrease self-harmful acts (e.g. taking too many hormone pills at once, injecting silicone, etc.).
5B - M-Health Innovation: the m-Klinic  
*Presented by Dennis Wali, KANCO, Kenya*

**Summary**

In recognition of the need for effective and innovative KP programming to concur the HIV epidemic, KANCO developed m-Klinic – a digital platform for mobile health. The m-Klinic features a unique client coding system and works with or without internet connectivity, allowing for mobile based registration, referrals, reminders and public health notifications. See the the below figure for reference.

The session provided an overview of how the m-Klinic works from the KP client and health care provider perspectives (including clinical officers, outreach workers, lab technicians, pharmacists and HIV testing and counselling officers) by demonstrating the various user interfaces and admin menus. Having multiple user rights allows people to access only specific information and maintains client confidentiality. The use of unique client IDs mean that clients are still identifiable by the system even if they change phone numbers.

The m-Klinic is currently operating in a single health care facility but can be scaled up to other health care facilities and to include all KP groups (not just MSM) as well as the general public. However, it costs an average of 20,000 USD to set up a functional m-Klinic at any given centre, and approximately 10,000 USD to maintain the system for 500 clients per annum.

**Discussion**

There was a great deal of interest in replicating the m-Klinic in other contexts. The participants had a number of technical questions about how the system works and links with other systems such as off site health care providers, SYREX and the national database. Not all of these questions could be answered on the spot,
because they were highly technical; however KANCO is available for follow up for those wishing to pursue implementing such a system.

In general though, KANCO uses a mobile service provider who manages the architecture of the system – the technology side, while KANCO manages the health care centre where the system is implemented. At this stage the project is not at full scale. It runs out of KANCO’s drop in centre, where there is a small health facility. The clinical officers, outreach workers, lab technicians, pharmacists and HIV testing and counselling officers are all housed within the facility, so the paperwork is already within the clinic. In this way, MSM can engage with the pharmacist, for example, via m-Klinic without needing to produce a script or talk to them directly. At this stage the system does not interface with off-site health care providers. The system uses unique identifier codes to ensure client confidentiality, plus notifications just contain general information. HIV test results are not given by SMS.

**Innovation, Insights and Implications**

What makes the m-Klinic particularly innovative is that it works without internet connectivity and doesn’t require a smart phone. Clients receive real time updates and can receive an SMS update even without phone credit. The system can broadcast to all users at once and send automatic follow up reminders, which helps to eliminate drop out. The system connects to different types of health care providers and there are variable user types with different access levels to ensure confidentiality. Clients are uniquely identified; even if they change phone numbers the system still recognises them.

The m-Klinic is a partnership with a mobile provider who manages the technical side. Start-up costs are about $20,000 USD, plus $10,000 USD per annum to maintain the codes (for approximately 500 clients). KANCO pays this so that the service is free for users. The m-Klinic can potentially be scaled up to all health care centres and KP groups as well as the general public, but is quite expensive and depends on partnership with mobile partner. KANCO is currently documenting the efficiency of the project to see if it is a viable model for scale up.

In addition to health-related notifications, the system may have broader applications – for example, the technology may be able to support safety and security. However, M-Klinic is essentially a client management system, therefore repurposing it for other uses such as safety and security, would require significant redesign.

Any LOs considering adopting such a system should first conduct a cost-benefit analysis, as costs may vary considerably country to country; and unless one is working to scale, the investment may not be justifiable. However the potential value of such a system in the public health system could be great. KANCO’s analysis and learning from this pilot will be very valuable for advocacy in this direction.
5C – The Twafiika Story: My three year affair with multiple partners

*Presented by Flavian Rhode & Ricardo Walters, Positive Vibes*

**Summary**

Twafiika’s regional programme included 17 partner organisations across nine SADC countries. The programme offered what was described as traditional organisational development (OD); personalisation and internalisation of gender identity; technical skills building; and executive coaching and mentoring and exchange visits. See the figure below.

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**The essence of Twafiika objectives:** Capacity Development support aimed at strengthening LGBTI groups in Southern Africa through increased organisational capacity and enhanced and augmented knowledge and skills of LGBTI organisations and activists.

LILo workshops (the personalisation component of the programme) were highly appreciated effect and in general, all basic indicators were met. However the team embarked on a self-reflective journey at the end of the programme that allowed them to question how participatory the approach had been. They felt there had been a lack of success tracking the development process *beyond* the outlined indicators – was there a need for tracking improved practices and skills for effective organisation? Partners felt excluded from processes of design, strategy, representation and evaluation.

Set of standards to feature in every Positive Vibes (PV) Process:

- Management of projects should go beyond managing resources, timelines and budgets; it needs to extend to include relationships, vision, expertise and personnel.
- Allow adequate time at the start-up phase of a project, consultation, team formation (personality, conviction and fit).
- Address the gap between vision and implementation: team members need to ensure that ways of working are consistent with values and vision.
- Work collaboratively with partner organisations as partners – not service beneficiaries; partners hold valuable experience and expertise… Are we asking the right questions?
- Develop a measurement framework that outlines what success would look like; it should be an inclusive process (project success, partner success, PV success).
Discussion

Discussion focused on the importance of relationships, both with beneficiaries and donors.

Twafiika invested heavily in building and developing partnerships and one-to-one relationships. This process takes time and effort, but is essential to building trust. This was particularly important for uptake of the coaching and mentoring elements of the programme, which requires commitment from both sides.

Anita Simon from Positive Vibes, shared her Twafiika experience of how to measure competence. Competence is measured when you notice that you start to reach your goals, and we must accept that some people are simply not coachable.

The discussion went on to focus on broader questions about how to be genuinely participatory in a large programme and manage donors at the same time, as demonstrated by the following comments from ANCS in Senegal:

“*There has been a real evolution in partnerships the past 10 – 15 years. I remember in the past with ANCS it was a more egalitarian relationship, we spent more time assessing and identifying real needs. The current ‘project-donor-beneficiary’ culture has affected how we build and develop partnerships.*” (Massogui Thiandoume, ANCS)

“We need to question ourselves more, and question donors, challenge them. Do they know where these organisations are located, physically? Some are in places where projects cannot even be implemented. At what point do we compromise security for visibility? We need to bring donors closer to our work, e.g. involve them in some of our activities.” (Jean-Marie Moise, ANCS)

Innovations, Insights and Implications

It is vital to be open to critical learning, and this often means that we should be open about our mistakes.

When doing OD support we must understand the varying needs of different organisations at different levels and we must design OD to support this. For example, some organisations struggle with rent and salaries, police raids, safety and security, etc. so we need to be sensitive to real needs. OD and capacity building (CB) also mean different things to different people, and we must be clear on what we mean. Accompaniment must be considered as a significant part of the support provided. It is dangerous to assume that OD is about growth of an organisation.

Management should look beyond managing resources, timelines and budgets. Organisations need to equally focus on relationships, vision, managing expertise and personnel.
6B - Increased access of MSM to SRHR and HIV Services in Uganda

Presented by David Bitira, CHAU, Uganda

Summary

This session highlighted CHAU’s work to improve access of MSM to Sexual Reproductive Health and Rights (SRHR) and HIV services in Uganda. MSM have a higher HIV prevalence than the general population, lower testing rates and few health care facilities provide KP friendly SRHR/HIV services.

In order to reduce transmission, mitigate the impacts of HIV and improve the health of MSM, CHAU implements a number of KP programmes including SHARP, SRH4KP, and Link-Up. These programmes focus on KP and HIV stigma reduction and integrated service provision. CHAU works in collaboration with the Ministry of Health, 2 MSM CBOs, 3 advocacy partners, 8 IPs, 17 local governments and the police.

As a result, CHAU has conducted 120 KP targeted community outreaches; established 45 KP friendly corners and 3 KP dedicated clinics in regional hospitals; tested 40 MSM for HIV; distributed 164 IEC (information, education & communication) materials, 990 condoms, and 549 lubricants to MSM; and referred 253 MSM for expert services.

Discussion

Participants were interested to learn more about the context in Uganda, in light of the Anti-Homosexuality Act and safety and security issues.

In response to the Anti-Homosexuality Act, CHAU identified a group of people who were interested and/or affected by the Act – leading MSM activists, media personalities and lawyers, CSOs, etc. There was a number of lobbying activities. However, the Act was nullified on a technicality because it was passed without quorum. Otherwise it is unclear whether civil society would have been able to overturn it. Despite the Act
being overturned, the penal code still stands, and the environment remains hostile towards MSM. As Rodgers Ampwera from CHAU noted, “If this workshop was in Uganda, we would have been raided”.

Because of this hostility, CHAU works closely with police to inform them of the programmes and get buy-in, so that they understand who is targeted and why, and the role the police play. There are limited areas where MSM congregate and sometimes they are rounded up and arrested or suffer violence, making it necessary to involve police. CHAU organised learning visits for police to KP-friendly clinics so they are informed about their work. Since then, police have helped to identify a few other hotspots where MSM gather, and actually refer MSM for psychosocial support.

Procurement of commodities such as lubricants remains a challenge in Uganda. Such commodities cannot be accessed through the Ministry of Health. Lubricants are difficult to access, because they are seen as promoting homosexuality. Organisations can import them, if they make a case that lubricants are not only for MSM and should be distributed together with condoms. Individuals will often bring lubricants back to Uganda when they travel, so there are loopholes. But community demand is greater than the supply that peer educators have, which makes it challenging to meet clients’ needs.

Innovation, Insights and Implications

Whilst the political environment hinders smooth implementation of KP, especially MSM, programs, there is a disconnection between the political stance and the national health guidelines, which can be leveraged to justify the provision of services to KPs.

These programmes work within established structures and partners primarily using a public health approach along with a ‘low key human rights advocacy approach’.

CHAU targets MSM within a broader group of KPs (such as sex workers and fisher folk), which makes it safer for them to reach more MSM - because they are not explicitly named as a target group and can remain hidden within ‘KPs’. This approach may not be suitable in all contexts, were there may be compelling reasons to explicitly name MSM as target beneficiaries.

A number of security measures have been adopted including engaging with police, using codes for anonymity and restricting access to data.
6C – LEGABIBO Registration: Lessons in Litigation  
Presented by Anna Mmolai-Chalmers, LEGABIBO, Botswana  

Summary  
The focus of this session was on LEGABIBO’s court case aimed at claiming their right to register as an organisation. LEGABIBO’s application for registration was rejected in 2012 on the grounds that the Botswana Constitution does not recognise homosexuals, and that the organisation’s objectives are contrary to the Societies Act and incompatible with peace and welfare in Botswana.  

In response LEGAGIBO explored and exhausted all legally accessible channels. In November 2014, the Botswana High Court ruled that the government cannot deny registration of the organisation LEGABIBO. This success required a meticulous, long term, strategic approach and persistence in order to wage a protracted ‘war’ on multiple fronts e.g. legal, in the media, government advocacy, and community advocacy.  

Throughout the litigation process, it was particularly important that this remain a Botswana issue (addressing national legislation with Botswana lawyers), rather than an international issue.  

However, the most remarkable take away from the session was the extent to which societal perceptions of and acceptance of LGBTI individuals in Botswana appear to have shifted dramatically in a positive direction over the last 10 years.  

Discussion  
There was a discussion on the use of Botswana institutions as allies – but none have been forthcoming – the main allies were foreign embassies who did discreet lobbying. But nevertheless they had broad support both in parliament and legal circles.  

The main approach to litigation was not LGBT rights, but the constitutional right of all Botswana citizens.  

Most legal work done at full fees, so very expensive and would not have been possible without OSISA support.  

Subsequently, there were a number of discussions on how to change perceptions in the community. In Anna’s view this was to a large extent down to the work done by BONELA and LEGABIBO since 2002, work in the community, e.g. with the media, with tribal leaders, with the church etc. and very much being driven by / coinciding with the growth of a young, educated, urban middle class, but also supported by the strong traditional system for dialogue etc. The main opposition is the growing evangelical churches who have been directly involved in the court case and are the ones appealing the positive outcome.  

An interesting discussion ensued around how to pace progress in legislation in relation to progress in societal attitudes. At this moment LEGABIBO has won a remarkable legal victory basically having a verdict saying homosexuality is legal. This will likely be appealed and if an appeal is unsuccessful, laws could be changed as the verdict is ahead of changes in society. When explaining the verdict to a group of traditional leaders, the response had been “but this is terrible, we cannot have that in Botswana, then the law needs to be changed” – which is a very real option. LEGABIBO is discussing this and seemingly moving towards the conclusion of keeping a low profile for now and not be pushing the verdict hard in their media and advocacy work.
When is Litigation the right move?

The discussion was so popular that a small group (Geraldine, PV, Namibia; Anna, LEGABIBO, Botswana; Felistus, BONELA, Botswana; Samuel, GALZ, Zimbabwe; and George, TACOSODE, Tanzania) reconvened the evening, to discuss further “when is Litigation the right move?”

The advice from the Botswana team was that Litigation should be a very last resort. Should an organisation/person want to enter into litigation all alternative options such as meetings and negotiation should exhausted first. Litigation is a costly process – financially and in human resources and time.

George provided an example of two specific journalists who are constantly slandering the work his organisation does or reports inappropriately around KPs. The group provided suggestions of how to deal with these individuals – To contact the journalist and establish what their reasons are for negative media reporting and perhaps engage with them to provide insight around the issues KPs face and how negative media impacts the individual or alternatively to write a press statement and have it published in response to the negative media report. Other options are ensuring that the media house/journalist is reminded of their ethical conduct and code of ethics. Additional advice included training of media institutions and journalists or identifying a media ‘champion’ who can influence journalist or call them to order.

Furthermore, the group encouraged that before litigation, one should first way up the pros and cons. Given the costs involved, litigation can be risky if the case is to be dismissed. All possible alternative solutions should be exhausted before taking the next step to litigation. In fact, these alternative solutions can actually become part of the case motivation.

Innovation, Insights and Implications

The session highlighted that strategic litigation can be used successfully at the right point in time, when the objective is not too far ahead of societal attitudes and when there is a strong group of young litigants willing to stand up and out, and when approached the right way in terms of use of prominent national lawyers and going for a realistic goal.

Having won this remarkable victory, LEGABIBO needs to step back, not push too hard using the victory, but rather go more low key and work at the level of societal change until the conditions are ripe for further legal advances.

The advice from the Botswana team was that litigation should be a very last resort, and only pursued when all other options had been exhausted and when the time is right.
Thematic Synthesis

The Alliance Centre for Practice, based in Cape Town, convened a Synthesis Working Group to meet over the duration of the event, in order to reflect on content and identify themes emerging from the discussions, and opportunities relating to MSM/LGBTI-programming.

The Synthesis Group members were self-nominated, and included:
- Martin Silukena (SAT, Zambia)
- Rodgers Bande (BONELA, Botswana)
- Massogui Thiandoume (Alliance Centre of Practice, Senegal)
- Franck-Arnaud Amani Kouadio (ANSCI, Cote d’Ivoire)
- Irie Lou Tana Pauline Epse Yapi (ANSCI, Cote d’Ivoire)
- Warren Banks (Positive Vibes, South Africa)
- Patsy Church (Positive Vibes, South Africa)
- Shaun Mellors (Alliance Secretariat, UK)
- Glen de Swardt (Health4Mne, South Africa)
- Konan Amenan Lucile (ANSCI, Cote d’Ivoire)
- Victor Digolo (MAAYGO, Kenya)
- Flavian Rhode (Alliance Centre of Practice, South Africa)
- Ricardo Walters (Alliance Centre of Practice, South Africa)

The Synthesis Working Group met each evening and opened the LSE each morning to recap the previous day, reconnect with the content and each other, and inject some thoughts into group and set the scene for the coming day. See Figure 5 for some of the connecting group captured.
On the final day, Frank Arnaud (ANSCI, Cote d’Ivoire) presented on the themes, gaps and opportunities that emerged during the parallel sessions, as follows:

- **Pride** – in the good work we are implementing
- **Participation of KPs** – in programmes
- **Language** – the word MSM and how MSM perceive this word, the definition and implications of this word
- **Safety and Security** – How to implement actions that guarantee the safety of KPs
- **Confidentiality** – because of the vulnerability of KPs
- **Religious and cultural influence** – on KPs and KP Programming
- **Advocacy** was a Cross cutting theme – especially media advocacy
- **Partnerships** – how to use and create partnerships in our own programmes
- **Social transformation** – how to sensitise the media and police to change attitudes and norms
- **Community systems** – to implement advocacy within the programmes for KPs
- **Adaptability** – each country has a different context – how do you adapt programmes in those different contexts?
- **Combination approach** – Which strategies to reach 90% 90% 90% target?
- **PLHIV** – How to involve PLHIV within KP programmes
- **Transgender community** – is not always taken into account. We need to address this.
- **Funding** – There is less and less funding but we are still expected to reach goals and achieve results so how do we still deliver quality services within this context?
- **Mental Health** – We often forget the mental health of KPs and PSS
• **Youth** – We often don’t work with youth because they are underage but how do we provide services for them. Because their needs also need to be addressed.

• **Data for advocacy** – There are big gaps in data - but how do we use the data that we do have?

*Figure 6* – Gathering around the Synthesis Group Mapping

*Figure 6* shows the participants gathering around the synthesis group map. An in-depth analysis of these themes and the underlying gaps, tensions, and opportunities will be presented in the corresponding LSE 1 synthesis report.
Country Group Insights and Intentions for Change

At the end of each day, participants met in their country groups to discuss and reflect on a number of questions emerging from the day, such as:

- What was new?
- What was confirmed?
- What new questions do we have?
- What were our most significant insights from today’s sessions?
- Any intentions for change/action?
- Other notes

Then on the final day of the event, participants were asked to reflect back on the whole event to identify 3-5 of their most significant insights/learnings from this event; and 3-5 action steps they plan to take back home. Presented here (in no particular order) is a summary of the documented insights and intentions for change drawing on country group reflections from the whole event.

Insights

Safety and Security – cannot be assumed. It is a major concern in KP programming and requires an appropriate policy and practical implementation. This includes elements of human safety and data security.

- Safety and security should not be assumed but ensured
- A comprehensive security plan is necessary to improve and ensure security of staffs and clients involved in KP programs
- Even small processes like shredding of paper, computer passwords, limiting printing of documents enhance security of staffs and clients

Peer educators – are vital to the success of LGBTI programs and need to be appropriately motivated and supported through the operationalisation of a volunteer management policy.

- Motivations of peer educators are of crucial importance
- Peer educators as vital personnel in LGBTI programs should be valued and motivated
- Peer educators are critical enablers to the success of a project.

Transgender programming – was identified as a significant gap. The specific needs of transgender people are often not taken into account or integrated into programmes. The notion of *gender affirming care* was new to many participants.

Use of Technology – Several organisations presented on the innovative use of technologies such as social media, web radio and SMS for communicating with and mobilising communities. Many participants could see these tools being utilised effectively within their own context.

KP Involvement – Participants recognised the need for greater involvement of KPs at all levels of programming and decision making.

- Better involvement of Key populations in programming
- The imperative of involving Key populations in the National HIV response
- Centrality of beneficiary involvement in programme design and delivery.

Sensitisation, stigma and discrimination – Participants identified the need for ongoing sensitisation work with a broad range of stakeholders – including family members, police, religious leaders and non-medical staff who work in health care facilities.

- Do targeted work with relatives, families and aunties of LGBTI
Training of health care workers in KP programming as an important recipe to offering of quality health services

KP friendliness of services needs to not only target service providers but a wider range of key people including leadership and support staffs like secretaries and gate keepers

The big challenge is opening hearts and minds. People are KEY!

Involving Media - The media constitutes an important stakeholder and should be engaged not evaded to encourage positive reporting on MSM / LGBTI.

Media should be engaged not confronted in our advocacy programmes

Involving media in KP programmes can help change the messages they convey, and public opinion on KPs.

We cannot forward our agenda without media

The Power of Partnerships – The need for real collaboration and partnerships was identified as particularly important for KP programming.

Implementation of a multi-sector task force to deliver interventions for MSM/LGBTI

Sharing experiences strengthens the bonds between stakeholders

A need to ensure collaboration on best practices with partner organisations

Engaging traditional leaders, security leaders and community leaders at grassroots level to gain acceptance

Public Health v. Human Rights approaches – Many participants identified the value in using a public health approach to advance SRHR for KPs in hostile environments. However, for others, such an approach also presented a risk of depoliticising LGBTI rights. This debate was also evident in discussions surrounding the language of MSM versus LGBTI. Particular approaches and/or language may have more traction in different national contexts.

Advance Public Health approach in programming to increase access to HIV and SRHR services for Key population incorporating Human Rights approaches. This is particularly so in hostile environments.

Potential backlashes arising from fronting Human rights approach in HIV and AIDS programming for KP in hostile environment

The use of the term MSM in health programs is depoliticising LGBTI advocacy and negating gains made towards decriminalisation and social justice.

LGBTI language needs to make a significant shift. i.e. the use and understanding of the term MSM

Boldness in KP programming using the Human Rights approach as opposed to hiding under the cocoon on Public Health.

HIV prevention and treatment is the door way for the LGBTI movement and ensuring equal rights

HIV and human rights need for harmonisation

Research and data – Participants recognised the need for more national level data, including population estimates, to inform advocacy. This was also an area where the Centre of Practice was considered to have a potential role.

On-going sharing and learning – There is a lot of existing knowledge, which can be leveraged. We can learn from each other’s experiences. This is something that should continue between events.

Leveraging on the existing wealth of knowledge across organisations

Participants from the various countries and organizations are a pool of resource persons to learn from, move and cause change and improvement in KP programs
- Need for mechanism to regularly share good practices, research findings, and support one another in implementation of MSM and KP programs

**Change is possible and it's happening** – the many examples of great work demonstrated that change is possible no matter how hostile the environment. There are loopholes that can be exploited, pockets of friendliness and opportunities for incremental change. It may take time and require a long term, innovative and multi-faceted effort, but shifts are happening across the continent.

- I was again reminded of the importance of PERSISTENCE and long-term, focused work. Getting in position to do good work takes time.
- In hostile environments organisations are STILL existent and how they found loopholes in legislation and constitutions.

These insights correspond closely with the emerging themes identified by the synthesis group. In general, participants described each other’s’ work as inspirational and insightful and were impressed with what each had been able to achieve in their respective contexts.

**Intentions for change**

In response to these insights, participating country groups also identified a number of intentions for change, these include following up with particular speakers or other participants that they connected with during the event, learning more about specific tools and programs, and implementing concrete actions as a result of the learnings. These include:

- Developing or revising the safety and security policy (includes data security as well as human safety).
- Developing or revising peer educator/volunteer management policy (including reviewing incentives and motivations).
- Explore options for engaging with a wider range of stakeholders, such as the LGBTI family members, police, religious leaders.
  - Review programme design and implementation to include the family structure/support system
  - Contemplate the idea of involving religious leaders in our fight against HIV/AIDS
- Engage more proactively with the media to encourage positive reporting.
  - Advocacy and sensitisation among media leaders
  - Work with media on positive reporting about MSM and LGBTI issues
- Greater sensitisation for health care workers, including non-medical personnel, regarding the needs of LGBTI people, with a special emphasis on transgender people.
  - Key population training for health care workers and non-medical personnel working in public health centres.
  - Advocacy to health authorities regarding the needs of transgender people.
  - Trainings targeting health care providers to present more quality of services without stigma
- Integration of technology into prevention and outreach activities (such as Web radio and SMS)
- Adoption of the Syrex system for monitoring and evaluation
- Do more Lobbying with the parliament for law change
- Create spaces that allow KPs to be more involved in decision making
- Engaging Implementing Partners on the 90:90:90
- Identify new partners and strengthen existing ones
- Sharing experiences with other staff/partner organisations

Country groups will be followed up with in terms of their progress towards implementing their intentions for change.
Participant Feedback

At the end of the event a feedback form was distributed to participants to understand participant’s level of satisfaction with the event and identify any areas that worked particularly well or needed improvement.

The feedback form was completed by 36 participants (26 English speakers and 10 French speakers).

Participants were asked to rate their level of satisfaction (using a five point scale from very satisfied to very unsatisfied) with:

- the workshop process as a whole (presentation, translation, coordination etc.); and
- the event content (range of topics, knowledge of presenters, relevance etc.)

The former received an average score of 4.6, while the latter received an average score of 4.4 as per the Figure 7 below. Ratings were marginally higher for French speaking participants than English speaking participants.

*Figure 7 – Level of participant satisfaction in the areas of process and content*

Participants were most likely to describe their experience of the workshop as Inspiring or Interesting.

What participants found most valuable about the workshop includes:

The opportunity for learning and sharing with participants with diverse experience from diverse contexts:

- An opportunity to hear a diversity of voices and experiences.
- Ability to share, engage and understand what work is being done by partners and LOs. To be inspired by the incredible individuals who do this work!
- Hearing other experiences; meeting others – seeing various approaches to similar issues.
- The exchange of experiences and the face to face discussions with other participants.
- The content was characterised by the diversity of the subjects/issues.
- In my opinion, the most valuable thing was the exchange of experiences, and I understood that the needs are the same despite different contexts and that we can all benefit again depending on the context that we work in.
The whole workshop structure and design, especially, the parallel sessions and solutions exchange. These were found to be practical and participatory:

- The arrangement of the whole workshop – it was very interesting, inspiring and the topic was good as well as facilitators.
- Good pace and energizing, good amount of time dedicated to each parallel session.
- The manner in which all of the content was being delivered. The presenters were carefully selected and they empowered me with great knowledge on MSM/LGBTI and its importance in HIV/SRH prevention and treatment.
- The LSE is a good example of capacity building based on reflection and deeper analysis of what we are doing. Practical analysis allows us to improve and learn in a non-judgemental manner.
- The discussions regarding solutions exchange around problematic issues.
- Solutions exchange, questions that were posed. I found it practical because it was very concrete.

Collaboration between English speakers and French speakers:

- Great that the English Speakers and French speakers could work together!

Knowledge and resources which can be useful for programme implementation:

- Going home with a resource pack and interacting with different participants from across Africa.
- The different experiences and models being implemented in various countries that can be adapted to influence programming in other countries.
- Best practice sharing – filling the gaps of our programming within the decreasing and limiting funding resources.

Participants were asked to rate the extent to which they agree to a range of statements about the workshop (using a five point scale from strongly agree to strongly disagree), as follows:

- My expectations for the workshop were met;
- I feel as though I am able to/know how to access the support I need in order to take the next steps to explore further and/or implement new approaches to MSM/LGBTI programming in-Country;
- Emerging themes were accurately and adequately captured and reflected back during the process.

The average score for each statement was 4.4; 4.2; and 4.5 respectively (Figure 8). As before, French speaking scores were marginally higher than English speaking scores (with the exception of expectations, which was essentially the same).
Participants also provided some suggestions on what could be done differently during the next workshop, which focused on:

**Duration** – there were mixed perspectives here ranging from 3-5 days, but 3 days seemed to be most commonly preferred duration. It was also suggested that the event finish at 5pm each day.
- If you could expand the days of the workshop that will be fantastic because the issues were many and the days were very few.
- A 4 day conference is too long. 3 days would be ideal.

**Translation** – comments indicated that translation worked very well, and this is an area we should continue to invest in...
- Keep investing in translation – worked well.
- The excellent work of the translators should be noted. Happy about the translation of documents to understand and follow the sessions.

**Presentations** – presentations could be shorter to allow for more discussion; there could be greater quality control over the presentations – some were better/seemed more prepared than others; presentations could be filmed so people don’t miss out on concurrent sessions.
- Check quality of presentations and limit time for presentation versus discussion
- Ensure that all parallel sessions are filmed to allow for other participants not in that session to review later and benefit from.
- Perhaps tighten some of the power point presentations in advance.
**Overall format** – In general, participants were very happy with the overall format and methodology of the event, but suggested including a formal welcome and/or social/dinner function next time and perhaps extending the market showcase, having more informal sessions, adding a panel discussion or repeating some parallel sessions so that no one missed out on anything.

- Great effort by the PV and KP Connect team! Impressive prep and support provided, well facilitated and great content!
- It was great. I liked the methodology of the workshop.
- Next time, have a get together dinner to allow for [interaction at a] personal level and get out of leadership role. Otherwise it was a great show!!
- Having a half day of the market showcase where each country can show the work they are doing in depth.
- The workshop format was good but if we could add a panel discussion with panellists touching on specific themes it would be good.
- Although the breakaway sessions were great, I felt that I needed to divide myself as most if not all were meaningful.
- Have a double slot for peer learning sessions so as to allow participants to benefit maximally if they had missed the session (some interesting sessions happened concurrently and we missed some).
### Appendix 1 - Participant List

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<thead>
<tr>
<th>Name</th>
<th>Surname</th>
<th>Organisation</th>
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<tbody>
<tr>
<td>1 Carsten</td>
<td>Norgaard</td>
<td>Positive Vibes Windhoek</td>
</tr>
<tr>
<td>2 Cecilia</td>
<td>Horsten</td>
<td>Positive Vibes Durban</td>
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<td>3 Pernille</td>
<td>Madsen</td>
<td>Positive Vibes Nairobi</td>
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<td>4 Warren</td>
<td>Banks</td>
<td>Positive Vibes Brisbane</td>
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<td>5 Sylvie</td>
<td>Pawele</td>
<td>Positive Vibes Windhoek</td>
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<tr>
<td>6 Katie</td>
<td>McDonald</td>
<td>Positive Vibes Cape Town</td>
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<tr>
<td>7 Casper</td>
<td>Erichsen</td>
<td>ORN (Out-Right Namibia) Windhoek</td>
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