SPEAKING OUT

TOOLKIT
FOR MSM-LED HIV/AIDS ADVOCACY

The Global Forum on MSM and HIV (MSMGF) is an expanding network of AIDS organizations, MSM networks, and advocates committed to ensuring robust coverage of and equitable access to effective HIV prevention, care, treatment, and support services tailored to the needs of gay men and other MSM. Guided by a Steering Committee of 20 members from 18 countries situated mainly in the Global South, and with administrative and fiscal support from AIDS Project Los Angeles (APLA), the MSMGF works to promote MSM health and human rights worldwide through advocacy, information exchange, knowledge production, networking, and capacity building.

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INTRODUCTION

This toolkit has been created to fulfill a dire need that exists for men who have sex with men (MSM) everywhere to engage in advocacy locally, nationally, and globally as a means to end the HIV epidemic and to secure fulfilling, meaningful futures. The need is urgent, as the burden of the epidemic continues to disproportionately affect MSM communities across the globe. The toolkit equips individuals and organizations with tools and techniques that enable them to become advocates right now, whoever and wherever they happen to be. A thread that runs through all the exercises in the toolkit is a fundamental belief in the capacity and vibrancy of MSM communities everywhere, and that when properly channeled, their energy can make meaningful and sustainable social change.

Now, more than ever, it is important for MSM communities to identify their own strengths, weaknesses, and needs, and to self-advocate as individuals and collectives for their rights in ways that work particularly for *them*. There are so many facets to the multiple ways in which MSM communities live and breathe, and it is up to these same communities to begin raising their voices on their own terms, from their own particular contexts. That is what this toolkit is all about: empowering MSM communities with the tools to become more involved in advocating for their rights, in their homes and schools as well as in government and global forums.

This toolkit is built upon other toolkits, with some key differences: (1) it is specifically MSM-focused with exercises and ideas that serve as conduits for MSM community energy and contribution; (2) it believes that organizations can start where they are, and assumes the skill sets and organizational maturity of MSM individuals and groups are wide-ranging and take time to develop; and (3) it approaches HIV/AIDS from a broad human rights framework, balancing public health and human rights approaches toward addressing MSM community susceptibility to HIV.

Intended audience

This toolkit is designed for MSM and MSM supporters who would like to incorporate MSM-related advocacy into their current work. It assumes at least some of the participants in the trainings based on this toolkit will have basic literacy skills. It also assumes they will have a rudimentary understanding of what advocacy means; however, the toolkit has the potential to stand as an introduction to advocacy with minor supplementation with other sources. The toolkit's exploration of advocacy as it relates to MSM and HIV in particular is a new approach, and therefore participants should expect their current definitions of advocacy to be challenged and enriched.

As the HIV epidemic is making a disproportionate impact in the Global South, and MSM in those areas have been found to have less access to services and often face hostile circumstances when seeking HIV-related information and support, this toolkit is designed to reach MSM in low-and middle-income countries making a careful attempt to address the unique challenges in those particular contexts.

Although there are undeniable differences across MSM culture between countries and, in some cases, within the same cultural and geographical context, the toolkit is designed to be selectively applicable across a wide spectrum of locales. If some exercises or chapters are not relevant to a particular context, toolkit users are encouraged to skip around, and to use what works best in their particular circumstances.

How to use this toolkit

The toolkit is like a cookbook, offering a range of recipes for action that orient participants to core concepts with ideas for building advocacy campaigns wherever they are. It is divided into 3 main sections: (A) an overview of advocacy; (B) a group of 5 topic areas that serve as potential advocacy foci, namely investment, services, stigma and discrimination, research, and civil society and networks; and finally (C) 2 chapters with a special focus on working with international human rights mechanisms and working in hostile environments. Each chapter is followed by a list of related resources in the event that groups would like to pursue the topic in more depth. In addition, there is also a set of annotations for the step-by-step advocacy skill cards found in The HIV/AIDS Alliance's Advocacy in Action[1] toolkit, presenting each advocacy skill in light of MSM-specific concerns and challenges. The chapters present information in an interactive format, in a manner that is intended to build upon community strengths and latent skills.

The toolkit should be used to craft a facilitated training. It can be used in a multi-day training, or shorter half-day or full-day training. However it is used, it is intended to introduce information in a manner that is both interactive and accessible. It is suggested that facilitators include an overview of advocacy, as well as review of the annotated skill cards, which provide an orientation to the various

concrete steps and processes through which an advocacy campaign is run. The other sections of the toolkit are focused on specific advocacy topics (eg, investment) and can be selected and used according to particular need.

Note to the facilitator

The exercises in this toolkit are of an extremely sensitive nature, taking up concepts and issues that will likely reach deeply into the personal lives of training participants. It is very likely that some of the concepts will run against the grain of socially and culturally sanctioned norms in the contexts where the trainings are held. It is crucial, therefore, that the information be presented in a format that is both comfortable for participants and sensitive to their particular circumstances and personal situations. Some of the exercises call upon participants to share personal information, which may be unpleasant or difficult for them to recollect and share. Some groups may not have a highly developed degree of capacity to carry forward many of the activities presented in the toolkit. It is the job of the facilitator, then, to strike up a workable balance and cover and present material in such a manner that participants will feel inspired to take forward advocacy work with whatever skills they *do* possess. It is also very important to note that this toolkit is just a beginning to a successful advocacy campaign, and that advocacy work is a process that takes time and energy over an extended period. Participants should leave the training inspired, but also with a realistic sense for advocacy's multiple processes and sometimes slow-going nature. It is suggested that individuals who have had some degree of experience leading trainings relating to HIV, AIDS, and MSM facilitate the training. If not, facilitators should prepare with the help of materials like the ones listed on the next page.

Ground rules

It's recommended that all facilitation sessions begin with a group discussion of ground rules to ensure a safe space. These should be written out clearly on a large piece of flipchart paper for the whole group to see and discuss. Review the list and ask the group for any further suggestions. Before beginning the training, ensure the group has understood and agreed to these principles.

Suggested ground rules:

≫ Confidentiality – What is said in the room, stays in the room.

≫ Respect – Do not interrupt others; speak for yourself (use "I" statements) and use constructive statements only (no "put downs").

≫ Right to pass – In roundtable discussions, participants may "pass" if they wish.

> "Step up, step back" – Allow for all of the voices in the room to be heard; if you find yourself speaking often while others are silent, encourage their participation by letting others speak.

Resources for facilitation

There have been a number of comprehensive guides to facilitating trainings in other places. It is suggested that facilitators go to these resources and prepare before leading a training:

The Naz Foundation (India) Trust. Training manual: an introduction to promoting sexual health for men who have sex with men and gay men. http://data.unaids. org/Publications/IRC-pub07/jc901-msm-asiapacific_en.pdf. Published 2001. Accessed on July 5, 2010. **See pages 1–6**

Pact Inc. and the International Center for Research on Women. Understanding and challenging stigma toward men who have sex with men: toolkit for action. Adapted version for use in Cambodia. http://www.icrw.org/files/publications/ Understanding-and-Challenging-Stigma-toward-Men-who-have-Sex-with-Men-Toolkit-for-Action.pdf. Published 2010. Accessed on June 23, 2010. **See pages 12–24**

International Planned Parenthood Federation. Handbook for advocacy planning. http://www.ippfwhr.org/en/advocacy_planning_manual. Published 2010. Accessed on July 5, 2010. **See pages 17–23**

1 **ADVOCACY**

A common theme across definitions of advocacy is an engagement with power structures to bring them into better service of communities that need their support. Citizens and communities touch leaders and policy makers to make positive change happen. Advocacy is a particularly powerful and meaningful tool for communities that have been systematically excluded and underrepresented, like MSM communities.

The International HIV/AIDS Alliance defines advocacy in the following way: "Advocacy is speaking up, drawing a community's attention to an important issue, and directing decision makers toward a solution."[1] The Latin American and Caribbean Council of AIDS Service Organizations (LACCASO) describes the key element of an advocacy campaign as commitment.[2] Advocacy is also a powerful tool that can yield positive social change, as well as community collectivization and systems strengthening as by-products. Whatever the result of individual advocacy campaigns, the process is always valuable.

Advocacy interventions ensure that MSM are perceived as an integral part of the solution to the HIV epidemic, not mere vectors of transmission. For MSM- and HIV-Related advocacy projects, long-term goals can include a review of current laws and drafting new legislation for rights protection—just as the Blue Diamond Society did in its successful submission of a petition to the Supreme Court of Nepal. This may also include repealing anti-sodomy laws, thereby legalizing sex between men, as was recently accomplished in India with the reading down of Indian Penal Code Section 377. More short-term goals might include lobbying with the country's health minister and AIDS control mechanisms for inclusion in program services and affirmation of the rights of MSM. Projects can be local as well.

This chapter of the handbook is composed of 9 exercises geared toward orienting participants to what advocacy means, some key skills for getting started on exploring advocacy as an action direction, an overview of the unique challenges advocacy work presents for HIV/AIDS and MSM, and a listing of resources for those who would like to explore advocacy in more depth. The scope of this toolkit does not allow for a full introduction to advocacy, nor is that the intention, as

many such introductions already exist (please see Advocacy Resources section). Instead, it seeks to give participants a taste for the advocacy processes, to begin the process of brainstorming around identifying issues and target populations for advocacy in their locales, and to provide direction and resources for taking larger-scale projects forward. Participants should consider running similar facilitated discussions in their own areas.

An advocacy campaign can be described as being composed of a common set of core steps, with some variation here and there in different conceptualizations of the advocacy process. This toolkit does not attempt to provide a comprehensive introduction to each of these steps; rather, it prioritizes a set of steps that can get communities started immediately on their own campaigns. It goes into just enough depth to give participants a feel for the processes and skills that comprise advocacy, recognizing that they will most likely want to follow each step more comprehensively over the course of their actual campaign. The toolkit provides direction to the resources required for them to do so. They key advocacy steps *not* covered in the toolkit are collectivization and monitoring and evaluation. The toolkit assumes that the training participants will have some degree of affiliation with an organization already, and that once their advocacy project is off the ground they can seek out resources for monitoring and evaluation independently.

Key points:

> MSM are integral to ending the HIV epidemic

> Fear, silence, and homophobia drive the HIV epidemic

> Advocacy is possible wherever and whoever you are

> Advocacy can happen *right now*—start where you are

Chapter goals:

Upon completing the exercises in this chapter, participants will be able to:

> Define advocacy

> Map local challenges

> Identify primary and secondary causes and effects of identified challenges

> Map local power structures

> Define and identify viable advocacy targets

> Explore specific fears and challenges relating to MSM-related advocacy

> Build a vision of a successful advocacy campaign in their locality

> Complete a self-assessment and identify preexisting community strengths and skills

> Develop advocacy plan for immediate action

EXERCISE 1.0

WHAT IS ADVOCACY?

1.0

Purpose:

Participants develop an understanding of what advocacy is through some concrete examples of the various shapes it can take.

Goals:

At the end of the exercise, participants will be able to:

> Articulate a definition of advocacy

> Cite a specific example of advocacy in action

> Understand the difference between advocacy actions and targets

> Differentiate between individual and systemic advocacy

Materials:

> *New York Times* article (Handout 1.0)

> Advocacy case studies (Handout 1.1)

Process:

① Facilitator gives background:

Tiwonge Chimbalanga and Steven Monjeza, who were sentenced to 14 years in prison and hard labor under Malawi's anti-sodomy statute, were recently pardoned. Discuss the role that advocacy played in this situation, and its potential for making positive social change.

② Break into smaller groups and distribute Handout 1.0. Have each group address the following questions:

> What specific examples of advocacy are explained in the article?
(letter writing, personal meeting)

> Who was the target of the advocacy?
(Malawi president—decision maker)

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> Who were the agents of the advocacy (ie, who carried out the advocacy work)?
> (celebrities—Madonna, Sir Elton John, UN; other players who weren't mentioned in this article?)

> Was there public support for the court's decision to jail the 2 men?
> (no—and yet, there was still a positive result)

> What are positive immediate effects of the advocacy? What are some potential far-reaching positive effects?
> (negative public response at first, potential to set example on a global scale)

> What are some potential negative effects?
> (Tiwonge and Steven may face backlash as individuals)

> The job doesn't stop here. What other efforts might be implemented in Malawi to prevent this from happening again?
> (work to change the law criminalizing same-sex acts)

③ Bring the group back together and facilitate a discussion. Points to mention:

> Advocacy works

> Effective advocacy efforts have clear targets—in this case, decision makers are targets of advocacy because they had the power to release the couple

> Results of advocacy can include wide-reaching change; in this case, individuals were freed, but decision serves as an example to other countries

> Involved multiple people: Madonna, Sir Elton John, Ban Ki-moon, and other players not mentioned in this article

④ Defining advocacy through case studies:

Divide the group into small groups again. Distribute Handout 1.1.

Questions for discussion:

> What policy level did the advocacy occur on? What are some other levels that could be advocacy targets?

> What kinds of problems were addressed in the case study examples?

> What different approaches to advocacy work were described?

> Why was advocacy used in the situations described?

> Who benefited from the advocacy work?

> Were those people involved in the advocacy work?

> What were some of the key verbs used in the presentations to describe advocacy?

Lead a group discussion about what has been learned, based on the handout questions.

(5) Write a definition of advocacy on a flipchart:

Advocacy must have 1 or more decision makers as its target audience.

Advocacy must have change as a goal, and such change must be attained through a decision made by the target audience[3]

Advocacy verbs:

Increase – Raise – Decrease – Reduce – Expand – Enlarge – Improve – Refine – Reinforce – Promote – Strengthen – Change – Modify – Elaborate – Create[2]

FACILITATOR NOTE:

Differentiate between individual-level advocacy (eg, speaking out to get an HIV test for an individual) and systemic advocacy (eg, pressuring key decision makers for increasing availability of confidential HIV testing sites).[4]

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1.1

MSM & LOCAL CHALLENGES

Purpose:

To introduce participants to the process of local MSM community issue identification. This goal is not to generate a comprehensive list but to give the group a basic grasp of the identification process. Prompting questions directs the group toward MSMGF key directions. A more in-depth exploration of problems and solutions as they relate to HIV prevention and care will occur in the services section. [5]

Goals:

At the end of the exercise, participants will be able to:

› Understand what makes an issue viable for advocacy

› Generate 3–5 core local issues that are viable for advocacy

› Group issues into broad categories

Materials:

› Alliance toolkit drawings

› Handout 1.2

Process:

① Divide the group into small groups and distribute illustrations and Handout 1.2.

② Ask the groups to reflect on problems and challenges relating to MSM in their own communities.

Mention that they should not feel confined by the examples in the illustrations and questions, and should include examples that may not be depicted as well. They should identify 3–5 core issues. Have each group write each of the issues it uncovers on a post-it note or separate piece of paper. This will facilitate sharing.

③ Come together and share issues.

Collect the post-it notes or papers from participants and group them according to the following categories: investment, services, stigma and discrimination, research, and networks. Do not feel confined by these 5 categories, and affirm problems/issues surfaced that do not fit neatly into them.

FACILITATOR NOTE:

When grouping the core issues this exercise surfaces, keep in mind that the focus should remain on issues that are appropriate for advocacy work. The core criteria for determining whether the issue is an appropriate one for advocacy work are:

• Will a solution to this problem or issue result in a real improvement in people's lives?

• Is this an issue or problem we think we can resolve?

• Is this an issue or problem that is fairly easily understood?

• Can we tackle this issue or problem within the resources available to us?

• Is this an issue that will not divide us?[6]

Registering your organization officially as a society or charitable trust is a powerful act of advocacy. Making organizations "official" through registration does 2 things:

(1) it lends organizations official credibility in a manner that can bolster future projects and work; and

(2) it forces local government to recognize the legitimate existence of MSM collectives, which is often ignored or denied. Organizations should also consider official registration as most funding agencies require grant applicants to furnish a registration number.

1.2

EXERCISE 1.2

IDENTIFYING CAUSES AND EFFECTS

Purpose:

To introduce groups to the process of analyzing a problem's causes and effects, and to use this information to develop advocacy initiatives. Extra emphasis will be given to community problems and their connectedness to HIV risk, as this may not be immediately obvious to participants.

Goals:

At the end of the exercise, participants will be able to:

> Identify causes and effects of issues

> Differentiate between primary and secondary causes and effects

> Make connections between effects and HIV risk

Materials:

> Handout 1.3

> Index cards

> Tape

Process:

(1) Divide participants into small groups.

(2) Assign each group a problem (from those identified in Exercise 1.1).

(3) Ask each group to think of the problem as the body of a person.

Explain that the legs represent the foundation, or causes, of the problem; the torso represents the problem itself; and the outstretched arms represent the problem's effects. The knees provide divisions between the immediate and underlying causes, and the elbows provide divisions between primary

and secondary effects. Ask participants to organize their responses in 2 tiers: primary and secondary effects and immediate and underlying causes, as they are in the diagram in Handout 1.3.

4) Write the problem on an index card first, and tape that to the stomach of a volunteer from the group.

The immediate and underlying causes should be written on cards and taped to the legs above and below the knees, and the primary and secondary effects written and taped to the arms (outstretched upward) above and below the elbows.

5) Each group should present their problem analysis to the group, with their volunteer standing with cards taped to their body as a visual representation.

6) Facilitator should explain that advocacy should target the core causes of problems in order to be effective.

Explain that in many cases, different problems share the same root causes (give examples from this group, if they apply). Identify the root causes as the piece of the puzzle to which advocacy can be applied for making positive change, and name them "advocacy issues." Explain that core problems are not always the same as the "advocacy issue" that can lead to their solution.

FACILITATOR NOTES:

1. Ensure that HIV transmission is listed as a second-tier effect (ie, placed on the torso), because it is the symptom of another issue (ie, homophobia, discrimination, lack of HIV-related services, etc). Highlight the way multiple root causes can contribute to HIV risk.

2. See the problems/effects through the lens of the 5 MSMGF groupings (investment, services, stigma and discrimination, research, and civil society and networks), when suggesting solutions.

3. Encourage participants to see ways in which the MSM community may actually contribute to these problems; and how they can avoid this and maximize their strengths to help solve them.

1.3

EXERCISE 1.3

IDENTIFYING ADVOCACY TARGETS – WHO MAKES THE DECISIONS? WHO HELPS THEM?

Purpose:

To introduce participants to the concepts of power mapping and primary target and secondary target identification for advocacy work. This exercise highlights the importance of approaching problems from multiple directions, and illustrates how advocacy involves multiple options. Specific examples will touch upon HIV services for MSM.[5]

Goals:

At the end of the exercise, participants will be able to:

≫ Analyze their local power scenario vis-à-vis identified advocacy issues

≫ Differentiate between the multiple players comprising the pyramid of influence

≫ Draw connections between advocacy issues and power structures

Materials:

≫ Handout 1.4

Process:

① Break into groups and have each choose an advocacy issue to be analyzed (ie, social discrimination against MSM; laws criminalizing same-sex acts; lack of MSM-specific services in clinics and in the national AIDS strategy, etc). If possible, use the issues surfaced from Exercise 1.2 ("Identifying Causes and Effects").

② Explain that once advocacy issues have surfaced, it is critical that groups identify the power structures that support their regulation and enforcement.

③ Identify the decision makers who have the actual responsibility to make the decisions to change or address these problems. Then identify the opinion leaders who can influence these decision makers.

④ All policy makers depend on a group of advisers or specialists, without whom they cannot operate. They make decisions based on advice they receive, the political regime around them, and their own beliefs and ideologies. They may also listen to interest groups, constituencies, lobbies, and donors. Furthermore, they may be influenced by the information they receive in the media, and more importantly, how it is reported.

⑤ Map the information as a pyramid of actors and influences using the handout provided. Example:[5]

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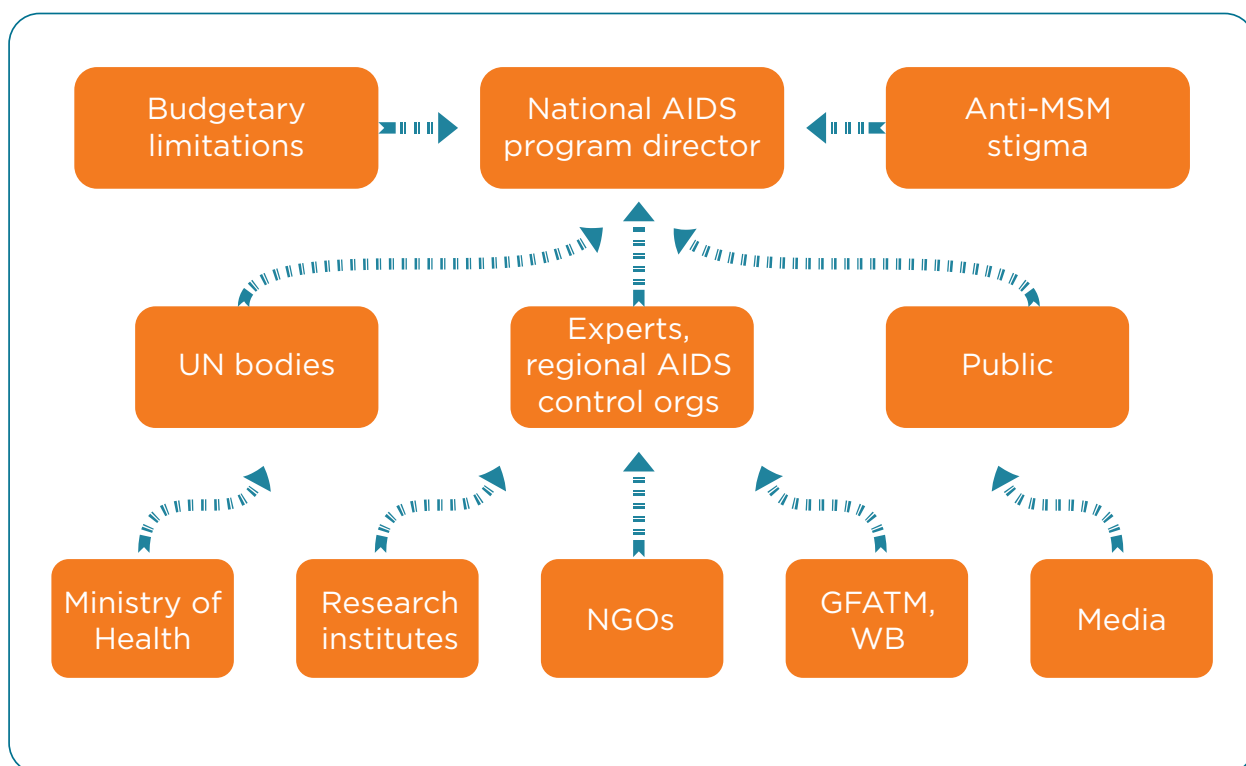
1.4

POWER ANALYSIS

Purpose:

To systematically prioritize targets for advocacy based on a set of criteria.[5]

Goals:

At the end of the exercise, participants will be able to:

> Understand the key factors for determining potential advocacy targets

> Prioritize advocacy targets in their own locales

Materials:

> Handout 1.5

Process:

(1) Once the key power audiences have been identified, the group members should analyze their positions on MSM, their key motives and their accessibility. Distribute Handout 1.5 and ask participants to fill it out to the best of their knowledge.

(2) Facilitate a short discussion about the audiences identified. Questions should include: Are they MSM supporters, allies, or uncommitted? Might they be afraid of the MSM issue? Why do they have the stance on MSM that they do? What is their agenda, either stated or implicit? What constraints do they face that might make it difficult for them to move from their position on MSM? These may be ideological or personal, cultural or social. They might be financial (eg, for monetary gain) or political, based on the views of their supporters, patrons, and voters.

(3) Assess how easy it will be to gain access and present the evidence or case. Which actors or influences would be difficult to convince on your issue, and why? Which may be easier to approach, and could be effective influences? Bring out interesting and new angles and approaches (eg, by linking your issue with their priority concerns).

(4) Create a list of individuals in the community who possess influence and garner local respect, such as local political leaders, businesspeople, and religious leaders. Do you know any of them personally? These people are powerful entry points.

EXERCISE 1.5

ADVOCACY MEDIUM, POTENTIAL CHALLENGES AND FEARS

1.5

The "advocacy medium" is the specific action used to deliver an advocacy message. Please see the annotated list of skill cards[1] at the end of the toolkit for an example of the many shapes an advocacy medium can take.

Purpose:

To introduce the range of advocacy media that can be used once an advocacy objective and target audience have been identified. Also, to address fears and apprehensions participants may foresee as the concept of an advocacy project crystallizes and becomes more tangible.

Goals:

At the end of the exercise, participants will be able to:

⟫ Understand specific examples of the forms advocacy messages take

⟫ List examples of specific challenges advocacy can pose to MSM communities

Materials:

⟫ Flipchart

⟫ Markers

⟫ Advocacy skill sheets

Process:

(1) Make a list of the advocacy media at the end of the toolkit. These are:

⟫ Analyzing and influencing legislation or policy

⟫ Preparing a briefing note or position paper

⟫ Working from inside the system

⟫ Lobbying or face-to-face meetings

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> Writing and delivering a presentation

> Persuading through drama

> Working with the media

> Using the Internet

(2) Explain the concept of an advocacy medium to the group, referring to the examples above, which you have written down on a flipchart. Explain:

The advocacy medium is the third part of an advocacy campaign, in addition to the advocacy message and advocacy target. The medium is the action through which the message is delivered.

(3) Break the group into smaller sections and ask them to identify potential advocacy media for approaching their identified target audiences. Facilitate a sharing session, wherein participants explain the medium they have chosen for their particular advocacy problem/target and the shape they imagine their campaign would take.

(4) Ask the participants about specific challenges they foresee or apprehensions they may have when they think through approaching their advocacy target with the chosen medium.

These might include:

Advocacy-Related Challenges[3]

> Countries often do not observe laws; hard to hold governments accountable

> Politics can be regarded as cheap and dirty; politicians feel no need to be accountable

> Highly controversial issues; decision makers wary of getting involved

> Antagonizing powerful groups is intimidating; potential loss of support or funding

> Increased work for NGO; staff and individuals are already overcommitted/stretched

> Increased visibility for NGO not always ideal, especially in environments hostile to LGBT issues

> Increased stigma and discrimination for members if they are seen to be publicly advocating on tough issues

MSM- and HIV-Related

> Dealing with institutionalized homophobia

> Stigma and discrimination—double for HIV and MSM

> Criminalization—risk of fines, penalties, imprisonment

> Internalized homophobia

> Risks associated with public exposure—many MSM are closeted

> MSM identity—not everyone has one—some MSM are hidden from everyone but their partners

5 Role play: devil's advocate. Ask participants to pair up. One member of the pair will play advocate, and the other will play the role of skeptic. The skeptic will mention the challenges associated with advocacy, and the advocate will speak to each challenge explaining (1) why it is worth attempting to face the challenge and (2) ways they will manage the challenge. For example:

Role player A: Countries don't even observe laws! Especially when in comes to MSM. Why bother? Even if the law changes, it won't help anything.

Role player B: You're right that it countries do not always observe laws; that is why advocacy is important, because it isn't only about changing laws but it is also about holding governments accountable. We are planning on documenting breaches in policy by local government officials as a means to hold the government to task. If we don't do it, who will?

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MAKING HEADLINES (VISIONING EXERCISE)

Purpose:

To assist groups in building a vision of what successful advocacy could look like in their locales. This will build enthusiasm and confidence for achieving a long-term goal.[7]

Goals:

At the end of the exercise, participants will be able to:

> Build a vision of what a successful advocacy project might look like in their area

Materials:

> 3–4 newspaper front pages with main headlines cut out.

Process:

1. Divide the participants into small groups.

2. Explain to participants that commitment and vision are extremely important components of a successful advocacy campaign. Based on their identified issues, advocacy targets, and advocacy medium, ask them to project 1 year into the future and envision a positive advocacy result relating to MSM and HIV in their local context. Explain that their work was so successful it has made national headlines!

3. Tape the local newspaper (with the main headline cut out) to the wall or flip-chart for each group.

4. Once the group members have deliberated, they should write the headline and the first paragraph of the accompanying story of their achieved target.

(5) Ask each group to select a representative to present its headline and story to the group.

(6) Lead a group discussion on the headlines produced. What kind of commitment does each individual/group feel will be needed in order to achieve this headline? How can we help support each other and our collective movement in achieving these goals? What are some of your own/your organization's biggest "headlines" or achievements, and what were the critical factors that helped get you to this victory?

Advocacy Success Stories

The following are real headlines that represent advocacy at work:

India penal code
http://www.hrw.org/en/news/2009/07/02/
india-court-strikes-down-sodomy-law

OAS rule
http://www.hrw.org/en/news/2008/06/05/
oas-adopts-resolution-protect-sexual-rights

Columbia
http://www.hrw.org/en/news/2008/04/17/
colombia-court-extends-benefits-same-sex-couples

Egypt
http://www.hrw.org/en/news/2003/07/21/
egypt-homosexual-prosecutions-overturned

Texas
http://www.hrw.org/en/news/2003/07/01/lawrence-v-texas

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SELF-ASSESSMENT

Purpose:

To have the participants assess the collective skills they possess as a group and see them in the context of skills required for launching an effective advocacy campaign. The importance of this lesson is helping groups to come to the realization that they can start with what they have, where they are right now.[2]

Goals:

At the end of the exercise, participants will be able to:

> Self-assess skills and understand strengths and weaknesses

> Articulate examples of skills that are useful for advocacy

Materials:

> Paper

> Markers

> Tape

> Music

Organizational capacity building is a key ingredient for community-based groups. We never reach a point when we're "done"—there is always scope to grow and improve. And the stronger we are as organizations, the stronger we are as advocates. Check out resources at the end to help in systems strengthening.

Process:

(1) Divide the group in half.

(2) Choose (a) or (b)

(a) For groups of people who know each other:

Ask the participants to face each other in a circle (ie, 2 circles, 1 inside the other facing each other) or in 2 lines (ie, one-half in front of the other). Each participant is given a piece of paper, which they will write their name on and tape to their back, and a marker.

The facilitator will designate the amount of time for each person in the outer circle to spend with each person in the inner circle (ie, 2 minutes). The facilitator will start the music and stop it after a minute has passed. This is the signal for the group to move 1 person in the specified direction (clockwise or counter-clockwise).

Ask each outer circle person to write down the strongest skills and capacities of the inner circle person standing in front of him or her. Once the time is up, the external circle will move on to the next person. Once all people have been marked, participants switch circles, so the former inner circle participants write on the backs of the former outer circle participants.

(b) For groups of people who do not know each other:

In the case that the participants do not know each other, it will be necessary to have participants ask about core skills and capacities for the person upon whom they are writing.

③ Once the exercise has been completed, the facilitator will collect the papers and make a master list of the groups' skills, without mentioning whom they pertain to. Once they start repeating, the facilitator can add a check mark to the skill.

The facilitator should note that every person has skills that can be used, and that even the simplest ones can contribute value.

Skills might include:

> Active listening
> Public speaking
> Documentation
> Planning
> Project design
> Graphic design
> Media skills (video, radio, etc)
> Research
> Networking
> Persuasive writing skills
> Planning/strategic thinking
> Theatre and dramatic arts/performance
> Creativity
> Knowledge of HIV services and response
> NGO/civil society work experience
> Knowledge of decision-making processes/lawmaking

1.8

EXERCISE 1.8

CELEBRATIONS AND HEROES

Purpose:

To help MSM participants to identify their local community's vibrancy and capability through skill identification using celebrations and local MSM role models. This is a building block for advocacy processes and should be tied in as such.

Materials:

> Flipcharts

Goals:

At the end of the exercise, participants will be able to:

> Identify preexisting community skills

> Connect relevance of those skills to advocacy

Process:

1. Break participants into small groups.

2. Ask participants to identify celebrations in which many community members participate. Ask for participants to identify ways in which the community works together to make the event a success. Details should include: What does the event entail? How long do preparations take? Do non-MSM participate in the event? How do participants feel after the event? How long has the event been happening? Certain skills might include cooking and other talents, such as dancing, art, and makeup.

3. Ask participants to identify some customs that are unique to them. Have them list them out and perform some for the group if possible.

④ Ask participants to identify individuals from their local MSM community who are role models, or heroes. Ask participants to note specific examples of why they are role models. What are the core qualities that made them special? What is a story about them that illustrates their special qualities? If they are no longer living, are they remembered in a special way?

⑤ Bring the group back together and have them each present their celebration and role model, and fit them into the following chart.

Celebrations:

Why are these celebrations important to community? What personal meaning do these traditions have for you? What work does the community put in to make the event a success?

Heroes:

Why are they important to the community? What skills do the heroes possess?

1. Bring the group back together and explain that the community comes together as a group on specific occasions and works together to make an event successful, and heroes possess special qualities and skills that win our admiration. Group brainstorm a list of skills that are illustrated by the celebrations and heroes the small discussions surfaced.

2. Prioritize the list of skills from most to least important, and take a moment to reflect on how we can take steps to embody these skills.

3. Finish the exercise by reminding participants that MSM groups are strong and already possess many traditions and methods of connecting as a group. These bonds and strength are very relevant to advocacy work and form the foundation of any successful campaign or project.

SPEAKING OUT

1.9

MAKING A PLAN FOR IMMEDIATE ACTION

Purpose:

To identify a concrete set of next steps toward creating an advocacy plan.[8]

Goals:

At the end of the exercise, participants will be able to:

> Chart immediate steps for a short-term course, with specific assigned responsibilities and time limits

Materials:

> Handout 1.6

Process:

(1) Distribute Handout 1.6.

(2) Ask participants to think about how they can begin organizing an advocacy planning process in their own locales.

Activities	Person responsible	Resources needed	Deadline	Outcome	Indicator	Documentation
Set planning meeting through phoning community members	Shivakumar	Phone	August 15	Meeting date set, confirmed attendees	Verbal confirmation	
Run planning meeting	Rama	Space, tea/ snacks, materials (flipcharts, markers)	Sept. 1	Advocacy plan identified		

③ Project or distribute the following illustration, "Framework for Planning an Advocacy Campaign," and close the exercise with an explanation of the core steps of an advocacy campaign. Remind participants that each step covered in this handbook can be explored in more depth, and that monitoring and evaluation is a step they should explore on their own.

1.9

Planning Framework for an Advocacy Campaign
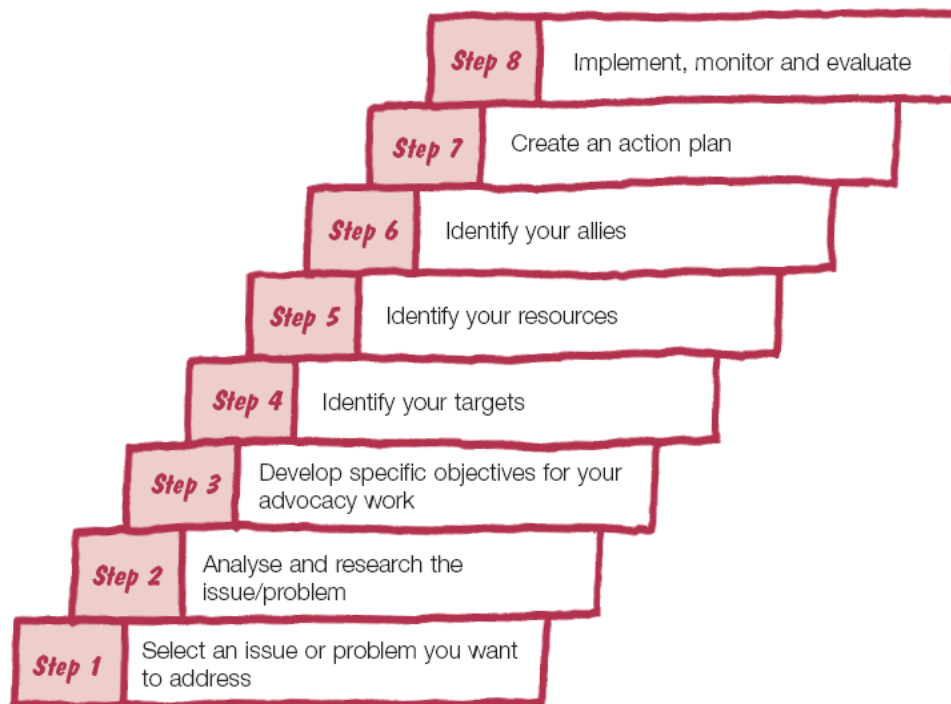
Step 8	Implement, monitor and evaluate
Step 7	Create an action plan
Step 6	Identify your allies
Step 5	Identify your resources
Step 4	Identify your targets
Step 3	Develop specific objectives for your advocacy work
Step 2	Analyse and research the issue/problem
Step 1	Select an issue or problem you want to address

From International HIV/AIDS Alliance and the International Council of AIDS Service Organizations. Advocacy in Action[1]

ADVOCACY RESOURCES

AN INTRODUCTION TO ADVOCACY: TRAINING GUIDE

Academy for Educational Development (AED)
http://www.globalhealthcommunication.org/tools/15

This training guide introduces the concept of advocacy and provides a framework for developing an advocacy campaign. The guide is designed for a workshop setting, but can also be used as a self-teaching device. Divided into twelve modules, the guide presents general information on advocacy training.

ADVOCACY FROM THE GROUND UP: A TOOLKIT FOR STRENGTHENING LOCAL RESPONSES

Asia Pacific Council of AIDS Service Oganisations (APCASO)
http://apcaso.org/index.php?option=com_content&view=article&id=28&Itemid=66

The toolkit provides a guide to a wide range of activities with resources and reference materials for both trainers and participants. It is intended to broadly elaborate on the concept of advocacy and how it plays a key role in effective HIV interventions and AIDS services. It is currently being used to structure advocacy capacity initiatives for the ongoing Community Advocacy Initiative (CAI) project.

A-SQUARED ADVOCACY TRAINING MANUAL

United States Agency for International Development (USAID)
http://www.healthpolicyinitiative.com/index.cfm?ID=publications&get=pubID&pubID=343

The manual draws from numerous HIV and advocacy resources and material from the Asia-Pacific region, and it integrates innovative approaches to advocacy and involvement in the policy development process that are specific to HIV epidemics in Asia, particularly China, Thailand, and Vietnam.

DEMANDING CREDIBILITY AND SUSTAINING ACTIVISM: A GUIDE TO SEXUALITY-BASED ADVOCACY

Global Rights
http://www.globalrights.org/site/PageServer?pagename=wwd_initiatives_lgbti

This Guide explains the human rights standards that are most relevant to the protection of LGBTI communities in terms that are easy to grasp and framed within a broad human rights context. By providing case studies, it helps illustrate how those standards are applied in real life. And it includes exercises to help advocacy organizations and activists better understand the complex social constructs that define our notions of gender, sexual health, and human sexuality.

HIV/AIDS ADVOCACY GUIDE

International Planned Parenthood Federation (IPPF)
http://www.ippfwhr.org/en/node/283

In confronting the challenges of the HIV/AIDS epidemic, this guide explains how advocacy can be a powerful tool in supporting prevention and treatment efforts and reducing the stigmatization of people living with HIV/AIDS.

ADVANCING THE SEXUAL AND REPRODUCTIVE HEALTH AND HUMAN RIGHTS OF PEOPLE LIVING WITH HIV

International Planned Parenthood Federation (IPPF)
http://www.ippf.org/en/Resources/Guides-toolkits/Advancing+the+Sexual+and+Reproductive+Health+and+Human+Rights+of+People+living+with+HIV.htm

With input from networks of people with HIV worldwide, the guidance package explains what global stakeholders in the areas of advocacy, health systems, policy making and law can do to support and advance the sexual and reproductive health of people living with HIV, and why these issues matter.

GENERATING POLITICAL CHANGE: USING ADVOCACY TO CREATE POLITICAL COMMITMENT

International Planned Parenthood Federation (IPPF)
http://www.ippf.org/en/Resources/Guides-toolkits/Generating+political+change.htm

This guide defines advocacy as any strategic activities that aim to bring about a desired change. These stories show that advocacy is not simply a series of ad hoc actions. Advocacy is a process of linked actions that, when combined, bring about change.

HANDBOOK FOR ADVOCACY PLANNING

International Planned Parenthood Federation (IPPF)
http://www.ippfwhr.org/en/advocacy_planning_manual

This handbook assists in developing advocacy activities through a series of highly specialized actions. Associations must analyze political processes, state structure, current legislation at the various government levels, international commitments, and the social, economic, geopolitical, and human development context.

ADVOCACY MANUAL: A PRACTICAL GUIDE FOR ORGANIZATIONS OF THE CIVIL SOCIETY

Latin America and the Caribbean Council of AIDS Service Organisation (LACASSO)
http://www.laccaso.org/index_english.html

HIV/AIDS POLICY ANALYSIS AND ADVOCACY FACILITATOR'S MANUAL AND TRAINING MODULE

Latin America and the Caribbean Council of AIDS Service Organisation (LACASSO)
http://www.laccaso.org/index_english.html

PARTICIPATORY ADVOCACY – A TOOLKIT FOR VSO STAFF, VOLUNTEERS AND PARTNERS

Volunteer Services Overseas (VSO)
http://www.aidsportal.org/Article_Details.aspx?ID=12831

The main body of the toolkit is divided into five parts, which represent five key stages of the participatory advocacy process.

SURVIVAL IS THE FIRST FREEDOM: APPLYING DEMOCRACY & GOVERNANCE APPROACHES TO HIV/AIDS WORK

UNAIDS
http://www.aidsportal.org/Article_Details.aspx?ID=7890

The purpose of this toolkit is to provide a collection of tools for use in applying democracy & governance (D&G) approaches to HIV/AIDS work.

ADVOCACY IN ACTION: A TOOLKIT TO SUPPORT NGOS AND CBOS RESPONDING TO HIV/AIDS

HIV/AIDS Alliance
http://www.aidsportal.org/Article_Details.aspx?ID=552

This toolkit, aims to help NGOs/CBOs develop a clear understanding of what advocacy is and how it might support the work of NGOs and CBOs, and to provide practical assistance in how to actually undertake advocacy work.

ICASO ADVOCACY AND PRIMERS

International Council of AIDS Service Organisations (ICASO)
http://icaso.org/advocacy_briefings.html

SPEAKING OUT

ADVOCACY TOOLS AND GUIDELINES: PROMOTING POLICY CHANGE

CARE
http://www.care.org/getinvolved/advocacy/tools.asp

These tools and guidelines provide a step-by-step guide for planning advocacy initiatives, as well as advice for successful implementation.

NETWORKING FOR POLICY CHANGE: AN ADVOCACY TRAINING MANUAL BY POLICY

The POLICY Project
http://www.policyproject.com/pubs/AdvocacyManual.cfm

The manual is based on the principle that advocacy strategies and methods can be learned. The building blocks of advocacy are the formation of networks, the identification of political opportunities, and the organization of campaigns. The manual includes a section on each of these building blocks, with specific subjects presented in individual units.

YOUTH AND THE GLOBAL HIV/AIDS CRISIS: A TOOLKIT FOR ACTION

United Nations Association in Canada
http://www.unac.org/en/link_learn/hiv_aids/en/index.asp

This Toolkit for Action has two components. In Part One, there is a sample of youth and youth workers (based in Ottawa) explaining what prevention, education, and awareness strategies have reached them, what they think about these strategies, and their own ideas for effective youth-centred HIV/AIDS actions for their communities.

Part Two looks at a range of for- and by-youth public education initiatives from Kenya, the US, South Africa, Bangladesh, and Canada. Included at the end of the report are pointers on what kinds of strategies and programmes have worked best over the past 20 years of HIV/AIDS practice.

HIV/AIDS ADVOCACY AND MEDIA RELATIONS MANUAL + STIGMA AND DISCRIMINATION HANDBOOK

Religions for Peace
http://religionsforpeace.org/resources/toolkits/hiv.html

ADVOCACY TOOLKIT: TOOLS TO ADVOCATE FOR LGBTQ YOUTH

The Trevor Project
www.thetrevorproject.org/documents/AdvocacyToolkit.pdf

Short guide to advocacy for LGBTQ with focus on mental health and suicide prevention. Includes guide to writing to elected officials with sample letters.

AMICAALL ADVOCACY TOOLKIT

Alliance of Mayors' Initiative for Community Action on AIDS at the Local Level (AMICALL)
http://www.amicaall.org/toolkits.html

The Alliance has developed a strategy: Alliance of Mayors' Initiative for Community Action on AIDS at the Local Level (AMICAALL), reflecting the importance of locally led, multisectoral action which complements supportive national policies.

LGBT COMMUNICATION MANUAL

The Brazilian Gay, Lesbian, Bisexual, Transvestite and Transexual Association (TABGLT)
http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2010/20100301_Brazil_LGBT.asp

The manual is directly related to the LGBT Movement's goals of contributing towards the production of tools capable of educating and informing Brazilian society about its human rights. Furthermore, it aims to reinforce the roles played by each and every citizen in building a fairer, more human society with solidarity and full access to the rights provided for by the Brazilian Constitution.

VISUALIZING INFORMATION FOR ADVOCACY: AN INTRODUCTION TO INFORMATION DESIGN

Open Society Institute (OSI)
http://www.soros.org/initiatives/information/focus/
communication/articles_publications/publications/
visualizing_20080311

A manual aimed at helping NGOs and advocates strengthen their campaigns and projects through communicating vital information with greater impact. The booklet aims to raise awareness, introduce concepts, and promote good practice in information design—a powerful tool for advocacy, outreach, research, organization, and education.

MAPPING FOR ADVOCACY CASE STUDIES

Open Society Institute (OSI)
http://www.soros.org/initiatives/information/focus/
communication/articles_publications/publications/
gis_20060412

The 10 case studies selected in this publication focus on GIS mapping projects primarily in the context of advocacy work in North America.

GLOBAL ADVOCACY FOR HIV PREVENTION AMONG MSM

International AIDS Society, Bill and Melinda Gates Foundation
http://www.rectalmicrobicides.org/docs/Global%20
Advocacy%20for%20HIV%20Prevention%20
Among%20MSM.doc

The International AIDS Society and the Bill & Melinda Gates Foundation held a meeting in Geneva, Switzerland, focusing on the state of global advocacy for the HIV prevention needs of gay men and men who have sex with men (MSM). Twenty-eight invited leaders participated in a full-day discussion that included an analysis of the current landscape of global MSM-HIV advocacy, reviewed priorities for research and resource allocation, and explored opportunities for leadership and collaboration. This documents the meeting.

MSM VERSUS IDU — POLICY AND PRACTICE LANDSCAPE

AIDS Projects Management Group (APMG)
www.aidsprojects.com/uploads/File/IDU%20
versus%20MSM%20policy%20and%20practice%20
landscape.pdf

A comparison of IDU and MSM policy landscapes with recommendations.

SEX WORKER HEALTH AND RIGHTS ADVOCATES' USE OF INFORMATION AND COMMUNICATIONS TECHNOLOGIES REPORT

Open Society Institute (OSI)
http://www.soros.org/initiatives/health/focus/
sharp/articles_publications/publications/
technologies_20070717

This report explores the ways in which sex worker health and rights advocacy groups currently use information and communications technology, and to discover how they could benefit from technology and training in the future.

CIVIL SOCIETY PERSPECTIVES ON TB/HIV: HIGHLIGHTS FROM A JOINT INITIATIVE TO PROMOTE COMMUNITY-LED ADVOCACY

Open Society Institute (OSI)
http://www.soros.org/initiatives/health/
focus/phw/articles_publications/publications/
highlights_20060811

Both the project and the publication underscore the importance of enhancing community engagement in the design, implementation, and evaluation of collaborative TB/HIV programs. The report presents case studies from Indonesia, Mexico, Sierra Leon, South Africa, Ukraine, and the Caribbean, highlighting community advocates' strategies, achievements, and lessons learned.

CHAPTER 1
REFERENCES

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INTRODUCTION TO CHAPTERS 2-7

Key advocacy issues pertaining to MSM & HIV

The following 6 chapters present 6 key areas on which MSM should consider focusing their advocacy efforts, namely investment, services, stigma and discrimination, research, documentation, and civil society and networks. These have been identified as priority MSM and HIV advocacy issues. The chapters are in no particular order, and facilitators should allow navigation through the chapters to be guided by the issues surfaced in the mapping processes in Chapter 1. Although these areas have been identified as priority advocacy areas, the list is certainly not exhaustive. In some instances the facilitator may choose to focus on topics outside of these 5 areas. The advocacy steps and skills can be applied to any problem surfaced by the issue identification exercise.

2 INVESTMENT

Generally speaking, there is significant disproportion between budgetary allocation and need when it comes to countries and donors investing in MSM-specific HIV/AIDS programs and services. Just as they do in day-to-day life, MSM face stigma in the HIV response, despite being disproportionately affected by the epidemic. It is crucial that communities learn exactly how resources are being allocated and spent in their locales and that they advocate for the resources required for an effective response.

Two core investment areas groups can investigate relating to a country's response to HIV/AIDS are (1) budgetary allocation and commitments it has made to programming and (2) actual expenditure patterns. In most cases where there are funds set aside for HIV/AIDS programs, there is a disproportionately lesser amount of resources allocated for programs and services for MSM—assuming, of course, resources have been allocated for MSM at all. To make matters worse, it is not uncommon for this funding information to simply be unavailable. It is crucial that civil society groups begin to understand what the current resource allocation is (if there is indeed an allocation), the degree to which resources are being applied to effective programs and according to budgetary plans, and the amount that is actually required to launch effective programs among MSM. It is particularly important to note gaps between budgets and expenditure, as well as between budgeted amounts and actual needs. Gathering this information forms the foundation for building budgets and expenditure into advocacy activities, and it is recognizably a difficult process when the information is not made available by governments.

This section of the toolkit gives participants an introduction to budgetary research and analysis as well as ideas for building budgets into their advocacy work. The exercises have been designed to give participants a hands-on experience of budgetary information, to facilitate a process whereby they can operate in conditions where there is very little or no information available, as is often the case, and to help them think about advocacy messaging.

Key points:

> Investment should be proportionate to the HIV epidemic's impact in the MSM community.

> Governments should have transparent budgets and expenditure information for HIV program efforts targeting MSM.

> Governments should make a commitment to fulfilling the health and human rights of MSM in their own nations; this responsibility cannot solely be shouldered by external funding bodies, as this is not a sustainable approach.

> Bilateral and multilateral organizations that fund programs for MSM should serve as examples to governments and other actors.

> It is time for urgent action. Where good data do exist, it shows the gap between HIV prevalence among MSM and HIV funding allocated toward HIV leads to MSM becoming the most heavily impacted group in the global epidemic.

> Funding commitments should be long-term and sustainable.

Chapter goals:

Upon completing the exercises in this chapter, participants will be able to:

> Complete simple budgetary analysis using UNGASS data

> Explore budgetary allotments as they relate to HIV burden

> Identify targets for budget advocacy

> Identify tools for estimating budgetary requirements

> Cite key issues relating to budgetary advocacy messaging

> Cite a specific example of budgetary advocacy

SPEAKING OUT

2.0

WORKING WITH COUNTRY-SPECIFIC HIV/AIDS AND MSM INFORMATION

Purpose:

To give participants an introduction to disparities between budgetary allotments and HIV prevalence rates. Also, to give the actual experience of assessing budget allocations/expenditure for MSM using the UNGASS Country Reports.

The MSMGF Web site (www.msmgf.org) is a powerful information tool. Country-specific information is all collated and available at the click of a button. All information in Handout 2.0 was downloaded from the Web site.

Consider the MSMGF Web site a "1-stop shop" for many of your research needs!

Goals:

At the end of the exercise, participants will be able to:

> Complete simple budgetary analysis using UNGASS data

> Cite specific examples of disparities in funding allotments versus disease burden for MSM

Materials:

> Handout 2.0

Process:

① Facilitator begins session by introducing the exercise:

Budgets are an index of how supportive a country or organization is of meeting the needs of MSM in the global AIDS epidemic. UNGASS reports contain information about key indicators relating to a country's HIV/AIDS response, and often contain rich budgetary information.

② Divide the group into 3 teams and assign each team a country (Thailand, Cambodia, or Nepal). Distribute handouts for each country.

FACILITATOR NOTE:

Explain that the information in the handout was obtained through the MSMGF Web site. Encourage participants to use it as a resource for their own research.

(1) Ask the participants to imagine they are part of a special task force to analyze the degree to which countries are allocating funds relative to HIV prevalence for MSM groups. Ask each team to identify the following elements in the budget:

> All existing budget items and programs that reflect actions in relation to MSM and HIV & AIDS.

> The percentage MSM-specific amounts represent of the total prevention budget (divide MSM amount by total prevention amount).

> The percentage allocated in the budget versus the HIV prevalence rate for MSM.

> Additional budget information they would like to see that is not available in the data. For example, what percentage of funds *other* than prevention were allocated to MSM in categories such as treatment and care? How did budgets compare to actual expenditure?

FACILITATOR NOTE:

Explain that it may not be possible to find budgetary information for every service provided, or for budgeted amounts as they relate to actual expenditure. There may even be cases where very little information is available at all. Nonetheless, these gaps should be noted, as they constitute important data because they underscore a *lack* of information.[4]

(1) While groups are working, write the latest HIV prevalence data for MSM for each country on a flipchart:

HIV PREVALANCE FOR MSM

> **Nepal: 5.2 percent[1]**
> **Cambodia: over 8.7 percent[2]**
> **Thailand: 28 percent[3]**

(2) The groups return in a plenary session and discuss their findings. They will find varying allotments for MSM-specific programs relative to total prevention spending, and a disparity between HIV prevalence among MSM and budgetary allocations. Lead a discussion whereby participants discuss their answers to the questions they answered with their data. What are some trends? What information would be useful that is not included? How does budgetary information work in their countries? Is it readily available? Have any participants seen country data with disaggregated amounts for MSM services?

SPEAKING OUT

2.1

ADVOCACY MESSAGES AND TARGETS

Purpose:

To learn key thinking skills about how to advocate for investment: target audiences, advocacy, messages, and timing.

Goals:

At the end of the exercise, participants will be able to:

> Identify targets for budget advocacy

> Identify tools for estimating budgetary requirements

> Cite key issues relating to budgetary advocacy messaging

Process:

1. Introduce this exercise with the example of a child who wants money to purchase a chocolate. To whom will the child go? Obviously he will be strategic and present his case to the parent most likely to be sympathetic to his cause. Budget advocacy is almost instinctual!

2. Group brainstorm: We have identified increasing spending for MSM as our advocacy objective. Thinking through the issue from the power-mapping framework in Exercise 1.4, ask yourself who would be a good audience for your advocacy? How would they best be reached? Think carefully about who influences decisions regarding your country's HIV/AIDS budget. Keep record of potential advocacy targets.

3. Break down into smaller groups. Ask the groups to consider how they could craft advocacy messages to communicate the need for more investment. What advocacy messages work? What additional information would they need to make their case? What is the government doing already that has been effective?

FACILITATOR NOTE:

Ensure these potential targets are covered:

- National AIDS Control Program
- Other government ministries and departments
- Bilaterals and multilaterals (UNAIDS, USAID, DFID, GFATM, WHO, World Bank)
- Media

Encourage participants to think outside the box. Directly approaching governments and explaining a need in terms of *lack* is 1 way, but is it the most effective for every audience? Make it clear that another way to approach messaging is to advocate for more programming and services based on demonstrated success. Governments and budgetary forces could potentially be more receptive to a message demonstrating a positive return on investments they have already made, and also demonstrations of cost-effectiveness.[4] This is an interesting angle that relates to advocacy research as well.

Think of ways to demonstrate effectiveness, in terms of programs and cost.

This can be a more effective strategic stance than highlighting lack in many instances.

Ideas for messaging might include:

Message	Additional information required for evidence
Budgeted/expended amounts are not reaching communities	Proof through creative sampling, budget tracking
There is a gap in services required versus services available	Estimation of needs—USAID calculation and RETA
Prevention programs are cost-effective and save money in the long run	Cost-effectiveness analysis of existing programs (use data from other countries, if necessary)
Leverage influence of funding governments	Proof that MSM spending is not happening in as robust a manner as it should
Increase coordination among funders	Which funding organizations are targeting MSM commonly?

FACILITATOR NOTE:

Make it clear that funding agencies have local offices, and getting in touch with them is easier than community members might think.

Calculating funding amounts required to scale up HIV programs for MSM:
There are 2 very good resources for calculating budgetary needs for quantifying the resource gap between budgets and minimum required MSM services. They are:

1. USAID estimate, based on the Asia-Pacific region:
   http://www.healthpolicyinitiative.com/index.cfm?ID=publications&get=pubID&pubID=189

2. Resource Estimation Tool for Advocacy:
   http://www.futuresgroup.com/resources/software/resource-estimation-tool-for-advocacy/

④ Raise the following question: What do you do when there is no information available, whatsoever? And explain the following:

Firstly, do not despair. It is a very common for little or no budgetary information to be immediately available. Try getting some information through simple creative sampling. For example, the group can make a simple questionnaire that they distribute to other groups working with MSM. How much money are they receiving from the government to run their intervention? Have their amounts been dispersed in a timely fashion, according to budget? Is the amount sufficient?

Another way to get information about budgets is through freedom of information legislation, if participants' countries have it (and some 85 countries do).

EXERCISE 2.2

CASE STUDY — BLUE DIAMOND SOCIETY, NEPAL

2.2

Purpose:

To give participants a real example of budgetary advocacy, and to inspire groups to act with a sense of possibility.

Goals:

At the end of the exercise, participants will be able to:

> Cite a specific example of budgetary advocacy

Materials:

> Handout 2.1

Process:

① Distribute Handout 2.1.

② Introduce the material: The Blue Diamond Society in Nepal, an organization championing the rights of MSM and other sexual and gender minorities, has done very successful advocacy with its government, including securing a provision in the country's constitution to protect the rights of sexual and gender minorities. This handout is an excerpt from the Ministry of Finance's budget speech, whereby the government makes known a specific portion of the budget that has been allocated to sexual and gender minorities.

③ Lead a discussion. Some questions:

> Surely there are more than 50 sexual minorities in Nepal. Is this inclusion significant? If yes, why?

> What do you feel about the language of the document? Is it specific? How is sexual difference conceptualized?

Pretend for a moment that all funds relating to MSM and HIV were to dry up tomorrow. Would programs be able to continue? Do most organizations and projects have backup plans? What are they? What happens when HIV/AIDS is no longer a hot funding topic, and governments continue to neglect MSM? Think about sustainability as it relates to funding. *What happens when no one is providing funding?*

SPEAKING OUT

2.2

⬦ Is a government commitment on a piece of paper enough? If not, what are some other actions required to ensure the advocacy has reached its goal?

⬦ How can this speech be used for further advocacy? In Nepal? Elsewhere?

Why invest in HIV services for MSM?

⬦ There is a disparity between the disease risk and disease burden borne by MSM and the current level of spending on HIV prevention programs for MSM.

⬦ Targeted interventions to prevent HIV among MSM have been proven to be effective, resulting in a reduced number of sexual partners, increased condom use, and less unprotected sex.

⬦ An example from a large sub-national location in the region illustrates that MSM are not only an important source of the number of new infections, **but also are a cost-effective option to include in a strategic response to HIV in Asian countries.**

from USAID Health Policy Initiative. HIV Expenditure on MSM Programming in the Asia-Pacific Region.[4]

INVESTMENT RESOURCES

HANDBOOK FOR INCORPORATING BUDGET WORK INTO ADVOCACY PROJECTS (PRELIMINARY VERSION)

International Planned Parenthood Federation (IPPF)
http://www.ippfwhr.org/en/advocacy_budget_work_handbook

The handbook is divided into 5 work modules. The first module is devoted to raising awareness regarding the relevance of governance, transparency, and advocacy work, explaining and defining each of the concepts. Modules 2 to 5 provide a step-by-step guide to introducing the budget work dimensions when designing and effective advocacy projects.

BUDGET ADVOCACY

International Budget Partnership Web site
http://www.internationalbudget.org/budget-advocacy/strategies-tools-tactics-opportunities/

The International Budget Partnership collaborates with civil society around the world to analyze and influence public budgets in order to reduce poverty and improve the quality of governance. Good resources for budget advocacy.

HIV EXPENDITURE ON MSM PROGRAMMING IN THE ASIA-PACIFIC REGION

USAID
http://www.healthpolicyinitiative.com/index.cfm?ID=publications&get=pubID&pubID=189

The aim of the paper is to (1) compile information on expenditure for HIV prevention programs for MSM in the Asia-Pacific region and compare it with overall HIV prevention expenditure; (2) identify the main financing sources of MSM expenditures and the implications from a public economics perspective, raising specific issues such as predictability, sustainability, and additionality, among others, as they apply to the financing of MSM programs; and (3) estimate the resource requirements for MSM-related programming in the Asia-Pacific region and, based on current expenditure, quantify the resource gap.

RESOURCE ESTIMATION TOOL FOR ADVOCACY (RETA)

Futures Group
http://www.futuresgroup.com/resources/software/resource-estimation-tool-for-advocacy/

The Resource Estimation Tool for Advocacy (RETA) is a new tool to estimate resource needs for scaling up comprehensive HIV prevention programming for men who have sex with men and transgenders. RETA estimates the resources needed for a 5-year period, based on user input of population size estimates, target coverage levels, and local costs of HIV prevention services.

CHAPTER ❷
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3 **SERVICES**

Despite rising rates of new HIV infections among MSM, there is a dispropor-tionately lesser amount of programming directed toward this community. Where services do exist, they often consist of a limited outreach model that is focused on condom distribution and HIV testing referral, missing other key structural and social factors that drive the epidemic such as stigma and discrimination, poverty, and substance abuse. This is the result of homophobia and enacted stigma at work within country and funding governments. It is also very likely the result of "invisibility" and silence among MSM communities, due in part to hostile stigma-tizing environments in which MSM cannot freely and openly assess and advocate for their unique needs.

Services most often fail to address drivers of the epidemic such as stigma and discrimination, which are key contributors to MSM community vulnerability to HIV. It is time that health ministries, NGOs delivering health and HIV services, and others began to think outside of the box of the current services that are offered and think more broadly about community needs, and how they might be met with innovative programming. Communities should do a basic assessment of the services available in their localities and develop a list of comprehensive services required to curb HIV transmission in their particular situations. These might in-clude STI diagnosis and treatment, provision of water-based lubricants, and psy-chosocial support structures for helping MSM deal with violence and other forms of stigma and discrimination. Another important factor that is often missing from services for MSM is *continuity* between services; the crucial interconnectivity that makes a response effective. For example, what is the use of providing referral to services in a community wherein the medical establishment stigmatizes MSM and refuses their treatment?

This chapter focuses on helping communities identify their particular needs, introducing the importance of continuity of services, and encouraging partici-pants to think outside the box of the condom/referral model through case study examples.

Key points:

⊳ Services for MSM are often unavailable and/or limited.

⊳ Services must go beyond simply "MSM referral" to information and services, and transform to become services that are truly MSM-friendly.

⊳ Water-based lubricant is rarely available.

⊳ STI care is rarely available.

⊳ Services are disconnected, allowing for MSM to fall through the cracks.

⊳ Initiatives should be evidence-based and include the right balance of human rights and public health focus.

Chapter goals:

Upon completing the exercises in this chapter, participants will be able to:

⊳ Understand some key elements comprising a comprehensive HIV response for MSM

⊳ Map the local HIV response for MSM in their areas

⊳ Prioritize services according to need

⊳ Understand UNDP-defined comprehensive services for MSM and prioritize those that would be useful in their own locales according to need

⊳ Understand concept of "continuum of care" through local examples

⊳ Cite specific examples of innovative service provision models

EXERCISE 3.0

MAPPING THE LOCAL RESPONSE

3.0

Purpose:

To have participants map the HIV response among MSM in their area and identify gaps where they could advocate for more services.[1]

Goals:

At the end of the exercise, participants will be able to:

> Understand some key elements comprising a comprehensive HIV response for MSM

> Map the local HIV response for MSM in their areas

> Prioritize services according to need

Materials:

> Handout 3.0

Process:

(1) Facilitator should introduce the exercise with the following:

Services for MSM are essential for stopping the HIV epidemic worldwide. There is no single set of services that has been empirically proven to be successful in this battle; however, there are some things we do know that are very likely to help. The purpose of this exercise is to get you thinking about what is being done in your area, and what some of the gaps might be in services for MSM.

(2) Through a brief survey of the group members, assess their knowledge of the AIDS control program in the country and what their commitments are to MSM. If this knowledge is lacking, ensure that they get information about main agencies.

3.0

③ Distribute Handout 3.0, ask participants to fill it out, and total their entries in the column at the right.

④ Ask a participant to do a collective mapping of the individual responses. In cases where participants are from the same area, are there gaps that stand out? In cases where participants are from different places, are there interesting services listed by other groups that look interesting? Are there commonalities across the board?

⑤ Agree upon services that participants would like to see offered in their area, or changes to existing services, and make a list. Make another list of services that are offered but that are not effective. How could these be changed to make them more effective?

⑥ Prioritize the list. Rank the most urgent gap as "No. 1," and the next most urgent as "No. 2," and continue in this way until all of the issues on the list are ranked.

CONTINUUM — FROM PREVENTION TO CARE

3.1

Purpose:

To introduce participants to the prevention-to-care continuum through examples, highlighting the importance of a holistic, interlinked response. Connect this exercise to cause-and-effect analysis (Exercise 1.2), explaining that this time we are starting with solutions instead of problems.

Goals:

At the end of the exercise, participants will be able to:

> Understand UNDP-defined comprehensive services for MSM

> Understand the concept of "continuum of care" through local examples

Materials:

> 3–5 Xerox copies of both Handout 3.1.1 and Handout 3.1.2 cut into squares, depending on group size

Process:

① Briefly survey the group for ideas about what constitutes a typical MSM-targeted response in their area (ie, outreach with condoms and referral to HIV testing and counseling).

② Divide into small groups by geographical region.

③ Pass out first group of cards (Handout 3.1.1), which represent access to services constituting comprehensive coverage as defined by UNDP. This set of services will be familiar to many participants, and many will have access to some or all of them.

SPEAKING OUT

3.1

④ Ask participants to look at the cutouts, thinking about their own locales. Have them identify which services are available in their area and which are not, and separate the cards accordingly into 2 sections: "available" and "not yet available."

⑤ Have the group answer the following questions:

Looking at the services that *are* available in your community:

How do the services that are provided in your community help prevent HIV? Can you think of specific people who have benefited from these services? Are some of these services less helpful or not helpful at all? Roughly, what percentage of your local MSM community access services?

Looking at the services that are *not yet* available in your community:

Can you think of examples of people you know who have required these missing services, and what consequences they faced?

What are some specific services you would like to see offered in your community from this set of examples?

What are some specific services you would like to see offered in your community that are not listed on any of these cards?

⑥ Next, pass out the second set of cards (Handout 3.1.2), explaining that in addition to *access to services* there are also key elements relating to legal, policy, and social environments in a comprehensive package of actions to address HIV risk among MSM. Explain that many of these may not yet be available in their communities; however, it will be important to recognize them so they can be included in advocacy campaigns.

⑦ As with the first exercise, have the groups divide the cards according to "available" and "not yet available." Ask the groups to go through the same questions listed in number 5 above.

⑧ Bring the group back together and reinforce the following main points:

Comprehensive coverage for MSM includes access to services (such as HIV testing, condoms, and lubricants) as well as elements relating to legal, policy, and social environments (such as referral to legal services and enabling legal and policy environments).

The interlinking of services is as important as services alone.

Ask the group to share examples of individuals they might know of who fell through the cracks of interventions in their locales. What are some examples of interlinked services? What are some examples of services that promote supportive legal, policy, and social environments for MSM?

FACILITATOR NOTE:

Take note of responses from the group, on flipchart paper if possible. It may be useful to end this activity with a group discussion of how the services that do exist came to be—and make note of potentially useful lessons learned from this process to advocate for implementation of those services identified as "not yet available."

SPEAKING OUT

3.2

BEYOND CONDOMS/ REFERRAL — SERVICES THROUGH EXAMPLE

Purpose:

To introduce some best practice examples by way of case study to:

> Explore options beyond rudimentary outreach and referral models

> Illustrate the prevention-to-care continuum through examples

> Give ideas for possible directions communities might want to move

Goals:

At the end of the exercise, participants will be able to:

> Cite specific examples of innovative service provision models

Materials:

> Handout 3.2

Process:

① Lead a discussion among the group around a typical set of MSM HIV prevention services.

② Distribute intervention case studies, and ask participants to identify core elements of the prevention-to-care continuum cards they see operating within the study. Which elements are missing?

③ Bring the group's attention to a list of studies that have been completed around the effectiveness of specific services for HIV prevention. Explain how these can be used in making the case for a need for services.

SOME ADVOCACY TARGETS FOR SERVICES:

National level:

National AIDS Control Program

GFATM CCM

Bilateral and multilateral organizations

NGOs

Local service providers:

Healthcare workers

Local lawyers

SERVICES RESOURCES

SUICIDE RISK AND PREVENTION FOR LESBIAN, GAY, BISEXUAL, AND TRANSGENDER YOUTH

Suicide Prevention Resource Center
http://library.sprc.org/browse.php?catid=32

This publication addresses the special concerns related to suicide prevention among lesbian, gay, bisexual, and transgender (LGBT) youth. It summarizes the current state of knowledge about suicidality in this population, and outlines twenty-one recommendations for helping to reduce suicidal behavior among LGBT youth. Includes a resource appendix and an extensive bibliography.

TRAINING MANUAL: AN INTRODUCTION TO PROMOTING SEXUAL HEALTH FOR MEN WHO HAVE SEX WITH MEN AND GAY MEN

Naz Foundation (India) Trust
http://www.aidsalliance.org/publicationsdetails.aspx?id=91

This manual provides training modules to provide a clear understanding of the sexuality and sexual health of men who have sex with men. Published in India by the Alliance in collaboration with the Naz Foundation (India) Trust, it is intended for NGOs and CBOs in South Asia wanting to develop services for MSM and gay men, or to incorporate their issues into existing services. It addresses how to raise awareness of these sensitive issues, and how to integrate them into NGO programmes.

MSM CBO DEVELOPMENT MANUAL

Naz Foundation International
http://nfi.net/training_resources.htm

This resource module provides a step-by-step approach to developing community-based organizations addressing issues affecting males who have sex with males (MSM), along with a theoretical framework. This toolkit has arisen out of the extensive community development work that the Naz Foundation International has undertaken in South Asia in addressing issues that affect MSM, since 1996.

BETWEEN MEN: HIV/AIDS PREVENTION FOR MEN WHO HAVE SEX WITH MEN (ENGLISH, FRENCH, SPANISH)

HIV/AIDS Alliance
http://www.aidsalliance.org/publication-search-results.aspx

Between Men gives an overview of basic issues for men who have sex with men in the context of HIV and other STIs. The booklet also provides ideas for developing prevention programmes with and for men who have sex with men. It is intended for people or organizations who provide support to NGOs and CBOs starting HIV/STI prevention work with and for men who have sex with men.

RESPONDING TO THE HIV-RELATED NEEDS OF MSM IN AFRICA (LINK INCLUDES 2 PRESENTATIONS WITH FACILITATION INFO)

HIV/AIDS Alliance
http://www.aidsalliance.org/publication-search-results.aspx

This guide has been produced for people who want to improve the response to the HIV-related needs of men who have sex with men (MSM) in Africa. The guide will help you to facilitate a participatory reflection meeting with key stakeholders who are responsible for improving local and national responses to HIV among MSM.

A CALL TO ACT: ENGAGING RELIGIOUS LEADERS AND COMMUNITIES IN ADDRESSING GENDER-BASED VIOLENCE AND HIV

USAID
http://www.healthpolicyinitiative.com/index.cfm?ID=publications&get=pubID&pubID=971

This guide was conceived and developed as the result of a USAID | Health Policy Initiative, Task Order 1, activity focusing on building the capacity of religious leaders—including women of faith—to address gender-based violence (GBV) in their communities, particularly in relation to HIV.

HIV/AIDS IN PLACES OF DETENTION: A TOOLKIT FOR POLICYMAKERS, PROGRAMME MANAGERS, PRISON OFFICERS AND HEALTH CARE PROVIDERS IN PRISON SETTINGS (ENGLISH, RUSSIAN)

World Health Organization (WHO), UNAIDS
http://www.unodc.org/unodc/en/hiv-aids/publications.html

This toolkit on HIV in prisons aims to provide information and guidance primarily to individuals and institutions with responsibilities for prisons and prisoners, and to people who work in and with prisons. In addition, it will assist everyone who has anything to do with prisons.

MANAGEMENT OF EFFECTIVE PROGRAMS ADDRESSING HIV PREVENTION, TREATMENT, CARE AND SUPPORT FOR GAY MEN AND OTHER MSM AND TRANSGENDER PEOPLE

AIDS Projects Management Group (APMG)
http://www.aidsprojects.com/05.Publications/index.html

A training curriculum for program management of MSM and TG HIV prevention and care programs.

HIV/AIDS AND THE LAW TRAINER'S MANUAL, MODULE 6: THE RIGHTS OF LESBIANS & GAY MEN

AIDS Legal Network
http://www.aidsportal.org/Article_Details.aspx?ID=2447

This module deals with issues that affect lesbians, gay people, as well as bisexuals and transgender persons, especially those living with HIV or AIDS in South Africa.

A PROVIDER'S INTRODUCTION TO SUBSTANCE ABUSE TREATMENT FOR LESBIAN, GAY, BISEXUAL, AND TRANSGENDER INDIVIDUALS

Substance Abuse and Mental Health Services Administration (SAMHSA)
http://www.kap.samhsa.gov/products/manuals/pdfs/lgbt.pdf

This publication presents information to assist providers in improving substance abuse treatment for lesbian, gay, bisexual, and transgender (LGBT) clients by raising awareness about the issues unique to LGBT clients.

CBO/FBO CAPACITY ANALYSIS: A TOOL FOR ASSESSING AND BUILDING CAPACITIES FOR HIGH QUALITY RESPONSES TO HIV/AIDS

CORE Initiative
http://www.coreinitiative.org/Resources/Publications/Capacity_Analysis/index.php

The tool is designed to facilitate group discussions between members of community organizations, allowing participants to assess their own strengths, weaknesses, and capacity-building needs.

GAY BREAKUPS: WHEN THE RAINBOW ENDS

www.thegaylovecoach.com
http://www.yocisco.com/cms/node/3215

Tips and healing strategies for breakups.

ENSURING UNIVERSAL ACCESS TO COMPREHENSIVE HIV SERVICES FOR MSM IN ASIA AND THE PACIFIC

American Foundation for AIDS Research (amfAR), MSM Initiative
http://www.amfar.org/msm/

This report summarizes an assessment that was carried out in early 2009 to identify priorities for operations research to better understand effective models for HIV prevention, treatment, care, and support among men who have sex with men (MSM) in Asia and the Pacific.

MEN WHO HAVE SEX WITH MEN – TECHNICAL POLICIES OF THE UNAIDS PROGRAMME

UNAIDS
http://www.unaids.org/en/KnowledgeCentre/Resources/PolicyGuidance/Techpolicies/men_men_sex_technical_policies.asp

The policy brief recommends actions for national and international policy makers as well as civil society partners who influence the policy environment and offers examples of the way forward including the summary of experiences of policy makers who have taken exemplary actions in this area.

MEN WHO HAVE SEX WITH MEN: KEY OPERATIONAL GUIDELINES OF THE UNAIDS PROGRAMME

UNAIDS

http://www.unaids.org/en/KnowledgeCentre/
Resources/PolicyGuidance/OperationGuidelines/men_
men_sex_operational_guidelines.asp

This Framework sets out how UNAIDS will facilitate and support universal access to HIV prevention, treatment, care and support for men who have sex with men and transgender people.

PREVENTION AND TREATMENT OF HIV AND OTHER SEXUALLY TRANSMITTED INFECTIONS AMONG MEN WHO HAVE SEX WITH MEN AND TRANSGENDER POPULATIONS

WHO

http://www.who.int/hiv/pub/populations/guide_msm/
en/index.html

There is an urgent need to address the emerging and re-emerging epidemics of HIV and other sexually trans-mitted infections (STIs) among men who have sex with men (MSM) and transgender people. Strengthening strategic information systems and implementing inter-ventions for the prevention and treatment of HIV and other STIs among MSM and transgender people should be considered a priority for all countries and regions as part of a comprehensive effort to ensure universal access to HIV prevention, care and treatment.

BEST PRACTICE PUBLICATION: HIV AND MEN WHO HAVE SEX WITH MEN IN ASIA AND THE PACIFIC

UNAIDS

http://www.unaids.org/en/PolicyAndPractice/
KeyPopulations/MenSexMen/

Collection of best practice interventions; advocacy is highlighted.

CHAPTER 3
REFERENCES

1. Asia-Pacific Network of People Living with HIV/AIDS and Asia-Pacific Council of AIDS Service Organisations. Valued Voices: GIPA toolkit for the greater involvement of people living with HIV/AIDS. http://www.gnpplus.net/cms-downloads/files/2005%20Valued%20Voices%20-%20A%20GIPA%20Toolkit.pdf. Accessed June 23, 2010.

4 STIGMA AND DISCRIMINATION

The presence of stigma and discrimination attached to MSM and their lifestyles is a common thread that runs through many cultures and communities. It takes a range of forms and manifests across contexts, from subtle teasing at school to criminalization of same-sex acts written into countries' legal architecture. An interesting quality of stigma and discrimination is that their targets, like MSM, often internalize the stigma, leading to low self-esteem and an exponential decrease in the community's compunction to protect itself. Drug abuse and suicide are common side effects of this trend. It has been clearly demonstrated that stigma and discrimination are core drivers of HIV infection. A careful exploration and treatment of stigma and discrimination in your particular area is highly recommended, and there are some very good tools that have been developed for this purpose (see Stigma and Discrimination Resources section). Do not feel overwhelmed or afraid to confront stigma and discrimination, despite their tendency to loom in what may seem like an impenetrable fashion. It is as simple as breaking it down into small steps and believing you can make a difference.

Acknowledging the specific ways stigma and discrimination exist is a first step toward its eradication; however, our work does not stop there. Ideas and beliefs take a long time to change. So while it is crucial that communities develop long-term strategies for eradicating MSM-related stigma and discrimination in their locales, it is equally important that they develop short-term strategies for coping with the stress and strain stigma and discrimination bring. It is also extremely important to target self-stigma. Growing up in homophobic families, schools, and communities has a deep and lasting impact on MSM and their behavior as adults.

This chapter focuses on helping participants to understand stigma and discrimination and its connection to HIV risk, identifying perpetrators of stigma as potential advocacy targets, and looking within at the importance of addressing self-stigma.

Key points:

> Stigma and discrimination vary from context to context, culture to culture—good resources and toolkits are available to explore these issues.

> Stigma and discrimination don't just come from the outside—they also come from inside individuals.

> Stigma and discrimination contribute to HIV risk.

> Changing attitudes takes time; coping strategies are important.

> Strategies for change should take their audience into careful account.

Chapter goals:

Upon completing the exercises in this chapter, participants will be able to:

> Identify personal experiences of stigma and discrimination and connect with others through shared experiences

> Understand how childhood experiences lead to self-stigma later in life

> Understand specific connections between stigma and discrimination and HIV risk

> Highlight the major forms and causes of stigma and discrimination

> Understand stigma and discrimination as occurring on both individual and societal levels

> Develop strategies for coping with discrimination reactively

> Develop strategies for ending discrimination proactively through advocacy

> Cite useful strategies for beginning the process of eradicating low self-esteem

> Cite specific example of stigma and discrimination–targeted advocacy

EXERCISE 4.0

NAME GAME — NAMING STIGMA AND DISCRIMINATION

4.0

Purpose:

To attune the participants' attention to their own experiences of discrimination, its predominance across different cultures, and the ways in which it can be internalized.

Goals:

At the end of the exercise, participants will be able to:

> Identify personal experiences of stigma and discrimination

> Connect with other participants through shared experiences of discrimination

> Understand how childhood experiences can lead to self-stigma later in life

Process:

① Ask participants to close their eyes and take a few deep breaths. Now ask them to think back to times in their childhood when they were teased or called names. Ask them to remember the faces of the perpetrators and what they called them exactly. Have them take careful note of their feelings, some of which may be very upsetting.

② Break participants into groups according to global region. Have participants share experiences with each other and compile a list of common names used to refer to MSM and MSM behavior.

③ Bring participants back together and have each group share the names. Ask the participants about how being called those names made them feel then. How does hearing the name make them feel now? Allow each group to share its names. Are there some examples whereby these names have been reclaimed and are used by MSM to refer to each other?

SPEAKING OUT

4.0

Explain that name-calling is a very simple example of stigma. It is an illustration of how stigma:

> Happens from the youngest of ages

> Is shared across cultures and contexts

> Has a deep impact that we feel even in adulthood

(4) Next, ask the participants to close their eyes and take a few deep breaths. Ask them to answer the following questions with a show of hands, anonymously:

> Do you feel guilty because you love men?

> Do you try hard to keep loving men a secret?

> Are you afraid you will be treated like an outcast if people find out you are an MSM?

> Do you worry that people might question your character if they find out you are an MSM?

> Do you apologize frequently when speaking?

> Are you often afraid or reluctant to say no?[1]

The facilitator should explain that stigma and discrimination come from both the inside and the outside, and that MSM need to advocate for their rights in society as well as engage in a personal struggle for self-acceptance and self-love. Many people will raise their hands and answer yes to the preceding questions. Explain that if participants raised their hands in response to any of the questions above, it is indicative of low self-esteem as it relates to their identity as MSM.

FACILITATOR NOTE:

At this point, underscore the importance of healing past wounds by examining some of the ways self-stigma manifests. Ask participants to make a commitment to assessing the degree to which they love themselves and feel worthy of health, security, and happiness, and to follow this with a commitment to work toward greater self-love and acceptance.

CONNECTING STIGMA AND DISCRIMINATION AND HIV

4.1

Purpose:

To get participants to interactively explore the connection between stigma and discrimination and HIV risk. A key part of planning for stigma and discrimination advocacy is to understand how the 2 connect.[2]

Goals:

At the end of the exercise, participants will be able to:

> Understand the specific connection between stigma and discrimination and HIV risk

Materials:

> Handout 4.0

> Handout 4.1

> LCD projector

Process:

① Break participants up into 3 groups and have them each read the story in Handout 4.0 to their group. They should address the following questions:

What happened in the story?

Why is Kiri behaving the way he is?

How does stigma affect disclosure to his partners and his use of health services?

How does MSM stigma result in the continuing spread of HIV?

If we stigmatize MSM, does it stop them from having sex with men?

Do you have any stories you would like to share that connect discrimination and HIV?

② Lead a discussion surfacing responses and project Handout 4.0 on a screen or wall for the group to review.

4.2

EXERCISE 4.2

ADVOCACY — REACTIVE AND PROACTIVE

Purpose:

To develop strategies for advocating for rights both reactively (when stigma is happening) and proactively (in general) through role play and analysis.[2]

Goals:

At the end of the exercise, participants will be able to:

> Understand stigma and discrimination as occurring on both individual and societal levels

> Cite strategies for coping with discrimination reactively

> Cite strategies for ending discrimination proactively through advocacy

Process:

(1) Choose 3 main issues from Exercise 4.1, and break down each into 3 paired roles (total of 6 actors, the rest audience).

Role A: perpetrator of discrimination

Role B: MSM recipient of discrimination

Issue examples include father/son, teacher/student, local rowdy/MSM, and doctor/patient. The actor pairs take turns enacting an experience of discrimination in as much detail as possible. Participants should dig deep into their own experience and make the role play as close to reality as possible.

FACILITATOR NOTE:

Ask the other participants (audience) to note the ways in which the recipient of discrimination (role B) is managing the discrimination. What tactics is he or she using? How does this resonate with their own experience? How would *they* react?

② Devise a list of tools for managing discrimination from the collective experience of the group.

This list might include:

> Talk to brothers or sisters who may be sympathetic and win their support.

> Be courageous and tell your family that you have a right to be different.

> Invite family members to attend MSM events so they learn more about MSM.

> Show you are as productive and valuable as any other family member.

> Be courageous and demand fair treatment in a polite but assertive way.

> Don't give up. Don't walk away. Stay and demand equal treatment like other patients.

> Go to the clinic with other MSM patients.

> Tell people what you think, feel, and want clearly and forcefully. Say "I" feel, think, or would like.

> Don't apologize for saying what you think or put yourself down.

> Stand or sit straight in a relaxed way.

> Hold your head up and look the other person in the eye.

> Speak so that people can hear you clearly. Stick with your own ideas and stand up for yourself. Don't be afraid to disagree with people.

> Accept other people's right to say "No" and learn how to say "No" yourself.

③ Explain to the group that this list is a useful set of tools for reacting to stigma when it is enacted in day-to-day settings, when there is little time to think. Explain that reactively responding to stigma in an intelligent, balanced manner is a form of advocacy. Encourage participants to take some time to prepare themselves for reacting to stigma in the future.

④ Bring the group back together and explain that responding reactively to stigma is not enough, and that proactive steps should be taken to proactively confront stigma. Group brainstorm a list of ideas about how advocacy can be used to address stigma proactively. Some of these ideas might include:

> Train doctors and other health workers on basic skills in the management of STIs in MSM.

> Train health workers on how to counsel MSM patients, for example in using non–judgmental, neutral language.

> Lobby local authorities to provide support to MSM. In some cases they are not even aware that there are MSM living in their communities.

4.2

> MSM should hold stigma workshops to first understand stigma themselves, and then educate service providers and community leaders.

> Build on existing HIV workplace policies with the goal of building an accepting atmosphere.

> Reach out to the general population through health camps, film festivals, bake sales, and dramatic performance.[2]

(5) Finish the exercise by emphasizing to the group the importance of building on strengths and skills they have already developed through personal experiences of stigma and discrimination. Preparation is key.

Coming out. This can be a powerful act of proactive advocacy that should be approached very carefully with thought and preparation. There are many wonderful guides to thinking through whether coming out is the right thing for you right now, and if it is, how to take steps towards making it as positive and stress-free an experience as possible. Please see the Stigma and Discrimination Resources section.

Remember, opening up about being MSM should not be forced, and should only happen when the time is right. You can be a good advocate at whatever stage in the coming-out process you happen to be.

EXERCISE 4.3

ADVOCATING FOR YOURSELF, WITHIN

Purpose:

To highlight the importance of dealing with self-stigma, and offer some strategies for "internal advocacy" both to cope with the stress caused by stigma and discrimination and to build self-esteem.

Goals:

At the end of the exercise, participants will be able to:

> Understand low self-esteem is a contributing factor to HIV risk for MSM

> List strategies for beginning the process of eradicating low self-esteem

Materials:

> Open space, preferably a quiet area

Process:

① Explain to the participants that stigma and discrimination can lead to stress and low self-esteem. These are contributors to a community's vulnerability to HIV risk, and should be addressed. Ask participants how they manage stress.

② Lead the participants in a **relaxation exercise, focused on the breath or walking**. There are some good resources available for this online. See Jack Kornfield's instructions for sitting meditation below:

http://www.jackkornfield.org/meditations/sittingMeditation.php

③ Explain the importance of **MSM coming together as a group** on a regular basis. This exercise is fun, is a great way to decompress and de-stress, and also serves as a key step in community collectivization. Encourage the community to set a regular meeting time and place, at least monthly, to accrue the benefits of coming together.

4.3

④ Lead the group in a small exercise that introduces the practice of **positive aspirations**. Ask the participants to repeat the following:

a. May I love myself just as I am.

b. May I feel self-worth and well-being.

c. May I trust this world.

d. May I make a difference in the lives of people I touch.

Explain that clearly stated aspirations like the above serve as helpful reminders and can have a positive effect and come to being.

⑤ Exercise! Ask the participants to get up from their seats and follow the facilitator in a combination of jumping jacks, sit-ups, and push-ups. Allow this to continue for 5 minutes. Ask the participants how they feel after the exercise. Are they energized? Explain that a **regular exercise routine** can be a very supportive way to eradicate self-stigma.

⑥ End the exercise with a **positive visualization** exercise. Ask participants to close their eyes and relax. Ask them to think about a time when they felt good about themselves. It could relate to the successful completion of a project, a time when they stood up for their rights, or just a time when they were carefree and relaxed. This serves as a positive note on which to end the exercise.

EXERCISE 4.4

CASE STUDY — LOTUS — ACT PROJECT, INDIA

4.4

Purpose:

To illustrate how stigma and discrimination can be approached with advocacy.

Goals:

At the end of the exercise, participants will be able to:

> Cite specific examples of stigma and discrimination–targeted advocacy

Materials:

> Handout 4.2

Process:

1. Hand out Handout 4.2 and have participants read it.

2. Questions:

   Who is the target of Lotus' advocacy?

   What is the medium of their message?

   Did Lotus leverage the support of other power players to support their advocacy?

FACILITATOR NOTE:

Note that the Lotus example illustrates:

1. Advocacy at a very local level

2. Community-driven advocacy

3. A medium that is easily understood and digested by the local population

4. Messages that target the general population

5. Leveraging the local leaders' approval publicly

6. Lotus got a letter for support from the State AIDS Control Society

Leveraging local power. Consider building alliances with local personages who carry clout and power—who the rest of the community looks up to. Their attendance at an event will magnify the chances that your message will hit home and change minds.

STIGMA AND DISCRIMINATION RESOURCES

POSITIVE PREVENTION TOOLKIT

International Training and Education Center for Health (I-TECH)
http://www.positiveprevention.ucsf.edu/moz?page=moz-CU06INDI

The overall goals of the training are that: (1) Counselors will be able to describe the importance of follow-up counseling in terms of improving the lives of PLHAs and stopping the spread of HIV via Prevention with Positives; (2) Counselors will demonstrate appropriate ways to use the follow-up counseling toolkit with HIV+ clients.

UNDERSTANDING AND CHALLENGING STIGMA TOWARD MEN WHO HAVE SEX WITH MEN: CAMBODIA EDITION

Toolkit for Action
International Center for Research on Women (ICRW) and Pact
http://www.icrw.org/publications/understanding-and-challenging-stigma-toward-men-who-have-sex-men-cambodia-edition

This toolkit, adapted and tested with local organizations in Cambodia, includes participatory, educational exercises that can be used with a wide range of individuals and groups to stop stigma and discrimination toward men who have sex with men.

UNDERSTANDING AND CHALLENGING HIV STIGMA: TOOLKIT FOR ACTION, MODULE H — MSM AND STIGMA

HIV/AIDS Alliance
http://www.aidsalliance.org/publication-search-results.aspx

The toolkit contains over 100 participatory exercises which can be adapted to fit different target groups and contexts. There are different sets of pictures, which help to identify stigma, discuss the rights of positive people, and help to stimulate discussions around gender and sexuality and morality issues linked to stigma.

UNDERSTANDING AND CHALLENGING HIV STIGMA: TOOLKIT FOR ACTION, MOVING TO ACTION MODULE

HIV/AIDS Alliance
http://www.aidsalliance.org/publication-search-results.aspx

Guide for translating knowledge about stigma and discrimination into action.

TRAINING MANUAL FOR COMMUNITY RESPONSE TO STIGMA AND DISCRIMINATION RELATED TO HIV/AIDS

Latin American and Caribbean Council of AIDS Service Organisations
http://www.laccaso.org/index_english.html

BEYOND HATRED

Public Broadcasting Service (PBS)
http://www.pbs.org/pov/beyondhatred/

Beyond Hatred, a feature-length (90 minutes) documentary, in French with English subtitles, provides a remarkable portrait of a family that rejected revenge in favor of a plea for tolerance and understanding. As an outreach tool, it challenges viewers to do the same. With no narrator to reinterpret events or people's words, audiences are left to draw their own conclusions about the ways in which societies, as well as individual decisions, produce killers.

DEALING WITH HOMOPHOBIA AND HOMOPHOBIC BULLYING IN SCOTTISH SCHOOLS

LGBT Youth Scotland
http://www.ltscotland.org.uk/resources/d/genericresource_tcm4512285.asp

This toolkit has been developed as one of a number of equality projects covering a range of issues. It follows research to identify policy, practice, awareness and confidence around dealing with homophobic incidents. The resource aims to provide confidence and skills to support school staff in recognizing, preventing and dealing with homophobia and homophobic bullying in schools in the context of curriculum for excellence.

AN INTRODUCTION TO WELCOMING SCHOOLS

Human Rights Campaign (HRC)
http://www.hrc.org/about_us/13336.htm

A primer version of the comprehensive Guide, An Introduction to Welcoming Schools includes an overview of Welcoming Schools and resources such as sample lesson plans and LGBT-inclusive bibliographies for children and adults.

RESOURCE GUIDE TO COMING OUT

Human Rights Campaign (HRC)
http://www.hrc.org/about_us/13278.htm

Throughout the process of coming out and living ever more openly, you should always be in the driver's seat about how, where, when and with whom you choose to be open. This guide was designed to help through that process in realistic and practical terms. It acknowledges that the experience of coming out and living openly covers the full spectrum of human emotion—from fear to euphoria.

ORDER OUT, SAFE & RESPECTED YOUR RIGHTS AT SCHOOL

Lambda Legal
http://www.lambdalegal.org/publications/out-safe-respected/

This kit is designed to help students know their rights at school and make sure they're respected, and to give concrete ideas about how to make a difference in school and community.

TAKING ACTION AGAINST HIV STIGMA AND DISCRIMINATION

UK Department for International Development (DFID)
http://www.aidsportal.org/Article_Details.aspx?ID=6575

The publication contains a wide range of information:

*On stigma and discrimination and the impact on AIDS responses;

*On ways to address it, toolkits and case studies of successful programmes; and

*On how stigma and discrimination can be measured and progress evaluated.

REVIEW OF LEGAL FRAMEWORKS AND THE SITUATION OF HUMAN RIGHTS RELATED TO SEXUAL DIVERSITY IN LOW AND MIDDLE INCOME COUNTRIES

UNAIDS
http://www.unaids.org/en/PolicyAndPractice/KeyPopulations/MenSexMen/

This study sought to review published and unpublished data and information of policies, legal frameworks and regulations, homophobic practices (including violence) and related human rights violations, as well as stigma and discrimination with a pilot study to fill the most relevant knowledge gaps in sub-Saharan Africa, Asia, the Middle East and North Africa, Eastern Europe, and Latin America and the Caribbean.

CHAPTER 4
REFERENCES

1. University of California, San Francisco. Positive prevention toolkit. http://www. positiveprevention.ucsf.edu/moz?page=moz-HOME00EN. Accessed June 14, 2010.

2. Pact Inc. and the International Center for Research on Women. Understanding and challenging stigma toward men who have sex with men: toolkit for action. Adapted version for use in Cambodia. http://www.icrw.org/files/publications/Understanding-and-Challenging-Stigma-toward-Men-who-have-Sex-with-Men-Toolkit-for-Action. pdf. Published 2010. Accessed June 23, 2010.

5 RESEARCH

Research is essential for effective tracking of epidemiological information relating to MSM, and for planning effective interventions and programs. It is also a core skill required for advocacy; solid research forms a foundation from which advocacy groups can make a case for a particular need or service. A strong evidence base enables communities to overcome the stigma that governs resource allocation in country and funding governments.[1]

This poses a challenge for MSM groups that want to move forward with advocacy projects, as there is a general lack of epidemiological and sociological research relating to MSM. Communities often find themselves in a position of needing and desiring to advocate for HIV-related programs and services for MSM without local epidemiological and social research to back their claims and lend evidence to their case that these services are needed. MSM must be creative in the way they approach advocating for programs, services, and research in light of this gap. The good news is much MSM epidemiological and sociological research has been conducted around the world, and this can be a useful tool in instances when local research and data are not readily available.

This chapter is divided into 2 main sections; research *on* MSM and research *by* MSM. The first section guides groups in assessing their country's current MSM research scenario, gives ideas for where MSM might think about directing advocacy for research, facilitates brainstorming about key issues and topics that research should cover in their locales, and provides guidance on how to move forward right now, despite gaps in the availability of localized research. Emphasis in the chapter is given to using research as a tool to help advocate for MSM-targeted programs and services, over advocating with governments and research institutions to include MSM in their overarching research agendas, The second section gives ideas about how MSM communities can apply simple research techniques themselves.

Key points:

> MSM-related data are crucial for organizing effective advocacy for programs.

> MSM are missing from many countries' surveillance data.

> Research into effectiveness and cost-effectiveness of programs—evaluation is an oft-neglected yet important step.

> Epidemiological *and* socio-behavioral research is needed.

> Communities can use basic research tools to begin this work.

> Research should be applied appropriately for different audiences.

Chapter goals:

Upon completing the exercises in this chapter, participants will be able to:

> Understand how research can be effective for the purposes of completing an action

> Identify core research areas for MSM

> Brainstorm core questions for their specific locale

> Understand that research can be transferable for the purposes of advocacy

> Apply research from other contexts to contexts where no research has been completed

> Cite specific ways to translate research into specific steps in an advocacy campaign

EXERCISE 5.0
WHY RESEARCH?

5.0

Purpose:

To bring participants to an understanding of research's importance to advocacy in a fun and interactive way.

Goals:

At the end of the exercise, participants will be able to:

> Understand how research can be effective for the purposes of completing an action

Materials:

> Candy bars, or other inexpensive material incentives (enough for the whole group), hidden in a bag

Process:

① Divide the group into teams of 5–8 members each. Explain to the participants that a number of special prizes have just become available for which they have a chance to qualify. The only catch is they must provide information that they meet the requirements and must provide evidence that they do.

② Explain to the group that they must meet the following criteria to be eligible for the prize, and must show proof.

> Highest percentage of people from the same country

> Greatest number of people with names beginning with the same letter

> Highest average number of sisters per participant

③ Give the group time to do the research and return with findings.

④ Bring the group members back together and thank them for their hard work. Ask for proof that they meet the eligibility requirements for the prize.

SPEAKING OUT

5.0

5. Explain that the group has just participated in research, which was later applied to further an action (proving that they are eligible for the prize). Explain that this is a very basic example of how research works in advocacy and how communities contain most of the skills required to complete research and/or advocate with research without even realizing it. Reward them all with a prize.

EXERCISE 5.1

WHICH RESEARCH TOPICS?

5.1

Purpose:

To identify core research topics relevant for MSM groups and potential advocacy targets for each.[2]

Goals:

At the end of the exercise, participants will be able to:

> Identify core research areas for MSM

> Brainstorm core questions for their specific locale

Process:

(1) Break into 3 groups, assigning each group 1 of the following 3 research topics: epidemiological, behavioral, and services. Without calling the groups by those particular names, as the terms may be unfamiliar, call the groups A, B, and C. Explain that the basis of research is a set of questions that need to be answered. Ask each group to brainstorm questions relating to the following topics:

> Group A: Patterns of HIV infection in their local MSM community

> Group B: Individual and collective behaviors that put MSM at higher risk for HIV transmission.

> Group C: Effectiveness of services currently available and what set of services would be the most effective possible for MSM

(2) Ask the group members to brainstorm questions for research exploration according to their topic. Clarify that the research objective is to build a better understanding of HIV and MSM communities in their locales.

5.1

③ Bring the group back together and compile a master list of potential topics for research.

Some responses could include:

Group A Epidemiological	Group B Behavioral	Group C Services
How many MSM?	Which MSM are more susceptible to the virus?	How effective are intervention services?
How many infected with HIV?	What is the sociocultural context in which male-to-male sex occurs?	How transparent is current resource allocation for services among all stakeholders?
How many MSM requiring care and treatment?	What behaviors contribute to MSM risk?	What is the optimal spectrum of services supporting HIV prevention and care?
How many MSM wives are HIV positive?	What behaviors associated with risk are the result of stigma and discrimination?	What are the best strategies for engaging diverse populations of MSM?
		What is best way to track service delivery and effects?

Adapted from USAID Health Policy Initiative. Policy Brief: Investing in HIV Prevention for Men Who Have Sex with Men: Averting a "Perfect Storm"[2]

④ Explain to the participants that these questions all represent viable research topics for MSM in their area.

Lead a group discussion based on the following questions: are any members of the group aware of research that has already explored some of the questions they raised? Who completed the research? In general, who completes research? Where can MSM go to advocate for this research to be included in agendas? Identify a list of potential targets. These could include:

BSS, National AIDS Control, GFATM Country Coordinating Mechanisms, universities, research institutions (consult MSMGF Web site for ideas)

EXERCISE 5.2

USING WHAT WE ALREADY HAVE

5.2

Purpose:

In most instances, communities will find that there is a dearth of data in their areas. There has, however, been much MSM-related research conducted across the globe. This exercise is designed to assist groups in thinking about how to use research that is *already* available to make a case for research in their locales.

Goals:

At the end of the exercise, participants will be able to:

> Understand that research can be transferable for the purposes of advocacy

> Apply research from other contexts to contexts where no research has been completed

Local universities are potential targets for advocacy. Many universities require their students to complete research. Building connections with universities and students is a great way for communities to get in touch with research skills and might even drive some locally based research.

Materials:

> Handout 5.0

Process:

1. Explain that one of the nice things about research is that it can be applied, which means that it is not necessary that it be tied to the particular area where it was completed for it to be relevant, as long as there is some degree of similarity shared between the 2 areas. For example, research completed in MSM populations in Indonesia can be relevant to MSM populations in Vietnam.

2. Distribute a list of research article abstracts about a range of topics as they relate to MSM. The topics should encompass a good deal of the information identified in exercise 5.0.

3. Break into the 3 groups again and request that the groups put together a plan for using research findings from other contexts to advocate for a particular service in their locality. Alternatively, if the participants come from different places, assign each group 1 of the following hypothetical cases:

    > MSM community group with rampant substance abuse

    > Married MSM engaging in sex with both men and women

❯ Community with little to no targeted intervention programming for MSM

❯ Rural MSM population without services

❯ Urban MSM population with limited services

❯ MSM in prisons

④ Ask participants to write a brief, 1-paragraph statement that

(a) articulates the need for a particular service/investment/research

(b) refers to evidence form other studies to make a case

Oftentimes, the most effective advocacy messages are concise. Encourage groups to keep this writing sample to less than 1 page; half a page is even better.

⑤ Return in plenary and share results. Emphasize that advocating for research in a situation where there is no research is difficult because research is an essential element in advocacy campaigns; however, research from similar contexts can be leveraged to strengthen their case.

FACILITATOR NOTE:

At the end of this exercise, point participants to the MSMGF Web site, which has country pages for each country around the world where research, reports, and other data are posted. If a particular country of interest lacks data, it may be useful to draw upon data from a nearby country in the region as an example.

EXERCISE 5.3

HOW TO USE RESEARCH AND DATA FOR ADVOCACY

5.3

Purpose:

To give participants ideas about how to use research findings for advocacy.

Goals:

At the end of the exercise, participants will be able to:

> Cite specific ways to translate research into specific steps in an advocacy campaign

Materials:

> PowerPoint presentation: Advocacy and Dissemination of Research Outcomes, Cary Alan Johnson, Africa Team Leader, IGLHRC

Available at:
http://www.soros.org/initiatives/health/focus/sharp/events/msmhiv_20080411/seroprevalance-probe.pdf

Consider conducting your own research. There are a number of tools and manuals to help communities get started on applying research methods such as doing surveys, interviews, and discussions. Think about whom you can reach out to for help if you need it, such as universities and colleges in your area that require their students to do project work. See resource section.

Process:

1. Give presentation.

2. Lead discussion. Ask if participants have experience using data for advocacy, and if so, how they used it and what the results were.

SPEAKING **OUT**

5.4

EXERCISE 5.4

CASE STUDIES

Try Triangulation

Triangulation presents one strategy for using diverse datasets to develop timely recommendations for policy implementation and program improvement to guide decision-making. See the guide in the Research Resources section.

Purpose:

To give examples of MSM research.

Goals:

At the end of the exercise, participants will be able to:

› Cite specific ways research has been integrated into advocacy campaigns

Materials:

› Handout 5.1

Process:

(1) Distribute Handout 5.1. Introduce the case studies as containing examples of community-driven research. After giving participants time to read through each example, lead a discussion around the following points:

What topics did the research cover?

Is there an example of how research was disseminated/used for advocacy?

Who was involved in the research projects? What organizations were involved in addition to NGOs?

SPEAKING OUT

RESEARCH RESOURCES

START : SIMPLE TOOLKIT FOR ADVOCACY RESEARCH TECHNIQUES

Volunteer Services Overseas (VSO)
http://www.search4dev.nl/record/288477

VSO's advocacy research toolkit, based on VSO's own experience of low-cost, non-academic professional research.

HIV TRIANGULATION RESOURCE GUIDE

World Health Organization (WHO)
http://www.who.int/hiv/pub/surveillance/triangulation/en/index.html

This guide offers a 12-step, systematic approach to conducting a data triangulation analysis. The examples used are adapted from real-life situations in countries affected by HIV and are interspersed throughout this guide.

THE HANDBOOK FOR EXCELLENCE IN FOCUS GROUP RESEARCH

Academy for Educational Development (AED)
http://www.globalhealthcommunication.org/tools/60

This document provides practical guidelines in appropriately using focus group research, as well as suggestions for modifications to developing world realities. This exhaustive handbook includes an overview of qualitative research and guidelines for setting up and implementing focus group research.

GUIDELINES FOR EFFECTIVE USE OF DATA FROM HIV SURVEILLANCE SYSTEMS (ENGLISH, SPANISH)

World Health Organization (WHO)
http://www.who.int/hiv/strategic/surveillance/hivpubsurveillance/en/index.html

This section gives an overview of some of the principles involved in the effective use of surveillance data for advocacy and then discusses how to package data for specific audiences. Later sections give practical guidance on how to prepare presentations and reports for greatest effect.

RAPID ASSESSMENT AND RESPONSE ADAPTATION GUIDE ON HIV AND MEN WHO HAVE SEX WITH MEN

World Health Organization (WHO)
http://www.who.int/hiv/pub/populations/guide_msm/en/index.html

This adaptation guide for work with men who have sex with men offers guidelines on how to conduct a Rapid Assessment and Response (RAR) focusing on lifestyles, behaviors, and HIV/AIDS concerns. It outlines a series of simple and practical activities that may be used to explore the circumstances, experiences and needs of men who have sex with men across a variety of settings. It is designed to be used either in conjunction with the WHO Rapid Assessment and Response Technical Guide (TG-RAR) or as an independent resource.

RAPID ASSESSMENT TOOL FOR SEXUAL & REPRODUCTIVE HEALTH AND HIV LINKAGES

International Planned Parenthood Federation (IPPF)
http://www.ippf.org/en/Resources/Guides-toolkits/Rapid+Assessment+Tool+for+Sexual+Reproductive+Health+and+HIV+Linkages.htm

This generic tool covers a broad range of linkages issues, such as policy, systems, and services. By design, it aims to provide a guide for assessing linkages that can be adapted as needed to regional or national contexts based on a number of factors.

MSM AND HIV/AIDS RISK IN ASIA

The American Foundation for AIDS Research (amfAR)
http://www.amfar.org/community/article.aspx?id=3710

This TREAT Asia special report examines the scope and surprising diversity of male-male sexual activity throughout Asia, illuminates its role in contributing to the spread of HIV infection, and offers solutions for reducing vulnerability to infection among these hard-to-reach populations.

SPEAKING OUT

OFF THE MAP: HOW HIV/AIDS PROGRAMMING IS FAILING SAME-SEX PRACTICING PEOPLE IN AFRICA

International Gay and Lesbian Human Rights Commission (ILGHRC)
http://www.aidsportal.org/Article_Details.aspx?ID=4103

Explores the ways in which HIV/AIDS stakeholders are potentially jeopardizing overall efforts to combat the AIDS epidemic.

LGBT HEALTH AND RIGHTS IN EAST AFRICA: A SNAPSHOT OF SUCCESSES AND CHALLENGES FOR THE ADVOCACY COMMUNITY

Open Society Institute (OSI)
http://www.soros.org/initiatives/health/focus/sharp/articles_publications/publications/lgbteastafrica_20070930

The information in this report is organized into five topics: Challenges to the LBGT movement; LGBT groups operating in East Africa; reports and convenings focusing on LGBT issues in Africa; potential opportunities for future advocacy on LGBT issues; and recommended next steps for funders.

CHAPTER **5**
REFERENCES

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2. USAID Health Policy Initiative. Policy brief: investing in HIV prevention for men who have sex with men: averting a perfect storm. http://www.healthpolicyinitiative.com/index.cfm?id=publications&get=keyword&keywordID=27. Published September 2009. Accessed June 23, 2010.

6 RESEARCHING & DOCUMENTING HUMAN RIGHTS ABUSES

Research uses systematic methods to collect and document human rights abuses. The results of these investigations provide valuable information to advocate for men who have sex men in the context of global public health and human rights. These methods can be effectively applied to a range of international human rights situations.

Human rights and HIV/AIDS have a close connection. First, human rights violations of MSM and others at risk for HIV increase the risk of contracting the virus. At the same time, having HIV/AIDS often leads to human rights violations. People living with HIV/AIDS may face discrimination by hospitals, employers, landlords, schools, and others. They may face barriers to treatment and violations of their right to privacy.

The purpose of the chapter is to enable MSM-led groups to plan and conduct rights research related to HIV/AIDS issues. The chapter contains exercises that help participants understand how to identify rights violations and then gather and organize that information in a systematic manner.

The goal of the chapter is to enable people to gather and use information to address human rights violations in their own countries. Skills used in research include gathering reliable and useful information, organizing data, and reporting information. Sensitivity to the safety and privacy of those experiencing or witnessing human rights abuses must be a high priority.

Key points:

❯ Rights research gathers and uses evidence about human rights violations.

❯ Rights research uses systematic methods that gather useful and verifiable information.

❯ Protections need to be in place to ensure the safety and privacy of rights workers and community members.

Chapter goals:

Upon completing the exercises in this chapter, participants will be able to:

❯ Understand the importance of research in human rights campaigns

❯ Identify local human rights issues and develop plans to gather information

❯ Assess and mitigate the potential risks in human rights research

❯ Develop skill in collecting factual and useful information through interviews

❯ Learn how to organize and analyze data

❯ Learn how to incorporate testimony into a human rights report

6.0

EXERCISE 6.0

INTRODUCTION TO HUMAN RIGHTS RESEARCH

Adapted from "The Power of Testimony" in Asia Catalyst's *Prove It: Documenting Human Rights – Trainer's Supplement,* pp. 10-14.[1]

Purpose:

This exercise orients participants to the importance of human rights research and why it is important to be systematic and mindful about informed consent and protective of those interviewed.

Goals:

At the end of this exercise, participants will be able to:

> Understand the importance of testimony in a rights report

> Place the interviewee at the center of the work

> Understand the importance of being systematic

Process:

1. Introduce the activity by explaining the power of testimony, which is the explanation of a human rights issue in a person's own words.

2. Discuss the definition of testimony and engage the group about the sample testimony. What makes testimony powerful and what additional information would be helpful to know?

3. Break the group into smaller groups to discuss the advantages and disadvantages of qualitative and quantitative research. You can walk among the groups and help explain the definitions of these 2 types of research and provide examples.

4. You may distribute an optional handout about the differences between qualitative and quantitative research after the discussion. If used, the handout would serve as a refresher about the different types of research.

(5) Lead discussion about considerations during rights research. Possible comments can include the following topics:

> **Informed consent** – In both quantitative and qualitative research, participants must be told about the nature of the study and potential risks. Research should take precautions around safety and privacy, but there are always some risks to research (even minimal such as taking time).

> **Reliability of testimony** – Research on court cases has found that people are not reliable witnesses. That is not anyone's fault but rather the nature of how people process information. You should always fact-check every piece of information and try to get multiple witnesses or look at pictures or footage of events.

> **Is testimony representative of the larger problem?** – When you gather information, you will begin to see patterns. You may hear the same story of people denied health care or discriminated against. Examine the testimony for larger patterns, rather than see them as isolated cases. However, one case does not make a pattern. Sometimes people believe something is universally true because it happened to them or their friends. That is called anecdotal evidence, which needs to be supported by finding other similar cases.

> **Building rapport and trust** – Issues related to human rights abuses, homophobia, and HIV/AIDS are sensitive. Therefore, the researcher must spend time building a relationship and trust. One way to build trust is to be reliable and discreet with information.

> **The ability to take good notes** – Note-taking requires practice and it should be systematic. It helps to determine in advance what categories of information you are looking for. Taking practice notes with a peer before a meeting or interview will help you practice active listening. One trick with notes is to write in shorthand during the interview and then transcribe your notes as soon as possible after a meeting so you do not forget what you wrote.

(6) Summary of information and discussion – This session is introductory and may develop in various directions. Try to summarize the main points of the exercise and ask if participants have questions or want to provide examples in their work. Some people learn better with concrete examples.

(7) Evaluation – Assess participant learning based on how they explain concepts during the small groups and in the full group discussion.

SPEAKING OUT

6.0

FACILITATOR NOTES:

- Share testimony examples, which are stories related to access to HIV services among men who have sex with men (see Handout 6.0.1).[2] The testimony can be shared as a handout or PowerPoint slide.

- You may explain that testimony is a form of qualitative research, which puts the participant or witness at the center of inquiry. You may refresh the participants' understanding about the distinction between qualitative and quantitative research. More information and training lessons on research are provided in the previous chapter of this manual.

EXERCISE 6.1

HOW TO IDENTIFY HUMAN RIGHTS VIOLATIONS

6.1

Adapted from "Rights Issues in Our Communities" in Asia Catalyst's *Prove It: Documenting Human Rights – Trainer's Supplement,* pp. 16-18.

Purpose:

This exercise will enable a diverse group of participants to discuss rights issues in their own communities.

Goals:

At the end of this exercise, participants will be able to:

⯈ Identify and discuss human rights issues in their own geographic areas or countries

⯈ Apply international rights standards to real-world cases

⯈ Understand that rights issues are complex

FACILITATOR NOTE:

Identifying human rights violations and what protections exist under national and international law is a complex subject. In advance of the training session, you may collect relevant constitutional or other legal information for the country where the training is held. Alternatively, you can collect information from a legal aid center or invite an AIDS lawyer to the session.

Process:

1 Introduce the exercise and explain that one starting point of research is gathering initial evidence of rights violations. That evidence may come from the experience of an individual or from an organization.

2 Ask the group to brainstorm specific rights violations. Try to have each member of the group give an example of a human rights violation, so that every member of the group has a chance to speak. Write down each violation on

6.1

a list in front of the group. Then, ask participants which rights are protected by national or international law. The participants can answer to the best of their ability.

3. Break the larger group into smaller groups of 3-4 people to discuss 1 specific rights violation from the list. Encourage the groups to choose different rights violations, but you may allow groups to discuss some of the same issues.

4. Hand out Universal Declaration of Human Rights (Handout 6.1)[3] and explain that this is a simple English version of the rights document created by the United Nations in 1948. Ask small groups to discuss how their issues relate to it.

5. After the small group discussion time, reconvene the large group. Each group can report on its discussion and engage the larger group. Additional rights information may be supplied. The group may debate issues, with the facilitator pointing out that rights issues are complex. There have been other laws enacted since the Universal Declaration of Human Rights.

6. Summary of information and discussion – Summarize the discussion and explain that it is reasonable for people to disagree about rights topics. Issues surrounding human rights are complex.

7. Evaluation – During the discussion, assess the level of understanding of general rights principles and how they apply to examples of human rights violations.

EXERCISE 6.2

ASKING QUESTIONS TO GET POWERFUL TESTIMONY

6.2

Adapted from "Who, What, Where, When, Why, and How" in Asia Catalyst's *Prove It: Documenting Human Rights – Trainer's Supplement,* pp. 57-63.

Purpose:

This exercise helps participants to learn the key questions to ask in interviews.

Goals:

At the end of this exercise, participants will be able to:

> Know what questions to ask in an interview (Who, What, Where, When, Why, and How)

> Practice how to prepare a list of questions prior to an interview

Process:

1 Provide introductory information. For rights information to be useful and credible, it must be specific. The key is to gather all of the relevant details during an interview, rather than try to do a follow-up later. Sometimes, an interviewer can believe he or she has done a thorough interview, only to later discover that he or she forgot about a key piece of information. Since there is so much information to gather, it is important to memorize the important types of questions to ask.

2 Next, distribute the handout titled "Key Questions." Then explain that having a good set of questions will help the interviewer gather useful and credible information. Details create powerful and believable testimony. Also, gathering specific details enables the researcher to identify patterns of human rights abuses. You may then explain each question in the handout and give some examples:

> Who? – The persons involved—names, physical descriptions, occupations, etc.

> What? – The topic of the story and its substance.

6.2

> **Where?** – The location(s) of the events. Be as specific as possible (eg, third floor).

> **When?** – Date, time of day.

> **Why?** – May be difficult to answer. What motives underlie the event?

> **How?** – Sequence of events and actions. Be specific so listener/reader can reenact events in own mind.

(3) Next, break the group into pairs to conduct mock interviews using the key questions. Each pair should practice with one person serving as a reporter and another as the person giving testimony. It's best to role-play about an actual event in the recent past. People may provide their own story topics or you can provide ideas, such as a meeting or event they attended.

(4) Ask the participants to report back on their interviews. You can engage the group in a brief discussion about what the participants have learned.

(5) Ask the participants to brainstorm questions that they would like to ask in an interview and write them down for the group. Then talk about the questions and how each of them answer the essential questions in an interview: Who, What, Where, When, Why, and How.

(6) The facilitator points out how each of the questions requires specific answers. For example, the statement, "I was detained for a long time," is a vague statement. A "long time" is a vague statement and could mean 8 hours or 3 days. Remind the participants that they should ask follow-up questions to gather more specific information.

(7) Distribute the handout "Is This Good Testimony?"[4] and break the group into smaller groups to discuss the testimony.

(8) After the small group session, reconvene the larger group to discuss the testimony and the questions.

(9) Summary of information and discussion – The exercise provided a lot of information. Summarize the key questions and how specificity is important in testimony. Ask participants to share what they have learned.

(10) Evaluation – Assess how well the participants integrated the information by how they were able to analyze the handout, "Is This Good Testimony?"

EXERCISE 6.3

HOW TO ORGANIZE INFORMATION FOR A HUMAN RIGHTS REPORT

Adapted from "Write the Report: Organize the Information" in Asia Catalyst's *Prove It: Documenting Human Rights – Trainer's Supplement,* pp. 82-85.

Purpose:

The lesson focuses on the importance of being systematic in documentation. Organizing the testimony into a compelling and well-documented narrative is an important first step in developing a report.

Goals:

At the end of this exercise, participants will be able to:

> Use case files to organize information to create a convincing narrative

> Preserve confidentiality of informants

Process:

1. Preparation – Create sample case files, with each containing a cover sheet, recording format, and some compelling photographs. Example of cover sheet and recording format are reproduced later in the handouts section.

2. Explain that the purpose of the activity is to learn to be organized and systematic with data. If information is organized, then it is easier to track and analyze the data and to turn it into an overarching narrative explaining the human rights violations. You can recommend that people use the same systems of organization for paper and/or computer files. Explain that these are good practices in using a systematic approach:

> **Be consistent** – Whatever system you use, make sure that same system is used for all of the information you organize. Try not to postpone the work of organizing or labeling data or you may lose it.

- ⟩ **Be universal** – Ensure that everyone who needs to know how to use the system understands how to use the system and follows the same procedures.

- ⟩ **Be secure** – Make sure that you are taking steps to protect the security of your sources and interviewees, even if you are not sure you need to do so. Be sure to secure your data with encrypted passwords and secure backups. Find ways to develop codes for names, so that if information is leaked, it won't be linked to the person.

③ Explain the basics of organization by using a slide or handout to reinforce information. These are the minimum things the participants will need to have an organized system:

- ⟩ A system to organize materials, which is a standard and universal procedure to collect and store information.

- ⟩ A folder for each individual who is interviewed.

- ⟩ A case file information sheet for each file. You can show the sheet in the prepared files.

- ⟩ Confidentiality. Remind the participants that case folders should not have the real names included. Instead, case numbers or fake names should be on the files.

- ⟩ People who know how to return the files they take out.

④ Describe the possible contents of a file, which will vary depending on the type of data.

- ⟩ **Transcript** – This is a written version of an interview. It is ideal to have full transcripts of all interviews, but transcription is time consuming. If you do not have the volunteers or time to fully transcribe interviews, then you can create a transcript outline.

- ⟩ **Transcript outline** – An outline includes each topic of the interview with the corresponding time on the recording (eg, 0:01 – introduction; 5:35 – police raid), so that you will know where to go on the recording to transcribe that portion and write the report.

- ⟩ **Recording log** – If you have taken photographs or have made recordings, you should list each of them by numbers that match the case files. You should also record a date and a brief description of the items.

⑤ Explain that the purpose of data organization is to enable the creation of a report that will tell a coherent story that emerged from the case files. Multiple cases can be summarized into a narrative or one case can be deeply examined. Both methods are acceptable and are used in human rights research.

6 Distribute the case files randomly among the group members. Have those holding the files briefly look through them and describe what they see. Write down the initial impressions on a large piece of paper in front of the group.

7 Then, explain that it is not enough to look at the information; you must also analyze the information into patterns before writing a report. For example, if you are investigating arrests of human rights workers, those arrested may have been from the same organization.

8 Then, break the group in half and distribute the case files equally between the 2 groups. Ask the small groups to examine the files and analyze them by developing categories and patterns as they see them.

9 Next, ask the groups to report back on their analyses. Then explain that once patterns are examined and found meaningful, then a report can be written describing these patterns.

10 Ask the group whether a story can be told from the analysis that reflects the case files accurately. Then ask the group to brainstorm key points that would create a coherent narrative. Write the ideas down in an outline format that organizes the general topics from the details. General topics are written as headings, whereas specific evidence or details would be bullet points under the headings.

11 Ask for volunteers to present an oral narrative that may serve as testimony about the case files they have analyzed during the day. Or, you may break the larger group into small groups to write brief narratives describing the analysis of the case files. You may choose the oral or written method based on the interests of the group.

12 Summary of information and discussion – This session was designed to enable the participants to organize, analyze, and create a narratives based on evidence. A human rights report is only as strong as the methods used to collect and analyze the information. Also, there are many insights that can be drawn from analysis, which means that having multiple people involved can improve the work.

13 Evaluation – The facilitator can examine the learning process in how the participants grow as they engage in a mock data analysis and narrative report.

CHAPTER 6
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7 CIVIL SOCIETY AND NETWORKS

Networks strengthen advocacy's power by multiplying the number of voices and the spectrum of representation for taking action on a particular issue. Networks become increasingly important for movements like MSM and HIV advocacy, which can very often be isolated and cut off from support structures in their local environments. Networking within the movement for MSM rights with organizations working directly with MSM and HIV issues is as important as networking outside the movement and building alliances with groups working in different areas. The power of groups and coalitions to leverage decision makers is oftentimes much stronger than individual group power. For example, MSM groups have built very strong connections with political parties, women's rights organizations, and sex worker collectives, to name a few.

Another important aspect of civil society and networks to keep in mind when working with MSM is the conflict that can occur when many organizations are competing for the same funding or services. Relationships between MSM groups can and do become strained, especially in situations when limited funds become available to a large number of groups, causing competition. At all costs, MSM groups should keep networks with other MSM groups healthy and strong, which requires groups to develop a clear mandate moving forward to avoid hostility and territorialism between groups, to encourage sharing and support, and to avoid reduplication of efforts and wheel reinvention.

This chapter trains participants in the importance of networking, instills within participants an understanding of networking as it relates to advocacy, and provides the resources for MSM to do network mapping for their locale to identify viable networking directions in which to navigate. It also brings participant attention to the issues of territorialism.

Key points:

⇒ Networks have a multiplying effect on advocacy's power.

⇒ Groups should network with preexisting networks.

⇒ Groups should forge networks with existing agencies and bodies working on MSM and HIV issues, such as the Global Fund's Country Coordination Mechanism (CCM).

⇒ Communities should consider forming their own networks.

⇒ Territorialism and work reduplication are not inevitable and can be avoided.

⇒ The MSMGF Web site is a "1-stop shop" for valuable information and resources.

Chapter goals:

Upon completing the exercises in this chapter, participants will be able to:

⇒ Understand the importance of networks to achieving an advocacy goal

⇒ Understand the Yogyakarta Principles, and how they came about through networking

⇒ Differentiate between an advocacy target and an ally

⇒ Identify local allies and potential network partners

⇒ Map challenges within individual organizations and networks that prevent work from happening effectively

⇒ Brainstorm ideas for dealing with these challenges

⇒ Identify next steps for networking

EXERCISE 7.0

BENEFITS OF NETWORKS

7.0

Purpose:

To give participants a solid example of how advocacy networks can yield very positive results.

Goals:

At the end of the exercise, participants will be able to:

> Understand the importance of networks to achieving a goal

> Understand the Yogyakarta Principles, and how they came about through networking

Materials:

> Synthetic yarn (different colors)

> Chair or other common heavy object

> Handout 7.0

Process:

(1) Distribute 1 single long piece of yarn to each participant. Ask participants to attempt to hang the chair (or other heavy object) with the yarn. The yarn should snap every time.

(2) Ask participants to come up with a way to hang the chair without snapping the yarn. Wrapping multiple pieces of yarn together to form a stronger twine can accomplish this.

(3) Distribute copies of Handout 7.0 and have participants read the story of the creation of the Yogyakarta Principles.

After reading the materials, have the group answer the following:

> What is the connection between the yarn exercise and the handout reading?

> Give 2–3 examples of network advocacy in the examples you just read.

> How did networking add special value to a process?

> What are some examples of networking you have engaged in?

Some responses might include:

> Accomplish something together that you could not accomplish alone; more effective research

> Influence others inside and outside the network

> Broaden the understanding of an issue or struggle by bringing together different constituencies (human rights groups, health/medicine organizations, students, academics, men and women, gay and straight, etc).

> Share the work

> Reduce duplication efforts and wasting resources

> Promote the exchanges of ideas, insights, experiences, and skills

> Provide a needed sense of solidarity and moral and psychological support

> Under certain circumstances, mobilize financial resources

> Enhance legitimacy—many united voices calling for action collectively can be more powerful than a single individual's statement[1]

NETWORKING AND ADVOCACY

Purpose:

To give participants specific ideas about how networking can work, through role play.[1]

Goals:

At the end of the exercise, participants will be able to:

> Understand how networking specifically relates to advocacy campaigns

Materials:

> Masking tape

Process:

Set up a role play with the following roles:

> Three persons to play members of the Local Council Committee, which is considering whether to set up an MSM clinic where integrated services will be provided—they are not necessarily opposed to it, but are concerned about what the local community will say.

> Three persons to play activists who are trying to influence the committee members to decide in favor of the clinic (increase or decrease the number in this group depending on the total number of participants but it should be about a third or less of the total number).

> The rest should be paired up to represent other NGOs, which, while also involved in HIV/AIDS, did not arrive at this meeting in support of initiating services for MSM—this could be for a number of different reasons. Assign different perspectives and considerations (eg, we do not have time, we do not have enough staff/funds, we will be seen as anti-government, we represent a different constituency, we want a clinic in our area, we are worried about losing donor funding if we work with this marginalized group, etc)

or ask them to come up with their own excuses. Encourage participants to take on an excuse that they often hear given to them in their own home communities.

Put a line down the middle of the room using masking tape to separate the 3 activists from the rest of the NGOs. The task is for the 3 activists to convince others to cross over and join them in getting the Committee to agree to the clinic being set up. Let this go on for about 15 minutes.

As the facilitator, you can introduce changes midway through the role play (eg, turnover of staff, executive director has decided that he or she does not like the 3 activists because they are too vocal, etc). Put a little pressure on the activists by telling them that they really need to get at least half of the representatives to join them if they want to convince any of the Local Council Committee. Announce the time loudly so that they feel some pressure, too. Extend the time if you feel they have just gotten into their respective roles. Halfway through the exercise, allow the 3 activists to call on 1 ally each to help them appeal to the other groups. They get to name their ally according to who they think would be most useful.

Stop the role play when you think enough issues have surfaced for a discussion. Ask for a round of applause and thank everyone.

Processing the role play:

a. Ask each person to describe his or her experience. How did they feel playing their assigned role?

b. Was it difficult? Easy? Frustrating? Why?

c. Why bother getting the others in? Why didn't the 3 activists simply go in alone?

d. What were your biggest considerations in crossing the line (changing your mind)?

e. By the way, what was the line?

f. What would it take for you to cross the line? Why do you think the NGOs did not want to cross the line? Did any of the activists go toward the NGOs to ask them why they were reluctant to cross?

g. Did you do more talking than listening, or more listening than talking? Did you ever tell the group on the other side of the line that you agree with 1 of their points?

h. What different sets of skills are required in doing networking? How do we go about building these skills?

i. Is this something we see in our own networking experiences?

j. What were the challenges?

While this discussion is taking place, have a volunteer write key words used in the discussion on flipchart paper.

After the discussion is over, reflect as a group, circling key challenges, skills, and advantages related to networking.

What the group will recognize are the challenges of building and sustaining a network, but also, more importantly, how critical it is for effective advocacy.

SPEAKING OUT

7.2

EXERCISE 7.2
NETWORK MAPPING

Purpose:

To map local networks of allies. [2]

Goals:

At the end of the exercise, participants will be able to:

> Understand the difference between an advocacy target and an ally

> Identify local allies and potential network partners

Materials:

> Handout 7.2

Process:

(1) The facilitator should first clarify the difference between a target and an ally, and how some allies can also be indirect targets.

(2) Facilitate a discussion with the participants to share their experiences of working in non-advocacy-related partnerships or coalitions for their work.

Focus the discussion on working in partnerships specifically for advocacy.

Questions might include:

What are your experiences of work with others?

What were the main advantages and disadvantages you identified in working with others?

Have you worked with others on advocacy projects?

What are the differences and similarities between partnerships for advocacy and partnerships for other activities?

③ Distribute Handout 7.2 and ask the participants to draw their potential allies in the diagram provided, as well as their targets. Give them the following guideline questions:

Who else could have a positive impact on the issue that has been chosen?

Who else is already working on this issue?

Who are usually your "natural" allies? Are they true allies for this issue?

Are they happy to work in a coalition?

④ Ask the participants to include in their diagram, for each ally:

What will they gain by joining your alliance?

What can they offer to the advocacy work?

What are their limitations?

7.2

EXERCISE 7.3

NETWORK TROUBLE

7.3

Purpose:

To get groups thinking about potential challenges that may hinder effective networking. Careful attention is given to territorialism and work reduplication.

Goals:

At the end of the exercise, participants will be able to:

> Map challenges within individual organizations and networks that prevent work from happening effectively

> Brainstorm ideas for dealing with these challenges

> Identify next steps for networking

Materials:

> Handout 7.3

Process:

1. Ask the participants to return to their small groups.

2. Reflecting on the last exercise, ask the groups to list down the challenges that they observed and whether these are from within their organizations or from within the networks (15 minutes). Are there other challenges that may not have come up during the case studies or role plays? Ask that they write these down as well.[1]

Examples:

Challenges/considerations within **individual organizations** that may prevent them from networking	Challenges within the **networks** that may hinder effective advocacy
Insecurities Lack of a clear advocacy objective Scattered leadership Single issue focus Lack of resources	Territorialism Narrow work focus Scattered work focus Lack of consensus

③ Ask the group to discuss strategies to overcome these challenges, both short-term, immediate actions and longer-term strategies that need to be adopted. Distribute Handout 7.3 and ask participants to fill it in.

④ Rejoin as a group and discuss.

⑤ The facilitator should ensure the discussion touches upon territorialism, as this is a very common problem in spaces where funding is as limited as it is for MSM. Explain that groups should expect a bit of competitiveness and territorialism when it comes to getting grants. Encourage groups to develop a plan of action for when this occurs, either now for a short time in the session or once they return to their locales. Some ideas are:

> Organizations should develop a plan for when 1 group or more is working in the same area to avoid reduplication. One option would be to make a policy that organizations will not work on the same issue in the same locale. Another solution would be to insist on weekly meetings and build partnerships with groups working in close proximity.

> Sometimes funding and resource agencies offer monetary and in-kind incentives for participation in projects. MSM community groups should develop a method for handling these handouts, ie, participate in studies/accept incentives insofar as they are not divisive to the community. Communities should be aware that incentives dry up quickly and they are certainly not worth fighting over.

> Encourage MSM community groups to develop a regular monthly meeting plan that is independent of outside funding agencies and projects. When communities strengthen core systems independently, they build up a strength that is less easily swayed and divided by outside forces. Allow the shared lack of resources and services to be a point of bonding around which to cohere, rather than a source of division and competition.

⑥ Close session by distributing Handout 7.1. Explain to participants that these are organizations with which they should ensure they are connected. They can fill it out immediately, or use it as a checklist to guide networking later.

NETWORKING RESOURCES

ADVOCACY FROM THE GROUND UP: A TOOLKIT FOR STRENGTHENING LOCAL RESPONSES

Asia Pacific Council of AIDS Service Organizations (APCASO), section 3
http://apcaso.org/index.php?option=com_content&view=article&id=28&Itemid=66

The toolkit provides a guide to a wide range of activities with resources and reference materials for both trainers and participants. It is intended to broadly elaborate on the concept of advocacy and how it plays a key role in effective HIV interventions and AIDS services. It is currently being used to structure advocacy capacity initiatives for the ongoing Community Advocacy Initiative (CAI) project.

NETWORKING FOR POLICY CHANGE: AN ADVOCACY TRAINING MANUAL BY POLICY

The POLICY Project
http://www.policyproject.com/pubs/AdvocacyManual.cfm

The manual is based on the principle that advocacy strategies and methods can be learned. The building blocks of advocacy are the formation of networks, the identification of political opportunities, and the organization of campaigns.

CHAPTER 7
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8 SELF-CARE & WORKING IN HOSTILE ENVIRONMENTS

The global landscape is composed of a range of support levels for MSM and other differently sexually- and gender-oriented populations, ranging from very supportive to unsupportive to hostile. As advocacy requires MSM and their allies to be open about their needs and beliefs and to make a stand for them in public ways, this poses a serious threat in environments that are hostile and sometimes even violent toward MSM. The recent arrests (and eventual pardon) of a couple whose engagement ceremony raised community ire in Malawi are an example of what can happen when MSM identity and culture finds its way into the public space, and the very serious denial of personal freedoms that can occur in hostile environments. And even though their situation fortunately worked out, the threat is very real. In some countries sex between men is punishable by death. Safety and self-care become very important considerations for groups living under such circumstances.

Despite the threat of imprisonment and even death, many MSM activists and groups continue their battle for very basic rights that many MSM in other parts of the world take for granted. And even for those MSM living in "accepting" and "affirming" environments, there are still pockets and places where bigotry against MSM is the status quo. The spirit and strength of MSM who persevere in the face of this adversity is inspiring, and is a testament to the fact that change is possible even in the most difficult of circumstances. Many MSM have been forced to develop coping tools for mitigating unfriendly, hostile situations from the youngest of ages.

In any advocacy efforts for MSM, whether they are in environments that are mostly hostile or environments that are only sometimes hostile, the safety of community members should always be at the top of the priority list of every action plan, every step toward bringing injustices and needs to light. To provide a comprehensive approach to situations of hostility and risk is certainly beyond the scope of this toolkit; however, the following chapter presents some ideas for preparing for hostility so groups are better equipped to cope if and when advocacy results in damage to the community in the form of detention or violence.

Key points:

- MSM community safety should always be a top priority.
- Communities should have a safe space in their locales for MSM to gather.
- MSM communities should have a "violence plan" in place.
- Documentation of violence can be a powerful advocacy tool.

Chapter goals:

Upon completing the exercises in this chapter, participants will be able to:

- Define hate violence
- Cite shared experiences of hate violence
- List safety strategies for dealing with hate violence, self-care, and healing

SPEAKING OUT

8.0

EXERCISE 8.0

RESPONDING TO HATE VIOLENCE

Purpose:

To facilitate sharing among the group about their personal experience of hate violence and to give direction for the creation of a violence response plan.

Goals:

At the end of the exercise, participants will be able to:

> Define hate violence

> Cite shared experiences of hate violence

Materials:

> International HIV/AIDS Alliance toolkit pictures depicting violence

> Handout 8.0

Process:

1. Facilitator should introduce the concept of hate violence, as it is defined in the Cambodia MSM toolkit:

   Hate violence is any act of intimidation, harassment, physical force, or threat of physical force directed against any person, or his or her family or property. It is motivated by hostility to the victim's real or perceived identity (eg, sexual orientation) with the intention of causing fear or intimidation. Hate violence can be perpetrated by any community member, even police officers who abuse their power.[1]

   Facilitator should acknowledge the fact that this is a difficult topic that can sometimes bring up hard feelings, which is perfectly natural.

2. Break out into small groups, distribute the handout, and have participants discuss the following:

   > Have you ever been the recipient of hate violence?

⧉ What form did it take (eg, intimidation, harassment, physical force)?

⧉ Who was the perpetrator (eg, family, rowdies, police)?

⧉ How did you mitigate the situation?

FACILITATOR NOTE:

Ask participants to take note of how they have managed violence when state actors have perpetrated it.

1. The members of each group should note down the situations they have faced in Handout 8.0.

2. Bring the group back together in plenary and come up with a master list of the types of violence they have experienced, the perpetrators, and strategies for managing/ mitigating hate violence.

3. Thank the group and reiterate that even though this is a difficult topic, it is crucial to look into the problem in order to find solutions. The facilitator should share resources with participants at the end of this chapter.

8.1

EXERCISE 8.1

PRACTICAL SAFETY STRATEGIES

Purpose:

To facilitate thinking around strategies for working safely in hostile environments.

Goals:

At the end of the exercise, participants will be able to:

> List some safety strategies for dealing with hate violence

Process:

1. Group brainstorm ideas for the specific ways hostility manifests as an obstacle to advocacy work. Facilitator should note these on a flipchart.

2. Divide the group into smaller groups and assign each team 1 of the obstacles. Some examples may include police violence, blackmail from local rowdies, and vandalism of MSM offices/work space.

3. Ask each group to brainstorm the most effective solution they can come up with for the obstacle they have been assigned. Have each group role-play a "before" scenario, depicting the obstacle; followed by an "after" scenario, in which its solution is depicted. The other groups guess which solution has been implemented.

4. After each role-play session, the facilitator opens the discussion up to the participants and asks if this resonates with their own experience. Do they agree that the solution chosen by the group is the most effective? Would they do something differently? What has worked in their communities?

Safety strategies:

> Set up phone trees for efficient network activation in emergency situations.

> Have a "fact-finding team" trained and on call, in the event it needs to be dispatched.

> Establish inconspicuous safe spaces.

> Develop exit strategies/plans for local emergency situations, such as violence. These should include certain "musts," such as getting authorized medical reports with documentation after cases of violence. These reports can be used for future advocacy.

> Build local networks with lawyers and advocates, who can serve as allies when necessary.

> Strengthen connectedness with Internet groups; this can be an effective way to reach beyond the confines of a hostile country.

> Set aside emergency funds for bail/support.

> Develop a checklist for police identification (badges, time of shift, location). If these details are noted during an incident of violence, filing a case later becomes possible even when literacy skills are lacking.

> Consider investing in self-defense classes and other trainings for the community.

8.2

EXERCISE 8.2

SELF-CARE

Purpose:

To bring group attention to care of the self and its connection to strong advocacy.

Goals:

At the end of the exercise, participants will be able to:

> List some safety strategies for self-care and self-healing

Process:

(1) Explain how MSM advocacy work can be incredibly energizing and reward-ing, but can also be exhausting and sap individual and group energy. There are also other aspects of MSM life that can be mentally and emotionally ex-hausting; leading a double life and dealing with lovers are just 2 examples! Ask the group to divide into pairs and discuss a time they felt emotionally exhausted with the group. This can be related to anything, not just advocacy work with MSM. Ask the participants to share with their partners how they managed those experiences.

(2) Return in plenary and share as a group the situations that sapped the group members' energy and the ways they managed to reenergize and move past the difficult time. The facilitator should keep notes in 2 columns on a flipchart; 1 titled "problem" and the other titled "solution."

Some ideas for solutions:

Living as an MSM can be incredibly difficult; especially in cultures where mar-riage is virtually impossible to avoid. MSM spend a lot of energy keeping up appearances and playing roles out of a need to survive. In cases like this, con-necting with other MSM in a social, relaxed manner can be incredibly help-ful. Organize get-togethers at least once a month, away from the stress of the double life. What would be a hit in your community? A fashion show? A cook-off?

MSM also often bottle up the stress and strain that come from romantic pursuits. In the event that you are experiencing stress related to relationships and sex, reach out to other men in your community; someone else will have already experienced what you are going through. Sharing (1) releases some of the tension and (2) can lead to coping strategies.

Mark and celebrate even the small victories when they occur. These lead to big victories.

Cultivate a spiritual practice. Meditation and prayer have been proven to reduce stress. Experience the collective spirit of your MSM community. If your religious establishment is not welcoming or affirming, mobilize the community to do something spiritual together.

3 End this session with a "backrub chain." Have the group form a circle, then turn to the person to their right (maintaining a circle formation). Ask that the participants place their hands on the shoulders of the people in front of them and give a 2–3 minute massage.

SPEAKING OUT

SELF-CARE RESOURCES

AVP COMMUNITY RAPID INCIDENT RESPONSE MANUAL

Anti-Violence Project
http://www.avp.org/publications.htm

This Guide to Community Rapid Incident Response (or CRIR guide) focuses specifically on anti-LGBTQH hate violence and in doing so addresses some of the unique factors that may need to be considered in before launching a response to this type of violence.

This CRIR guide can be used by anyone, but it has been specifically developed with a beginner or a less experienced community activist in mind to provide a number of helpful tips, each of which are simple enough to be learned over a lunch break.

CREATING SAFE SPACE FOR GLBTQ YOUTH: A TOOLKIT

Advocates for Youth
http://www.advocatesforyouth.org/index.php?option=com_content&task=view&id=608&Itemid=177

This special section of Advocates for Youth's web site is devoted to helping communities create safe spaces for young people of all sexual orientations and gender identities. Because homophobia is a real problem, for gay, lesbian, bisexual, transgender, and questioning (GLBTQ) and straight youth, this online toolkit is a timely guide.

RUNAWAY & HOMELESS YOUTH AND RELATIONSHIP VIOLENCE TOOLKIT

The National Resource Center on Domestic Violence (NRCDV)
http://www.nrcdv.org/rhydvtoolkit/terms-definitions/

Developed by and for experts and advocates in both the runaway and homeless youth (RHY) and the domestic and sexual violence (DV/SA) fields, the Toolkit provides information, resources, tips, and tools to better address relationship violence with runaway and homeless youth.

OUT AT WORK: A TOOL KIT FOR WORKPLACE EQUALITY

Lambda Legal
http://www.lambdalegal.org/take-action/tool-kits/out-at-work/

More and more LGBT people are coming out at work. No matter where you work or what you do, you'll feel more secure in your job if you know your rights. For more than three decades, workplace equality has been a top priority for Lambda Legal. This tool kit gives the information needed to help guide LGBT groups through your work life.

IDENTIFYING VIOLENCE AGAINST MOST-AT-RISK POPULATIONS: A FOCUS ON MSM AND TRANSGENDERS

USAID
http://www.healthpolicyinitiative.com/index.cfm?ID=-publications&get=pubID&pubID=1097

Negative attitudes and violence toward MSM and TG are common worldwide and, in fact, are condoned by many societies. In this way, violence against MSM and TG is a form of gender-based violence (GBV). Researchers have only recently begun to explore the intersection between violence and HIV vulnerability in most-at-risk populations (MARPs). Nonetheless, strong evidence points to the importance of these linkages. Health professionals have the potential to play a key role in the promotion of sexual health, including the prevention of GBV associated with stigma and discrimination in most-at-risk populations for HIV.

TRAINING MANUAL FOR HEALTH PROVIDERS GENDER IDENTITY AND VIOLENCE IN MSM AND TRANSGENDERS

USAID
http://www.healthpolicyinitiative.com/index.cfm?ID=publications&get=pubID&pubID=1101

There are two primary goals of this review. First, it aims to synthesize the literature on violence and related forms of stigma and discrimination among MSM and TG, particularly those engaging in sex work, through a gender perspective. In doing so, it analyzes ways in which violence and S&D among MSM and TG are gender based. Second, the review looks at how violence and related S&D against MSM and TG affects vulnerability to HIV.

CHAPTER 8
REFERENCES

1. Pact Inc. and the International Center for Research on Women. Understanding and challenging stigma toward men who have sex with men: toolkit for action. Adapted version for use in Cambodia. http://www.icrw.org/files/publications/Understanding-and-Challenging-Stigma-toward-Men-who-have-Sex-with-Men-Toolkit-for-Action.pdf. Published 2010. Accessed June 23, 2010.

9 UNITED NATIONS HUMAN RIGHTS MECHANISMS

The United Nations system can be a useful tool in the fight for the rights of MSM worldwide. Most recently, a visit from the Secretary General of the United Nations, Ban Ki-moon, with Malawi's President Bingu wa Mutharika was followed by the 2 men being pardoned from their 14-year prison sentence, initially triggered by their engagement party. Other examples have shown that engaging with the UN can be a useful means to advocate for the rights of MSM.

Before engaging with the system, however, one should understand what the pros and cons of working at an international level are, and, more specifically, how working internationally affects local work. For example, groups are unaware that in addition to the UN's valuable contributions to securing human rights for MSM on an international scale, the global human rights mechanisms can also have a very positive effect and usage locally. Conversely, they can also drain a group's time and energy in some instances, and prove to be discouraging.

If a group decides to go forward with engaging with UN human rights committees or commissions, Special Rapporteurs, or Working Groups, there is a set of concrete actions relating to each that makes advocacy possible. Relevant to the discussion of MSM rights as they relate to HIV/AIDS, UNGASS[1] is another very important related mechanism organizations should consider engaging.

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1   UNGASS, the United Nations General Assembly Special Session on HIV, held in 2001, formed the Declaration of Commitment, which states that HIV/AIDS is a "global emergency," and under which countries come under review on a regular basis.

This chapter is divided into 3 sections. The first explores the concept of advocacy at an international level and contains exercises and information to help organizations decide if this kind of advocacy is something they would like to try, and, if so, understand how it can be locally relevant. The second section relates to the elements within the UN system that are relevant to MSM rights and ways groups might begin engaging the system. The third section looks at UNGASS, which provides interesting opportunities for organizations to do advocacy around MSM and HIV. Please note that this chapter assumes a basic level of understanding among participants of human rights as they relate to MSM. In the event that this understanding has yet to be established, please see the resource section at the end of this chapter for some useful, interactive ways to do this.

Key points:

> Groups should be empowered to make an informed choice about taking on international rights advocacy.

> International advocacy should benefit local work and not take energy away.

> Simply building networks with UN human rights people from your home country can be useful.

> UNGASS is something about which organizations should consider developing an understanding.

Chapter goals:

Upon completing the exercises in this chapter, participants will be able to:

> Conduct a pros-and-cons analysis of engaging the UN system

> Understand local relevance of UN work

> Understand the basics of the UN human rights mechanisms as they relate to MSM

> Generate concrete ideas for engaging the UN system

> Understand basics of the UNGASS and the Declaration of Commitment on HIV/AIDS

> Generate concrete ideas for engaging UNGASS processes

> Cite a specific example of UN human rights advocacy

EXERCISE 9.0

INTERNATIONAL ADVOCACY — PROS AND CONS

9.0

Purpose:

To allow groups to chart the pros and cons of working with the UN human rights mechanisms so they can make an informed choice about potential involvement. Facilitator should guide participants to appreciate the importance of the following question: *What results can potentially help with our local advocacy?*[1]

Goals:

At the end of the exercise, participants will be able to:

> Understand pros and cons of engaging the UN system

> Understand local relevance of UN work

> Determine whether or not engaging the UN system is the right step at this time

Process:

(1) Break into smaller groups and have participants make a list of pros and cons about engaging with the bureaucratic, sometimes slow-moving UN human rights mechanism that does not necessarily hold any guarantees for concrete action. Ask them to think about experiences they have had engaging with the system in the past, or just to think about the issue theoretically.

(2) Write in a visible place: *The UN and other international bodies can condemn human rights violations—but they cannot truly enforce their condemnations. In many cases the process is very slow and does not yield immediate results. UN condemnations can however serve as useful reference points for MSM communities to use to substantiate their claim to the right to health.*

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SPEAKING OUT

9.0

Pros	Cons
Fresh perspectives	Heavy investment of time and energy
Local work bolstered by UN endorsement; having a "seal of approval" from a UN official can go a long way locally	Distraction from local issues
Sometimes the "international shaming" effect works to pressure national governments to change their laws, policies, or stances	May be too abstract for all community members to get excited
Alliances can form with other groups	
Pave the way for future work	
Can be meaningful for local communities to share their stories with an international audience	

③ Bring the group back together and compile their thoughts on the pros and cons. Ask them to come up with a list of criteria for an organization that could benefit from engaging with the UN system (eg, need new perspective on work, need international endorsement, need to forge alliances, story that would be therapeutic to tell for victims, time and skills, progress has stalled at a local and national level).

④ Facilitator should close the session reminding participants that the decision to engage the UN system is entirely up to them. Reiterate the fact that many groups have had good results with the system, but they are not guaranteed.

EXERCISE 9.1

INTRODUCTION TO THE UN HUMAN RIGHTS MECHANISMS

9.1

Purpose:

To give a basic introduction to the UN human rights mechanisms, and clear ways for MSM groups to engage the UN human rights system.[1]

Goals:

At the end of the exercise, participants will be able to:

> Understand basics of the UN human rights mechanisms as they relate to MSM

> Generate concrete ideas for engaging the UN system

FACILITATOR NOTE:

Prior to presenting this section to a particular group, please give a general introduction of the UN human rights treaty and non-treaty-based systems. This could also include a presentation on basic human rights as they relate to MSM. Please see the Human Rights Resources section at the end of this chapter for sources and information.

Process:

Give a brief presentation covering the following:

Work with the UN can be divided into 2 action camps: urgent and non-urgent. Depending on the issue, time required, and resources available to an organization, they should decide accordingly which action route to take. They are described in detail as follows:

> For urgent action: *Special Rapporteurs* and *Working Groups*

9.1

When there is a pressing human rights concern, it is best for groups to approach the non-treaty-based sections of the UN system. Non-treaty-based systems afford a degree of flexibility, as countries are *not* required to have ratified a treaty with the UN in order to engage this part of the system. In addition to flexibility around eligibility, this section of the system is the "fastest" track; of course, speed is defined relatively, especially when one is working with bureaucracy. The main point of contact for this group are (a) individuals called Special Rapporteurs and (b) Working Groups. Of the 2, Special Rapporteurs are the most directly approachable. They present an annual report to the Human Rights Commission with recommendations for action, are in constant communication with governments and, when required, undertake fact-finding missions.

Meet Mr. Anand Grover, Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of health

Anand Grover is a pioneer in the field of HIV and has handled several hundred HIV/AIDS-related litigations in India. He appeared in the first HIV case relating to the HIV activist Dominic D'Souza, The Lucy D' Souza case, challenging the isolationist Goa Public Health Amendment Act. He also fought the first case on blood transfusion in the Calcutta High Court, P v. Uol as well as successfully arguing against the patenting of anti-AIDS drug Nevirapine Hemi-hydrate.

from: http://www2.ohchr.org/english/issues/health/right/SRBio.htm

The Working Groups are most useful for specialized cases such as disappearance and detention. The groups most relevant to MSM are: Working Group on Enforced or Involuntary Disappearances and Working Group on Arbitrary Detention. For a more detailed discussion of these groups, please see the resources section.

Steps to contacting Special Rapporteurs:

1. Determine who the relevant rapporteurs are:

    http://www.ohchr.org/EN/Issues/Pages/ListOfIssues.aspx

2. Either arrange for a meeting or write a letter

    Things to include in the letter:

    > Your own name and address

    > As much information as possible about the victim or victims (if you are writing about a law or government action that affects a large group, explain the way it affects them)

- Description of the violation (if it is a particular incident, give dates and locations; if you are writing about a law or policy, cite it and explain how it is employed)

- Any information you have about the persons who committed the violation

- Information about any steps the victims or their representatives may have taken to obtain a remedy

- Information about whether any official response or investigation has taken place

- Your own recommendation for a response, or for measures to prevent future violation

- What you want the Rapporteur or Working Group to do and why

In preparing reports, referral to the Yogyakarta Principles is recommended. In fact, referencing the principles can be useful for any writing.

Rapporteurs can communicate with the government, but can also visit countries to investigate serious situations directly. Working Groups ask governments for information and request release of the detained.

- Network directly with members of the treaty bodies from your country.

  On the UN Web site you can find the names of members of all the treaty bodies. It is worthwhile to do some Internet research and determine which treaty body members are from your country. Try to meet them in person and speak with them about their stand on MSM, HIV, and human rights, and any other relevant items on your advocacy agenda. For example, members of the human rights commission are:

  http://www2.ohchr.org/english/bodies/hrc/members.htm.

- Shadow reporting

  Shadow reports are the mechanism whereby NGOs and CBOs from countries that have ratified treaties with the UN can contribute their analysis of their country's compliance with the treaty terms and conditions at the time the country submits its compliance report. Shadow reports can vary in length and depth. The steps for writing a shadow report are as follows:

- Determine whether or not your country meets the treaty ratification requirement between your country and the UN. This information can be found here:

  http://www2.ohchr.org/english/

SPEAKING OUT

9.1

≫ Stay up to date in regards to which countries are up for compliance review and when your country will be reviewed next. It is a good idea to plan shadow reporting projects well in advance, as they take time. This information is available here:

http://www2.ohchr.org/english/bodies/hrc/hrcs99.htm

≫ There is a collection of shadow reports drafted by Global Rights that are available at the following link. Before beginning a shadow reporting project read through examples to get a sense for what they entail.

http://www.globalrights.org/site/PageServer?pagename=res_country

≫ There are useful guides for planning shadow reports. Please see the resource section of this chapter for more information.

EXERCISE 9.2

INTRODUCTION TO UNGASS

9.2

Purpose:

To give groups action ideas for engaging with the UNGASS process.[2]

Goals:

At the end of the exercise, participants will be able to:

> Understand basics of the UNGASS and the Declaration of Commitment on HIV/AIDS

> Generate concrete ideas for engaging UNGASS processes

FACILITATOR NOTE:

Like in Exercise 9.1, it is recommended that you prepare a presentation covering the basics of the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) and the Declaration of Commitment on HIV/AIDS.

Process:

Give a brief presentation covering the following:

Like the treaty-governed sections of the UN, countries make compliance reports relating to the UNGASS Declaration of Commitment on HIV/AIDS goals. The latest review and reporting process just occurred in March 2010; however, it is a good idea to think about planning action for 2012. Here is a list of 5 simple steps you can take:

① Review the "Coordinating with Communities" section of the UNGASS document and then **promote meaningful community involvement among your cohorts** in the civil society sector space.

SPEAKING OUT

9.2

(2) Identify the UNAIDS Country Coordinator (UCC) or Partnerships Officer in your country and assess what he or she is doing to involve community in the review process. **Request that UNAIDS facilitate an inclusive and participatory process** among all stakeholders, including advocates and allies working on MSM and HIV issues.

(3) **Review relevant documents**, such as commitments made, etc.

(4) **Contact the National AIDS Program (or equivalent) in your country** and ask how they plan to involve the community sector in the UNGASS review and reporting process. Meet the person who leads the preparation of the report.

(5) **Share all the information you find** about these processes and the outcomes with community partners. This will increase accountability and transparency and will provide support for advocacy actions.

EXERCISE 9.3

SHADOW REPORT CASE STUDY

9.3

Purpose:

To give participants a concrete example of the shape advocacy with the UN can take.

Goals:

At the end of the exercise, participants will be able to:

> Cite a specific example of UN advocacy

Materials:

> Handout 9.0

Process:

①　Break into small groups and distribute Handout 9.0, a shadow report from Zambia.

②　Ask groups to answer the following questions:

How many pages is the shadow report?

Does it seem like it would be difficult or easy to produce?

Do you have experience engaging with the UN?

Do you know UN members in your country? Where is the office?

What are some issues you might consider including in a letter to a Special Rapporteur or in a shadow report?

HUMAN RIGHTS RESOURCES

GUIDE TO SHADOW REPORTING

Global Rights
http://www.globalrights.org/site/
PageServer?pagename=wwd_initiatives_lgbti

The purpose of this short guide is to assist civil society groups and activists—also known as "non-governmental organizations" or NGOs—to participate effectively in the shadow reporting process to the U.N. Human Rights Committee (the Committee). The Committee is responsible for monitoring government compliance with the International Covenant on Civil and Political Rights (ICCPR), one of the eight core human rights treaties of the United Nations.

AMNESTY LGBT HUMAN RIGHTS PRIMER

Amnesty International
http://www.amnesty.org/en/library/info/
IOR40/004/2005

The purpose of this document is to provide basic guidance on how non-governmental organizations (NGOs) can use the United Nations (UN) Treaty Monitoring Bodies (referred to as the "Treaty Bodies") and the Special Procedures of the UN Commission on Human Rights (the Commission) to raise cases concerning the promotion and protection of the human rights of people who are lesbian, gay, bisexual or transgender (LGBT).

TOGETHER, APART: ORGANIZING AROUND SEXUAL ORIENTATION AND GENDER IDENTITY

Human Rights Watch (HRW)
http://www.hrw.org/en/reports/2009/06/10/together-apart

This 44-page report demonstrates that many groups defending LGBT rights—especially throughout the global South—still have limited access to funding, and courageously face sometimes-murderous attacks without adequate support from a broader human rights community.

HOW TO PROMOTE AND PROTECT THE HUMAN RIGHTS OF LGBT PEOPLE — A TOOLKIT FOR THE FCO (BRITISH FOREIGN AND COMMONWEALTH OFFICE)

British Foreign and Commonwealth Office (FCO)
www.msmgf.org/documents/GT_ta_lgbttoolkit.pdf

ILGA-EUROPE WEB GUIDE ON INTERNATIONAL HUMAN RIGHTS REFERENCES TO SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

International Lesbian and Gay Association
http://www.soros.org/initiatives/health/focus/
sharp/articles_publications/publications/
ilgawebguide_20080112

The reference guide will help advocates use international human rights instruments more effectively in their work domestically and regionally. At the same time it will increase their knowledge of the references and of their place within international human rights law and discourse.

MAKING THE MOUNTAIN MOVE: AN ACTIVIST'S GUIDE TO HOW INTERNATIONAL HUMAN RIGHTS MECHANISMS CAN WORK FOR YOU

International Gay and Lesbian Human Rights Commission (ILGHRC)
http://ihrc.digitopia.net/cgi-bin/iowa/article/publications/reportsandpublications/756.html

INTERNATIONAL: TEACHING HUMAN RIGHTS & SEXUALITY (SYDNEY GAY GAMES MODULES 2002)

International Gay and Lesbian Human Rights Commission (ILGHRC)
http://www.iglhrc.org/cgi-bin/iowa/article/takeaction/
resourcecenter/27.html

Introduction to human rights principles and advocacy.

HUMAN RIGHTS AND SEXUAL ORIENTATION: INTERNATIONAL AND REGIONAL STANDARDS SEXUAL RIGHTS: MOVING BEYOND IDENTITY POLITICS – DOCUMENTING HUMAN RIGHTS VIOLATIONS HANDBOOK ON HIV AND HUMAN RIGHTS FOR NATIONAL HUMAN RIGHTS INSTITUTIONS (PUBLISHED JOINTLY WITH UNAIDS)

UN
http://www.ohchr.org/EN/PublicationsResources/
Pages/HumanRightsBasics.aspx

This Handbook is designed to assist national human rights institutions to integrate HIV into their mandate to protect and promote human rights. It provides a basic overview of the role of human rights in an effective response to the epidemic and suggests concrete activities that national institutions can carry out within their existing work.

HUMAN RIGHTS AND HIV/AIDS: NOW MORE THAN EVER 10 REASONS WHY HUMAN RIGHTS SHOULD OCCUPY THE CENTER OF THE GLOBAL AIDS STRUGGLE

Open Society Institute (OSI)
http://www.soros.org/initiatives/health/
focus/law/articles_publications/publications/
human_20071017

Now more than ever, law and human rights should occupy the center of the global HIV/AIDS struggle. This booklet, published by OSI's Law and Health Initiative, presents 10 reasons why.

CHAPTER 9
REFERENCES

1. International Lesbian and Gay Human Rights Commission. Making the mountain move: an activist's guide to how international human rights mechanisms can work for you. http://www.iglhrc.org/binary-data/ATTACHMENT/file/000/000/179-1.pdf. Published 2000. Accessed June 23, 2010.

2. International Council of AIDS Service Organizations. AIDS advocacy alert. http://www.icaso.org/publications/2010/aa_2010ungass.pdf. Published 2010. Accessed June 23, 2010.

10 HOW-TO RESOURCES AND CORE REFERENCE DOCUMENTS

In addition to the resources included at the end of each chapter, this section has been included as an easy reference. It contains a collection of annotations that match up with the HIV/AIDS Alliance's Advocacy in Action toolkit and attunes the skill cards to MSM communities. The skills are the medium through which advocacy messages are delivered, and are broken down into easy-to-understand steps. Also included are links to 2 core reference documents: (1) the Yogyakarta Principles and (2) the UNGASS Declaration of Commitment on HIV/AIDS. These are very useful for references when drafting advocacy documents. Find them at the end of this section. It is suggested that toolkit users download the Advocacy in Action toolkit and read the skill cards in tandem with the annotations below. The following information is included:

- Analyzing and influencing legislation or policies

- Preparing a briefing note or position paper

- Working from inside the system

- Lobbying or face-to-face meetings

- Writing and delivering a presentation

- Persuading through drama

- Working with the media

- Writing and using a press release

> Carrying out a media interview

> Preparing a press conference

> Using the Internet

Please access the HIV/AIDS Alliance's Advocacy in Action toolkit skill cards at the following link:

http://www.aidsalliance.org/publicationsdetails.aspx?id=142

Please note that another very good set of skill cards is available in the APCASO Advocacy toolkit accessible at:

http://www.apcaso.org/index.php?option=com_content&view=article&id=28&Itemid=66

SKILL CARD ANNOTATIONS:

Analyzing and influencing legislation or policies

In some countries, anal intercourse and other expressions of same-sex union are criminalized, leading to incarceration and execution. These policies not only affect individuals, but also obstruct MSM rights by officially condoning anti-MSM attitudes and obstructing HIV prevention efforts.

There are also more subtle ways that policy can impede freedom of movement and expression for MSM communities. For example, in many countries vagrancy laws against petty theft, "public nuisance," and drugs are often regularly and falsely used against MSM in certain communities. In these cases, MSM are charged and taken into police custody in an effort to clear them from public areas.

Of course, it is not enough to stop at analyzing legislation and policies that impede and obstruct MSM individual and collective rights. It is also important to work for new policies that safeguard the rights of MSM and other groups with different sexual and gender identities. In many communities this may not happen for a number of years; nonetheless, it is important to begin thinking and working for these protective policies immediately.

Action step(s):

> Lead focus group discussions or interviews among MSM community members in your area to determine which legislation or policies are serving as obstructions. These might include penal code criminalization of MSM and local vagrancy laws that are used regularly to keep MSM out of the public space.

Preparing a briefing note or position paper

It is clear that there is much work to be done for MSM populations, which means there will be a number of positions and stands to take on multiple issues. In a situation like this, advocacy messages can be amplified by getting consensus from as many groups working with MSM as possible on stances around issues and how issues rank according to priority. Otherwise, the community runs the risk of sending mixed signals, or diluting the potential of their advocacy efforts to make change.

Action step(s):

> Network with other MSM groups in your area and learn about their stances on particular issues, as well as their own advocacy agendas and priority items.

> When possible, come to a consensus on these issues as well as their priority ranking to avoid sending mixed signals.

Working from inside the system

It is alarming how disproportionate the amount of MSM community representation is in systems that are purportedly working for MSM rights and protection. Luckily, there is increasing support for involving community members in decision-making processes, especially in HIV prevention planning bodies. As this need for greater involvement has been articulated in a number of international forums, there is a great deal of scope for leveraging these stated priorities to secure a place for more MSM in decision- and policy-making forums.

It is also important to note that representation is also very often limited to a particular segment of the MSM population; usually the educated, English-speaking, and socially mobile segments. If this is the case in your country, it is important to diversify MSM community representation so it reflects as much of the spectrum of MSM identities as possible, including MSM who may have less education, language ability, or mobility. MSM living with HIV should also be included as a very important voice.

Action step(s):

> Map potential bodies and committees to which community members can potentially contribute their voice as regular or guest participants.

> Identify commitments made by well-respected organizations on the topic of "community ownership" and "greater involvement" of MSM and marginalized communities. These can be leveraged to make a case for participation.

> Be cognizant of what MSM community members are participating and who is missing. Rotate opportunities to represent MSM among diverse types of MSM.

Lobbying or face-to-face meetings

In advocacy work with MSM, terminology is always an important question. As a general rule, use language that your advocacy target audience will understand. For example, the term "MSM" comes from the world of HIV research and prevention, and will certainly not be understood by the majority of audiences. It is also a difficult term in cultural contexts where "sex" as a term is not used openly. The terms gay, bisexual, and homosexual may work in some cultural contexts, but in

others they may not properly represent the MSM population doing the advocacy or may also be very stigmatized terms. Many communities have advocated successfully with targets in conservative cultural settings by using creative terminology to refer to MSM (for example, "ostracized men," "feminine men," "men with the hearts of women"). Making your advocacy target comfortable is key; tactful language use can allow for a meeting to run smoothly and for a longer duration. Another tactic in conservative settings is to consider how appearance can positively or negatively impact a meeting, and your goal should be to make your audience as comfortable as possible. MSM should not feel as if they are compromising their identity; tact is an incredibly important part of making advocacy effective.

Action step(s):

> Lead participatory discussions with MSM in your area to create a list of terms that can be used with various audiences on the basis of their being the most "appropriate" and "palpable" for that particular audience.

> Create a dress code policy as well. For example, when is it appropriate to use drag as a tool to raise awareness, and when is it more appropriate for the community to represent itself more conservatively?

Writing and delivering a presentation

The situation in which many MSM communities find themselves is shot through with gaps, missing pieces, and shortfalls. When making presentations, avoid the tendency to focus on the negative. Build into presentations a sense of positivity and possibility without getting bogged down in what is wrong, what is missing, and what is unworkable about a given situation. Be sure to include at least some examples of what is working or what has worked elsewhere, and articulate clear steps toward a solution to an articulated problem.

Action step(s):

> Designate a community member as editor for all publications and presentations to read documents for language that (1) could potentially offend important advocacy targets, such as National AIDS Program bodies, and (2) assess the degree to which a piece of writing gives readers a sense of positivity and workability.

Persuading through drama

Drama is a very powerful medium through which communities can reach the local public, especially in rural locales. Drama suits MSM community groups for a few reasons. In many cultures MSM are traditionally the keepers of the art of theater and costume, and already have the tools to put up a compelling performance. In

many cultures, drama and theater are culturally sanctioned and important parts of day-to-day life. Bringing messages about MSM to the general population in a familiar cultural medium will increase the chances that the message will reach people. Drama is also a wonderful way for communities to deliver multiple messages, depending on the theme and story of the performance, which the community can control. This makes it an incredibly flexible medium that can be changed according to context.

Action step(s):

> Convene a working group composed of MSM community members who have some degree of experience in performance or theater to assess the possibility of using drama as an advocacy tool. Consider potential actors, potential audiences (local decision makers, schools, festivals where dramas are regularly performed), and messages the community might deliver through a performance.

Working with the media:

Note: These annotations relate to the following skill cards:

(1) Writing and using a press release

(2) Carrying out a media interview

(3) Preparing a press conference

When approaching and working with the media, MSM should remember that the media is not an objective force that necessarily sees the truth in a particular group's message or struggle, despite many people's deep trust in media outlets. Particularly in cultural contexts where MSM rights are still in a nascent stage, or where MSM identities are relegated to a particular societal segment or profession, the media can perpetuate stereotypes even though many often go to the media to learn the "truth."

The media can be used strategically and effectively to sensitize the general public about MSM issues. To do this, consider a few things:

> What is the current depiction of MSM by the local media? What kinds of stories are reported about MSM, and how are MSM portrayed? Is there a particular story that repeats regularly? What terms are used to refer to MSM? Are these in alignment with the truth of the MSM in your community? If not, what are the core stereotypes, and what parts of the story are not being told?

> Like doctors, members of the media are trained in their profession. During their training under most circumstances they do not learn about ethically and sensitively covering MSM. Consider organizing trainings for working

media personnel as well as local media college faculty and students to raise awareness about what constitutes ethical and sensitive MSM community portrayal.

> Another way to sensitize media to MSM concerns is to prepare a leaflet with key points about sensitive coverage, eg, what terminology to use, what stereotypes to avoid, etc. This "takeaway" can assist them when they are putting together their final article or news segment.

> For many MSM, participating in anything media-related can be a terrifying experience because there is the potential for people finding out their MSM status. For this reason confidentiality is a key concern. For the media, communities can prepare a set of regulations around use of names, as well as photographing community members. For a community organization, it is important to train members of the community so they understand these issues, particularly the risks of being exposed. Many MSM who were hiding their identities have been made public by the media because they did not have the knowledge to protect themselves.

> Consent forms are another good way to regulate media coverage of community names and faces. Create a template and require that media people get a signature before publishing names or faces.

> Media also includes film and TV in which the portrayal of MSM is another way stereotypes are perpetuated and learned. What are some examples in your community of MSM in film and TV? What stereotypes repeat regularly?

Action step(s):

> Do a mapping of the local media and its portrayal of MSM. Identify stereotypes that are being perpetuated by these portrayals, as well as aspects that are missing from the story the media is telling.

> Identify media colleges in your area and network with them in the interest of leading a training on ethical and sensitive portrayal of MSM.

> Bring local MSM community members to an awareness of "do's and don't's" when engaging with media to assist them in protecting their privacy if they do not want their names or photographs to appear in the media. Develop a similar list for media people who cover events where MSM are present.

> As a community, come up with a core set of simple, easy-to-articulate points relating to an issue that all participating community members can master in preparation for an event where media will likely be present. This increases the chances that a clear message will reach the media.

Internet

Groups should consider launching an e-advocacy campaign through the Internet, which is accessible in many cultures and a very cost-effective option. This can be done in a number of ways. There are e-forums that host discussions on a number

Two key resources that may be useful when writing for advocacy are:

Yogyakarta Principles: a set of international principles relating to the application of international human rights law to issues of sexual orientation and gender identity, centered on affirming binding international legal standards with which all states must comply.

http://www.yogyakarta principles.org/

UNGASS Declaration of Commitment on HIV/AIDS: a framework of action to halt and reverse the spread of HIV, agreed to by governments and including specific milestones and deadlines.

http://www.unaids.org/en/AboutUNAIDS/Goals/UNGASS/default.asp

of topics relating to MSM, human rights, and HIV in various regions of the world. It can also be achieved through creating a blog about a particular body of work or issue. E-mail blasts can be used to send a number of select recipients documents about particular issues. And social networking pages can be used to get the word out about issues that relate to MSM.

Action step(s):

> Designate an Internet action plan and delegate specific responsibilities (eg, blogger, e-forum manager, facebook manager) to community members with computer skills.

HANDOUTS

NY Times

Malawi President Pardons Gay Couple

By BARRY BEARAK
Published: May 29, 2010[i]

JOHANNESBURG — A gay couple in Malawi sentenced to 14 years in prison for "unnatural acts" was pardoned Saturday shortly after Secretary General Ban Ki-moon of the United Nations met with that country's president.

"These boys committed a crime against our culture, our religion and our laws," President Bingu wa Mutharika said at a news conference in Lilongwe, the capital, before adding that he nevertheless was ordering the couple's unconditional release on "humanitarian grounds."

The two men, Tiwonge Chimbalanga, 33, and Steven Monjeza, 26, were arrested Dec. 28, two days after holding an engagement party in Blantyre, the nation's largest city. As a rule, gays, lesbians, bisexuals and transgender people do not dare make any public show of affection in their deeply conservative country. The event made front-page headlines in a Malawian newspaper.

"These boys committed sodomy, and while the harsh sentence was generally welcomed by the Malawian public, it drew international rebuke. The nation, one of the poorest in Africa, is heavily dependent on foreign aid, and several donors suggested they might have to reconsider their generosity.

Pop stars issued their own condemnations. Madonna, who has adopted two children from Malawi, said the nation had taken "a giant step backward." Elton John wrote an appeal to Mr. Mutharika, asking him to release the couple and "expunge Malawi's discriminatory laws against homosexuality."

In announcing the pardon, the president emphasized that he was not condoning gay marriage. "It's unheard of in Malawi, and it's illegal," he said.

Mr. Mutharika, an economist and the chairman of the African Union, is often praised for recent improvements in Malawi's health and education systems. Mr. Ban arrived Saturday to begin a two-day visit.

"The secretary general told the president rather strongly that the current controversy was having a negative effect on Malawi's reputation and obscuring the progress it had made in other spheres," said a member of the United Nations delegation who said he was not authorized to comment and could only speak anonymously.

Mr. Ban then addressed Parliament, informing legislators that their president had made a "courageous decision" to grant the pardon. The legislators responded with dreary silence while foreign diplomats in the gallery above cheered and applauded.

The secretary general further told the lawmakers, "It is unfortunate that laws that criminalize people on the basis of their sexual orientation should still exist in some countries."

A White House spokesman, Robert Gibbs, greeted news of the pardon with approval, declaring that "these individuals were not criminals and their struggle is not unique."

Late Saturday, Mr. Chimbalanga, who has said he considers himself a woman in a man's body, and Mr. Monjeza were released from custody.

The police escorted Mr. Chimbalanga back to his home village in the remote hills of Thyolo District. He stayed for a reunion with family members, and planned to return to Blantyre early Sunday.

"I've been under so much emotional stress that I need to find somewhere to rest," said Mr. Chimbalanga, speaking by cellphone through an interpreter. "I still want to marry Steven. But I don't know what he is thinking any more. We've been through so much."

He said: "I think it is going to be hard to stay in Malawi. I am afraid of what people might do to us. We probably need to seek asylum in some other country. Is there a place for us? I don't know." Celia W. Dugger contributed reporting.

Case Studies from Sri Lanka

① Local

MSM were facing regular harassment in their community in a local park where they gathered in the evenings. Rowdies blackmailed them, saying if they did not pay them, they would "out" them and tell their parents that they are MSM. Members of the MSM community banded together and took matters into their own hands. The MSM did an analysis of the major decision makers in their area and decided to network with 2 key individuals: (1) the local municipal leader and (2) an influential businessman known to 1 of the MSM. They had personal meetings with both. They asked the municipal leader to pass a resolution that the rights of MSM would be protected in their locality, and also asked the businessman to speak to the chief of police, who was a regular customer of his. The group had to speak politely and in a manner that the leader and businessman would understand. Instead of directly naming themselves as "MSM," they referred to themselves as "marginalized men," getting their point across in polite language that their targets could understand. The municipal leader signed the resolution, and the businessman spoke to his chief of police friend, who in turn spoke to the police force and asked them to provide extra protection for MSM in the park. The municipal leader suggested the MSM register as a formal society, which they did. The harassment in the park stopped completely.

② National

A number of films were portraying MSM in a negative light, reinforcing stereotypes and leading to teasing and harassment of MSM, both in the audience and also in their communities. This was despite the film censor board's official guideline against hate speech or discrimination toward any groups. A number of groups banded together to speak out about this issue, including an NGO that has been working in the field of HIV/AIDS prevention for over 15 years. The group reached out to the National Cinema Actors Guild, film producers, the minister of cultural affairs, the film censorship board, fan clubs of the actor in the film, the actor himself, the local Human Rights Commission, and the press. They reached these groups through letter-writing, boycotting of the film through their local network, and filing a complaint with the local Human Rights Commission. Initially, the boards, ministries, and film clubs were ignoring their requests. Later, a letter of support was obtained from the Human Rights Commission, which enabled the group to put pressure on the film board. The scene negatively portraying MSM was removed from the film, and the censor board invited MSM community members to train their staff on sexuality difference and related stereotypes.

③ International

There was a lack of sexual orientation–related protections in the human rights treaties and bodies in the United Nations system. A coalition of NGOs and experts banded together and decided to do something. They approached the UN High Commissioner of Human Rights and expressed concern about this issue. Although it took time, with patience and persistence the Commission on Human Rights called together a working group and drafted a set of principles geared toward protecting individuals' rights with regard to sexual orientation and gender identity.

Questions for discussion:

> On what level did the advocacy occur?

> What kinds of issues were being addressed in the case studies?

> What different approaches to advocacy work were described?

> Why was advocacy used in the situations described?

> Who benefited from the advocacy work?

> Were those people involved in the advocacy work?

> What were some of the key verbs used in the presentations to describe advocacy?

Stigma and Discrimination

Do MSM marry women and produce children? Do some stay single?

How many MSM are out in your community?

Where do MSM cruise for sex? Do they face problems from police?

Are MSM arrested in your area, and if so, under what laws?

How educated are the MSM in your area?

How common is alcohol and drug use in your local MSM community?

Are suicides common in your community?

Are rowdies a threat in your area? Have MSM been blackmailed?

Are MSM portrayed on TV, in movies, and in newspapers? How?

Research

How much is known about MSM in your area?

Has there been research exploring the following questions, or do you just have a general idea?

How many MSM are living with HIV in your area?

How many MSM practice safer sex?

Is there stigma against HIV within the MSM community?

What do MSM in your area use condoms for?

How many MSM are married with wives and children? Do their families know?

How many MSM experienced sexual abuse as children?

Services/Investment

Does the government have special programs for MSM? Trainings? Services?

Are condoms available in your area? Water-based lubricant? Where do MSM get their condoms?

Where do MSM congregate in your area?

Is there a health clinic for MSM in your area?

Are there support groups for MSM youth?

What does someone in your community do if they need a lawyer?

Where do MSM go to seek justice in their communities?

Do the MSM in your area understand HIV/AIDS?

What do MSM in your area do for work?

SPEAKING OUT

Secondary effects

Suicide

Unsafe scenarios, HIV transmission

Family confine MSM to home, force marriage

Abuse leads to promiscuity and stigma

MSM run away to cities without support

Primary effects

MSM status is disclosed to family

Station setting is unsafe, and abuse happens

MSM feel unsafe and threatened in their cities

MSM who congregate in the park and bus station are routinely picked up by police and held under vagrancy laws for being a "public nuisance"

Immediate causes

No regular meeting place

Police don't understand MSM behavior

Prior run-ins with police have made bad relations

MSM congregating in inhabited areas is taboo

MSM do not speak openly about their lives

Lack of respect for a system that discriminates

Underlying causes

Societal stigma attached to MSM

Internalized stigma and self-hatred

External environment → Decision maker ← Culture, beliefs, ideology

Int'l orgs → (Decision maker)

Adviser and opinion leader → (Decision maker)

Public → (Decision maker)

Govt. dept. → Int'l orgs

Research inst. → Adviser and opinion leader

Networks and lobbies → Adviser and opinion leader

Donors → Public

Media → Public
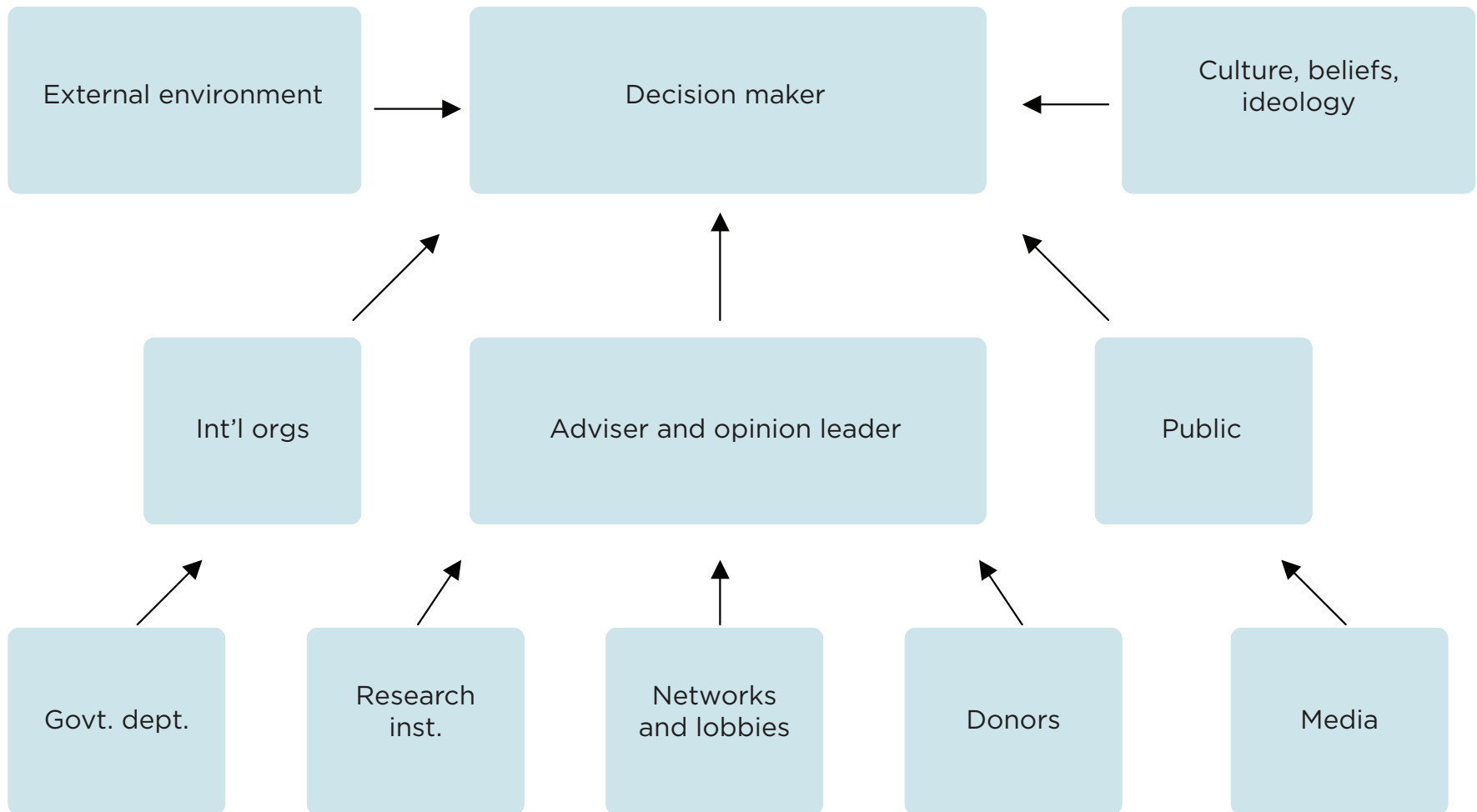
Target	Ease of contact	Ease of being able to convince	Target makes decisions by...	Target listens to...	How to influence target	Any connections already?	Rating

Activities	Person responsible	Resources needed	Deadline	Outcome	Indicator	Documentation

SPEAKING OUT

CAMBODIA 2006ᵛ

AIDS SPENDING MATRIX DATA SHEET BY FINANCING SOURCES YEAR 2006								
NATIONAL AIDS AUTHORITY					**UNAIDS**			
					International Resources			
						MULTILATERAL		
AIDS Spending Categories (Currency USD/Riets)	**Total Spending 2006**	**%**	**Public Sources**	**Private Sources**	Bilateral	UN Agencies	Global Fund	Other International
1. Prevention	20,775,489	44.9%	5,133,539	827,955	7,122,992	3,048,158	3,958,634	684,111
1.1 Media	723,167		-	37,698	20,964	346,723	180,242	137,540
1.2 Community mobilization	162,988		9,920	6,305	17,628	30,471	30,143	68,521
1.3 ABC	4,801		-	830	-	-	3,970	-
1.4 Counseling and testing	2,587,065		-	178	1,646,000	940,034	853	-
1.5 Program for vulnerable	216,117		-	2,839	-	87,656	13,572	112,050
1.6 Prevention youth in school	2,237,551		-	330,089	155,000	174,235	1,578,227	-
1.7 Prevention youth out of schools	1,486,456		-	164,223	155,000	282,057	785,186	-
1.8 Prevention programs inv people living with HIV	60,526		-	3,149	-	42,319	15,057	-
1.9 Prevention programs involving sex workers	185,013		-	29,904	-	12,129	142,980	-
1.10 Prevention programs involving men who have sex with men (MSM)	17,377		-	1,387	-	9,360	6,630	-
1.11 Harm-reduction for injecting drug user	455,431		-	231	378,000	76,098	1,102	-
1.12 HIV prevention workplace services	189.576		-	4,610	-	162,923	22,043	-
1.13 Condom and social marketing	4,344,051		-	632	3,974,400	-	3,020	366,000
1.14 Microbicides	363		-	63	-	-	301	-
1.15 Improving STIs management and treatment	44,697		-	7,731	-	-	38,988	-
1.16 Prevention of mother-to-child transmission	267,558		-	2,513	-	253,028	12,017	-
1.17 Blood safety	6,270,029		4,129,509	199,883	878,000	309,851	955,688	-
1.18 Post-exposure prophylaxis	-	-	-	-	-	-	-	-
1.19 Safe medical injections	63,762		-	-	-	63,762	-	-
1.20 Universal precautions	2,529		-	437	-	-	2,091	-
1.21 Other preventions	1,455,520		994,210	35,252	-	257,512	168,547	-

NEPAL 2008[vi]

Annex 1: UNGASS Indicator 1: AIDS spending

EXPENDITURE BY AIDS SPENDING CATEGORY	AMOUNT AND PERCENTAGE OF TOTAL	
Mass Communication	289,229.00	3.18%
Community Mobilization	870,379.00	9.58%
Program -Vulnerable & Special Population	478,160.00	5.26%
Voluntary counseling and testing	280,663.00	3.09%
Youth In School	226,458.00	2.49%
Youth Out Of School	121,416.00	1.34%
Prevention Programs aimed at PLHA	62,627.00	0.69%
Programs For SW & Clients	740,938.00	8.15%
Programs For MSM	562,304.00	6.19%
Harm Reduction- IDUs	923,334.00	10.16%
Workplace Activities	116,969.00	1.29%
Social Marketing	1,326,338.00	14.59%
Management Of STIs	193,695.00	2.13%
Blood Safety	42,432.00	0.47%
Prevention	6,234,942.00	68.59%
Outpatient Care	23,762.00	0.26%
Provider Initiated Testing and Counseling	52,742.00	0.58%
Antiretroviral	13,289.00	0.15%
Palliative Care	22,216.00	0.26%
Nutritional Support	850,744.00	9.36%
Specific HIV Lab Monitoring	3,481.00	0.04%
Home Based Care	201,903.00	2.22%
Opportunistic Infection (OI) Treatment	31,746.00	0.35%
Care and Treatment	1,199,883.00	13.20%
Education	22,315.00	0.25%
Orphans and Vulnerable Children	22,315.00	0.25%
Program Management	174,284.00	1.92%
Planning & Coordination	285,642.00	3.14%
Monitoring & Evaluation	81,106.00	0.89%
Serological Surveillance	192,916.00	2.12%
Drug Supply System	4,064.00	0.04%
Information Technology	61,650.00	0.68%
Upgrading Lab. Infrastructure	14,561.00	0.16%
Construction of New Health Centres	147,364.00	1.62%
Program Management & Adm. Strengthening	961,587.00	10.58%
Training	247,309.00	2.72%
Incentives for Human Resources	247,309.00	2.72%
Income Generation	14,922.00	0.16%
Social Protection & Social Protection excluding OVC	14,922.00	0.16%
Advocacy & Strategic Communication	155,624.00	1.71%
AIDS specific programs for women	8,386.00	0.09%
Aids-Specific Institutional Development	213,947.00	2.35%
Enabling Environment & Community Dev.	377,957.00	4.16%
Epidemiological Research	2,517.00	0.03%
Social Science Research	15,854.00	0.17%
Behavioural Research	12,388.00	0.14%
Research excluding Operation research	30,759.00	0.34%
Grand Total	$ 9,089,674.00	100.00%

THAILAND 2008[vii]

Table 4: Total expenditures on HIV/AIDS by health care functions in detail, 2007

CATEGORY OF HEALTHCARE FUNCTION	BAHT	PERCENTAGE
1. Prevention sub-total	949,855,219	14%
1.1 Mass media	6,322,00	1%
1.2 Communication mobilization	10,691,291	
1.3 Voluntary counseling and testing	185,240.00	2%
1.4 Program for vulnerable special population	115,147,373	12%
1.5 Youth in school	46,370,545	5%
1.6 Youth out of school	89,460,554	
1.7 Prevention program for PLHA	3,764,561	0%
1.8 Programs for sex workers and their clients	9,248,564	1%
1.9 Programs for MSM	8,149,570	1%
1.10 Harm reduction programs for IDUs	17,268,414	2%
1.11 Workplace activities	16,611,941	2%
1.12 Condom social marketing	20,220,000	
1.13 Public and commercial sector condom provision	65,021,724	7%
1.14 Female condom	-	
1.15 Microbicides	-	
1.16 Improving management of STIs	2,465,000	0%
1.17 Prevention of mother-to-child transmission	119,348,682	13%
1.18 Blood safety	-	
1.19 Post-exposure prophylaxis	-	
1.20 Safe medical injection	-	
1.21 Male circumcisions	-	
1.22 Universal precautions	-	
1.99 Other/not elswhere classified	234,525,000	25%

232. I have increased grant to the amount of Rs. 10 million for National Disabled Federation in order to rehabilitate disabled person based on community approach by collecting data of disabled person from their physical disability; to imparting skills and leadership development training; to providing a training for self-reliance life style; and institutional strengthening of Khagendra Nava Jeewan Kendra, Jorpati.

Social and Cultural Promotion

233. A Cultural Policy will be formulated and implemented within this Fiscal Year and the preservation and promotional activities will be conducted to preserve the shrine of Lumbini and Pashupatinath.

234. The activities relating to updating of data and keeping integrated record of seen and unseen cultural heritage spreading across the country will be continued and Local Bodies and Communities will be mobilized for the preservation and promotion of the places registered in the list of World Heritage.

235. The activities relating to preservation of overall cultural uniqueness of different languages, literatures, arts, music will be conducted and put forwarded through the establishment of separate academy for the language, literatures, arts, music and drama. I have allocated Rs. 2 million for the establishment of Krishna Sen Ichhuk Cultural Academy.

236. I have allocated Rs. 2.5 million to mark the centenary ceremony of the Great Poet Laxmi Prasad Devkota by launching different activities.

237. The state will accord special priority to solve the core problems of Nepali people relating to sexual and gender minorities and a common house for 50 people will be provisioned to live together for their socialization.

Mark an "x" if services are available, leave blank if not

Local Services	Govt.	Networks	CBO/NGO	INGO	Hospital	University	Private sector	Total
MSM community representation in HIV/AIDS response								
Design								
Implementation								
Monitoring and evaluation								
Funding support for MSM-related programs and interventions run by NGOs and CBOs								
Access to other health services for MSM, including mental health and substance abuse treatment								
STI diagnosis and treatment services								
Community education and outreach services targeting MSM								
Condoms and water-based lubricants								
Programs for MSM that address poverty, stigma and discrimination, and unemployment								
Health facilities and care providers that are friendly toward MSM								
Easy access to voluntary testing and counseling for HIV								
Sexuality education in schools promoting sexual diversity								
Easy access to treatment and care for HIV-positive MSM								
Safe space in community for MSM to congregate and decompress								

Comprehensive Package of HIV services for MSM

Access to information and education about HIV and other STIs, and support for safer sex and safer drug use, through appropriate services (including peer-led, managed, and provided services)	**Access to condoms and water-based lubricants**	**Access to confidential, voluntary HIV counseling and testing**	**Access to STI detection and management** through the provision of clinical services (by staff members trained to deal with STIs as they affect MSM
Access to referral systems for legal, welfare, and health services, and access to appropriate services; safer drug-use commodities and services	**Access to appropriate antiretroviral and related treatments**, where necessary, together with HIV care and support	**Access to prevention and treatment of viral hepatitis**	**Access to referrals between prevention, care, and treatment services**, and services that address the HIV-related risks and **needs of the female sexual partners of MSM**

Speaking Out

Key elements relating to legal, policy, and social environments in a comprehensive package of actions to address HIV risk among MSM

Protection from discrimination and the removal of legal barriers to access to appropriate HIV-related prevention, treatment, care, and support services, such as laws that criminalize sex between males	**Understanding of the numbers, characteristics, and needs of MSM regarding HIV and related issues**	**Ensuring that MSM are appropriately addressed in national and local AIDS plans**, that sufficient funding is budgeted for work, and that this work is planned and undertaken by suitably qualified and appropriate staff
Empowering MSM communities to participate equally in social and political life	**Ensuring the participation of MSM in the planning, implementation, and review of HIV-related responses**	**Public campaigns to address homophobia**
Training and sensitization of health-care providers to avoid discriminating against MSM, and ensuring the provision of appropriate HIV-related services for MSM	**Access to medical and legal assistance for those who experience or have experienced sexual abuse**	**The promotion of multi-sectoral links and coordinated policy-making, planning, and programming**, including health, justice (including the police), home, social welfare, similar and related ministries, at the national, regional, and local levels

Malaysia's PT Foundation

PT Foundation started in 1987 as Pink Triangle in Kuala Lumpur. It provided HIV prevention and sex advice to MSM through telephone counseling. It later expanded to respond to various appeals by communities experiencing discrimination because of HIV and their sexuality. PT now provides services to a range of at-risk communities through a complex model that includes prevention-based outreach, VCT and other clinical referral services, community drop-in centers, telephone counseling, and advocacy. It provides VCT to most-at-risk-populations in Penang and Kuala Lumpur, including sex workers, transgendered people, IDUs, and MSM. It also provides a follow-up service for clients who test HIV-positive at local hospitals and clinics. The latest evaluation shows that around 90 percent of these newly diagnosed people access follow-up services. PT Foundation supports HIV treatment, care, and support through close relationships between its peer workers and the staff of government HIV treatment services. This allows it to assist in treatment adherence and support for MSM. PT Foundation does this in the midst of a relatively hostile policing environment, in which carrying condoms is seen as a sign of sex work or immorality. The Foundation wants to expand its reach into East Malaysia and Johore. It has developed effective local models, but wants assistance in packaging these for expansion to reach scale. PT plans to expand into a hub of training, mentoring, and generating new knowledge for HIV clinical prevention and care that would incorporate training healthcare workers and physicians, working alongside nurses in clinics, and accompanying patients to hospital services. PT is also planning to establish MSM-friendly clinics in collaboration with state health departments by bringing in MSM-friendly visiting doctors and other health workers to make use of government clinics after hours and linking this to its outreach and drop-in work. The PT model shows the kind of innovation that can lead to a rapid increase in coverage of populations once isolated from HIV prevention and care. A focus on state-level rather than national-level health service planners helps clients access direct health services. Bringing in visiting health staff to a separate clinic for most-at-risk populations avoids the fear of some health workers that increasing their client load of these populations in their own clinics might somehow alienate their other clients.

Bandhu Social Welfare Society

Bandhu Social Welfare Society was formed in 1996 to address concerns of human rights abuse and denial of sexual health rights, and provide a rights-based approach to health and social services for one of the most stigmatized and vulnerable populations in Bangladesh, kothis/hijras and their partners. The organization was born in response to surveillance studies and a needs assessment that identified MSM as a population in need of services in Bangladesh. BSWS has been officially registered since 1997. It started with a staff of 2 and a small program in Central Dhaka. Over the years it has emerged as a national MSM NGO with more than 200 employees who currently provide social and health services to a broad range of MSM in 14 districts. A core objective of BSWS' work is to advocate and provide an environment that assures the respect and dignity of all MSM and transgendered people—irrespective of their specific gender and/or sexual identity. It also works to create a supportive social, policy, and legal environment to ensure the basic human rights of MSM in Bangladesh, including their right to sexual health.

The BSWS model is based on field offices that provide drop-in centers. The centers provide safe space for the MSM community, HIV prevention services, and referrals for STI treatment and care. The current services that BSWS provides to MSM (including hijras and other transgendered people) reflect the key objective of community strengthening and mobilizing to engage more effectively in governance, policy development, and sexual health and rights service delivery. Services focus on 3 key areas:

1.   Community development and response: Provision of safe spaces for community development and mobilization; outreach and community-building services; health education; distribution of sexual health products; knowledge generation; capacity building; and networking, information dissemination, policy development, and advocacy.

2.   Social welfare and support services: Social support services, psychosexual and psychosocial counseling, and a livelihood skills program.

3.   Health services: STI management and general health treatment services, HIV VCT, care and support services; and referrals for ART and other health services.

Clinical services include STI and general health treatment, HIV VCT, and psychosexual counseling. BSWS hires doctors on a part-time basis to provide these services, but would eventually like to develop its own clinical team rather than procure services from others. There is a low prevalence rate among the clients of BSWS and it does not provide extensive services to HIV-positive MSM.

Field services include outreach and friendship building, community development and mobilization, social meetings, education and awareness, behavior change communications, condom distribution, and referrals to clinics. Center-based activities include socializing and support groups, vocational training and skill building, drop-in services, and community-building activities. BSWS is developing VCT services for MSM, and also provides subsidized STI treatment, counseling, and support at some of its sites.

BSWS also uses a case management model in which clients move from receiving field services to becoming regular members. This is possible for the kothi (feminized MSM) who identify as part of a community, but not for panthi (masculine MSM) who come from all walks of life. Therefore, most services are aimed at kothi, while panthi and other non-kothi access clinical services. Transgendered people have their own group, Shustha Jiban (Happy Life), which was established in October 2000 as a part of BSWS, and then became independent in May 2005. BSWS provides them with support and capacity building. The organization was recognized as a best practice model by UNAIDS in 2001 and, in coordination with a national AIDS/STD program in Bangladesh, it is in the process of forming a national taskforce on HIV and human rights for MSM and transgendered populations.

Mumbai's Humsafar Trust

Humsafar was set up in 1989 by a small group of friends who had chosen to live as gay men and not to marry women, but were concerned about isolation and loneliness as they grew older. Out of that group came Bombay Dost, a gay magazine that later became a successful community communication tool for MSM. The founding board decided early in Humsafar's life that it would be an organization committed to dialogue and negotiation with authorities rather than confrontation. They decided that they would not duplicate or substitute services provided by the state, but would work on getting access to these services for their constituents.
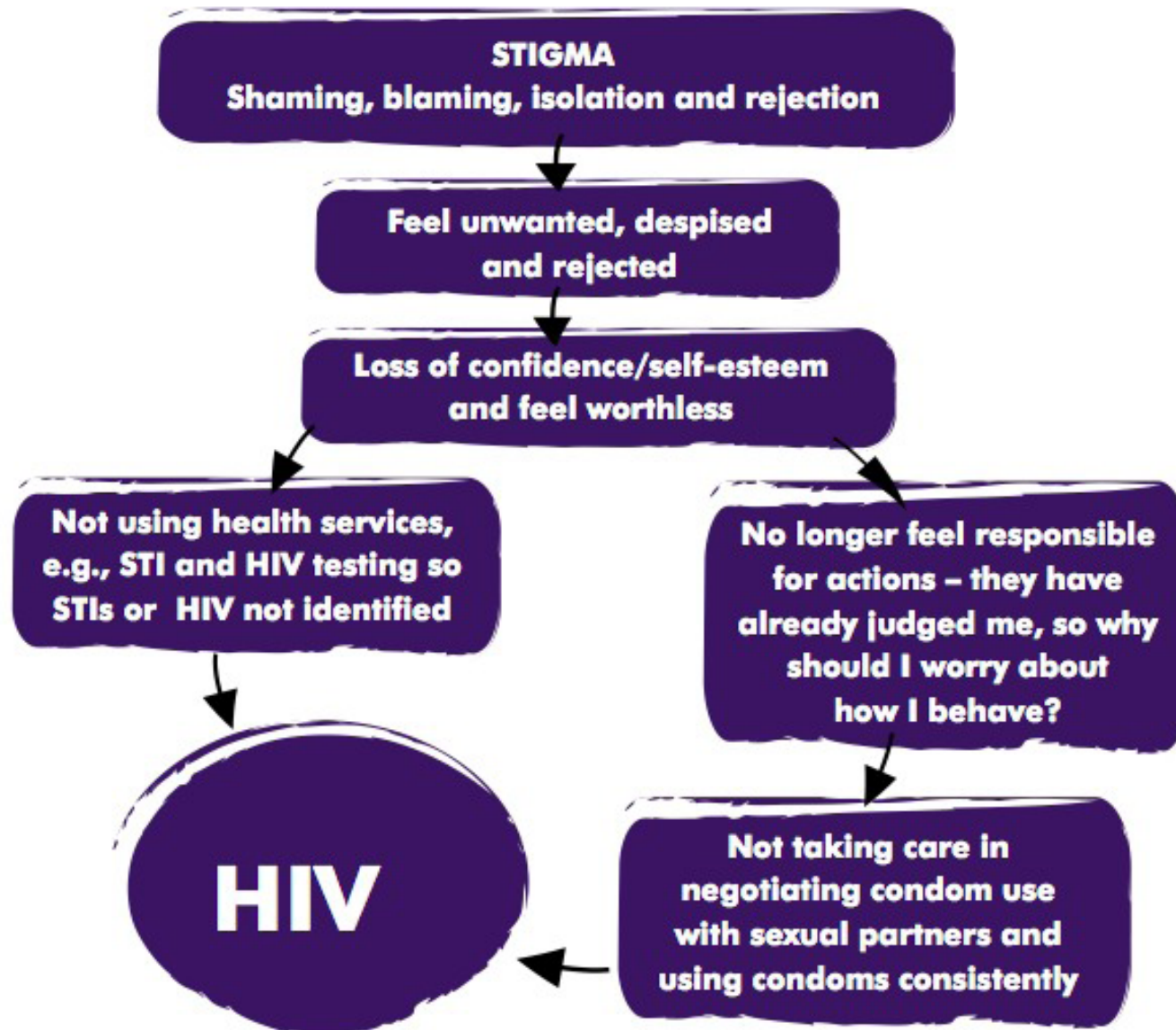
They began with an HIV information service for MSM, provided via phone and mail, along with a drop-in center, and conducted outreach at sites where MSM gathered socially or where they had sex. They developed a good relationship with a Mumbai government hospital (Sion) and developed a unique referral system that minimized the discrimination and poor treatment that MSM had been experiencing when they tried to access STI services. This involved giving out cards at outreach sites that qualified MSM for quick and MSM-friendly services at the hospital and having outreach staff accompany people to clinics. Gradually, with the assistance of Sion hospital doctors, they introduced their own clinical services at the drop-in center and now have 3 centers across Mumbai with drop-in and clinical services for MSM sub-populations. Humsafar also provides legal advice and other welfare services at these centers. Humsafar now has 206 staff and 198 of these are MSM. It acts as a mentoring agency for emerging MSM CBOs, helping them to build the capacity they need to serve their communities. While Humsafar works with a variety of sub-populations—male sex workers, transgendered people, homeless MSM—it does not make assumptions about HIV risk based on an individual's perceived membership of a particular MSM sub-population, but bases risk assessment and service development on the individual's actual risk behaviors.

Humsafar found that male sex workers were not using its drop-in and clinical services as much as other MSM, so it set up a separate service for this group, linking this sub-population into its wider network. As clinical services developed, Humsafar recognized the need for particular support for MSM with HIV and now operate a peer volunteer support system for MSM with HIV and a support group called Safe Sailors. In keeping with its non-substitution philosophy, Humsafar does not provide ART, but helps its clients to participate in the government's HIV treatment program. It does, however, provide an ART start-up program for people who may find it difficult to qualify for the government system—transgendered people without the correct identity papers for example—and then assists them in accessing government services.

Humsafar is now funded from a range of sources, but primary among them are the Maharashtra State and Mumbai District AIDS Control Societies. This recognition by government AIDS response groups is essential to Humsafar's sustainability. Humsafar's success contains some important lessons on MSM NGO involvement:

- It started with drop-in and outreach, and expanded gradually into providing on-site clinical services as it became more stable and confident

- It is firmly established as part of the state and local government response

- It avoids duplication of government services whenever possible

- It contributes to achieving scale by mentoring other local MSM CBOs and NGOs

How Stigma Affects Men who Have Sex with Men

STIGMA
Shaming, blaming, isolation and rejection

↓

Feel unwanted, despised and rejected

↓

Loss of confidence/self-esteem and feel worthless

↓ ↘

Not using health services, e.g., STI and HIV testing so STIs or HIV not identified

No longer feel responsible for actions – they have already judged me, so why should I worry about how I behave?

↓

Not taking care in negotiating condom use with sexual partners and using condoms consistently

↓

HIV

Kiri started to have sex with men when he was a teenager, and managed to hide this from his family. He knew that being MSM was natural for him, but he was worried his family would find out and make his life miserable. Other MSM friends had been "discovered" by their parents and their lives had become hell and he wanted to avoid this.

When he grew older he lived in the same town as his family, but lived on his own. His family suspected he might be MSM, but they didn't bother him until he was 30, when they started to pressure him to get married. He agreed to the marriage to get them off his back.

Soon after getting married, he found out that one of his previous male partners had tested HIV positive, so he started to worry about his own status. What would people think if he was HIV positive? Would they find out that he was MSM? How would he be treated?

He went to the clinic to take an HIV test, but the counselor made him feel very uncomfortable. He asked lots of questions about Kiri's sex life. When Kiri mentioned having had sex with men, the counselor said, "No, you are not one of those! You seem different!" Kiri left the clinic without taking the test and told himself he would never go back.

He started to worry about infecting his wife and his new male partner. He insisted on using condoms with his wife, but she got angry and said he must be having an affair. He was so worried about losing his new male partner that he had sex with her without using a condom. He became very depressed and worried about what he would do next.

Case Study — Lotus Integrated AIDS Awareness Sangam — ACT Project

In India, stigma and discrimination often prevent MSM from accessing government entitlements or from seeking justice for rights abuses such as police violence or refusal of health services. Their experience of stigma is particularly severe because it stems not only from the perceived association with HIV, but also from their sexuality and gender non-conformity.

ACT brings panchayat leaders to an increased understanding and sensitivity toward MSM through dramatic performance, and also brings about an increase in instances of collaboration between MSM and panchayat officials. Panchayats are powerful local bodies that regulate the socio-political norms at the village and semi-urban levels and are the primary avenue through which citizens pursue justice at the village and semi-urban levels, even before engaging local police. As recognized leaders, they are in a unique position to model new attitudes and behaviors of the broader community, setting an example that could enhance the quality of life and access to benefits and services among marginalized populations.

Lotus recognizes the capacity of theater to catalyze positive social change and change deep-seated cultural attitudes and societal norms. With its World Bank South Asia Regional Development Marketplace grant, Lotus developed a theater program in and around its base in Tamil Nadu to change harmful attitudes and practices that make it difficult for MSM and transgender persons to access legal redress through their panchayats.

Lotus undertook a careful process to develop and implement its intervention. They conducted focus group interviews with men who have sex with men and panchayat leaders to inform script development. A member of Lotus wrote the script. Lotus selected villages for the performances based on their knowledge of where MSM resided and the willingness of the local Panchayat leaders to have a performance in their community. As Lotus had government support via a letter of endorsement from the Tamil Nadu State AIDS Control Society, their entry into villages was relatively smooth.

1. Folch C, Esteve A, Zaragoza K, Muñoz R, Casabona J. Eur J Public Health. 2010 Apr;20(2):139–45. Published June 29, 2009.

Correlates of intensive alcohol and drug use in men who have sex with men in Catalonia, Spain.

Centre for Sexually Transmitted Infection and AIDS Epidemiological Studies of Catalonia (CEEISCAT) - ICO, Hospital Universitari Germans Trias i Pujol, Badalona, Spain. cft.ceescat.germanstrias@gencat.cat

Abstract

BACKGROUND: The objectives of the study were to determine the prevalence of alcohol and drug use before or during sex among men who have sex with men (MSM) in Catalonia during 2006, and to identify factors associated with variables of intensive alcohol and drug use. METHODS: Cross-sectional study using self-administered questionnaires. Men were recruited in saunas, sex shops, bars and a public park and by mail to all the members of the Catalonia Gay Federation. RESULTS: 19.6% of men said they were frequent users of alcohol, some type of drug (21.7%), or that they were multidrug users (18%) in the last 12 months. The multivariate analysis showed an association between having suffered discrimination and frequent alcohol and multidrug use. Being human immunodeficiency virus (HIV)-positive was associated with frequent use of drugs and multidrug use. Associations between substance use and sexual risk behaviour also emerged. CONCLUSION: The high percentage of MSM who use alcohol and drugs before and during sex and association between these substances and sexual risk behaviours reveals the need to intensify interventions to reduce their levels of use and/or to reduce the associated damage and risks. These programs must try to cover MSM-specific psychosocial aspects and include prevention for HIV-positive men.

2. Blas MM, Alva IE, Carcamo CP, Cabello R, Goodreau SM, Kimball AM, Kurth AE. PLoS One. 2010 May 3;5(5):e10448.

Effect of an online video-based intervention to increase HIV testing in men who have sex with men in Peru.

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Abstract

BACKGROUND: Although many men who have sex with men (MSM) in Peru are unaware of their HIV status, they are frequent users of the Internet, and can be approached by that medium for promotion of HIV testing. METHODS: We conducted an online randomized controlled trial to compare the effect of HIV-testing motivational videos versus standard public health text, both offered through a gay website. The videos were customized for two 2 audiences based on self-identification: either gay or non-gay men. The outcomes evaluated were 'intention to get tested' and 'HIV testing at the clinic.' FINDINGS: In the non-gay identified group, 97 men were randomly assigned to the video-based intervention and 90 to the text-based intervention. Non-gay identified participants randomized to the video-based intervention were more likely to report their intention of getting tested for HIV within the next 30 days (62.5% vs. 15.4%, Relative Risk (RR): 2.77, 95% Confidence Interval (CI): 1.42-5.39). After a mean of 125.5 days of observation (range 42-209 days), 11 participants randomized to the video and none of the participants randomized to text attended our clinic requesting HIV testing (p = 0.001). In the gay-identified group, 142 men were randomized to the video-based intervention and 130 to the text-based intervention. Gay-identified participants randomized to the video were more likely to report intentions of getting an HIV test within 30 days, although not significantly (50% vs. 21.6%, RR: 1.54, 95% CI: 0.74-3.20). At the end of follow up, 8 participants who watched the video and 10 who read the text visited our clinic for HIV testing (Hazard Ratio: 1.07, 95% CI: 0.40-2.85). CONCLUSION: This study provides some evidence of the efficacy of a video-based online intervention in improving HIV testing among non-gay-identified MSM in Peru. This intervention may be adopted by institutions with websites oriented to motivate HIV testing among similar MSM populations. TRIAL REGISTRATION: Clinicaltrials.gov NCT00751192.

3. Solomon SS, Srikrishnan AK, Sifakis F, Mehta SH, Vasudevan CK, Balakrishnan P, Mayer KH, Solomon S, Celentano DD. The Emerging HIV Epidemic among Men Who have Sex with Men in Tamil Nadu, India: Geographic Diffusion and Bisexual Concurrency [published online ahead of print May 14, 2010]. AIDS Behav. 2010 May 14.

YR Gaitonde Centre for AIDS Research and Education (YRGCARE), VHS Adyar, Taramani, Chennai, India, sunil@yrgcare.org.

Abstract

In India, men who have sex with men (MSM) remain hidden because anal intercourse was criminalized and marriage socially required. We characterize HIV/STI prevalence among MSM in Tamil Nadu. Eligible participants were recruited using respondent-driven sampling in eight cities (n = 721). Median age was 28, 34% were married and 40% self-identified as homosexual. Median number of male partners in the prior year was 15; 45% reported any unprotected anal intercourse (UAI). HIV, herpes simplex virus-2 (HSV-2), chronic hepatitis B virus (HBV) and syphilis prevalence were 9, 26, 2 and 8%, respectively; among married men, all were higher: 14, 32, 3 and 11% (p < 0.01 for HIV and HSV-2). Less education, HSV-2, more male partners, UAI and not having a main male partner were associated with HIV prevalence. The high STI and UAI prevalence may lead to a burgeoning HIV epidemic among MSM, reinforcing the need for focused preventive measures incorporating complex circumstances.

4. Wade AS, Larmarange J, Diop AK, Diop O, Gueye K, Marra A, Sene A, Enel C, Niang Diallo P, Toure Kane NC, Mboup S, Desgrées-du-Lou A. AIDS Care. 2010 Apr;22(4):409–14.

Reduction in risk-taking behaviors among MSM in Senegal between 2004 and 2007 and prevalence of HIV and other STIs. ELIHoS Project, ANRS 12139.

Programme Sida, Institut d'Hygiène Sociale, Dakar, Senegal.

Abstract

An epidemiological survey conducted in Senegal in 2004 among men having sex with men (MSM) revealed high HIV prevalence and a high rate of risky behaviors within this population. Consequently, several prevention campaigns targeting MSM were implemented. A second survey was carried out in 2007 to assess the impact of these measures. This paper aims to examine trends in HIV and STI prevalence and in sexual behaviors between 2004 and 2007. The two surveys were conducted in four urban sites among 440 and 501 MSM—recruited using the snowball sampling method—in 2004 and 2007, respectively. A similar methodology was applied for both surveys. This consisted of a closed-ended questionnaire concerning socio-demographic, behavioral, and biomedical information plus a clinical examination including urine and blood tests to detect STIs and HIV infection. Between 2004 and 2007, the frequency of different sexual practices reported by MSM remained stable, but condom use for each type of sexual practice rose. The percentage of men who reported consistent condom use during previous-month anal sex has increased by about 35% (p<0.01). The percentage of men who reported consistent condom use during previous-month non-commercial sex with women has increased by 14% (p<0.01). HIV prevalence remained stable from 22.4% [95% CI: 18.6-26.8] in 2004 to 21.8% [95% CI: 18.3-25.7] in 2007 (adjusted OR = 1.05, p=0.8). Gonorrhea prevalence decreased from 5.5% [95% CI: 3.6-8.3] in 2004 to 2.6% [95% CI: 1.5-4.5] in 2007 (adjusted OR=0.5, p=0.07). The prevention campaigns, STI and HIV care and support programs conducted in Senegal among MSM have been followed by a reduction of risk-taking behaviors and STI prevalence among this population. Specific targeting of this group within HIV/STI prevention programs seems to be effective in decreasing sexual infections.

5. Morineau G, Nugrahini N, Riono P, Nurhayati, Girault P, Mustikawati DE, Magnani R. Sexual Risk Taking, STI and HIV Prevalence Among Men Who Have Sex with Men in Six Indonesian Cities [published online ahead of print July 30, 2009]. AIDS Behav. 2009 Jul 30.

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Abstract

Using surveillance data on men who have sex with men (MSM) from six Indonesian cities, this article reports prevalence of sexual risk taking, HIV and other sexually transmitted infections. Factors associated with HIV, other STIs and consistent condom use were assessed. Behavioral data were collected from 1,450 MSM, among whom 749 were tested for HIV and syphilis and 738 for gonorrhea and chlamydia. Associations were assessed using multivariate logistic regression. Over 80% of MSM knew HIV transmission routes, 65% of MSM had multiple male sexual partners, 27% unprotected anal sex with multiple male partners, and 27% sex with a female in the prior month. Consistent condom use ranged from 30 to 40% with male partners and 20 to 30% with female partners, depending upon partner type. HIV prevalence averaged 5.2%, but was 8.0% in Jakarta. Prevalence of rectal gonorrhea or chlamydia was 32%. Multivariate analyses revealed recent methamphetamine use and current rectal gonorrheal or chlamydial infection to be associated with HIV infection. The data confirm diverse sexual networks and substantial sexual risk-taking, despite relatively high levels of education and HIV-related knowledge. In addition to promoting partner reduction and more consistent condom and lubricant use, prevention efforts must also address substance abuse.

6. Zhonghua Yu Fang Yi Xue Za Zhi. 2009 Nov;43(11):977–80.

[Evaluation of effect of community-based HIV/AIDS interventions among men who have sex with men in eighteen cities, China]

[Article in Chinese]

Zeng G, Xiao Y, Xu P, Feng N, Jin CR, Lü F.

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Abstract

OBJECTIVE: To evaluate the effect of a community-based intervention project among men who have sex with men (MSM) after 2-year implementation. METHODS: Comprehensive interventions among MSM in 18 cities of 7 provinces were conducted. The pre-intervention questionnaire was conducted in September 2006 and 5178 subjects were investigated through snowball method. In May 2007, post-questionnaire was conducted and 5460 subjects were investigated through snowball or accompanier recommendation method. For each subject, a questionnaire was completed, including basic information, HIV/AIDS knowledge, behaviours and intervention status. At the same time, 5 ml intravenous blood sample was collected to detect HIV infection and evaluated the intervention effect. RESULTS: After 2-year implementation, the awareness rate of HIV/AIDS knowledge increased from 76.0% (3933/5178) in 2006 to 90.5% (4943/5460) in 2008 (chi(2) = 451.786, P < 0.001); the rate of condom use in the last anal sex with males increased from 58.0% (2382/4105) to 76.7% (3643/4750) (chi(2) = 215.491, P < 0.01); the rate of consistent condom use in the last six months increased from 28.2% (1163/4118) to 44.5% (2114/4753) (chi(2) = 264.606, P < 0.01); the proportion of MSM receiving HIV antibody test increased from 18.8% (973/5170) to 39.1% (2136/5454) (chi(2) = 530.181, P < 0.01); and the HIV infection rate increased from 2.3% (118/5178) to 5.0% (271/5427) (chi(2) = 47.613, P < 0.01). CONCLUSION: The MSM community-based intervention project achieved some good results after two-year implementation and contributed to an increase in HIV/AIDS knowledge and safe sex.

7. Colby D, Minh TT, Toan TT. Down on the farm: homosexual behaviour, HIV risk and HIV prevalence in rural communities in Khanh Hoa province, Vietnam. Sex Transm Infect. 2008 Nov;84(6):439–43.

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Abstract

OBJECTIVES: To determine HIV prevalence, measure risk behaviour and determine levels of knowledge among men who have sex with men (MSM) in both urban and rural districts within Khanh Hoa province, Vietnam. METHODS: 295 MSM were recruited using respondent-driven sampling from one urban and four rural districts. Information on demographics, risk behaviour, knowledge and attitudes was obtained using a standardised questionnaire. HIV testing was performed on all subjects. RESULTS: Rural MSM had

fewer risk behaviours when compared with urban MSM in the province: they became sexually active at a later age, were less likely to buy or sell sex and were less likely to use drugs. However, they had poorer knowledge about HIV transmission and prevention and were less likely to know that unprotected anal sex was high risk for HIV. Condom use was high among both rural and urban MSM, but most MSM in rural areas had never used water-based lubricant. None of the 295 men tested for HIV were infected (HIV prevalence 0%). CONCLUSIONS: Although most programmes for MSM in Vietnam and other Asian countries target urban areas, there are significant numbers of MSM in rural areas who can be reached through peer educator interventions. Rural MSM have less access to specific HIV prevention information on homosexual sex and less knowledge about how to protect themselves from HIV infection. More programmes are needed for MSM in the rural areas of Vietnam.

8. Beyrer C, Jittiwutikarn J, Teokul W, Razak MH, Suriyanon V, Srirak N, Vongchuk T, Tovanabutra S, Sripaipan T, Celentano DD. Drug use, increasing incarceration rates, and prison-associated HIV risks in Thailand. AIDS Behav. 2003 Jun;7(2):153–61.

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Abstract

BACKGROUND: Incarceration is a known risk for HIV infection in Thai drug users. Through the 1990s, incarceration rates for drug-related offenses rose sharply, whereas HIV prevention and drug treatment in prisons remained limited. METHODS: We assessed HIV and incarceration risks for injection drug users (IDU) and non-IDU in a large treatment center cohort in northern Thailand to investigate HIV and prison risks in this period. We used Thai Bureau of Corrections data to assess incarceration and prevention funds in prisons, 1992-2000. RESULTS: Among 1,865 drug users in the treatment cohort, 503 (27.0%) had ever been jailed. Men (OR 3.3, 95% CI 2.1, 5.2), IDU (OR 6.3, 95% CI 5.1, 7.9), and men who have sex with men (MSM) (OR 3.4, 95% CI 1.8, 6.3) were more likely to have been jailed. Among male IDU who had ever been jailed (N = 272), 15.8% had used drugs in prison. In a multivariate model, incarceration and ever IDU remained independently associated with HIV infection; IDU, MSM behaviors, and harmful traditional practices remained independently associated with having been jailed. From 1992 to 2000, overall alleged narcotics offenses increased from 117,000 to 276,000/year. The number of persons incarcerated for narcotics offenses increased fivefold from 1992 to 1999, from 12,860 to 67,440. For FY 2000, narcotics treatment accounted for 0.06% of the Thai corrections budget, whereas HIV programs in prisons were 0.017%. CONCLUSIONS: Incarceration rates for narcotics offenses have increased sharply in Thailand, whereas prevention has lagged. Having been jailed is an important independent risk for HIV infection among Thai male drug users, especially IDU and MSM. HIV prevention and drug treatment are urgently needed in Thai prisons.

9. Zhonghua Liu Xing Bing Xue Za Zhi. 2009 Jan;30(1):14–7.

[The impact of childhood sexual abuse on the development of AIDS related high risk behaviors and psychological appearances among men who have sex with men]

[Article in Chinese]

Yu ZZ, Zhang BC, Li XF, Wang N, Shi TX, Chu QS.

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Abstract

OBJECTIVE: To study the AIDS related high risk behaviors and psychological appearances among men who have sex with men (MSM) who ever experienced childhood sexual abuse (CSA). METHODS: Target sampling for a cross-sectional study was developed and valid anonymous questionnaires were adopted to compare the differences of high risk behaviors related to AIDS and psychological appearances between those with or without CSA experiences among 2147 MSM from nine cities. RESULTS: Compared to corresponding ones without CSA experience, CSA group had a significant larger numbers in the following events: total sexual partners, anal sex episodes with same sex, female sexual partners and anal sex in the previous six months, with the figures of median as 20.0, 10.0, 3.0, 3.0 respectively. In the previous year, 30.8% of them had ever participated in 'group sex', 19.2% ever exchanged money for sex, 36.7%

bled while having sexual intercourse, 37.3% had sex with male partners away from his own region. All the above said figures were higher than non-CSA group, with significant differences. It also appeared that CSA experience had an impact on significant lower rate of condom use (67.3%) in the last anal sex. Those with CSA experience had more psychological problems which appeared as: 75.6% considered they would suffer from serious discrimination if their sexual orientation ever disclosed, 34.7% had a strong intention of suicide and 24.3% ever having had suicidal attempts. The differences of the two groups showed statistical significance. CONCLUSION: CSA experience not only increased the number of AIDS related high risk behaviors in adulthood, but also had negative impact on their psychological appearances. It is of urgent need to carry out psychological intervention approaches to target on MSM with CSA experiences while childhood sexual education and rights assurance towards juvenile population should also not be neglected.

10. Schwappach DL, Bruggmann P. An integrated model of care to counter high incidence of HIV and sexually transmitted diseases in men who have sex with men – initial analysis of service utilizers in Zurich. BMC Public Health. 2008 May 27;8:180.

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Abstract

BACKGROUND: As other countries, Switzerland experiences a high or even rising incidence of HIV and sexually transmitted infections (STI) among men who have sex with men (MSM). An outpatient clinic for gay men ("Checkpoint") was opened in 2006 in Zurich (Switzerland) in order to provide sexual health services. The clinic provides counselling, testing, medical treatment and follow-up at one location under an "open-door-policy" and with a high level of personal continuity. We describe first experiences with the new service and report the characteristics of the population that utilized it. METHODS: During the 6-month evaluation period, individuals who requested counselling, testing or treatment were asked to participate in a survey at their first visit prior to the consultation. The instrument includes questions regarding personal data, reasons for presenting, sexual behaviour, and risk situations. Number and results of HIV/STI tests and treatments for STI were also recorded. RESULTS: During the evaluation period, 632 consultations were conducted and 247 patients were seen by the physician. 406 HIV tests were performed (3.4% positive). 402 men completed the entry survey (64% of all consultations). The majority of respondents had 4 and more partners during the last 12 months and engaged in either receptive, insertive or both forms of anal intercourse. More than half of the responders used drugs or alcohol to get to know other men or in conjunction with sexual activity (42% infrequently, 10% frequently and 0.5% used drugs always). The main reasons for requesting testing were a prior risk situation (46.3%), followed by routine screening without a prior risk situation (24.1%) and clarification of HIV/STI status due to a new relationship (29.6%). A fifth of men that consulted the service had no history of prior tests for HIV or other STIs. CONCLUSION: Since its first months of activity, the service achieved high levels of recognition, acceptance and demand in the MSM community. Contrary to common concepts of "testing clinics", the Checkpoint service provides post-exposure prophylaxis, HIV and STI treatment, psychological support and counselling and general medical care. It thus follows a holistic approach to health in the MSM community with the particular aim to serve as a "door opener" between the established system of care and those men that have no access to, or for any reason hesitate to utilize traditional health care.

11. De Santis JP, Colin JM, Provencio Vasquez E, McCain GC. The relationship of depressive symptoms, self-esteem, and sexual behaviors in a predominantly Hispanic sample of men who have sex with men. Am J Mens Health. 2008 Dec;2(4):314–21. Published January 23, 2008.

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Abstract

Despite public health campaigns and safer sex messages, many men who have sex with men (MSM) continue to participate in high-risk sexual behaviors, which may make them vulnerable to HIV infection and sexually transmitted infections. The purpose of this study was to determine the relationship of depressive

symptoms, self-esteem, and sexual behaviors in a pre-dominantly Hispanic sample of MSM. This correlational study sampled 205 MSM (M = 37 years of age, SD = +/-8) representing the diverse ethnic composition of South Florida. This sample consisted of ethnic minorities (79%) with a large number of foreign-born men (69%). Participants completed measures of depressive symptoms, self-esteem, and sexual behaviors. Results indicated that higher levels of depressive symptoms and higher levels of self-esteem had a statistically significant relationship to lower levels of safer sexual behaviors. Lower income, lower educational level, and preference for Spanish language were associated with higher levels of depressive symptoms; lower income was associated with lower levels of self-esteem; and foreign birth and a preference for Spanish language were associated with lower levels of safer sex behaviors. Higher levels of depressive symptoms and higher levels of self-esteem were associated with high-risk sexual behaviors in this sample of MSM. Further research needs to be directed at culturally specific mental health and HIV prevention strategies for these vulnerable MSM.

Hong Kong — SAR Foundation

Research

In 2001, a research project was undertaken to determine the prevalence of high risk behaviors among sauna clients, levels of access to free condoms and lubricant, and the nature of information materials that would be best suited to sauna clients. Data was collected through five preliminary unstructured interview, 31 semi-structured qualitative interviews and a survey conducted at 15 saunas, resulting in 617 responses.

Condom use seemed to be higher among sauna customers than among the general population of men who have sex with men, through sauna customers had more sexual partners and anal sex more frequently. Another finding was that though condoms were available in the saunas, they were not always accessible, particularly in areas where sexual encounters normally take place. This relates to one of the most common reasons given for not using condoms—the fact that no condom was available.

Philippines - Library Foundation

Research

The Library Foundation investigates the sexual practices and networking of men who have sex with men, assesses the need for programmes and explores possible programming options, particularly in locations or venues where sex between men takes place. One research project investigated the sexual activities of men who have sex with men in two resort areas near Metro Manila and the findings and recommendations were presented to stakeholders, including local health care agencies. The Library Foundation was also involved in a collaborative project with the

Japan Association for the Lesbian and Gay Movement (OCCUR) aimed at comparing programmes related to men who have sex with men in the two countries.

The Library Foundation developed a research agenda for men who have sex with men and AIDS, supported by USAID through The Futures Group. The results were basis for developing research initiatives and for advocacy efforts with stakeholders including government, nongovernmental organizations and international agencies to influence their research agendas.

Bangladesh - Bandhu Social Welfare Society

Research

Bandhu Social Welfare Society has participated in the Government's National Surveillance Programme and has also been involved with needs assessment projects, for example, with the International Centre for Diarrhoeal Disease Research Bangladesh (ICDDRB) on a study of sexually transmitted infection clinical services for men who have sex with men in Chittagong.

The society has also been involved in research projects:

- on non-*kothi* men who have sex with men, with La Trobe University, Melbourne, Australia;

- the impact of legal, sociocultural, legislative and socioeconomic impediments for effective HIV intervention with Institutional Development of Human Rights in Bangladesh, UNDP's Regional HIV and Development Programme and Naz Foudation International(49); and

- constructions of masculinity and sexuality with Naz Foundation International. Plans for participation in a CATALYST/USAID project involving qualitative formative research on young males and HIV are being discussed.

CASE STUDY
Global HIV/AIDS Discrimination Report

Access to HIV Prevention and Treatment for Men Who Have Sex with Men: Findings from the 2012 Global Men's Health and Rights Study (GMHR), was released by the Global Forum on MSM & HIV (MSMGF). The study, which had a global survey and a focus group, aimed to understand HIV access in a global contest and to identify barriers to access to HIV services and for men who have sex with men (MSM).

The full report is available here: **http://www.msmgf.org/files/msmgf//documents/GMHR_2012.pdf**

SAMPLE TESTIMONY FROM THE REPORT

[In South Africa] we do not have laws that criminalize gay/MSM, but this does not mean that the legal system has a mechanism for protecting gay/MSM from hate crimes and violence.

Same-sex sexual activity among men has been legal in South Africa since 1998; and is illegal in Kenya (Penalty: up to 14 years' imprisonment) and in Nigeria (penalty varies).

The best care is at MSM-specific organizations, where they understand our needs. I can come here to get tested for HIV and if I am positive, I can get some treatment here. However, if I get referred out to a public health clinic for something they do not treat here, then I am in trouble.

I went to the hospital and the nurse pulled out a bible to lecture me about being gay. She did not pay attention to my health.

As hard as it is here in the urban area, men who are struggling in the rural areas have it worse. They come here looking for work and sexual freedom and end up in the sex trade.

Qualitative and Quantitative Research

Qualitative Research	Quantitative Research
The information gathered is words and images.	The information gathered is numbers and statistics.
The aim is a detailed, complete description in the words of the interviewee.	The aim is to organize information into categories and count things that fit in those categories.
The researcher him- or herself is the tool for gathering information.	The researcher uses tools, such as surveys, to gather information.
The information is more rich, detailed, and descriptive of the specific context or individual case.	The information is less detailed, but easier to compare across many locations or individuals.
The questions can be tailored to meet the specific context.	The questions must not be altered.
Testimony of individuals can be emotionally powerful.	People are not usually emotionally moved by statistics, but data can provide a picture of a larger problem that affects many people.
Participants can serve as co-investigators and develop their own questions. This is common with what is called "action research."	While participants may inform the development of questions, they usually do not act as co-investigators.

Universal Declaration of Human Rights
(Simple English Version)

Drafted by: Amnesty International Australia
Available here: http://www.universalrights.net/main/decl_fm.htm

All people everywhere have the same human rights, which no one can take away. This is the basis of freedom, justice and peace in the world.

This Declaration affirms the dignity and worth of all people, and the equal rights of women and men. The rights described here are the common standard for all people everywhere.

Every person and nation is asked to support the understanding and respect for these rights, and to take steps to make sure that they are recognised and observed everywhere, for all people.

Article 1: You have the same human rights as everyone else in the world, because you are a human being. These rights cannot be taken away from you. Everybody, no matter who they are or where they live, should be treated with dignity.

Article 2: You should not be treated differently, nor have your rights taken away, because of your race, colour, sex, language, religion or political opinions. Your basic rights should be respected no matter what country you are born in or how rich or poor you are.

Article 3: Everyone has the right to life, liberty and security of person.

Article 4: Human beings must not be owned, bought or sold. No one has the right to enslave anyone else. Slavery is a crime.

Article 5: Torture is forbidden at all times and in all circumstances. No one should suffer treatment or punishment that is cruel or makes him or her feel less than human.

Article 6: Everyone has the right to be treated as a person in the eyes of the law.

Article 7: You have the right to be treated by law in the same way as everyone else. You have the same right to be protected by the laws of your country as anyone else.

Article 8: If your rights under the law are violated by someone else, you have the right to see justice done.

Article 9: You may not be arrested or held in a police station without good reason. You may not be kept out of your own country. If you are detained, you have the right to challenge the detention in a court of law.

Article 10: You have the right to a fair and public hearing if you are ever accused of breaking the law, or if you have to go to court for some other reason. The courts must be independent from the government, qualified to understand the law, and free to make their own decisions.

Article 11: If you are accused of a crime, you have the right to be treated as innocent until you are proved guilty, according to the law. You have the right to a fair and public trial where you are allowed to defend yourself. You can not be tried for doing something, which was not a criminal offence in law at the time it was done.

Article 12: No one has the right to intrude in your private life or to interfere with your home or family without good reason. No one has the right to attack your good name without reason. The law should protect you against such interference.

Article 13: You have the right to move about freely within your country. You also have the right to travel to and from your own country, and to leave any country.

Article 14: If you are forced to flee your home because of human rights abuses, you have the right to seek safety in another country. This right does not apply if you have committed a non-political crime or an act that is not in keeping with the UDHR.

Article 15: You have the right to be treated as a citizen of the country you come from. No one can take away your citizenship, or prevent you from changing your country, without good reason.

Article 16: All adults have the right to marry, regardless of their race, country or religion. Both partners have equal rights in the marriage, and their free and full agreement is needed for the marriage to take place. All families are entitled to protection by the state.

Article 17: You have the right to own goods, land and other property, alone or with other people. No one has the right to take your property away without any good reason.

Article 18: You have the right to hold views on any issue you like without fear of punishment or censure. You also have the right to believe in any religion—or none at all. You have the right to change your religion if you wish, and to practice and teach your religion and beliefs.

Article 19: You have the right to tell people your opinion. You should be able to express your views, however unpopular, without fear of punishment. You have the right to communicate your views within your country and to people in other countries.

Article 20: You have the right to peacefully gather together with other people, in public or private. No one should force you to join any group if you do not wish to.

Article 21: You have the right to take part in the government of your own country directly or by being represented. Everyone has the right to equal access to public service in his or her country. Governments represent the will of the people. Therefore free and fair elections should be held on a regular basis.

Article 22: You have the right to have your basic needs met. Everyone is entitled to live in economic, social and cultural conditions that allow them dignity and let them develop as individuals. All countries should do everything they can to make this happen.

Article 23: You have the right to work in fair and safe conditions and to choose your job. You have the right to be paid enough for a decent standard of living, or to receive supplementary benefits. You also have the right to form or join trade unions to protect your interests.

Article 24: You have the right to time off from work. No one may force you to work unreasonable hours, and you have the right to holidays with pay.

Article 25: Everyone has the right to a decent life, including enough food, clothing, housing, medical care and social services. Society should help those unable to work because they are unemployed, sick, disabled or too old to work. Mothers and children are entitled to special care and assistance.

Article 26: Everyone has the right to an education. In the early years of schooling, it should be free of charge and compulsory. Education at a higher lever should be equally available to everyone on the basis of merit. Education should develop the full human being and increase respect for human rights.

Article 27: No one may stop you from participating in the cultural life of your community. You also have the right to share in the benefits scientific discovery may bring, and the right to have any interests from your scientific, literary or artistic work protected.

Article 28: Human beings have the right to live in the kind of world where their rights and freedoms are respected.

Article 29: We all have a responsibility to the people around us, and we can only develop fully as individuals by taking care of each other. All the rights in the UDHR can be limited only be law and then only if necessary to protect other people's rights, meet society's sense of right and wrong, maintain order, and look after the welfare of society as a whole.

Article 30: There is nothing in the UDHR that justifies any person or state doing anything that takes away from the rights, which we are all entitled.

Key Questions

There are several key pieces of information explained in the following table.

Remember: Get as many details as possible—try to get a clear and credible story of what happened.

Ask open questions—allow the interviewee to tell his or her story without being led.

Do not suggest answers—if the interviewee is upset or cannot remember, take a break.

KEY QUESTION	EXPLANATION
WHO committed abuse or was the victim?	"Who" questions may include the name of the person or the description, such as height and weight or whether he or she was wearing a uniform. Some victims may be reluctant to identify an abuser for fear of retribution. Do not pressure victims or witnesses to identify an abuser if they are afraid to do so.
WHAT happened?	What exactly happened? Try to get a sequence of events. Go slowly with the victim or witness and take breaks, for the testimony may be traumatic. If you are confused about details, go back and ask again.
WHERE did it happen?	Where did the abuse happen? Try to get locations for every part of the story. For example, if it happened on the street, which street? You can gather details about the location, such as whether the prison has food or drink, or whether the street was empty or busy.
WHEN did it happen?	When did the abuse happen? What date, day of the week, and time of day? How long did the event happen?
WHY did it happen?	Why did this event happen? What was the context? Were there previous interactions? The explanation of an event may be complex, so take your time to understand the details. If the story doesn't make sense to you, ask more questions.
HOW did it happen?	How did the abuse happen? Depending on the nature of the violation, ask in what manner it happened. If the victim was beaten, how many times and with what weapon? If the victim was arrested, what were the charges?

Is This Good Testimony?

Here are 2 examples of testimony that came from a qualitative research study of criminalizing same-sex practices in Senegal. The full article is available here: http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal. pone.0028760

Testimony example:

> If the hospital people know that you are MSM, you cannot go there for fear of being assaulted. I have a friend who was sick and was afraid to seek treatment from Dr [name withheld] after the events...he was afraid of being assaulted.

What questions has the testimony answered?

What other questions could you have asked?

Is this useful and powerful testimony? Why or why not?

Testimony example:

> We have been tortured. I even think the word [torture] is too weak. I had done everything to hide my sexual orientation, and when I was arrested, the officer took the phone and called "Hello, the *goordjigen* are here." Every day we had 10 blows with the baton in the morning and 10 blows in the evening. Other officers who were even from outside the police unit came to beat us. They insulted our mothers, fathers, and they treated us like *goordjigen*, *pédes*, etc. We were not entitled to the shower because we were homosexual.
>
> Note: *goordijigen* translates as "man-woman" in Wolof; *péde* is a derogatory term for homosexual that roughly translates as "queer."

What questions has the testimony answered?

What other questions could you have asked?

Is this useful and powerful testimony? Why or why not?

Basics of Organization

⋙ Create a system to organize materials

⋙ Create a folder for each individual

⋙ Create a case file information sheet

⋙ If you need to protect confidentiality, keep a list of real names separate from the list of fake names or numbers used on the case folders

⋙ Basic principles for organizing data: systematic and universal

⋙ Make sure that everyone who has access to the folders knows that if they take something out, they have to put it back in exactly the same place

Contents of Case Folders

⋙ Organized by topics, locations, or subjects

⋙ Cover sheets for each folder with basic information

⋙ Same numbering system for recordings, transcripts, videos, and photographs

⋙ Keep index in a secure location

⋙ What goes in a case folder?

      o   Transcripts

      o   Recording logs

      o   Photographs

      o   Brochures from the individual's organization, and

      o   Slips and scraps of paper on which you have written accounts

Sample Case Cover Sheet

Code/reference no.	Code should not include real name
Interview contact (phone, e-mail)	Can mask the information so it is not identifiable
Contents of file	Interview transcript and date
	Photo 1: Site of incident
	Photo 2: Evidence of abuses on interviewee's back
	Arrest warrant issued to family, date
	Interview audio recording, date
Projects/services participated in at organization	Legal workshop for those living with HIV/AIDS
Referrals	Came to us through AIDS Law Center
Special needs	Needs methadone, second-line ARVs
Notes	Hospitalized on date, released on date Called to speak with XX on date regarding discrimination by hospital staff

Case Cover Sheet

Code/reference no.	
Interview contact (phone, e-mail)	
Contents of file	
Projects/services participated in at organization	
Referrals	
Special needs	
Notes	

Recording Cover Sheet

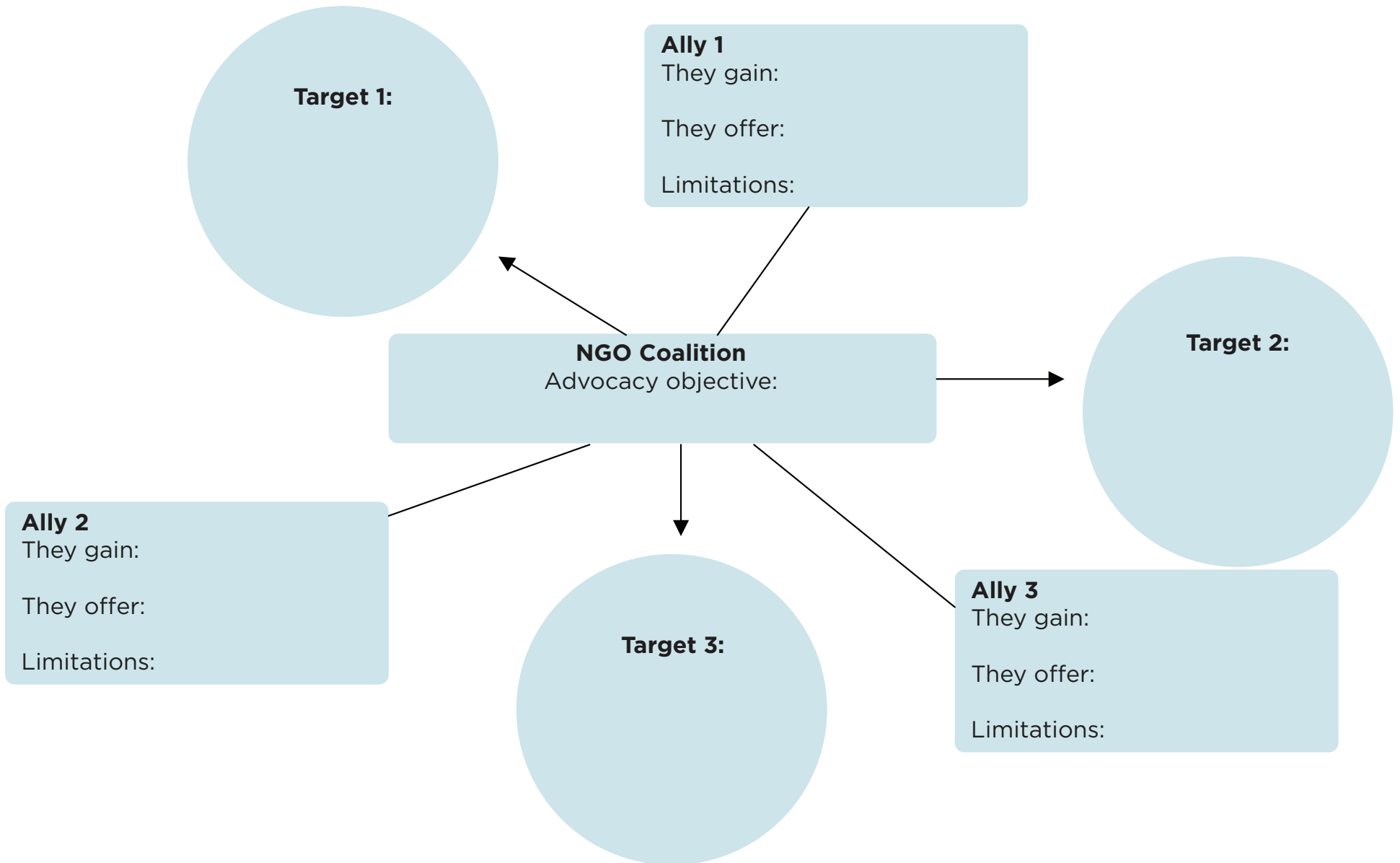|	
Code/reference no.	
Audio, video, photo	
Date of interview	
Time of interview	
Place	
Interviewers	
Major findings	
Key notes	

Yogyakarta Principles

"It is in this context of such diverse approaches, inconsistency, gaps and opportunities that the Yogyakarta Principles on the application of international human rights law in relation to sexual orientation and gender identity (the Yogyakarta Principles) were conceived. The proposal to develop the Yogyakarta Principles originated, in 2005, with a coalition of human rights NGOs that was subsequently facilitated by the International Service for Human Rights and the International Commission of Jurists. It was proposed that the Principles have a tri-partite function. In the first place they should constitute a 'mapping' of the experiences of human rights violations experienced by people of diverse sexual orientations and gender identities. This exercise should be as inclusive and wide ranging as possible, taking account of the distinct ways in which human rights violations may be experienced in different regions of the world. Second, the application of international human rights law to such experiences should be articulated in as clear and precise a manner as possible. Finally, the Principles should spell out in some detail the nature of the obligation on States for effective implementation of each of the human rights obligations.

Twenty-nine experts were invited to undertake the drafting of the Principles. They came from 25 countries representative of all geographic regions. They included 1 former UN High Commissioner for Human Rights (Mary Robinson, also a former head of state), 13 current or former UN human rights special mechanism office holders or treaty body members, 2 serving judges of domestic courts and a number of academics and activists. Seventeen of the experts were women."

Networking checklist:

Connected?	Group	Contact information
	Regional E-forums	
	Regional UNAIDS Country Coordinator	
	Global Fund to Fight AIDS, TB and Malaria (MFATM) —advocate for involvement in CSS	
	USAID/PEPFAR	
	DFID	
	National AIDS Control Program	
	Services: HIV testing centers, advocates, etc.	
	UN treaty body members from your country	

Target 1:

Ally 1
They gain:

They offer:

Limitations:

NGO Coalition
Advocacy objective:

Target 2:

Ally 2
They gain:

They offer:

Limitations:

Target 3:

Ally 3
They gain:

They offer:

Limitations:

Challenges/considerations within **individual organizations** that may prevent them from networking	Challenges within the **networks** that may hinder effective advocacy

Type of violence	Perpetrator	Coping Strategy
Intimidation		
Harassment		
Physical force		
Threat of physical force		
Other		

The Violations of the Rights of Lesbian, Gay, Bisexual and Transgender Persons in ZAMBIA

Submitted to the Human Rights Committee by: Stefano Fabeni, Director, LGBTI Initiative, Global Rights, Cary Alan Johnson, Senior Coordinator for Africa, International Gay and Lesbian Human Rights Commission, Joel Nana, Research and Policy Associate, Southern and West Africa, International Gay and Lesbian Human Rights Commission

Introduction

Zambia is state party of the International Covenant on Civil and Political Rights (ICCPR) following its accession on April 10, 1984, and will present its third periodic report due on June 30, 1998 before the U.N. Human Rights Committee.

The Constitution of Zambia of 1991, as amended by Act no. 17 of 1996, establishes in its article 11 that "every person in Zambia has been and shall continue to be entitled to the fundamental rights and freedoms of the individual, that is to say, the right, whatever his race, place of origin, political opinions, color, creed, sex or marital status (…)". Furthermore, article 23(1) of the Constitution states that "no law shall make any provision that is discriminatory either of itself or in its effect". The constitutional antidiscrimination clause is established by article 23(2) that reads "no person shall be treated in a discriminatory manner by any person acting by virtue of any written law or in the performance of the functions of any public office or any public authority" whereby discrimination is defined, according to article 23(3), any "different treatment to different persons attributable, wholly or mainly to their respective descriptions by race, tribe, sex, place of origin, marital status, political opinions color or creed whereby persons of one such description are subjected to disabilities or restrictions to which persons of another such description are not made subject or are accorded privileges or advantages which are not accorded to persons of another such description".

Substantive Violations of the Convention

Articles 2(1), 26 (Non-discrimination) and 17 (Freedom from Arbitrary Interference with Privacy, Family, Home)

In 1994, in Toonen v Australia[1], the Human Rights Committee found that the criminalization of same-sex sexual conducts between consenting adults violated Articles 2(1), 17, and 26 of the Covenant. According to the Committee the notion of sex of Articles 2(1) and 26 must be interpreted as including sexual orientation. That decision constitutes an important term of reference for the Committee as well as for other treaty bodies and U.N. special procedures with reference to discrimination on grounds of sexual orientation in the light of the ICCPR.

The most egregious violation of LGBT rights in Zambia is constituted by the Zambian penal code that still criminalizes same-sex sexual conducts in private between consenting adults contravening to Articles 2(1), 17 and 26 of the ICCPR.
Section 155 of the Penal Code Act of 1995, Chapter 87 of the Laws of Zambia (as amended by Act no. 26 of 1933), establishes that "Any person who- (a) has carnal knowledge of any person against the order of nature; or (b) has carnal knowledge of an animal; or (c) permits a male person to have carnal knowledge of him or her against the order of nature; is guilty of a felony and is liable to imprisonment for fourteen years". Similarly to the Tasmanian statute outlawed by the Human Rights Committee in Toonen, section 155 punishes the crime of "unnatural offences". Section 156 punishes with imprisonment for seven years the "attempt to commit unnatural offences".

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1   Toonen v. Australia, Communication no. 488/1992, U.N. Doc CCPR/C/50/D/488/1992 (1994).

Section 157 of the Penal Code explicitly targets same-sex sexual conducts with the provision that criminalizes "indecent practices between males". Section 157 reads "Any male person who, whether in public or private, commits any act of gross indecency with another male person, or procures another male person to commit any act of gross indecency with him, or attempts to procure the commission of any such act by any male person with himself or with another male person, whether in public or private, is guilty of a felony and is liable to imprisonment for five years".

As indicated below, the criminal provisions above mentioned not only per se violate the ICCPR, but reinforce social stigma and homophobia against sexual and gender non normative behaviour, whether perceived or real, that may easily cause discrimination or more serious forms of human rights abuses, such as crimes motivated by hatred that attempt to life or physical integrity of individuals perceived as gay, lesbian, bisexual or transgender.

Practical Impact of these Violations

The retention of codes that criminalize sexual relationships between same-sex consenting adults has a devastating impact on same-sex practicing people in Zambia. Gays, lesbians, and bisexuals in Zambia live in constant fear of arbitrary detention, discrimination in education, employment, housing, and access to services, and extortion—all buttressed by the existence of sections 155 - 157 and lack of specific legal protections for LGBT under Zambian law.

Zambians who have fought against discrimination related to sexual orientation or gender identity have been systematically silenced. On 23 September 1998 in a statement to parliament, published in the Times of Zambia, Zambian Vice President Christon Tempo vowed that, "If anybody promotes gay rights after this statement, the law will take its course. We need to protect public morality. Human rights do not operate in a vacuum." It was a clear instruction for arrests by the police of anybody who identified or supported gays and lesbians. As a result an NGO calling itself Zambia Against People with Abnormal Sexual Acts [ZAPASA] was formed to fight against homosexuals.

When LGBT organizers appeared in the newspaper to announce their wishes to register the organization, government officials warned that any attempt to register the group or hold public meetings would be met with arrests. The then Home Affairs Minister Peter Machungwa ordered police to arrest anyone who attempted to register a group advocating for homosexual rights. Registrar of Societies Herbert Nyendwa, who is responsible for processing requests for legal recognition of civic groups, swore he personally would never register an LGBT group. LGBT activists were forced to go underground. Francis Chisambisa, one of the founding members of Lesbians Gays and Transgender Association (LEGATRA), was forced to flee Zambia in 1988, after local newspapers printed articles exposing his sexuality in a highly inflammatory manner. Chisambisa was eventually granted political asylum in South Africa where he has been living for the past nine years away from his family, friends and with limited financial support.

Extortion of gay men remains a major problem, and is often conducted with police participation. Gay men interviewed for this note all reported that blackmail of men believed to be gay was a regular occurrence and often led its victims to financial ruin, depression and ostracism from family and community. A recent report on a Zambian human rights website included an report by a police officer in which he described the targeting of gay men—both Zambian and foreigners—for police-instigated extortion attempts.

Equally disturbing, given Zambia's HIV seroprevalence rates which runs about 17% among adults, at present, there are no programs—government-sponsored or privately funded—that respond to the HIV-related needs of same-sex practicing men in Zambia. Statistics gathered throughout Africa have shown that men who have sex with men are at increased risk for HIV transmission. The government of Zambia's National AIDS Control Program fails to even mention men who have sex with men. Concluding Notes Sections 155-157 of the Zambian Penal Code criminalize any form of consensual same sex conduct in private between consenting adults providing for the possibility of imprisonment from seven to fourteen yeas. Such provisions reinforce social stigma against gay, lesbian, bisexual and transgender individuals and expose them to the risk of deprivation of liberty, life, physical integrity and health. Sections 155-157 of the Zambian Penal Code are contrary to the equality principle and anti-discrimination clause of the Zambian Constitution and violate Articles 2(1), 17 and 26 of the ICCPR.

Released in July 2007.

i.   Used with permission, © NY Times

ii.   Adapted from Voluntary Service Overseas. Participatory Advocacy: A toolkit for VSO staff, volunteers and partners. http://www.vsointernational.org/Images/advocacy-toolkit_tcm76-25498.pdf. Published November 2009. Accessed on June 23, 2010.

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iv.   Adapted USAID Health Policy Initiative. Advocacy Training Manual. http://www.healthpolicy-initiative.com/index.cfm?ID=publications&get=pubID&pubID=343. Published October 2007. Accessed on June 23, 2010.

v.   Kingdom of Cambodia National AIDS Authority. UNGASS Country Report. http://data.unaids.org/pub/Report/2008/cambodia_2008_country_progress_report_en.pdf. Published Januaray 2008. Accessed on July 6, 2010.

vi.   Nepal Ministry of Health and Population. UNGASS Country Progress Report. http://data.unaids.org/pub/Report/2008/nepal_2008_country_progress_report_en.pdf. Published January 2008. Accessed on July 6, 2010.

vii.   Thailand National AIDS Prevention and Alleviation Committee. UNGASS Country Progress Report. http://data.unaids.org/pub/Report/2008/thailand_2008_country_progress_report_en.pdf. Published September 2008. Accessed on July 6, 2010.

viii.   Government of Nepal Ministry of Finance. Budget Speech of the Fiscal Year 2008-2009. http://www.mof.gov.np/publication/speech/2008_1/index.php. Published 2008. Accessed on July 6, 2010.

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xvii.   Global Rights. The Violations of the Rights of Lesbian, Gay, Bisexual and Transgender Persons in ZAMBIA. http://www.globalrights.org/site/DocServer/Shadow_Report_Zambia.pdf?docID=9965. Published July 2007. Accessed on July 6, 2010.

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