HANDOUTS

NY Times

Malawi President Pardons Gay Couple

By BARRY BEARAK
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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.

SPEAKING OUT

HANDOUT 1.1

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 treatises 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?

SPEAKING OUT

HANDOUT 1.2

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?

HANDOUT 1.3

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"

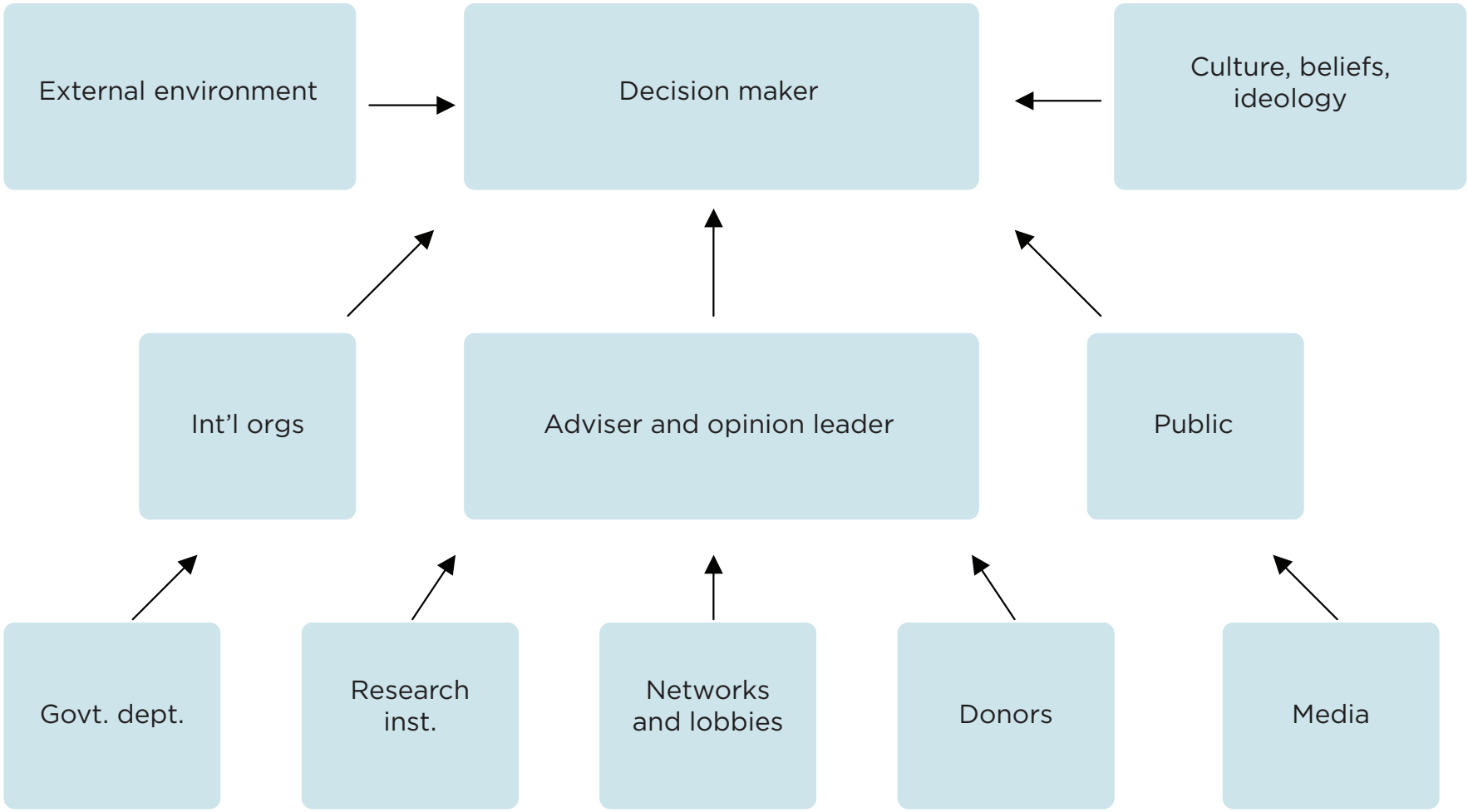
Immediate causes

- 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

HANDOUT 1.4[ii]



SPEAKING OUT

HANDOUT 1.5[iii]

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

SPEAKING OUT

HANDOUT 1.6[iv]

Activities	Person responsible	Resources needed	Deadline	Outcome	Indicator	Documentation

SPEAKING OUT

HANDOUT 2.0

CAMBODIA 2006[v]

AIDS SPENDING MATRIX DATA SHEET BY FINANCING SOURCES YEAR 2006								
NATIONAL AIDS AUTHORITY			UNAIDS					
AIDS Spending Categories (Currency USD/Riets)	Total Spending 2006	%	Public Sources	Private Sources	International Resources			
						MULTILATERAL		
					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.

SPEAKING OUT

HANDOUT 3.0[ix]

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								

SPEAKING OUT

HANDOUT 3.1.1[x]

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

HANDOUT 3.1.2[x]

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

SPEAKING OUT

HANDOUT 3.2[xi]

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.

SPEAKING OUT

HANDOUT 3.2[xi]

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.

SPEAKING OUT

HANDOUT 3.2[xi]

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.

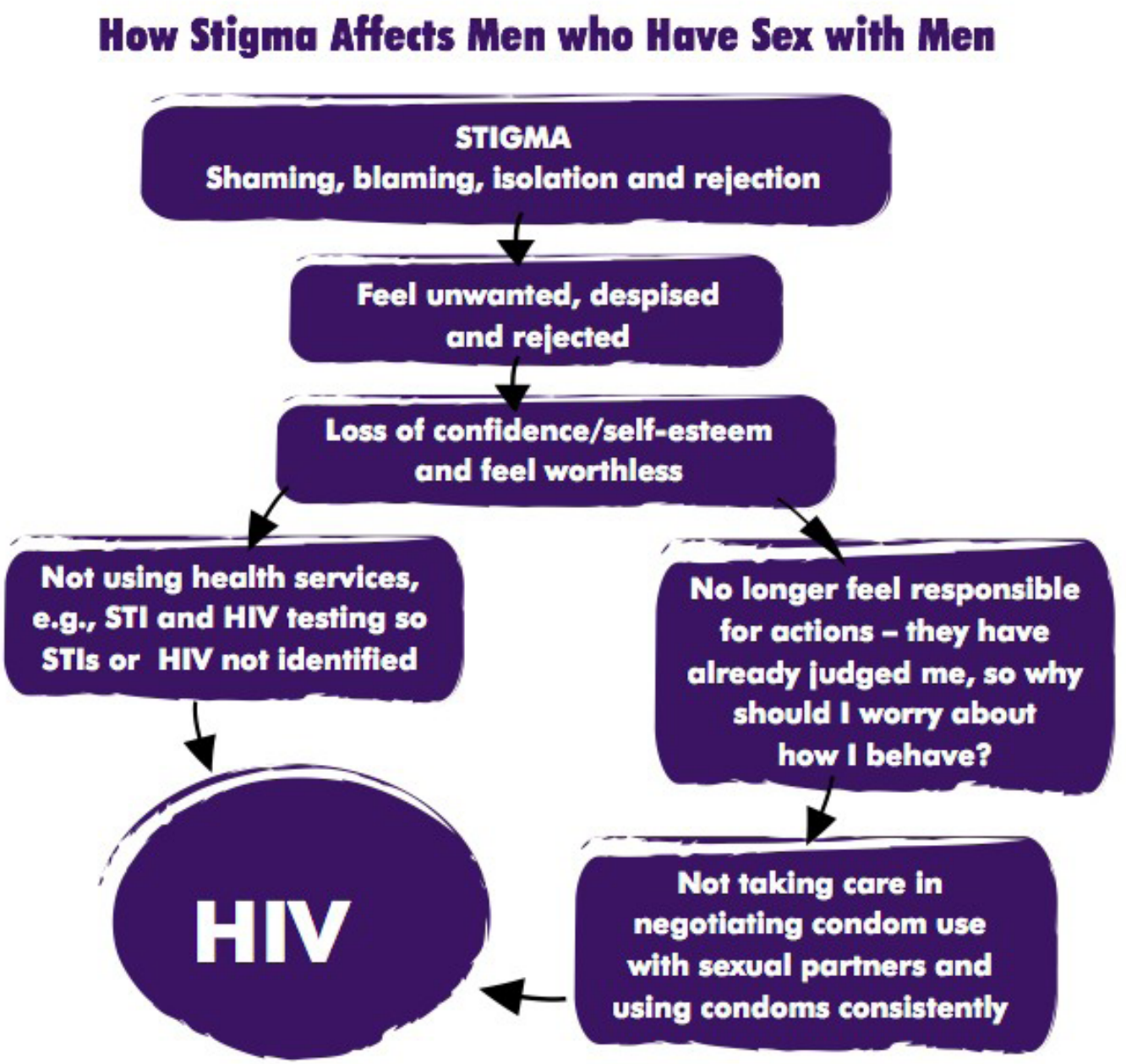
They began with an HIV information service for MSM, provided via phone and mail, along with a drop-in center, and conducted outreach at sites where MSM gathered socially or where they had sex. They developed a good relationship with a Mumbai government hospital (Sion) and developed a unique referral 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

Handout 4.0[xii]



HANDOUT 4.1[xii]

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.

SPEAKING OUT

HANDOUT 4.2

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.

SPEAKING OUT

HANDOUT 5.0[xiii]

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'Hygiene 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.

Harvard Medical School AIDS Initiative in Vietnam, Tropical Disease Hospital, 190 Ham Tu, Q5, Ho Chi Minh City, Vietnam. donn@haivn.org

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 predominantly 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.

SPEAKING OUT

HANDOUT 5.1[xiv]

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.

SPEAKING OUT

HANDOUT 6.0.1

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.

SPEAKING OUT

HANDOUT 6.0.2

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.

SPEAKING OUT

HANDOUT 6.1

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.

SPEAKING OUT

HANDOUT 6.2

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?

SPEAKING OUT

WORKSHEET 6.2

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?

SPEAKING OUT

HANDOUT 6.3

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?
    - Transcripts
    - Recording logs
    - Photographs
    - Brochures from the individual's organization, and
    - Slips and scraps of paper on which you have written accounts

SPEAKING OUT

WORKSHEET 6.3

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

SPEAKING OUT

WORKSHEET 6.3

Case Cover Sheet

Code/reference no.	
Interview contact (phone, e-mail)	
Contents of file	
Projects/services participated in at organization	
Referrals	
Special needs	
Notes	

SPEAKING OUT

WORKSHEET 6.3

Recording Cover Sheet

Code/reference no.	
Audio, video, photo	
Date of interview	
Time of interview	
Place	
Interviewers	
Major findings	
Key notes	

HANDOUT 7.0[xv]

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."

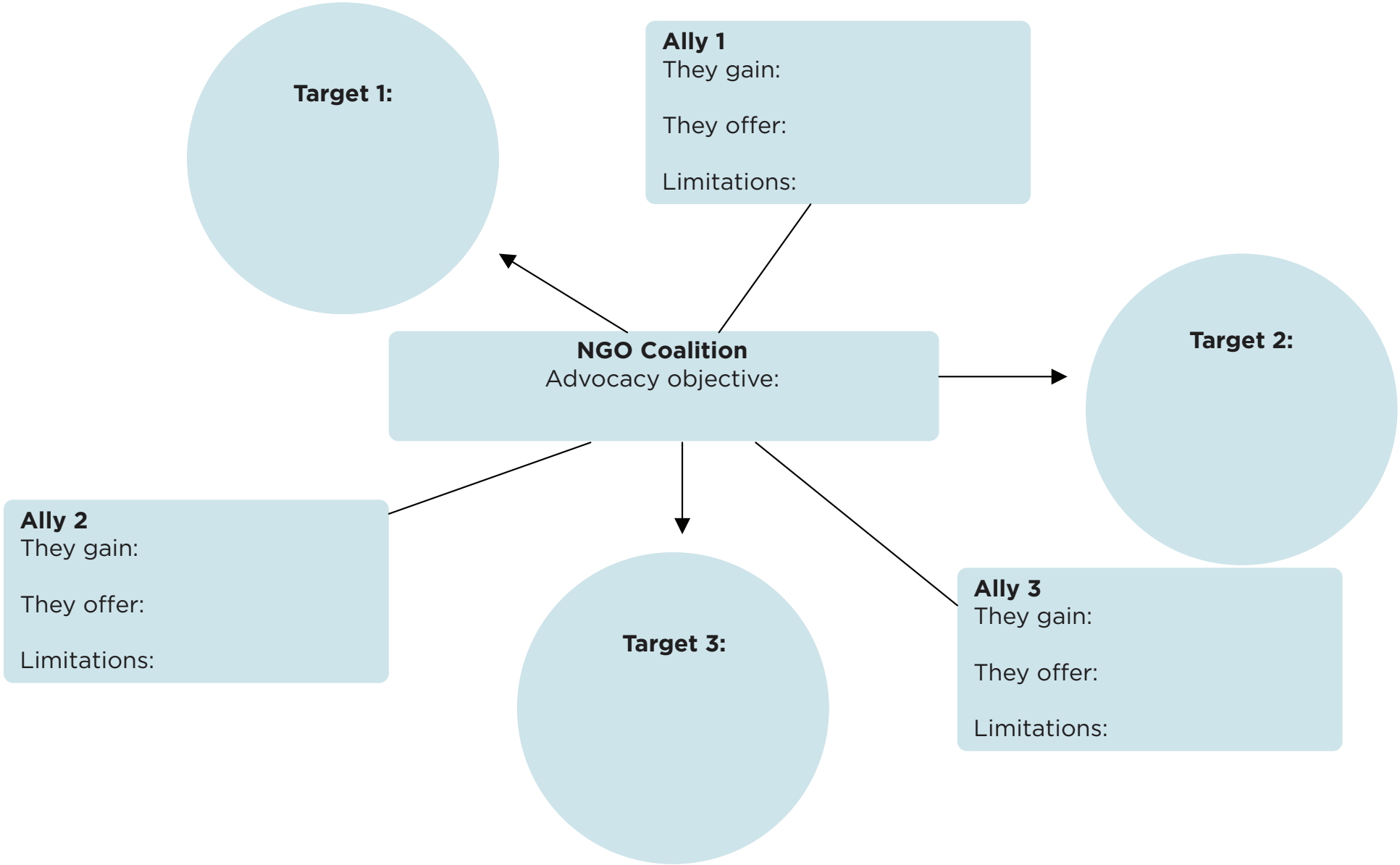
SPEAKING OUT

HANDOUT 7.1

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	

HANDOUT 7.2[iii]



HANDOUT 7.3[xvi]

Challenges/considerations within **individual organizations** that may prevent them from networking	Challenges within the **networks** that may hinder effective advocacy

SPEAKING OUT

HANDOUT 8.0

Type of violence	Perpetrator	Coping Strategy
Intimidation		
Harassment		
Physical force		
Threat of physical force		
Other		

SPEAKING OUT

HANDOUT 9.0[xvii]

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".

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.

SPEAKING OUT

(ENDNOTES)

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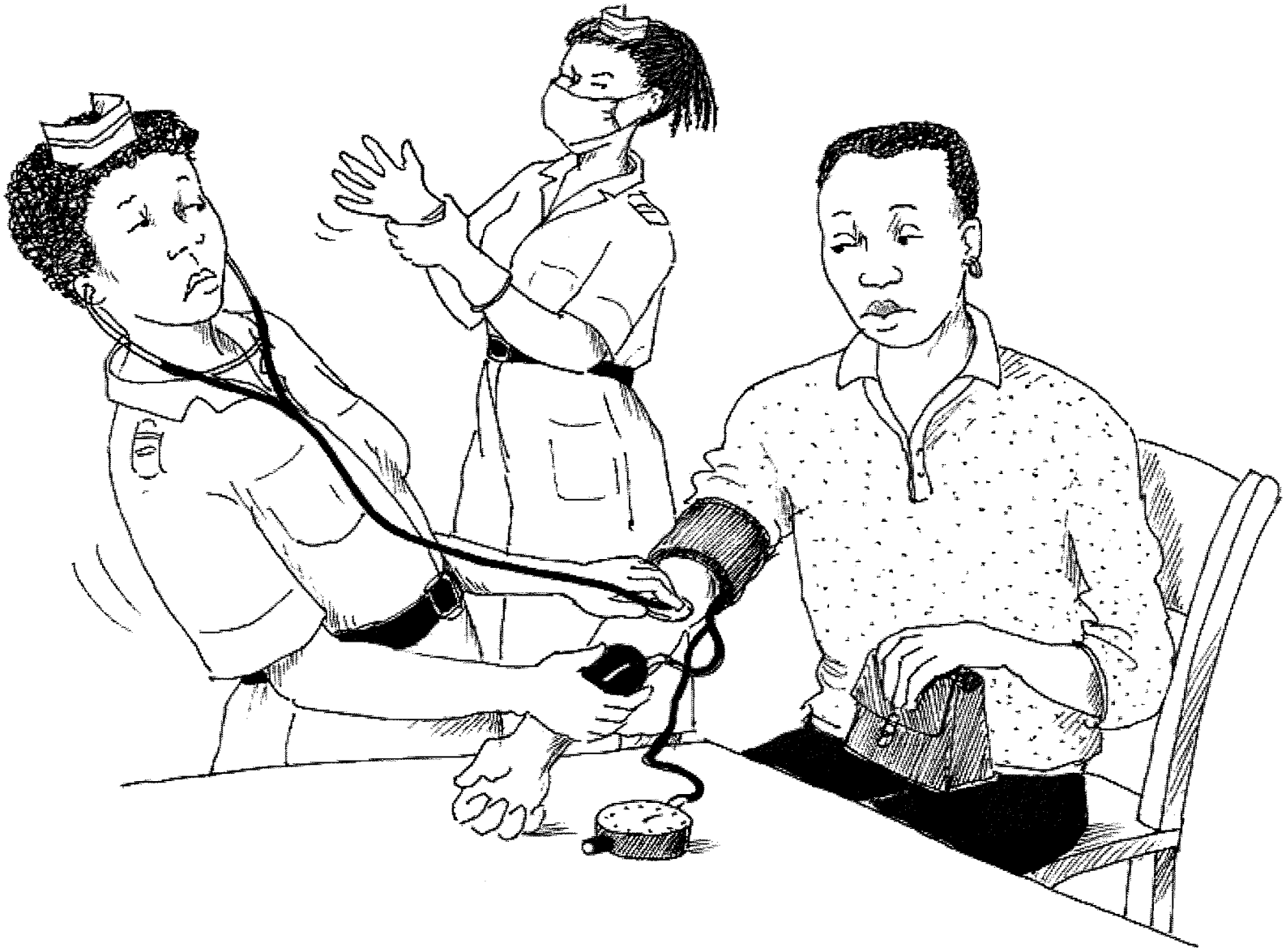

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