

*Text of the presentation by Felicity Young, Health Policy Initiative - China and the Mekong Sub-region/Research Triangle Institute, delivered to the APCOM 200 Forum, 8th August 2009, in Bali, Indonesia.*

Thank you

I am honored to have been invited by APCOM to speak today – especially knowing the caliber and experience of the people in this room.

The title of this presentation is Advocacy: simple to complex and I'm going to set the stage by asking some questions.

- Why in the face of reasonable evidence as early as 2000 about emerging HIV epidemics among men who have sex with men have we experienced, until very recently, profound policy inertia?
- Why has there been so little financial investment in interventions to address HIV risk among men who have sex with men?
- Why is the estimated coverage for prevention of HIV programs among men who have sex with men estimated at a mere 5% or lower?
- Why do so few countries include men who have sex with men and transgenders as part of their routine HIV surveillance systems?
- Why have the human rights of men who have sex with men and transgenders been repeatedly violated and ignored?
- Why have the efforts at supporting men who have sex with men leadership building and related community mobilization efforts been *ad hoc* and spasmodic?

Was the evidence not compelling enough?

Were we not capable of pulling together the multiple forms of existing data and combine that with the '*lived experience*' of men who have sex with men and transgenders and use that information to effectively advocate to power brokers?

We have been wandering in an advocacy wilderness - but the climate is changing for the better.

Our advocacy manuals have snappy titles like "policy to practice" – "advocacy to action" – as though this was straightforward – indeed, nothing about this work is straight.

I learned how to do HIV advocacy by trial and error and truthfully, I am not sure how well it can be taught formally.

I was schooled in MSM and HIV advocacy by the best – the Australian gay community - with whom I had the pleasure of working with in the early 1990s and I thank them for their lessons. But doing MSM HIV advocacy in Australia led by a politically savvy gay community within the context of a supportive enabling environment is a different ball game than doing it in many of the countries in which you work.

Advocacy is both an art and a science combined with knowing when to play dirty and when to play nice – doing both simultaneously is best!

Advocacy is affected by both objective and subjective factors - with the subjective factors being beyond our immediate control.

Although I am sure I don't need to remind anyone here about the negative impact of HIV-related stigma and discrimination and how HIV and stigma and discrimination against men who have sex with men and transgenders are interwoven.

For example, the 2007 Pew Global Attitudes survey reported that 95% of the general Indonesian public surveyed rejected same sex relationships.

The negative attitudes towards men who have with men and transgenders and HIV that persist throughout the region combined with the criminalization of same sex behaviors in some countries nurtures a “culture of oppression” or at its most extreme a “culture of hatred”.

There is no question that institutionalized and individual homophobia negatively impacts on decision-making resulting in poor and harmful policy making, human rights violations, violence against men who have sex with men and transgenders, inadequate funding of programs, which all lead to a failure to reach coverage and undermine support for MSM leadership.

The only way to address this is to be aware that advocacy must be context and politically-specific and our advocacy experience to-date shows that community-led advocacy is the most effective approach.

I also know that with advocacy there is always a back room story – hopefully, it's a story you create – but unfortunately, often not. There is the 'other side' working against you and you can be surprised by whom both your allies and enemies are. Advocacy is about more than sharing information – it's about bringing politically palatable and realistic solutions to the policy table – solutions that can be worked through the system, funded and implemented.

The back room story of HIV and MSM advocacy is also a story of individuals and coalitions of individuals - many strange bedfellows – who have worked tirelessly behind the scenes massaging and piling bureaucratic systems, slowly chipping away at number crunching, staging and manipulating meetings, running interference and giving meaning to the opaque concept of building “political will” – combined with the many people who turn up to work each day and

deliver the programs - time and time again despite low funding levels and hostile environments. Many of you are in this room today...

In 1997, UNAIDS estimated that 5-10% of HIV infections globally were transmitted via male-to-male sex and called upon governments to include MSM in their national programs. The clicking of fingers from UNAIDS did not result in immediate action and it took some countries up to 10 years to incorporate MSM into their national strategies, protocols and guidelines and even today, not all countries have done so – most notably Viet Nam and PNG.

However, let's be honest – adding paragraph in a national strategy or signing an international consensus statement does not necessarily translate to action – words are cheap. And, its only when those lovely statements are translated into funded service coverage at-scale should we pop the champagne.

I'd suggest we keep the bottle on the ice for a while longer.

For some time there has been an epidemiological mantra we chant: HIV prevalence in Bangkok among men who have sex with men went from 3% in 1990 to 17% in 2003 to 28% in 2005 to 30.7% in 2007. And, in 2000, MSM HIV prevalence of 15% was reported in Phnom Penh and in 2001, HIV prevalence among MSM was 17% and 68% among transgenders in Mumbai.

In 1997, the Monitoring the AIDS pandemic (MAP) report said that in the Asia-Pacific region we should focus on sex workers and drug users – not on men who have sex with men. By 2004 MAP was reporting while Asian countries ignored MSM, HIV was spreading rapidly among them and the 'shocking' prevalence studies from Bangkok, Phnom Penh and Mumbai were noted.

From 2002 onwards, programmatic interventions were emerging – including the Humsafar Trust, mPlus+ and SWING to name only a very few.

In 2003, The US President's Emergency plan for AIDS Relief (PEPFAR) was announced and along with it the 'ABC' dance wreaked havoc. It can be argued that given the US political context of the day and with the exception of Viet Nam – PEPFAR meant there wasn't much attention paid to this region and that was a good thing. Nevertheless, an undeniable chilling effect was cast over many of our advocacy efforts.

The USAID Mekong regional program and US CDC GAP left to their own devices staged two important MSM meetings in 2005 to advocate for an urgent response and in 2006, the Purple Sky Network was created to facilitate greater MSM leadership and participation. With the notable exception of UNESCO, the multi-laterals chose not to participate in these meetings.

By 2006, a head of steam was building with the establishment of the Global Forum on MSM & HIV and the ground-breaking Risks & Responsibilities Conference, co-hosted by the Naz Foundation & NACO. APCOM was conceived at this conference and birthed the following year.

At the Risk and Responsibilities conference, USAID/Health Policy Initiative - at APCOM's request - tabled a report suggesting that MSM expenditure levels in the Asia-Pacific region would have to increase their HIV prevention expenditure by between 4 to 25 times in order to achieve 60 percent coverage with just peer education and outreach programs, and much more if we include VCT and condoms. This paper estimated that less than 2% of total HIV expenditure was ear-marked for MSM prevention in 2004 in Thailand, Burma, Vietnam, Cambodia, Lao and Yunnan and Guangxi provinces of China. .

Nonetheless, even when we knew undeniably that HIV prevalence in Bangkok was at 31%, in 2007, USAID was **still** the only significant donor in the region.

Although we gratefully took USAID's money and used it wisely for service and model development we never envisaged that this would be the main source of funding for MSM programs and, as a result, many programs have remained as boutique items with trivial levels of coverage.

Others needed to come to the party and start helping.

So where is the Global Fund in all of this?

Despite having funded programs for MSM since its inception, very few proposals came from Asia until Round 7 – beginning with Cambodia and now Round 8 with Thailand and hopefully, followed by China and Lao and Round 9 in Burma is being planned. Interestingly, Viet Nam has not included MSM in their Round 8 proposal. Of course, with this, comes the responsibility to ensure that the implementers of these programs are provided with technical assistance – an ongoing challenge.

In 2007, the Positive MSM working group was launched under the auspices APN+ and this has provided a welcome advocacy platform for positive MSM issues.

In 2008, UNDP was officially tasked with addressing MSM and HIV within the UN system.

The 2008, Commission on AIDS in Asia Report has been one of the most important advocacy documents to-date and it called for scaling-up of HIV prevention programs for MSM to 80% coverage and this message has helped to galvanize our advocacy efforts.

2009 began with a bang with the Hong Kong Department of Health, WHO, UNDP and UNAIDS co-hosting a Technical Consultation meeting on HIV among MSM and followed in June, by the Regional Consensus Meeting to develop a Comprehensive Package of Services to Reduce HIV among MSM. UNDP, WHO, ASEAN (and with support from USAID) here today are issuing a consensus statement announcing on the Comprehensive Package of Services and this will provide a focal point for our future advocacy work.

We now have many of the advocacy building blocks in place.

Finally, multilateral and bilateral support has grown and now our advocacy efforts must be targeted at country level and focused on leadership and program expansion and I'd suggested concentrated in 4 main areas:

1. Mobilizing increased financial resources in support of the comprehensive package of services
2. Increasing MSM leadership and strengthening MSM-led and controlled NGOs and CBOs
3. Addressing human rights and improving policy environments
4. Developing appropriate models of care and support for HIV-positive MSM & transgenders

I am only going to speak to the first issue today – because I believe this is the weakest plank in our advocacy platform and because, without adequate financing, the other three will not be achieved. The AIDS Commission report, based on modeling from 2007, says that \$330 million will be required annually for MSM prevention in 17 Asian countries. It is estimated that, currently, there is only 25million available in funding. This is a SIGNIFICANT short fall.

This leads us to ask:

How can we advocate for interventions that are effective at a public health level?

How can we effectively encourage changes in sexual behavior at a population level in an economically feasible way?

If we are unable to answer these questions, we will see 50% of all new infections occurring among MSM within 10 years, as projected by the AIDS Commission Report.

We need to better understand the difference between resource needs and current levels of spending – country-by-country.

In order to do this, we need better MSM population size estimates, and as importantly, estimates of sub-populations of MSM (transgenders, sex workers, highly sexually active men, etc).

We need to better understand which behaviours are fuelling the HIV epidemic among MSM – particularly among the various MSM sub-populations.

We need to understand which interventions will be effective to change the behaviour of MSM; how to target those interventions and how much they will cost to deliver.

We need more transparency from governments and donors on how much they spend on HIV especially MSM and transgender targeted programming and increased willingness to share this information.

We need a more sophisticated methodology to bring this information together to help us estimate how much it will cost to scale up effective prevention programs which target the most vulnerable and the drivers of the epidemic at country level.

I am pleased to say that we are now some way towards improving our methodologies and analytic tools.

With USAID funding, the HPI (and Burnet), APCOM and UNDP has produced a resource estimation tool designed for community advocates to improve their understanding of the resources needed to scale up HIV prevention programs for MSM.

The tool allows users to adjust parameters such as population size estimates, coverage targets, targeting of specific services to sub-groups of sex workers, transgenders, incarcerated men, accessible and less-accessible men, and allows users to base their estimates on local costs of services.

My colleague, Brad Otto will discuss this new tool in a session on Wed 12 August and he will demonstrate a preliminary run through of the tool and will outline some of the advocacy issues we need to address.

Most importantly, we need MSM community advocates to become literate in the language of resource allocation and skilled at using this information to inform their MSM advocacy from local to national to regional levels to global levels.

We need MSM and transgender community advocates to lead governments and donors in how to respond most effectively to the epidemic. This will be our next generation of advocacy work.

Finally, it only by employing such analyses and marshalling all of our advocacy skills, experience and enthusiasm, can we make the line between advocacy and action stronger - it doesn't need to be **straight** to be effective!