



USAID
FROM THE AMERICAN PEOPLE

**HEALTH POLICY
INITIATIVE**



A² Advocacy Training Manual



October 2007

This publication was produced for review by the U.S. Agency for International Development (USAID). It was prepared by staff of the Health Policy Initiative, Task Order 1.

Photo Credit: At a booth in the exhibition hall of the XV International AIDS Conference in Bangkok, delegates express their hopes, prayers, and identities on pieces of paper stuck on a globe.
Courtesy of Paul Jeffrey/Ecumenical Advocacy Alliance.

Initial preparation of this publication was supported by the POLICY Project, funded by the U.S. Agency for International Development (USAID) under Contract No. HRN-C-00-00-0006-00, ending June 30, 2006. Subsequent work continued under the USAID | Health Policy Initiative, Task Order 1, funded under Contract No. GPO-I-01-05-00040-00, beginning September 30, 2005. HIV-related activities of the Initiative are supported by the President's Emergency Plan for AIDS Relief. Task Order 1 is implemented by Constella Futures, in collaboration with the Centre for Development and Population Activities (CEDPA), White Ribbon Alliance for Safe Motherhood (WRA), Futures Institute, and World Conference of Religions for Peace (WCRP). Funding for the A² Project has primarily been through USAID's Regional Development Mission/Asia. The A² Project is jointly implemented by Family Health International, the East-West Center, and Constella Futures/Health Policy Initiative.

Table of Contents

SECTION I: Introducing the A² Advocacy Training and Project	1
Workshop Opening and Introductions	5
A ² Concept	9
SECTION II: Introducing HIV and AIDS Advocacy	1
What Is Advocacy?	3
Advocacy and Related Concepts	7
Examples of Advocacy Leading to Policy Change	13
Steps in the Advocacy Process	15
What Is Particular to HIV and AIDS Advocacy?	19
SECTION III: Identifying Advocacy Issues and the Role of Data	1
Key HIV and AIDS Issues in Asia	3
Introduction to Data Analysis	7
Introduction to Data Analysis in the A ² Project	17
Analyzing Secondary Data I: Behavioral and Epidemiological Data	19
Analyzing Secondary Data II: Program and Policy Responses	21
SECTION IV: Understanding the Policy Process	1
The Policy Process	3
SECTION V: Moving from Issues to Advocacy Objectives	1
Advocacy Issue Prioritization	3
Identifying Potential Policy Solutions	7
Developing Advocacy Goals and Objectives	9
SECTION VI: Identifying and Analyzing Target Audiences	1
Mapping Key Decisionmaking Processes for Advocacy Objectives	3
Power Maps: Identifying Support and Opposition	7
Analyzing a Target Audience	11
SECTION VII: Developing Advocacy Messages and Methods	1
Introduction to Effective Advocacy Communication	3
The One-Minute Message	11
Advocacy Messages and Methods (Guest Speaker)	15
Increasing Message Effectiveness (Role Play)	17
Written Communication (Policy Briefs)	21
SECTION VIII: Using the Mass Media for Advocacy	1
Using Mass Media as an Advocacy Tool	3
International HIV/AIDS Alliance “Advocacy in Action” Cards	11
SECTION IX: Working with People Living with and Affected by HIV and AIDS	1
Learning from People Living with and Affected by HIV and AIDS	5
Challenges to GIPA	9
SECTION X: Making Advocacy Plans and Next Steps	1
Action Plans	3
ANNEX: Additional Resources	1
Guest Speaker Invitation – Advocacy Methods	3
Guest Speaker Invitation – Policy Process	5
BIBLIOGRAPHY	11

Acknowledgments

A wide range of advocacy and training experts, as well as individuals involved in the A² Project, contributed to the development of this training manual. The POLICY Project began the drafting of the manual, which was then finalized under Task Order 1 of the USAID | Health Policy Initiative, with input from A² Project partners, the East-West Center and Family Health International.

The manual was adapted from the *Networking for Policy Change: An Advocacy Training Manual*, prepared by the POLICY Project in 1999. The A² Advocacy Training Manual draws from numerous HIV and advocacy resources and materials from the Asia-Pacific region, as well as from the experiences of practitioners working on advocacy and policy development and implementation in the region, particularly China, Thailand, and Viet Nam. The manual integrates innovative approaches to advocacy and involvement in the policy development process that are specific to HIV epidemics in Asia.

The A² Project aims to promote effective advocacy for evidence-based responses to HIV in Asian countries. We hope that this manual will foster a greater understanding of the role of advocacy in policymaking and decisionmaking and build advocacy skills that will promote the development of effective policies and appropriately targeted and resourced HIV and AIDS programs.

The USAID | Health Policy Initiative, Task Order 1 would like to acknowledge the contributions of the following technical writers and reviewers: Nadia Carvalho, Shetal Datta, Anne Eckman, Kai Spratt, Chris Ward, and Felicity Young of Constella Futures; and Imelda Feranil and Anne Jorgensen of CEDPA. We would also like to acknowledge the following editors: Nancy McGirr, Lori Merritt, and Mark Wehling of Constella Futures; Jeremy Ross of Family Health International; and Tim Brown of the East-West Center. Finally, we are especially grateful for funding provided to the A² Project from the USAID Regional Development Mission in Asia (RDM/A) and would like to specifically thank Clif Cortez, Patchara Rumakom, and Rattanaporn Tangthanaseth for their continuous support of the project.

Introduction to the A² Advocacy Manual

“Vision without action is a daydream. Action without vision is a nightmare.”

~ Japanese Proverb

Purpose of the Manual

Much is known about Asian epidemics, their evolution, and prevention. Despite this, a real divide continues between lessons learned and the implementation of programs and policies. Prevention coverage of key populations that drive epidemics (sex workers and clients, injecting drug users, and men who have sex with men) is most often extremely limited. Few countries can estimate the size of key populations or their respective contributions to new infections. Surveillance systems suffer from quality issues, the inability to access most-at-risk populations, failure to adapt as epidemics evolve, and poor linkages with key decisionmakers and affected communities. Data collected remain peripheral to decisionmaking processes, and it can be difficult to build political commitment for prevention and care services for key populations who experience extreme stigma and hence are “politically unpopular.”

This training manual aims to promote effective advocacy in support of evidence-based responses to HIV in Asian countries. Authors include staff of the Analysis and Advocacy (A²) Project, a joint regional project of Family Health International, the East-West Center, and the USAID | Health Policy Initiative, Task Order 1, with funding from the United States Agency for International Development. The A² Project is being implemented in Bangladesh, Thailand, Viet Nam, and the Yunnan and Guangxi provinces in southern China. In each country, national and provincial-level governments and research institutions that monitor and respond to the HIV epidemic are also project partners.

The A² Project’s overall goal is to **develop a clear understanding of the HIV epidemic in countries in the region and to translate that understanding into effective policies and appropriately targeted and resourced programs.** The project aims to foster national and provincial responses that will make a difference in resource-constrained settings by building capacity to bring together local epidemiological, behavioral, and program response and costing data; analyze that data using state-of-the-art modeling tools; determine responses and resources needed for maximum impact; and target policymakers, program managers, and donors with this information so that they will make the most effective choices.

Advocacy is a core component of all A² processes—from decisions regarding data collection and analysis through to dialogue with policymakers. We believe that a synergy of analysis and advocacy will promote increased political commitment and improved decisionmaking through better use of local evidence, improved surveillance systems leading to increased understanding of epidemic dynamics, improved evaluation and direction of national responses, increased and more efficiently used resources, and reduced stigma and discrimination.

Training curricula on advocacy, whether focused on HIV or other development issues, are increasingly available in the public domain. We saw the need for a new manual that builds both core advocacy skills and more specialized skills in using data to identify advocacy issues, goals, and objectives. Equally important to the data generated through A² is the capacity to extract the messages reflected in the data and then to convey them effectively to decisionmakers.

Evidence for Advocacy

The A² Project uses two modeling tools to generate evidence to inform advocacy. The Asian Epidemic Model (AEM), developed by the East-West Center, replicates the dynamics of HIV epidemics in Asian settings to project future epidemiological trends. The Goals Model, developed by Constella Futures (formerly the Futures Group), supports strategic planning by linking program goals (e.g., goals set in a national HIV and AIDS strategy) to the resources needed to achieve those goals. Using both the AEM and Goals Model, the effectiveness of past and current responses is evaluated, and projections are developed for future epidemiological trends and resource needs based on responses to date. Alternative responses, their impact on the future course of the epidemic, and their resource implications are also evaluated. Key implications for policies and programs are identified. Knowledge and data gaps are identified, as are strategies to fill these gaps and address weaknesses in data and surveillance systems.

While this manual uses the AEM and the Goals Model as sources of “evidence” for advocacy, the models are relatively resource-intensive to apply, and not everyone who wishes to advocate for evidence-based responses to HIV will have access to the resources needed to use these models. This constraint does not prevent the use of this manual as a resource for evidence-based HIV advocacy. There are multiple sources of information about epidemics in Asian countries—from epidemiological and behavioral data in the public domain to the experiences of people living with and affected by HIV and the organizations that work with them. An emphasis on epidemiological and economic modeling does not preclude the unique contribution that people directly affected by the epidemic can make. On the contrary, it can empower affected communities with the “hard” evidence that reflects and supports their own experiences and needs. This manual seeks to promote synergies between modeling and the experience of affected communities, so that

the two can be mobilized for advocacy in ways that decisionmakers will find less easy to ignore.

How to Use this Manual

This manual has been adapted from the POLICY Project’s *Networking for Policy Change: An Advocacy Training Manual* and its well-developed model that has been tested over time in diverse cultures for accomplishing advocacy objectives. Each section of this manual begins with an introduction to the particular topic, followed by learning objectives, background notes, activities, and handouts. Each section includes information about time and material requirements and detailed instructions for activities, such as role-plays, discussions, and brainstorming, to help participants internalize the skills.

The manual consists of four components:

1. A curriculum for trainers and workshop facilitators.
2. A series of PowerPoint presentations on CD-ROM to accompany various units, which can be used or adapted according to the needs of the participants and the particular epidemic with which trainees are concerned.
3. Resources for trainers:
 - a. Sample agenda and overview of the training including objectives for each day.
 - b. A checklist of materials needed to run a workshop.
 - c. A questionnaire for participants to complete and return prior to the workshop.
 - d. Evaluation forms for participants to complete at the end of each day.
 - e. A final evaluation form covering the entire training.
4. Resources for participants:
 - a. Background notes on topics addressed in the different modules.
 - b. Information sheets on key concepts, worksheets, and planning tools.

- c. Hard copies of PowerPoint presentations.
- d. A collection of policy briefs for which we are indebted to the Foundation for AIDS Research, the National Rural Health Association, the Medical Research Council of South Africa, the United Nations Economic and Social Commission for Asia and the Pacific, and the Joint United Nations Program on HIV/AIDS.
- e. “Advocacy in Action” cards for which we are indebted to the International HIV/AIDS Alliance, which developed these for its own advocacy training.

Trainers will need to decide how much of the material in the manual they will use. Under the A² Project, the USAID | Health Policy Initiative, Task Order 1, has generally implemented a five-day training, although more than five days are needed if all the modules are used. Often it is not feasible to secure the participation of trainees for more than five days, and in this case, trainers must choose which modules to use. Decisions should

be based on the needs of participants, their level of technical skill in the various areas covered by the curriculum, and the feasibility and utility of building participants’ capacity in areas such as data analysis, the production of policy briefing papers, and working with the media. Assessment of these factors should be informed by the results of the pre-training questionnaire for participants. The overall aim in the selection of material should be to deliver a training package most useful to participants in building their skills in evidence-based advocacy.

We hope that this manual makes a real and positive contribution to effective, evidence-based responses to HIV in Asian settings. We hope it will lead to the development and implementation of policies and appropriately resourced programs that reduce HIV infection rates; mitigate the impact of the epidemic on individuals, families, and communities; and ultimately reverse the epidemic we continue to see in almost all countries in the region. ■

SECTION I: Introducing the A² Advocacy Training and Project

- Content:**
- Activity 1 — Workshop Opening and Introductions
 - Activity 2 — A² Concept
- Purpose:**
- The purpose of the activities in this section is to introduce participants to each other and to familiarize them with the workshop objectives and the overall A² Project, especially the role of advocacy in the project.
- Objectives:**
- By the end of this section, participants will
- Understand the objectives of the workshop;
 - Meet other participants; and
 - Gain familiarity with the A² project purpose and structure, with a particular focus on A²'s goal of linking data and advocacy.

Background Notes:

A² is a joint project being implemented by Family Health International (FHI), the East-West Center, the USAID | Health Policy Initiative, Task Order 1, and a variety of organizations across Asia. Many of the in-country organizations are national or provincial AIDS control committees, departments of health, or epidemiology centers responsible for tracking the course of and responding to the epidemic. A² grew out of and builds on the integrated analysis work pioneered by the East-West Center.

Integrated Analysis

Integrated analysis involves the collation and analysis of all available biological, behavioral, programmatic, and economic data to provide a complete picture of the nature of the epidemic in a particular country environment. The aim is to enhance the effectiveness of responses to HIV and AIDS by using the evidence gained through integrated analysis to guide interventions and the application of resources and focus them on those factors driving the epidemic. Analysis by the East-West Center has identified particular features of Asian epidemics:

- HIV epidemics in Asia follow a similar pattern but vary in timing and severity.
- Asian epidemics begin with injecting drug users (IDUs) who share needles and men who have sex with men (MSM).
- HIV then starts to rise among sex workers and their clients.
- MSM, clients of sex workers, and male IDUs transmit HIV to their wives, who in turn transmit HIV to their children.
- Some of the variations among countries include how quickly the epidemics grow and the level of HIV prevalence reached in different populations.

Given all we know about the factors driving Asian epidemics, why do those factors continue to exert the influence they do? Generally, it is not the case that governments, donors, and civil society fail to act, but rather that their actions are not targeted appropriately. A real divide exists among lessons learned and the programs and policies implemented in Asian countries:

- Prevention coverage of key populations driving the epidemic is extremely limited.
- Most Asian countries do not operate with a clear picture of their own epidemics.
- Data collected remain peripheral to the decisionmaking process.
- Data systems do not evolve strategically to fill gaps and help direct responses.
- Even where data exist, there is often insufficient political commitment to forge effective responses with the stigmatized populations affected by the epidemic.

Combining Data Use with Advocacy

A² takes the integrated analysis process a step further by incorporating advocacy at all stages of the analysis and response to the epidemic. The problem is not necessarily that data do not exist, but that existing information is not being analyzed systematically, improved over time, and then applied to inform advocacy and guide responses in appropriate directions. The A² process provides a practical approach to gathering, analyzing, and using this information; extracting from this information relevant evidence-based recommendations for policies and programs; and proactively advocating for these recommendations to be mobilized into more effective policies and programs.

Our Approach

A² aims to create national and provincial responses that will make a difference in resource-constrained settings by building capacity to

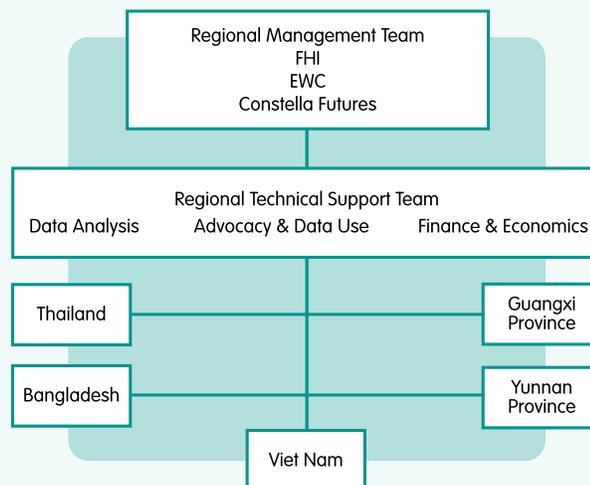
- Bring together local epidemiological, behavioral, response, and program-costing data;
- Analyze that data with state-of-the-art modeling tools;
- Determine responses and resources needed for maximum impact; and
- Target policymakers, program managers, and donors with this information so they can make the best choices.

We believe that a synergy of analysis and advocacy will promote

- Increased political commitment and improved decisionmaking through expanded use of local evidence;
- Improved design and quality of surveillance systems;
- Better monitoring and understanding of epidemic dynamics;
- Improved evaluation and direction of national responses;
- Increased and more efficient resource allocation; and
- Reduced stigma and discrimination.

The Structure of A²

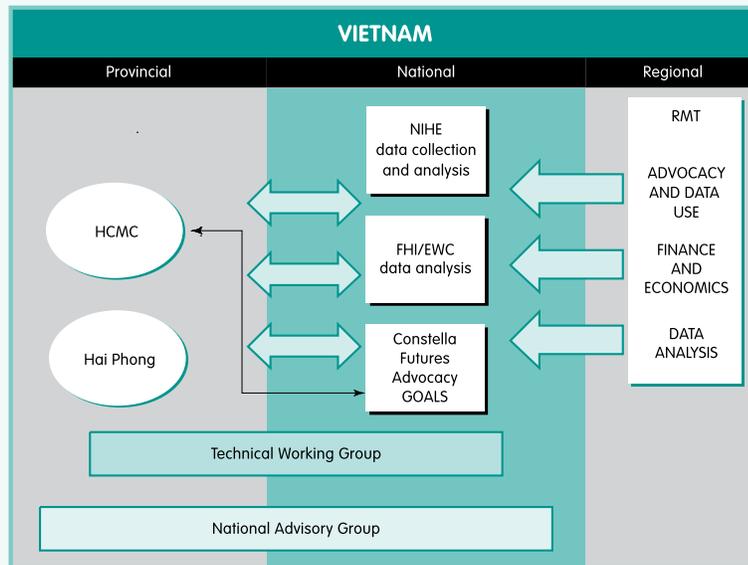
A² implementation is based on the model developed at the inaugural project meeting held in Bangkok in November 2004 and represented in the following diagram:



A² is guided by a Regional Management Team, comprising representatives from FHI, the East-West Center, and Constella Futures. In addition, there is a Regional Technical Support Team that provides support to the Country/Province Teams working on A² activities. All of the international partners contribute staff and resources to the Regional Technical Support Team.

Country Teams

All Country Teams involve partnerships between international and national or provincial partners. The following diagram from Viet Nam is an example of how A² implementation is planned at the country level, with the project having commenced in Ho Chi Minh City and implementation planned for Hai Phong:



* HCMC: Ho Chi Minh City; RMT: Regional Management Team; NIHE: National Institute of Hygiene and Epidemiology

Linking the Asian Epidemic Model and the Goals Model

An important development contributing to the establishment of A² has been the merger of two key modeling tools, the Asian Epidemic Model (AEM) and the Goals Model. AEM calculates expected trends in HIV infection based on observed patterns of HIV spread in the region. The Goals Model supports effective strategic planning by linking program goals, such as those constituting a national strategy, to the level of resources necessary to achieve those goals. The Goals Model can answer the following questions:

- What resources are required to achieve the goals of a national strategic plan?
- What outcomes can be achieved within a given level of resources?
- What is the impact on the epidemic if resources are allocated in different ways?

The information generated from the application of these models provides valuable evidence for advocacy campaigns to use in increasing the effectiveness of local, provincial, and national responses to epidemics in Asia. Synthesis reports using the integrated analysis methodology and further data and analyses from the AEM and Goals Model are also produced at each project site.

The Benefits: Stronger Responses and Fewer Infections

HIV is a complex epidemic, calling for well-designed, evidence-based responses. By synthesizing data from all available sources, the A² process offers an opportunity to understand this complexity at national, provincial, and even sub-provincial levels and decide among alternative responses on the basis of impact and cost-effectiveness. The potential benefits of this process are numerous:

- For the first time, HIV information of all types from multiple sources will be brought together.
- Data gaps will be identified and filled, and a better understanding of the epidemic situation and its driving forces will be obtained.
- Government and nongovernmental institutions, donors, and communities will have a more accurate picture of the effectiveness of their responses to date and will be better able to evaluate future alternatives systematically.
- Affected communities will be more empowered with data for use in advocating for better prevention and impact mitigation services.
- Resource allocation decisions by donors, governments, and nongovernmental organizations can be based on evidence, making these decisions more effective in reducing stigma and discrimination in the allocation of resources and in maximizing the impact of interventions.
- Responses will become more effective, and the number of new infections will fall.

One of the exciting things about A² is the increased access it provides to valuable information, analyses, and technical assistance, as we work to improve the way in which responses to HIV and AIDS are devised and implemented. In each country, millions of dollars are spent annually on data collection. The A² process offers an opportunity to obtain an even greater return on that investment in terms of infections averted, lives saved, and the impact of mitigation.

Activity 1 — Workshop Opening and Introductions

Time: 1 hour and 45 minutes

Materials: Flipchart, tape, markers, computer, projector, display screen

Prepared Materials:

PPT*: Agenda and objectives

Flipchart: Interview topics

Other: Continuum cards

Handouts: Sample Agenda,^o Goals, and Objectives of the Workshop

* PowerPoint slide.

^o Make sure an updated agenda for the week is disseminated.

- Objectives:**
- To welcome participants and dignitaries to the workshop.
 - To introduce participants to the workshop objectives and to each other.

Introductory speeches:

Time: 30 minutes

- **Explain** that the workshop will begin with short welcoming speeches from dignitaries, host organizations, and workshop facilitators.
- **Invite** designated speakers to give short speeches welcoming workshop participants.

Group photographs:

Time: 15 minutes

- **Assemble** workshop participants and visiting dignitaries for a group photograph.

Informal introductions, norms, rules, and expectations:

Time: 1 hour

Activity Instructions:

Introductions

Begin by introducing the facilitators and participants and the agenda for the training workshop. (Note to Facilitator: Instructions you will give to the participants are in italics.)

1. **Greet** participants and welcome them to the workshop.
2. **Introduce** yourself:
 - Name
 - Affiliation
 - Background
 - Why you're here
 - Introduce the rest of the training team
3. **Ask** co-facilitators to introduce themselves, share similar information, and clarify their roles during the training.
4. **Introduce** any guests from USAID, host-country institutions, etc., who have not already made welcoming speeches during the workshop opening and formal introductions.

- 5. Note:** Now we'd like to learn more about all of you.
- 6. Display the flipchart** with interview topics, and **ask** participants to find someone they do not know well and interview each other by sharing the following information:
- Name
 - Something interesting about oneself
 - Organization/professional background/current job
 - Highest expectations for the workshop

Note: In a few minutes, you will introduce each other to the larger group, so you may want to take notes on your interviewee's responses.

- Participants will have 5 minutes for both of the interviews (2½ minutes for each person).
 - **Begin** time.
 - After 5 minutes, call time.
- 7. Ask** for pairs to volunteer to introduce each other to the larger group. Tell the group that each pair will have a total of 3 minutes to make their introductions. (Please keep to that time limit to move things along.)
- List each person's expectations on one flipchart.
 - Thank the participants for sharing their information:
 - Reinforce the wealth of experience in the room, noting the types of work in which participants are involved and what they bring to the group; and
 - Confirm how much of a participatory style the workshop will follow.

Transition to Purpose

- 8. Return** to the flipcharts with responses for highest expectations of the workshop, because this really leads us to its purpose: Why are we here?
- 9. Review/summarize** the expressed expectations.
- Clarify any that may not be clear.
- 10. Request** that we bring it up one level, and ask ourselves, "So what?"
- Ask: What is the big picture?
 - Ask the participants to fill in the rest of this sentence:
"We want to be involved in using data effectively for HIV and AIDS advocacy so that..."
- 11. Ask** participants and facilitators to stand up and participate in an activity to see if we can come together about a purpose. Take the **three continuum cards**:
- Make a large continuum across the front of the room using cards labeled:
None – Some – A lot
 - Ask: How much influence do you think that evidence has in shaping HIV and AIDS policy development in your country?
- 12. Repeat and note** that this is a complicated and diverse question, and perhaps there is no clear answer. Explain the following:
- Consider this continuum, with "no influence" [the "None" continuum card] at one end, "some influence" ["Some" card] in the middle, and "a very strong influence" ["A lot" card] at the other end.

- Repeat the question.
 - Ask participants to stand at the point on the continuum that best represents their opinions.
13. After everyone has chosen a spot, **debrief** the activity by asking the following types of questions:
- Observations? The observations can be on your own choice of a position, that of another participant, or on the pattern of distribution resulting from the group choosing their particular places along the continuum.
 - Why did you place yourself where you did?
 - Ask another person the same question, perhaps at one end of the spectrum. Don't hesitate to ask those standing in the middle as well!
 - Other observations by the whole group?
 - Are you surprised by any of the participants' choices? If so, why?
 - What do you think this pattern indicates?
 - Ask if there are any participants with advocacy experience. Has this experience affected where they have placed themselves on the spectrum?
 - If participants from the same country stand in different areas of the continuum, ask them to explain why they think this is so.

PAUSE>>>

Ask:

- What gives you hope? What current trends make you believe you could move up in this continuum (that is, to the "A lot" end)?
 - What is your role in making this change?
 - What is your community's role in making this change?
 - Do you believe this can happen? (Enlist the support of a person at the "A lot" end of the spectrum.)
14. **Note:** *This is why we are here, right? We have specific goals and objectives for this workshop. Let's keep the big picture in mind as we spend this time together.*
- Ask other facilitators/participants for any comments/thoughts.
 - Thank participants and ask them to return to their seats.

Transition to Workshop Goals and Objectives

15. **Tell** participants that next you would like to discuss what will happen during the workshop. If a pre-workshop questionnaire was distributed to them, explain how you took their responses into consideration in designing the workshop, and thank them for their responses.
16. **Display** the PowerPoint slide on the purpose of the workshop.
17. Transition to **Agenda Review**.

- 18. Display** the PowerPoint slide that has the workshop agenda.
- Note that this is a very full agenda... Ask for prompt start times, and note that we will do our best to finish on time.
 - Ask the group if they have any questions/concerns about the workshop purpose or agenda.
- 19. Review** people's expectations, and note which ones will be covered and any that you are unable to.

Transition to Workshop Norms

- 20. Ask** the participants how they want to be together. What type of atmosphere do they want to create for the workshop to help meet the goals and objectives? For example, they may know that giving everyone a chance to speak is important. These and other group rules are called "norms."
- Ask the group to brainstorm a list of suggested norms for the workshop.
 - Clarify any that are vague or unclear.
 - List responses and record them on a flipchart.
- 21.** After the list is developed, **suggest** other important norms not already listed (e.g., attending sessions on time, not interrupting each other, asking for clarification if facilitators are not clear, switching off mobile phones or turning them to silent mode, etc.).



Reminder to Facilitator: Post flipchart of group norms on the wall, and keep it up throughout the workshop. If necessary, refer to the flipchart to remind participants of the norms they agreed to.

Activity 2 — A² Concept

Time: 45 minutes

Materials: Computer, projector, display screen

Prepared Materials:

PPT: A² Concept

Flipchart: N/A

Other: N/A

Handouts: Background Notes, PowerPoint presentation

Objective: ■ To familiarize all participants with the A² Project: its structure, goals, activities, and partner organizations.

Introduction: ■ **Explain** that because participants have different levels of familiarity with the A² Project, this presentation is designed to ensure that all will have a common understanding.

■ **Encourage** participants to ask questions throughout the presentation.

Activity Instructions:

1. **Present** the A² PowerPoint for participants (30 minutes).
2. **Answer** any questions (15 minutes).

SECTION I: Introducing A² Advocacy Training and Project Activity 1 – Workshop Opening and Introductions

Sample Agenda, Goals, and Objectives of the Workshop

A²: Mobilizing Effective HIV and AIDS Responses in Asia
through Improved Analysis Linked to Innovative Advocacy

[Insert venue]

[Insert dates]

Workshop Purpose

To improve participants' understanding of the role of advocacy in assuring that appropriate and relevant data is collected, analyzed, and used to inform policy development; and to build participants' practical skills to integrate and carry out advocacy through the A2 project.

A² Advocacy Training Objectives

By the end of Advocacy Training, participants will be able to

- Understand the role of advocacy and data collection in the policy development process;
- Define advocacy within the context of HIV and distinguish it from related concepts;
- Explain key policy and decisionmaking processes at the provincial level;
- Understand and be able to apply each step of the advocacy process:
 - Identify and prioritize key HIV advocacy issues in [insert country];
 - Use data to identify advocacy and policy issues;
 - Learn the process of establishing an advocacy goal and objectives for selected issue(s);
 - Identify primary and secondary target audiences, as well as allies and opponents;
 - Develop and deliver effective advocacy messages;
 - Identify and create different methods for presenting advocacy messages;
 - Practice how to package and use data in advocacy messages most effectively; and
 - Draft an advocacy action plan, including indicators for monitoring and evaluation (M&E).

SECTION I: Introducing A² Advocacy Training and Project Activity 1 – Workshop Opening and Introductions

Workshop Overview [Sample only—update before handing out]

Day	Morning	Afternoon
1	Workshop Opening and Formal Introductions	Advocacy and Related Concepts Steps in the Advocacy Process
	Group Photographs Informal Introductions Workshop Norms & Rules Workshop Expectations	Examples of Advocacy Leading to Policy Change
	The A ² Concept	What Is Particular to HIV and AIDS Advocacy?
	What is Advocacy?	Close of Day 1; Feedback & Evaluation
2	Recap/Introduction to Day 2	Data Analysis to Identify Issues: Where is the Epidemic Going? How Have Programs Responded?
	Introduction to Identifying Issues: <ul style="list-style-type: none"> • How are issues identified? • Key issues in [insert country] • Key issues in Asia 	Data Analysis to Inform Advocacy Messages: A Preview
	Introduction to Data Analysis	The Policy Process: Guest Speaker
	Overview of Specific Types of Data from A ²	Close of Day 2 & Evaluation

Workshop Overview [Sample only—update before handing out]

Day	Morning	Afternoon
3	Recap/Introduction to Day 3	Developing Advocacy Goals and Objectives (continued)
	Prioritizing Advocacy Issues	Close of Day 3 & Evaluation
	Identifying Potential Policy Solutions	
	Introduction to Developing Advocacy Goals and Objectives	
4	Recap/Introduction to Day 4	Techniques of Persuasion
	Primary/Secondary Audiences: Identifying Support and Opposition	Elements of Effective Advocacy Communication
	Analyzing a Target Audience	The One-Minute Message
		Policy Briefs
		Close of Day 4 & Evaluation
5	Recap/Introduction to Day 5	Action Plans (continued)
	Advocacy Messages and Methods in Action: Guest Speaker	Evaluation & Closing
	Working with Vulnerable Groups	
	Introduction to Action Plans	

Day 1: What Is Advocacy? [Sample only—update before handing out]

Session Title	Time	Session Objectives
Workshop Opening and Formal Introductions	8:30–9:00	To welcome participants and dignitaries to the opening, and to give the host (Health Policy Initiative/COUNTRY NAME) and project global and regional staff (where applicable) the opportunity to make brief welcoming speeches
Group Photographs Informal Introductions Workshop Norms & Rules Workshop Expectations	9:00–10:00	To introduce participants to each other, and to build a shared understanding of training goals and participant expectations
TEA BREAK 10:00–10:15		
The A ² Concept	10:15–10:45	To familiarize participants with the A ² project goals and partners
What is Advocacy?	10:45–12:00	To build a common definition of advocacy
LUNCH 12:00–2:30		
Steps in the Advocacy Process	2:30–3:30	To identify the common steps in an advocacy process
Examples of Advocacy Leading to Policy Change	3:30–4:30	To share real-world case studies of how advocacy has led to policy change
TEA BREAK 4:30–4:45		
What Is Particular to HIV and AIDS Advocacy?	4:45–6:15	To reflect on the unique challenges and opportunities of advocacy for HIV and AIDS at both regional and country-specific levels
Close of Day 1; Feedback & Evaluation	6:15–6:30	

Day 2: Introduction to Identifying Issues and Data

Session Title	Time	Session Objectives
Recap/Introduction to Day	8:30–8:45	
Introduction to Identifying Issues: <ul style="list-style-type: none"> • How are issues identified? • Key issues in [insert country] • Key issues in Asia 	8:45–10:00	To examine different ways that advocacy issues can be identified (including the role of data), and to gain familiarity with key advocacy issues in [insert country] and the Asia region
TTEA BREAK 10:00–10:15		
Introduction to Data	10:15–11:00	To understand different methods of data analysis and their role in identifying issues and influencing policy change
Overview of Specific Types of Data from A ²	11:00–12:00	To understand the specific data that will become available in [insert country] through A ²
LUNCH 12:00–2:30		
Data Analysis to Identify Issues: <ul style="list-style-type: none"> • Where is the epidemic going? • How have programs responded? 	2:30–4:15	To identify potential key advocacy issues emerging from behavioral and epidemiologic data, as well as Goals modeling in the [insert country or area of discussion]
TEA BREAK 4:15–4:30		
Data Analysis to Inform Advocacy Messages: A Preview	4:30–5:00	To consider explicitly how data from A ² support key information needed for advocacy messages, and what other information also would be persuasive
Polycymaking Process: Guest Speaker	5:00–6:15	To identify crucial common steps in the policymaking process, and to assess where advocacy and data fit into the process
Close Day 2 & Evaluation	6:15–6:30	

Day 3: From Issues to Advocacy Goals and Objectives

Session Title	Time	Session Objectives
Recap/Introduction to Day	8:30–8:45*	
Prioritizing Advocacy Issues (Tea break included)	8:45–10:45	To understand and be able to apply a process of prioritizing advocacy issues for A ² in [insert country or region/province]
Identifying Policy Solutions	10:45–11:30	To understand the different types of policy solutions possible for a given issue
Introduction to Developing Advocacy Goals and Objectives	11:30–12:00	To understand and develop advocacy goals and objectives specific to the prioritized advocacy issue for [insert country or region/province]
LUNCH 12:00–2:30*		
Developing Advocacy Goals and Objectives (continued)	2:30–4:30	Continued
Close of Day 3 & Evaluation	4:30–4:45	
Unstructured time from 4:45 onward*		

* Note: Participants may want to adjust the schedule so that unstructured time begins earlier.

Day 4: Advocacy Communication

Session Title	Time	Session Objectives
Recap/Introduction to Day	8:30–8:45	
Primary/Secondary Target Audiences: Identifying Support and Opposition (Tea break included)	8:45–11:00	To identify primary and secondary target audiences for an advocacy objective, and to diagram visually the relative support and opposition for their objectives
Analyzing a Target Audience	11:00–12:00	To understand and apply a technique for analyzing target audiences
LUNCH 12:00–2:30		
Techniques of Persuasion	2:30–3:00	To identify what factors influence whether advocacy messages are effective
Elements of Advocacy Communication	3:00–3:45	To understand the key elements of effective advocacy messages
The One-Minute Message	3:45–4:15	To practice developing and delivering effective advocacy messages
TEA BREAK 4:15–4:30		
The One-Minute Message (continued)	4:30–5:30	To practice developing and delivering effective advocacy messages
Policy Briefs	5:30–6:00	To identify effective elements of policy briefs
Close of Day 4 & Evaluation	6:00–6:15	

Day 5: Putting It All Together

Session Title	Time	Session Objectives
Recap/Introduction to Day	8:30–8:45	
Advocacy Messages & Methods in Action: Guest Speaker	8:45–10:00	To deepen an understanding of how to develop and deliver effective advocacy messages, based on advocates' real-world experiences
TEA BREAK 10:00-10:15		
Working with Vulnerable Groups	10:15–12:00	To understand the Greater Involvement of People Living with HIV and AIDS (GIPA) principle, the benefits and challenges of working with people living with HIV (PLHIV) and affected communities, and the key features of an enabling environment for GIPA
Introduction to Action Plans	12:00–12:30	To understand the components of and process for developing an advocacy action plan, including outcomes, indicators, and evidence
LUNCH 12:30-2:00		
Action Plans (continued) (Tea break included)	2:00–4:15	To develop an advocacy action plan, including indicators for monitoring and evaluation (M&E)
Evaluation & Closing	4:15–5:30	To evaluate what was achieved during the week, and to recognize participants' accomplishments

SECTION I: Introducing A² Advocacy Training and Project Activity 2 — A² Concept

Background Notes

A² is a joint project being implemented by Family Health International (FHI), the East-West Center (EWC), the USAID | Health Policy Initiative, Task Order 1, with a number of organizations in countries in Asia. Many of the in-country organizations are national or provincial AIDS control committees, departments of health, or epidemiology centers responsible for tracking the course of the epidemic. A² grew out of and builds on the integrated analysis work pioneered by the East-West Center.

Integrated Analysis

Integrated analysis involves the collation and analysis of all available biological, behavioral, programmatic, and economic data to provide a complete picture of the nature of the epidemic in a particular country environment. The aim is to enhance the effectiveness of responses to HIV and AIDS by using the evidence gained through integrated analysis to guide interventions and the application of resources and focus them on those factors driving the epidemic. Analysis by the East-West Center has identified particular features of Asian epidemics:

- HIV epidemics in Asia follow a similar pattern but vary in timing and severity.
- Asian epidemics begin with injecting drug users (IDUs) who share needles and men who have sex with men (MSM).
- HIV then starts to rise among sex workers and their clients.
- MSM, clients of sex workers, and male IDUs transmit HIV to their wives, who in turn transmit HIV to their children.
- Some of the variations among countries include how quickly the epidemics grow and the level of HIV prevalence reached in different populations.

Given all we know about the factors driving Asian epidemics, why do those factors continue to exert the influence they do? Generally, it is not the case that governments, donors, and civil society fail to act, but rather that their actions are not targeted appropriately. A real divide exists among lessons learned and the programs and policies implemented in Asian countries:

- Prevention coverage of key populations driving the epidemic is extremely limited.
- Most Asian countries do not operate with a clear picture of their own epidemics.
- Data collected remain peripheral to the decisionmaking process.
- Data systems do not evolve strategically to fill gaps and help direct responses.
- Even where data exist, often there is insufficient political commitment to forge effective responses with the stigmatized populations affected by the epidemic.

Combining Data Use with Advocacy

A² takes the integrated analysis process a step further by incorporating advocacy at all stages of the analysis and response to the epidemic. The problem is not necessarily that data do not exist, but that existing information is not being analyzed systematically, improved over time, and then applied to inform advocacy and guide responses in appropriate directions. The A² process provides a practical approach to gathering, analyzing, and using this information; extracting from this information relevant evidence-based recommendations for policies and programs; and proactively advocating for these recommendations to be mobilized into more effective policies and programs.

Our Approach

A² aims to create national and provincial responses that will make a difference in resource-constrained settings by building capacity to

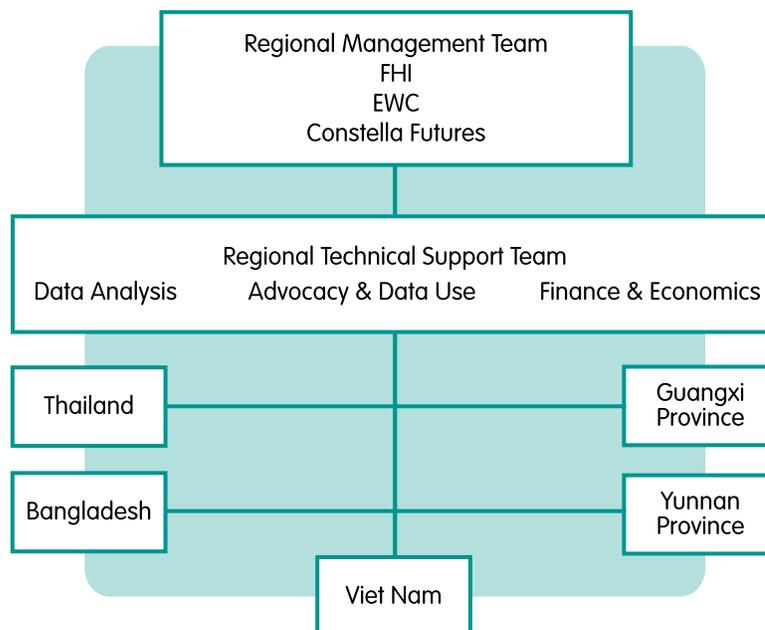
- Bring together local epidemiological, behavioral, response, and program-costing data;
- Analyze that data with state-of-the-art modeling tools;
- Determine responses and resources needed for maximum impact; and
- Target policymakers, program managers, and donors with this information so they can make the best choices.

We believe that a synergy of analysis and advocacy will promote

- Increased political commitment and improved decisionmaking through expanded use of local evidence;
- Improved design and quality of surveillance systems;
- Better monitoring and understanding of epidemic dynamics;
- Improved evaluation and direction of national responses;
- Increased and more efficient resource allocation; and
- Reduced stigma and discrimination.

The Structure of A²

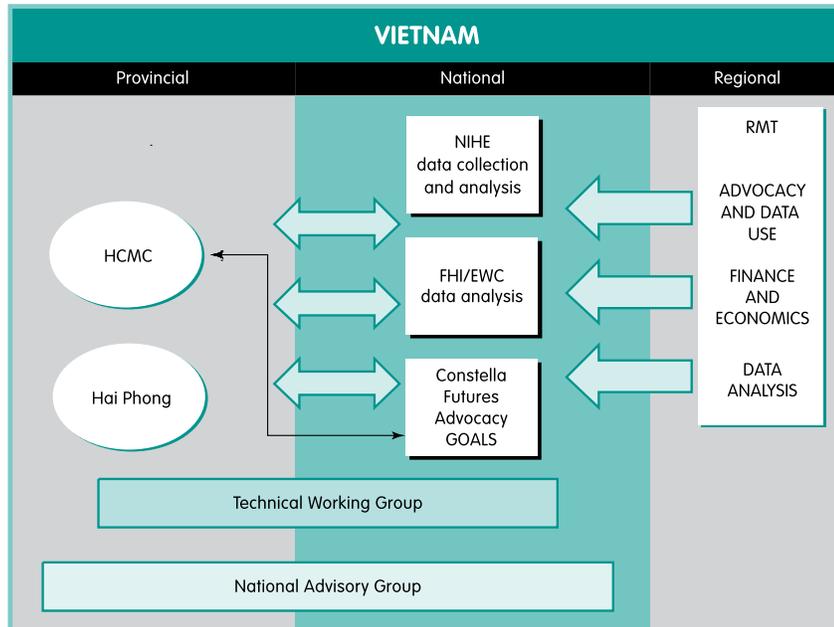
Implementation of A² is based on the model developed at the inaugural project meeting held in Bangkok in November 2004, and represented in the following diagram:



A² is guided by a Regional Management Team, comprising representatives from FHI, the East-West Center, and Constella Futures. In addition, there is a Regional Technical Support Team that provides support to the Country/Province Teams working on A² activities. All of the international partners contribute staff and resources to the Regional Technical Support Team.

Country/Province Teams

Country/Province Teams involve partnerships between international and national or provincial partners. The following diagram from Viet Nam is an example of how A² implementation is planned at the country level:



*RMT: Regional Management Team
 * NIHE: National Institute of Hygiene and Epidemiology
 ***HCMC: Ho Chi Minh City

Linking the Asian Epidemic Model and the Goals Model

An important development contributing to the establishment of A² has been the merger of two key modeling tools, the Asian Epidemic Model (AEM) and the Goals Model. AEM calculates expected trends in HIV infection based on observed patterns of HIV spread in the region. The Goals Model supports effective strategic planning by linking program goals, such as those constituting a national strategy, to the level of resources necessary to achieve those goals. The Goals Model can answer the following questions:

- What resources are required to achieve the goals of a national strategic plan?
- What outcomes can be achieved within a given level of resources?
- What is the impact on the epidemic if resources are allocated in different ways?

The information generated from the application of these models provides valuable evidence for advocacy campaigns to use in increasing the effectiveness of local, provincial, and national responses to epidemics in Asia. Synthesis reports using the integrated analysis methodology and further data and analyses from the AEM and Goals Model also will be available at each project site.

The Benefits: Stronger Responses and Fewer Infections

HIV is a complex epidemic, calling for well-designed, evidence-based responses. By synthesizing data from all available sources, the A² process offers an opportunity to understand this complexity at national, provincial, and even sub-provincial levels; and to decide among alternative responses on the basis of impact and cost effectiveness. The potential benefits of this process are numerous:

- For the first time, HIV information of all types from multiple sources will be collected in one place.
- Data gaps will be identified and filled, and a better understanding of the epidemic situation and its driving forces will be obtained.
- Government institutions, donors, and communities will have a more accurate picture of the effectiveness of their responses to date and will be better able to evaluate future alternatives systematically.
- Affected communities will be more empowered with data for use in advocating for better prevention and care services.
- Resource allocation decisions by donors, governments, and nongovernmental organizations can be based on evidence, making these decisions more effective in reducing stigma and discrimination in the allocation of resources and in maximizing the impact of interventions.
- Responses will become more effective, and the number of new infections will fall.

One of the exciting things about A² is the access it provides to valuable information, analyses, and technical assistance, as we work to improve the way in which responses to HIV and AIDS are devised and implemented. In each country, millions of dollars are spent annually on data collection. The A² process offers an opportunity to obtain an even greater return on that investment in terms of infections averted, lives saved, and the impact of mitigation.

**USAID** | HEALTH POLICY
INITIATIVE

A² Concept



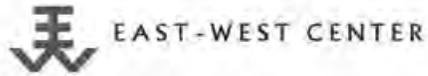
A² Concept • Slide 1

FACILITATOR NOTES:

All of us are involved in some aspect of the A-Squared project, and I don't propose to spend too much time telling you why you are here. Having said that, A-Squared is a relatively new and still developing project that is being implemented with some variations in different countries; and it is worth taking a few minutes to remind ourselves about the project's goals and structure.

A² ANALYSIS & ADVOCACY

East West Center



Family Health International



**USAID | Health Policy Initiative,
Task Order 1**



Section I

A² Concept • Slide 2

From Integrated Analysis to A²

- We know the determinants of the epidemic in Asian countries, subject to variations between countries
- Stigma, discrimination, and denial can prevent appropriate targeting of interventions and allocation of resources
- Advocacy is needed to promote effective evidence-based responses



A² Concept • Slide 3

FACILITATOR NOTES:

A-Squared is a joint project being implemented by Family Health International (FHI), the East-West Center (EWC), the USAID | Health Policy Initiative, Task Order 1 (HPI-TO1), and local government and nongovernmental organizations. Many of these in-country organizations are national or provincial AIDS control committees, departments of health, and epidemiology centers that track the epidemic's course. A-Squared grew out of and builds on the integrated analysis work pioneered by the EWC, in which some of you have been involved.

Integrated analysis involves the collation and analysis of all available biological, behavioral, programmatic, and costing data to provide a complete picture of the epidemic in the particular country environment. The purpose of the analysis is to enhance the effectiveness of responses to HIV and AIDS by using the findings to guide evidence-based interventions and the application of resources toward factors that are driving the epidemic. Integrated analysis is about creating evidence-based responses to HIV prevention.

A-Squared takes the integrated analysis process a step further by incorporating advocacy at all stages of the analysis and response to the epidemic. To a large extent, the determinants of HIV vulnerability and transmission in Asian countries are known—although they are at the same time subject to numerous variations among countries, including the time of onset and prevalence. Tim Brown from the East-West Center gave a presentation at the International AIDS Conference in Bangkok, during which he identified the factors driving the epidemics in Asia: “They [the factors] are largely injecting drug use, commercial sex, and sex between men. Other factors of vulnerability and routes of transmission derive from these, which distinguish Asian epidemics from those in many other parts of the world, and particularly from epidemics in African countries.”

Objectives of A²

Capacity building:

- Surveillance systems
- Data analysis
- Epidemiological projections
- Response evaluations

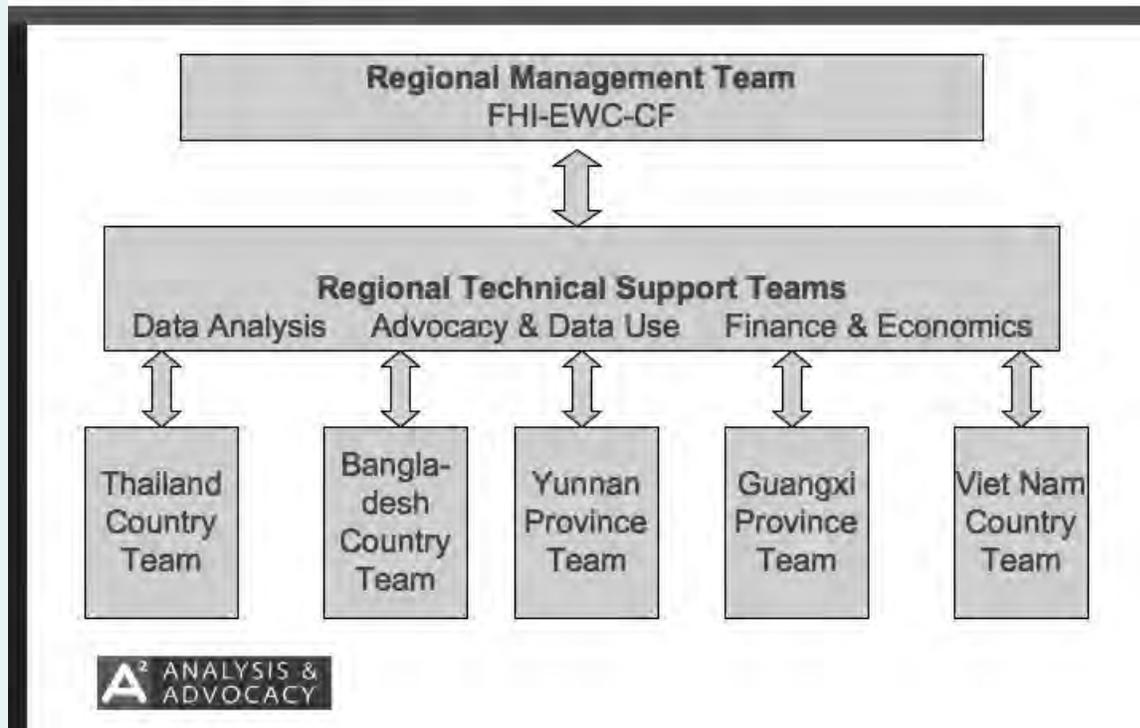
Objectives of A²

Capacity building:

- Model alternative response scenarios
- Effectively mobilize resources
- Foster efficient resource allocation
- Produce resources for decisionmakers



Regional Structure



A² Concept • Slide 6

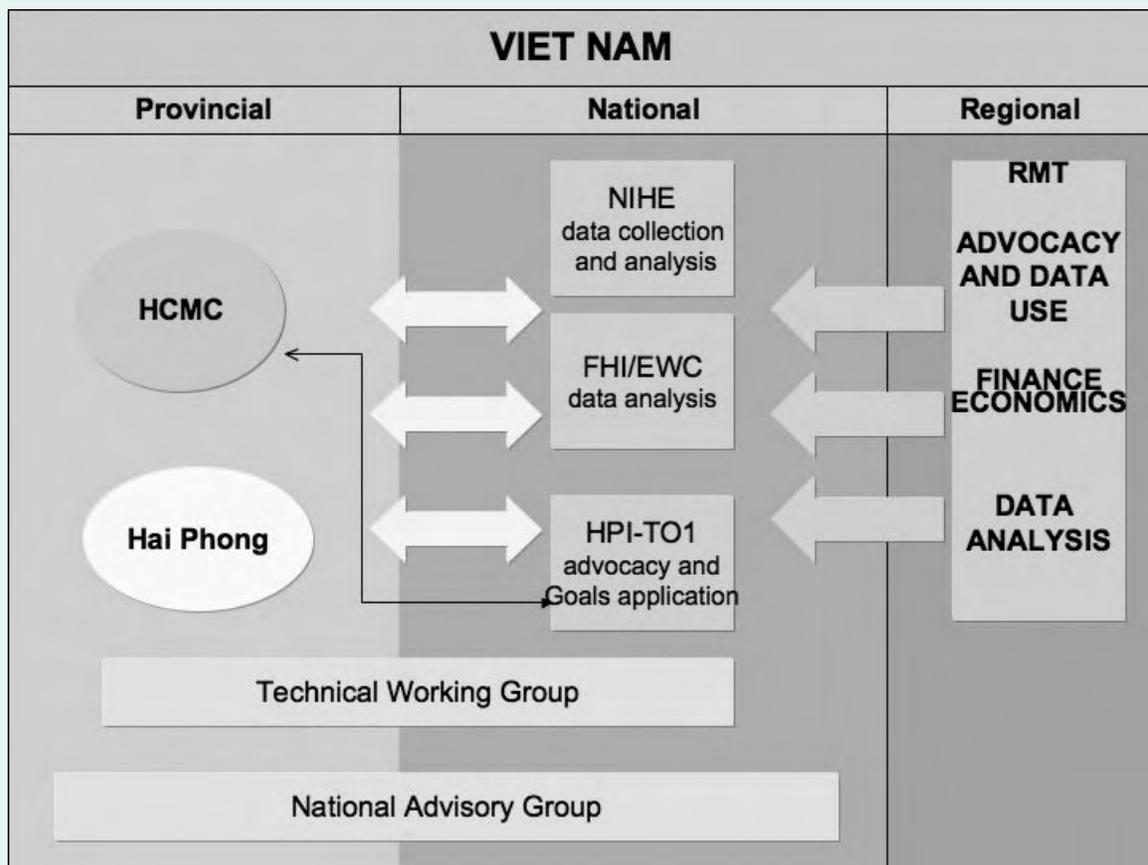
FACILITATOR NOTES:

A-Squared is being implemented in various ways in the different participating countries. These differences reflect the way in which national or provincial responses to HIV and AIDS are designed and implemented and whether the international partners in A-Squared are present in the country. First, we should recall the discussion at the November 2004 inaugural partners meeting on how the project would be structured; and for clarity, how the project has functioned given the realities of organizational resources and the developments since the November meeting.

A-Squared is guided by a core Regional Management Team (RMT), including representatives of FHI, the EWC, and CF. Jeremy Ross from FHI ensures coordination of the project at the regional level. At the November meeting, all the international A-Squared partners agreed to establish and contribute staff and resources to three Regional Technical Support Teams, as shown in this diagram. The teams provide support to the Country/Province Teams working on A-Squared activities.

The three regional support teams — the Data Analysis Team, Advocacy and Data Use Team, and Finance and Economics Team — also include representatives of the A-Squared partners.

At the country level, implementation becomes a little more complicated. There is no need to try to commit all of this to memory, but it is useful to have some idea of the structure and scale of A-Squared activities in the countries we work in.



Section I

A² Concept • Slide 7

FACILITATOR NOTES:

- This slide shows how A-Squared is being implemented in Viet Nam.
- The two program sites are Ho Chi Minh City (HCMC) and Hai Phong.
- FHI and the National Institute of Hygiene and Epidemiology (NIHE) provide technical assistance to provincial AIDS authorities, and they are preparing a synthesis report for each location, which will provide the basis for further A-Squared activities.
- A Technical Working Group provides input to the development of the synthesis report, and NIHE staff will produce the report.
- This slide also shows a National Advisory Group, which is proposed to be established in the near future to keep stakeholders informed about A-Squared activities and to provide a forum for discussing the issues the project is addressing.

A² Marriage: AEM and Goals

- Asian Epidemic Model (AEM): calculates expected trends in HIV infection
- Goals Model: links program goals to level of resources necessary to achieve them
- Combining the two allows for the modeling of alternative response scenarios and their impact on the epidemic



A² Concept • Slide 8

FACILITATOR NOTES:

Members of the Regional Technical Support Team have begun to merge two important modeling tools, the Asian Epidemic Model (AEM) and the Goals Model.

AEM calculates expected trends in HIV infection based on usual patterns of HIV spread in the region. By varying “average” levels of HIV-related risk behavior to reflect actual differences among countries, AEM accurately models HIV prevalence trends based on measured behavior trends. It can tell us what course the epidemic in a given country can be expected to take.

The Goals Model supports effective strategic planning by linking program goals, such as those contained in a national strategy, to the level of resources needed to achieve those goals. Goals can answer the following questions:

- What resources are needed to achieve the goals of a national strategic plan?
- What outcomes can be achieved within a given level of resources?
- What is the effect on the epidemic if resources are allocated in different ways?

The Goals Model can help planners understand how funding levels and patterns of funding allocation can lead to a reduction in HIV incidence and prevalence and improved coverage of treatment, care, and support programs.

Results

- Increased political commitment
- Improved surveillance systems
- Increased resource mobilization
- More efficient resource allocation

Results

- Improved evaluation and direction of national/provincial responses
- Reduced stigma and discrimination
- Fewer HIV infections
- Mitigation of impact



Advocacy at Each Step

- Advocacy does not begin when data collection and analysis has finished
- Focus on what is missing, as well as what is available
- Use a stronger evidence base to achieve a more effective response



A² Concept • Slide 11

FACILITATOR NOTES:

Data gaps are one example of why advocacy is an integral component of all A-Squared activities. Advocacy does not begin when data collection and analysis has finished.

We need to critically assess decisions about which data are collected and how, as well as how the data are analyzed and how the results are recorded and communicated. All these factors are relevant to the ways in which policies and programs are designed and implemented.

What is exciting about A-Squared is the access we have to information and analysis tools and the technical assistance we can provide to improve the way in which responses to HIV and AIDS are devised and implemented in-country.

We hope that the advocacy training this week will provide useful skills for your in-country responses to HIV and AIDS.

Some A² Achievements

- Using linked AEM-Goals analysis (2007), the Provincial HIV/AIDS Action Plan for Ho Chi Minh City 2006–2010 was developed
- Using AEM-Goals analysis to reach its decision (2006), the Thai Ministry of Public Health committed to a new HIV prevention goal, including increased resources for men who have sex with men (MSM) programs



Some A² Achievements

- Resource allocation for HIV and AIDS programs modified in Yunnan and Guangxi provinces based on AEM-Goals analysis, resulting in additional prevention programs for MSM (2006)



Ultimate Objectives of A²

Increased capacity for evidence-based decisionmaking:

- Gain a clear understanding of the HIV epidemic in countries in the region
- Translate that understanding into appropriately targeting resources to effective policies and programs
- Strengthen political commitment
- Reduce stigma and discrimination





USAID | HEALTH POLICY INITIATIVE
FROM THE AMERICAN PEOPLE



A² Concept

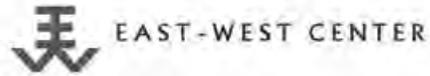


A² Concept • Slide 1

NOTES:

A² ANALYSIS & ADVOCACY

East West Center



Family Health International



**USAID | Health Policy Initiative,
Task Order 1**



Section I

A² Concept • Slide 2

NOTES:

From Integrated Analysis to A²

- We know the determinants of the epidemic in Asian countries, subject to variations between countries
- Stigma, discrimination, and denial can prevent appropriate targeting of interventions and allocation of resources
- Advocacy is needed to promote effective evidence-based responses



A² Concept • Slide 3

NOTES:

Objectives of A²

Capacity building:

- Surveillance systems
- Data analysis
- Epidemiological projections
- Response evaluations



A² Concept • Slide 4

NOTES:

Objectives of A²

Capacity building:

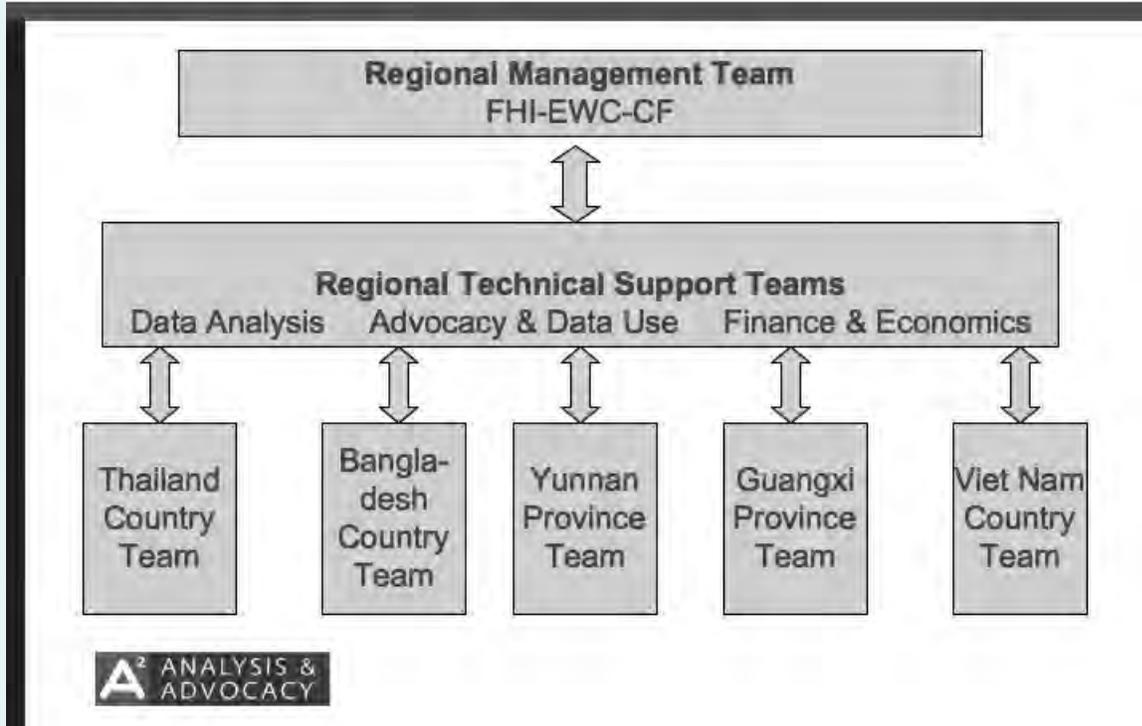
- Model alternative response scenarios
- Effectively mobilize resources
- Foster efficient resource allocation
- Produce resources for decisionmakers



A² Concept • Slide 5

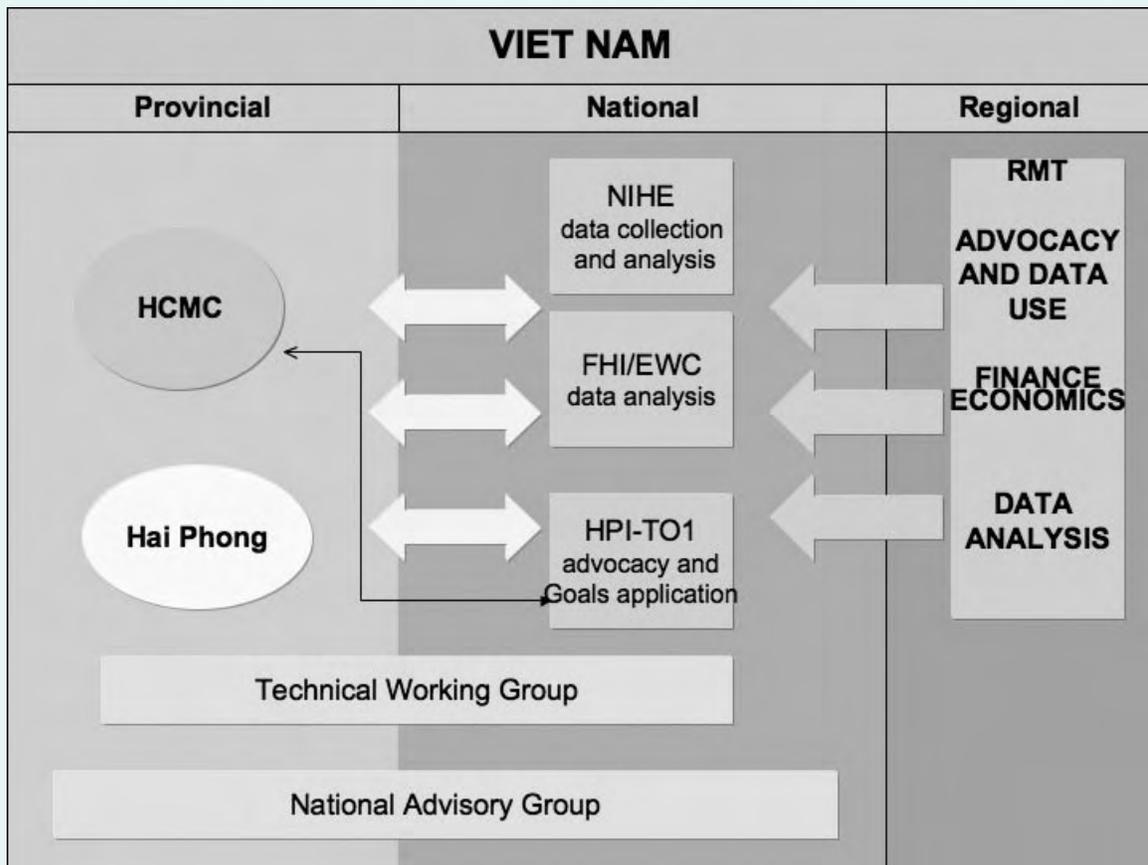
NOTES:

Regional Structure



A² Concept • Slide 6

NOTES:



Section I

A² Concept • Slide 7

NOTES:

A² Marriage: AEM and Goals

- Asian Epidemic Model (AEM): calculates expected trends in HIV infection
- Goals Model: links program goals to level of resources necessary to achieve them
- Combining the two allows for the modeling of alternative response scenarios and their impact on the epidemic



A² Concept • Slide 8

NOTES:

Results

- Increased political commitment
- Improved surveillance systems
- Increased resource mobilization
- More efficient resource allocation



A² Concept • Slide 9

NOTES:

Results

- Improved evaluation and direction of national/provincial responses
- Reduced stigma and discrimination
- Fewer HIV infections
- Mitigation of impact



A² Concept • Slide 10

NOTES:

Advocacy at Each Step

- Advocacy does not begin when data collection and analysis has finished
- Focus on what is missing, as well as what is available
- Use a stronger evidence base to achieve a more effective response



A² Concept • Slide 11

NOTES:

Some A² Achievements

- Using linked AEM-Goals analysis (2007), the Provincial HIV/AIDS Action Plan for Ho Chi Minh City 2006–2010 was developed
- Using AEM-Goals analysis to reach its decision (2006), the Thai Ministry of Public Health committed to a new HIV prevention goal, including increased resources for men who have sex with men (MSM) programs



A² Concept • Slide 12

NOTES:

Some A² Achievements

- Resource allocation for HIV and AIDS programs modified in Yunnan and Guangxi provinces based on AEM-Goals analysis, resulting in additional prevention programs for MSM (2006)



A² Concept • Slide 13

NOTES:

Ultimate Objectives of A²

Increased capacity for evidence-based decisionmaking:

- Gain a clear understanding of the HIV epidemic in countries in the region
- Translate that understanding into appropriately targeting resources to effective policies and programs
- Strengthen political commitment
- Reduce stigma and discrimination



A² Concept • Slide 14

NOTES:

SECTION II: Introducing HIV and AIDS Advocacy

- Content:**
- Activity 1 — What Is Advocacy?
 - Activity 2 — Advocacy and Related Concepts
 - Activity 3 — Examples of Advocacy Leading to Policy Change
 - Activity 4 — Steps in the Advocacy Process
 - Activity 5 — What Is Particular to HIV and AIDS Advocacy?
- Purpose:** The overall purpose of this section is to introduce and build participants' shared understanding of key concepts related to advocacy:
- What is advocacy?
 - What are the key steps in the advocacy process?
 - How is advocacy linked to the policymaking process?
 - What is particular to HIV-related advocacy, especially in the context of participants' particular region, country, and/or province?
- Objectives:** By the end of this section, participants will be able to
- Define advocacy;
 - Distinguish advocacy from related concepts;
 - Be familiar with real-world examples of advocacy leading to policy change;
 - Understand the steps in the advocacy process; and
 - Identify key aspects of HIV and AIDS advocacy.

Background Notes:

What Is Advocacy?

There is no one internationally agreed upon definition of the term “advocacy.” You will find as many definitions of advocacy as you will find groups, networks, and coalitions advocating. However, each definition shares common language and concepts, as illustrated in the handouts accompanying this section. Advocacy is also strategic and targets well-designed activities to key stakeholders and decisionmakers. Advocacy is always directed at influencing policy, laws, regulations, programs, or funding—decisions made at the uppermost levels of public or private sector institutions.

Lastly, advocacy includes both single-issue, time-limited campaigns, as well as ongoing work undertaken around a range of issues. Advocacy activities may be conducted at the national, regional, or local levels.

Within the HIV and AIDS policy arena, advocacy efforts might address such things as affordable access to medications for HIV infection and related conditions or the enactment of laws prohibiting discrimination on the basis of a person's HIV status. Operational HIV and AIDS policies—such as specific resource allocation and service delivery guidelines—also are potential objects for advocacy campaigns. For example, advocacy could focus on the timing or cost of voluntary HIV testing and counseling or eligibility criteria for state-funded interventions to reduce mother-to-child transmission of HIV.

Advocacy is a set of targeted actions directed at decisionmakers in support of a specific policy issue.

Activity 1 — What Is Advocacy?

Time: 1 hour 5 minutes

Materials: Markers, pens, ball of yarn or twine

Prepared Materials:

PPT: N/A

Flipchart: Definition of “advocacy”; Instructions for group work

Other: N/A

Handouts: Background Notes, Sample Definitions of Advocacy

Objective: ■ To build a common definition of “advocacy.”

Introduction: ■ **Tell** participants that there is not just one international definition of the term “advocacy.” You will find as many definitions as you will find groups, networks, and coalitions advocating.

■ **Tell** participants that, in this session, we want to come up with a common definition of advocacy.

Activity Instructions:

Step 1: Icebreaker/Building a Web

Time: 20 Minutes

1. **Tell** participants that you would like them to stand up and form a circle in the center of the room, and explain that we will do a “Word Association Activity.”
2. **Show** the group the ball of yarn/twine.
3. **Explain** the following:
 - You (the facilitator) will hold the end of the yarn and throw it to someone else in the circle.
 - When you throw the yarn, say the first word or phrase that comes to mind when you think of the word “advocacy.”
 - The other person catches the yarn, holds on to it, and then throws it to someone else, saying a word or phrase associated with the word advocacy. Be sure to hold on to the end of the string before you throw it!
 - Ask if the activity is clear to everyone, and start it yourself as an example.
 - Repeat these steps until everyone has had an opportunity to catch and throw the yarn and share their first thoughts associated with the word “advocacy.”
 - Ask participants to keep hold of the string at the end of the activity.
4. As the activity proceeds, **record** participants’ words on a flipchart.
5. **Debrief** this portion of the activity by asking the following types of questions:
 - What we have formed? (Typical answers are; a web, a net, a network.)
 - What can the web signify? (Answers typically include: all of our ideas are linked, there are many facets to advocacy, etc.)
 - What can happen if someone drops his/her end of the string?
 - If everyone holds on tight, what happens when pressure is applied to this net? (Use your hand to push down on the net once everyone is holding tight.)

- What does this metaphor help us understand in relation to advocacy? (Typical answers: A web is stronger than a single strand. Or... people working together in a network are stronger than people working alone.)

6. **Thank** the participants, and ask them to return to their seats. (Note: In most cases, the participants want to “preserve” the net, so instruct them to lay it down on the floor gently before returning to their seats.)



Note to Facilitator: This activity typically elicits the following:

Defending	Sensitizing	Persuasion
Exposure	Communication	Change
Decisionmaking	Intervening	Influence
Attracting attention	Selling an idea	Lobbying
Providing a solution		

7. **Lead** a brief discussion on advocacy, making the following points:

- Networks, coalitions, or other groups of advocates must be guided by specific steps when designing and implementing an advocacy campaign; each step requires distinct knowledge and skills.
- Advocacy is both a science and an art. From a scientific perspective, while there is no universal formula for effective advocacy, experience has shown that advocacy is most effective when it is planned systematically.
- Advocacy is also an art. Successful advocates are able to articulate issues in ways that inspire and motivate others to take action. Successful advocates are skilled negotiators and consensus builders who look for opportunities to win modest but strategic policy gains, while still creating other opportunities for larger victories.
- Artful advocates incorporate creativity, style, and even humor into their advocacy events in order to draw public and media attention to their cause.
- The art of advocacy cannot be taught through a training workshop— rather, it emerges from within network members themselves. Advocacy training provides the tools, but participants must add the spark.



Note to Facilitator: The activities in this manual are designed to teach both the science and the art of designing and implementing an advocacy campaign. The activities correspond to the different steps identified in the module “Steps of the Advocacy Process.” Participants will learn how to use advocacy strategies and tools to influence decisionmakers and bring about more favorable HIV and AIDS policies and programs.

Step 2: Defining Advocacy

Time: 45 minutes

1. **Divide** participants into small groups of four to five persons for the activity.
2. **Make a transition** from the first activity by explaining that now we want to let the participants deepen their thinking about advocacy by personally working to develop a full definition.
3. **Instruct** each group to **draft** a definition of advocacy. Encourage the groups to use the words on the flipchart to prepare their definitions.
4. **Ask** each group to think about how best the word “advocacy” translates into their own languages. **Ask** them to write these words on the flipchart, and to be prepared to explain the translation.
5. **Ask** the groups to write their definitions and translations on flipchart paper and post them on the wall and to select one person who will be prepared to share his/her group’s definition.
6. After the groups have finished the task, **ask** each group’s representative to read the definition aloud.
7. After all groups have read their definitions, **discuss** them by asking the group to identify the following:
 - Similarities among the definitions (i.e., words or phrases that appear in more than one definition). On the wall posting, circle the commonalities with a colored marker.
 - Elements that are unique to a definition. Circle the words not repeated in any of the other definitions or phrases with a different colored marker.
8. If participants are all from the same country and/or need a shared definition of advocacy: **Ask** them to decide whether one of the posted definitions should be the agreed-upon definition of advocacy (for the workshop, for the project, or for the group); or whether they want to craft a new definition by using the common elements and ideas represented in their definitions.

Activity Option:

1. The facilitator can work with the group to construct a shared definition of advocacy. Using clean colored paper, **help** the group write a definition that reflects the full group’s input.
2. Alternatively, the facilitator can **ask** for a group of volunteers to synthesize the definition and to be prepared to present it to the full group for consensus the following day.



9. **Share** the USAID | Health Policy Initiative, Task Order 1 definition for consideration. Point out similarities and differences to what the participants have come up with.

**Prepared Flip Chart:**

Advocacy is a set of targeted actions directed at decisionmakers in support of a specific policy issue.

– POLICY Project

10. **Distribute** handouts “What Is Advocacy” and “Sample Definitions of Advocacy.” The definitions come from a variety of sources.
11. **Tell** participants that they may want to review the definitions and identify points that are consistent with their own definitions.

Activity 2 — Advocacy and Related Concepts

Time: 45 minutes

Materials: N/A

Prepared Materials:

PPT: N/A

Flipchart: Blank Chart; definition of “activism”

Other: N/A

Handouts: Related Concepts Chart; Behavior Change Communication/Community Mobilization

Objective: ■ To distinguish between “advocacy” and related concepts.

Introduction: ■ After reviewing the various definitions of advocacy, participants should have a clear sense of the meaning of advocacy.
 ■ Nevertheless, advocacy often is confused with other concepts that share certain common elements, especially behavior change communication (BCC) and community mobilization.
 ■ This activity is designed to compare and contrast advocacy with related concepts to ensure a shared understanding of the meaning of these different concepts.

Activity Instructions:

Step 1: Completing Chart

Time: 25 minutes

1. Show participants the chart (below) that you have already put on a flipchart.

Advocacy and Related Concepts

	Behavior Change Communication (BCC)	Community Mobilization	Advocacy
Target Audience			
Objective			
How to Measure Success			

- 2. Help** participants fill in the chart, beginning with BCC. Ask the group the following questions, and **write** the responses in the appropriate box on the flipchart. Common answers could include the following:
- Target audience:** Various at-risk populations
- Objective:** Reduce harmful or high-risk behaviors through behavior change
- Measure of success:** Reduction in the prevalence of HIV and sexually transmitted infections (STIs); increased use of condoms; or changes in knowledge, attitudes, and practices (KAP)
- 3. Help** the group think about a community mobilization campaign. Repeat the same questions and fill in the answers on the flipchart. Common answers could include the following:
- Target Audience:** Community members and leaders
- Objective:** Increase the number of people within a community who are actively engaged in addressing an issue; build a community's capacity to identify and prioritize its needs and then take action accordingly
- Measure of Success:** Increased participation in and ownership of the problem-solving process; increased mobilization of community resources drawn from different actors/levels; a community problem is identified and solved or a need is met
- 4. Now, help** the group think about an advocacy campaign. Repeat the same questions and fill in the answers on the flipchart. Common answers for the advocacy questions could include the following:
- Target Audience:** Policymakers (the decisionmakers with the authority to make an institutional change)
- Objective:** Change policies, programs, or the allocation of public resources
- Measure of Success:** Adoption of a new or more favorable policy or program; percent shift in resource allocation; new line item in a public sector budget, etc.
- 5. Summarize** the activity by moderating a discussion organized around the following questions:
- What characteristics do all three of these approaches share? (Among the range of answers, participants might note that all approaches include strategies for promoting change, which are most effective when planned systematically.)
 - How is advocacy distinct from the other approaches? (Advocacy always seeks to change a policy, whether a high-level policy, operational policy, guidelines, or resource allocation. Advocacy efforts usually include an information, education, and communication (IEC) component to raise the awareness of key audiences, but advocacy does not stop with awareness raising. The advocacy process is complete when a policymaker implements the prescribed policy action. While the general public may be one of the audiences for an advocacy campaign, the public is mainly targeted to engender support for change and to apply additional pressure to policymakers. If the group focuses on the objective of its activity, it will be able to distinguish advocacy from related concepts.)

**Note to Facilitator:**

If the terms “BCC” and “community mobilization” are unclear, you may wish to introduce the following definitions and ideas during the discussion:

Behavior change communication is defined as developing, distributing, and promoting tailored health information that enables individuals and communities to take up and sustain changes in their behavior that will reduce the risk of HIV infection. Effective BCC should increase knowledge and stimulate community dialogue. BCC should create a demand for information and services and should spur action for reducing risk, vulnerability, and stigma. It should promote services for prevention, care, and support; and ensure that such services are accessible and appropriate for those most affected by HIV and AIDS.*

Community mobilization is a process whereby a group of people become aware of a shared concern or common need and decide to take action to create shared benefits.** A mobilized community is likely to display some or all of the following characteristics:***

- Members are aware, in a detailed and realistic way, of their individual and collective vulnerability to HIV.
- Members are motivated to do something about this vulnerability.
- Members have practical knowledge of the different options for reducing vulnerability.
- Members take action within their capabilities, applying their own strengths and investing their own resources, including money, labor, materials, or whatever else they have to contribute.
- Members participate in decisionmaking, evaluate the results, and take responsibility for both success and failure.
- The community seeks outside assistance and cooperation when these are needed.

* Adapted from: Family Health International, www.fhi.org.

** United Nations Programme on HIV/AIDS (UNAIDS). 1997. Community Mobilization and AIDS: UNAIDS Technical Update. Geneva: UNAIDS.

*** Adapted from: Essential Advocacy Project (EAP). 2007. The Power to Change: A Training Manual for Building Advocacy Capacity for India's HIV/AIDS Response. New Delhi: Constella Futures/EAP.

Step 2: Discussion of Advocacy versus Activism

Time: 20 minutes



Activity Option:

1. The facilitator can go through the initial facilitated questions (see 1, 2, and 3 below), and then present the definition of activism.
2. Alternatively, the facilitator can go directly to a review of the definition of activism (see 4 below).

1. **Explain** to participants that sometimes there are also discussions and debates about how advocacy and activism are related. In some cases, the two words are used to mean the same thing; other times, people believe that the words imply very different things.
2. **Ask** participants: Have you used the word “activism,” or heard it used? If yes, ask them to describe the circumstances in which the word was used. Ask for examples of groups that come to mind when we think of the word “activism.” Take a few responses from around the room.
3. **Ask** participants to then list what they think are some of the defining characteristics of activism. **Record** participants’ responses on the flipchart.
4. Once participants have finished brainstorming, **show** them the definition of activism posted on a flipchart.



“The use of direct, often confrontational action, such as a demonstration or strike, in opposition to or support of a cause.”

—The American Heritage Dictionary of the English Language,
Fourth Edition, 2004.

5. **Point out** the similarities and differences between their list of characteristics and the definition.
6. **Ask** participants: How are activism and advocacy the same, different, or related?

Note to Facilitator: Remind participants that both activism and advocacy seek to bring about a change in policies, programs, or actions in support of an issue, but that activism often uses a particular set of methods/strategies that are more direct or confrontational. Activism also tends to be associated with those groups that have not had a voice or influence within the policymaking system.



Some differences between Advocacy and Activism:*

Advocacy

- More formal political negotiation
- Often from within, or in dialogue with, official political circles/systems
- Measured tone

Activism

- Confrontation/political protest
- Often from outside of the system; groups often are autonomous, with accountability to people's groups/causes
- Confrontational tone

* Source: Australian National University. 2004. "Advocacy or activism: Gender politics in Fiji." *Working Paper 2004/4*. Canberra, Australia: Research School of Pacific and Asian Studies. The analysis draws on literature from political science and women's movements.

7. Conclude by saying that many see activism as a particular style/strategy of advocacy, whereas others see the two as fundamentally different (especially when advocacy is defined as necessarily working within the system; so activism, with its emphasis on working from outside the system, is seen as different). Note that most efforts to bring about social change, especially for groups that have been excluded, rely on working both outside and inside "the system" of policymaking. This has been true for many of the advocacy successes associated with HIV and AIDS. For instance, ACT-UP in USA/New York in the early days of the epidemic relied on both theatrical and visible demonstrations (such as lining up coffins in front of the Food and Drug Administration offices) and also on inside negotiation (such as getting a seat at high-level meetings focused on how to speed up drug trials). The same is true in the case of the Thai Network of People Living with HIV and AIDS (TNP+) and its 100% Bactrim campaign. The important point is to understand the range of strategies that can be used—and how to select those that will be most effective in the circumstances prevailing when the strategies are implemented.

Activity 3 — Examples of Advocacy Leading to Policy Change

Time: 1 hour

Materials: Computer, projector, display screen

Prepared Materials:

PPT: Examples of Advocacy Leading to Policy Change

Flipchart: N/A

Other: N/A

Handouts: PowerPoint presentation, TNP+

Objective: ■ To share real-world case studies of how advocacy has led to policy change and how policy changes can have a beneficial effect on the lives of people living with or affected by HIV and AIDS.

Introduction: ■ **Recap** for participants some key messages from the previous session about the role of advocacy in the A² Project:

- A substantial amount is known about the factors that drive the HIV and AIDS epidemic in Asian countries (although A² also is concerned with filling knowledge gaps).
- A² proposes to integrate advocacy with information collection and analysis in order to achieve beneficial changes in the policy environment.
- People who work on policy issues might understand or assume that “good” changes in the policy environment will help to prevent the spread of HIV and mitigate the impact of the epidemic. For other people, this may seem like a leap of logic.

■ **Note** that during the training, there will be other sessions that look at steps in the advocacy process in more detail. This session is designed to be no more than illustrative and introductory. The hope is that providing these case studies will help to make advocacy more real by giving concrete examples of the need to be concerned with advocacy for policy change, when at first glance, it may seem an esoteric activity unrelated to the realities of people’s lives and welfare.

Activity Instructions:

1. **Present** the “Examples of Advocacy Leading to Policy Change” PowerPoint presentation.

Note to Facilitator: Speaker’s notes are contained in the notes page of the PowerPoint presentation “Examples of Advocacy Leading to Policy Change.”



2. After the presentation, **ask** participants the following:
 - What questions do they have?
 - What struck them about the example?
 - What did they learn about different approaches to advocacy from the PowerPoint presentation and about the possible impact of advocacy for policy change?
 - Which approaches and lessons learned seem more applicable to their own situations, and which do not? Why?
3. **Conclude** by reminding participants that in other activities during the week, there will be a chance to reconsider the content of this presentation—and in particular, the various strategies, opportunities seized, missed opportunities, and lessons learned.

Activity 4 — Steps in the Advocacy Process

Time: 1 hour 5 minutes

Materials: Advocacy cards (sufficient sets of cards to distribute one to each group, plus 1 for facilitator—each set of cards should be printed on different colored paper), tape, flipchart, markers

Prepared Materials:

PPT: N/A

Flipchart: N/A

Other: N/A

Handouts: Advocacy Process, Steps in the Advocacy Process

Objective: ■ To identify the common steps in an advocacy process.

Introduction:

Time: 5 minutes

- Now that participants have reached consensus on a working definition of advocacy, they will look at the different steps that constitute the advocacy process.
- Experience shows that advocacy is rarely an orderly, linear process. Some of the most successful advocacy efforts have resulted from rapid responses to needs and/or opportunities and have materialized amid chaotic environments.
- The ability to seize opportunities, however, does not replace the importance of a sound process and careful planning.
- This activity demonstrates that looking at advocacy in a systematic way can help groups plan and implement effective advocacy campaigns.

Activity Instructions:

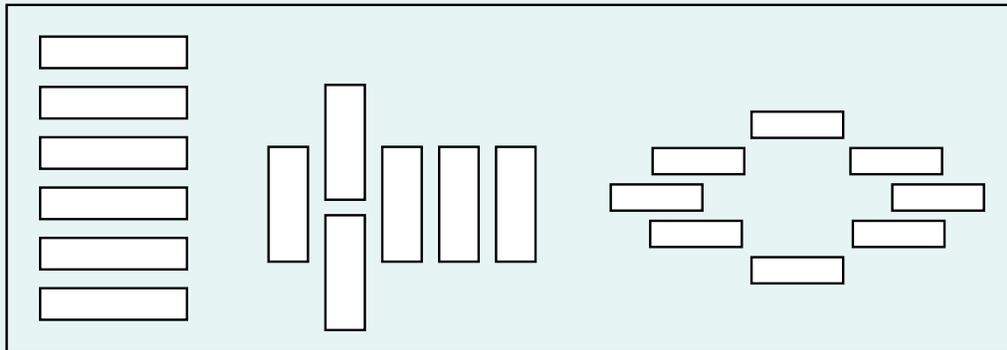
Step 1: Sequencing the Steps

Time: 40 minutes

1. **Divide** participants into teams; an ideal team size for this exercise is 4–6 people.
2. **Distribute** one set of advocacy cards to each team. Be certain that the cards are NOT in the correct order when you give the sets to the teams.
3. **Explain** that each card in the set has one step in the advocacy process written on one side of the card and a brief definition/explanation of the step on the other side.

4. **Ask each team** to read the cards and reach consensus on the order that would be followed to plan and implement an advocacy campaign. Explain that the order does not have to be linear but can take any shape. Allow 20 minutes for groups to order their cards.

Note to Facilitator: Generally, the teams order their cards to look something like the following:



5. **Ask** the teams to post their cards on the wall or display them on the floor so they are visible to the full group. If possible, have all the sets of cards **displayed** near one another so that participants can make comparisons among the different arrangements.
6. When each team has posted its cards, **ask** participants to gather around the arrangements and identify similarities and differences.
7. **Refer** to the first set of cards and ask the relevant team members the following:
 - Did everyone agree on the final order?
 - Where did group members disagree on the sequence of cards, and what were the areas of debate?
 - Which steps, if any, did participants have difficulty in understanding?
8. When all teams have presented their work, **lead** a general discussion structured around the following questions:
 - Did the teams all start with the same step? Did they have the same or different ending step?
 - Were there any steps that were ordered concurrently in the process?
 - Were there any steps that teams thought should take place more than once?

Step 2: Presentation of the Advocacy Process

Time: 20 minutes

1. **Explain** to participants that the purpose of the sequencing activity was to introduce advocacy as a systematic process with distinct steps and activities. While the steps may not always occur in the same order during an actual advocacy campaign, it is important to consider each step as a critical and integral piece of the advocacy effort.
2. **Refer** to the handout “Steps in the Advocacy Process,” or present it on an overhead transparency or flipchart.

3. **Briefly explain** and discuss each step in the process by using the notes and questions below as a guide. In the process, the facilitator may want to use one of the card sets and order them in the sequence suggested in the handout as each step is described; note that some of the steps (especially data collection and monitoring and evaluation) may be placed along the side to show that these occur throughout the process.
4. **Debrief** the activity with the following questions:
 - Do you think that any one of these steps is more important than the others?
 - Do you think that any one of these steps is more challenging?
 - In terms of the A² process, do you feel that some of these steps are not crucial or applicable?
5. In closing, **remind** participants that advocacy activities often are carried out in turbulent environments. Frequently, groups do not have the opportunity to follow each step in the advocacy process according to the model presented here. Nevertheless, a systematic understanding of the advocacy process will help advocates plan wisely, use resources efficiently, and stay focused on the advocacy objective.
6. **Note** that the remaining units in the workshop will address each of these steps in greater detail, in approximately the same sequence as in the model.

Reminder to Facilitator: Tape up one set of cards with the advocacy steps on the wall for the rest of the week. The facilitator then can visually remind participants which steps they are working on in subsequent activities and can assist in keeping them orientated to the whole advocacy process.



Activity 5 — What Is Particular to HIV and AIDS Advocacy?

Time: 1 hour

Materials: Colored paper, markers, tape, computer, projector, display screen

Prepared Materials:

PPT: What Is Particular to HIV and AIDS Advocacy?

Flipchart: Questions (Activity 2)

Other: N/A

Handouts: PowerPoint presentation, Background Notes

Objective: ■ To reflect on the unique challenges and opportunities of advocacy related to HIV and AIDS at both the regional and country-specific levels.

Background Notes:

While there are commonalities, there also are differences between advocacy on HIV and AIDS issues and advocacy on other issues. Some of the features particular to HIV and AIDS advocacy are discussed below.

Stigma and Discrimination

HIV- and AIDS-related stigma and discrimination influence how individuals, communities, and governments respond to the epidemic. Stigma and discrimination often are a reflection of the social taboos associated with high-risk behaviors that can lead to the transmission of HIV. To effectively respond to the epidemic, policies and programs must address these behaviors, as well as health promotion for people living with HIV (PLHIV). These barriers have been approached in various ways. HIV-positive speakers provide an opportunity—by their presence and willingness to share experiences—to confront the notion that PLHIV are somehow different and not worthy of the same fundamental respect accorded to other human beings.

AIDS as an Incurable, Terminal Illness: Fear and Denial

The concept of AIDS as an incurable, terminal condition has contributed to a fear of HIV and of PLHIV. Attitudes toward people living with or vulnerable to HIV infection also have influenced the way in which governments implement HIV prevention programs.

Urgent Action Is Needed

It is only through appropriately targeted interventions that the transmission of HIV can be slowed or stopped and the impact of HIV infection mitigated. The challenge is to mobilize the political will and resources to implement such interventions on a scale that truly will make a difference. Time wasted fuels the epidemic, in part because the deaths of people from affected communities result in the loss of knowledge and experience that are vital to effective responses.

The Greater Involvement of People Living with HIV and AIDS (GIPA) Principle

The GIPA principle was first articulated in a statement adopted by countries attending the Paris AIDS Summit in 1994. PLHIV and people vulnerable to HIV infection should be involved in all aspects of responding to the epidemic because they are able to contribute their knowledge and expertise through their first-hand experience of the epidemic. This includes involvement in the design, implementation, and evaluation of policies and programs for HIV and AIDS prevention, treatment, care, and support. One way in which PLHIV or those vulnerable to HIV can contribute

their expertise is through peer education. This has proven to be an effective HIV prevention and health promotion method because people living with or vulnerable to HIV infection respect their peers as a source of health education and information and because peer educators have a better understanding, through personal experience, of HIV health promotion issues.

It is not only medical or scientific expertise that determines how effectively we respond to HIV. The causes of HIV vulnerability are multidimensional and include biological, behavioral, social, and economic factors. HIV transmission is mostly the result of intimate behaviors that take place in private, such as sex or injection drug use. Being able to draw on the experience of people vulnerable to or living with HIV can enhance the effectiveness of HIV-related policies and programs at all levels—whether that involvement is as a target audience, program implementer, or the highest level of decision- and policymaking.

Risks Associated with Public Exposure

People can face criminal prosecution, the risk of violence, social ostracism, loss of employment, and rejection by family and community if their personal HIV information becomes publicly known. Therefore, decisions about publicly identifying people as living with HIV or AIDS or vulnerable to HIV infection should be considered carefully. The decision whether to disclose should always be made by the affected person. Other alternatives to disclosing one's status and identity also should be considered. For example, a person can be quoted or interviewed as a PLHIV without disclosing his or her identity. HIV advocacy coalitions always include people living with and vulnerable to HIV infection but will usually include other concerned people and organizations as well. In these circumstances, advocacy activities and events can be structured in such a way that it is unnecessary to identify which members of a coalition are living with or vulnerable to HIV.

A Global Issue with a Global Infrastructure

HIV has spread to almost all parts of the globe. As a consequence, advocacy groups have formed in most of the world's countries. With HIV advocacy, the more appropriate course of action often will be to identify and engage with existing alliances as a first step in building support for an advocacy issue. When we take on an HIV advocacy issue, we do so in the context of a worldwide movement of advocates and activists at all levels.

There are various types of HIV advocacy organizations and activities and numerous national organizations representing the interests of PLHIV. The largest network in Asia, representing people living with and affected by HIV and their service providers, is the Coalition of Asia Pacific Regional Networks on HIV and AIDS, known informally as the “Seven Sisters.” The members of this network are the Asia-Pacific Council of AIDS Service Organizations (APCASO); the Asia Pacific Network of Sex Workers Organizations (APNSW); the Asia Pacific Network of People Living with HIV and AIDS (APN+); AP Rainbow (representing lesbian, gay, bisexual, and transgender people in the Asia-Pacific region); the AIDS Society of Asia and the Pacific (ASAP), the Asian Harm Reduction Network (AHRN), and Coordination of Action Research on AIDS and Mobility in Asia (CARAM Asia).

There also are many resources available to civil society and nongovernmental organizations planning and implementing advocacy activities. Some organizations that have useful resources include the International HIV/AIDS Alliance (<http://www.aidsalliance.org/sw1280.asp>), the POLICY Project (www.policyproject.com), the USAID | Health Policy Initiative (www.healthpolicyinitiative.com), the International Council of AIDS Service Organizations (ICASO; <http://www.icaso.org/>), and aidsmap (<http://www.aidsmap.com/en/default.asp>).

Intergovernmental and Multilateral Forums

One of the best examples of global commitment to fighting the HIV and AIDS pandemic is the Declaration of Commitment agreed to by all 191 members of the United Nations, following the UN General Assembly's Special Session (UNGASS) on HIV/AIDS in 2002. The UNGASS Declaration, as it is known, commits all member states to demonstrating strong leadership; providing prevention, treatment, care, and support services; promoting respect for HIV-related human rights; and allocating new, additional, and sustained resources to the response to HIV and AIDS. ICASO has produced a guide to using the UNGASS Declaration in advocacy activities, which is available on its website at <http://www.icaso.org/>. In September 2005, the 60th session of the United Nations General Assembly also endorsed the goal of providing universal access to treatment for all who need it by 2010. Two UN agencies, the World Health Organization (www.who.int) and UNAIDS (www.unaids.org), are rich sources of best practice policies spanning the full spectrum of interventions required for effective responses to the epidemic.

Regional Forums

Many regional forums can also be valuable sources for resources to use in advocacy campaigns and potential allies in working toward the achievement of an advocacy goal. Some examples of regional forums include the members of the Coalition of Regional Networks on HIV/AIDS; the Asia-Pacific Leadership Forum (APLF), which focuses on enhancing the capacity of senior policy advisors and civil servants in the ministries of national governments to respond to HIV; and the Association of South East Asian Nations (ASEAN), which has established a Task Force on AIDS and has made a number of commitments related to responding to HIV and AIDS. More information can be found on the ASEAN website at <http://www.aseansec.org/home.htm>.

The Importance of Human Rights

For several reasons, respect for human rights is particularly relevant in the context of HIV and AIDS. An environment in which human rights are respected ensures that vulnerability to HIV is reduced, people infected with or affected by HIV can live a life of dignity without discrimination, and the personal and societal impact of HIV infection is alleviated. Policymakers can maximize the effectiveness of programs by aiming to achieve an optimal synergy between human rights and public health outcomes. Violations of rights undermine HIV-related strategies because if people at risk are not assured that their rights will be respected, they will be driven underground and out of reach of HIV services. This is particularly true for populations already socially marginalized, such as sex workers, injecting drug users (IDUs), and men who have sex with men (MSM).

Human rights important in the context of HIV include

- Rights to comprehensive HIV prevention, treatment, care, and support services;
- Rights to non-discrimination, including in healthcare services, housing, and work;
- Rights of all to equality under laws, policies, and programs (women and girls, in particular);
- Rights of children to education and the services necessary for health and life;
- Rights to privacy (including sexual privacy), confidentiality of HIV status, and informed consent to HIV testing;
- Rights to liberty, freedom of movement, and protection against arbitrary and oppressive laws and policies;
- Rights to security of the person and freedom from violence, including gender-based violence; and
- Rights of PLHIV and those vulnerable to HIV to participate in the planning and delivery of programs affecting their lives.

Introduction:

Time: 10 minutes

- Briefly **review** key points from earlier sessions on defining advocacy and the advocacy process, noting that advocacy shares these common elements:
 - Advocacy is a set of targeted actions directed at decisionmakers in support of a specific policy issue.
 - Advocacy is a process occurring over a period of time.
 - Advocacy uses strategic, targeted well-designed activities to key stakeholders and decisionmakers.
 - Advocacy for policy change is directed at influencing policy, laws, regulations, programs, or funding—decisions made at the highest levels of public or private sector institutions.
 - Advocacy is both a science (it is most effective when it is planned systematically) and an art—successful advocates can motivate and inspire, seize opportunities, and incorporate creativity, style, and even humor into advocacy events to draw public and media attention to their cause.
 - Advocacy is a systematic process with distinct steps and activities.
- **Explain**, though, that many have argued that advocacy related to HIV and AIDS also has features that are distinct and different from advocacy on other topics.
- **Introduce** the objectives of this session, which are to help assess what these distinct features are and how they may affect the approaches and strategies participants decide to adopt.

Activity Instructions:**Step 1: Small Groups**

Time: 30 minutes

1. **Write** each of the following questions on separate sheets of paper and post them around the room.

What is particular to HIV and AIDS advocacy?

- What distinct challenges and opportunities does HIV present for advocates?
- What is different about the way HIV-related advocacy has been done compared to advocacy on other issues?
- What forums exist for HIV-related advocacy? How do they differ from forums for advocacy on other issues?
- Are human rights any more relevant to HIV than to other illnesses? If so, why?

2. **Review** the questions to ensure they are understood.
3. **Divide** participants into groups.
4. **Ask** the groups to discuss all four questions and reach consensus on their responses.
5. **Ask** each group to write its responses to the questions on flipchart paper. Other groups can give feedback if new information is presented.

Step 2: General Discussion

Time: 20 minutes

1. **Present** the PowerPoint presentation, “What Is Particular to HIV and AIDS Advocacy.”
2. **Read** the responses for each question from the exercise above, and lead a general discussion of the responses. Include the following questions as prompts:
 - On which questions was there agreement among the responses of the different groups?
 - On which questions did responses differ?
 - Do groups, or individual group members, feel differently about their responses having seen the responses of other groups?
 - How did cultural and political factors influence responses to the questions? For example, to what extent would arguments based on human rights assist in an advocacy campaign on an HIV-related issue?
 - Note that effective advocacy strategies may vary according to the cultural and political environments in which they are implemented. Remind participants that they will have the opportunity to consider these questions further in other modules during the workshop.
3. **Distribute** the background notes on “What Is Particular to HIV and AIDS Advocacy?”

SECTION II: Introducing HIV and AIDS Advocacy

Activity 1 — What Is Advocacy?

Background Notes

There is no one internationally agreed upon definition of the term “advocacy.” There are as many definitions of advocacy as there are groups, networks, and coalitions advocating. However, each definition shares a common language and concepts. Advocacy is also strategic and targets well-designed activities to key stakeholders and decisionmakers. Finally, advocacy is always directed at influencing policy, laws, regulations, programs, or funding—decisions made at the highest levels of public or private sector institutions.

Advocacy includes both single-issue, time-limited campaigns and ongoing work undertaken around a range of issues. Advocacy activities may be conducted at national, regional, or local levels.

Within the HIV and AIDS policy arena, advocacy efforts might address such things as affordable access to medications for HIV infection and related conditions or the enactment of laws prohibiting discrimination on the basis of a person’s HIV status. Operational HIV and AIDS policies—where specific resource allocation and service delivery guidelines are formulated—are also potential objects for advocacy campaigns. For example, advocacy could focus on voluntary HIV testing and counseling or interventions to reduce mother-to-child transmission of HIV.

Advocacy is a set of targeted actions directed at decisionmakers in support of a specific policy issue.

SECTION II: Introducing HIV and AIDS Advocacy

Activity 1 — What Is Advocacy?

Definitions of Advocacy

“Advocacy is a set of targeted actions directed at decisionmakers in support of a specific policy issue.”

POLICY Project. 1999. Networking for Change: An Advocacy Training Manual. Washington, DC: Futures Group/POLICY Project.

“Advocacy means putting across your message to other people to bring about wider public understanding about HIV and other issues, changes in policies, laws, and services. Advocacy work can involve action at all levels, locally and through representation of national decisionmaking bodies.”

Maasdorp, A. 1998. Positive Development: Setting Up Self-help Groups and Advocating for Change—A Manual for People Living with HIV. Amsterdam: Global Network of People Living with HIV/AIDS (GNP+).

“Advocacy is not just about getting to the table with a new set of interests; it is about changing the size and configuration of the table to accommodate a whole new set of actors. Effective advocacy challenges imbalances of power and changes thinking.”

VeneKlasen, L., and V. Miller. 2002 (reprinted 2007). A New Weave of People, Power & Politics: The Action Guide for Advocacy and Citizen Participation. Washington, DC: Just Associates.

“Advocacy is an action directed at changing the policies, positions, and programs of any type of institution.”

Sharma, R. 1997. An Introduction to Advocacy: Training Guide. Washington, DC: Academy for Educational Development/Support for Analysis and Research in Africa (SARA) Project.

SECTION II: Introducing HIV and AIDS Advocacy

Activity 2 — Advocacy and Related Concepts

Related Concepts Chart

The following chart illustrates the differences among advocacy and several related concepts. Advocacy can usually be distinguished from other approaches, in that the objective of advocacy is policy change.

Approach	Actors/Organizers	Target Audience	Objective	Strategies	Measuring Success
Behavior Change Communication (BCC)	Service providers; Community organizations;	At-risk groups; Segments of a community (women, men, youth)	Raise awareness and change behavior	Community outreach; Peer education; Mass media campaigns	Process indicators (numbers reached); Change in knowledge, attitudes, and behavior Focus groups; Service statistics
Community Mobilization	Community members and organizations	Community members and leaders	Build a community's capacity to rank needs and take action	Door-to-door visits; Village meetings; Participatory Rural Appraisal (PRA)	Issue-specific process and outcome indicators; Quality and quantity of participation
Advocacy	Nongovernmental organizations/networks; Special interest groups; Professional associations	Public institutions and policymakers	Change policies, programs, and resource allocation	Targeting of policymakers with the power to affect the advocacy objective; High-level meetings; Public events (debates, protests, press releases, etc.)	Process indicators; Media scans; Key informant interviews; Focus groups; Opinion surveys

¹ Adapted from: POLICY Project. 1999. Networking for Change: An Advocacy Training Manual. Washington, DC: Futures Group/POLICY Project.

SECTION II: Introducing HIV and AIDS Advocacy

Activity 2 — Advocacy and Related Concepts

Behavior Change Communication

Behavior change communication (BCC) is defined as developing, distributing, and promoting tailored health information that enables individuals and communities to take up and sustain changes in their behavior that reduce the risk of HIV infection. Effective BCC should increase knowledge and stimulate community dialogue. BCC should create a demand for information and services and spur action for reducing risk, vulnerability, and stigma. It should promote services for prevention, care, and support; and ensure that such services are accessible and appropriate for those most affected by HIV and AIDS.

Community Mobilization

Community mobilization is a process whereby a group of people become aware of a shared concern or common need and decide to take action to create shared benefits. A mobilized community is likely to display some or all of the following characteristics:

- Members are aware, in a detailed and realistic way, of their individual and collective vulnerability to HIV.
- Members are motivated to do something about this vulnerability.
- Members have practical knowledge of the different options for reducing vulnerability.
- Members take action within their capabilities, applying their own strengths and investing their own resources, including money, labor, materials, or whatever else they have to contribute.
- Members participate in decisionmaking, evaluate the results, and take responsibility for both success and failure.
- The community seeks outside assistance and cooperation when these are needed.

²Adapted from: Family Health International, www.fhi.org.

³United Nations Programme on HIV/AIDS (UNAIDS). 1997. Community Mobilization and AIDS: UNAIDS Technical Update. Geneva: UNAIDS.

⁴Adapted from: Essential Advocacy Project (EAP). 2007. The Power to Change: A Training Manual for Building Advocacy Capacity for India's HIV/AIDS Response. New Delhi: Constella Futures/EAP.

SECTION II: Introducing HIV and AIDS Advocacy

Activity 3 — Examples of Advocacy Leading to Policy Change

Thai Network of People Living with HIV and AIDS⁵



Background

The Thai Network of People Living with HIV/AIDS (TNP+) was formed in 1997. It provides broad national representation to the issues and concerns of PLWHA and functions as a national support network to Thailand's many small PLWHA groups.



Advocacy Environment

Paisan Tan-Ud, the former chair and one of the founders of TNP+, helped create the organization at a time when most people in Thailand had little information about HIV/AIDS. In addition, as was the case in many developing countries, most doctors were both uneducated about HIV/AIDS and unable to care adequately for persons with the disease. Seeing too many friends living under duress and others dying from AIDS without care and support, Paisan and other PLWHA friends and colleagues decided that the delivery of care and speaking out on HIV/AIDS was not enough. They wanted—and needed—to do more. With this sense of passion, they set out to establish a PLWHA network.

When the organizers of the Asia Pacific Islands AIDS Conference in Chiang Mai, Thailand, in the mid-1990s provided Paisan and his friends with the opportunity to meet at their conference, Paisan realized that they had a unique opportunity to bring people together. They seized the moment to gather PLWHA from all over Thailand in one room—the first time that PLWHA from Thailand had ever assembled—and used the opportunity to push for greater organization and networking among themselves. From this one chance to network and strategize, a national group emerged. A year later, a national network was formed, with Paisan elected as chairperson.

⁵ The following is an excerpt from: POLICY Project. 2003. Moments in Time: HIV/AIDS Advocacy Stories. Washington, DC: Futures Group/POLICY Project.

Advocacy Focus and Strategy

TNP+'s mission is to improve the quality of life for PLWHA and all those affected by HIV/AIDS.

The organization adopted the following objectives:

- Support and strengthen PLWHA groups;
- Campaign for human rights and social welfare for all PLWHA and those affected with HIV/AIDS; and
- Cooperate with NGOs and government entities to respond to the epidemic.

At the outset, TNP+ identified two critical tasks for itself: (1) challenge and push the government to support PLWHA and their concerns as a way to confront the epidemic; and (2) support the government in its efforts to eliminate barriers created by other international bodies as it tries to support PLWHA.

In the five years since its formation, TNP+ has grown from 100 groups based mostly in northern Thailand to 495 groups located in every region of the country. Financial support from the government has been central to TNP+'s growth. TNP+'s advocacy and pressure from community groups has led to the creation of an HIV/AIDS budget within the national government budget.

TNP+ also successfully convinced government officials to allocate a percentage of the HIV/AIDS national budget to PLWHA groups. Financial support from AIDSNet, a large NGO in Chiang Mai, has also been pivotal to TNP+'s growth.

Identifying Allies

From the outset, TNP+ recognized the importance of identifying and forming partnerships with allies. Thus, TNP+ members built and strengthened their relationships with other NGOs that were similarly dedicated to both guaranteeing the right to health care for all and making treatment available to PLWHA. These relationships proved critical. It was through Médecins Sans Frontiers (MSF)/Doctors without Borders and the AIDS Access Foundation that TNP+ discovered that treatment was available to prevent certain opportunistic infections (OIs). This piece of crucial information led TNP+ to identify and select the 100% Bactrim® Campaign as its first advocacy effort.

Choosing a Winnable Issue

During its first year, TNP+ devoted itself to identifying its strengths and advocacy focus along with the strategies the organization would adopt to pursue its goals. It used the opportunity of a subsequent national AIDS conference and the gathering of PLWHA to determine its first advocacy focus and long-term plan. It identified access to preventive treatment for *Pneumocystis carinii pneumonia* (PCP) as its priority banner issue. Commitment to the issue led, in 2000, to the creation of the 100% Bactrim® Campaign, which informed the group's later campaigns and activities.

Two factors led TNP+ to decide on the Bactrim campaign as opposed to another campaign. First, given that PCP is a major killer of PLWHA and that Bactrim can prevent and/or treat the disease at a relatively low cost, TNP+ recognized that the government could make the drug available. Second, with only two tablets a day needed, the Bactrim regimen is simple to follow. The careful choice of an advocacy objective—a winnable issue—permitted TNP+ to realize a success around which it could structure other campaigns and achieve future successes, particularly the

strengthening of the basic infrastructure of the health care system. In addition, the campaign managed to save hundreds, perhaps thousands, of lives. Since its beginnings, the campaign has made it possible for 80 percent of TNP+ members to receive Bactrim prophylaxis.

Laying the Groundwork: Advocacy for Access to ARV

About the same time that TNP+ initiated the Bactrim campaign, members began to hear about antiretroviral (ARV) therapy from friends and researchers who had attended the 1996 International AIDS Conference in Vancouver, Canada. Realizing that the high costs of ARVs would make treatment inaccessible to most PLWHA, TNP+ decided to run a campaign in parallel with the Bactrim campaign aimed at reducing the price of ARVs. In many ways, the Bactrim campaign served as a pilot project for the ARV campaign by strengthening the group's capability and the infrastructure for developing and implementing an ARV treatment program.

To reduce the price of ARVs, TNP+ saw that it would have to develop relationships with a new set of partners. In addition to the relationships already formed, TNP+ forged alliances with, among others, university professors, the Consumer Protection Foundation, and the Center for AIDS Rights.

Nonetheless, TNP+ had to overcome several obstacles to ensure that ARVs would become more accessible. One of the most daunting obstacles revolved around compulsory licensing and safety monitoring procedures (SMPs) for the production of drugs. Even though Thailand commanded the expertise and ability to produce several of the needed new drugs, international trade law prohibited the country from producing generic drugs. The production issue became one of the major advocacy issues that TNP+ had to address in fulfilling its commitment to make ARV treatment available to PLWHA. The organization recognized that it had to learn about the issue and teach others about it.

"We needed to show government and the people of Thailand that access to antiretroviral treatment for PLWHA was really a human rights issue and about equity and equal access for all. It was not a money issue."

Paisan Tan-Ud,
TNP+

Advancing Advocacy by Raising Visibility of Issues Inside Thailand and Internationally

In 2000, TNP+ held its first PLWHA public demonstration in front of the Ministry of Public Health, with about 200 people in attendance. The demonstration was intended to pressure the government to invoke its legal right to use compulsory licensing to ensure access to affordable medicines, in this case, to produce the pill form of ddI (didanosine), an ARV drug used in combination therapy. Vowing not to leave until the government issued a response; the demonstrators continued their action for 3 days and 2 nights. The government finally responded by requesting more time. TNP+ agreed to end the demonstration but put the government on notice and vowed to return if its issues were not addressed. In addition to pushing the government to use its right to produce generic drugs, the demonstration increased awareness of HIV/AIDS, particularly the need for treatment, and raised the profile of TNP+. To gain national and international support for its issues, TNP+ wrote letters to world leaders, met with representatives from the government Office of Intellectual Property, and lobbied the government's Generic Production Office. In addition, TNP+ met with treatment activists from the Treatment Action Campaign in South Africa and partnered with international organizations, such as MSF, Health GAP, and ACT UP.

Although TNP+'s activities, as of this writing, have not led the Thai government to produce the pill form of ddI, its campaign can boast of several other successes. The pressure that TNP+ brought to bear on the government has brought TNP+ into the public's consciousness, thus raising its stature in the eyes of both the citizenry and the government. TNP+'s work, along with other treatment advocacy organizations' efforts, contributed to the decision on the part of the World Health Organization (WHO) and UNAIDS to review issues related to drug pricing. TNP+ also initiated a review of the SMPs, which led to the government's undertaking a similar review. As a result, the Thai government changed the law governing drug pricing so that certain drug prices would be more equitable and affordable.

Knowing the Issues

Like ACT UP before it, TNP+ recognized the importance of becoming well informed on the issues. As part of its advocacy work, TNP+ leaned about and became an expert on a range of issues previously foreign to the group—government structure and how it operates, national and international law, drug production, and international relations. Its enhanced knowledge increased TNP+'s credibility with decision makers and won allies both nationally and internationally.

Recognizing Access to Health Care as a Human Rights Issue

Another accomplishment of TNP+ is its ability to integrate HIV/AIDS into the broader issues of health care in Thailand, forming coalitions with groups that address issues related to the elderly, children, and other consumer groups. TNP+'s response to a government health plan provides an example. In 2001, the Thai government initiated a type of universal health care program called the "30 baht plan," launching the program with the following slogan: "30 baht cures all diseases." The program covered all diseases except chronic liver failure and HIV/AIDS. In 2002, a year after the 30 baht plan took effect and just before World AIDS Day, TNP+ decided the time was right to push for access to ARV treatment for PLWHA and that the "30 baht plan" was the ideal vehicle for its advocacy campaign. Accordingly, TNP+ set a goal of securing ARV treatment coverage under the "30 baht plan." TNP+ again organized a demonstration in front of the government house and, within a week, drew 1,000 participants who demanded that the "30 baht plan" cover ARV treatment. At a press conference, TNP+ deftly made the case that the main barrier to access to treatment for PLWHA was the lack of political will, not the lack of financial resources as the government claimed.

It identified government corruption and military spending as problems that, if addressed, would free up resources for HIV/AIDS care. TNP+ pointed out that, while HIV/AIDS was the number one killer in Thailand, the government still maintained that treatment was too expensive and not cost-effective.

To refute that argument, TNP+ noted that, even though a study on the cost-effectiveness of treatment for HIV-positive individuals had never been performed, such studies had been performed with other diseases. As part of an overall plan of action, TNP+ joined with other networks, including a law society, to bring an alternative health care plan before Parliament. The plan was structured around two considerations: (1) the constitutional principle of nondiscrimination in access to health care; and (2) the premise that people pay taxes equally such that everyone deserves equal coverage for health care.

In order for the bill to be introduced into Parliament, the partnership needed to collect 50,000 signatures. In a short time, TNP+ succeeded in collecting over 30,000 of the required signatures.

In response, the Minister of Public Health said that the government would eventually cover ARV treatment in the plan but that the “right process” had to be followed. Not content with waiting for the “right process”, TNP+ formed a committee to assist the government in developing the capacity to include ARV treatment in the universal health care plan. The committee is composed of 10 people from government and 10 people from NGOs, 6 of whom are PLWHA, including Paisan.

Challenges as TNP+ Moves Forward

Reaching Rural Constituents

An important issue facing TNP+ is the need to address the gap between what is available to people in urban versus rural areas. In rural areas, many people, including doctors, are not fully educated on basic treatment options for OIs while, in Bangkok, PLWHA are able to access ARVs as well as treatment for OIs, even if only in clinical trials. Not surprisingly, many PLWHA in rural areas are dying more quickly. While the move to challenge the government to produce its own drugs will go a long way toward addressing urban-rural differences, much more needs to be done.

Developing Leadership

TNP+ recognizes that it must address capacity building and leadership development as priority issues. Many TNP+ members are poor and sense that their government has never valued them. Now, as HIV/AIDS advocates, they are challenging and fighting their government. Their success depends on the expenditure of time, energy, and resources to develop their leadership abilities. In addition, many network members do not have access to computers and the Internet. Given that communication is essential in coalition work and that TNP+ members must resolve complex issues, access to information is critical.

Overcoming Stigma and Discrimination

TNP+ is working on the development of a training curriculum and other educational materials on sexuality, drugs, and HIV/AIDS. The effort grows out of the recognition that much of the public— PLWHA included—lacks information or misunderstands these issues and that few programs exist to prevent or treat HIV and other diseases among IDUs. Stigma and discrimination against drug users in Thailand is particularly high. TNP+ hopes to contribute toward a national climate and policy environment centered more on human rights and away from stereotypes and moralistic judgments.

▣ Questions for Dialogue

1. What were some of the criteria that led to TNP+'s focus on the 100% Bactrim Campaign as its first advocacy objective? What were the benefits of choosing the campaign as a first advocacy objective?
2. In the “30 Baht Campaign,” what were some of the strategies used by TNP+ to move coverage of ARVs onto the policy agenda?
3. In selecting its issues, designing its campaigns, and reaching its target audiences, TNP+ was keenly aware of the importance of information. What are the risks of moving forward without understanding your information needs? What types of information would help your group and your advocacy efforts? How can you obtain the needed information?

This story was based on an interview with Paisan Tan-Ud, founder and first chairperson of TNP+. Paisan has since founded and now works with the Thai AIDS Treatment Action Group.

SECTION II: Introducing HIV and AIDS Advocacy Activity 4 — Steps in the Advocacy Process

Advocacy Process

Advocacy Process

D
A
T
A

C
O
L
L
E
C
T
I
O
N

- Issue
- Goal and Objectives
- Target Audience
- Building Support
- Message Development
- Channels of Communication
- Fundraising
- Implementation

M
O
N
I
T
O
R
I
N
G

&

E
V
A
L
U
A
T
I
O
N

SECTION II: Introducing HIV and AIDS Advocacy

Activity 4 — Steps in the Advocacy Process

Steps in the Advocacy Process

Define the Issue

Advocacy begins with an issue or problem that the network or group agrees to support to promote a policy change. An issue should meet a group's agreed-upon criteria and support the network's overall mission (e.g., the issue is focused, clear, and widely understood by network constituents). Ways in which a group could identify issues include

- Analysis of the external environment, including political, economic, social, and other factors;
- Discussion with PLHIV and other affected groups;
- Organization of issue identification meetings; and
- Collection and analysis of data about the HIV and AIDS situation (surveillance data, UNAIDS country data, DHS, surveys, focus groups, censuses, etc.)

Set Goal and Objectives

A goal is a general statement of what the group hopes to achieve in the long term (three to five years). The advocacy objective describes short-term, specific, measurable achievements that contribute to the advocacy goal.

Identify Target Audience

The primary target audience includes the decisionmakers who have the authority to bring about the desired policy change. The secondary target audience includes persons who have access to and are able to influence the primary audience—such as other policymakers, friends or relatives, the media, and religious leaders. Just as advocates need to use data to define their issues, goals, and objectives, wise advocates also collect data to identify and understand their target audiences. The group must identify individuals in a target audience and their positions and relative power base and then determine whether the various individuals support, oppose, or are neutral regarding the advocacy issue.

Build Support

Building a constituency to support the group's advocacy issue is critical for success. The larger the support base, the greater the chances of success. Advocates must reach out to create alliances with other nongovernmental organizations, networks, PLHIV groups, care and treatment organizations, donors, coalitions, civic groups, professional associations, women's groups, activists, and individuals who support the issue and will work with you to achieve your advocacy goals. How do you identify potential collaborators? Members can attend conferences and seminars, enlist the support of the media, hold public meetings, review publications, and use the Internet. Many groups have found it helpful to develop a database containing their supporters' contact information so they can send information and advocacy materials to others.

Develop the Message

Advocacy messages are developed and tailored to specific target audiences to frame the issue and persuade the message recipient to support the group's position. There are three important questions to answer when preparing advocacy messages: Who are you trying to reach with the message? What do you want to achieve with the message? What do you want the recipient of the message to do as a result? (What action do you want taken?)

How can pre-testing your advocacy messages help to gather information about their effectiveness? How and with whom might you do a pre-test?

Select Channels of Communication

Selection of the most appropriate medium for advocacy messages depends on the target audience. The choice varies for reaching the general public, influencing decisionmakers, educating the media, or generating support for the issue among like-minded organizations and networks. Some of the more common channels of communication for advocates include such tools as press kits and press releases, press conferences, fact sheets, public debates, and conferences for policymakers.

Raise Funds

Advocacy campaigns can always benefit from outside funds and other resources. Such resources can help support the development and dissemination of materials, cover group members' travel to meet with decisionmakers and generate support, underwrite meetings or seminars, or absorb communication expenses. Advocates should create a fundraising strategy at the outset of the campaign to identify potential contributors of financial and other resources.

Develop Implementation Plan

Advocates should develop an implementation plan to guide their advocacy campaign. At a minimum, the plan should identify activities and tasks, target audiences, responsible persons/committees, the desired timeframe, expected outcomes, and needed resources.

Collect Data (ongoing activity)

As we have noted throughout, data collection supports all stages of the advocacy process shown in the model. Advocates should collect and analyze data to identify and select their issue, as well as develop advocacy objectives, craft messages, expand their base of support, and influence policymakers.

Monitor and Evaluate (ongoing activity)

As with data collection, monitoring and evaluation occur throughout the advocacy process. Before undertaking the advocacy campaign, the network must determine how it will monitor the activities in its implementation plan. In addition, the group should decide how it will evaluate or measure results. Can the group realistically expect to bring about a change in policy, programs, or funding as a result of its efforts? In specific terms, what will be different following the completion of the advocacy campaign? How will the group know that the situation has changed?

SECTION II: Introducing HIV and AIDS Advocacy

Activity 5 — What Is Particular to HIV and AIDS Advocacy?

Background Notes

While there are commonalities, there also are differences between advocacy on HIV-related issues and advocacy on other issues. Some of the features particular to HIV and AIDS advocacy are discussed below.

Stigma and Discrimination

HIV-related stigma and discrimination influence how individuals, communities, and governments respond to the epidemic. Stigma and discrimination are often a reflection of the social taboos associated with behaviors that can lead to the transmission of HIV. To effectively respond to the epidemic, policies and programs must address these high-risk behaviors, as well as health promotion for people living with HIV (PLHIV). These barriers have been approached in various ways. HIV-positive speakers also provide an opportunity—by their presence and willingness to share experiences—to confront the notion that PLHIV are somehow different and not worthy of the same fundamental respect accorded to other human beings.

AIDS as an Incurable, Terminal Illness: Fear and Denial

The concept of AIDS as incurable, terminal conditions has contributed to a fear of HIV and of PLHIV. Attitudes toward people living with or vulnerable to HIV infection have also influenced the way in which governments implement HIV prevention programs.

Urgent Action Is Needed

It is only through appropriately targeted interventions that the transmission of HIV can be slowed or stopped and the impact of HIV infection mitigated. The challenge is to mobilize the political will and resources to implement such interventions on a scale that truly will make a difference. Time wasted fuels the epidemic, in part because the deaths of people from affected communities result in the loss of knowledge and experience that are vital to effective responses.

The Greater Involvement of People Living with HIV and AIDS (GIPA) Principle

The GIPA principle was first articulated in a statement adopted by countries attending the Paris AIDS Summit in 1994. PLHIV and people who are vulnerable to HIV infection should be involved in all aspects of responding to the epidemic because they contribute their expertise through their first-hand experience of the epidemic. This includes involvement in the design, implementation, and evaluation of policies and programs for HIV and AIDS prevention, treatment, care and support. One way in which PLHIV or those vulnerable to HIV can contribute their expertise is through peer education. This has proven to be an effective HIV prevention and health promotion method, because people living with or vulnerable to HIV infection respect their peers as a source of health education and information and because peer educators have a better understanding, through personal experience, of HIV health promotion issues.

It is not only medical or scientific expertise that determines how effectively we respond to HIV. The causes of HIV vulnerability are multidimensional and include biological, behavioral, social, and economic factors. HIV transmission is mostly the result of intimate behaviors that take place in private, such as sex or injection drug use. Being able to draw on the experience of people living with and vulnerable to HIV can enhance the effectiveness of HIV-related policies and programs at all levels, whether that involvement is as a target audience, program implementer, or the highest level of decision- and policymaking.

Risks Associated with Public Exposure

People can face criminal prosecution, the risk of violence, social ostracism, loss of employment, and rejection by family and community if personal HIV information becomes publicly known. Therefore, decisions about publicly identifying people as living with HIV or vulnerable to HIV infection should be carefully considered. The decision whether to disclose should always be made by the affected person. Other alternatives to disclosing one's status and identity also should be considered. For example, a person can be quoted or interviewed as a PLHIV without disclosing his or her identity. HIV-related advocacy coalitions always include people living with and vulnerable to HIV infection but will usually include other concerned people and organizations as well. In these circumstances, advocacy activities and events can be structured in such a way that it is unnecessary to identify which members of a coalition are living with or vulnerable to HIV.

A Global Issue with a Global Infrastructure

HIV has spread to almost all parts of the globe. As a consequence, advocacy groups have formed in most of the world's countries. With HIV advocacy, the more appropriate course of action will often be to identify and engage with existing alliances as a first step in building support for an advocacy issue. When we take on an HIV advocacy issue, we do so in the context of a worldwide movement of advocates and activists at all levels.

There are various types of HIV-related advocacy organizations and activities and numerous national organizations representing the interests of PLHIV. The largest network in our region, representing people living with and affected by HIV their and service providers, is the Coalition of Asia Pacific Regional Networks on HIV/AIDS, known informally as the "Seven Sisters." The members of this network are the Asia-Pacific Council of AIDS Service Organizations (APCASO); the Asia Pacific Network of Sex Workers Organizations (APNSW); the Asia Pacific Network of People Living with HIV/AIDS (APN+); AP Rainbow (representing lesbian, gay, bisexual and transgender people in the Asia Pacific region); the AIDS Society of Asia and the Pacific (ASAP); the Asian Harm Reduction Network (AHRN); and Coordination of Action Research on AIDS and Mobility in Asia (CARAM Asia).

There also are many resources available to civil society and nongovernmental organizations for use in planning and implementing advocacy activities. Some organizations that have useful resources include the International HIV/AIDS Alliance (<http://www.aidsalliance.org/sw1280.asp>), the POLICY Project (www.policyproject.com), the International Council of AIDS Service Organizations (ICASO; <http://www.icaso.org/>), and aidsmap (<http://www.aidsmap.com/en/default.asp>).

Intergovernmental and Multilateral Forums

One of the best examples of global commitment to fighting the HIV pandemic is the Declaration of Commitment agreed to by all 191 members of the United Nations, following the UN General Assembly's Special Session (UNGASS) on HIV and AIDS in 2002. The UNGASS Declaration, as it is known, commits all member states to demonstrating strong leadership; providing prevention, treatment, care, and support services; promoting respect for HIV-related human rights; and allocating new, additional, and sustained resources to the response to HIV and AIDS. ICASO has produced a guide to using the UNGASS Declaration in advocacy activities, which is available on its website at <http://www.icaso.org/>. In September 2005, the 60th session of the United Nations General Assembly also endorsed the goal of providing universal access to treatment for all who need it by 2010. Two UN agencies, the World Health Organization (www.who.int) and UNAIDS (www.unaids.org), are rich sources of best practice policies spanning the full spectrum of interventions required for effective responses to the epidemic.

Regional Forums

Many regional forums can also be valuable sources for resources to use in advocacy campaigns and potential allies in working toward the achievement of an advocacy goal. Some examples of regional forums are the members of the Coalition of Regional Networks on HIV/AIDS; the Asia-Pacific Leadership Forum (APLF), which focuses on enhancing the capacity of senior policy advisors and civil servants in the ministries of national governments to respond to HIV; and the Association of South East Asian Nations (ASEAN), which has established a Task Force on AIDS and has made a number of commitments relative to responding to HIV and AIDS. More information can be found on the ASEAN website at <http://www.aseansec.org/home.htm>.

The Importance of Human Rights

For several reasons, respect for human rights is particularly relevant in the context of HIV and AIDS. An environment in which human rights are respected ensures that vulnerability to HIV is reduced, people living with or affected by HIV can live a life of dignity without discrimination, and the personal and societal impact of HIV infection is alleviated. Policymakers can maximize the effectiveness of programs by aiming to achieve an optimal synergy between human rights and public health outcomes. Violations of rights undermine HIV-related strategies, because if people at risk are not assured that their rights will be respected, they will be driven underground and out of reach of HIV services. This is particularly the case for populations that are already socially marginalized, such as sex workers, injecting drug users, and MSM.

Human rights that are important in the context of HIV include:

- Rights to comprehensive HIV prevention, treatment, care, and support services;
- Rights to non-discrimination, including in healthcare services, housing, and work;
- Rights of all to equality under laws, policies, and programs (women and girls in particular);
- Rights of children to education and the services necessary for health and life;
- Rights to privacy (including sexual privacy), confidentiality of HIV status, and informed consent to HIV testing;
- Rights to liberty, freedom of movement, and protection against arbitrary and oppressive laws and policies;
- Rights to security of the person and freedom from violence, including gender-based violence; and
- Rights of PLHIV and those vulnerable to HIV to participate in planning and delivery of programs affecting their lives.



USAID | HEALTH POLICY INITIATIVE
FROM THE AMERICAN PEOPLE



Examples of Advocacy Leading to Policy Change



Examples: Advocacy Leading to Policy Change



Left: Billboard from USAID-funded media campaign to reduce stigma and discrimination (at major intersection in Kathmandu, Nepal), depicting a famous Nepali actress. Courtesy of the POLICY Project, Constella Futures.

Right: Chinese leaders bringing HIV and AIDS issues into the open. Premier Wen Jai Bao greets a member of the PLHIV community. Courtesy of Xinhua News Agency.

Advocacy with the Nepal Police: Behind the Scenes



Examples of Advocacy Leading to Policy Change • Slide 3

Issues Facing Vulnerable Groups

Men who have sex with men (MSM)

- Risks associated with clients
- Verbal, physical, mental, and sexual harassment/violence
- Extortion
- Arrested for carrying condoms

Injecting drug users (IDUs)

- Regarded as criminals
- Harassment
- Extortion
- Arrested for carrying needles

Sex workers

- Risks associated with clients
- Sexual harassment and violence
- Extortion
- Arrested for carrying condoms

Supportive Information

- Newspaper clippings
- Interviews with nongovernmental organizations working with vulnerable groups
- Focus group discussions with vulnerable groups
- Behavioral surveillance
- Sex workers documentation of violence by Nepal Police



Target Audience

- Secretary and other senior-level officials of the Ministry of Home Affairs
- Policymakers within Nepal Police—Inspector General Police (IGP), Assistant IGP, Deputy IGP)
- Police officers



Audience Analysis

Why do police behave this way?

- Lack of understanding of HIV and AIDS
- Lack of understanding about vulnerable groups (especially in lower ranks)
- Conflicting viewpoints between the Ministry of Health and Ministry of Home Affairs
- Social norms



Audience Analysis

How do you best bring about change?

- Top-to-bottom approach works in uniformed services!
- If leaders set an example... the changes can easily be achieved!



First Steps to Building Support

Initial Personal Meetings

- High-level police officers
- Ministry of Home Affairs
- Nepal Police IGP



First Steps to Building Support

Framing the Message

- Actions will protect police, vulnerable groups, and society



Commitment of Nepal Police Secured

Solutions identified to protect Nepal Police and vulnerable groups from HIV:

- Develop HIV and AIDS strategy for the Nepal Police
- Develop and integrate HIV issues into the regular training program
- Sensitize police, involving vulnerable groups
- Organize exposure trips with police officials
- Form an HIV/AIDS advisory committee to coordinate and monitor future Nepal Police programs



Appropriate and Ongoing Advocacy Methods

- Personal meetings
- Nepal Police leaders take initiative, with ongoing capacity building and support
- Orientation meetings
- National and international exposure trips
- Dialogue and interaction with vulnerable groups



Appropriate and Ongoing Advocacy Methods

- Integration of HIV and AIDS issues into Nepal Police training programs
- Sensitization programs, involving vulnerable groups
- Attendance of police at vulnerable groups' advocacy events and forums



Sex Workers Dialogue with Senior Police Officers: “Advocacy for Change” Training



Courtesy of the POLICY Project, Constella Futures.



**Example:
Sex Worker Message to Police Deputy Inspector General****Statement:**

Sex workers should not be abused or arrested if they have condoms with them.

Evidence:

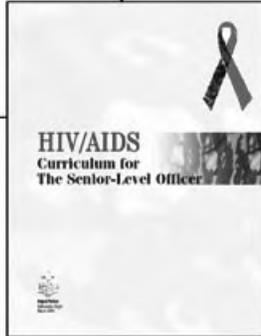
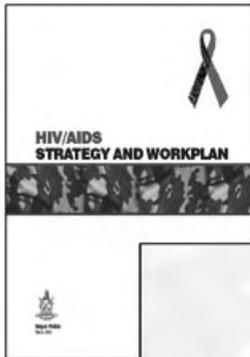
On March 10, after police stopped Sita and found that she was carrying condoms, Sita was arrested in Thamel, taken into custody, and badly abused.

Solution:

Please issue an ordinance not to arrest women carrying a condom as evidence of sex work and not to abuse women when in custody.



Nepal Police IGP Launches Nepal Police Strategy and Curriculum



Courtesy of the POLICY Project, Constella Futures.

New Recruits Interact with Vulnerable Groups to Learn How They Can Make a Difference



Courtesy of the POLICY Project, Constella Futures.



Conclusion

The carefully planned and implemented advocacy campaign led to:

- An HIV/AIDS Strategy and Workplan for Nepal Police
- An HIV/AIDS training curriculum for senior-level police
- Communication between police and vulnerable groups



Conclusion

- Reduced harassment of sex workers
- Ceased practice of using condom possession as evidence of sex work
- Improved effectiveness of HIV prevention programs

Advocacy for policy change positively impacted the lives of sex workers in Nepal and improved HIV prevention programs for sex workers and clients





USAID | HEALTH POLICY INITIATIVE
FROM THE AMERICAN PEOPLE



Examples of Advocacy Leading to Policy Change



Examples of Advocacy Leading to Policy Change • Slide 1

NOTES:

Examples: Advocacy Leading to Policy Change



Left: Billboard from USAID-funded media campaign to reduce stigma and discrimination (at major intersection in Kathmandu, Nepal), depicting a famous Nepali actress. Courtesy of the POLICY Project, Constella Futures.

Right: Chinese leaders bringing HIV and AIDS issues into the open. Premier Wen Jai Bao greets a member of the PLHIV community. Courtesy of Xinhua News Agency.



Examples of Advocacy Leading to Policy Change • Slide 2

NOTES:

Advocacy with the Nepal Police: Behind the Scenes



Examples of Advocacy Leading to Policy Change • Slide 3

NOTES:

Issues Facing Vulnerable Groups

Men who have sex with men (MSM)

- Risks associated with clients
- Verbal, physical, mental, and sexual harassment/violence
- Extortion
- Arrested for carrying condoms

Injecting drug users (IDUs)

- Regarded as criminals
- Harassment
- Extortion
- Arrested for carrying needles

Sex workers

- Risks associated with clients
- Sexual harassment and violence
- Extortion
- Arrested for carrying condoms

Examples of Advocacy Leading to Policy Change • Slide 4

NOTES:

Supportive Information

- Newspaper clippings
- Interviews with nongovernmental organizations working with vulnerable groups
- Focus group discussions with vulnerable groups
- Behavioral surveillance
- Sex workers documentation of violence by Nepal Police



A² Concepts • Slide 5

NOTES:

Target Audience

- Secretary and other senior-level officials of the Ministry of Home Affairs
- Policymakers within Nepal Police—Inspector General Police (IGP), Assistant IGP, Deputy IGP)
- Police officers



Examples of Advocacy Leading to Policy Change • Slide 6

NOTES:

Audience Analysis

Why do police behave this way?

- Lack of understanding of HIV and AIDS
- Lack of understanding about vulnerable groups (especially in lower ranks)
- Conflicting viewpoints between the Ministry of Health and Ministry of Home Affairs
- Social norms



Examples of Advocacy Leading to Policy Change • Slide 7

NOTES:

Audience Analysis

How do you best bring about change?

- Top-to-bottom approach works in uniformed services!
- If leaders set an example... the changes can easily be achieved!



Examples of Advocacy Leading to Policy Change • Slide 8

NOTES:

First Steps to Building Support

Initial Personal Meetings

- High-level police officers
- Ministry of Home Affairs
- Nepal Police IGP



Examples of Advocacy Leading to Policy Change • Slide 9

NOTES:

First Steps to Building Support

Framing the Message

- Actions will protect police, vulnerable groups, and society



Examples of Advocacy Leading to Policy Change • Slide 10

NOTES:

Commitment of Nepal Police Secured

Solutions identified to protect Nepal Police and vulnerable groups from HIV:

- Develop HIV and AIDS strategy for the Nepal Police
- Develop and integrate HIV issues into the regular training program
- Sensitize police, involving vulnerable groups
- Organize exposure trips with police officials
- Form an HIV/AIDS advisory committee to coordinate and monitor future Nepal Police programs



Examples of Advocacy Leading to Policy Change • Slide 11

NOTES:

Appropriate and Ongoing Advocacy Methods

- Personal meetings
- Nepal Police leaders take initiative, with ongoing capacity building and support
- Orientation meetings
- National and international exposure trips
- Dialogue and interaction with vulnerable groups



Examples of Advocacy Leading to Policy Change • Slide 12

NOTES:

Appropriate and Ongoing Advocacy Methods

- Integration of HIV and AIDS issues into Nepal Police training programs
- Sensitization programs, involving vulnerable groups
- Attendance of police at vulnerable groups' advocacy events and forums



Examples of Advocacy Leading to Policy Change • Slide 13

NOTES:

Sex Workers Dialogue with Senior Police Officers: “Advocacy for Change” Training



Courtesy of the POLICY Project, Constella Futures.



Examples of Advocacy Leading to Policy Change • Slide 14

NOTES:

Example: Sex Worker Message to Police Deputy Inspector General

Statement:

Sex workers should not be abused or arrested if they have condoms with them.

Evidence:

On March 10, after police stopped Sita and found that she was carrying condoms, Sita was arrested in Thamel, taken into custody, and badly abused.

Solution:

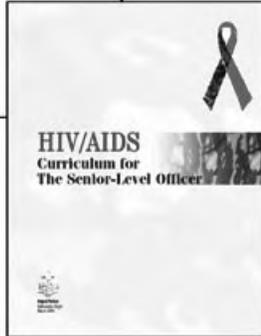
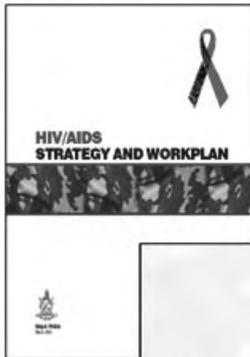
Please issue an ordinance not to arrest women carrying a condom as evidence of sex work and not to abuse women when in custody.



Examples of Advocacy Leading to Policy Change • Slide 15

NOTES:

Nepal Police IGP Launches Nepal Police Strategy and Curriculum



Courtesy of the POLICY Project, Constella Futures.



Examples of Advocacy Leading to Policy Change • Slide 16

NOTES:

New Recruits Interact with Vulnerable Groups to Learn How They Can Make a Difference



Courtesy of the POLICY Project, Constella Futures.



Examples of Advocacy Leading to Policy Change • Slide 17

NOTES:

Conclusion

The carefully planned and implemented advocacy campaign led to:

- An HIV/AIDS Strategy and Workplan for Nepal Police
- An HIV/AIDS training curriculum for senior-level police
- Communication between police and vulnerable groups



Examples of Advocacy Leading to Policy Change • Slide 18

NOTES:

Conclusion

- Reduced harassment of sex workers
- Ceased practice of using condom possession as evidence of sex work
- Improved effectiveness of HIV prevention programs

Advocacy for policy change positively impacted the lives of sex workers in Nepal and improved HIV prevention programs for sex workers and clients



Examples of Advocacy Leading to Policy Change • Slide 19

NOTES:



USAID | HEALTH POLICY INITIATIVE
FROM THE AMERICAN PEOPLE



What Is Particular to HIV-Related Advocacy?



What Is Particular to HIV-Related Advocacy? • Slide 1

What Is Particular to HIV-Related Advocacy?

Stigma and discrimination:

- Often reflects social taboos associated with behaviors that can transmit HIV (e.g., injecting drug use, sex between men)
- Affects how governments and communities respond to the epidemic

Effective responses to the epidemic require us to address stigma and discrimination through policies and programs



What Is Particular to HIV-Related Advocacy? • Slide 2

What Is Particular to HIV-Related Advocacy?

A common perception among the public that AIDS is an incurable, terminal illness:

- Has led to fear of people living with HIV (PLHIV)
- Has influenced the way in which governments respond to the epidemic with appropriate policies and programs



What Is Particular to HIV-Related Advocacy?

Urgent action is needed:

- Time wasted fuels the epidemic
- Inaction leads to more deaths of PLHIV, whose knowledge and experience are vital to effective responses

What Is Particular to HIV-Related Advocacy?

The GIPA Principle:

- Defined as the “Greater Involvement of People Living with HIV/AIDS”
- People living with and affected by HIV should be involved in all aspects of the response to the epidemic
- Not only medical and scientific knowledge determine effective responses to HIV
- Causes of HIV vulnerability are multidimensional; can only be fully understood through the involvement of PLHIV



What Is Particular to HIV-Related Advocacy?

Risks associated with public exposure include:

- Violence
- Discrimination
- Harassment
- Loss of employment
- Social ostracism
- Rejection by family and community

PLHIV involvement does not require public disclosure of HIV status – organizations need to ensure confidentiality

What Is Particular to HIV-Related Advocacy?

HIV is a global issue with global infrastructure. Advocacy groups exist in hundreds of countries and globally:

- Always identify existing networks and alliances
- Use regional networks, e.g., “Seven Sisters” representing APCASO, APNSW, APN+, AP Rainbow, ASAP, AHRN, and CARAM Asia



What Is Particular to HIV-Related Advocacy? • Slide 7

What Is Particular to HIV-Related Advocacy?

Intergovernmental and multilateral forums:

- UNGASS Declaration
- Universal Access goal
- ICASO Guide to using the UNGASS Declaration
- Asia-Pacific Leadership Forum
- ASEAN Task Force on AIDS

What Is Particular to HIV-Related Advocacy?

Respect for human rights:

- Reduces vulnerability
- Mitigates impact
- Takes into account pre-existing social marginalization of many vulnerable populations





USAID | HEALTH POLICY INITIATIVE
FROM THE AMERICAN PEOPLE



What Is Particular to HIV-Related Advocacy?



What Is Particular to HIV-Related Advocacy? • Slide 1

NOTES:

What Is Particular to HIV-Related Advocacy?

Stigma and discrimination:

- Often reflects social taboos associated with behaviors that can transmit HIV (e.g., injecting drug use, sex between men)
- Affects how governments and communities respond to the epidemic

Effective responses to the epidemic require us to address stigma and discrimination through policies and programs



What Is Particular to HIV-Related Advocacy? • Slide 2

NOTES:

What Is Particular to HIV-Related Advocacy?

A common perception among the public that AIDS is an incurable, terminal illness:

- Has led to fear of people living with HIV (PLHIV)
- Has influenced the way in which governments respond to the epidemic with appropriate policies and programs



What Is Particular to HIV-Related Advocacy? • Slide 3

NOTES:

What Is Particular to HIV-Related Advocacy?

Urgent action is needed:

- Time wasted fuels the epidemic
- Inaction leads to more deaths of PLHIV, whose knowledge and experience are vital to effective responses



What Is Particular to HIV-Related Advocacy? • Slide 4

NOTES:

What Is Particular to HIV-Related Advocacy?

The GIPA Principle:

- Defined as the “Greater Involvement of People Living with HIV/AIDS”
- People living with and affected by HIV should be involved in all aspects of the response to the epidemic
- Not only medical and scientific knowledge determine effective responses to HIV
- Causes of HIV vulnerability are multidimensional; can only be fully understood through the involvement of PLHIV



What Is Particular to HIV-Related Advocacy? • Slide 5

NOTES:

What Is Particular to HIV-Related Advocacy?

Risks associated with public exposure include:

- Violence
- Discrimination
- Harassment
- Loss of employment
- Social ostracism
- Rejection by family and community

PLHIV involvement does not require public disclosure of HIV status – organizations need to ensure confidentiality



What Is Particular to HIV-Related Advocacy? • Slide 6

NOTES:

What Is Particular to HIV-Related Advocacy?

HIV is a global issue with global infrastructure. Advocacy groups exist in hundreds of countries and globally:

- Always identify existing networks and alliances
- Use regional networks, e.g., “Seven Sisters” representing APCASO, APNSW, APN+, AP Rainbow, ASAP, AHRN, and CARAM Asia



What Is Particular to HIV-Related Advocacy? • Slide 7

NOTES:

What Is Particular to HIV-Related Advocacy?

Intergovernmental and multilateral forums:

- UNGASS Declaration
- Universal Access goal
- ICASO Guide to using the UNGASS Declaration
- Asia-Pacific Leadership Forum
- ASEAN Task Force on AIDS



What Is Particular to HIV-Related Advocacy? • Slide 8

NOTES:

What Is Particular to HIV-Related Advocacy?

Respect for human rights:

- Reduces vulnerability
- Mitigates impact
- Takes into account pre-existing social marginalization of many vulnerable populations



What Is Particular to HIV-Related Advocacy? • Slide 9

NOTES:

SECTION III: Identifying Advocacy Issues and the Role of Data

- Content:**
- Activity 1 — Key HIV and AIDS Issues in Asia
 - Activity 2 — Introduction to Data Analysis
 - Activity 3 — Introduction to Data Analysis in the A² Project
 - Activity 4 — Analyzing Secondary Data I: Behavioral and Epidemiological Data
 - Activity 5 — Analyzing Secondary Data II: Program and Policy Responses
- Purpose:**
- This session is designed to familiarize participants with the role of data in advocacy, the types of data that will be available through the A² process, and the key processes for moving from analyzing data to identifying advocacy issues.
- Objectives:** By the end of this unit, participants will be able to
- Understand different types (qualitative and quantitative) and sources (primary and secondary) of data;
 - Identify important factors regarding the quality of data;
 - Recognize that primary data collection may be needed as part of an advocacy campaign;
 - Understand the key types of data synthesized and generated by the A² process; and
 - Analyze data to identify issues that require policy actions or solutions (i.e., advocacy issues).

Activity 1 — Key HIV and AIDS Issues in Asia

Time: 30 minutes

Materials: Colored paper, markers, tape, computer, projector, display screen

Prepared Materials:

PPT: HIV and AIDS in Asia: Key Issues

Flipchart: N/A

Other: N/A

Handouts: Background Notes, PowerPoint presentation

- Objectives:**
- To identify the various ways that advocacy issues can be identified (including through the use of data).
 - To gain familiarity with key HIV and AIDS advocacy issues in Asia.

Background Notes:

In 2004, Asia was home to 60 percent of the world's population and 19 percent of the people living with HIV (PLHIV). HIV prevalence rates are low in Asia compared with some other continents, particularly Africa, but because the populations of many Asian countries are so large, HIV infections add up to a large number in absolute terms: approximately 5.2 million men, 2 million women, and 168,000 children are living with HIV, according to estimates from World Health Organization (WHO) and the Joint United Nations Program on HIV/AIDS (UNAIDS).¹

The earliest cases of HIV in Asia were reported in 1984 and 1985. The potential for widespread epidemics was not appreciated until the early 1990s, however, with the more extensive spread of HIV in Cambodia, Myanmar, Thailand, and parts of India. Today, these countries have the highest adult HIV prevalence in the region. By contrast, Bangladesh, Laos, and the Philippines have much lower rates. China, Indonesia, Nepal, and Viet Nam, have epidemics in transition, characterized by recent increases in HIV infection rates, some in particular populations, after an extended period of low prevalence.

Despite strong evidence that the HIV epidemic is spreading, national responses in most countries remain weak. Surveillance systems are inadequate, with only limited coverage of geographic and at-risk populations.

The following are summary points from an article, published by the East-West Center,² which addressed three key questions:

1. What drives Asian epidemics, and why are there major differences among countries across the region?
2. In what direction are these epidemics likely to move if prevention efforts are not strengthened?
3. What can be done to stop the growth of the epidemics?

¹ Pisani, E. 2004. AIDS in Asia: Face the Facts—A Comprehensive Analysis of the AIDS Epidemics in Asia. Washington, DC: Monitoring the AIDS Pandemic (MAP) Network.

² East-West Center (EWC). 2004. "Tackling the HIV/AIDS Epidemic in Asia." Asia-Pacific Population and Policy No 68. EWC, Population and Health Studies. Accessible at <http://www.eastwestcenter.org>.

What Drives Asian Epidemics?

The situation in Asia is characterized almost entirely by multiple interrelated epidemics among key most-at-risk populations and their immediate sexual partners. These populations include

- 1. Injecting drug users (IDUs).** Epidemics among IDUs have played an important role in the spread of the virus in many countries, such as China, Viet Nam, and Malaysia.
- 2. Men who have sex with men (MSM).** This population group largely has been ignored by HIV programs in Asia, but recent surveys in many countries have found prevalence 10 to 20 times the national prevalence among groups of MSM. For example, in Bangkok, a prevalence rate of 28 percent among MSM has been found, while national prevalence is only 1.3 percent. Small-scale surveys in other countries such as Cambodia also indicate that this population is at heightened risk of HIV infection.
- 3. Sex workers and clients.** This is by far the largest component of the HIV epidemic in Asia, and the source of many female and most male infections.
- 4. Married women.** The epidemic also is affecting the female partners of men at high risk of infection. More than three-fourths of the women in Asia who have become infected with HIV do not engage in high-risk behavior by conventional definitions. They have contracted HIV through sex with their husbands.

Clients of Sex Workers

The term “general population spread” (as in the boyfriend-girlfriend transmission dominant in Africa) does not apply in most Asian countries because female sexuality tends to be constrained. But the concentration of HIV in most-at-risk populations and their immediate partners does not mean that Asian epidemics will remain at low levels.

The percentage of adults in Asian countries who may be at risk of HIV is between 5 and 15 percent when the numbers of men who visit sex workers and those men’s wives are added to the smaller numbers of sex workers, MSM, and IDUs.

Links between Risk Factors

Growth of the epidemic can be greatly accelerated by the linkages between sub-epidemics among sex workers and their clients and among IDUs and MSM. Behavioral studies in several countries have shown that anywhere from one-third to three-quarters of IDUs visited a sex worker in the previous year. Some IDUs sell sex, some sex workers use injecting drugs, and some MSM also visit female sex workers. As a result of these interrelationships among at-risk populations, growth of the epidemic is accelerated, driving up the national epidemic growth rate.

What Will Work in Asia?

Thailand and Cambodia offer good examples of what can be accomplished with a well-targeted prevention program. Both countries identified sex work as the key source of new infections, and both governments mounted pragmatic and well-funded campaigns aimed at clients and sex workers—warning of the risks involved in sex work and encouraging condom use. In both countries, the number of sex workers and clients went down by more than half in a 3–4 year period. Both countries also reported that condom use in sex work increased to 90 percent or above. As a result, HIV prevalence rates have fallen in virtually all surveillance groups.

To be successful, prevention programs must be implemented with high levels of coverage. Yet, many political leaders find it difficult to acknowledge the level of HIV risk in their own societies. They may find it even more difficult to work with the stigmatized population groups who can help halt the epidemic—sex workers and their clients, IDUs, MSM, and PLHIV.

When it comes to addressing issues of sex and illicit drug use, most Asian countries face considerable religious and political resistance, which will take time to overcome. Access to the key most-at-risk populations in most countries is limited, and building bridges to these groups also will take time.

Prevention efforts must adapt continuously if they are to stay relevant. Even in the countries widely viewed as having responded successfully to their HIV epidemic, there are major gaps. For many years, neither Thailand nor Cambodia addressed risk among MSM, despite measured HIV prevalence rates of about 7–28 percent among this group in both countries. In Thailand, HIV prevention programs for IDUs are ineffective and coverage is limited. Furthermore, little has been done to address the increasing number of infections occurring within marriage as current and former clients of sex workers infect their wives.

The stakes are high. If HIV prevalence reaches even 2–3 percent in Asian countries, there will be a tremendous care burden. Despite Thailand's successful prevention efforts, more than 1 million Thais have been infected with HIV, and 450,000 people have died. Even at these prevalence levels, it is estimated that antiretroviral therapy will place a financial demand of \$400–500 million annually, at current drug prices, on the Thai government over the next decade.

Donors, governments, and other organizations must advocate for and support appropriate, pragmatic, and effective responses. This means creating or sustaining programs that focus on behaviors that make some people uncomfortable—sex work, injecting drug use, and male-male sex. Addressing these risk behaviors today is the only way to prevent HIV transmission in the future—both for particular at-risk groups and for the rest of the population.

Asian governments, for their part, must anticipate care needs and provide compassionate, nondiscriminatory, and appropriate care for people living with HIV and AIDS. At the same time, they must build up and maintain focused prevention programs. Societies in Asia will bear much greater costs tomorrow, both in human and financial terms, should they fail to prevent expansion of the HIV epidemic today.

Introduction:

- **Introduce** the session by reviewing the objectives.
- **Explain** that the goal of this session is for participants to start identifying a list of advocacy issues important to their countries and the region.
- **Refer** back to the steps in the advocacy process, and ask participants to draw on those discussions and their own experiences and observations to answer the question: “How do advocacy issues get identified?”
- **Highlight** that advocacy issues are often identified through a combination of data collected on specific aspects of the epidemic, a review of existing evidence on an issue, and people's own experiences and understanding of what is most important (and feasible) to address at a particular time.
- **Note** that for the purposes of the A² project, using evidence to identify advocacy issues is a key step. In this session, participants will focus on using data as a key resource for identifying advocacy issues.

Activity Instructions:**Step 1: Brief Lecture**

Time: 15 minutes

1. **Present** the PowerPoint presentation and make the following points:
 - There are common features of HIV and AIDS epidemics in Asian countries that distinguish them from those in other parts of the world, such as Africa.
 - Common features of Asian epidemics include the concentration of HIV in most-at-risk populations of sex workers, IDUs, and MSM; and their immediate partners.
 - The fact that epidemics are concentrated does not mean that they are or will remain small. Absolute numbers affected depend on the size of most-at-risk populations, which in Asian countries, may be large by world standards.
 - The growth of epidemics can be greatly accelerated by linkages between sub-epidemics among most-at-risk populations. For example, some IDUs are clients of sex workers. Some sex workers use injecting drugs. Some MSM also have sex with women. Many clients of sex workers are married or also have non-commercial sex partners.
 - There are successful examples of focused prevention, such as programs targeting the sex industry in Thailand.
 - As a result of HIV-related stigma and discrimination, many political leaders find it difficult to acknowledge the level of HIV risk in their own societies, and may find it even more difficult to work with the stigmatized population groups who can help to halt the epidemic—clients and sex workers, IDUs, and MSM.
 - When it comes to addressing issues of sex and drugs, many Asian countries face considerable resistance from political and religious leaders.
 - Prevention efforts must adapt continually if they are to remain relevant; for example, neither Thailand nor Cambodia has addressed risk among MSM until recently, resulting in HIV prevalence rates of up to 28 percent in one survey of MSM in Bangkok, for example. In many countries, programs for IDUs are limited and ineffective, and little has been done to address the increasing number of infections occurring within marriage as current and former male clients of sex workers infect their wives.

Step 2: Brainstorm Key Issues by Participants

Time: 15 minutes

1. **Ask** participants to identify key HIV-related issues in their national/provincial contexts.
2. **Record** their responses on the flipcharts. If the participants come from different areas, record their responses separately, according to the country or province.



Reminder to Facilitator: Save flipchart pages that record these identified issues for use later when participants practice prioritizing issues.

Activity 2 — Introduction to Data Analysis

Time: 50 minutes

Materials: Flipchart, markers

Prepared Materials:

PPT: N/A

Flipchart: Quote (Step 1)

Other: N/A

Handouts: Background Notes, Data Scenario Handouts

- Objectives:**
- To articulate the benefits and limitations of using data to identify advocacy issues and move advocacy agendas forward.
 - To understand the differences between qualitative vs. quantitative and primary vs. secondary data.
 - To be aware of issues concerning data quality.

Background Notes:

To be effective advocates for HIV and AIDS issues, policymakers, advocates, and advocacy networks must understand and accurately represent the dynamics and impact of the HIV epidemic—and the needs, priorities, and interests of their constituencies. In some situations, advocates need to collect and obtain information and analyze it to produce reliable estimates of the current epidemic, as well as its future course; in other cases, they may need to understand the extent and effectiveness of responses to date and then identify priority advocacy issues for improving the response to the epidemic and mitigating its impact. Data gathering and analysis also involves getting to know communities and affected groups to find out how current HIV and AIDS policies and programs affect them, as well as their understanding of what changes are needed in the policy and program environments. It does not make sense, for example, to develop an advocacy campaign in support of an HIV and AIDS drop-in center at a local school for youth if the epidemic mostly affects out-of-school youth or clients of sex workers in the 30–39 age group. The more information and data advocates possess, the more realistic and representative their policy demands will be.

When creating a data collection and analysis plan, advocates should consider their own information needs, as well as those of policymakers. Advocates need to be strategic in the data they collect and in how they analyze that data. Which data will help them truly understand and clarify issues, and which data will best strengthen capacity to design and implement better programs and policies? Whenever possible, efforts to involve affected communities in data collection and analysis should be seen as part of a long-term process of relationship and capacity building with community groups and should be designed to increase community members' own understanding and ability to use the data for advocacy, while broadening awareness of the epidemic in the community. It also is important to estimate the costs in time and effort of collecting and analyzing various data and to weigh the benefits against those costs.

In short, data are tools that can be used to identify key advocacy issues—and to present and explain these issues to policymakers. This session focuses on different types of data that can be collected and analyzed to understand the epidemic, the effectiveness of responses to the epidemic, and community needs and priorities.

Data Sources

Primary and secondary data

Understanding the HIV epidemic, its impact, and the effectiveness of current national and community responses may require collecting different kinds of data. Some may be available already, while other kinds of data may need to be collected for the first time. Advocates can sometimes gain access to already available data to do secondary data analyses. If important data are not available already, advocates may need to obtain the information firsthand or do primary data collection.

Primary data are collected directly by individuals, organizations, or government agencies through the use of surveys, focus groups, or interviews. The information collected is then compiled, entered into databases, analyzed, and disseminated in reports and documents.

Secondary data have already been collected and are available as files, databases, or documents for others to re-analyze or review. The Behavioral Surveillance Survey (BSS) and the UNAIDS Periodic Reports are examples of secondary data that are available to advocates, policymakers and others. Organizations also often have collected data that advocates can obtain and use for secondary data analysis.

Qualitative and quantitative data

Data can be collected by using qualitative or quantitative methods, or a combination of both. Each kind of data must be collected using specific methods. Each method has its strengths and weaknesses; data are often most comprehensive when a combination of the two methods is used.

Qualitative data are descriptive or narrative texts that describe behavior and institutions by conveying impressions, opinions, values, rituals, beliefs, and emotions. They provide information on what people think, feel, and do, using their own words. For example, what does a national AIDS program mean to people in the community, how did people feel when they had to undergo compulsory testing, or what did pregnant HIV-positive women feel when clinic staff chided them for putting their unborn babies at risk? Qualitative data also describe processes and often answer questions about how or why something happened. For example, how do MSM in a rural community obtain information about their specific health needs and concerns? Qualitative data are collected through various methods, including interviews and observations, or by using direct quotes or discussions.

One of the advantages of qualitative data is that they offer detailed, rich, and in-depth information. However, qualitative data are usually collected from a small number of individuals and thus cannot be used to make generalizations about entire populations or large groups of people.

Quantitative data measure amounts or degrees. They give us information in terms of numbers, such as the number of children under five who are orphans or otherwise made vulnerable by HIV in a certain province, or the average number of years of education of members of a post-test club support group. They also provide numeric estimates of what segment of a population would have a specific characteristic—for example, the percentage of HIV-positive adults ages 15–49.

When large amounts of quantitative data are collected, they can be used to make comparisons between groups and do more complex data analyses. However, one of the disadvantages of quantitative data is that important contextual information or subtle nuances can be missed. For example, a survey can reveal the number or percentage of those interviewed who have been tested

for AIDS, but these figures do not indicate what people felt during and after testing or the details of how and why certain people did or did not choose to be tested. Such information is critical to the design of effective prevention and care efforts.

Thoroughly understanding a situation requires use of both forms of data. Properly collected quantitative data gives population-representative answers to important questions such as the magnitude of the HIV problem, the number of people with a specific risk behavior, or an indication of the distribution of important reasons why some people do not use condoms. However, designing effective programs requires more than just a numerical understanding of the issues. We must know why people engage in risk behavior, what circumstances or situations predispose them to risk, how they perceive their own risk of HIV, or what factors make it difficult for them to negotiate condom use with partners—that is, we must know the context in which the behaviors occur and which prevention and care programs must be mounted. Only when both magnitude and context are understood and taken into account will programs reach maximum effectiveness.

Data Quality

For data to be persuasive and help advocates and policymakers understand a situation, they need to be of high quality. It is important to evaluate data that are collected and analyzed to ensure that they are valid, reliable, and unbiased. Policies or programs that use invalid, unreliable, or biased data—or data that have important gaps—are unlikely to improve HIV and AIDS prevention, care, or support services and interventions. The data are also likely to be disregarded and the conclusions based on them rejected by decisionmakers should the quality issues become known.

Reliability refers to whether a measurement (or a method for collecting data) gives the same result when it is repeated over time for the same situation.

For example, at a presentation of a country's recent maternal and child health survey data, network members were shown data on HIV infection in all children 18 months of age tested at the national pediatric hospital outpatient clinic: results showed that, at baseline, 12 percent of this group of children were infected with HIV; at three months it was 25 percent, and at six months, results came back as 6 percent. Given the broad fluctuations in the percent of children infected, the testing methodology is not likely being done correctly or reliably.

Validity refers to how well a measurement (or a method for collecting data) actually reflects what you are hoping to understand.

For example, an advocacy group wants to focus on decreasing the number of new HIV infections among adolescent girls ages 15–21 whose boyfriends or husbands are using injecting drugs. The group found a survey assessing adolescent girls' knowledge and attitudes about reproductive health. While the survey does focus on girls' reproductive health, it does not include information specific to HIV transmission. The general adolescent health survey would not be a valid measure of specific knowledge and attitudes about HIV or IDU risk behavior.

Bias refers to a systematic distortion in the measurement (or the method for collecting data).

For example, an advocacy group wants to understand the HIV needs of MSM in their country. They have been able to access recent surveillance data for MSM, but the research was conducted only in the capital city. The information collected in this case would be biased toward the experiences of men living in urban areas and thus would not be representative of all MSM in the country.

Introduction:

Time: 5 minutes

- **Remind** participants that data collection and analysis are activities that inform the entire advocacy process. Briefly review how data inform the different steps of the advocacy process, which include
 - Deciding what specific issue to target for advocacy;
 - Analyzing the knowledge and attitudes that specific target audiences possess regarding a specific issue;
 - Developing appropriate messages;
 - Tracking support for an advocacy campaign; and
 - Monitoring and evaluating the campaign.
- **Explain** that for the purposes of this session, activities are focused on how groups can use data to help identify key advocacy issues.
- **Highlight** that one of the key activities for groups with access to a lot of data is to interpret what the data mean in terms of key messages, especially regarding appropriate policy and program responses.
- **Review** the session's overall set of objectives and accompanying activities.



Final Note: When initiating a data collection and analysis activity, a group should take into account its own information needs and those of the relevant policymakers. Determining the time, money, and skilled human resources needed to collect, analyze, and present the most necessary data will affect the kind and amount that can be collected realistically.

Step 1: Use and Limits of Data in Advocacy

Time: 5 minutes

“I’ve made up my mind; don’t confuse me with the facts.”
(quoting a U.S. Senator)

1. Use the quote above, posted on a flipchart, and lead a discussion:

- What is the quote saying?
- What does the quote suggest about the role of data in policymaking?

Some points might include the following:

- Decisionmakers do not necessarily rely on evidence when reaching a decision.
 - Data may be presented in ways that are not clear or not clearly related to the action sought from decisionmakers.
 - While data can be crucial in identifying effective responses to the epidemic and in providing persuasive arguments for identified responses, evidence alone does not build political will or result in action.
 - To increase the likelihood of data being able to inform the development of policies and programs, they need to be analyzed and presented in ways that clearly point to key issues and the actions that policymakers and program staff can take.
2. **Note** that another unit of the training will look at how advocates determine priorities for advocacy activities—and whether the issue makes it on to the agenda of decisionmakers. Note that data can play an important role in persuading decisionmakers to act, but that data alone are unlikely to result in action. Also note that a later module in the training will focus on how best to present evidence, including data, in advocacy messages.
 3. **Reaffirm** that data nevertheless are crucial for advocates and those responsible for policies and programs to be able to identify issues. Data also are crucial for advocates to persuade decisionmakers to act in ways that improve the effectiveness of the response to HIV and AIDS. Key steps in using data in advocacy are identifying what data are available in relation to a particular issue and understanding what they can tell us about how to address the issue.

Step 2: Kinds of Data and Data Sources

Time: 20 Minutes

1. **Introduce** this step by explaining that it is important for participants to have a shared understanding of key terms and concepts related to data collection.
2. **Write** “Qualitative” and “Quantitative” as column headings on a sheet of colored paper.
3. **Ask** several participants to explain briefly the differences between the two types of data.
4. **Ask** the group to list the characteristics of the different types of data, with a focus on what types of information qualitative and quantitative data tend to provide.

Qualitative Data Characteristics	Quantitative Data Characteristics
<ul style="list-style-type: none"> • Descriptive, narrative • Seeks to answer the question “why” • Focuses on processes • Encourages in-depth probing • Records participants’ emotions, feelings, perceptions, attitudes, and motivation • Enables the researcher to study selected cases, issues, or events in depth • Uses small, purposive samples 	<ul style="list-style-type: none"> • Quantifiable, deals with numbers • Seeks to establish “how many” • Focuses on measuring discrete/ predetermined indicators of knowledge, behavior (actions), attitudes • Examines the relationships between variables and trends • Facilitates the use of statistics for aggregating, summarizing, and comparing data • Depending on the sample size, allows for broad generalizations of findings to larger populations

5. **Ask the full group** to identify data collection methods for each category of data. Write the various responses under the appropriate heading. Note that some types of data collection methods can be used to gather types of data.

Qualitative Data Sources	Quantitative Data Sources
<ul style="list-style-type: none"> • Narrative documents • Focus groups • Key informant interviews • Observations • Surveys/interviews with open-ended sections 	<ul style="list-style-type: none"> • HIV surveillance data • Behavioral surveillance data • Demographic Health Surveys • Other sample surveys

6. **Review** with participants a second set of terms: “primary” and “secondary” data. Note that primary data are collected directly for an activity, whereas secondary data are obtained from data sets or documents that already exist. Note that all of the data sources listed above could be collected either primary or secondary data. Check with the group to see if they are familiar with the terms or have any questions.
7. **Ask** the group to consider: What are the strengths and weaknesses of qualitative and quantitative data? Note that, methodologically, the two types of data collection complement each other and are often used iteratively; in other words, qualitative data collection helps to identify key issues that can be investigated on a larger scale through the collection of quantitative data. In turn, when there are questions about relationships among quantitative findings, qualitative data collection may help to answer them.
8. **Also ask:** What are some of the strengths and weaknesses of each type of data in the context of advocacy for policy change? Note that, in advocacy, concrete numbers that can be generalized to a larger number of people and that show clear trends can have a powerful impact on policymakers; they can help officials understand the large-scale effects of taking action. Nevertheless, being able to show what such numbers mean to individual people and communities is also crucial; for this, qualitative evidence is invaluable.

9. **Conclude** by asking participants: Which techniques do you have experience in using? Which techniques do you think you could undertake most easily? What issues should you take into consideration before deciding to collect data or choosing which technique(s) to employ? For example, what are the group's data needs? Do data already exist? How much time would be needed to collect relevant data? How costly is it? Does the group have the skills to design and carry out the data collection activity? Will the activity have other benefits, such as building new and important skills among the group members or building relationships with others for advocacy activities (your own constituents or potential allies, for example)?

Step 3: Data Quality

Time: 20 minutes

1. **Explain** that in addition to advocates needing to understand potential sources of data, they also need to understand key issues related to data quality. Being able to identify quality issues associated with data sets helps advocates to identify advocacy issues accurately, and it can increase the persuasiveness and credibility when using data in their advocacy activities.
2. **Hand out** the Data Quality Scenarios—Participant Worksheets, and explain that each scenario is designed to help identify a key data quality issue.
3. **Follow** the same process for each scenario (see scenarios below).
 - Ask a participant to read scenario #1.
 - Ask the group for their responses to the question.
 - Debrief the question with the Facilitator Notes included in the box below, and write the key word (i.e., validity, reliability, or bias) on a flipchart after debriefing.
 - Repeat the process with scenarios #2 and #3.

Scenario #1: An advocacy network decided to focus its advocacy efforts on decreasing the number of new HIV infections among adolescent girls ages 15–21 whose boyfriends or husbands were using injecting drugs. The network wanted to address this issue in its advocacy messages and strategy and needed more information about these adolescents to make sure their advocacy approach was appropriate. The network found a report of a survey on adolescent girls' knowledge and attitudes about reproductive health and decided to use the results of that survey as a source of information for developing its advocacy strategy.

Ask participants: What are the potential data quality issues here?

Note to Facilitator: While the survey focuses on adolescent girls' knowledge of reproductive health issues, it does not focus on their knowledge and behaviors regarding HIV transmission or prevention. A general adolescent health survey would not be a valid measure of specific knowledge and attitudes about HIV and AIDS or IDU risk behavior. The network may be able to use some of the data from this survey, but to develop an advocacy strategy that would better address the issues of adolescent girls whose partners use injecting drugs, it would need a survey that specifically explores knowledge and attitudes about HIV and AIDS and IDU risk behavior.



Scenario #2: At a presentation of a country’s recent maternal and child health survey data, members of the Reproductive Health Network were shown data on HIV infection in all children ages 18 months who had been tested at the national pediatric hospital’s outpatient clinic. At baseline, 12 percent of these children were shown to be infected with HIV; at three months, 25 percent were infected; and at six months, the results came back as 6 percent of children infected.

Ask participants: What are the potential data quality issues here?



Note to Facilitator: Given the substantial fluctuations in prevalence, network members should question whether testing procedures were carried out correctly and whether the methodology used (either for a rapid HIV or an ELISA test) was correct and reliable. The network should be skeptical about using these data, given that such fluctuations are difficult to explain—and this brings data reliability into question. The network should request that a quality assurance program be put in place at the hospital and the information gathered again.

Scenario #3: An advocacy group wants to understand the HIV needs of MSM in its country. They have been able to access recent behavioral surveillance data for MSM. However, the surveillance was carried out only in the capital city and thus might not be valid for the whole country. The group members decided to find out more about the behavior of MSM in rural areas. To gather this information, the advocacy group arranged for healthcare providers treating sexually transmitted infections (STIs) for men in provincial health centers to interview male patients about their sexual behaviors. The results obtained by the healthcare workers indicated that few men reported sexual relations with other men. The conclusion seemed to be that there were few men in rural areas engaged in sexual relations with other men.

Ask participants: What are the potential data quality issues here?



Note to Facilitator: It is possible that many of the men interviewed did not answer the questions accurately or completely due to their fear of disclosing information about intimate and highly stigmatized behavior to an interviewer who knew them (their healthcare provider). Failing to have a neutral interviewer conduct the interview, with the option for anonymity on the part of the men interviewed, biased the findings. This may have resulted in under-reporting of relevant behaviors by men living in rural areas who have sex with other men.

4. **Ask** participants to consider, in the context of the HIV epidemic in their country or province, the issues they have worked on:
 - What issues of bias, reliability, and validity in data collection have been most notable?
 - Have these affected the response to the epidemic? If yes, how?
 - Are there any planned changes or works in progress to address issues in data quality?
5. **Conclude** the discussion by noting that policies or guidelines based on data that are unreliable or have significant gaps are likely to compromise the effectiveness of HIV and AIDS prevention, care, and support services and interventions.

Activity 3 — Introduction to Data Analysis in the A² Project

Time: 30 minutes

Materials: Flipchart, markers, computer, projector, display screen

Prepared Materials:

PPT: Introduction to Data Analysis in the A² Project

Flipchart: N/A

Other: N/A

Handouts: Types of Data Available through the A² Project, PowerPoint presentation

Objective: ■ To familiarize participants with the different data sources and analyses available through the A² Project.

Introduction:

Time: 10 minutes

- **Remind** participants that one of the core objectives of A² is to synthesize all available HIV and AIDS data in the countries and provinces where the project is being implemented. Given this, it is important to be aware of the different sources and types of data being collected and analyzed as part of the A² Project.

Types of Data Available through the A² Project

The A² Project brings together local epidemiological, behavioral, and response data, along with program effectiveness and financial data, which then are analyzed with state-of-the-art modeling tools. Many types of data are used in the A² Project.

Epidemiological data

- HIV and STI prevalence in a population (e.g., sex workers, IDUs, MSM, uniformed services, and general population males and females)

Sources: HIV and STI surveillance data, epidemiologic and behavioral surveillance surveys, HIV and STI testing data from testing centers, blood donor data, etc.

Behavioral data

- Consistent condom use, by population
- Condom use at last high-risk sex act, by population
- Percent of males and females having premarital or extramarital sex
- Frequency of high-risk sex
- Frequency of injecting and needle sharing
- Use of clean injecting equipment

Sources: Behavioral surveillance surveys, project baseline or evaluation studies, demographic and health surveys, project reports, etc.

Environmental and structural data

- Qualitative studies of factors influencing HIV prevention or care (e.g., focus group discussions, in-depth interviews, etc.)
- Policy documents, laws, or strategic plans related to HIV and AIDS
- Case studies of prevention and care programs
- Studies of economic, social, and other impacts of HIV and AIDS

Sources: Studies, documents, case studies, laws, etc.

Population sizes and census/projection data

- Size of population groups (e.g., sex workers, IDUs, MSM, clients, STI patients)
- Number of youth, by age group
- Disaggregation of population, by urban/rural location and gender

Sources: Census reports, population surveys, behavioral surveillance surveys, etc.

Programmatic data

- Percentage of women with access to antenatal care
- Coverage of condom social marketing programs, by specific most-at-risk group
- Antiretroviral (ARV) program coverage

Sources: Project reports, situation analyses, etc.

Financial data

- Total expenditures on prevention, care, and treatment, impact mitigation, etc.
- Expenditures on specific prevention interventions (e.g., outreach and peer education directed at sex workers, IDUs, MSM)
- Expenditures on antiretroviral therapy (ART)

Sources: National AIDS Accounts, AIDS expenditure surveys, Ministry of Finance reports, donor AIDS expenditure reports, etc.

Economic data

- Labor force participation rate, by gender
- Percentage of 15–49 year olds employed in formal sector

Sources: Central or national statistical authority, World Bank and IMF websites

Activity Instructions:

Time: 20 minutes

1. **Present** the PowerPoint presentation, and encourage questions throughout.
2. Following the presentation, **ask** any participants who have been involved in the A² Project to share their experiences with the data collection and analysis process and to reflect—as they feel able or comfortable—on their successes and challenges to date in synthesizing the data.

Activity 4 — Analyzing Secondary Data I: Behavioral and Epidemiological Data

Time: 1 hour 15 minutes

Materials: Flipchart, markers

Prepared Materials:

PPT: N/A

Flipchart: Questions (Step 1)

Other: N/A

Handouts: Introduction to Asian Epidemic Model and Goals Model, Data Sets, Data Analysis I

- Objectives:**
- To identify potential key advocacy issues emerging from behavioral and epidemiological data and Asian Epidemic Model (AEM) modeling in the A² Project.

Note to Facilitator: This module requires participants to work with data sets to practice the interpretation of data and to begin identifying issues or “messages” from data sets. Ideally, participants will work with data used in the application of AEM in their own province or country. However, the use of such data is subject to clearance by in-country government partners and may not be available to workshop participants. Facilitators need to establish, in advance of the workshop, what data will be available for use. Where local A² data is not available, then participants can complete the activities in this module using HIV and AIDS data that is in the public domain, such as UNAIDS estimates and projections. It is important that the issue of data availability be discussed with the relevant government authorities prior to the workshop. An example of default data that can be used is included in the handouts section of this manual. Additional data sets are available on the UNAIDS website at www.unaids.org.



- Introduction:**
- **Explain** that during this activity, participants will work in groups to examine actual data related to the behaviors and epidemiology of the epidemic.
 - **Note** that the purpose of the activity is to help advocates understand the value of examining data that already exist—and to recognize their various uses and applications in identifying advocacy issues.
 - **Highlight** that another important aspect of this exercise is for participants to identify additional data needed to support advocacy for HIV and AIDS issues.

Activity Instructions:**Step 1: Small Group Work**

Time: 45 minutes

1. **Divide participants** into groups of 4–6 people (depending on the number of participants and the regions they represent).
2. **Distribute** the appropriate data set to each group, and write the following task on a flipchart. Allow 45 minutes for the small group work.

**Prepared Flipchart:****Task**

- Review your assigned data set carefully.
- Cite 2–3 interesting findings or issues relevant to HIV and AIDS policy advocacy.
- Describe the types and sources of any additional data needed to support an advocacy campaign on these issues.
- Write the group's responses on the flipchart paper, and select someone to present the group's output.

Step 2: Group Reports

Time: 30 minutes

1. **Invite** presenters to summarize their group's responses to the questions (5 minutes per group).
2. **Facilitate** a full group discussion by inviting reflection on the process of identifying potential advocacy issues from an examination of data. Use the following questions to generate discussion:
 - a. **Process of identifying issues from data:**
 - Can you describe the process of moving from data to identifying advocacy issues?
 - What did you learn from this process?
 - How will you apply what you have learned about data analysis to your own work?
 - b. **Data gaps:**
 - What are the main data gaps you identified?
 - What are some opportunities to fill these gaps? Note: ask participants to share information about different resources their own organizations or others could contribute to help fill some of these data gaps.
 - What are the implications of these gaps for HIV and AIDS advocacy?

Activity 5 — Analyzing Secondary Data II: Program And Policy Responses

Time: 1 hour 35 minutes

Materials: Flipchart, markers, computer, projector, display screen

Prepared Materials:

PPT: Introduction to the Goals Model

Flipchart: Questions (Step 1)

Other: N/A

Handouts: Data Sets, Data Analysis II, PowerPoint presentation

Objectives: ■ To identify potential key advocacy issues emerging from program response data, especially Goals Model data in the A² Project.

Introduction:

Time: 5 minutes

- **Explain** that, to assess advocacy issues, it is vital to not only know where an epidemic is going but to also understand what the actual policy and program responses have been to date.
- **Note** that the purpose of the activity is to help advocates assess program responses in their own country or region. Based on information about program responses and the data on epidemic trends from the previous exercise, participants will be able to identify potential advocacy issues with greater precision.
- **Explain** that, during this activity, participants will work in groups to examine actual data related to program responses to the epidemic, using the Goals Model.
- **Highlight** that another important aspect of this exercise is for participants to consider additional data (besides Goals data) needed to understand program responses to HIV and AIDS in order to further identify potential advocacy issues.

Activity Instructions:

Step 1: Introduction to Data Available through Goals

Time: 15 minutes

Activity Option:

This step is optional, depending on the familiarity of all participants with the Goals Model.





Note to Facilitator: This module requires participants to work with data sets to practice the interpretation of data and to begin to identify issues or “messages” from data sets. Ideally, participants will work with data used in the application of the Goals Model in their own province or country. However, the use of such data is subject to clearance by in-country government partners and may not be available to workshop participants. Facilitators need to establish in advance of the workshop what data will be available for use. Where local A2 data is not available, participants can complete the activities in this module using Goals data that is in the public domain from project sites where data already has been cleared for publication. It is important that the issue of data access be discussed with the relevant government authorities prior to the workshop. An example of default data that can be used for this module is included in the handouts section. Additional data sets are available from Constella Futures at www.constellagroup.com or by e-mailing info@constellagroup.com.

1. **Present** the PowerPoint presentation, and encourage questions throughout.
2. **Following the presentation, ask** any participants who have been involved in the A² Goals work to share their experiences of the data collection and analysis process and to reflect—as they feel able or comfortable—on their successes and challenges to date.

Step 2: Small Group Work

Time: 40 minutes

1. **Divide** participants into small groups (same as in the previous activity).
2. **Distribute** the appropriate data set to each group, and write the following tasks on a flipchart. Allow 40 minutes.



Prepared Flipchart:

Task

- Review your assigned data sets carefully.
- Cite 2–3 interesting findings that point to potential HIV and AIDS policy advocacy issues.
- Describe the types and sources of additional data needed to help support your analysis of program and policy responses.
- Write the group’s responses on the flipchart paper, and select someone to present the group’s output.

Step 3: Group Reports

Time: 25 minutes

1. **Invite** presenters to summarize their group's response to the questions (5 minutes per group).
2. **Facilitate** a full group discussion by inviting reflection on the process of identifying potential advocacy issues from data analysis (related here to program and policy responses). Use the following questions to generate discussion:
 - Can you describe the process of identifying advocacy issues using program and policy response data (i.e., Goals data)?
 - How did having program response data—in addition to the earlier epidemiological/behavioral data—affect your ability to identify potential advocacy issues?
 - Based on your experience of this analysis process using two types of data, what do you see as the key “lessons learned” (that you would share with others) for moving from data analysis to identifying advocacy issues?

Step 4: Wrap-up to Data Analysis Unit

Time: 10 minutes

1. **Review** briefly the key activities covered in the data unit.
2. **Facilitate** a brief discussion by asking what participants felt were their most important lessons learned from the day.
3. **Conclude** by recapping the following points:
 - Successfully advocating for HIV and AIDS issues involves using data that identify the dynamics of the epidemic, as well as priorities for allocating resources where they will have the greatest impact in preventing the transmission of HIV and mitigating the impact of HIV infection on individuals, families, and communities. Advocates need to collect and use data that accurately represent those needs and priorities and support political action.
 - Data quality issues need to be addressed appropriately to ensure that data is credible to policymakers.
 - The data collected should match the information needs of both advocates and decisionmakers.
 - Data collection and analysis requires resources, and advocates may need to advocate for additional resources to fill data gaps or improve data quality, where problems with existing data systems are identified.
 - It takes careful analysis and ongoing consultation to identify key advocacy issues from data. The questions used in the data analysis exercises are one way to move from data to evidence that can be used to inform policy and program decisions. A key part of the process was building consensus regarding advocacy issues identified through the analysis of data. Participants should consider how to adapt these processes and with whom they want to consult in their own work, so they can move from data analysis to identifying key advocacy issues and messages.

- Although data alone does not determine policy or programs, without good data, sensitive, controversial, or unpopular issues can be ignored more easily by policymakers. High-quality relevant data help reduce stigma and discrimination in the response to HIV and AIDS.
- In addition to improving the collection and analysis of data, advocates also may need to address the issue of making these data more widely available for use.

SECTION III: Identifying Advocacy Issues and the Roles of Data

Activity 1 — Key Advocacy and Policy Issues for HIV and AIDS in Asia

Background Notes

In 2004, Asia was home to 60 percent of the world's population and 19 percent of the people living with HIV (PLHIV). HIV prevalence rates are low in Asia compared with some other continents, particularly Africa, but because the populations of many Asian countries are so large, HIV infections add up to a large number in absolute terms: approximately 5.2 million men, 2 million women, and 168,000 children are living with HIV, according to estimates from World Health Organization (WHO) and the Joint United Nations Program on HIV/AIDS (UNAIDS).¹

The earliest cases of HIV in Asia were reported in 1984 and 1985. The potential for widespread epidemics was not appreciated until the early 1990s, however, with the more extensive spread of HIV in Cambodia, Myanmar, Thailand, and parts of India. Today, these countries have the highest adult HIV prevalence in the region. By contrast, Bangladesh, Laos, and the Philippines have much lower rates. China, Indonesia, Nepal, and Viet Nam, have epidemics in transition, characterized by recent increases in HIV infection rates after an extended period of low prevalence.

Despite strong evidence that the HIV epidemic is spreading, national responses in most countries remain weak. Surveillance systems are inadequate, with only limited geographic and at-risk population coverage.

The following are summary points from an article, published by the East-West Center,² which addressed three key questions:

1. What drives Asian epidemics, and why are there major differences among countries across the region?
2. In what direction are these epidemics likely to move if prevention efforts are not strengthened?
3. What can be done to stop the growth of the epidemics?

What Drives Asian Epidemics?

The situation in Asia is characterized almost entirely by multiple interrelated epidemics among key most-at-risk populations and their immediate sexual partners. These populations include

1. **Injecting drug users (IDUs).** Epidemics among IDUs have played an important role in the spread of the virus in many countries, such as China, Viet Nam, and Malaysia.
2. **Men who have sex with men (MSM).** This population group largely has been ignored by HIV programs in Asia, but recent surveys in many countries have found prevalence 10 to 20 times the national prevalence in groups of MSM. For example in Bangkok prevalence rates of 28 percent in MSM have been seen while national prevalence is only 1.3 percent.

¹ Pisani, E. 2004. *AIDS in Asia: Face the Facts—A Comprehensive Analysis of the AIDS Epidemics in Asia*. Washington, DC: Monitoring the AIDS Pandemic (MAP) Network.

² East-West Center (EWC). 2004. "Tackling the HIV/AIDS Epidemic in Asia." *Asia-Pacific Population and Policy* No 68. EWC, Population and Health Studies. Accessible at <http://www.eastwestcenter.org>.

- 3. Sex workers and clients.** This is by far the largest component of the HIV epidemic in Asia, and the source of many female and most male infections.
- 4. Married women.** The epidemic also is affecting the female partners of men at high risk of infection. More than three-fourths of the women in Asia who have become infected with HIV do not engage in high-risk behavior by conventional definitions. They have contracted HIV through sex with their husbands.

Clients of Sex Workers

The term “general population spread” (as in the boyfriend-girlfriend transmission dominant in Africa) does not apply in most Asian countries because female sexuality tends to be constrained. But the concentration of HIV in most-at-risk populations and their immediate partners does not mean that Asian epidemics will remain at low levels.

The percentage of adults in Asian countries who may be at risk of HIV is between 5 and 15 percent when the numbers of men who visit sex workers and those men’s wives are added to the smaller numbers of sex workers, MSM, and IDUs.

Links between Risk Factors

Growth of the epidemic can be greatly accelerated by the linkages between sub-epidemics among sex workers and their clients and among IDUs and MSM. Behavioral studies in several countries have shown that anywhere from one-third to three-quarters of IDUs visited a sex worker in the previous year. Some IDUs sell sex, some sex workers use injecting drugs, and some MSM also visit female sex workers. Because IDUs also visit sex workers, growth of the sex-work epidemic is accelerated, driving up the overall national epidemic growth rate.

What Will Work in Asia?

Thailand and Cambodia offer good examples of what can be accomplished with a well-targeted prevention program. Both countries identified sex work as the key source of new infections, and both governments mounted pragmatic and well-funded campaigns aimed at clients and sex workers—warning of the risks involved in sex work and encouraging condom use. In both countries, the number of sex workers and clients went down by more than half in a 3–4 year period. Both countries also reported that condom use in sex work increased to 90 percent or above. As a result, HIV prevalence rates have fallen in virtually all surveillance groups.

To be successful, prevention programs must be implemented with high levels of coverage. Yet, many political leaders find it difficult to acknowledge the level of HIV risk in their own societies. They may find it even more difficult to work with the stigmatized population groups who can help halt the epidemic—sex workers and their clients, IDUs, MSM, and PLHIV.

When it comes to addressing issues of sex and drugs, most Asian countries face considerable religious and political resistance, which will take time to overcome. Access to the key most-at-risk populations is limited, and building bridges to these groups also will take time.

Prevention efforts must adapt continuously if they are to stay relevant. Even in the countries widely viewed as successful, there are major gaps. Neither Thailand nor Cambodia has addressed risk among MSM, despite measured HIV prevalence rates of about 7–28 percent among this group in both countries. In Thailand, programs for IDUs are limited and ineffective, and little has been done to address the increasing number of infections occurring within marriage as current and former clients of sex workers infect their wives.

The stakes are high. If HIV prevalence reaches even 2–3 percent in Asian countries, there will be a tremendous care burden. Despite Thailand’s successful prevention efforts, more than 1 million Thais have been infected with HIV, and 450,000 have died. Even at these prevalence levels, it is estimated that antiretroviral therapy will place a financial demand of \$400-500 million annually on the Thai government over the next decade at current drug prices.

Donor governments and other organizations must advocate for and support appropriate, pragmatic, and effective responses. This means creating or sustaining programs that focus on behaviors that make some people uncomfortable—sex work, injecting drug use, and male-male sex. Working with these groups today is the only way to protect the “general population” tomorrow.

Asian governments, for their part, must anticipate care needs and provide compassionate, nondiscriminatory, and appropriate care for people living with HIV and AIDS. At the same time, they must build up and maintain focused prevention programs. Societies in Asia will bear much greater costs tomorrow, both in human and financial terms, should they fail to prevent expansion of the HIV epidemic today.

SECTION III: Identifying Advocacy Issues and the Roles of Data

Activity 2 — Introduction to Data Analysis

Background Notes

To be effective advocates for HIV and AIDS issues, policymakers, advocates, and advocacy networks must understand and accurately represent the dynamics and impact of the HIV epidemic—and the needs, priorities, and interests of their constituencies. In some situations, advocates need to collect and obtain information and analyze it to produce reliable estimates of the current epidemic, as well as its future course; in other cases, they may need to understand the extent and effectiveness of responses to date and then identify priority advocacy issues for improving the response to the epidemic and mitigating its impact. Data gathering and analysis also involves getting to know communities and affected groups to find out how current HIV and AIDS policies and programs affect them, as well as their understanding of what changes are needed in the policy and program environments. It does not make sense, for example, to develop an advocacy campaign in support of an HIV and AIDS drop-in center at a local school for youth if the epidemic mostly affects out-of-school youth or clients of sex workers in the 30–39 age group. The more information and data advocates possess, the more realistic and representative their policy demands will be.

When creating a data collection and analysis plan, advocates should consider their own information needs, as well as those of policymakers. Advocates need to be strategic in the data they collect and in how they analyze that data. Which data will help them truly understand and clarify issues, and which data will best strengthen capacity to design and implement better programs and policies? Whenever possible, efforts to involve affected communities in data collection and analysis should be seen as part of a long-term process of relationship and capacity building with community groups and should be designed to increase community members' own understanding and ability to use the data for advocacy, while raising wider awareness of the epidemic in the community. It also is important to estimate the time and costs involved in collecting and analyzing various data and to weigh the benefits of this collection and analysis against the costs in time and effort.

In short, data are tools that can be used to identify key advocacy issues—and to present and explain these issues to policymakers. This session focuses on different types of data that can be collected and analyzed to understand the epidemic, the effectiveness of responses to the epidemic, and community needs and priorities.

Data Sources

Primary and secondary data

Understanding the HIV epidemic, its impact, and the effectiveness of current national and community responses may require collecting different kinds of data. Some may be available already, while other kinds of data may need to be collected for the first time. Advocates can sometimes gain access to already available data to do secondary data analyses. If important data are not available already, advocates may need to obtain the information firsthand or do primary data collection.

Primary data are collected directly by individuals, organizations, or government agencies through the use of surveys, focus groups, or interviews. The information collected is then compiled, entered into databases, analyzed, and disseminated in reports and documents.

Secondary data have already been collected and are available as files, databases, or documents for others to re-analyze or review. The Behavioral Surveillance Survey (BSS) and the UNAIDS Periodic Reports are examples of secondary data that are available to advocates, policymakers and others. Organizations also often have collected data that advocates can obtain and use for secondary data analysis.

Qualitative and quantitative data

Data can be collected by using qualitative or quantitative methods, or a combination of both. Each kind of data must be collected using specific methods. Each method has its strengths and weaknesses; data are often most comprehensive when a combination of the two methods is used.

Qualitative data are descriptive or narrative texts that describe behavior and institutions by conveying impressions, opinions, values, rituals, beliefs, and emotions. They provide information on what people think, feel, and do, using their own words. For example, what does a national AIDS program mean to people in the community, how did people feel when they had to undergo compulsory testing, or what did pregnant HIV-positive women feel when clinic staff chided them for putting their unborn babies at risk? Qualitative data also describe processes and often answer questions about how or why something happened. For example, how do MSM in a rural community obtain information about their specific health needs and concerns? Qualitative data are collected through various methods, including interviews and observations, or by using direct quotes or discussions.

One of the advantages of qualitative data is that they offer detailed, rich, and in-depth information. However, qualitative data are usually collected from a small number of individuals and thus cannot be used to make generalizations about entire populations or large groups of people.

Quantitative data measure amounts or degrees. They give us information in terms of numbers, such as the number of children under five who are orphans or otherwise made vulnerable by HIV and AIDS in a certain province, or the average number of years of education of members of a post-test club support group. They also provide numeric estimates of what segment of a population would have a specific characteristic—for example, the percentage of HIV-positive adults ages 15–49.

When large amounts of quantitative data are collected, they can be used to make comparisons between groups and do more complex data analyses. However, one of the disadvantages of quantitative data is that important contextual information or subtle nuances can be missed. For example, a survey can reveal the number or percentage of those interviewed who have been tested for AIDS, but these figures do not indicate what people felt during and after testing or the details of how and why certain people did or did not choose to be tested. Such information is critical to the design of effective prevention and care efforts.

Truly understanding a situation requires use of both forms of data. Properly collected quantitative data gives population representative answers to important questions such as the magnitude of the HIV problem, the number of people with a specific risk behavior, or an indication of the distribution of important reasons why some people don't use condoms. However, designing effective programs requires more than just a numerical understanding of the issues. We must know why people engage in risk behavior, what circumstances or situations predispose them to risk, how they perceive their own risk of HIV, or what factors make it difficult for them to negotiate condom use with partners – that is, we must know the context in which the

behaviors occur and in which prevention and care programs must be mounted. Only when both magnitude and context are understood and taken into account will programs reach maximum effectiveness.

Data quality

For data to be persuasive and help advocates and policymakers understand a situation, they need to be of high quality. It is important to evaluate data that are collected and analyzed to ensure that they are valid, reliable, and unbiased. Policies or programs that use invalid, unreliable, or biased data—or data that have important gaps—are unlikely to improve HIV and AIDS prevention, care, or support services and interventions. They are also likely to be disregarded and the conclusions based on them rejected by decision makers should the data quality issues become known.

Reliability refers to whether a measurement (or a method for collecting data) gives the same result when it is repeated over time for the same situation.

For example, at a presentation of a country's recent maternal and child health survey data, network members were shown data on HIV infection in all children 18 months of age tested at the national pediatric hospital outpatient clinic: results showed that, at baseline, 12 percent of this group of children were infected with HIV; at three months it was 25 percent, and at six months, results came back as 6 percent. Given the broad fluctuations in the percent of children infected, the testing methodology is not likely being done correctly or reliably.

Validity refers to how well a measurement (or a method for collecting data) actually reflects what you are hoping to understand.

For example, an advocacy group wants to focus on decreasing the number of new HIV infections among adolescent girls ages 15–21 whose boyfriends or husbands are using injecting drugs. The group found a survey assessing adolescent girls' knowledge and attitudes about reproductive health. While the survey does focus on girls' reproductive health, it does not include information specific to HIV transmission. The general adolescent health survey would not be a valid measure of specific knowledge and attitudes about HIV or IDU risk behavior.

Bias refers to a systematic distortion in the measurement (or the method for collecting data).

For example, an advocacy group wants to understand the HIV needs of MSM in their country. They have been able to access recent surveillance data for MSM, but the research was conducted only in the capital city. The information collected in this case would be biased toward the experiences of men living in urban areas and thus would not be representative of all MSM in the country.

SECTION III: Identifying Advocacy Issues and the Roles of Data

Activity 2 — Introduction to Data Analysis

Data Quality Scenarios – Participants’ Worksheets

Scenario #1:

An advocacy network decided to focus its advocacy efforts on decreasing the number of new HIV infections among adolescent girls ages 15–21 years whose boyfriends or husbands were using injecting drugs. The network wanted to address this issue in its advocacy messages and strategy and needed more information about these adolescents to make sure their advocacy approach was appropriate. The network found a survey on adolescent girls’ knowledge and attitudes about reproductive health and decided to use that survey as a source of information for developing its advocacy strategy.

What are the data quality issues here?

Scenario #2:

At a presentation of the country’s recent maternal and child health survey data, network members were shown data on HIV infection in all children 18 months of age who had been tested at the national pediatric hospital outpatient clinic: at baseline, 12 percent of these children were shown to be infected with HIV; at three months, 25 percent were infected; and at six months, the results were 6 percent of children infected.

What are the data quality issues here?

Scenario #3:

An advocacy group wants to understand the HIV needs of MSM in its country. They have been able to access recent surveillance data for MSM. However, the surveillance data was carried out only in the capital city and thus might not be valid for the whole country. The group members decided to find out more about the behaviors of MSM in rural areas. To gather this information, the advocacy group arranged for healthcare providers treating sexually transmitted infections (STI) for men to interview their male patients about their sexual behaviors; the service providers found few men who reported sexual relations with other men. The conclusion seemed to be that there were few men in rural areas engaged in sexual relations with other men.

What are the data quality issues here?

SECTION III: Identifying Advocacy Issues and the Roles of Data

Activity 3 — Introduction to Data Analysis in the A² Project

Types of Data Available through the A² Project

The A² Project brings together local epidemiological, behavioral, and response data, along with program effectiveness and financial data, which then are analyzed with state-of-the-art modeling tools. Many types of data are used in the A² Project.

Epidemiological data

- HIV and STI prevalence in a population (e.g., sex workers, IDUs, MSM, uniformed services, and general population males and females)

Sources: HIV and STI surveillance data, epidemiologic and behavioral surveillance surveys, HIV and STI testing data from testing centers, blood donor data, etc.

Behavioral data

- Consistent condom use, by population
- Condom use at last high-risk sex act, by population
- Percent of males and females having premarital or extramarital sex
- Frequency of high-risk sex
- Frequency of injecting and needle sharing
- Use of clean injecting equipment

Sources: Behavioral surveillance surveys, project baseline or evaluation studies, demographic and health surveys, project reports, etc.

Environmental and structural data

- Qualitative studies of factors influencing HIV prevention or care (e.g., focus group discussions, in-depth interviews, etc.)
- Policy documents, laws, or strategic plans related to HIV and AIDS
- Case studies of prevention and care programs
- Studies of economic, social, and other impacts of HIV and AIDS

Sources: Studies, documents, case studies, laws, etc.

Population sizes and census/projection data

- Size of population groups (e.g., sex workers, IDUs, MSM, clients, STI patients)
- Number of youth, by age group
- Disaggregation of population, by urban/rural location and gender

Sources: Census reports, population surveys, behavioral surveillance surveys, etc.

Programmatic data

- Percentage of women with access to antenatal care
- Coverage of condom social marketing programs, by specific most-at-risk group
- Antiretroviral (ARV) program coverage

Sources: Project reports, situation analyses, etc.

Financial data

- Total expenditures on prevention, care, and treatment, impact mitigation, etc.
- Expenditures on specific prevention interventions (e.g., outreach and peer education directed at sex workers, IDUs, MSM)
- Expenditures on antiretroviral therapy (ART)

Sources: National AIDS Accounts, AIDS expenditure surveys, Ministry of Finance reports, donor AIDS expenditure reports, etc.

Economic data

- Labor force participation rate, by gender
- Percentage of 15-49 year olds employed in formal sector

Sources: Central or national statistical authority, World Bank and IMF websites

SECTION III: Identifying Advocacy Issues and the Roles of Data

Activities 4 & 5 — Analyzing Secondary Data I, II

Introduction to Asian Epidemic Model (AEM) and Goals Model

In the A² Project, the AEM and Goals Model are linked. The application of these two models will produce high-quality data about

- The current state of the epidemic and response, and
- Alternative scenarios of the possible future course of the epidemic based on changes in risk behavior and resource allocations.

Such scenarios, when validated against past trends in HIV prevalence and other sources of data on the epidemic, provide compelling material for use in advocacy activities to promote more effective responses to the epidemic.

It is not necessary for advocates to be epidemiologists or health economists to use the information produced by the models. However, they should understand what the models can and cannot tell us about the consequences of different responses to the epidemic.

Asian Epidemic Model

The Asian Epidemic Model (AEM) calculates expected trends in HIV infection based on the usual patterns of HIV spread seen in the Asia region. It uses observed behavior and STI trends along with transmission probabilities and other relevant cofactors (such as circumcision) to fit the observed HIV trends in different risk groups. Once these fits or “baseline scenarios” are available, AEM can be used to explore the impact of changes in risk behavior, STI prevalence, ART access, and other relevant factors that result from alternative prevention and care efforts. By varying the levels of risk behavior in the model to reflect actual differences between countries, AEM has been used to accurately model HIV prevalence trends based on measured behavioral trends. The model has been successfully applied in a number of countries.

Goals Model

The Goals Model supports strategic planning at the national level by providing a tool to link program goals and funding. The model can assist planners in understanding the effects of funding levels and allocation patterns on program impact. It can assist program managers in setting priorities for resource allocation within HIV and AIDS programming. The model calculates resources needed by considering (1) the size of the population in need, (2) the level of coverage to be achieved, and (3) the unit cost per person covered. It also translates program coverage into levels of behavior change, which are then fed into AEM to calculate the numbers of infections averted that are attributable to various types of programs. This allows for exploration of the impact of different resource allocation patterns and strategies (i.e., alternative program choices) on the future of the epidemic.

Integration of the AEM and Goals Model

The process of using the AEM and Goals Model together is as follows:

- The AEM is used to generate a baseline scenario that fits the local epidemic. This model is carefully validated against the historical trends of HIV in the different sub-populations to ensure it accurately reflects the current national situation.

- This scenario is then used to set the baseline values for population sizes and risk behaviors in the Goals Model.
- The Goals Model is then used to develop alternate scenarios (around the AEM baseline scenario) to help policymakers understand how different funding levels and patterns would lead to reductions in HIV incidence and prevalence and improved coverage of treatment, care, and support programs. Once a scenario is constructed by selecting the interventions that will be done, Goals then determines the projected behavior change (5 years out) that is anticipated based on the choices made from the various interventions possible.
- The changes in behavior are then fed back into the AEM to calculate future infections and deaths, averted infections, and future care needs.

The combination of the two models allows for the best of both worlds under the A² project. A major output of linking these models is the ability to present information that can influence policymakers' decisions about resource allocation. The two models, when combined, let planners and policymakers explore infections averted, costs, and impacts on future needs for different combinations of interventions.

SECTION III: Identifying Advocacy Issues and the Roles of Data Analysis I for Issue Identification

National trends in the number of adults and women living with HIV, 2001 and 2003

Socioeconomic Characteristic	Bangladesh	Cambodia	China	India	Nepal	Pakistan	Philippines	Sri Lanka	Thailand	Vietnam
Total population of the country (2003)	138M	13.4M	1.28B	1.06B	24.7M	148.4M	81.5M	19.2M	62M	81.3M
Adults (15–49) living with HIV in 2001	2,200 – 13,000	170,000	650,000	3.97M	45,000	63,000	4,400	2,200	630,000	150,000
Adults (15–49) living with HIV in 2003	2,400 – 15,000	170,000	830,000	5M	60,000	73,000	8,900	3,500	560,000	200,000
Women living with HIV in 2001	300 – 2,100	48,000	130,000	1.5M	9,100	4,300	900	<500	200,000	41,000
Women living with HIV in 2003	400 – 2,500	51,000	190,000	1.9M	16,000	8,900	2,000	600	200,000	65,000

< means “less than”

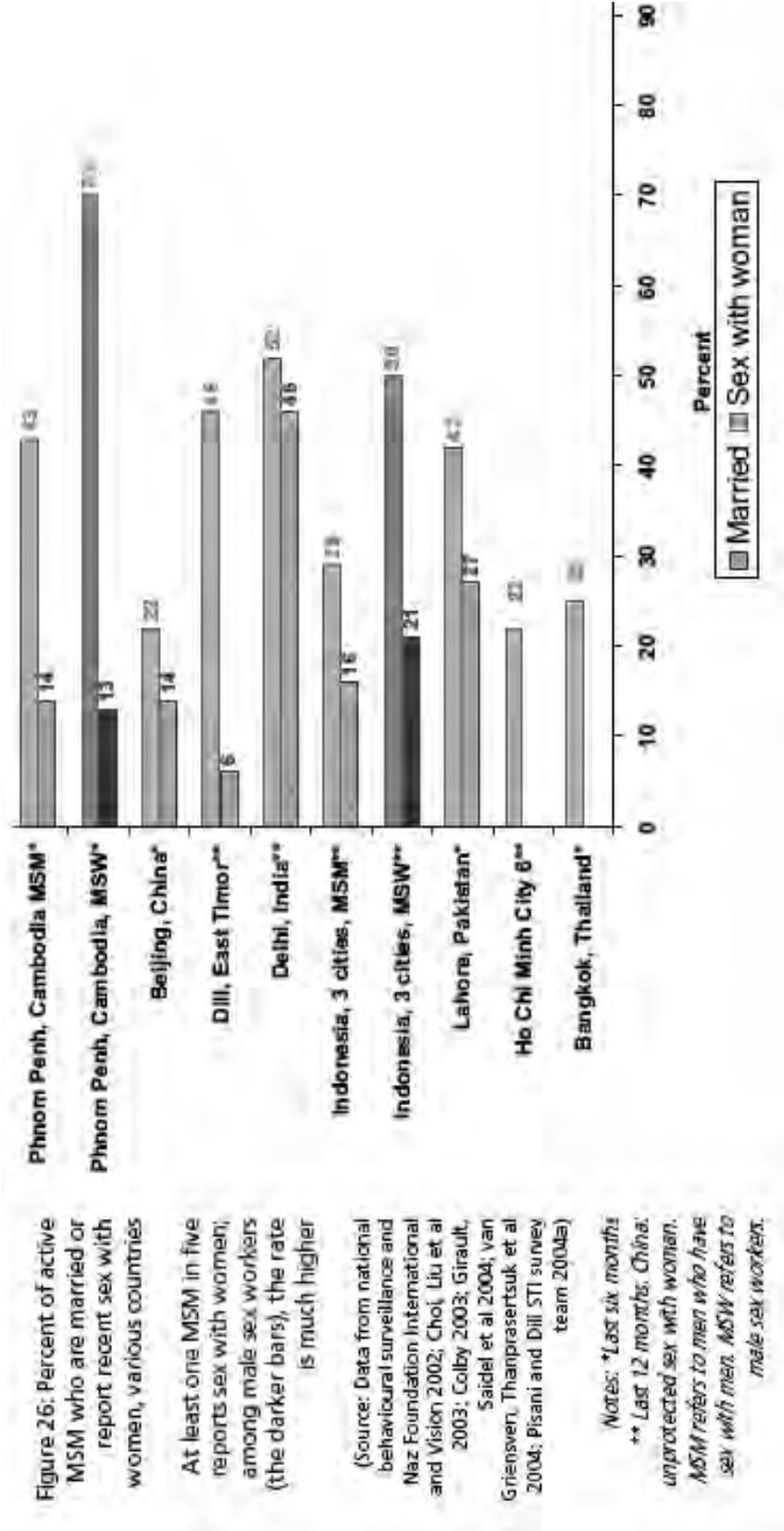
Source: UNAIDS. 2004. Report on the Global AIDS Epidemic. Geneva: UNAIDS.

Questions to guide analysis of data by HIV and AIDS advocates:

1. Are the numbers of adults living with HIV increasing in all of the Asian countries shown in the table? In which countries are numbers of people living with HIV increasing in very large numbers? In which countries did numbers nearly double between 2001 and 2003?
2. Data experts who attended the 2004 HIV and AIDS international conference in Bangkok pointed out that the face of HIV is changing: there are more women living with HIV than ever before. Do you agree? Do available data for your country/region support this contention?

SECTION III: Identifying Advocacy Issues and the Roles of Data Data Analysis I for Issue Identification

National trends in the number of adults and women living with HIV, 2001 and 2003



Source: Pisani, E. 2004. AIDS in Asia—A Comprehensive Analysis of the AIDS Epidemics in Asia. Washington, DC: Monitoring the AIDS Pandemic (MAP) Network.

SECTION III: Identifying Advocacy Issues and the Roles of Data

Activity 5 — Analyzing Secondary Data II

Background Notes

Successfully advocating for HIV and AIDS issues involves using data that identify the dynamics of the epidemic, as well as priorities for allocating resources where they will have the greatest impact in preventing the transmission of HIV and mitigating the impact of HIV infection on individuals, families, and communities. Advocates need to collect and use data that accurately represent those needs and priorities and support political action.

Data quality issues need to be addressed appropriately to ensure that data is credible to policymakers. The data collected should match the information needs of both advocates and decisionmakers.

Data collection and analysis requires resources, and advocates may need to advocate for additional resources to fill data gaps or improve data quality where problems with existing data systems are identified.

It takes careful analysis and ongoing consultation to identify key advocacy issues from data. The questions used in the data analysis exercises are one possible way to move from data to evidence that can be used to inform policy and program decisions. A key part of the process was building consensus regarding advocacy issues identified through the analysis of data. Participants should consider how to adapt these processes and with whom they want to consult in their own work, so they can move from data analysis to identifying key advocacy issues and messages.

Although data alone do not determine policy or programs, without good data, sensitive, controversial, or unpopular issues can be ignored more easily by policymakers. High-quality relevant data help reduce stigma and discrimination in the response to HIV and AIDS. In addition to improving the collection and analysis of data, advocates also may need to address the issue of making these data more widely available for use.



USAID | HEALTH POLICY INITIATIVE
FROM THE AMERICAN PEOPLE



HIV and AIDS in Asia: Key Issues



Outline of Presentation

- Overview of HIV epidemic dynamics in Asia
- The epidemic in [LOCATION X]
- Where are epidemics likely to go?
- What can be done to stop their growth?



What Drives Asian Epidemics?

Key populations engaging in high-risk behaviors:

- Sex workers (SWs) and their clients
- Injecting drug users (IDUs)
- Men who have sex with men (MSM)



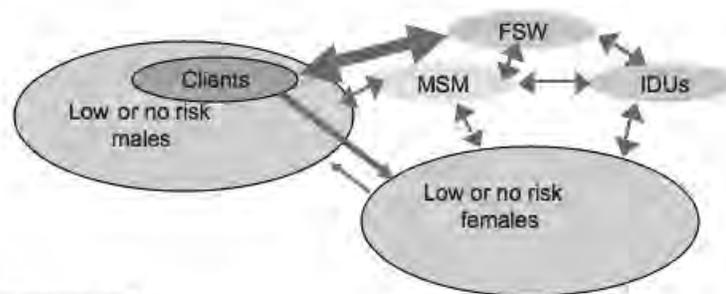
What Drives Asian Epidemics?

- High-risk populations are linked behaviorally with each other and with low-risk partners
- Concentrated epidemics mean focused prevention can succeed
- Although “concentrated,” from 7-25% of populations are at risk



What Drives Asian Epidemics?

- Most new infections occur in specific populations engaging in high-risk behaviors (female SWs, IDUs, MSM)
- These populations are strongly linked behaviorally
 - ➡ We understand the dynamics of HIV in Asia



Why Do Epidemics Continue to Grow?

- Prevention coverage is limited
- Surveillance systems cannot provide sufficient information
- Data remains peripheral to decisionmaking
- Stigma and discrimination contribute to low levels of political commitment



“Success Stories” in Asia

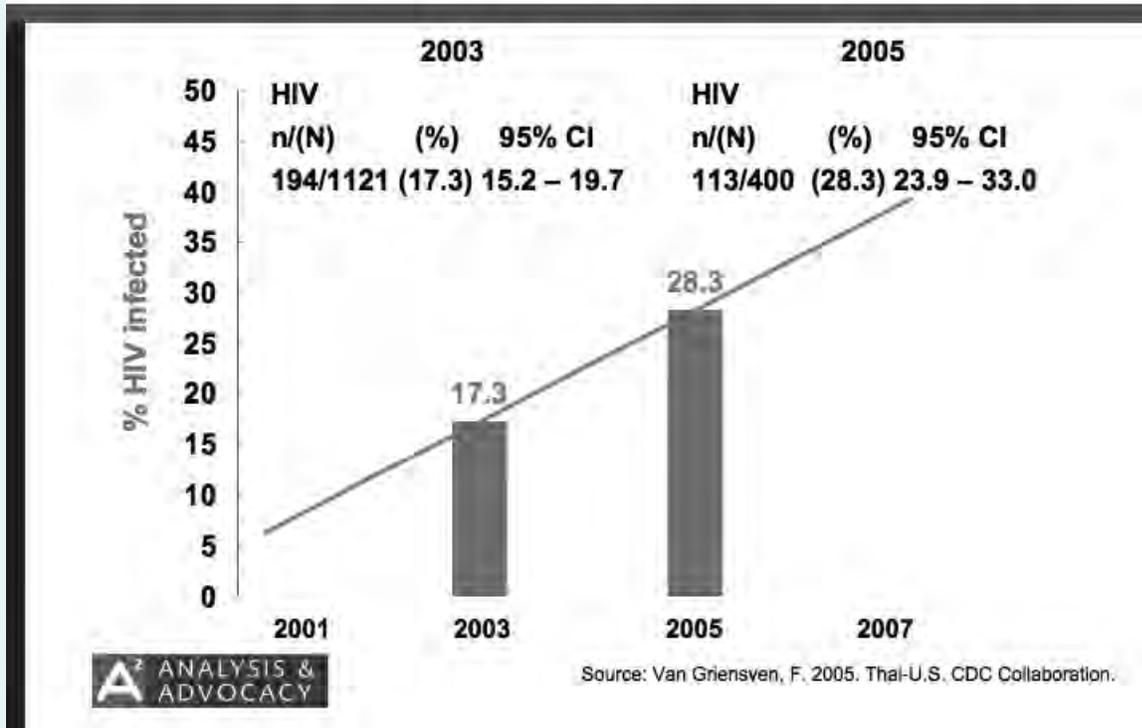
- Cambodia’s reversal in HIV prevalence, as shown by the declining prevalence among adults from 3% in 1997 to 1.9% in 2003.*
- Focused prevention efforts on sex workers and their clients

BUT

- Ignoring other at-risk populations puts prevention successes at risk: MSM in Thailand ...

*Source: Buhler, M., D. Wilkinson, J. Roberts, and P. Catella. 2004. Turning the Tide. Cambodia's Response to HIV & AIDS 1991-2005. New York: UNAIDS.

HIV Prevalence of MSM in Bangkok, Thailand, 2003-2005



The Epidemic in [LOCATION X]

[Insert relevant, up-to-date data to give an overview of the epidemic in your country]



Where Are Epidemics Likely to Go?

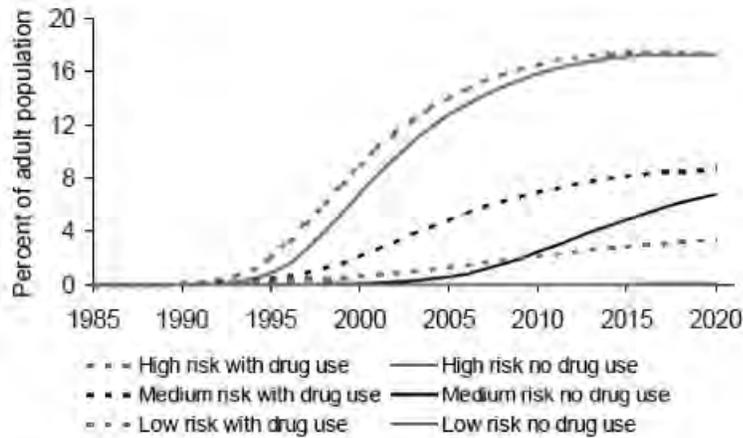


Figure 1 Projected percentage of adult population (15 years and older) infected with HIV through sex work and needle sharing among injecting drug users

Source: East-West Center, 2004, "Tackling the HIV/AIDS Epidemic in Asia," *Asia-Pacific Population & Policy* No. 6B.



HIV and AIDS in Asia: Key Issues • Slide 10

FACILITATOR NOTES:

- Potential HIV prevalence levels have been modeled for countries with three levels of risk behavior.
- The upper solid red line shows a country where 20 percent of men visit sex workers in a year and sex workers have on average two clients per night. This was the situation in Thailand and Cambodia in the early 1990s. Under these conditions, the increase in HIV prevalence is explosive.
- The solid black line in the middle shows a country where 10 percent of men visit sex workers in a year, and sex workers have on average one client per night. This might be Viet Nam or Nepal today. The epidemic begins almost a decade later and grows more gradually.
- The lower solid red line shows a country where 5 percent of men visit sex workers in a year and sex workers have on average one client every other night, not unlike the situation in Hong Kong or Singapore. In these circumstances, the epidemic is very slow to take off.
- Broken lines show the projected percentages of the adult pop infected with HIV when an epidemic among IDUs and SWs is taken into account.

What Will Work in Asia?

Building political commitment to achieve:

- Reduced stigma and discrimination
- Well-targeted prevention programs with high coverage
- Well-targeted prevention programs sustained over time and adapted to changing conditions



Source: East-West Center, 2004, "Tackling the HIV/AIDS Epidemic in Asia," *Asia-Pacific Population & Policy* No. 68.



USAID | HEALTH POLICY INITIATIVE
FROM THE AMERICAN PEOPLE



HIV and AIDS in Asia: Key Issues



HIV and AIDS in Asia: Key Issues • Slide 1

NOTES:

Outline of Presentation

- Overview of HIV epidemic dynamics in Asia
- The epidemic in [LOCATION X]
- Where are epidemics likely to go?
- What can be done to stop their growth?



HIV and AIDS in Asia: Key Issues • Slide 2

NOTES:

What Drives Asian Epidemics?

Key populations engaging in high-risk behaviors:

- Sex workers (SWs) and their clients
- Injecting drug users (IDUs)
- Men who have sex with men (MSM)



HIV and AIDS in Asia: Key Issues • Slide 3

NOTES:

What Drives Asian Epidemics?

- High-risk populations are linked behaviorally with each other and with low-risk partners
- Concentrated epidemics mean focused prevention can succeed
- Although “concentrated,” from 7-25% of populations are at risk

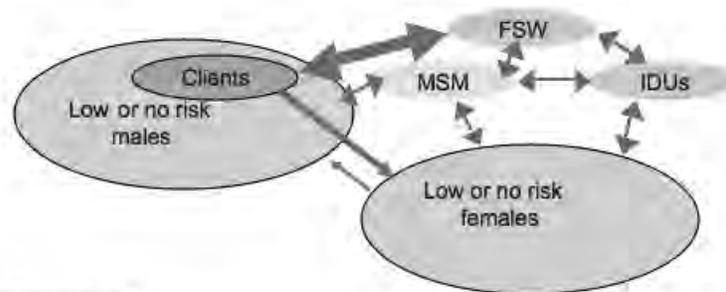


HIV and AIDS in Asia: Key Issues • Slide 4

NOTES:

What Drives Asian Epidemics?

- Most new infections occur in specific populations engaging in high-risk behaviors (female SWs, IDUs, MSM)
- These populations are strongly linked behaviorally
➡ We understand the dynamics of HIV in Asia



HIV and AIDS in Asia: Key Issues • Slide 5

NOTES:

Why Do Epidemics Continue to Grow?

- Prevention coverage is limited
- Surveillance systems cannot provide sufficient information
- Data remains peripheral to decisionmaking
- Stigma and discrimination contribute to low levels of political commitment



“Success Stories” in Asia

- Cambodia’s reversal in HIV prevalence, as shown by the declining prevalence among adults from 3% in 1997 to 1.9% in 2003.*
- Focused prevention efforts on sex workers and their clients

BUT

- Ignoring other at-risk populations puts prevention successes at risk: MSM in Thailand ...

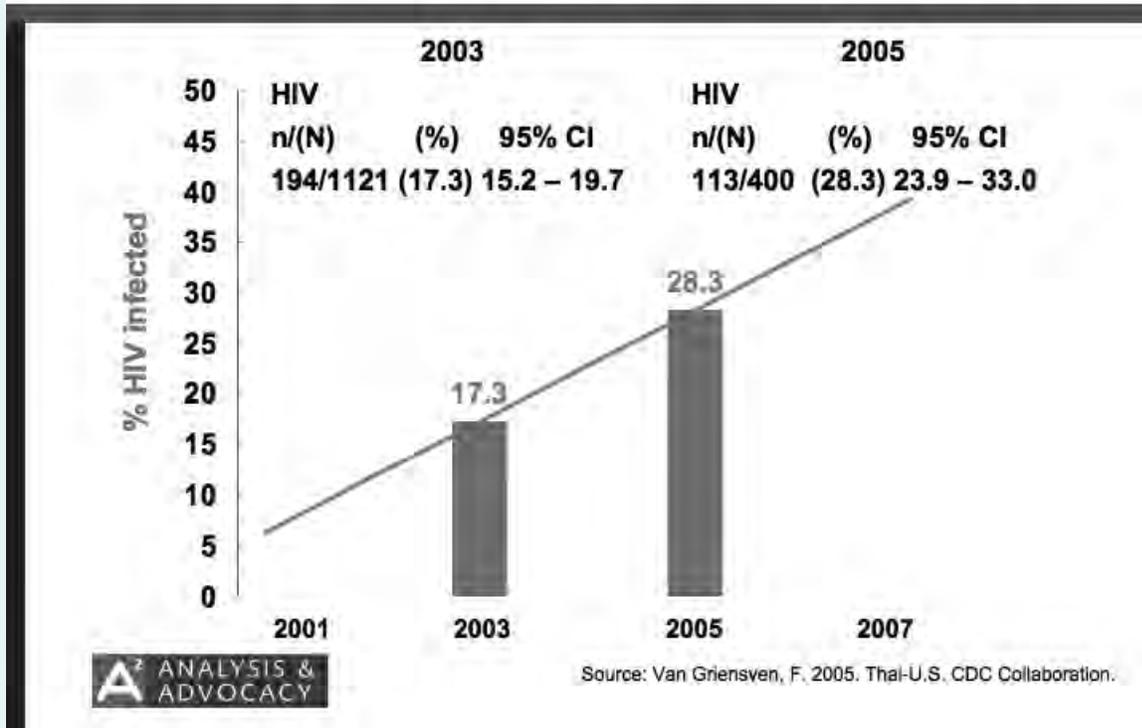
*Source: Buhler, M., D. Wilkinson, J. Roberts, and P. Catella. 2004. Turning the Tide. Cambodia’s Response to HIV & AIDS 1991-2005. New York: UNAIDS.



HIV and AIDS in Asia: Key Issues • Slide 7

NOTES:

HIV Prevalence of MSM in Bangkok, Thailand, 2003-2005



Section III

HIV and AIDS in Asia: Key Issues • Slide 8

NOTES:

The Epidemic in [LOCATION X]

[Insert relevant, up-to-date data to give an overview of the epidemic in your country]



HIV and AIDS in Asia: Key Issues • Slide 9

NOTES:

Where Are Epidemics Likely to Go?

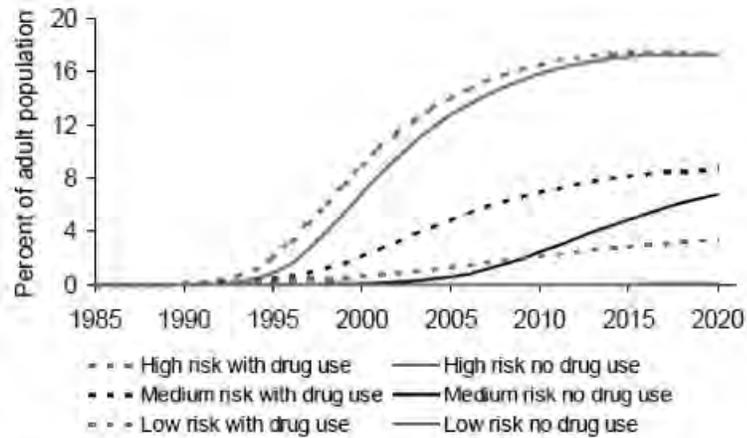


Figure 1 Projected percentage of adult population (15 years and older) infected with HIV through sex work and needle sharing among injecting drug users

Source: East-West Center, 2004, "Tackling the HIV/AIDS Epidemic in Asia," *Asia-Pacific Population & Policy* No. 6B.



HIV and AIDS in Asia: Key Issues • Slide 10

NOTES:

What Will Work in Asia?

Building political commitment to achieve:

- Reduced stigma and discrimination
- Well-targeted prevention programs with high coverage
- Well-targeted prevention programs sustained over time and adapted to changing conditions



Source: East-West Center, 2004, "Tackling the HIV/AIDS Epidemic in Asia," *Asia-Pacific Population & Policy* No. 68.

HIV and AIDS in Asia: Key Issues • Slide 11

NOTES:



USAID | HEALTH POLICY INITIATIVE
FROM THE AMERICAN PEOPLE



Introduction to Data Analysis in the A² Project



Sources of Data (1): Synthesis Report

- Biological and behavioral data
- Response data:
 - Policies
 - Programs and coverage
 - Cost



Role of Data in A²

- Identify key trends to understand the evolution of the epidemic
- Identify gaps and weaknesses in surveillance systems, and how to address them
- Prepare baseline scenarios and projections using existing data
- Use in modeling tools to develop and cost alternative strategies
- Conduct evidence-based advocacy for evidence-based responses



Modeling Tools (1): Asian Epidemic Model (AEM)

- Developed by the East-West Center
- Replicates dynamics of HIV epidemics in Asian settings to project future course of the epidemic
- Three transmission routes:
 - Sexual transmission
 - Injecting drug use
 - Mother-to-child transmission



Introduction to Data Analysis in the A² Project • Slide 4

FACILITATOR NOTES:

The AEM also takes into account sexual transmission among men who have sex with men (MSM). (The transmission route is sexual, but the risk group is MSM).

The risk groups considered are:

- Clients of female sex workers
- Non-injecting high frequency (direct) sex workers
- Non-injecting low frequency (indirect) sex workers
- Injecting high frequency (direct) sex workers
- Injecting low frequency (indirect) sex workers
- Male injecting drug users
- Men who have sex with men
- Male sex workers
- Low-risk males above age 15
- Low-risk females above age 15

Modeling Tools (1): Asian Epidemic Model (AEM)

Inputs to AEM:

- Size of most-at-risk populations
- Frequency of risk behaviors:
 - Rate of condom use
 - Rate of sharing injecting equipment
 - Frequency of sex acts in different contexts, etc.
- Inputs vary by year according to available data
- Model then calculates epidemiological trends over time



Asian Epidemic Model Populations

- Males who are clients of sex workers (SWs)
- Males who are not clients of SWs
- Lower risk general population females
- Direct female SWs (higher frequency of partnering)
- Indirect female SWs (lower frequency of partnering)
- Injecting drug users (IDUs) in higher risk sharing networks
- IDUs in lower risk or non-sharing networks
- Male SWs
- MSM who are not SWs



Asian Epidemic Model

- Each population divided into HIV positive and HIV negative
- Pediatric impacts calculated based on fertility data and female infection rates
- Model allows for movement between categories as this happens in real life (e.g., most female SWs return to a lower risk female population after 2-10 years of sex work)



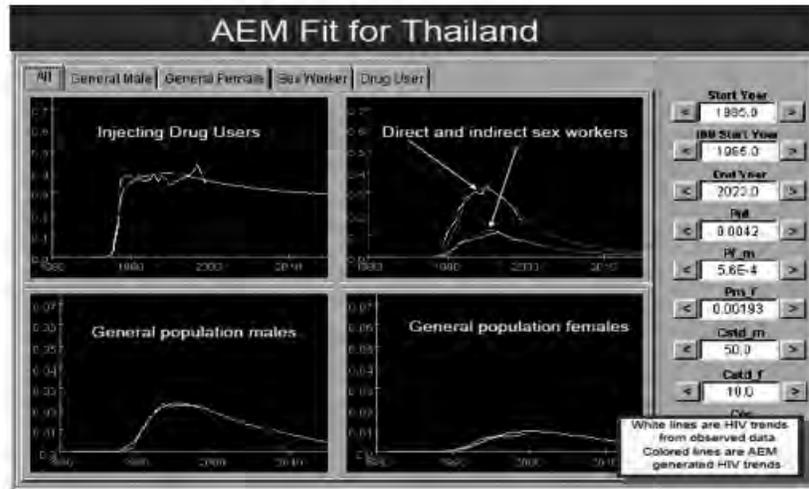
Asian Epidemic Model

Number of new infections calculated based on:

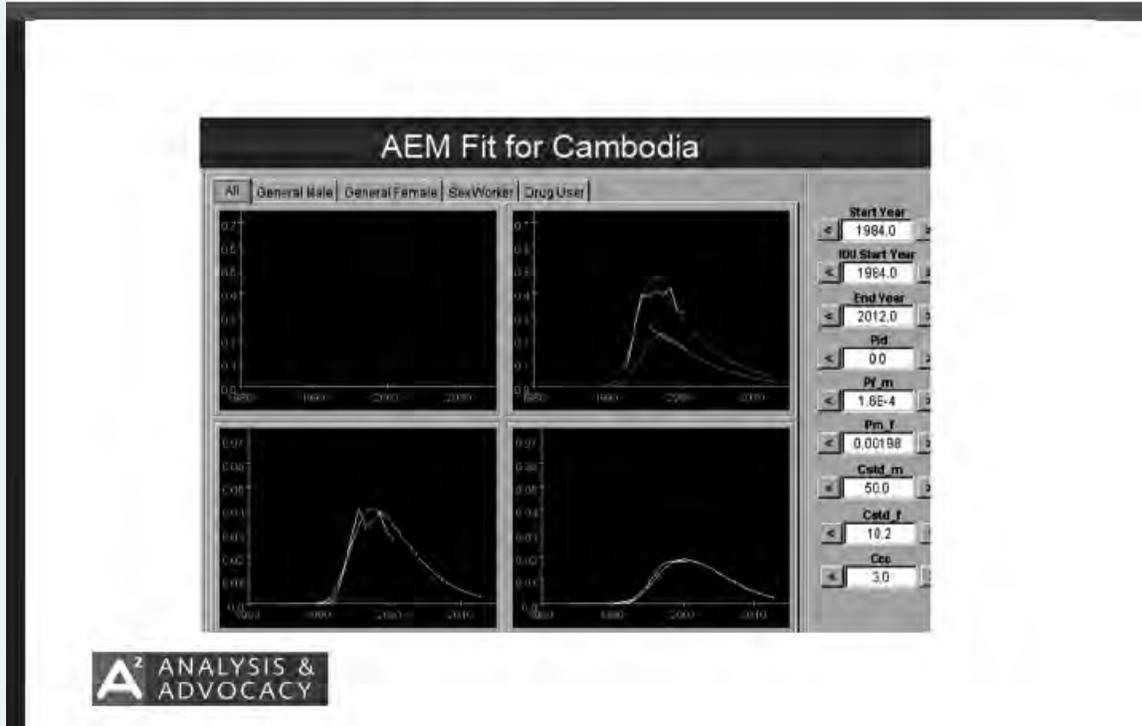
- Prevalence in partner population
- Frequency of sex or injecting acts
- Probability of HIV transmission
- Country-specific co-factors (e.g., prevalence of sexually transmitted infections (STIs) and rate of male circumcision)



Asian Epidemic Model



Asian Epidemic Model





USAID | HEALTH POLICY INITIATIVE
FROM THE AMERICAN PEOPLE



Introduction to Data Analysis in the A² Project



Introduction to Data Analysis in the A² Project • Slide 1

NOTES:

Sources of Data (1): Synthesis Report

- Biological and behavioral data
- Response data:
 - Policies
 - Programs and coverage
 - Cost



Introduction to Data Analysis in the A² Project • Slide 2

NOTES:

Role of Data in A²

- Identify key trends to understand the evolution of the epidemic
- Identify gaps and weaknesses in surveillance systems, and how to address them
- Prepare baseline scenarios and projections using existing data
- Use in modeling tools to develop and cost alternative strategies
- Conduct evidence-based advocacy for evidence-based responses



Introduction to Data Analysis in the A² Project • Slide 3

NOTES:

Modeling Tools (1): Asian Epidemic Model (AEM)

- Developed by the East-West Center
- Replicates dynamics of HIV epidemics in Asian settings to project future course of the epidemic
- Three transmission routes:
 - Sexual transmission
 - Injecting drug use
 - Mother-to-child transmission



Introduction to Data Analysis in the A² Project • Slide 4

NOTES:

Modeling Tools (1): Asian Epidemic Model (AEM)

Inputs to AEM:

- Size of most-at-risk populations
- Frequency of risk behaviors:
 - Rate of condom use
 - Rate of sharing injecting equipment
 - Frequency of sex acts in different contexts, etc.
- Inputs vary by year according to available data
- Model then calculates epidemiological trends over time



Introduction to Data Analysis in the A² Project • Slide 5

NOTES:

Asian Epidemic Model Populations

- Males who are clients of sex workers (SWs)
- Males who are not clients of SWs
- Lower risk general population females
- Direct female SWs (higher frequency of partnering)
- Indirect female SWs (lower frequency of partnering)
- Injecting drug users (IDUs) in higher risk sharing networks
- IDUs in lower risk or non-sharing networks
- Male SWs
- MSM who are not SWs



Introduction to Data Analysis in the A² Project • Slide 6

NOTES:

Asian Epidemic Model

- Each population divided into HIV positive and HIV negative
- Pediatric impacts calculated based on fertility data and female infection rates
- Model allows for movement between categories as this happens in real life (e.g., most female SWs return to a lower risk female population after 2-10 years of sex work)



Introduction to Data Analysis in the A² Project • Slide 7

NOTES:

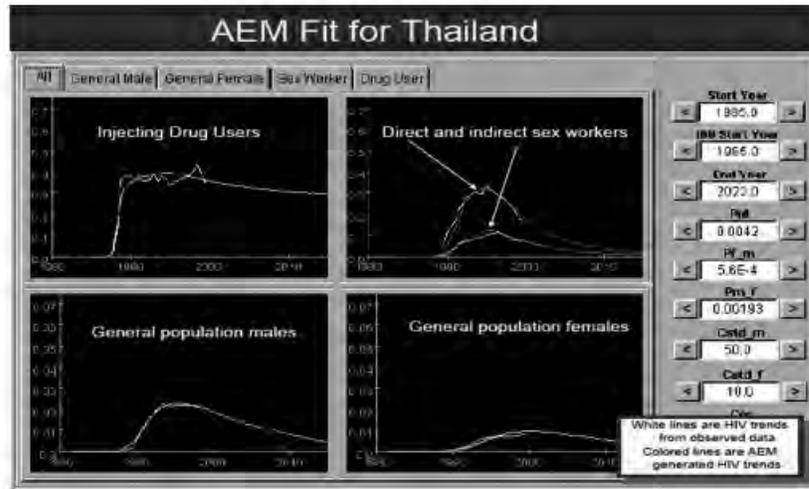
Asian Epidemic Model

Number of new infections calculated based on:

- Prevalence in partner population
- Frequency of sex or injecting acts
- Probability of HIV transmission
- Country-specific co-factors (e.g., prevalence of sexually transmitted infections (STIs) and rate of male circumcision)



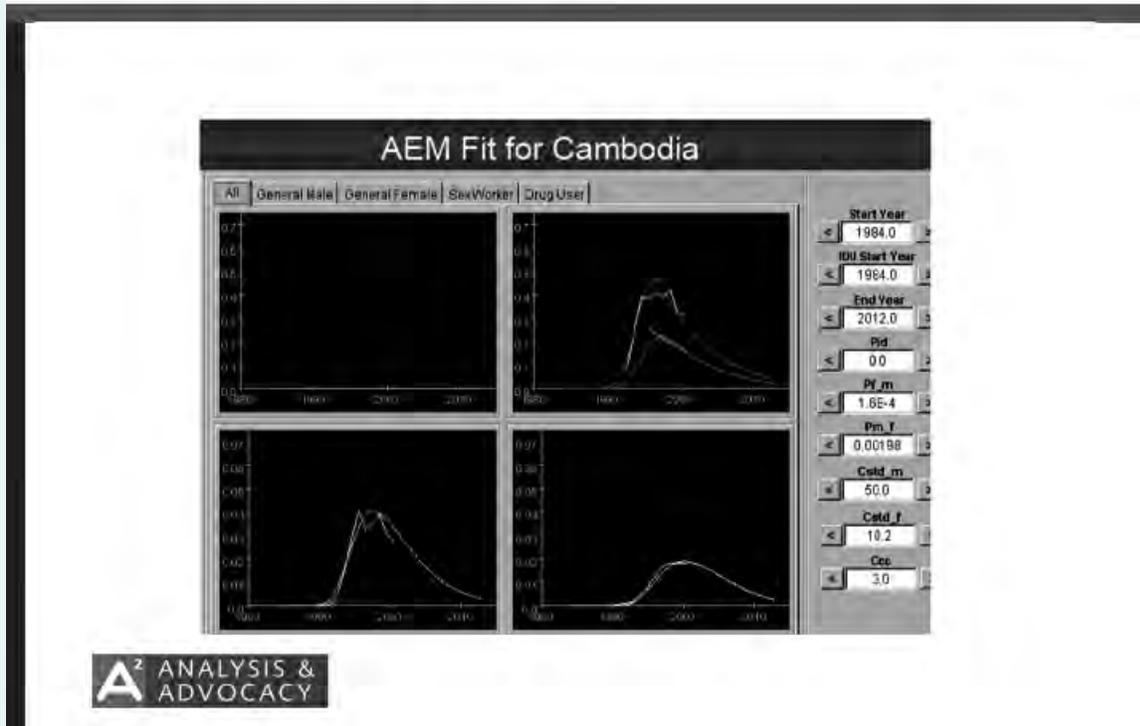
Asian Epidemic Model



Introduction to Data Analysis in the A² Project • Slide 9

NOTES:

Asian Epidemic Model



Introduction to Data Analysis in the A² Project • Slide 10

NOTES:



USAID | HEALTH POLICY INITIATIVE
FROM THE AMERICAN PEOPLE



Introduction to the Goals Model



Goals Model

A suite of computer models developed by Constella Futures* to support strategic planning by providing a tool to link program goals (e.g., in a national HIV/AIDS strategy) to funding:

- Resource Needs Module
- Human Capacity Module
- Impact Module



* Formerly the Futures Group.

Goals Model

Questions Goals can answer:

- How much funding is required to achieve the goals of a strategic plan?
- What outcomes can be achieved with the available resources?
- What is the affect of alternate patterns of resource allocation on the achievement of program goals?



Goals Model

Activities Goals can support:

- Estimating reductions in HIV prevalence
- Estimating increases in coverage of services
- Setting priorities for high-risk populations
- Assessing training required for the provision of services



Goals Model

Questions Goals cannot answer:

- What is the “optimum” pattern of the allocation of existing resources?
- How should resources be divided among prevention, treatment, care, and other impact mitigation programs?



Inputs Needed for Goals

Resource Needs Module

- Demographics
- Sexual behavior by risk group
- HIV and STI prevalence
- Unit costs
- Coverage of public sector interventions
- Care costs
- Proportion of people living with HIV (PLHIV) succeeding and failing on antiretroviral therapy (ART), annually



Inputs Needed for Goals

Capacity Module

- Number of people each activity will reach
- Existing trained staff for each occupation
- Clients reached per trained person
- Calculation of salary, attrition, death rates, sick leave, etc.

Infections Averted

Impact Module

- Difference between the number of new infections that would occur with no new prevention funding and the number that would occur if current prevention interventions continue
- Cost per infection averted is the total additional funding for prevention programs divided by the number of infections averted

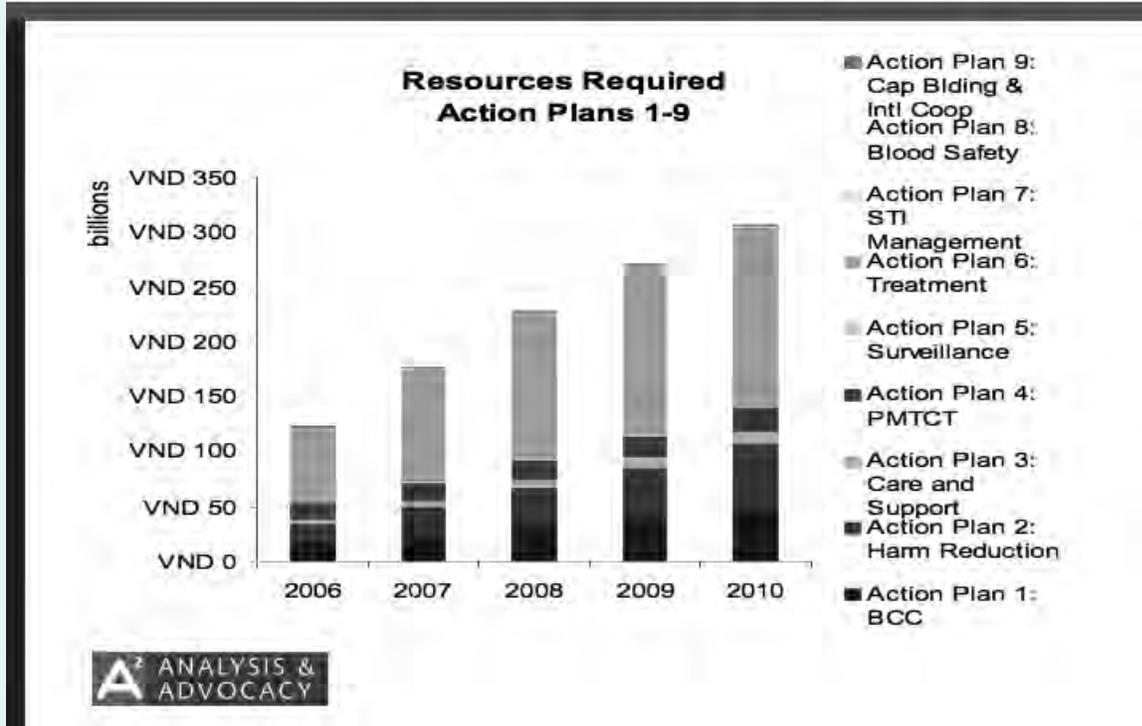


Example of Goals Use in A²

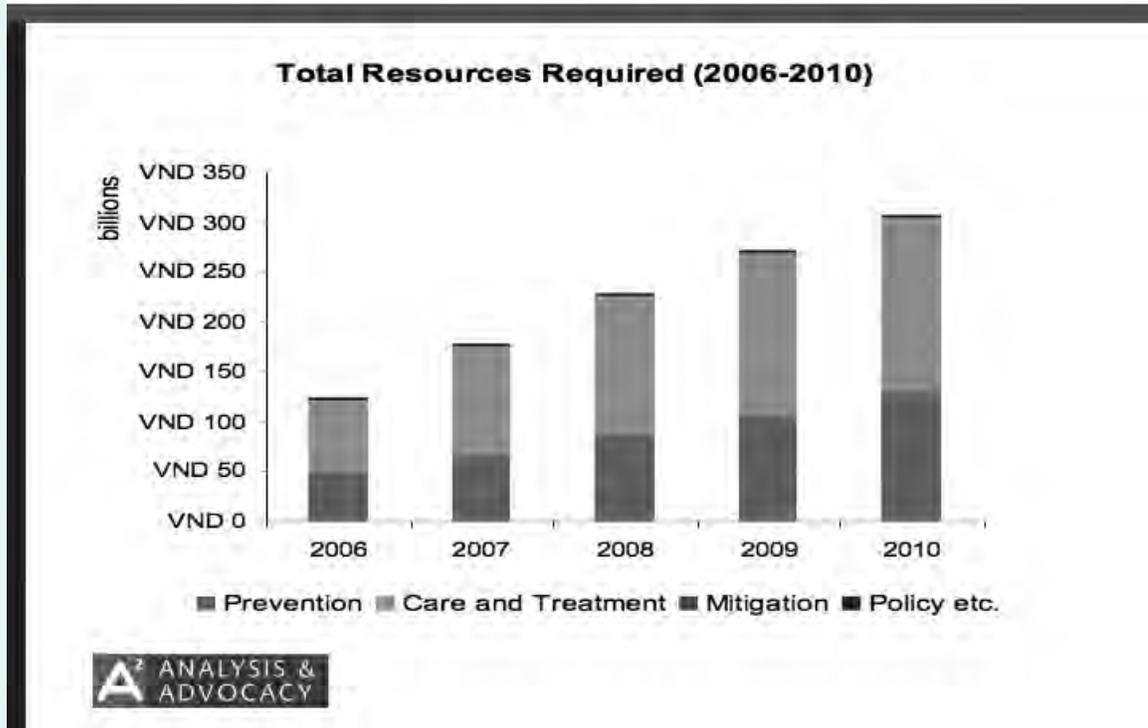
- Goals Model used to assess the cost of implementing each of the nine action plans required by Viet Nam's National HIV/AIDS Strategy 2005-2010
- Each province required to develop and implement action plans. Ho Chi Minh City is the province with the highest number of PLHIV in Viet Nam



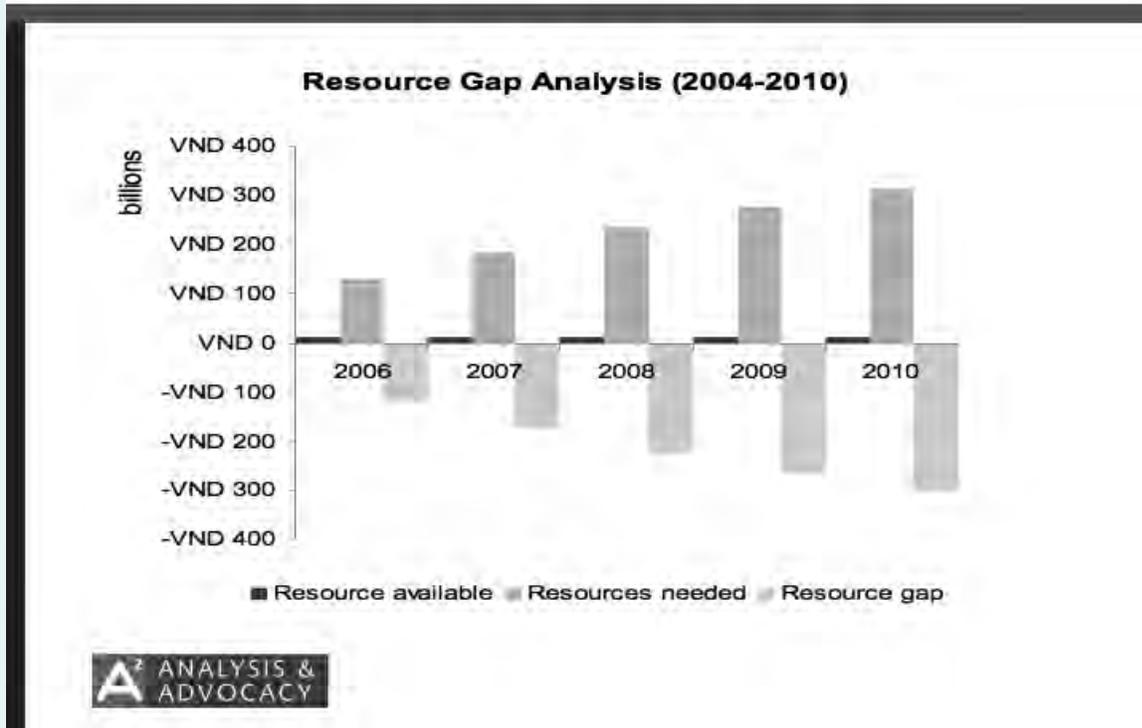
Illustrative Example of Goals Use in A²



Illustrative Example of Goals Use in A²



Illustrative Example of Goals Use in A²



Ongoing Adjustments to Models

- Interface has been developed between Goals and AEM, allowing for greater integration of epidemic projections and resource implications
- AEM modules updated to take into account drug-injecting SWs and use of ART



Outputs as Advocacy Tools

- Goals and AEM are part of A² because they provide valuable evidence on which to base effective responses to the epidemic
- Capacity to implement the models is not as important as the capacity to use the outputs for advocacy purposes





USAID | HEALTH POLICY INITIATIVE
FROM THE AMERICAN PEOPLE



Introduction to the Goals Model



Introduction to the Goals Model • Slide 1

NOTES:

Goals Model

A suite of computer models developed by Constella Futures* to support strategic planning by providing a tool to link program goals (e.g., in a national HIV/AIDS strategy) to funding:

- Resource Needs Module
- Human Capacity Module
- Impact Module



* Formerly the Futures Group.

Introduction to the Goals Model • Slide 2

NOTES:

Goals Model

Questions Goals can answer:

- How much funding is required to achieve the goals of a strategic plan?
- What outcomes can be achieved with the available resources?
- What is the affect of alternate patterns of resource allocation on the achievement of program goals?



Introduction to the Goals Model • Slide 3

NOTES:

Goals Model

Activities Goals can support:

- Estimating reductions in HIV prevalence
- Estimating increases in coverage of services
- Setting priorities for high-risk populations
- Assessing training required for the provision of services



Introduction to the Goals Model • Slide 4

NOTES:

Goals Model

Questions Goals cannot answer:

- What is the “optimum” pattern of the allocation of existing resources?
- How should resources be divided among prevention, treatment, care, and other impact mitigation programs?



Introduction to the Goals Model • Slide 5

NOTES:

Inputs Needed for Goals

Resource Needs Module

- Demographics
- Sexual behavior by risk group
- HIV and STI prevalence
- Unit costs
- Coverage of public sector interventions
- Care costs
- Proportion of people living with HIV (PLHIV) succeeding and failing on antiretroviral therapy (ART), annually



Introduction to the Goals Model • Slide 6

NOTES:

Inputs Needed for Goals

Capacity Module

- Number of people each activity will reach
- Existing trained staff for each occupation
- Clients reached per trained person
- Calculation of salary, attrition, death rates, sick leave, etc.



Introduction to the Goals Model • Slide 7

NOTES:

Infections Averted

Impact Module

- Difference between the number of new infections that would occur with no new prevention funding and the number that would occur if current prevention interventions continue
- Cost per infection averted is the total additional funding for prevention programs divided by the number of infections averted



Introduction to the Goals Model • Slide 8

NOTES:

Example of Goals Use in A²

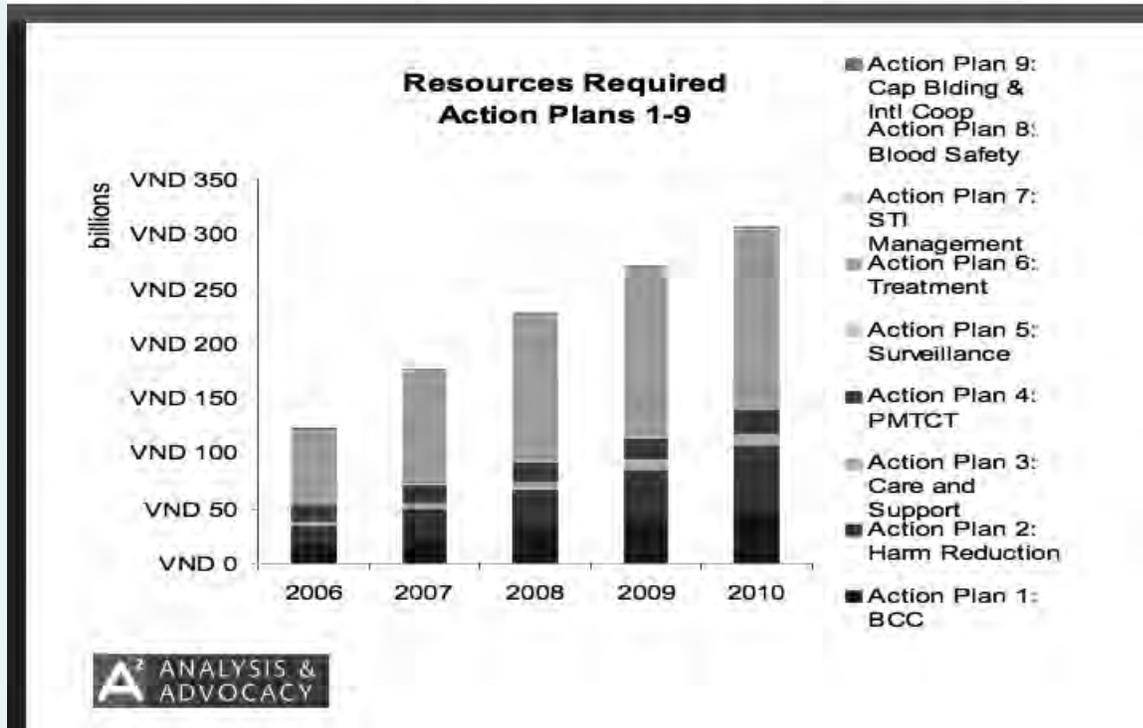
- Goals Model used to assess the cost of implementing each of the nine action plans required by Viet Nam's National HIV/AIDS Strategy 2005-2010
- Each province required to develop and implement action plans. Ho Chi Minh City is the province with the highest number of PLHIV in Viet Nam



Introduction to the Goals Model • Slide 9

NOTES:

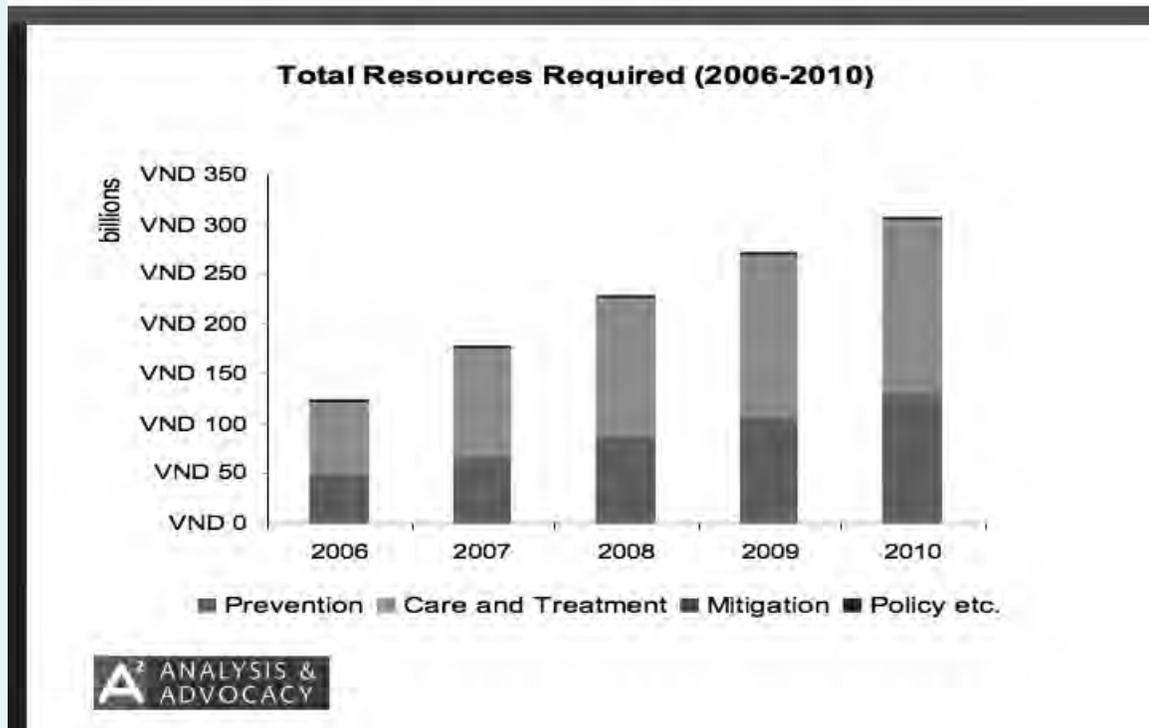
Illustrative Example of Goals Use in A²



Introduction to the Goals Model • Slide 10

NOTES:

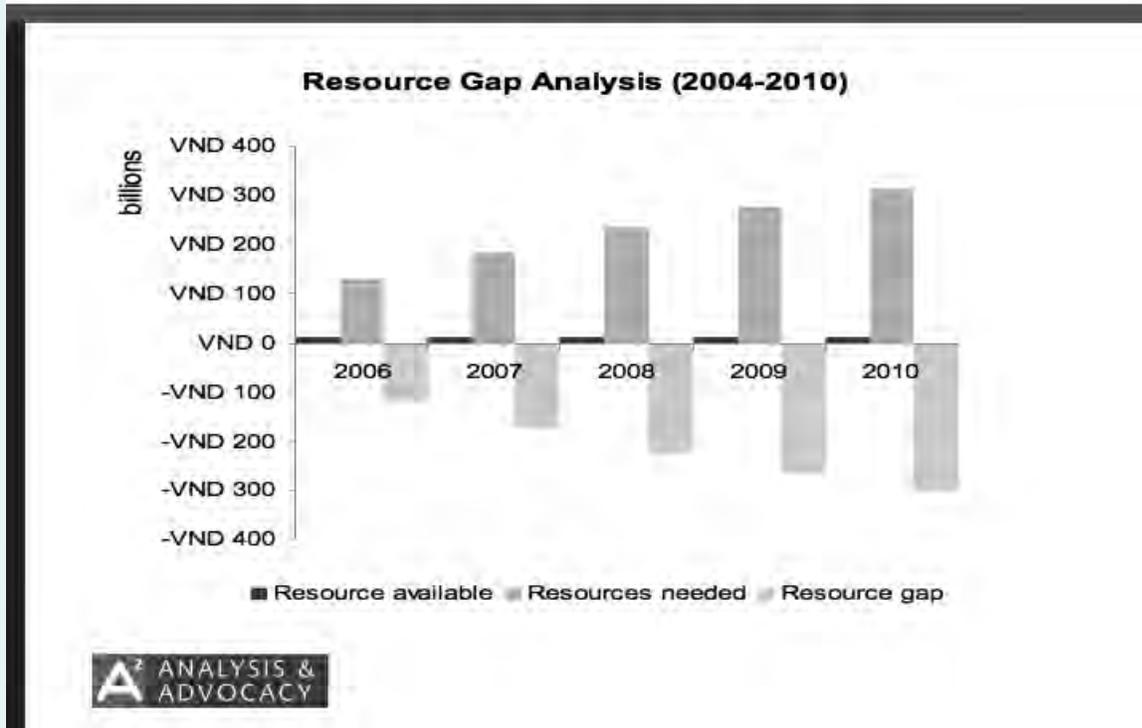
Illustrative Example of Goals Use in A²



Introduction to the Goals Model • Slide 11

NOTES:

Illustrative Example of Goals Use in A²



Introduction to the Goals Model • Slide 12

NOTES:

Ongoing Adjustments to Models

- Interface has been developed between Goals and AEM, allowing for greater integration of epidemic projections and resource implications
- AEM modules updated to take into account drug-injecting SWs and use of ART



Introduction to the Goals Model • Slide 13

NOTES:

Outputs as Advocacy Tools

- Goals and AEM are part of A² because they provide valuable evidence on which to base effective responses to the epidemic
- Capacity to implement the models is not as important as the capacity to use the outputs for advocacy purposes



Introduction to the Goals Model • Slide 14

NOTES:

SECTION IV: Understanding the Policy Process

Content: ■ Activity 1 — The Policy Process

Purpose: ■ To introduce participants to key aspects of the policy development process, including understanding the various actors and processes involved and the different types (and levels) of policy solutions that advocates may identify to address advocacy issues.

Objectives: By the end of this unit, participants will be able to

- Explain and illustrate how the policy process works in their country;
- Develop a policy process map for a key policy or specific advocacy objective; and
- Understand and identify different levels of policy solutions for advocacy issues.

Background Notes:

A critical element in the success of any advocacy effort is a thorough understanding of the opportunities that exist for influencing the policy process—nationally, regionally, or locally. Advocacy groups need to determine how the policy process works and what they realistically can expect to achieve at the policy level—given the realities of their particular political environment. This assessment is important because it focuses a group's efforts on what is potentially achievable.

Policymaking—a course of action dealing with a problem or matter of concern—occurs within a web of interacting forces. Policymaking occurs within a context of multiple sources of information, complex power relations, and changing institutional arrangements. These factors feed into three main processes: problem recognition, the formation and refinement of proposals, and politics.

Some issues probably can be settled by facts, analysis, and persuasion. Others are determined by voting, bargaining, or delegating a decision to someone in a position of authority. In all cases, decisionmakers generally are forced to make policy choices in ambiguous and uncertain conditions.

Effective policy action begins with assessment. It may not be easy to determine the processes through which a country or local authorities formulate and implement HIV and AIDS policies. It is important, however, to identify—as accurately as possible—the various factors that affect policy development decisions, so that appropriate strategies can be adopted to influence the policymaking process—whether at the national level, where discussions are focused on broad policy issues and official national policies, or at the operational level, where specific resource

allocation and service delivery guidelines are formulated. To identify opportunities, an advocacy group or network first needs to understand the formal rules and procedures its country uses to make policy decisions. Identifying these factors will help a group use its resources in a manner that maximizes impact.

Activity 1 — The Policy Process

Time: 2 hours 45 minutes

Materials: Colored paper, markers, tape

Prepared Materials:

PPT: N/A

Flipchart: Discussion Questions: How Policy is Made

Other: N/A

Handouts: Background Notes, Definitions—Policy and Advocacy

Objective: ■ To explain how the policy process works in participants' countries or regions.

- Introduction:** ■ **Note** that a critical element for the success of any advocacy effort is a thorough understanding of how policy is made. In HIV and AIDS advocacy, this includes how HIV issues are identified by policymakers; how policies are formulated, approved, and implemented; which institutions and individuals are involved; the roles, relationships, and balance of power among individuals and institutions; and how, where, and when advocates should act to achieve maximum impact.
- **Explain** that the purpose of this activity is to gain insights and skills that will strengthen advocates' ability to engage in dialogue with policymakers and move their advocacy agendas forward.
 - **Explain** that this module requires an understanding of various terms and concepts. We will begin by defining them; this will be explored in more detail in later modules.

Activity Instructions:

Step 1: What Is an Advocacy Issue?

Time: 40 minutes

1. **Refer** to a prepared flipchart with the definition of "advocacy issue" written on it:

Advocacy Issue: A problem that requires a policy- or decisionmaker's action or solution.



2. **Explain** that it is important to note that not every issue is best resolved through a policy action or solution. Having a better understanding of policy issues and solutions helps advocates to prioritize which issues are best addressed through advocacy for policy change.

3. If workshop participants are unfamiliar with policy or policy actions, **help** them to gain an understanding through brainstorming and examples:
 - Ask participants what words they associate with “policy.” Write the responses on a flipchart.
 - Show the following definition of policy on a flipchart and modify it, using words that participants give.



Policy: A law, rule, regulation or a set of guidelines, procedures, or norms from a higher-level authority to guide a course of action.

4. **Point** out that policies can come from various authorities.
 - Many times, policies come from the government. In the public health field, the national government or the Ministry of Health (MOH) is the high-level authority that decides or gives the orders or policies intended to guide courses of action or interventions affecting the health of individuals in the country/locality.
 - Local governments also have their own regulations; for example, the rules guiding the issuance of licenses to operate commercial establishments may require application of health or safety permits.
 - In addition, institutions have their own policies. Civil service laws cover government employees. A private company also has its own policies; for example, for hiring and firing employees. A government clinic has a policy on what day and time it is open or closed or the kinds of services it can provide and what types of services will be referred to another facility.
5. **Ask** all participants to review the issues they identified earlier, and ask someone to volunteer an issue.
 - Can it be addressed by a policy action?
 - If so, what types of policy actions?
6. **Write** the participant-generated issue at the top of a flipchart. Elicit ideas about the types of policy actions that could address the issue. Record the responses.



Facilitator Tip:

The following are examples of issues and descriptions of how the guide questions can be used for discussion to help participants understand “policy actions”:

Examples of identified issues	Is a policy action needed?	What kinds of policy actions should be considered?
Youth are the most vulnerable, but no data on HIV risk behavior, prevention, and access to voluntary counseling and testing (VCT)	Yes (to ensure that needed data are collected)	<ul style="list-style-type: none"> • MOH decides to start Behavioral Sentinel Surveillance (BSS) • New policy developed to establish guidelines for confidential VCT in youth-friendly centers
Limited services and resources for growing numbers of women living with HIV	Yes (data are available but not really used in policy and planning)	<ul style="list-style-type: none"> • Appoint an HIV-positive woman leader as member of the National AIDS Council • Antiretroviral therapy (ART) policy and guidelines set a target annual increase in numbers of women receiving ART
HIV-positive workers are fired or discriminated against in workplaces	Yes	<ul style="list-style-type: none"> • The three largest businesses in the country approve anti-discriminatory workplace policies • Labor ministry sets up system to regularly collect data on discrimination against HIV-positive workers

Step 2: Understanding Different Levels of Policy Solutions

Time: 20 minutes

- 1. Explain** to participants that, as their brainstorming shows, there are different types of policies at different levels.
- 2. Review** the different types of policies and levels (by posting the terms on a flipchart), and explain each term.
 - Laws
 - Plans or strategies
 - Policies
 - Operational policies
 - Program guidelines
- 3. Ask** participants to review each possible policy action that they brainstormed and identify its level of policy. Write the level next to each of the identified actions on the flipchart. For any type or level of policy that has not been included in the list, ask participants to generate a concrete example to ensure that everyone understands the range of levels.

4. **Note** again that many of these types of policies can exist within different institutions—that is, within a national or provincial government but also, for example, within a faith-based organization or other group.
5. **Check** with participants to see if they have any questions or need clarification.



Note to Facilitator: This module needs to be based on the presentation of detailed information regarding policymaking processes in the environments in which participants work. As the required information will vary, it is not possible to provide such information in this training curriculum. Participants will benefit most from a presentation by a person involved in policymaking in the relevant environment. For this reason, this module is based on the assumption that a guest speaker will give a presentation on policymaking processes in that environment. A sample letter of invitation to a guest speaker, which provides guidance on appropriate topics to be covered during a presentation, is in the annex of additional resources.

Step 3: Guest Speaker

Time: 1 hour

1. **Introduce** the guest speaker.
2. After the presentation, **facilitate** a question and answer session that includes any questions not already covered in the presentation. See suggested questions for discussion in the text box below.
3. **Thank** the presenter and conclude the activity.



Prepared Flipchart:

Discussion Questions: How Policy is Made

- How are ideas or issues generated for new or revised policies?
- How is a proposed issue introduced into the formal decisionmaking process?
- What is the process for discussing, debating, and perhaps altering the proposal? Who are the players involved?
- How is the proposal approved or rejected?
- If approved, what are the steps to move the proposal to the next level of decisionmaking?

Step 4: Policymaking Process Specific to a Policy

Time: 45 minutes

Note to Facilitator: This step is optional, depending on time.



1. **Explain** that to further understand the policy process, we will examine an existing policy.
2. **Write** “Examples of Policies” as a heading on flipchart paper.
3. **Ask** participants to brainstorm examples of policies (regardless of sector or level) currently in place and list their responses on the flipchart.

Examples of Policies:

- National HIV and AIDS Policy
- Only nurses can provide VCT
- Education fees are waived for orphans and other vulnerable children (OVC)
- Faith-based organizations’ policies on HIV prevention
- No smoking in public places

4. **Refer** to the flipchart, “Discussion Questions: How Policy is Made,” from the session on the policymaking process, and choose ONE of the policies listed during the brainstorming session. Ask participants to take 10 minutes individually (or in pairs) and relate each question to the chosen policy, answering the questions as they apply.
5. **Facilitate** a discussion based on the participants’ responses to each question. When all of the questions have been discussed, facilitate a discussion regarding:
 - What additional information is needed to clarify the process?
 - What does this imply about understanding the policymaking process?
6. **Conclude** the exercise by noting that understanding the policy process is important at the multiple levels at which policies are made—from a school’s decision about fees, or a clinic’s guidelines on opening hours, to a national level HIV and AIDS policy.

SECTION IV: Understanding the Policy Process

Activity 1 — The Policy Process

Background Notes

A critical element in the success of any advocacy effort is a thorough understanding of the opportunities that exist for influencing the policy process—nationally, regionally, or locally. Advocacy groups need to determine how the policy process works and what they realistically can expect to achieve at the policy level—given the realities of their particular political environment. This assessment is important because it focuses a group's efforts on what is potentially achievable.

Policymaking—a course of action dealing with a problem or matter of concern—occurs within a web of interacting forces. Policymaking occurs within a context of multiple sources of information, complex power relations, and changing institutional arrangements. These factors feed into three main processes: problem recognition, the formation and refinement of proposals, and politics.

Some issues probably can be settled by facts, analysis, and persuasion. Others are determined by voting, bargaining, or delegating a decision to someone in a position of authority. In all cases, decisionmakers generally are forced to make policy choices in ambiguous and uncertain conditions.

Effective policy action begins with assessment. It may not be easy to determine the processes through which a country or local authorities formulate and implement HIV and AIDS policies. It is important, however, to identify—as accurately as possible—the various factors that affect policy development decisions, so that appropriate strategies can be adopted to influence the policymaking process—whether at the national level, where discussions are focused on broad policy issues and official national policies, or at the operational level, where specific resource allocation and service delivery guidelines are formulated. To identify opportunities, an advocacy group or network first needs to understand the formal rules and procedures its country uses to make policy decisions. Identifying these factors will help a group use its resources in a manner that maximizes impact.

SECTION IV: Understanding the Policy Process

Activity 1 — The Policy Process

Definitions — Policy and Advocacy

Advocacy Issue: A problem that requires a policy- or decisionmaker's action or solution.

Policy: A law, rule, regulation or a set of guidelines, procedures, or norms from a higher-level authority to guide a course of action.

SECTION V: Moving From Issues to Advocacy Objectives

- Content:**
- Activity 1 — Advocacy Issue Prioritization
 - Activity 2 — Identifying Potential Policy Solutions
 - Activity 3 — Developing Advocacy Goals and Objectives
- Purpose:**
- To introduce participants to the difference between advocacy goals and objectives and to help them prioritize their advocacy issues.
- Objectives:** By the end of this unit, participants will be able to
- Understand and apply a process of prioritizing advocacy issues for A²; and
 - Develop advocacy goals and objectives specific to prioritized advocacy issues.

Background Notes:

The first two steps in any advocacy campaign are selecting the advocacy issue and identifying the goals and objectives. These steps make up some of the most challenging analytic work facing an advocacy organization or network. Completing them requires an ability to analyze complex environments and interrelated problems, discern policy solutions for selected problems, envision long-term results, and articulate short-term objectives. The quality of the advocates' work on these activities will have an important bearing on the success of the advocacy activities that follow. These elements provide the foundation for an effective advocacy campaign. Without a clear, articulated issue and well-defined goal and objectives, the remaining steps of the campaign will lack focus.

An **advocacy issue** is the problem or situation that an advocacy group seeks to rectify. Some advocates have focused their efforts around issues such as HIV- and AIDS-related stigma and discrimination against people living with HIV (PLHIV). We also can examine and learn from the successful advocacy of issues other than HIV and AIDS. Some advocacy issues that have attracted attention on a global scale are the use of antipersonnel landmines; universal, safe working conditions; and the widespread sexual exploitation of women and girls. In this session, participants will select an issue that they agree is a priority and begin to build an advocacy campaign around it.

In various settings, the terms “goal” and “objective” are used interchangeably. In some instances, an objective is broad and a goal is narrow; in others, the meanings are reversed. For the purpose of A² advocacy training, an **advocacy goal** is the long-term result (3–5 years) that advocates seek to achieve. Participants should envision how the policy environment will be changed as a result of their

Advocacy Goal:

The goal is what you hope to achieve over the next 3–5 years. The policy goal is your vision. It also is the subject of your advocacy efforts. Goals can be general.

advocacy efforts. Will all PLHIV have access to antiretrovirals (ARVs)? Will the government draft, approve, and implement a national HIV and AIDS policy, using a transparent, participatory approach? These examples represent long-term visions for policy change. A particular organization may not be capable of achieving its goal single-handed, but the goal statement can orient and focus advocates over the long term.

Advocacy Objective:

The objective is a smaller and realistic step toward the achievement of your goal. It is usually what you hope to achieve in the next 1–3 years. Advocacy objectives need to be:

- S** – specific
- M** – measurable
- A** – achievable
- R** – realistic
- T** – time-bound

An **advocacy objective** is a short-term target (1–2 years) that contributes toward the achievement of the long-term goal. A sound objective is specific, measurable, achievable, realistic, and time-bound. These are known as the “SMART” criteria and are widely used. Often, groups will work on two or more objectives simultaneously in their efforts to achieve a single goal. It is important that an advocacy objective identify the specific policy body with the authority to make the policy decision or take the action that is desired and thus to fulfill the advocacy objective. Two examples of sound advocacy objectives are to

(1) secure a commitment from the Ministry of Health (MOH) that, within one year, it will adopt a policy on affordable ARV treatments for PLHIV; and (2) promote the drafting and submission of a National HIV and AIDS Policy and Operational Plan for approval within one year.

Activity 1 — Advocacy Issue Prioritization

Time: 2 hours

Materials: Markers, flipchart, tape

Prepared Materials:

PPT: N/A

Flipchart: Brainstormed List of Issues (from earlier), Instructions (Step 1), Definition of “Advocacy Issue”

Other: N/A

Handouts: Background Notes, Checklist for Choosing an Issue Worksheet

Objective: ■ To understand and be able to apply a process of prioritizing HIV advocacy issues.

Introduction: ■ Explain that prioritizing advocacy issues is an important strategic decision requiring much analysis and consensus building. Note that this activity provides experience with using some key processes to help prioritize issues.

Activity Instructions:

Step 1: Small Groups

Time: 30 minutes

1. **Explain** to participants that now they will be asked to look in more detail at the issues that had been identified in the discussions about key HIV and AIDS issues in their countries or provinces, as well as the implications of the session’s data analysis. **Highlight** that the purpose of this exercise is to brainstorm a list of issues from which groups of participants will prioritize one advocacy issue to focus on.
2. **Divide** participants into small groups, according to the country or region in which they work, or randomly, if they all work in the same geographical location.
3. **Review** instructions on a flipchart:

Prepared Flipchart:

1. Brainstorm a list of key advocacy issues.
 - a. Based on the evidence that we have analyzed, what are the priority HIV issues?
 - b. Are there other critical issues that have not been mentioned? What are they?
2. Discuss and select the top three advocacy issues, and record these on a flipchart.



4. **Allow** participants 25 minutes to complete the brainstorming and selection of their three priority issues.

Step 2: Group Reports and Discussion

Time: 20 minutes

1. **Ask** one member from each group to present the group's flipchart paper and report on the group's work.
2. **Ask** each member to reflect on their experience of the process: Was it easy or challenging to identify the top three issues, and why?
3. **Ask** all participants as a group to identify commonalities in the ideas generated in the small groups, and compare them with the dynamics of Asian epidemics identified by the East-West Center and the results of other discussions from earlier in the workshop.
4. **Ask** the group to consider whether, in the course of the group discussion, they have confirmed their previously chosen issues or changed their priorities.

Step 3: Issue Prioritization

Time: 1 hour 10 minutes

1. **Explain** to participants that there are many ways to prioritize issues. One is through discussion, as they just had when identifying three key issues. Another way is to rank issues according to a set of criteria.
2. **Introduce** the fact that other advocates have found using a set of criteria as a checklist to be helpful in prioritizing issues. Discuss how, and the extent to which, setting priorities according to fixed criteria determines activities in the A² Project.
3. **Handout and review** the criteria on the sample "Checklist for Choosing an Issue." Note, in particular, the importance of "choosing a winnable issue." Here, the facilitator may want to refer back, for instance, to the example of the Nepal sex workers' campaign to reduce police harassment through strategic advocacy. Note that these criteria will help you determine "at the end of the day, which advocacy issues are the highest priorities." Invite questions and discussion of the criteria on the checklist, and ensure that participants understand each of the criteria and how to use the checklist to rank their issues.



Note to Facilitator: There are likely to be participants who have not worked with the A² Project and thus will find the A²-specific criteria, such as enhancing the advocacy credibility of the project, inapplicable to their own work. It is important to acknowledge that the checklist may need modification, depending on the circumstances in which it is used. Nevertheless, the use of agreed-upon criteria in determining priority advocacy issues should be reinforced.

4. **Ask** participants if there are any additional criteria they would like to add. If so, note these on a flipchart and instruct participants to add them to the bottom of their checklists.

5. **Divide** participants into their small groups, and give them 30 minutes to rank their three issues and identify the most important one. (Note: If participants have already chosen the most important advocacy issue in the previous exercise, ask them to reassess the relative priority of the three issues, using the checklist.)
6. After 30 minutes, **ask** each group to present the following to the large group:
 - Their top-ranked issue.
 - A brief discussion of the process, and key criteria that made it their top-ranked issue.
7. **Allow** other participants to ask questions about any of the decisions made in terms of ranking.
8. **Facilitate** a discussion with the whole group about the usefulness of this process in identifying a priority issue.

Activity 2 – Identifying Potential Policy Solutions

Time: 1 hour 15 minutes

Materials: Markers, colored paper, flipchart, tape

Prepared Materials:

PPT: N/A

Flipchart: Definition of “Advocacy Issue” (Introduction), Definition of “Policy” (Step 1), Policy Solutions chart (Step 3)

Other: N/A

Handouts: Definitions—Policy and Advocacy (see previous section’s handout for Activity 1)

Objective: ■ Understand and identify different levels of policy solutions for advocacy issues.

Introduction:

Time: 5 minutes

- **Introduce** the session by telling the participants that, in moving from an issue to what they might want to achieve through advocacy (i.e., what their advocacy goals and objectives might be), it is important to think about what policy solutions are needed and which of these could be considered most important.
- **Recap** and post the definitions of “advocacy issue” and “policy” on a flipchart.

Advocacy Issue: A problem that requires a policy action or solution.

Policy: A law, rule, or regulation or a set of guidelines, procedures, or norms from a higher level authority to guide a course of action.



- Highlight the following points:
- Usually, there are many possible policy solutions for a given advocacy issue, and so it is important to understand the range of possible policy solutions to a given issue—and to assess which might have the most impact and be most feasible.
- It is important to note that not every issue is best resolved through a policy action or solution.
- Having a better understanding of policy solutions helps advocates to prioritize which issues are best addressed through advocacy for policy change and of the level of policy change at which issues are most effectively addressed.

Step 1: Assessing the Impact of Different Policy Solutions

Time: 40 minutes

- Instruct** participants to return to the top three advocacy issues they identified during the sessions dealing with data.
- Tell** participants that they will now use their three advocacy issues to brainstorm possible policy solutions. **Ask** participants to use these issues to complete the chart in Step #3:
 - Policy actions: Is there a policy action that can be taken to address this advocacy issue? Are there multiple policy actions for the issue? (Brainstorm all identifiable policy actions for this issue.)
 - Feasibility: How feasible are the policy actions for your country (or region)?
 - Strategic: Could the issue potentially result in adverse consequences?
 - Impact: How much difference will the policy action make to the epidemic in your country?
- Allow** 20 minutes for each group to complete this exercise.



Prepared Flipchart:

	Policy Actions?	For each possible policy action, answer each question (Low, Medium, or High)		
		How Feasible?	How Strategic?	Impact?
Advocacy Issue #1	1.			
	2.			
	3. (and so on)			
Advocacy Issue #2				
Advocacy Issue #3				

Step 2: Group Reports

Time: 30 minutes

- Ask** groups to report, sharing their charts for just one of their advocacy issues.
- Facilitate discussion** to make sure that participants understand the policy actions needed to address their chosen advocacy issue. Ask them to consider: “How does your analysis of a specific policy affect your prioritized advocacy issue?”
- Conclude** by asking participants: “What are the most important lessons you have learned from having worked to identify possible policy solutions?”

Activity 3 — Developing Advocacy Goals and Objectives

Time: 2 hours 30 minutes

Materials: Markers, flipchart, tape

Prepared Materials:

PPT: N/A

Flipchart: Definition of “Advocacy Goal” and “Advocacy Objective” for Step 1; Examples of Advocacy Issues, Goals, and Objectives; Elements of an Advocacy Objective; SMART Criteria

Other: N/A

Handouts: Advocacy Objective

Objective: ■ To understand the utility of appropriate advocacy goals and objectives specific to the prioritized advocacy issue and how to develop the goals.

Introduction: ■ Explain that, having identified and prioritized advocacy issues, participants will now learn to develop advocacy goals and objectives for their priority advocacy issues.

■ Highlight that defining advocacy goals and objectives is the key process by which concern for an advocacy issue is shaped into a specific course of action to bring about change. It is a critically important strategic moment, as there usually are many possible solutions to a given issue. Choosing advocacy goals and objectives largely determines the changes you, as advocates, will seek.

Activity Instructions:

Step 1: Developing an Advocacy Goal

Time: 45 minutes

- 1. Introduce** the topic of advocacy goals and objectives by sharing the definitions on flipchart paper or on a PowerPoint slide. **Read** the definitions aloud and make the following points:
 - It is important, at this stage, to differentiate an advocacy goal and an objective, because the definitions often vary from one country and one network to another.
 - For the purpose of this workshop, the following definitions are used:

Prepared Flipchart/Slide:

An **advocacy goal** is the long-term result (3–5 years) of your advocacy effort; it is your vision for change.

An **advocacy objective** is the short-term goal (1–2 years) that contributes toward achieving your advocacy goal.



2. Share the following examples to clarify the differences and relationships among advocacy issues, goals, and objectives. Write them on flipcharts.



Prepared Flipchart:

Example from a PLHIV Group

Advocacy Issue – PLHIV in Malawi denied access to care, treatment, and support.

Advocacy Goal – Equal access to high-quality health services for all PLHIV in Malawi.

Advocacy Objective – Secure a commitment from the MOH that it will adopt a policy of providing high-quality health services to all PLHIV.



Prepared Flipchart:

Example from Country-Level Discussion/Effort

Advocacy Issue – Lack of government commitment (policy and resources) to the national HIV and AIDS program.

Advocacy Goal – Adoption of national HIV and AIDS policy, as well as appropriate resources for its implementation.

Advocacy Objective – National AIDS Council will draft and submit a National HIV and AIDS Policy and Operational Plan for approval within one year.

3. Ask participants to highlight the differences between the goal and the objective. Include the following points:
- The **advocacy goal** is a long-term result.

Example 1: It is unlikely that a PLHIV group, which developed this goal, can achieve it alone; therefore, the goal is considered external to the PLHIV group. In other words, the PLHIV group will not hold itself accountable for achieving the goal, even though the goal is the ultimate and desired result.

Example 2: The adoption of a national HIV and AIDS policy with appropriate resources is a difficult goal for one group or organization to achieve alone.
 - The **advocacy objective** is something achievable by a specific group/organization.

Example 1: The objective is achievable by a PLHIV group itself. It is a short-term target that is achievable within the one to two years. Success can be measured easily—either the MOH adopts a policy to provide quality services to all PLHIV or it does not. The advocacy objective clearly contributes to the broader goal.

Example 2: The objective is achievable by an in-country coordinated group of organizations. It has a target that appears achievable within the timeframe of one year.

4. **Divide** participants into groups (by country or by issue).
5. **Ask** each group to draft an advocacy goal for the advocacy issue they have selected. The goal statement should describe a long-term, desired change related to the issue. Allow 10–15 minutes, and ask the group to write their goals on flipchart paper.
6. **Ask** each group to share its goal statement.
7. **Review** each goal statement by using the following questions to guide the discussion:
 - Is the goal achievable through a series of policy decisions or actions? If policy change cannot contribute to achieving a particular goal, it probably is not an advocacy goal. Often, a goal calls for public awareness raising, as well as policy action. In that case, an advocacy strategy can be used to bring about the necessary policy changes, while a public awareness campaign or one based on information, education, and communication (IEC) can focus on changing public behavior or norms, including promoting support for the advocacy goal.
 - How are the group's goal statements similar to or different from one another?

Step 2: Setting Advocacy Objectives

Time: 1 hour 45 minutes

1. Start by **referring** to the definition of advocacy objective again (already posted on flipchart):

Advocacy Objective: Short-term target (1–2 years) that contributes toward achievement of the long-term goal.

2. **Ask** participants if anyone has experience in establishing programmatic objectives. Explain that such experience is helpful in setting advocacy objectives. Sound objectives are essential to any planning process, whether planning an HIV and AIDS program or an advocacy campaign. Clear and concise written objectives can bring clarity and direction to the rest of the planning process.
3. **Ask** participants to list the criteria or characteristics they generally use to develop programmatic objectives, and write their responses on a flipchart.

Note to Facilitator:

Many groups mention the SMART criteria for objectives, but other criteria may be listed as well. Refer to the SMART criteria, and open the flipchart containing the SMART list. Ask:

1. Do the SMART objectives also apply to advocacy objectives?
2. What, if any, other criteria or elements should be included in an advocacy objective?

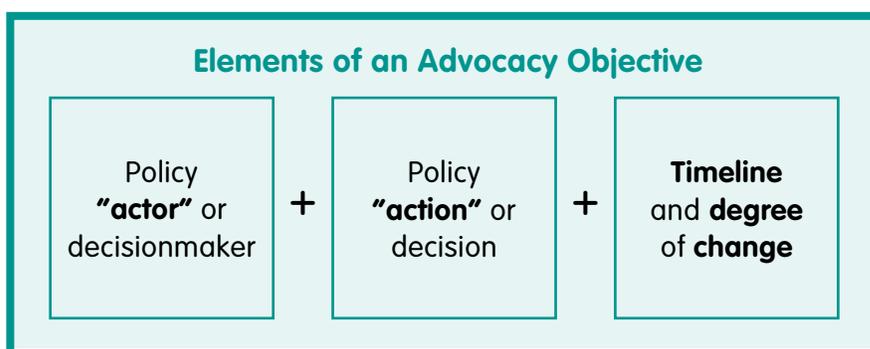


SMART Criteria

Criteria for Setting Objectives

- S – specific
- M – measurable
- A – achievable
- R – realistic
- T – time-bound

4. **Explain** that an advocacy objective includes several key elements. Write the following on the flipchart, and give a brief description of each element:



- a. **Policy actor** or **decisionmaker** is the individual who has the power to convert the advocacy objective into action (e.g., MOH, Parliamentary Finance Committee, etc.)
 - b. **Policy action** or **decision** is the action required to achieve the objective (e.g., adopt a certain policy, allocate funds to support a specific program or initiative, etc.)
 - c. **Timeline** describes when the objective will be achieved. Advocacy objectives should be achievable within one to two years. Some advocacy objectives also indicate the **degree of change**—or a quantitative measure of change—desired from the policy action. For example, degree of change could be expressed as redirecting 25 percent of the regional HIV and AIDS budget to target adolescent services.
5. **Remind** participants that, based on SMART criteria, it also is important to assess whether an objective is **ACHIEVABLE** and **REALISTIC**.
6. **Review** one of the earlier examples, and ask whether it contains these three elements. (Note: The example is not time-bound and needs revising for this reason.)

Example 1: Example from a PLHIV group

Advocacy Issue – PLHIV in Malawi denied access to care, treatment, and support.

Advocacy Goal – Equal access to high-quality health services for all PLHIV in Malawi.

Advocacy Objective – Secure a commitment from the MOH that it will provide high-quality health services to PLHIV.

7. **Divide** participants into three groups, and ask each group to draft three key advocacy objectives that
 - Respond to the advocacy issue;
 - Contribute toward achieving the advocacy goal; and
 - Include the elements listed on the flipchart (three elements) and satisfy the SMART criteria.
8. **Allow** 45 minutes to 1 hour for groups to complete this exercise.
9. When the groups have completed the exercise, **invite someone from each group** to read the group's objective and present the results of its analysis. Be sure that the policy actor, policy action, and timeframe are clearly identified in each group's objective and that the SMART criteria are satisfied.
10. **Ask** the participants for comments or suggestions after each group's presentation.

SECTION V: Moving From Issues To Advocacy Objectives

Activity 1 — Advocacy Issue Prioritization

Background Notes

The first two steps in any advocacy campaign are selecting the advocacy issue and identifying the goals and objectives. These steps make up some of the most challenging analytic work facing an advocacy organization or network. Completing them requires an ability to analyze complex environments and interrelated problems, discern policy solutions for selected problems, envision long-term results, and articulate short-term objectives. The quality of the advocates' work on these activities will have an important bearing on the success of the advocacy activities that follow. These elements provide the foundation for an effective advocacy campaign. Without a clear, articulated issue and well-defined goal and objectives, the remaining steps of the campaign will lack focus.

An **advocacy issue** is the problem or situation that an advocacy group seeks to rectify. Some advocates have focused their efforts around issues such as HIV and AIDS stigma and discrimination against people living with HIV (PLHIV). We also can examine and learn from the successful advocacy of issues other than HIV and AIDS. Some advocacy issues that have attracted attention on a global scale are the use of antipersonnel landmines; universal, safe working conditions; and the widespread sexual exploitation of women and girls. In this session, participants will select an issue that they agree is a priority and begin to build an advocacy campaign around it.

In various settings, the terms “goal” and “objective” are used interchangeably. In some instances, an objective is broad and a goal is narrow; in others, the meanings are reversed. For the purpose of A² advocacy training, an **advocacy goal** is the long-term result (3–5 years) that advocates seek to achieve. Participants should envision how the policy environment will be changed as a result of their advocacy efforts. Will all PLHIV have access to antiretrovirals (ARVs)? Will the government draft, approve, and implement a national HIV and AIDS policy, using a transparent, participatory approach? These examples represent long-term visions for policy change. A particular organization may not be capable of achieving its goal single-handed, but the goal statement can orient and focus advocates over the long term.

An **advocacy objective** is a short-term target (1–2 years) that contributes toward the achievement of the long-term goal. A sound objective is specific, measurable, achievable, realistic, and time-bound. These are known as the “SMART” criteria and are widely used. Often, groups will work on two or more objectives simultaneously in their efforts to achieve a single goal. It is important that an advocacy objective identify the specific policy body with the authority to make the policy decision or take the action that is desired and thus to fulfill the advocacy objective. Two examples of sound advocacy objectives are to (1) secure a commitment from the Ministry of Health (MOH) that, within one year, it will adopt a policy on affordable ARV treatments for PLHIV; and (2) promote the drafting and submission of a National HIV and AIDS Policy and Operational Plan for approval within one year.

Advocacy Goal:

The goal is what you hope to achieve over the next 3–5 years. The policy goal is your vision. It also is the subject of your advocacy efforts. Goals can be general.

Advocacy Objective:

The objective is a smaller and realistic step towards the achievement of your goal. It is usually what you hope to achieve in the next 1–3 years. Advocacy objectives need to be:

- S – specific
- M – measurable
- A – achievable
- R – realistic
- T – time-bound

SECTION V: Moving From Issues To Advocacy Objectives Activity 1 — Advocacy Issue Prioritization

Checklist for Choosing an Issue¹

A good policy advocacy issue is one that answers most of these criteria.

Rank your three priority issues against the questions as high, medium, or low.

HIGH = XXX MEDIUM = XX LOW = X

Issue 1:	Issue 2:	Issue 3:	Will the issue...
			1. Be widely felt (by many people)?
			2. Have broad support?
			3. Be easily understood?
			4. Result in real improvement in people’s lives?
			5. Promote awareness of and respect for rights?
			6. Help build alliances among groups?
			7. Build grassroots leadership?
			8. Enable you to further your groups’ vision and priorities?
			9. Be supported by evidence?
			10. Have a clear policy solution?
			11. Have a clear target and timeframe?
			12. Be winnable/achievable?

High – Always or almost always meets the criterion.

Medium - Often meets the criterion.

Low – Rarely or never meets the criterion.

¹ Adapted from: Bobo, K., J. Kendall, and S. Max. 1991 (reprinted 1996). *Organizing for Social Change: A Manual for Activists in the 1990s*. Santa Ana, CA: Seven Locks Press.

SECTION V: Moving From Issues To Advocacy Objectives

Activity 3 — Development of Advocacy Goals and Objectives

Advocacy Objective

Advocacy objectives should include three parts:

What Change You Want
(In policy or support for an issue)

+

By Whom
(The person or institution)

+

By When

Example:

“By X (2 years from now), the Y specific institution (name specific institution) will have established a functioning standing committee on issue Z with joint representation of the government and the affected group” (name specific advocacy issue and change desired).

SECTION VI: Identifying and Analyzing Target Audiences

- Content:**
- Activity 1 — Mapping Key Decisionmaking Processes for Advocacy Objectives
 - Activity 2 — Power Maps: Identifying Support and Opposition
 - Activity 3 — Analyzing a Target Audience

- Purpose:** In this unit, participants will continue to develop their advocacy strategy around their issue, goal, and objectives by learning to
- Create power maps to identify members of the target audience as sources of support or opposition for each advocacy objective;
 - Assess their level of influence in being able to bring about the policy change sought; and
 - Assess in more detail their target audience's knowledge, support, and actions related to particular advocacy objectives.

- Objectives:** By the end of this activity, participants will be able to create a power map and use it to identify support and opposition around a particular advocacy issue.

Background Notes:

To increase their chances of success, advocacy groups must identify and study all of the individuals and groups that may support and/or oppose the group's issue and goal. A target audience must be determined for each advocacy campaign's objective. This includes the primary target audience—persons or institutional bodies that themselves have decisionmaking authority—as well as the secondary target audience—persons or institutional bodies that can influence the decisionmakers. Documenting information about these audiences will help the group to target its advocacy activities, develop effective messages, and select the appropriate channels of communication.

While the categories of people in the target audience are not identical in every setting, the HIV policy target audience is likely to include political leaders; national and local government officials; religious leaders; private and public sector service providers; groups of people living with HIV (PLHIV); other groups representing populations vulnerable to HIV, such as sex workers, men who sex with men (MSM), and injecting drug users (IDUs); the media; community and traditional leaders; nongovernmental organizations (NGOs); women's organizations; professional associations; and business and civic groups. In some places, and for some issues, the range of audiences is even wider and may encompass groups unlikely ever to meet each other under other circumstances, such as foreign donors and traditional healers.

Once the audiences are identified, the advocacy group must determine the level of support or opposition to be expected from those in the primary and secondary target audiences. For many reasons—religious, cultural, and historical—HIV-related issues are often controversial. People

on both sides of the issue feel strongly that their position is the right one; therefore, they are likely to devote considerable energy, and sometimes resources, to supporting that position.

Whether opposition is mild or strong, advocacy groups should be prepared to address it in ways that are most beneficial to their own efforts. The best advice is to be informed as much as possible about the opposition's specific attitudes and the extent and nature of their support—in order to preempt oppositional efforts with messages that anticipate and refute the opponents' arguments.

On the other side of the coin, advocacy networks should also consider broadening their own support base. The larger the number of persons or groups working to achieve the advocacy objective, the greater the chance of success. Groups can create coalitions with other groups or formal networks, expand their own memberships, create alliances with commercial or private sector entities, or generate public and community support to enlarge their support base.

Finally, advocacy groups cannot afford to forget the “undecided” or “neutral” parties. In some cases, the best investment of time and energy is to appeal to the neutral public, who may be open to reasonable and well-expressed appeals for support and who lack strong objections to the relevant issue. The same logic applies to those decisionmakers who are known to be neutral or undecided on an issue. There still will be decisionmakers who, although not openly opposed to an advocacy goal, hesitate to voice an opinion due to the controversial nature of the HIV and AIDS issue; they may support the advocacy efforts in private but prefer to appear neutral in public. The group may decide to direct its efforts toward convincing these influential neutrals to join and support the campaign publicly or else lend their support in less public ways.

Activity 1 — Mapping Key Decisionmaking Processes for Advocacy Objectives

Time: 1 hour 15 minutes

Materials: Colored paper, markers, flipchart, tape

Prepared Materials:

PPT: N/A

Flipchart: Map of Policymaking Process, Discussion Questions: How Policy is Made (from The Policy Process Step 1)

Other: N/A

Handouts: Policy Process Map, Policy Process Example: Romania

Activity Option:

This activity can be framed either to focus participants on mapping a particular policymaking process (for example, for the National HIV and AIDS policy or another policy they seek to change) or to help participants map the specific decisionmaking process related to one of their identified advocacy issues. The process works well in both cases.



Objective: ■ To develop a policy process map for a key policy or specific advocacy objective.

Introduction:

Time: 5 minutes

- **Explain** the following:
 - For the success of the A² Project, participants must understand the specifics of how HIV and AIDS policy decisions are made, as well as the political climate in which they take place.
 - Now that participants understand the generic policymaking process, they need to move their thinking toward mapping how specific processes work when policies are formulated specifically for HIV and AIDS or how decisions are made related to a specific advocacy issue.
 - Understanding the policy decisionmaking process for a particular policy issue provides a basis for determining the degree of difficulty involved in changing that policy. It also can provide guidance for anticipating which groups will oppose reform of the policy and which will support it.

Activity Instructions:**Step 1: Mapping Decisionmaking Processes**

Time: 50 minutes

1. **Explain** that, in this exercise, participants will focus on mapping decisionmaking processes either for a key policy (such as the national HIV and AIDS policy) or a policy issue identified during the sessions on data analysis.
2. **Review** the activity instructions, noting that each group needs to
 - Select either a key policy or a policy issue identified by the group; and
 - Develop a decisionmaking/policy map that tracks the issue from its identification to the desired policy change.
3. **Direct** the groups to use the following resources for the mapping exercise, noting that the same tools used to map the overall HIV and AIDS policy process are now being applied to map decisionmaking processes specific to their key policy issues:
 - The flipchart with a schematic map for the overall policymaking process.
 - Their own knowledge of decisionmaking processes and the individuals and institutions involved.

**Note to Facilitator:**

You should be able to use the same flipchart as for the “How Policy is Made” activity; it is re-created below.

**Prepared Flipchart:****Discussion Questions: How Policy Is Made**

- How are ideas or issues generated for new or revised policies?
- How is a proposed issue introduced into the formal decisionmaking process?
- What is the process for discussing, debating, and perhaps altering the proposal? Who are the players involved?
- How is the proposal approved or rejected?
- If approved, what are the steps to move the proposal to the next level of decisionmaking?

4. **Explain** that participants will work in the same groups as they did for identifying policy issues from data.
5. **Divide** participants into groups, and distribute flipchart paper and markers to each group. Allow 45 minutes for drawing the map.

Step 2: Group Reports and Discussion

Time: 20 minutes

1. As each group presents its map, **discuss** similarities or differences among them.
2. **Facilitate** a discussion to help the participants reach agreement on the most accurate details of each map. Highlight that the participants will likely have gaps in the information needed regarding who is responsible for which decisions, details of the procedures that are followed, the timetable for policymaking processes, etc.

Activity 2 — Power Maps: Identifying Support and Opposition

Time: 1 hour 30 minutes

Materials: Each group should get numerous sheets of colored paper, marker pens, scissors, glue, flipchart paper, tape, colored paper, and old magazines that can be cut up for making power maps.

Prepared Materials:

PPT: N/A

Flipchart: Sample power map, Task for group work

Other: N/A

Handouts: Background Notes, Power Map for Audience Analysis

Objective: ■ To create a power map and use it to identify support and opposition around a particular advocacy issue.

Introduction:

Time: 10 minutes

- **Give** a brief introduction to this activity by reviewing its overall purpose, covering the major points from the Background Notes.
- **Note** that there are many strategic advocacy decisions based on a thorough analysis of the relevant target audience.
- In this activity, participants will first learn a technique to identify primary and secondary target audiences for their specific advocacy objectives.
- Participants then will assess in more detail the audiences' levels of knowledge and support for the issue and objective.

Activity Instructions:

Step 1: Creating a Power Map

Time: 35 minutes

1. **Construct** a hypothetical power map to demonstrate this activity to participants.
2. Use the following example to **review** the steps in the mapping process:

Advocacy objective: Within the next year, convince the government in your country that at least two PLHIV networks need to be a part of the Country Coordination Mechanism.

Target audience: Allies might include national and regional PLHIV networks, a coalition of AIDS service organizations, or AIDS-related NGOs. These would be placed on the left of the map, in proper relation to one another. Opposition might include the Minister of Health (MOH) or other government members who have expressed discrimination against PLHIV groups. These would be placed on the right side of the map.

3. **Present** the sample power map on flipchart paper or a PowerPoint slide. Divide the power map into quadrants to account for primary and secondary audiences and those who are supporters, opponents, or neutral, as below:

Advocacy Objective:		
SUPPORT	NEUTRAL	OPPOSITION
Primary		
Secondary		

4. **Explain** that participants will work in the same groups as they did for the advocacy goals and objectives. The task for each group is to create a “power map” that visually depicts the target audience—primary and secondary audiences, supporters, opponents, and those who are neutral—for its own advocacy objective.
5. **Review** the task written on the flipchart by using the sample map as a model.
6. **Distribute** colored paper and markers to the groups, and show them the scissors, colored paper, magazines, glue, and other supplies to use in creating their power maps.

Task for Power Maps

1. List all institutions and individuals with interest in your issue/objective (supporters, allies, opposition, undecided, or unknown), by primary and secondary audience.
2. For each institution or individual, cut out a symbol and label it. You can use different sizes to show the relative importance and influence of each decisionmaker.

7. As you **review** the task, elaborate on several steps, as follows:
- a. Participants should think of traditional as well as nontraditional actors in the policy process, including community leaders, celebrities, or business leaders. Groups should be as creative as possible when thinking about their primary and secondary audiences. Influential persons can often be found beyond professional circles, including in personal relationships. For example, a relative or friend of a high-level decisionmaker can be a great intermediary.
 - b. If the actor is highly supportive of the issue/objective, the symbol should be placed on the left side of the map. If the actor represents strong opposition, the symbol should be placed on the right side. The line of neutrality is in the center of the map, and those actors who are undecided or whose opinion is unknown should be placed closer to the center line. If any actor is closely linked to another, their symbols can overlap or touch to reflect the interrelationship. Note that on the power maps, **size = power** and the participants may want to indicate the relative power of members of their primary and secondary target audiences.

Note to Facilitator: Remind the participants not to assume that there will be no conflict when working with other allies. Just because you may be working toward the same cause, does not mean that everyone always will be amenable and flexible regarding all of the activities and suggestions in an advocacy action plan. Make sure to have good communication with your allies regarding all aspects of your plan so as to attain your goals and objectives.



Step 2: Discussing the Power Map

Time: 45 minutes

1. **Allow** the groups 45 minutes to complete their power maps.

Note to Facilitator: If you have a camera or photographer at the workshop, this exercise offers a good photo opportunity. Following the presentations, you can take photos of each group with its power map.



2. **Ask each group** to present its map. Moderate a discussion of each map with the full group. Ask the following questions:
 - Are there any additional allies that belong on the map? Who are they?
 - Are there additional opponents? Who are they?
 - Does the map capture the interrelationships or connections among the different actors?
 - Where on the map do most of the power and influence reside?
 - What does this map suggest to you about where to focus your advocacy efforts?
3. **Conclude** by noting that this mapping exercise also helps to identify where and with whom to build alliances and support; this is a key step in the advocacy process.

Activity 3 — Analyzing a Target Audience

Time: 1 hour 5 minutes

Prepared Materials:

PPT: N/A

Flipchart: N/A

Other: N/A

Handouts: Primary and Secondary Audience Analysis Form

Objective: ■ To identify primary and secondary target audiences, and analyze their interest in an advocacy issue.

Introduction: ■ Explain that, to better understand one's support and opposition—a key component of effective advocacy—it is important to have an in-depth understanding of each potential target audience. This activity presents a method for analyzing target audiences in more detail.

Activity Instructions:

Step 1: Selecting Primary and Secondary Target Audiences

Time: 20 minutes

1. **Ask** participants to continue working in the same groups as they did for the power map activity.
2. **Distribute and review handout:** Primary and Secondary Audience Analysis Form.
3. **Explain** that the form is a planning tool to help design effective advocacy activities and messages for the various actors in the target audiences.
4. **Ask each group** to refer to the actors they identified on their power map. Identify which of those actors are members of the primary audience—the person(s) and/or institutional bodies with the power to achieve advocacy objectives directly, which are members of the secondary audience—and which are the person(s) and/or institutional bodies that can influence members of the primary audience and will work as your allies in implementing your advocacy activities. The groups should write the names in the appropriate box on the form, and complete the remaining columns as follows:
 - **Level of knowledge about the advocacy issue.** Is the audience well informed or does it lack accurate information? How much does the audience know about the issue?
 - **Level of demonstrated support toward the issue.** Has the audience actively and/or publicly supported this issue? Rank the evidence of support.
 - **Level of demonstrated opposition toward the issue.** Has the audience actively/or publicly opposed the issue? Rank the evidence of opposition.
 - **Undecided or unknown.** Has the audience failed to declare its position on the issue? Are you uncertain of its position at this time? If the assessment is “undecided or unknown,” place a question mark in this column. Otherwise, leave it blank.

- **Potential benefits to the audience.** How might the target audience for your advocacy activities benefit from supporting your issue and objective? For example, celebrities from the entertainment industry may believe that it will enhance their image to be associated publicly with a “benevolent cause,” such as increasing access to antiretrovirals (ARVs) for PLHIV who are from resource-constrained settings. Or politicians may feel that they gain kudos in regional forums when they are seen as taking the lead on a serious global issue such as HIV prevention.
5. **Ask** participants to choose 1–2 key audience members from their primary and secondary audience list (which they have previously brainstormed for the purposes of constructing the power map).

Step 2: Analyzing Primary and Secondary Target Audiences

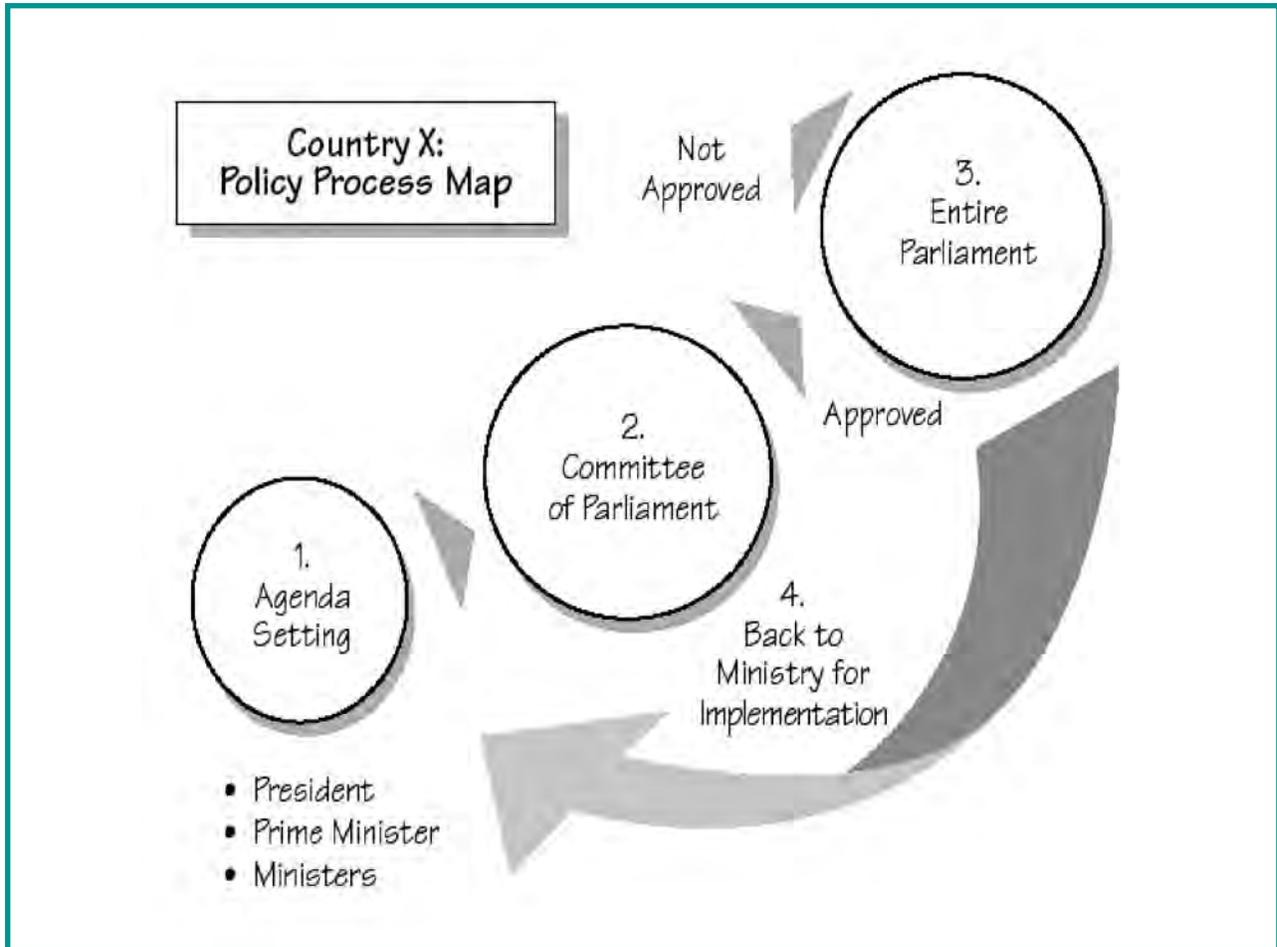
Time: 45 minutes

1. **Allow** 45 minutes for the groups to complete their primary and secondary audience analysis forms.
2. When the groups have completed the forms, **invite each group** to summarize its work. **Moderate** a discussion with the full group. Some sample questions include the following:
 - What are the general observations about the audience analysis? For example:
 - Is there more information needed about some key actors?
 - Is the opposition more vocal/public than the supporters?
 - Has a relative of the MOH publicly supported your advocacy issue?
 - Based on the use of the Primary and Secondary Audience Analysis Form, would you make any changes to the focus of your advocacy efforts?
 - Why is it important to identify potential benefits to target audiences?
 - What, if any, additional information is needed for an accurate assessment of the target audience? Where will you get the information?
3. **Conclude** the activity by reminding participants that their advocacy group should continue to collect information about its target audiences and add it to the form. Information on the various audience members will help to define the overall strategy and the appropriate tailoring of messages.

SECTION VI: Identifying and Analyzing Target Audiences

Activity 1 — Mapping Key Decisionmaking Processes for Advocacy Objectives

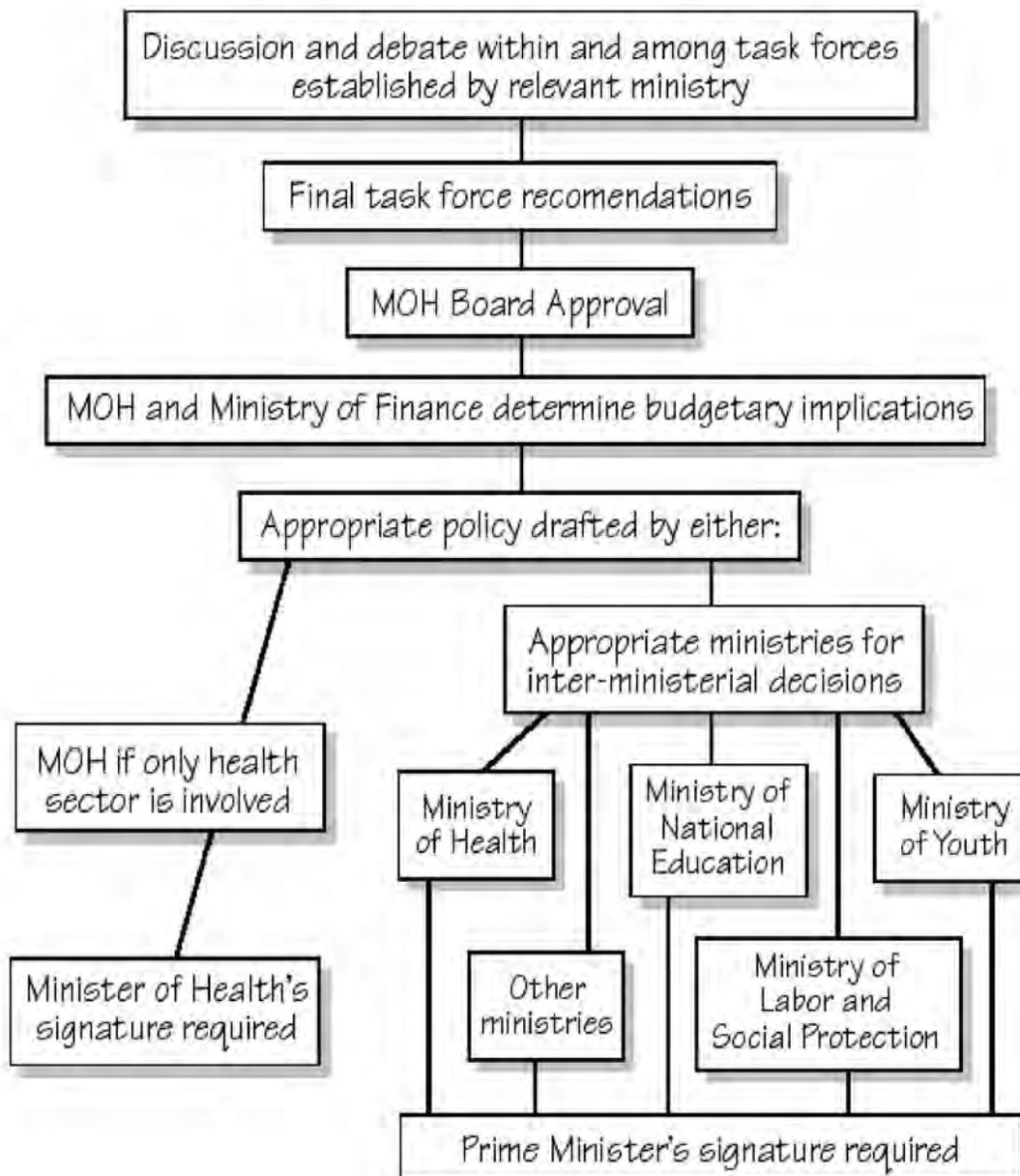
Policy Process Map



SECTION VI: Identifying and Analyzing Target Audiences Activity 1 — Mapping Key Decisionmaking Processes for Advocacy Objectives

Policy Process Example: Romania

Regulatory Stage of the Process of Health Care Reform in Romania



SECTION VI: Identifying and Analyzing Target Audiences

Activity 2 — Power Maps: Identifying Support and Opposition

Background Notes

To increase their chances of success, advocacy groups must identify and study all of the individuals and groups that may support and/or oppose the group's issue and goal. A target audience must be determined for each advocacy campaign's objective. This includes the primary target audience—persons or institutional bodies that themselves have decisionmaking authority—as well as the secondary target audience—persons or institutional bodies that can influence the decisionmakers. Documenting information about these audiences will help the group to target its advocacy activities, develop effective messages, and select the appropriate channels of communication.

While the categories of people in the target audience are not identical in every setting, the HIV policy target audience is likely to include political leaders; national and local government officials; religious leaders; private and public sector service providers; groups of people living with HIV (PLHIV); other groups representing populations vulnerable to HIV, such as sex workers, men who sex with men (MSM), and injecting drug users (IDUs); the media; community and traditional leaders; nongovernmental organizations (NGOs); women's organizations; professional associations; and business and civic groups. In some places, and for some issues, the range of audiences is even wider and may encompass groups unlikely ever to meet each other under other circumstances, such as foreign donors and traditional healers.

Once the audiences are identified, the advocacy group must determine the level of support or opposition to be expected from those in the primary and secondary target audiences. For many reasons—religious, cultural, and historical—HIV-related issues are often controversial. People on both sides of the issue feel strongly that their position is the right one; therefore, they are likely to devote considerable energy, and sometimes resources, to supporting that position.

Whether opposition is mild or strong, advocacy groups should be prepared to address it in ways that are most beneficial to their own efforts. The best advice is to be informed as much as possible about the opposition's specific attitudes and the extent and nature of their support—in order to preempt oppositional efforts with messages that anticipate and refute the opponents' arguments.

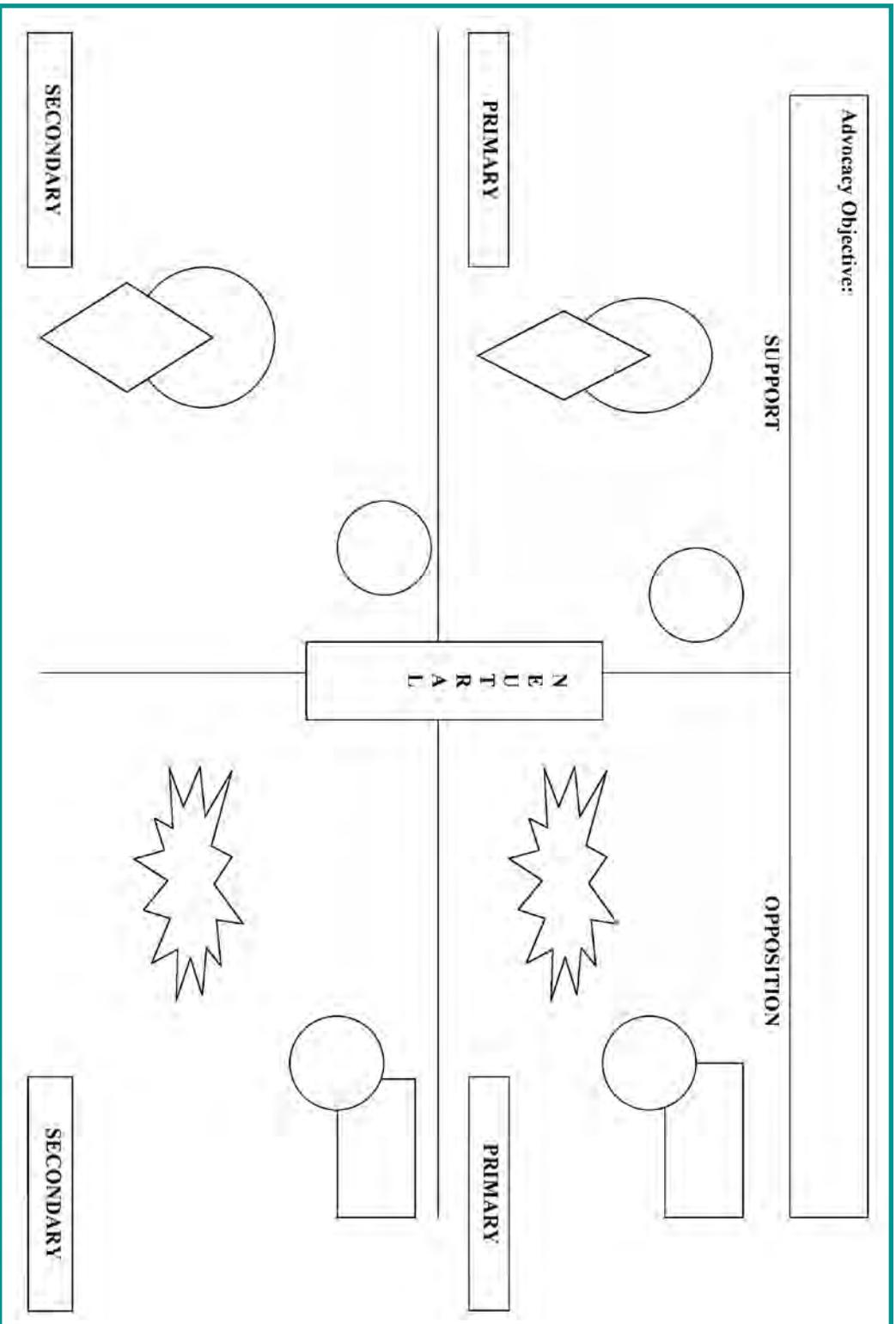
On the other side of the coin, advocacy networks should also consider broadening their own support base. The larger the number of persons or groups working to achieve the advocacy objective, the greater the chance of success. Groups can create coalitions with other groups or formal networks, expand their own memberships, create alliances with commercial or private sector entities, or generate public and community support to enlarge their support base.

Finally, advocacy groups cannot afford to forget the “undecided” or “neutral” parties. In some cases, the best investment of time and energy is to appeal to the neutral public, who may be open to reasonable and well-expressed appeals for support and who lack strong objections to the relevant issue. The same logic applies to those decisionmakers who are known to be neutral or undecided on an issue. There still will be decisionmakers who, although not openly opposed to an advocacy goal, hesitate to voice an opinion due to the controversial nature of the HIV and AIDS issue; they may support the advocacy efforts in private but prefer to appear neutral in public. The group may decide to direct its efforts toward convincing these influential neutrals to join and support the campaign publicly or else lend their support in less public ways.

SECTION VI: Identifying and Analyzing Target Audiences

Activity 2 — Power Maps: Identifying Support and Opposition

Power Map for Audience Analysis



SECTION VI: Identifying and Analyzing Target Audiences Activity 3 — Analyzing a Target Audience

Primary and Secondary Audience Analysis Form

PRIMARY AUDIENCE. The individuals and/or institutional bodies with decisionmaking authority (re: advocacy objective).	Level of Knowledge About the Issue (Rank 1-5) 1—low; 5—high; if unknown=?	Level of Previous Support Demonstrated (Rank 1-5) 1—low; 5—high; if unknown=?	Level of Previous Opposition Demonstrated (Rank 1-5) 1—low; 5—high; if unknown=?	Potential Benefits to Audience Related to the Issue
SECONDARY AUDIENCE. The individuals and/or institutional bodies that can influence the primary audience.				

SECTION VII: Developing Advocacy Messages and Methods

- Content:**
- Activity 1 — Introduction to Effective Advocacy Communication
 - Activity 2 — The One-Minute Message
 - Activity 3 — Advocacy Messages and Methods (Guest Speaker)
 - Activity 4 — Increasing Message Effectiveness (Role Play)
 - Activity 5 — Written Communication (Policy Briefs)
- Purpose:**
- To familiarize participants with the essential components of effective advocacy messages for HIV and AIDS.
 - To provide practical opportunities to practice and refine advocacy messages.
- Objectives:** By the end of this unit, participants will be able to
- Identify the factors that influence whether advocacy messages are effective;
 - Understand and apply the elements and characteristics of effective HIV and AIDS advocacy messages (both oral and written);
 - Practice developing and delivering effective advocacy messages; and
 - Appreciate the complexities of developing and delivering effective advocacy messages based on advocates' real-world experiences.

Background Notes:

In most countries, people are bombarded by messages every day. The intent of the message may be to sell us a product, inform or educate us in some way, or change our opinion about an issue. An advocacy communication strategy follows many of the same principles as an advertising or social marketing campaign. It is essential to know your audience thoroughly and to deliver a concise and consistent message that is tailored to your audience's interests and has the maximum chance of appealing to them.

As a matter of common sense, most people shape their messages to the needs and interests of a particular audience. For example, the message communicated to a parents group about providing family planning services to adolescents would differ from the message transmitted to officials in the Ministry of Health.

Audience research—particularly qualitative research, such as focus group discussions and in-depth interviews—helps to identify appropriate message forms and content for various advocacy audiences. Whatever the target audience, it is important to remember three other points about advocacy message development:

1. Ideally there should be only **one main point communicated**, or, if that is not possible, two or three at most. It is better to leave people with a clear impression of one message than to confuse them with too many.
2. Messages always should be **pre-tested with representatives of the target audience** to ensure that the message sent is the one received. When a network develops an advocacy message directed toward the Minister of Health (MOH), for example, it is always useful

to practice delivering the message to a supportive ministry official, or other person familiar with your target audience, as a test run. The ministry official may offer valuable feedback about how the message will be interpreted by the MOH and how your message could be revised for maximum effectiveness.

3. The message should not only persuade through valid data and sound logic, but also **describe the action the audience is being encouraged to take**. The audience needs to know clearly what it is that you want it to do—for example, include antiretroviral therapy (ART) in the national health insurance program and show support for the issue by attending a rally on the steps of Parliament.

This section addresses the essential components of a message—content, language, source, medium, format, and time and place of delivery. Following skills-building exercises, participants will be asked to apply what they know about advocacy message development and delivery through role-play scenarios with decisionmakers.

Activity 1 — Introduction to Effective Advocacy Communication

Time: 1 hour 10 minutes

Materials: Colored paper, markers, flipchart, tape

Prepared Materials:

PPT: N/A

Flipchart: Write two statements on flipchart (Step 1); write Advocacy Communication definition on flipchart (Step 2, Part C), write Advocacy Communication Model on flipchart (Step 2, Part C)

Other: Three sheets of colored paper with “Strongly Agree,” “Strongly Disagree,” and “Undecided” written on them: (Part 1), five elements of messages (Step 2, Part B)

Handouts: Background Notes, Five Key Elements of an Advocacy Message, How to Choose Appropriate Advocacy Methods, “Advocacy in Action” Card: Lobbying or Face-to-Face Meetings, “Advocacy in Action” Card: Writing and Delivering a Presentation

- Objectives:**
- To understand the key elements of effective advocacy messages.
 - To practice developing and delivering advocacy messages.

Introduction:

As advocates, you will need skills to effectively communicate information—sometimes of a complex or technical nature—to policymakers. If you gain direct access to policymakers, you are likely to have only a short time to present information regarding your advocacy issue. You should aim for a communication style—whether written or oral—that is brief, clear, evidence-based, and identifies the problem to be solved and the way to solve it. The following activities aim to contribute to the development of the skills needed for effective advocacy communication.

Activity Instructions:

Step 1: Techniques of Persuasion

Time: 30 minutes

1. **Post** one piece of colored paper (Strongly Agree) at one end of the longest wall in the training room; post the second piece of colored paper (Strongly Disagree) at the other end of the same wall; and post the third piece of colored paper (Undecided) in the middle.
2. On a flipchart, **write** two controversial statements that will elicit both strongly positive and strongly negative responses from participants. You should develop these statements according to the local environment. Some examples include the following:
 - Education on HIV and AIDS should be incorporated into the formal curriculum for all students from grade 5 (average age 10 years) upwards.
 - All people living with HIV should be expected to make a financial contribution to the cost of receiving ART and other HIV-related healthcare services, according to their ability to pay. No one should expect to receive services for free.

3. **Explain** that this activity is designed as a warm-up for the topic of message development, public opinion, and techniques of persuasion.
4. **Point out** the three sheets of colored paper on the wall, and explain that they represent a continuum of public opinion, ranging from “strongly agree” to “strongly disagree.” Participants should imagine that they are participating in a quick public opinion survey. Tell participants that you will read a statement aloud, and that they will express their opinion by standing at the point on the continuum that best reflects their viewpoint. They need not stand precisely under any of the signs but may choose to position themselves at any point along the continuum, according to their opinion on the relevant issue. The participants must react to the statement exactly as you read it—they may not alter or question it.
5. **Be certain** that everyone understands the instructions before you read the first statement.
6. **Read** the first statement slowly and clearly so that everyone hears the same words. Display the statement on the flipchart, and slowly read the statement a second time. Ask all participants to stand up and position themselves along the continuum according to their opinion.
7. Once each participant has taken a position, **explain** that the purpose of the activity is to practice the skill of persuasion. Participants standing under “strongly agree” or “strongly disagree” may try to convince the “undecided” to move over and support their positions. If any participant changes his/her opinion during the exercise, he/she should move to the appropriate point on the continuum.
8. **Turn** first to those standing under “strongly agree.” Invite one or two participants to explain their position in an effort to persuade the “undecided” to change their opinion. Check to see if any “undecided” feel persuaded to move.
9. Next, **invite** one or two participants who “strongly disagree” to articulate their position in an effort to persuade the “undecided” to move.
10. Finally, **ask** any remaining “undecided” why they did not move, and whether they feel inclined at this point to change their minds.



Note to Facilitator: Try to manage the group in such a way that a heated argument does not develop. If the discussion gets too heated, simply remind participants that the objective of the activity is not to debate the issue but rather to convince an undecided audience.

11. After 5 to 10 minutes have elapsed, **stop** the discussion and **read** the second statement. Follow the same instructions as for the first statement.
12. After 5 to 10 minutes again have elapsed, stop the discussion and **ask** participants to return to their seats.

13. “Moderate” a discussion about what the participants learned from the exercise.

Discussion questions and possible responses include the following:

- As you stood along the continuum, which persuasive techniques (if any) influenced you to change your position? (Try to pinpoint the specific argument or communication technique that led them to change their opinion.)
 - Use of facts and figures
 - Use of real-life, human examples
 - Appealing to individuals on a personal level
 - Listening to the speaker’s viewpoint
 - Did the speakers use any techniques that alienated you (e.g., a loud or aggressive voice or exaggeration of the facts)?
- When the objective is to build support for your cause or issue, which is more effective—to debate with your adversaries or to persuade neutral parties? Note: the response may vary from one advocacy campaign to another; however, in many cases, an attack on the opposition simply heats up the debate. At times, an attack on your opponents may alienate a neutral public.
- If any of the “undecided” failed to change their opinion, ask them to explain why the arguments were unappealing or unpersuasive.

Final Note: Transition to the next activity by concluding with the following points:

- As demonstrated in this exercise, advocacy communication often involves the ability to persuade a policymaker, an influential person, or the public to listen to a reasoned argument and to agree to support an issue. This type of communication requires messages that are tailored to the specific audience that advocates are trying to reach. It also requires that the purpose of advocates’ communication is clear. The communication could seek to inform an audience about an issue to generate support, persuade an audience to join and support the advocacy effort, and ultimately move the audience to take action to support or implement the desired policy change.
- Note that this session will focus on understanding the theory of effective communication and providing opportunities to put this theory into practice.



Step 2: Brief Lecture on the Characteristics of an Effective Advocacy Message and Advocacy Communication Model

Total Time: 40 minutes

Characteristics of an Effective Advocacy Message

Time: 10 minutes

1. **Remind** the group that they have had a lot of life experience in evaluating what makes effective messages. In addition to the exercise on persuasive messages, every day they are bombarded with messages.
2. **Explain** that, based on this experience, we want to capture what makes for effective and ineffective messages.
3. **Invite** the group as a whole to share its collective thinking about and experience with messages.
4. **Ask** the group to share its ideas about what makes for appealing message characteristics. Capture these on the flipchart. Be certain to include the characteristics shown below:

Characteristics of Effective Messages

- Simple
- Concise
- Tone/language consistent with message (serious, humorous)
- Appropriate language
- Credible messenger (spokesperson)

5. Also, **ask** the group to consider the characteristics of unappealing messages. Again, capture these on a flipchart.

Characteristics of Ineffective Messages

- Complicated
- Too long
- Inappropriate images/language
- Uninteresting
- Not relevant to audience

6. **Conclude** by reminding participants to keep these characteristics in mind when they begin developing their HIV and AIDS advocacy messages. It is important to remember that not everyone understands HIV issues or considers them priorities and that messages must be kept simple and precise to inform, persuade, and move audiences to act.

Elements of Messages

Time: 10 minutes

1. **Explain** that in actually developing messages, there are key elements or building blocks.
2. **Write** the following elements of a message on colored paper:

Five Elements of Messages

- Content/ideas
- Messenger/source
- Time/place
- Language
- Format/medium

3. **Review** each element of a message using the following notes:
 - **Content/ideas.** The content refers to the central idea of the message. What is the main point you want to communicate to your audience? What single idea do you hope the audience will retain after receiving your message?
 - **Language.** Language consists of the words you choose for communicating your message. Is the language appropriate for your target audience? Is the choice of words clear or could they be interpreted differently by various audiences? Is it necessary to use a local dialect or vernacular to communicate the message?
 - **Messenger/source.** Source refers to the person or persons delivering the message. Is the messenger credible to your target audience? Is it possible to include beneficiaries as spokespersons or messengers? For example, you might invite a community or religious leader to join you for a high-level meeting with a policymaker. Advocacy groups can send a powerful and more meaningful message to policymakers by letting the message come from a member of the affected population.
 - **Format/medium.** The format or medium is the communication channel you choose for delivering the message. What is the most compelling format to use in reaching your target audience? Different channels are more effective for different audiences.
 - **Time/Place.** Choosing the time and place for delivery of your advocacy message can affect the impact the message. Where you want to achieve media coverage of your issue, you will need to know and coordinate with journalists' timetables for covering and submitting news stories, as well as taking into account the times of the day or week when your particular issue is more likely to receive media coverage. Other considerations regarding timing will apply, depending on the targeted audience. The place you choose to deliver your message can also affect the impact of your message. For example, an advocacy group seeking stronger environmental protection laws may choose an environmentally degraded site to launch their campaign—or they may hold a public meeting in front of the relevant legislature to illustrate that policymakers need to act. Advocates should think about their target audience when choosing a place to deliver their advocacy message.

Advocacy Communication Model

Time: 10 minutes

1. **Explain** that, in communicating a message for advocacy, you want your target audience to take action and bring about a desired policy change.
2. **Review** the advocacy communication definition.
3. **Display** a flipchart or PowerPoint slide:

Advocacy communication is any planned communication activity that seeks to achieve one of the following communication goals: inform, persuade, or move to action.

4. **Explain** that there is a model that illustrates the definition. Display flipchart:



5. **Tell** participants that the key to effective communication is a clear understanding of the audience and an ability to see the issue from the audience's perspective.
6. **Tell** participants to think back to their target audience analysis:
 - Participants identified how each individual in the audience could benefit professionally, politically, or personally from supporting the advocacy issue/objective.
 - These answers should be considered and incorporated into an advocacy message directed to each member of the target audience.
7. **Tell** participants to look at the model and note that advocacy communication often focuses on the first level—**INFORM**. Information, education, and communication activities occur here. Audiences often need more information to develop a thorough understanding of the issue and the desired policy change.
8. **Explain** that, once the audience is informed, the strategy moves to the next level to produce greater impact. At this level, the advocate wants to **PERSUADE** the audience to feel as strongly as the advocate does about the issue and to adopt the desired position.
9. **Explain** that, once understanding and support are achieved, communication moves to the highest level. At this point, advocacy messages move the audience to **ACT** in support of the issue.
10. **Explain** that every advocacy effort should have moving the target audience to action as its ultimate goal.

Advocacy Communication Methods

Time: 10 minutes

1. **Remind** the group that one of the elements of advocacy messages is the medium they choose, and explain that the final part of the lecture on advocacy communication basics will focus on this element.
2. **Ask** the group to brainstorm a list of communication methods for advocacy messages. Record the responses on the flipchart and be certain to include the following:

Methods (Medium) for Delivering Messages

- Face-to-face meetings
- Executive briefing packets
- Public rallies
- Fact sheets
- Policy forums
- Contests to design posters, coin slogans
- Poster, flyers in public places
- Petitions
- Public debate
- Press releases
- Press conferences

3. After the participants have brainstormed an exhaustive list of ways to deliver messages, **ask** them to think about the criteria they would use when choosing an appropriate medium. Possible responses may include the following:
 - **Audience.** Some formats are more effective and more appropriate for specific audiences. For example, high-level policymakers have little time and many constituents. The message needs to give them the facts and move them to action quickly; also, always leave information for them to read later. Effective media for policymakers include briefing packets, fact sheets, face-to-face meetings, and policy forums.
 - **Cost.** Using mass media such as radio, television, or print media can be extremely costly. Advocates should seek out any free or reduced-cost opportunities if the mass media is the medium of choice. An example of how this can be done is providing information and spokespersons for news and current affairs programs and articles dealing with your advocacy issue. In these circumstances, the media outlet generally will cover the production costs of reporting on your advocacy issue. Note that there is a separate module in this training course on “Using the Mass Media for Advocacy.”
 - **Risk.** When advocates go public with an HIV-related advocacy issue, there is always the risk of creating controversy. Certain advocacy tactics entail more risk than others. Public debates and live forums highlighting both sides of an issue can turn into heated events. Nevertheless, this risk can be minimized through careful planning, selection of speakers, and rehearsals.
 - **Visibility.** Advocates may choose one medium over another if they can use a media contact or connection to raise the visibility of an event. Perhaps a celebrity or high-ranking public official would be willing to pay a site visit to a project or make the opening speech at a meeting. Such an event may provide an excellent opportunity to recruit other decisionmakers and promote a particular advocacy objective.

- **Time/place.** When and where will the message be delivered? Are there other political events to which you can link to draw more attention to the issue? Some advocacy groups connect their advocacy activities with events such as World AIDS Day or International Women’s Day. Is there an electoral campaign underway that might make policymakers more receptive than normal to your message?
4. **Ask** participants to consider whether some methods (and messengers) are more appropriate to their local cultural contexts or the advocacy issues they have prioritized. Elicit a few responses.
 5. **Conclude** by reminding participants that the methods they choose interact with all of the other elements of an effective advocacy communication message. Also note that it is rare for one method to be used in isolation. Instead, various methods usually are combined, either simultaneously or over time.
 6. **Transition** by explaining that participants should now have a basic understanding of the characteristics and elements of effective advocacy messages. The next few activities provide an opportunity for them to practice developing and delivering advocacy messages to members of their hypothetical target audiences—as well as to further refine their assessments of what makes advocacy messages effective.

Activity 2 — The One-Minute Message

Time: 1 hour 15 minutes

Materials: Marker pens, colored paper, flipchart paper, tape

Prepared Materials:

PPT: N/A

Flipchart: Elements of the One-Minute Message

Other: N/A

Handouts: The One-Minute Message, Message Development Worksheet

Objective: ■ To practice developing and delivering effective advocacy messages.

Introduction:

Time: 5 minutes

- Remind participants of the importance of presenting clear and concise messages to achieve effective advocacy communication.
- Explain that, to gain practice in delivering messages, we will start by using a simple framework to structure our approach to developing the message's content.

Activity Instructions:

Step 1: Introduction to the One-Minute Message

Time: 10 minutes

1. **Show** the flipchart with the One-Minute Message written on it. Use the following notes to provide an overview:
 - A critical component of advocacy campaigns is media attention. Advocates may invite journalists to attend selected events to increase the visibility of the issue and to ensure that their message reaches a wider audience. Media presence usually means that someone from the advocacy group will be interviewed about the event and the issue. In interactions with mass media, it is vital that the spokesperson communicate both the main idea and the desired action of the advocacy message in 30 to 60 seconds. In some cases, additional time may be allocated to your issue but prepare for 30 to 60 seconds if the item is part of news or current affairs reporting.
 - To ensure that the central points of the message are communicated during such a brief period, spokespersons must be skilled at delivering the One-Minute Message. This simple model will help to focus the speaker on constructing or tailoring a message for a television or radio interview. It also can be used for print media interviews or for introducing issues to policymakers in face-to-face meetings.
2. **Explain** that the One-Minute Message includes four components:
 - **Statement.** The statement is the central idea of the message (as defined on the Message Development Worksheet). The spokesperson should be able to present the essence of his or her message in several strong sentences.

- **Evidence.** The evidence supports the statement or central idea with facts and/or figures. The message should include limited data that the audience can understand easily—such as “only one out of ten sex workers has access to reproductive health services, including STI screening” rather than “4,253,800 sex workers in our country do not have access to reproductive health or STI services.”
- **Example.** After providing the facts, the spokesperson should add a human face to the story. An anecdote based on a personal experience can personalize the facts and figures. It reminds listeners that this not just an abstract policy issue but rather one that affects people’s health and well-being.
- **Action Desired.** The desired action is what you want the audience to do as a result of hearing the message. The advocacy objective should be stated clearly to the target audience as a call to action.

The One-Minute Message

Statement + Evidence + Example + Action Desired

3. Read the following example provided by a group of volunteers providing home care support to people living with HIV:

Example: One-Minute Message (Option 1):

Statement. HIV and AIDS are serious threats to our country’s economic well-being and are creating a huge burden on individual families and communities. We no longer can afford to avoid this issue at the national level.

Evidence. There are more than one million people infected with HIV, and this figure continues to grow. In the next five years, one million children will have lost one or both parents to AIDS-related illnesses. The age group most affected by HIV is the 15–50 year olds, so HIV negatively affects our labor force, family structures, and community development efforts.

Example. Our group has been supporting Paew, a young teen-aged woman, during the past two years. Paew has lost both parents and several other extended family members to AIDS-related illnesses. Her village knows that her family has been affected by HIV, and, as a result, she and her siblings experience stigma. She is unable to continue her education because she must spend her time caring for younger siblings. They do not have enough to eat. Paew has had to leave her siblings in the care of neighbors in the village and move to an urban center, where she engages in sex work to send money home to feed and clothe her siblings. Her situation is typical of many women in our country.

Example: One-Minute Message (Option 2):

Statement. The region’s HIV epidemic is accelerating; however, the response of most governments has been low key, according to the Asia-Pacific Leadership Forum on HIV/AIDS and Development (APLF).

Evidence. HIV threatens every country in Asia. More than a 1 million people in the region became infected with HIV in 2005—that is, two people every minute. Until now, overall levels of HIV infection in most countries have remained low. However, a low prevalence rate in the country as a whole can mask extremely high infection rates in local populations.

Example. Many leaders in the region treat HIV and AIDS as a distant or even nonexistent problem. Warnings about the current and potential future impact of the epidemic receive little official attention and sometimes provoke hostility. “People claim we are exaggerating. Their response is: ‘Oh we’re not Africa, we’re not Thailand, we’re different’. It’s that denial thing even now.” Nafsiah Mboim, ex-member of Parliament, HIV activist, Indonesia.

4. **Ask** participants the following:
 - What is missing from each message? (The action desired from the audience.)
 - How would you complete this message with a prescription for action?
5. **Ask** participants if they have any questions about the elements and characteristics of effective messages.
6. **Remind** them that they need to develop messages for their different audiences.

Step 2: Group Work

Time: 30 minutes

1. Explain the One-Minute Message exercise to the group.
2. Review the following instructions; write them on a flipchart.

One-Minute Message

1. Decide the Advocacy Communication Objective
2. Choose one Target Audience
3. Decide the Context
 - a. Time/place
 - b. Who is delivering the message
 - c. What method (s) you are using
4. Develop a One-Minute Message

3. **Allow** 30 minutes for each group to develop its message.

Step 3: Presentation of One-Minute Messages

Time: 30 minutes

4. **Ask** each group to present its One-Minute Message, allowing no more than 5 minutes for the group presentation and questions.
5. Following each role play, **ask** the full group for feedback. Use the following questions to guide the discussion:
 - Were any elements of the One-Minute Message missing?
 - Was the central advocacy statement clear? What was it?
6. **Conclude** the activity by noting that it is important to remember all of the key elements of communicating the message effectively (format/medium; time/place; messenger/source; language; content/idea) to make the messages as effective as possible.

Activity 3 — Advocacy Messages and Methods (Guest Speaker)

Time: 1 hour

Materials: Markers, flipchart, tape

Prepared Materials:

PPT: As required by guest speaker

Flipchart: N/A

Other: N/A

Handouts: As provided by guest speaker

Objective: ■ To deepen participants' understanding of how to develop and deliver effective advocacy messages based on the advocate's real-world experiences.

Introduction: ■ Explain that the art of developing advocacy messages is best understood in the context of real-world experience. Hence, it is important to learn, based on people's actual experiences, how effective advocacy messages have been developed and delivered in the context of real-world advocacy.

Activity Instructions:

Step 1: Learning About Effective Advocacy Messages

Time: 1 hour

1. **Introduce** the guest speaker.
2. After the presentation, **facilitate** a question and answer session that includes any discussion questions not already answered in the presentation.

Discussion Questions: Effective Advocacy Messages and Methods

- What was the issue with which the advocate had to deal?
 - What was the advocacy objective?
 - Who decided to advocate to address the problem (who was involved)?
 - Who were the members of the target audience?
 - What were the key messages (main focus)? What methods were used to convey those messages?
 - What difficulties did the advocate face, and how were these overcome?
 - What were the results of the advocacy activities?
 - What sources of support did the advocate find most useful?
 - What did the advocate, and the others involved, learn from undertaking these advocacy activities?
3. **Thank** the presenter and conclude the activity.

Note to Facilitator:

A sample letter of invitation to a guest speaker, including suggested topics for the speaker's presentation, is included in the annex of additional materials.



Activity 4 — Increasing Message Effectiveness: Role Play

Time: 1 hour 15 minutes

Materials: Stopwatch to indicate time left, marker pens, flipchart, tape

Prepared Materials:

PPT: N/A

Flipchart: Elements of the One-Minute Message (from earlier session)

Other: N/A

Handouts: N/A

- Objectives:**
- To improve the effectiveness of advocacy messages by focusing on the use of evidence and appeals to audience interests.
 - To demonstrate improved ability in effectively developing and delivering advocacy messages.

- Introduction:**
- **Ask** participants to reflect on their experiences in delivering their One-Minute Message and on the real-world experiences shared by the guest speaker. Note that, among other things, we saw that effective messages need to reach their target audience as powerfully as possible by using the right information, motivational images, language, and reasoning that will truly move their target audiences.
 - **Explain** that this exercise provides the opportunity for participants to refine and further develop their understanding of what makes for effective advocacy communication.

Activity Instructions:

Step 1: Introduction to Refining Effective Advocacy Communication Skills

Time: 5 minutes

1. **Explain** that, to refine the effectiveness of their messages, participants should focus on two key elements: statement of the advocacy issue in a way that will best motivate their particular audience (based on their personal interests) and how best to present data as part of the message.

Note to Facilitator:

Based on the original One-Minute Messages, for the additional session, the facilitator could choose to highlight two other aspects of developing effective messages.



2. For each of the two areas, **ask** participants to highlight the keys to success. Record their answers on a flipchart.

Step 2: Group Work

Time: 30 minutes

1. **Explain** that now we want to give participants the chance to practice developing and delivering advocacy messages, using what they see as a particularly effective method to reach that audience. Explain that this will be accomplished by providing them with the opportunity to refine their One-Minute Message.
2. **Ask** participants to regroup in the same teams as for the previous session on the One-Minute Message.
3. **Note** that they will have 30 minutes to complete their preparations.

Step 3: Deliver Role Plays and Feedback

Time: 40 minutes

1. **Reconvene** all of the groups.
2. **Remind** the groups that they will have one minute each to present their One-Minute Messages, followed immediately afterward by a debriefing/group discussion.
3. **Suggest** that a member of each group briefly set the scene by letting the audience know who the target audience is, as well as any other key context.
4. Have each group **present** its role play.
5. After each presentation, **debrief** with the following questions for no more than 10 minutes per group:

Ask the full group (audience plus presenters):

- What did you observe in this role play?
- What struck you the most?
- Are there any special aspects of what the advocates or their target audience did or said that stood out?

Ask the audience:

- What was the main advocacy message? (Check the response with the presenters.)
- Was the desired action clearly articulated? Was it appropriate?
- Did participants agree with the choice of time, place, method, and messenger?
- Were data used effectively?

Ask the full group (audience plus presenters):

- If there were certain reactions, why did they (targets or advocates) respond that way?
- Consider: Were there other options for time, place, method, or messenger that might have been more effective?
- What lessons can we learn from this presentation?



Note to Facilitator: Lessons may include:

- Effectiveness of techniques used/skill with which they were used.
- Preparation needed.
- Appropriateness of the choice of method, time, place, delivery, and messenger.
- What further information is needed about the target audience.

6. After each discussion is completed, **thank the participants** for their efforts and the audience for their attention.
7. **Repeat** steps 2 through 6 for all groups.
8. After all groups have presented, **explain** that they have been engaged in role play but now they should step back and think about how this activity applies to their own work. Ask:
 - Are there any main learning points or take-away thoughts from all of these role plays that you want to share?
 - In thinking about data and its use, how can you apply these lessons in your own work?
 - What lessons in general can you apply to your work as advocates?
9. **Close** the session. Note that this kind of practice is a key method in developing and preparing to deliver effective advocacy messages. It is an important method of “pre-testing” an advocacy message; participants should consider who they may want to invite as their “audience” for pre-testing their advocacy messages. Also note that this sort of debriefing after real meetings or other efforts to deliver advocacy messages is important in improving their skills and next advocacy efforts. Debriefing is also a good monitoring tool for advocates.

Activity 5 — Written Communication (Policy Briefs)

Time: 45 minutes

Materials: Stopwatch to indicate time left, marker pens, flipchart paper, tape

Prepared Materials:

PPT: N/A

Flipchart: Effective and Ineffective Features of Policy Briefs

Other: Copies of six policy briefing papers, preferably reproduced in color in A3 size

Handouts: Copies of six policy briefing papers; “Advocacy in Action” Card: Preparing a Briefing Note/Position Paper

Objective: ■ To identify effective elements of policy briefing papers.

Introduction: Policy briefing papers are important tools for advocates.

- They can form the basis of discussion for face-to-face meetings with decisionmakers.
- They can be left with decisionmakers following these meetings so that there is a clear record of the advocacy issue and the change that the advocate is seeking.
- They can be distributed to members of both the primary and secondary target audiences to generate knowledge of and support for an issue.

In this session, we will examine examples of policy briefing papers to identify those features that contribute to their effectiveness in achieving one or more of the goals of advocacy communication: informing, persuading, and moving to action.

Note to Facilitator: Have six flipcharts divided into two columns, headed “Effective Features” and “Ineffective Features” to evaluate the six policy briefs.



Activity Instructions:

Step 1: Assessment of Policy Briefs

Time: 45 minutes

1. **Refer** participants to the examples of policy briefs displayed around the room.
2. **Ask** them to circulate around the room, visiting at least four of the six policy briefs. Ask participants to write comments on the flipchart in the “Effective Features” and “Ineffective Features” columns for each brief.
3. **Remind** participants that the objective is not necessarily to read every word in the brief but rather to record reactions to what works and does not work during a brief review of each.

4. **Remind** participants that they have 30 minutes to review and write their comments for at least four of the briefs.
5. When the participants finish, **lead** a walk around the various policy briefs, noting those features that participants identified as contributing to an effective or ineffective policy brief. For each of the examples, add your own comments on the features you notice.
6. **Ask** participants: Does anyone have experience in writing or developing policy briefs? Ask the responders to share their lessons learned. Note: If you have examples, please bring them up so we can post them.
7. Also **ask** participants: What have you learned from this about using data in effective advocacy messages?

**Note to Facilitator:**

Be sure that these points are mentioned:

- Data must be clear, concise, and support main messages.
- You must pick your points selectively.
- Often you have limited time or space to convey data.
- Graphs or tables are important, but they must send a clear message.

8. To close the session, **hand out** the Policy Briefing Sheet tips (from the International AIDS Alliance). Review the different sections in the tips sheet. Explain that, as we go through the workshop, we will explore in more depth how to hone effective messages as well as other formats and scenarios for delivering messages.

SECTION VII: Developing Advocacy Messages and Methods

Activity 1 — Introduction to Effective Advocacy Communication

Background Notes

In most countries, people are bombarded by messages every day. The intent of the message may be to sell us a product, inform or educate us in some way, or change our opinion about an issue. An advocacy communication strategy follows many of the same principles as an advertising or social marketing campaign. It is essential to know your audience thoroughly and to deliver a concise and consistent message that is tailored to your audience's interests and has the maximum chance of appealing to them.

As a matter of common sense, most people shape their messages to the needs and interests of a particular audience. For example, the message communicated to a parents group about providing family planning services to adolescents would differ from the message transmitted to officials in the Ministry of Health.

Audience research—particularly qualitative research, such as focus group discussions and in-depth interviews—helps to identify appropriate message forms and content for various advocacy audiences. Whatever the target audience, it is important to remember three other points about advocacy message development:

1. Ideally there should be only **one main point communicated**, or, if that is not possible, two or three at most. It is better to leave people with a clear impression of one message than to confuse them with too many.
2. Messages always should be **pre-tested with representatives of the target audience** to ensure that the message sent is the one received. When a network develops an advocacy message directed toward the Minister of Health (MOH), for example, it is always useful to practice delivering the message to a supportive ministry official as a test run. The ministry official may offer valuable feedback about how the message will be interpreted by the MOH.
3. The message should not only persuade through valid data and sound logic, but also **describe the action the audience is being encouraged to take**. The audience needs to know clearly what it is that you want it to do—for example, include antiretroviral therapy (ART) in the national health insurance program and show support for the issue by attending a rally on the steps of Parliament.

SECTION VII: Developing Advocacy Messages and Methods

Activity 1 — Introduction to Effective Advocacy Communication

Five Key Elements of an Advocacy Message

1. Content/Ideas
2. Language (words, images, etc.)
3. Format/Medium (mass media, one-on-one meeting, demonstration, street theater, etc.)
4. Messenger or spokesperson (member of the affected group, an expert, colleague, etc.)
5. Time/Place

SECTION VII: Developing Advocacy Messages and Methods

Activity 1 — Introduction to Effective Advocacy Communication

How to Choose Appropriate Advocacy Methods

There are no simple rules for choosing the best advocacy methods. Your choice will depend on many factors: (a) the target person, group, institution; (b) the advocacy issue; (c) your advocacy objective; (d) the evidence to support your objective; (e) the skills and resources of your coalition; and (f) timing—for example, external political events, when a law is still in draft form, immediately before a budgeting process, time of year, or stage of advocacy process. Below is an example of the strengths and weaknesses of some methods for a particular advocacy objective and targets. Remember that every case is different.

Advocacy objective: To persuade managers of the 10 largest companies in the Andhra Pradesh state to end compulsory testing of workers and dismissal of HIV-positive workers.

Direct targets: General managers of companies.

Indirect targets: Labor unions, boards of directors, personnel managers.

Method	Strengths	Weaknesses
Analyzing and influencing legislation and policies or their implementation	<p>If analysis shows that a company's current practices are costing them money, this can be powerful evidence.</p> <p>Beneficiaries can provide expertise.</p>	<p>Criticism of policies could anger managers.</p> <p>Not useful for managers who dislike formal policies.</p>
Position paper or briefing note	<p>Suitable for presenting to senior directors and managers.</p> <p>Useful background briefing for journalists.</p> <p>Ensures that public statements by allies always agree.</p>	<p>Can easily be lost among other paperwork.</p> <p>Some managers do not like reading papers.</p> <p>Difficult to involve beneficiaries.</p>
Working from inside	<p>Some managers will listen more closely to people they know.</p> <p>Many opportunities within labor unions.</p>	<p>Limited opportunities in companies – all policy is made by managers and directors.</p>
Lobbying or face-to-face meetings	<p>Opportunity to present the "human face" of the issue and to build a personal relationship.</p> <p>Beneficiaries can explain their case directly.</p>	<p>Managers often too busy to attend.</p> <p>Board members not interested in the issue, and afraid of HIV-positive people.</p>
Presentation	<p>Opportunity to present the issue in a controlled way, direct to decisionmakers.</p> <p>Beneficiaries can speak directly.</p>	<p>Managers often too busy.</p> <p>Difficult to gain permission for presentation to board of directors.</p>

How to Choose Appropriate Advocacy Methods (continued)

Method	Strengths	Weaknesses
Drama	<p>Emotional appeal works with some managers.</p> <p>Suitable for mass meetings of labor unions.</p> <p>Beneficiaries can advise on story, or perform.</p>	<p>Some decisionmakers will feel that drama is only for the illiterate.</p> <p>Difficult to find opportunity to perform to managers or directors.</p>
Press release	<p>Useful for organizations needing public support.</p> <p>Useful to launch a campaign or for quick reaction to opposition or new developments.</p> <p>Inexpensive.</p>	<p>No use for companies who do not need/want public support.</p> <p>Difficult to involve beneficiaries.</p>
Media interview	<p>Same as for press release.</p> <p>Useful at times when advocacy issue needs 'a human face.'</p> <p>Inexpensive.</p>	<p>Can have negative impact if the interviewee is not prepared or does not deliver message well.</p> <p>Can be manipulated by journalists.</p>
Press conference	<p>Same as for press release.</p> <p>Good for presenting evidence, especially case studies/examples.</p> <p>Useful to launch a major campaign or for reaction to serious opposition or major new developments.</p> <p>Easy to involve beneficiaries and allies, and give them public recognition.</p>	<p>Same as for press release.</p> <p>Requires high level of organization.</p> <p>Expensive.</p>
Public demonstration	<p>Draws public and media attention.</p> <p>Mobilizes beneficiaries.</p> <p>Creates pressure.</p>	<p>May require permission from government/local authorities.</p> <p>Can cause target to change, but can also anger target and cause to react depending on timing, etc.</p>

SECTION VII: Developing Advocacy Messages and Methods

Activity 1 — Introduction to Effective Advocacy Communication

“Advocacy in Action” Card

Advocacy in Action Card 4

Lobbying or face-to-face meetings



ALLIANCE

Advocacy in Action Card 4 Lobbying or face-to-face meetings

Introduction

A face-to-face meeting with a targeted decision-maker (also known as ‘lobbying’) is one of the most frequently used advocacy methodologies and is often the starting point in a series of activities.

Personal contact provides the opportunity to build relationships with decision-makers, which could prove very useful in future. Try to set up a channel for regular contacts.

It is important to choose the right time for meeting decision-makers, when your issue or problem is already on their agenda or most likely to be taken up – for example, before an important vote – or when they are able to take action in support of your advocacy – for example, during the budget-setting process, or at the time of an annual meeting.

Try to imagine how the issue or problem looks from the decision-maker’s point of view. Why should they support your advocacy objective? How can they benefit from taking the action you are requesting? This can be answered more easily if you have fully researched the ‘target person’ you are meeting.

Make realistic requests. Show the decision-maker that there is widespread support for your advocacy objective. Encourage allies to also lobby the same decision-maker, giving the same message (use briefing notes to ensure the message is the same – see Advocacy in Action Card 2). It is difficult for officials to ignore large numbers of advocates.

Do not be satisfied with vague expressions of support. Return to two basic questions:

- Does the decision-maker agree that things need to change?
- What are they willing to do to make change happen?

Advantages

- ✓ It shows the human face of the issue or problem to decision-makers, especially if people directly affected by the issue are involved.
- ✓ No need for literacy.
- ✓ Good for involving people at community level.
- ✓ It an opportunity to express emotions and share personal experiences.
- ✓ It allows you to discuss the issue rather than just present you position.
- ✓ Creates a personal connection which is more likely to lead to things being done.

Disadvantages

- ✗ The message could fail to make an impact if the decision-maker takes a personal dislike to the messenger(s).
- ✗ A decision-maker with greater negotiating skills could make the meeting a waste of time, or could persuade you to agree to actions you later regret.

Example: Lobbying or face-to-face meetings**Workshop participants meet city administrator to oppose mandatory testing**

During an advocacy workshop held in the Philippines in 1998, participants read in the local press that the Mayor of Davao City planned to introduce mandatory HIV testing of 'Guest Relations Officers' (sex workers). This contradicted the Philippine AIDS Law that was passed in February 1998.

A request was made for an audience with the mayor, to explain the harmful effects of mandatory testing and highlight that this acted against the recently passed AIDS Law. Lawig Dabaw, one of the NGOs at the workshop, had built good relations with city officials through its previous external relations work and was able to arrange a meeting with the city administrator.

In preparation for the meeting, the participants with experience of working with sex workers and of gender and power relations drafted a position paper on mandatory HIV testing and a covering letter. The group presented their draft to all the participants at the workshop, and made revisions after comments from other participants and resource persons. The whole group worked together to improve the documents and everyone signed the letter. The group prepared for the meeting with discussion, identification of a lead spokesperson and support team, sequencing and logistical arrangements.

Along with a local sex worker group, Lawig Bubai, the group met the city administrator at City Hall to explain the content of their position paper, and requested that he pass the paper to the mayor. Two local journalists attended the meeting.

The mayor was persuaded and did not impose the mandatory HIV testing. The meeting also received coverage in two local newspapers.

After the meeting, the group reviewed and analysed how the meeting had gone. The exercise illustrated several points to the participants:

- Preparation for a meeting is as important as the meeting itself
- Opportunities for advocacy are often unplanned, so be prepared for unforeseen events
- Advocacy work is often done under time pressures and as reactions to events.

Reference: Adapted from an advocacy workshop, International HIV/AIDS Alliance and International Council of AIDS Service Organizations (ICASO), Philippines, November 1998.

Advice

- ✓ **Try to** begin by praising the decision-maker for any past support on your issue.
- ✓ **Try to** begin by pointing out areas of agreement and mutual interest with the decision-maker.
- ✓ **Try to** listen, as well as talk – you need to hear what your target thinks.
- ✓ **Try to** link your objective to an issue the decision-maker cares about.
- ✓ **Try to** know more about the issue than the decision-maker! Gain a reputation for being knowledgeable.
- ✓ **Try to** be willing to negotiate, but be clear about how far you will compromise.
- ✓ **Try to** decide who will say what, if there is more than one of you.
- ✓ **Try to** end by summarising what the decision-maker has said or promised.

- ✗ **Try not to** ask the decision-maker to do more than one thing at a time, unless he or she seems very eager to help you.
- ✗ **Try not to** confuse the decision-maker with too many messages.
- ✗ **Try not to** give too much information – for example, graphs, statistics.
- ✗ **Try not to** use technical terms or jargon.
- ✗ **Try not to** give false or misleading information – it can cause you problems in future.

How to...lobby/hold a face-to-face meeting

Establish 'points of entry'

Think creatively about how you can get a meeting with the target person. Is there something you have in common? For example, if a friend of yours attends the same mosque as the decision-maker, ask your friend to introduce you to them so that you can negotiate a time to meet, or alternatively use the opportunity as a face-to-face meeting in itself.

Ask for a meeting

Send a letter explaining what your advocacy goal is and why you would like a meeting. Follow up with a phone call. Often you will not get a meeting with the 'direct target' but with one of their staff (an 'indirect target'). Always meet with the staff, and treat them in the same way you would treat the decision-maker.

Invite them to see the issue or problem themselves

Invite them out of their office to see the issue or problem first-hand and to show them why you need their support. If the decision-maker cannot leave their office, try taking your issue to them – bring people directly affected by the issue to your meeting, show a short video addressing the issue or take a few photographs with you. If you have a friend who knows the decision-maker or someone on their staff, ask your friend to send the letter or make the phone call to support your views.

Preparing for meetings

Step 1: Know your target

Analyse your target, using the questions/table headings in Step 4 of the advocacy framework (Section 2).

Step 2: Focus on your message

Choose your main objective and develop a simple message from it:

- **What** you want to achieve
- **Why** you want to achieve it (the benefits of taking action, and/or the negative effects of doing nothing; evidence for the problem – statistics and anecdotes)
- **How** you propose to achieve it
- **What** action you want the target person to take.

Write a short position paper (see Advocacy in Action Card 2) to give to the decision-maker, to remind them of your points.

Step 3: Choose the right messenger

Often the messenger is as important as the message. If a friend arranged the meeting, ask them to come to the meeting with you. Or someone directly affected by the issue or problem may be able to 'personalise' the issue and get the decision-maker's attention. Make sure the messenger has appropriate negotiation skills and appropriate attitude to result in a positive outcome.

Step 4: Practise!

Rehearse your message with colleagues or friends. Ask someone to role-play the meeting, pretending to be the decision-maker, asking difficult questions.

After the meeting

Write to the person who you met, thanking them for the meeting (even if the person was not helpful), briefly repeating your key points and any supporting comments made by the target person, especially any promises to take action. Tell the target person what you plan to do next, promise to keep them informed, and express the hope that you will be able to work together on the issue in future.

*Reference: Adapted from **An Introduction to Advocacy** by Ritu Sharma (SARA Project).*

SECTION VII: Developing Advocacy Messages and Methods

Activity 1 — Introduction to Effective Advocacy Communication

“Advocacy in Action” Card

Advocacy in Action Card 5

Writing and delivering a presentation



ALLIANCE

Advocacy in Action Card 5 Writing and delivering a presentation

Introduction

A presentation is a formal way of delivering a message face-to-face to an audience. It can vary from a brief talk to a small group, to a formal presentation to hundreds of people at an international conference. Giving a presentation can be a nerve-wracking ordeal, but this can be lessened by good preparation and practice. The stages in developing a presentation include planning, writing and delivering.

Advantages

- ✓ You can offer *your* selection of facts and opinions.
- ✓ You can speak directly to an audience.
- ✓ You can show visuals to illustrate your message.
- ✓ A presentation is easy and cheap to organise and can have a powerful impact if planned well.
- ✓ You can give out copies of your presentation as a written record (unless you need to change the focus during the event).

Disadvantages

- ✗ It is not easy to make an interesting, lively presentation.
- ✗ A bad environment could spoil your presentation – noise, distractions, bad lighting, etc.
- ✗ You could be open to difficult questions from an unpredictable audience.
- ✗ Some people are not good at giving presentations (but it is a skill that can be learnt).

For more information about delivering effective presentations see *Documenting and Communicating HIV/AIDS Work – A Toolkit to Support NGOs and CBOs*, International HIV/AIDS Alliance.

How to...write and deliver a presentation

ALLIANCE

Advocacy in Action Card 5 Writing and delivering a presentation

Planning a presentation

- Review the key factors that will affect your presentation, i.e.: Who is the audience? What are their interests and level of knowledge about the topic? How much time has been given for the presentation? Does this include time for questions? Where will it take place? What equipment will be available? How formal will it be? What is the broader context of the event – is the presentation the main event or part of something else? How will the presentation fit?
- Gather the information and materials that will inform the presentation.

Writing a presentation

- Some people just use bullet points as the basis for their talks, while others prefer to have the text written out in full.
- Make sure the presentation has a beginning which introduces the topic, a middle which contains the bulk of the talk, and a summary or conclusion.
- Catch the audience's attention at the start with a quote/anecdote to make the situation human and real for them.
- Identify and list the key points and ensure that each has supporting facts and references. Place these key points in a logical order. Persuade the audience by supporting each statement with quotes, comparisons and examples.
- Make or select visual aids that support your presentation but also add some value – for example, added interest or a 'human angle'.

Delivering the presentation

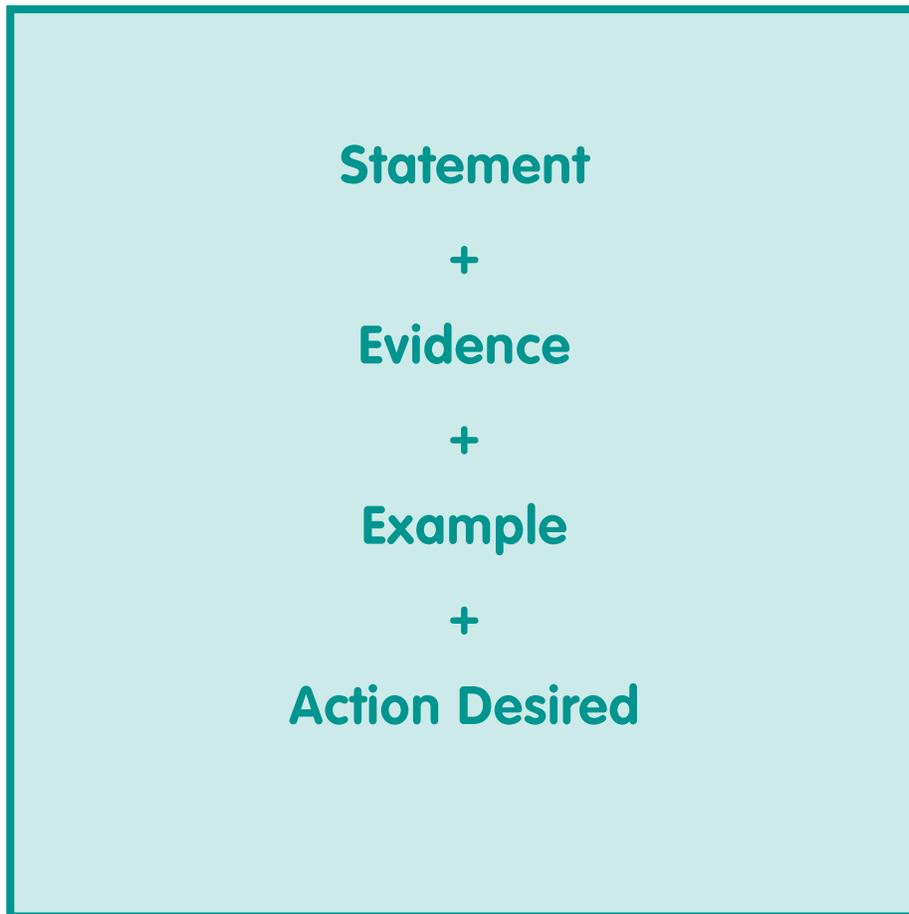
- Try not to read your written text aloud – try to either learn the text or just use bullet points as a reminder of each point.
- Keep to within the required timeframe.
- Speak loudly, clearly and slowly, and pause to allow people to consider key points.
- Use good visual aids to make the presentation more interesting and easier to understand.
- Make eye contact with the audience – don't look at the floor or at one person in the audience.
- Make the presentation like a conversation – don't talk at people, talk to them.

Dealing with questions

- If the question is complex, repeat and rephrase it so that it is clearly understood.
- Reply to the whole audience, not just the individual who asked the question.
- Think before responding to a question.
- Take a light-hearted approach to sarcastic questions – don't get flustered by them.
- Don't bluff if you don't know the answer. Better to admit you do not know, throw it back to the audience or say you will find out the answer.

SECTION VII: Developing Advocacy Messages and Methods Activity 2 — The One-Minute Message

The One-Minute Message



SECTION VII: Developing Advocacy Messages and Methods

Activity 2 — The One-Minute Message

Message Development Worksheet²	
Target Audience	
Audience Background <ul style="list-style-type: none"> • Knowledge? • Support? Opposition? • Benefit from issue? 	
Message Purpose What do you want the audience to know, to support, or to do?	
Message Content	
Possible Format(s)	
Messengers	
Time and Place for Delivery	

²Adapted from: Sharma, R. 1997. An Introduction to Advocacy: Training Guide. Washington, DC: Academy for Educational Development/Support for Analysis and Research in Africa (SARA) Project.

SECTION VII: Developing Advocacy Messages and Methods

Activity 5 — Written Communication (Policy Briefs)

Examples of Policy Briefs

These should be chosen according to the country/language in which the training takes place. Some useful sources are:

UNAIDS: www.unaids.org

WHO: www.who.int

amfAR: www.amfar.org

The Cochrane Collaboration: www.cochrane.org

Examples of Policy Briefs

amfAR MSM 2006

Issue Brief No. 4
June 2006

The year 2006 marks the 25th anniversary of the first reported cases of HIV/AIDS. Initially diagnosed in the United States among men who have sex with men (MSM),¹ HIV's impact on MSM in the U.S. and other developed countries led to swift grass-roots responses from the gay community and eventually to targeted interventions from the public health sector to address high-risk behaviors such as unprotected anal intercourse and substance use. These interventions, implemented in the 1980s and 1990s, resulted in significant reductions in sexual risk and the prevention of new HIV infections in MSM.

The Foundation for
AIDS Research

amfAR
AIDS RESEARCH

issue brief

HIV Prevention for Men Who Have Sex With Men

Over time, these achievements have leveled off, and recent evidence indicates that HIV infection is re-emerging in new cohorts of MSM in developed countries² and is an emerging epidemic in MSM in developing countries.^{3,4} This situation calls for an assessment of current trends in HIV infection in MSM and of the status of effective and promising interventions for these populations.

Who Are MSM?

The category of men who have sex with men (MSM) encompasses a range of sexual and gender identities and behaviors among people in various socio-cultural and sexual contexts.^{5,6} It includes men who identify as gay or bisexual, as well as some who identify as heterosexual or transgendered (such as the *Katoy* in Thailand or the *Hijras* in India). In relation to HIV among MSM, high-risk sexual activities are what transmit the virus, but these take place in social and cultural contexts in which identity also matters. Thus, it is important to understand the interaction of identity and behaviors when devising and implementing interventions to prevent sexual transmission of HIV in MSM.^{5,7}

Trends in HIV/AIDS Among MSM

Despite significant success in reducing HIV/AIDS rates among MSM in the United States during the late 1980s and early 1990s, recent data indicate that HIV infection may be resurging among this group.^{8,9}

From 2001 to 2003, of the 157,252 persons diagnosed with HIV/AIDS, nearly 71% were men; for 61% of these men, the primary route of infection was male-to-male sexual contact.¹⁰ Although white men still comprise the bulk of new infections in MSM, the epidemic is growing fast among Blacks and Hispanics.¹⁰

Male-to-male sex still comprises the major route of HIV transmission in other parts of the developed world.¹¹ Slight to significant increases in the number of HIV diagnoses in MSM have been observed in European countries such as Belgium,

Denmark, Italy, Portugal, Switzerland, and Germany.^{11,12} In the developing world, most available data on MSM come from Latin America and South Asia. There are very little HIV incidence or prevalence data on MSM in Sub-Saharan Africa and the Middle East. From the global data that are available, estimates indicate that HIV prevalence in MSM varies widely by country and region—from 0% in the Middle East to 36.5% in Latin America.^{3,13,14}

What Puts MSM at Risk?

The rising rates of infection in MSM in developed and developing countries can be attributed to a complex set of biological, behavioral, and socio-cultural factors that may place MSM at increased risk for acquiring and transmitting HIV.

Biological Factors

While there is no evidence that MSM are biologically more susceptible to HIV infection than others, there are biological factors associated with male-to-male sexual behavior—in particular, anal intercourse—that do increase individuals' risk.

This issue brief was made possible thanks to a generous grant from The Helene Foundation.

- Both vaginal and anal intercourse have been shown to be efficient routes for HIV transmission, as the epithelium of both tracts has receptors that easily bind to HIV. However, compared to the vagina, rectal tissue is much more vulnerable to tearing during intercourse and the larger surface area of the rectum/colon provides more opportunity for viral penetration and infection.

For these reasons, unprotected receptive anal intercourse is believed to be at least 10 times more risky than unprotected receptive vaginal intercourse for acquiring HIV.¹⁶⁻¹⁷

- The presence of genital ulcer disease (GUD)—most notably herpes simplex virus-2 (HSV-2), primary syphilis, and chancroid—also facilitates HIV acquisition. While MSM populations are not biologically predisposed to sexually transmitted infections (STI), many men—and the providers to whom they go for care—do not think to screen for STIs that present rectally, resulting in infections that go undiagnosed and untreated. For these reasons, some STIs are quite prevalent in MSM populations, thereby contributing to increased risk of HIV acquisition.¹⁶⁻¹⁷

Behavioral Factors

Several behavioral risk factors can also increase the vulnerability of MSM to HIV infection.

- Specific sexual acts in the repertoire of MSM confer risk of HIV infection. In descending order of risk, these include unprotected receptive anal intercourse, unprotected insertive anal intercourse, and oral sex.²²⁻²⁵
- Multiple sex partners, inconsistent condom use, lack of knowledge about HIV risk, and negative or complacent attitudes toward safer sex have also been shown to be factors associated with increased risk of HIV infection.²⁶⁻³²

- The prevalence of alcohol and drug use in MSM is also quite high, which in turn can increase the risk for acquiring HIV.³³ Several studies link alcohol and drug use (particularly methamphetamine) to higher rates of unprotected anal intercourse, higher numbers of sex partners, and inconsistent condom use.³⁴⁻³⁶

- Depression in MSM has been linked to increases in risky behaviors such as unprotected anal intercourse, drug and alcohol use, inconsistent condom use, and multiple sexual partnerships.^{36,43,44}

- Some studies have found that MSM, particularly young MSM, who have a history of childhood sexual abuse are more likely to engage in high-risk behaviors, such as unprotected anal intercourse, substance abuse, and exchanging sex for money or drugs. These studies also found that MSM with a history of childhood sexual abuse are more likely to report being HIV positive and to have experienced relationship violence.⁴⁵⁻⁴⁷

- For many MSM, the Internet (e.g., through MSM personal ads and chat rooms) offers a wider pool of men available for sexual liaisons, often on short notice. But these expeditious partnerships may also bring increased risk of HIV infection.⁴⁸

Some studies have found that MSM who use the Internet to find sex partners are more likely than other men to report an STI and are more likely to engage in risky sexual behavior.⁴⁹⁻⁵²

Socio-Cultural Factors

Socio-cultural factors, such as perceptions and experiences of stigma and discrimination, homophobia, racism, and internalized oppression, may also lead to increased risk of HIV infection in MSM.

- Several studies indicate that these factors may play a significant role in increasing the risk of drug use before or during sexual encounters, unprotected insertive/receptive anal sex, multiple sexual partnerships, and inconsistent condom use.⁵³⁻⁵⁵

- Stigma associated with acknowledging homosexual or bisexual activity may inhibit many MSM from identifying as such,⁵⁶ potentially leading to denial of their own risk and alienation from prevention programs that target self-identified gay/bisexual populations.

- While race/ethnicity itself is not a risk factor for HIV infection, social and economic factors—such as higher rates of poverty, unemployment, and lack of health care access—that are often more prevalent in communities of color may be associated with risk behaviors that facilitate HIV infection and with reduced access to testing, prevention, and treatment services.^{57,58} This is supported by a recent review that indicates black MSM are more likely than other MSM to contract STIs that facilitate the acquisition and transmission of HIV and are also less likely than other MSM to be tested for HIV or to know their HIV status.⁵⁹

- Optimism about the availability and efficacy of new HIV therapies has been associated with sexual risk behavior in young MSM. This optimism may either reduce individuals' concerns about becoming infected (thereby facilitating risk behavior)⁶⁰ or may be a post hoc rationalization after risky sex has occurred.⁶¹

HIV Prevention Interventions For MSM

Since the beginning of the HIV/AIDS epidemic, individual-level, small group, and community-level behavioral prevention interventions targeting at-risk MSM have been effective in changing risk behaviors that facilitate HIV transmission and acquisition.⁶²⁻⁶⁹

- A recent review of 54 behavioral interventions for MSM in the United States found that 38 of these interventions resulted in a 27% reduction in the number of unprotected sex acts, and the remaining 16 interventions reduced unprotected sex by 17%.⁶⁰
- Another review of 33 behavioral interventions for MSM conducted globally showed that HIV prevention efforts were successful in reducing the number of sex partners, reducing unprotected anal intercourse by 23%, and increasing condom use by 61%. Successful interventions incorporated interpersonal skills-building, utilized several delivery methods, and were delivered over multiple sessions.⁶²
- Because individual-level interventions often cannot address the social factors that contribute to HIV risk-taking, community-level interventions have been advocated as an important strategy for HIV prevention.⁷⁰ Two effective models that have been widely replicated involve mobilizing young gay/bisexual men to shape a healthy community for themselves and to encourage their friends to have safer sex, and using popular opinion leaders in gay/bisexual communities to change norms around sexual behaviors. In communities where these interventions have been implemented, rates of unprotected anal sex decreased, condom use increased, and overall numbers of sex partners decreased.^{65,71} These HIV prevention interventions also have been shown to be cost-effective.^{72,73}

In addition to behavioral interventions, a few promising biomedical approaches are being tested for prevention of sexual transmission of HIV in MSM. Two such approaches are the treatment of HSV-2 infection among HIV-negative MSM to reduce risk of HIV acquisition, and the use of pre-exposure prophylaxis (PrEP), which tests the safety and efficacy of antiretroviral drugs to prevent the establishment of HIV infection if a person is exposed through sexual contact. Clinical trials of these two biomedical interventions are currently under way, with

results expected by 2007. Additionally, there are continued efforts to develop safe and effective topical microbicides (that could be used rectally)^{66,74} and vaccines that may be helpful in preventing HIV infection in this population.

Barriers to Reaching MSM

Despite accomplishments in modifying risky behavior and reducing HIV infections in some MSM populations, many intervention efforts may be undermined by specific policies that contribute to stigma and discrimination against this group.

For example, U.S. government programs that promote abstinence-only-until-marriage as an HIV prevention strategy implicitly and explicitly condemn or deny the existence and sexual rights of gay, bisexual, and transgendered people.⁷⁵ Moreover, educational curricula supported through these programs in many cases convey medically inaccurate information about STIs and HIV infection. In fact, they are prohibited by law from providing information about the significant effectiveness of male condoms for HIV prevention, and instead must emphasize their failure rates.⁷⁶ This may have the deleterious effect of discouraging condom use, which in turn could increase the risk of HIV infection in MSM.

Conclusion

There is a great deal of scientific evidence supporting the effectiveness of HIV prevention interventions for MSM. Despite this body of research, recent increases in HIV diagnoses in MSM, both domestically and internationally, indicate that prevention efforts have not been scaled up and intensified sufficiently to curb the spread of HIV infection in this population.

Difficulties in collecting accurate data on HIV infection in MSM, particularly in developing countries, confusion about the definition of MSM, and ongoing stigma and discrimination against gay, bisexual, and transgendered people remain significant barriers to implementing effective interventions on a global level.

In order to mitigate the HIV epidemic in MSM, both domestically and globally, adequate resources must be dedicated to improving accurate data collection, addressing the socio-cultural factors that contribute to MSM risk behavior, and implementing evidence-based behavioral, biomedical, and social interventions that address growing rates of HIV infection in multiple settings.

References

1. Foe T, Brown TM, Michael S. Gottlieb and the identification of AIDS. *Am J Public Health* 2006;96(6):902-3.
2. Catania JA et al. The continuing HIV epidemic among men who have sex with men. *Am J Public Health* 2001;91(8):107-14.
3. Cáceres CF et al. Prevalence of HIV Infection and the Epidemiology of Preventive and Risk-Behavior among MSM in Low and Middle-Income Countries. Unpublished Draft, 2005.
4. Monitoring the AIDS Pandemic Network. Male-Male Sex and HIV/AIDS in Asia. FHI, UNAIDS, USAID. 2006.
5. Jenkins H. Conceptualizing MSM and Male Sexualities in South East Asia. HIV Prevention, Care, and Treatment for Men Who Have Sex With Men in Viet Nam, 2005. <http://www.unaids.org/vietnam/docs/GHermes.pdf>, conceptualizing_MSM&Male_Sexualities_in_SE_Asia_Jenkins.pdf
6. Dwyett GW. Some considerations on sexuality and gender in the context of AIDS. *Regnal Health Matters* 2003;11(2):21-3.
7. Rieder. Education and Adolescent Gender Variance: A Primer. Accessed May 15 2006 <http://www.gender.org/resources/dge/gea01004.pdf>
8. Centers for Disease Control and Prevention. HIV/AIDS Surveillance Report. Centers for Disease Control and Prevention. 2003.
9. Centers for Disease Control and Prevention. HIV/AIDS Surveillance Report 2004. Centers for Disease Control and Prevention. 2005.
10. Centers for Disease Control and Prevention Trends in HIV/AIDS Diagnoses — 39 States, 2001–2004. Centers for Disease Control and Prevention. November 18 2005.
11. UNAIDS. AIDS Epidemic Update. Joint United Nations Programme on HIV/AIDS and World Health Organization. December 2005.
12. Giuliano M et al. Increased HIV incidence among men who have sex with men in Rome. *AIDS* 2005;19(13):1420-31.
13. UNAIDS. Men Who Have Sex With Men, HIV Prevention and Care. UNAIDS. November 10-11 2005.
14. van Grunsven F et al. Evidence of a previously undetected epidemic of HIV infection among men who have sex with men in Bangkok, Thailand. *AIDS* 2005;19(5):521-6.
15. Shattuck RJ, Moore JP. Inhibiting sexual transmission of HIV-1 infection. *Nat Rev Microbiol* 2003;1(1):25-34.
16. Roethel R, Gross M, Mayer K. Creating a Research and Development Agenda for Microbicides that Protect Against HIV Infection. amfAR, The Foundation for AIDS Research. June 7-8 2001.
17. King County Public Health Department. HIV Infection: Information Update on HIV/AIDS and Sexually Transmitted Diseases. Accessed May 17 2006 http://www.metrokc.gov/health/ppu/infograms/hiv_transmission_0302.pdf
18. Reiss C et al. Herpes simplex virus type 2 infection as a risk factor for human immunodeficiency virus acquisition in men who have sex with men. *J Infect Dis* 2003;187(1):139-26.
19. Tabet SR et al. Incidence of HIV and sexually transmitted diseases (STD) in a cohort of HIV-negative men who have sex with men (MSM). *AIDS* 1998;12(15):2041-8.
20. Page-Shalter K et al. Sexual risk behavior and risk factors for HIV-1 seroconversion in homosexual men participating in the Tri-Continental Seroconverter Study, 1982-1994. *Am J Epidemiol* 1997;146(7):531-42.
21. Wasserheit JN. Epidemiological synergy: Interrelationships between human immunodeficiency virus infection and other sexually transmitted diseases. *Sex Transm Dis* 1992;19(2):61-77.
22. Vittinghoff E et al. Per-contact risk of human immunodeficiency virus transmission between male sexual partners. *Am J Epidemiol* 1999;150(3):306-11.
23. High-risk sexual behavior by HIV-positive men who have sex with men—16 sites, United States, 2000-2002. *MMWR Morbidity and Mortality Weekly Report* 2004;53(38):891-4.
24. Keet IP et al. Orally transmitted HIV and the transmission of HIV among homosexual men. *AIDS* 1992;6(2):223-6.
25. Page-Shalter K et al. Risk of HIV infection attributable to oral sex among men who have sex with men and in the population of men who have sex with men. *AIDS* 2002;16(17):2350-2.
26. Koblin EA et al. Risk factors for HIV infection among men who have sex with men. *AIDS* 2006;20(5):731-9.
27. Kelly JA et al. HIV risk characteristics and prevention needs in a community sample of bisexual men in St. Petersburg, Russia. *AIDS Care* 2002;14(1):63-76.
28. Lau JT et al. HIV-related behaviors and attitudes among Chinese men who have sex with men in Hong Kong, a population-based study. *Sex Transm Infect* 2004;80(6):459-65.
29. Colby D et al. Men who have sex with men and HIV in Vietnam: a review. *AIDS Educ Prev* 2004;16(1):45-54.
30. Colby DJ. HIV knowledge and risk factors among men who have sex with men in Ho Chi Minh City, Vietnam. *J Acquir Immune Defic Syndr* 2003;32(1):100-5.
31. Dandona L et al. Sex behaviour of men who have sex with men and risk of HIV in Andhra Pradesh, India. *AIDS* 2005;19(6):611-9.
32. Mansergh G et al. "Barabackery" in a diverse sample of men who have sex with men. *AIDS* 2002;16(4):653-9.
33. Stall R et al. Alcohol use, drug use and alcohol-related problems among men who have sex with men: The Urban Men's Health Study. *Addiction* 2001;96(11):1589-801.
34. Colfax GN et al. Drug use and sexual risk behavior among gay and bisexual men who attend circuit parties: a venue-based comparison. *J Acquir Immune Defic Syndr* 2001;28(4):372-8.
35. Greenwood FL et al. Correlates of heavy substance use among young gay and bisexual men: The San Francisco Young Men's Health Study. *Drug Alcohol Depend* 2001;61(2):105-12.
36. Coates TJ et al. Behavioral factors in the spread of HIV infection. *AIDS* 1988;2(Suppl 1):S29-46.
37. Koblin EA et al. High-risk behaviors among men who have sex with men in 6 U.S. cities: baseline data from the EXPLORE Study. *Am J Public Health* 2003;93(6):326-32.
38. Mansergh G et al. The Circuit Party Men's Health Survey: findings and implications for gay and bisexual men. *Am J Public Health* 2001;91(6):953-8.
39. Mansergh G et al. Methamphetamine and sildenafil (Viagra) use are linked to unprotected receptive and insertive anal sex, respectively, in a sample of men who have sex with men. *Sex Transm Infect* 2006;82(2):131-4.
40. Morin SF et al. Predicting HIV transmission risk among HIV-infected men who have sex with men: findings from the healthy living project. *J Acquir Immune Defic Syndr* 2005;40(2):226-35.
41. Colfax G et al. Longitudinal patterns of methamphetamine, popper (amyl nitrite), and cocaine use and high-risk sexual behavior among a cohort of San Francisco men who have sex with men. *J Urban Health* 2005;82(1 Suppl 1):62-70.
42. Buchacz K et al. Amphetamine use is associated with increased HIV incidence among men who have sex with men in San Francisco. *AIDS* 2005;19(13):1423-4.
43. Fardieu I et al. Depression and HIV risk behavior among Seattle-area injection drug users and young men who have sex with men. *AIDS Educ Prev* 2003;15(1):91-92.
44. Strathdee SA et al. Determinants of sexual risk-taking among young HIV-negative gay and bisexual men. *J Acquir Immune Defic Syndr* 1998;19(1):61-6.
45. Klichman SC et al. Trauma symptoms, sexual behaviors, and substance abuse: correlates of childhood sexual abuse and HIV risks among men who have sex with men. *J Child Sex Abuse* 2004;13(1):1-15.
46. Paul JP et al. Understanding childhood sexual abuse as a predictor of sexual risk-taking among men who have sex with men: The Urban Men's Health Study. *Child Abuse Negl* 2001;25(4):557-84.
47. Sawick E et al. Sexual Orientation, Sexual Abuse, and HIV Risk Behaviors Among Adolescents in the Pacific Northwest. *Am J Public Health* 2006;96(9):1104-10.
48. Bull SS, McFarlane M. Selecting sex on the Internet: what are the risks for sexually transmitted diseases and HIV? *Sex Transm Dis* 2000;27(9):585-90.
49. McFarlane M, Bull SS, Rietmeijer DA. The Internet as a newly emerging risk environment for sexually transmitted diseases. *JAMA* 2000;284(4):443-5.
50. Rietmeijer CA et al. Risks and benefits of the internet for populations at risk for sexually transmitted infections (STIs): results of an STI clinic survey. *Sex Transm Dis* 2003;80(1):15-9.
51. Bolding G et al. Gay men who look for sex on the Internet: is there more HIV/STI risk with online partners? *AIDS* 2005;19(9):961-8.
52. Lau A, Millett G, Marks G. Meta-analytic Examination of Online Sex-Seeking and Sexual Risk Behavior Among Men Who Have Sex With Men. *Sex Transm Dis* 2006; Publish Ahead of Print.
53. Ortiz-Herrandez L, Garcia Torres M. Intensified oppression and high-risk sexual practices among homosexual and bisexual males, Mexico. *Rev Saude Publica* 2005;39(6):666-84.
54. Diaz RM, Ayala G, Marin BV. Latino gay men and HIV risk behavior as a sign of oppression. *Focus* 2000;15(7):1-5.
55. Diaz RM, Ayala G, Bean R. Sexual risk as an outcome of sexual oppression: data from a probability sample of Latino gay men in three U.S. cities. *Qualitative Health Ethn Minor Psychol* 2004;1(3):265-67.
56. Doll LS, Beeker C. Male bisexual behavior and HIV risk in the United States: synthesis of research with implications for behavioral interventions. *AIDS Educ Prev* 1995;8(3):235-25.
57. National Commission on AIDS. The challenge of HIV/AIDS in communities of color. Washington, DC, 1992.
58. Blair JM, Fleming PL, Karim JM. Trends in AIDS incidence and survival among racial/ethnic minority men who have sex with men, United States, 1990-1999. *J Acquir Immune Defic Syndr* 2002;31(3):339-47.
59. Millett GA et al. Greater Risk for HIV Infection of Black Men Who Have Sex With Men: A Critical Literature Review. *Am J Public Health* 2006;96(6):1007-19.
60. Van de Ven P et al. HIV testaments, optimism and sexual behaviour among gay men in Sydney and Melbourne. *AIDS* 1996;10(15):2289-94.
61. Huebner DM, Riebschick GM, Kegles SM. A longitudinal study of the association between treatment optimism and sexual risk behavior in young adult gay and bisexual men. *J Acquir Immune Defic Syndr* 2004;37(4):1514-9.
62. Herbst JH et al. A Meta-Analytic Review of HIV Behavioral Interventions for Reducing Sexual Risk Behavior of Men Who Have Sex With Men. *J Acquir Immune Defic Syndr* 2005;39(2):228-241.
63. Valdisseri RO et al. AIDS prevention in homosexual and bisexual men: results of a randomized trial evaluating two risk reduction interventions. *AIDS* 1989;3(1):21-6.
64. Kegles SM, Wert EJ. Recent HIV prevention interventions for gay men: individual, small group and community based studies. *AIDS* 1998;12(Suppl 4):S204-15.
65. Kegles SM, Hays RB, Coates TJ. The Empowerment Project: a community-level HIV prevention intervention for young gay men. *Am J Public Health* 1996;86(9 Pt 1):1129-36.
66. Kelly JA et al. Behavioral intervention to reduce AIDS risk activities. *J Consult Clin Psychol* 1989;57(1):60-7.
67. Kelly JA et al. HIV risk behavior reduction following intervention with key opinion leaders of population: an experimental analysis. *Am J Public Health* 1991;81(2):188-71.
68. Koblin B, Chesney M, Coates T. Effects of a behavioural intervention to reduce acquisition of HIV infection among men who have sex with men: the EXPLORE randomised controlled study. *The Lancet* 2004;364(9428):41-50.
69. Johnson WG et al. HIV intervention research for men who have sex with men: a 7-year update. *AIDS Educ Prev* 2005;17(6):569-86.
70. Coates TJ, Greenblatt RM. Behavior change using interventions at a community level. *Sexually Transmitted Diseases*. New York: McGraw-Hill, Inc; 1998:1075-1090.
71. Kelly JA. Randomised, controlled, community-level HIV prevention intervention for sexual risk behavior among homosexual men in US cities. *The Lancet* 1997;350.
72. Pinkston SD et al. Cost-effectiveness of a community-level HIV risk reduction intervention. *Am J Public Health* 1998;88(8):1238-42.
73. Pinkston SD, Hollibaugh DR, Valdisseri RO. Cost effectiveness of HIV-prevention skills training for men who have sex with men. *AIDS* 1997;11(3):347-52.
74. Fauci C. Rectal Microbicides: Investments and Advocacy. International Rectal Microbicides Working Group. April 2006.
75. Santelli J et al. Abstinence and abstinence-only education: a review of U.S. policies and programs. *J Adolesc Health* 2006;38(1):72-81.
76. United States Government Reform Committee Minority Staff. The Content of Federally Funded Abstinence-Only Education Programs. Prepared for Rep. Henry A. Waxman. U.S. House of Representatives. December 2004.



www.amfar.org

Public Policy Office

1150 17th Street NW
Suite 406
Washington, DC 20036-4622
Tel: 202-331-0600
Fax: 202-331-8606

Judith Auerbach, Ph.D.

Vice President, Public Policy
and Program Development

Monica S. Ruiz, Ph.D., M.P.H.
Deputy Director, Public Policy

Emily P. Byram, M.P.H.
Legislative Analyst

Sonia M. Kandathil, M.P.H.
Research and Program Analyst

New York Office

120 Wall Street, 13th Floor
New York, NY 10005-3908
Tel: 212-806-1600
Fax: 212-806-1601

Examples of Policy Briefs

MRC Child Mortality

MRC POLICY BRIEF

No. 3, December 2003



What are the leading causes of death among South African children?

Debbie Bradshaw,
David Bourne,
Nadine Nannan

Burden of Disease Research Unit, Medical Research Council,
PO Box 10970, Tygerberg, 7505, South Africa.
Tel. +27 (0)21 938 0327. <http://www.mrc.ac.za/bod/bod.htm>

Investing in the health and wellbeing of the children of South Africa is an investment in the future development of our country. South Africa still has a relatively youthful population with a third of the population under 15 years of age¹, although we are in the midst of demographic transition. The health of these children needs to be a priority, a principle adopted through the ratification of the 1990 United Nations Convention of the Rights of the Child.

The level of mortality is a fundamental indicator of child health and understanding the causes of death of children provides insight as to how it can be reduced. The lack of reliable vital statistics has created a void when it comes to these

The Medical Research Council published the Initial Burden of Disease Estimates for South Africa, 2000 in March 2003^{1,2}. This was the first attempt to derive consistent and coherent estimates of all causes of death from a range of data sources and models. A major finding of the study was the quadruple burden of disease experienced in South Africa resulting from the combination of the pre-transitional causes related to underdevelopment, the emerging chronic diseases, the injury burden and HIV/AIDS. This policy brief examines the causes of mortality among children in more detail.

indicators, but the recent burden of disease study has made use of available data from the emerging health information system to estimate the levels and causes¹.

The 1998 Demographic and Health Survey⁴ found that the Infant Mortality Rate was 45 per 1000 live births for the preceding 10 years. This overall figure is lower than the WHO 'Health for All' target of 50 per 1000 births, but does conceal the variations between population groups, according to socio-economic status or region. The survey also highlighted the wide racial and socio-economic status inequalities in child mortality. It also conceals the reversal in the downward trend that occurred during the 1990's. This has

largely been ascribed to the impact of the HIV/AIDS epidemic. Furthermore, the level of mortality has not given any insight into the causes of mortality.

The South African National Burden of Disease Study (NBD)

Since the disease burden in South Africa is undergoing rapid change due to the spread of HIV/AIDS⁵, the usual burden of disease approach was considered inappropriate and a modelling approach calibrated to empirical data was adopted. An adapted version of the 1990



Global Burden of Disease (GBD) list of causes of death^{A2} was developed for the South African National Burden of Disease study. The total number of deaths, as well as the age-specific population was calculated using the ASSA2000 model of the Actuarial Society of South Africa⁸. Empirical estimates from surveys and vital registration of the level of childhood and adult mortality were used in the model for the period prior to the AIDS epidemic. Ill-defined causes within a disease category were reallocated proportionally by age and sex to specified causes within that category. Cause of death information processed by the Department of Home Affairs was used to estimate the overall proportion of deaths due to injuries by age and sex. Finally the UNISAMRC national injury mortality surveillance system (NIMSS)⁹ was used to estimate the profile of deaths arising from injury. The estimates are hence a synthesis derived by analysis of a variety of often incomplete data sources. Full details of the methodology appear in the complete report¹. Variations of prevalence at a subnational level are not reflected in this study.

The NBD study estimated just over half a million deaths of which 106 000 were of children under the age of 5 years and a further 7800 were children aged 5-14 years. In general, young babies are much more vulnerable than older. In addition, the cause of death patterns in the different age groups are very different.

Infant and Under-5 mortality

The NBD study estimates that by the year 2000, the Infant Mortality Rate had risen to 60 per 1000 live births and the Under-5 mortality rate had risen to 95 per 1000. This deterioration in child health occurred despite the introduction of free health care and nutrition programmes and was attributable to paediatric AIDS, commensurate with the high prevalence of HIV observed among pregnant women.

The top twenty causes for children under the age of 5 are shown in Table 1 and by age and sex in Figures 1 and 2. HIV/AIDS is the leading cause of death among young children and accounts for 40% of the deaths in 2000. Although the percentage of deaths due to HIV/AIDS is higher in the 1-4 year age group, the largest number of deaths occurs in the under-one age group. Low birth weight, diarrhoea, lower respiratory infections and protein energy malnutrition account for a further 30% of the childhood deaths. A large number of these deaths are preventable through the delivery of the standard conventional primary health care package approach. Birth defects, particularly of the heart and neural tubes also are among the top ranking infant deaths. Protein-energy malnutrition begins to show in the 1-4 age group. There is little gender difference in mortality among the under-fives.

Projections indicate that without effective prevention of mother-to-child

Table 1: Top twenty specific causes of death in children under 5 years, South Africa 2000

Rank	Cause of death	Deaths	%
1	HIV/AIDS	42749	40.3
2	Low birth weight	11876	11.2
3	Diarrhoeal diseases	10786	10.2
4	Lower respiratory infections	6110	5.8
5	Protein-energy malnutrition	4564	4.3
6	Neonatal infections	2920	2.8
7	Birth asphyxia and trauma	2584	2.4
8	Congenital heart disease	1238	1.2
9	Road traffic accidents	1219	1.1
10	Bacterial meningitis	1141	1.1
11	Fires	1102	1.0
12	Neural tube defects	1019	1.0
13	Septicaemia	980	0.9
14	Tuberculosis	743	0.7
15	Homicide/violence	654	0.6
16	Drowning	532	0.5
17	Cot death	491	0.5
18	Down syndrome and other chromosomal	445	0.4
19	Congenital disorders of GIT	379	0.4
20	Congenital syphilis	257	0.2
	All causes	106070	

transmission (PMTCT), the child mortality rate is likely to have continued to rise in subsequent years¹⁰. This pattern, however, can be expected to change as the epidemic matures and as the roll-out of PMTCT takes effect, reducing the number of infected babies.

Most of the other causes of death of infants and toddlers are associated with poor socio-economic conditions. The 2001 census reveals extensive variations in living conditions. Over two thirds of households have formal homes, 16% are informal and 14% are traditional. Access to clean water and basic sanitation is important from a health perspective. The census shows that the majority of households do have access to piped water (84.5%) – whether it is in the home, the yard or a public facility. However, the Eastern Cape has a much lower proportion with only 62.4% of households having access to piped water. The Eastern Cape also had a very high proportion of households without any toilet facilities (30%). Nationally, 13.6% of households have no toilet facility, also a health hazard. Just over half the households have regular refuse removal services. The high levels of poverty and unemployment are clearly

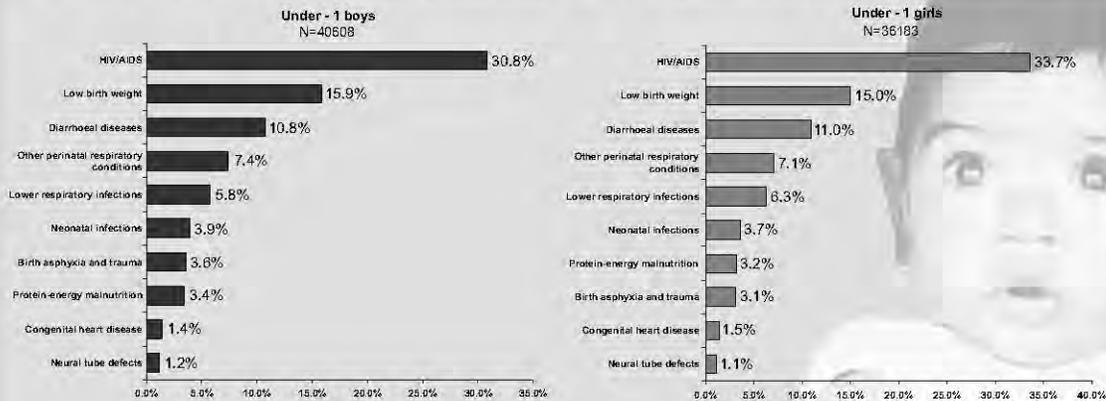


Figure 1. Leading causes of death among infants under 1 year of age, South Africa 2000

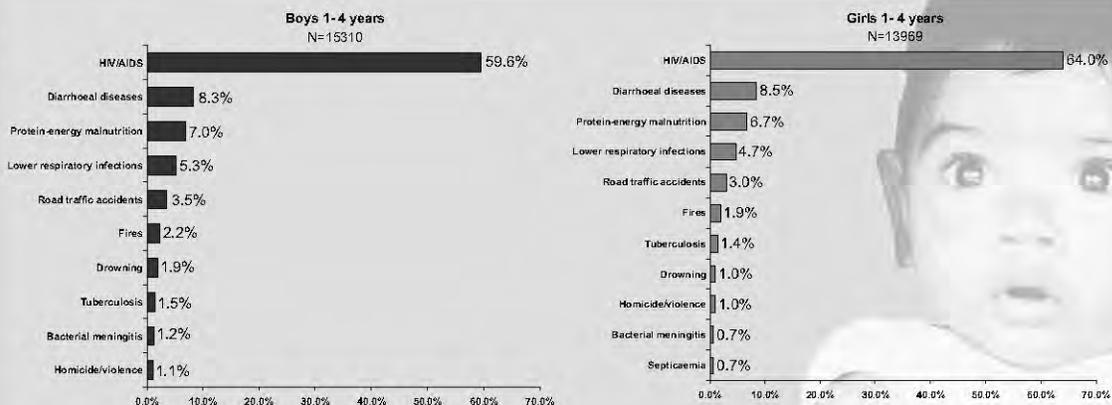


Figure 2. Leading causes of death among children aged 1-4 years, South Africa 2000

fundamental issues that bear on child health, also indicated by the estimated 4564 deaths from protein-energy malnutrition (Kwashiorkor). Many of these deaths can be prevented. Reducing poverty, meeting basic needs and adopting a comprehensive primary health care approach with renewed vigour must be high on the agenda in the next few years.

Older children 5-14 years

As children get older, external causes of death (eg. road traffic injuries and drowning) rise in importance. This is particularly noticeable among boys who die in greater numbers than girls. This pattern becomes particularly marked among the 10 -14 year age group, where road traffic accidents is the leading cause of death. Homicide and suicide feature in the top causes

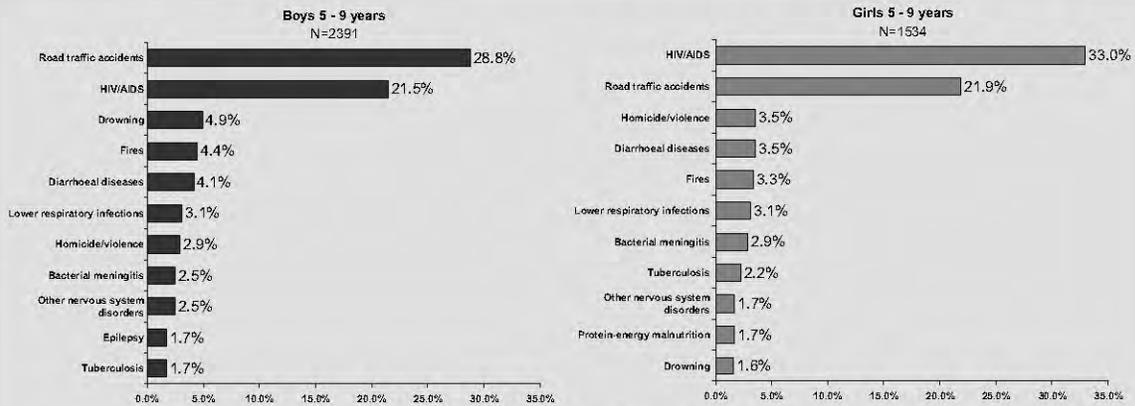


Figure 3. Leading cause of death among children aged 5-9 years, South Africa 2000

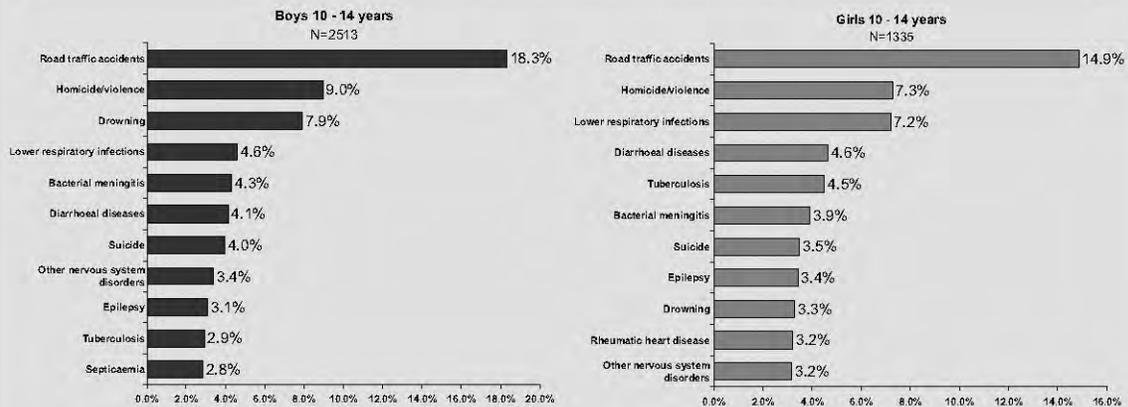


Figure 4. Leading Causes of death among children aged 10-14 years, South Africa 2000

Policy Implications

The mortality data indicates that many of the child deaths occurring in South Africa are preventable. We have identified three broad areas that will require differing approaches for intervention:

- The prevention of mother-to-child transmission of HIV, even at its current efficacy, is the single most effective intervention to reduce mortality among under-5-year olds, eclipsing all other interventions for other causes of death combined.
- Although dominated by the rise of HIV/AIDS, the classic infectious diseases such as diarrhoea, respiratory infections and malnutrition are still important causes of mortality. Environment and development initiatives such as access to sufficient quantities of safe water, sanitation, reductions in exposure to indoor smoke, improved personal and domestic hygiene as well as comprehensive primary health care will go a long way to preventing these diseases. Poverty reduction initiatives are also important in this regard.
- Road traffic accidents and violence, which includes homicide and suicide is another group of high mortality conditions that will require dedicated interventions.

The data presented in this policy brief represent an average for the whole country and do not highlight the inequalities in health care and outcomes that exist in different parts of the country. Detailed investigation of these inequalities will, however, require more comprehensive information systems than are currently available, and are beyond the scope of this policy brief.

of death in these ages and among the 10-14 year age group, homicide is the second leading cause of death. HIV/AIDS is no longer a leading cause of death, in this age group, although other infectious diseases make up a large proportion of the remaining top causes.

Acknowledgements

This research work had partial financial support from UNICEF, South Africa. The modeling of the HIV/AIDS epidemic was carried out at the Centre for Actuarial Research at the University of Cape Town.

The Impact of Adult Mortality on Child Mortality

In recent years, mortality among young adults, and in particular young women, has increased dramatically as a result of HIV/AIDS. Such mortality and also the illness preceeding it, has a devastating effect on children leading to increased morbidity, mortality and orphanhood. One of the most important results of the roll-out of anti-retroviral therapy among the general population will be the extension of the lives of AIDS sick parents leading to a dramatic decline in the number of orphans.¹¹

References

1. Bradshaw D, Groenewald P, Laubscher R, Nannan N, Nojilana B, Norman R, Pieterse D, Schneider M. *Initial Burden of Disease Estimates for South Africa, 2000*. Cape Town: South African Medical Research Council, 2003. <http://www.mrc.ac.za/bod/bod.htm>
2. Bradshaw D, Groenewald P, Laubscher R, Nannan N, Nojilana B, Norman R, Pieterse D, Schneider M, Dorrington RE, Bourne D, Johnson L, Timaeus I. Initial burden of disease estimates for South Africa, 2000. *South African Medical Journal*, 92: 618-623.
3. Statistics South Africa. Census 2001: Census in brief. Pretoria: Statistics South Africa, 2003. <http://www.statssa.gov.za>
4. Department of Health, Medical Research Council, Macro International. *South Africa Demographic and Health Survey 1998*. Full report. Pretoria: Department of Health, 2002.
5. Bradshaw D, Schneider M, Dorrington R, Bourne D, Laubscher R 2002. South African cause of death profile in transition – 1996 and future trends. *South African Medical Journal*; 92: 618-623.
6. Murray CJ, Lopez AD. *The Global Burden of Disease: a comprehensive assessment of mortality and disability from diseases, injuries and risk factors in 1990 and projected to 2020*. Vol. 1, Global Burden of Disease and Injury series. Boston: Harvard School of Public Health, 1996.
7. Murray CJ, Lopez AD. *Global Health Statistics: Vol 2, Global Burden of Disease and Injury Series*. Boston: Harvard School of Public Health, 1995.
8. Actuarial Society of South Africa. AIDS and demographic model. ASSA 2000. <http://www.assa.org.za>
9. Burrows S, Bowman B, Matzopoulos R, Van Niekerk A, eds. *A profile of fatal injuries in South Africa 2000: Second annual report of the National Injury Mortality Surveillance System (NIMSS) 2000*. Cape Town: MRC/UNISA Crime, Violence and Injury Lead Programme Technical Report, 2001.
10. Dorrington RE, Bradshaw D, Budlender D. HIV/AIDS profile in the provinces of South Africa: Indicators for 2002. Cape Town: MRC and UCT, 2002. <http://www.commerce.uct.ac.za/care>
11. Bradshaw D, Johnson L, Schneider H, Bourne D, Dorrington R. Orphans of the HIV/AIDS epidemic – the time to act is now. MRC Policy Brief No 2. Cape Town: Medical Research Council, 2002.

Examples of Policy Briefs

Oral Health 2005

Meeting Oral Health Care Needs in Rural America

April 2005

National Rural Health Association

Introduction

For too long, oral health and oral health care have enjoyed far less attention than other aspects of health and health care. As one prominent study put it, “the perception that oral health is in some way less important than and separate from general health has been deeply ingrained in American consciousness.”¹ When they have focused on oral health, policymakers, health care providers, and the general public alike have focused primarily on teeth, rather than the person around the teeth.

Fortunately, recognition of the importance of oral health and its interconnectedness to overall health is growing. In her introductory letter to the report, *Oral Health in America: A Report of the Surgeon General*, then-Secretary of Health and Human Services Donna Shalala wrote, “The terms oral health and general health should not be interpreted as separate entities. Oral health is integral to general health...oral health means more than healthy teeth ...you cannot be healthy without oral health.”²

Recognition is also growing of the importance of oral health to self-esteem, employability, and overall well-being. For example, studies have shown that a healthy smile increases the chances that job applicants will receive an offer. Conversely, one study in West Virginia found that the number one obstacle in going from welfare to work is poor oral health.³

Out of this growing recognition have come calls for action to improve oral health and oral health care throughout the country. This policy brief is itself a call to action to improve oral health and oral health care in a part of the country that often gets overlooked and underserved when it comes to health care: rural America.

Oral Health in Rural America

In keeping with its mission to improve the health and healthcare of rural Americans and to provide leadership on rural issues through advocacy, communications, education and research, the National Rural Health Association (NRHA) has undertaken an effort to describe the status of rural Americans with regard to oral health and to recommend ways to improve it. While data on rural oral health and health care are somewhat limited, sufficient evidence exists to suggest a distinct disparity in rural America.

- Even after controlling for population density and income, non-metropolitan counties have lower dentist-to-population ratios (62 dentists per 100,000 population in large metropolitan areas versus 29 dentists per 100,000 population in the most rural counties).⁴
- Rural persons are more likely to have lost all their teeth than their non-rural counterparts; in fact, adults aged 18 to 64 are nearly twice as likely to be edentulous if they are rural residents.⁵
- Rural adults are significantly more likely than non-rural adults to have untreated dental decay (32.6 percent versus 25.7 percent).⁵

NRHA Policy Brief

NRHA Policy Brief

- In 2001, 67.1 percent of urban residents had visited a dentist in the previous year, while only 58.3 percent of rural Americans had done so.⁷
- Rural residents are less likely than their urban counterparts to have dental insurance.⁸
- Of the 2,235 Dental Health Professional Shortage Areas, 74 percent are in non-metropolitan areas.⁹

According to the National Advisory Committee on Rural Health and Human Services, several factors contribute to the problems of rural oral health.¹⁰

- *Geographic isolation.* People in remote rural areas have farther to travel to obtain care and fewer dentists, hygienists, and other professionals to provide it.
- *Lack of adequate transportation.* In many parts of rural America, private automobiles are the only source of transportation. Public transit is non-existent, as are taxicabs and other transportation for hire. Consequently, many rural residents—especially low-income residents—face great difficulty in going to the dentist or any other service provider.
- *Lack of fluoridated community water supplies.* This most basic preventative treatment against tooth decay is unavailable in countless rural communities.
- *Higher rates of poverty.* Low-income status prevents many people from seeking and obtaining oral health care. It also prevents them from purchasing dental insurance. In addition, rural employers are less likely to purchase or offer dental insurance for their employees due to the smaller average size for most rural employers.
- *Larger percentage of elderly population.* With increasing age come increasing dental and oral health problems. The percentages of rural Americans who are older and sicker are greater than those of urban Americans, and Medicare does not provide dental benefits.
- *Lower dental insurance rates.* Insurance reimbursement rates—both public and private—for dental procedures are typically lower in rural areas than in urban. However, the actual costs of providing the services are often higher in rural areas.
- *Acute provider shortages.* As indicated above, the ratio of dentists per 100,000 population in non-metropolitan counties is less than half of what it is in metropolitan counties. Not surprisingly then, three-quarters of the nation's Dental Health Professional Shortage Areas are in rural America. Worse still, the acute shortage of dentists nationwide is expected to worsen in coming years as dental schools graduate fewer students, despite the fact that dental school applications were up some 18 percent last year. Indeed, with the closing of seven dental schools since 1986, and subsequent opening of only three new ones, more people want to become dentists than there are slots for. On top of that, many dentists are nearing retirement age—especially in rural areas. In addition, it can be predicted that the combination of increasing levels of dental school indebtedness and fee disparities between urban and rural locations will lead to a reduced percentage of the dental school graduates locating in rural locations.
- *Difficulty finding providers willing to treat Medicaid patients.* Because of low reimbursement rates, paperwork burdens, and a perception of a higher percentage of broken appointments, many dentists simply do not accept Medicaid or Children's Health Insurance Program (CHIP) patients—of which there are many in rural America due to the higher proportion of people living in poverty.¹¹

NRHA Policy Brief

As a result of these factors, working individually and in tandem, rural residents in general have a harder time accessing, utilizing, and affording oral health care. That need not be the case. Corrective measures are available. Rural Americans can and should enjoy access to high-quality, affordable oral health care.

Improving Oral Health in Rural America

Improving rural Americans' access to high-quality, affordable oral health care cannot be achieved overnight, nor with the stroke of a pen. It will require in-depth analysis and careful crafting of legislation, regulations, policies, and programs to meet the needs and bridge the gaps. Most of all, it will require dedication and political will from policymakers at all levels of government, from faculty and administrators in oral health programs around the country, and from oral health providers themselves. If implemented, the recommendations presented here can help further that process and hasten the day when rural Americans have the oral health care they need and deserve.

Recommendations

Access to oral health care in rural America

- The National Health Service Corps should place more emphasis on loan repayment and scholarships for oral health providers.
- State loan repayment programs should cover dentists and other allied health professionals that provide oral health care.
- Dental schools should create a residency or externship requirement for dental students to increase their practical experience and their service to underserved communities, including those in rural America. Such a requirement would increase the number of residents providing care by some 3,000 per year, and increase the number of people getting care by several million. Delaware and New York have already instituted such a requirement.
- Congress should allow foreign-trained dental students who complete their residency in the US to obtain US license in return for work in underserved areas.
- Congress should create and fund capital improvement programs that invest in rural oral health care by helping private practices remodel and update, purchase equipment, etc.
- Congress should provide dental schools and residency programs with financial incentives to rotate students and faculty through private practices and health centers in rural areas.
- Congress should increase support for public health infrastructure aimed at providing oral health care.
- Federal support should be increased to encourage community health centers to more fully integrate oral health care.

Reimbursement for rural oral health services

- Congress and the states should expand Medicaid coverage as a mandatory service for oral health services to eligible adults, including the elderly in long term care settings and the disabled. While Medicaid mandates some dental care for children, very few programs in Medicaid mandate dental care for adults.
- Congress and the states should require that Medicaid cover preventive and basic restorative oral health care, not just emergency care and include transportation as a covered ancillary service.
- Congress and the states should require Medicaid reimbursement for oral health screening and treatment during pregnancy.
- Congress should add dental services as a rural health clinic reimbursable service as well as allowing rural health clinics to contract with local providers for these services.
- Congress and the Centers for Medicare and Medicaid Services should provide Medicare reimbursement for dental care.
- Congress and the states should require Medicaid reimbursement for medical practitioners for doing oral health exams.

NRHA Policy Brief

- Congress should encourage oral health care within school-based clinics and within programs such as Head Start aimed at low-income children.

Oral health training programs

Dental and dental hygiene education institutions should:

- Orient the admissions process to encourage applications from students with rural backgrounds and those with demonstrated service to the underprivileged and minority populations.
- Ensure that adequate dental student and dental faculty slots are filled so to lessen the expected shortage of providers due to retirement.
- Emphasize serving as a safety net provider in the training of oral health care providers
- Increase dental student rotations through rural settings
- Create a rural residency or externship program
- Mandate that family practitioners and pediatricians as well as mid-level providers have training in oral health assessment
- Make scholarships available for practicing dentists, dental hygienists and students to do fellowships in geriatric oral health care.

Rural oral health research

The NRHA calls for a national rural oral health initiative including all stakeholders to look at a comprehensive way of improving rural oral health. In addition, Rural health research centers should:

- Synthesize rural-specific data from existing public and private sources.
- Conduct a comprehensive study of the functions and utilization of allied health professionals, differences among state practice acts and the supply of personnel in these fields, to explore the expanded use of so-called mid-level or allied health providers such as dental assistants, hygienists, and others.
- Study, catalogue, and promote the adoption of best practices among state practice acts that enhance the rural oral health care workforce.
- Study the issue of licensure reciprocity for dentists.

- 1) A National Call to Action to Promote Oral Health, U.S. Department of Health and Human Services, May 2003, p. 12.
- 2) Ibid.
- 3) The 2004 Report to the Secretary: Rural Health and Human Service Issues, National Advisory Committee on Rural Health and Human Services, April 2004.
- 4) National Rural Health Association, Policy Brief: Oral Health in Rural America, June 2001.
- 5) Ibid.
- 6) Ibid.
- 7) National Center for Health Statistics, Health, 2001, September, 2001.
- 8) Ibid.
- 9) U.S. Dept. of Health and Human Services, Bureau of Health Professions, Division of Shortage Designation.
- 10) The 2004 Report to the Secretary: Rural Health and Human Service Issues, National Advisory Committee on Rural Health and Human Services, April 2004.
- 11) Nationally, approximately one-fifth of dentists participate in Medicaid.

Questions in regard to this policy brief should be directed to the NRHA Government Affairs Office at 703/519-7910

Visit us on-line at www.NRHArural.org



National Rural Health Association
One West Armour Blvd., Suite 203
Kansas City, MO 64111-2087
www.NRHArural.org

Examples of Policy Briefs

Socio-Economic Policy Brief



TURNING THE TIDE AGAINST HIV/AIDS: TARGETING YOUTH

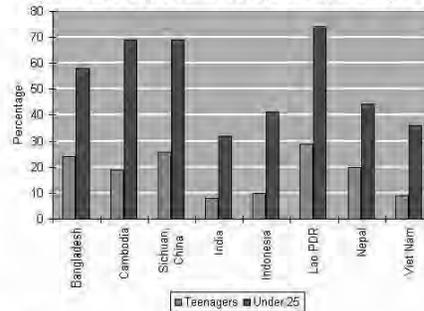
An estimated 9 million people are living with HIV in the ESCAP region.¹ While 1 million people in the region were newly infected in 2005, half a million lives were lost due to AIDS in the same year.

Young people are the hardest hit – half of all new infections have occurred among youth. In Viet Nam, 63 per cent of the people infected by HIV are under the age of 30. In Thailand, 50 to 60 per cent of new infections each year are among people under 24 years of age. While young people in general are vulnerable to HIV infection, the most at risk are those engaged in commercial sex and those injecting illicit drugs – the main drivers of the HIV pandemic in the region.

There is a high prevalence of HIV among brothel-based sex workers. In Cambodia, HIV among brothel-based sex workers accounted for 21 per cent of the total in 2003. In Viet Nam, the average prevalence of HIV among sex workers is about 16 per cent; in Mumbai, India, it remains above 50 per cent among female sex workers. Data

from a number of Asian countries reveal that 32 to 74 per cent of female sex workers are below 25 years of age (figure 1). Young men who have sex with other men (MSM) are also at a high risk of HIV infection. In Bangkok, studies carried out in 2003 and 2005 found that the HIV infection rate among this group had increased from 17 to 27 per cent. Among transgender sex workers in Jakarta, HIV prevalence increased from 6 to 22 per cent in 2002.

Figure 1. Percentage of female sex workers under the age of 25^a



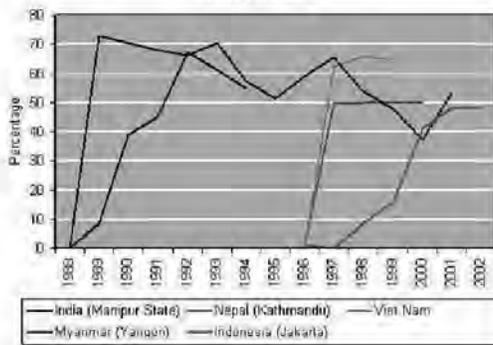
Source: National behaviour surveillance data.

^a Data refer to 2003 or latest available year.

¹ The figure for the ESCAP region was obtained by adding the number of people living with HIV and AIDS in East Asia, South-East Asia, South Asia, Oceania, Central Asia and the Russian Federation (UNAIDS, 2005a).

HIV prevalence could rise further among injecting drug users (IDUs) (figure 2), as the sharing of injection instruments is a very effective way of transmitting HIV. Injecting drug use accounts for at least 40 per cent of all HIV transmission in China, Indonesia, Malaysia, Myanmar and Viet Nam. More than 50 per cent of injecting drug users in India, Thailand and Myanmar are aged 15-24.

Figure 2. Sharp rises in HIV prevalence among injecting drug users, 1988-2002



Source: UNAIDS fact sheet update 2005 – prevalence among injecting drug users, and national surveillance systems, Indonesia and Viet Nam.

Why are youth so vulnerable?

Throughout the region the face of HIV/AIDS is becoming younger and more feminine. While most countries in the region have a national HIV prevalence below 1 per cent, vulnerable groups are much more prone to HIV infection due to globalization, poverty, gender discrimination and lack of access to information and health services. Figure 3 below shows aspects of the population at risk of HIV infection:

- Globalization and poverty increase population migration within and across countries in search of better economic opportunities. The majority of migrant workers are young people. Isolated from mainstream society and with little knowledge and few life skills, they are at risk of acquiring HIV as a result of unprotected casual sex and injecting drugs.

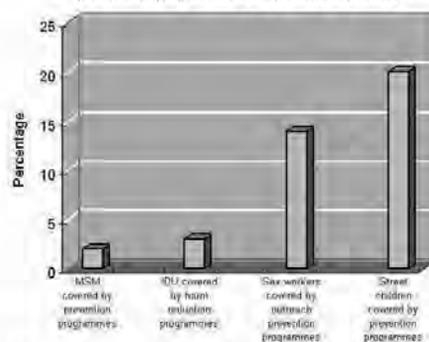
- Biological and social factors render girls and women more vulnerable to HIV/AIDS. Young women constitute more than half the young people living with HIV in Asia and the Pacific. Research shows that, during unprotected sex, the risk of HIV infection is two to four times higher for women than men.

- Entrenched gender biases often deprive girls of education; as a result, girls and women have much less knowledge of HIV/AIDS than men. Also, early marriage and gender violence increase the risk of HIV infection among them.

- Adolescents and young people are poorly informed about sexuality, reproductive health and the consequences of unprotected sex or drug use. In a 2004 survey in China, 80 per cent of high school students said they had never participated in a course, or in extra-curricular activities, at school related to HIV prevention.

- Access to essential health services is lacking in the region. For example, the coverage of voluntary counselling and testing services was less than 0.1 per cent of the population (aged 15-49) in Asia and the Pacific in 2003.

Figure 3. Populations at risk of HIV infection covered by prevention programmes in 15 Asian countries



Source: USAID, UNAIDS, WHO, UNICEF and the Policy Project. Coverage of Selected Services for HIV/AIDS Prevention, Care and Support in Low and Middle Income Countries in 2003 (Washington, D.C., Policy Project 2004).

How to turn the tide against HIV/AIDS

Focusing HIV prevention on youth offers the greatest hope for containing the spread of HIV in Asia and the Pacific. To be effective, prevention efforts should go hand in hand with treatment and care.

1. Enhancing knowledge, skills and preventive services

Schools are the best channels for reaching the majority of teenagers and youth. Merely incorporating information on HIV/AIDS in the curriculum, however, is not sufficient. Schools should be encouraged to promote a life-skills approach, which emphasizes interactive teaching methods to encourage young people to face health risks and make responsible decisions.

There is no easy way to reach youth who are out of school. While workplace HIV/AIDS education can be an efficient way to reach some, community-based peer education would be more effective for targeting a larger segment of youth. Positive peer influence and the community approach – engaging parents, teachers, health workers, village leaders and religious leaders – can foster positive behaviour among young people.

Life skills-based education in schools and community settings needs to be complemented by providing access to youth-friendly health services, including the availability of condoms, the provision of voluntary and confidential HIV counseling and testing, and the treatment of sexually transmitted infections. Youth-friendly health services can be delivered through hospitals, clinics, community outreach services, schools, the workplace and youth centres

2. Scaling up comprehensive services to those at risk

In September 2005 at the United Nations General Assembly, Governments resolved to move towards providing universal access to HIV prevention, treatment and care. To achieve this goal, it will be necessary to expand these comprehensive services for the populations most at risk. Countries that have targeted vulnerable groups have successfully

contained the spread of HIV. For example, Cambodia and Thailand managed to reverse the spread of HIV through 100 per cent condom use among sex workers.

Investments in harm-reduction programmes that target IDUs have proven to be effective. These programmes typically include substitution therapy, the provision of clean injection instruments, access to health-care facilities, law enforcement and prevention education. Australia invested US\$ 122 million in a needle-exchange programme during the late 1980s and 2000. It succeeded in preventing 25,000 HIV and 210,000 hepatitis C virus infections. More recently, the Government of China has announced plans to establish 1,400 needle-exchange sites and over 1,500 clinics for the treatment of drug users.

3. Improving policy coherence

Lack of policy coherence has been one of the major obstacles to scaling up HIV-prevention services for those most in need of them. While one ministry tries to promote safe and healthy behaviour among sex workers and drug users, another may arrest the same sex workers and drug users simply because they are in possession of a condom or a needle.

To ensure the effectiveness of HIV-prevention programmes, Governments also need to reform legal and policy frameworks, including decriminalization of HIV-related risk behaviour.

Where proactive and coherent policies do exist, there is often a gap between policies and implementation. Addressing this gap calls for wider engagement of the ministries of health with the ministries of justice, public security, law enforcement and other key actors that have not been part of the public health response to the AIDS pandemic.

4. Closing the resource gap

A comprehensive response to the AIDS pandemic in Asia and the Pacific will require an estimated investment of US\$ 5.1 billion annually by 2007. It is estimated that only US\$ 1.6 billion would be available. Most of it would come from bilateral donors, foundations and international institutions, including the Global Fund to Fight AIDS, Tuberculosis and Malaria.

To close the resource gap, significantly increased international assistance would be needed, particularly for the lower-income and the least developed countries. At the same time, domestic resources would have to be bolstered. Creative financing mechanisms, such as taxes on alcohol and tobacco, could be considered by countries. Also, better targeting of funds is needed in order to have a strategic impact on the AIDS pandemic. Funding should be prioritized for programmes and services for vulnerable and marginalized groups, including youth most at risk.

5. Addressing root causes of vulnerability

Poverty and gender discrimination are the root causes that endanger youth and other vulnerable groups with regard to the spread of HIV. Youth employment should be placed at the top of the national development agenda. Youth-oriented livelihood and income-generation projects need to be developed to prevent young people from seeking survival in the treachery of the streets and from exploitation by the sex industry.

Eliminating gender discrimination that subjects young girls and women to health risks requires strong political will and the full

participation of society in order to change cultural and social norms as well as to do away with laws that perpetuate gender bias. It is crucial to build enabling environments for girls and women to fulfil their rights to sexual and reproductive health and to live a dignified life.

6. Initiating a pro-poor regional compact to fight HIV/AIDS

A "pro-poor" regional compact could be developed to ensure that essential commodities are available for vulnerable and marginalized populations, including young people. Access to condoms, antiretroviral therapy, treatment of opportunistic and sexually transmitted infections, and substitution drugs and clean needles at affordable prices is therefore a priority in scaling up prevention and treatment services. Furthermore, countries should fully utilize the flexibility and safeguards allowed under the Agreement on Trade-Related Aspects of Intellectual Property Rights to ensure their access to affordable life-saving medicines. Major producers of these drugs and supplies, such as China, India and Thailand, could consider the formation of a regional compact to make them available at prices which the poor and vulnerable groups, including youth, could afford.

REFERENCES:

- ADB/UNAIDS (2004). *Asia-Pacific's Opportunity: Investing to Avert an HIV/AIDS Crisis* (Manila, ADB; Bangkok, UNAIDS Regional Support Team for Asia and the Pacific)
- Monitoring the AIDS Pandemic Network (2005). *Drug Injection and HIV and AIDS in Asia; Sex work and HIV and AIDS in Asia; Male-Male Sex and HIV and AIDS in Asia* (Geneva, MAP)
- Population Reference Bureau (2006). *The World's Youth 2006 Data Sheet* (Washington, PRB)
- UNAIDS (2005a). *AIDS Epidemic Update* (Geneva, UNAIDS)
- UNAIDS (2005b). *A Scaled-up Response to AIDS in Asia and the Pacific* (Bangkok, UNAIDS Regional Support Team for Asia and the Pacific)
- UNAIDS (2004). *2004 Report on the Global AIDS Epidemic* (Geneva, UNAIDS)
- UNICEF EAPRO (2005). *Situation Review on Adolescents and HIV and AIDS* (Bangkok, UNICEF EAPRO)
- United Nations Regional Task Force on Injecting Drug Use and HIV and AIDS for Asia and the Pacific, Background Paper, February 2006
- USAID, UNAIDS, WHO, UNICEF, and the Policy Project (2004). *Coverage of selected services for HIV and AIDS prevention, care and support in low and middle income countries in 2003*

This issue of the Socio-Economic Policy Brief has been prepared with substantive contribution from Ms. Cai Cai, formerly of Health and Development Section, Emerging Social Issues Division, ESCAP.

Please contact the Director, Emerging Social Issues Division (ESID), ESCAP.
Tel: +662 288 1989, e-mail: kay.unescap@un.org, for further information.

The Socio-Economic Policy Briefs are coordinated by the Poverty and Development Division, ESCAP.
E-mail: ratnayaker@un.org

Examples of Policy Briefs

UNAIDS MSM Brief



POLICY BRIEF

HIV and SEX BETWEEN MEN

Context

Sex between men occurs in every culture and society, though its extent and public acknowledgement vary from place to place.¹ In terms of HIV, sex between men is significant because it can involve anal sex, which when unprotected carries a very high risk.² At least 5–10% of HIV infections worldwide are estimated to occur through sex between men, though this figure varies considerably between countries and regions.³

As men who have sex with men may also have sex with women, if infected they can transmit the virus to their female partners or wives.⁴ Although sex between men is often associated with a discrete HIV epidemic, it should also be regarded as linked to the epidemic in the general population.

- In a project in Senegal (Dakar), 88% of men who had sex with men also reported vaginal sex, and 20% reported anal sex with a woman.⁵
- In a study in China, half the men who have sex with men reported having sex with a woman, and one third of them were married.⁶
- In some cities in central and eastern Europe, one third of men in gay venues reported having both male and female partners.⁷

Sex between men occurs in diverse circumstances and among men whose experiences, lifestyles, behaviours and associated risks for HIV vary greatly. It encompasses a range of sexual and gender identities among people in various sociocultural contexts. It may involve men who

- Between three and 20% of all men are estimated to have sex with other men at least once in their lives in parts of Asia, Europe and Latin America.⁹
- Significant anthropological and anecdotal evidence on sex between men from across Africa exists. In the Middle East and North Africa, a significant proportion of AIDS cases are known to occur among men who have sex with men.¹⁰
- Sex between men is the most prominent mode of HIV transmission in nearly all Latin American countries, the United States, Canada and some Western European countries.¹¹
- Among men who acknowledged having sex with men in Thailand (Bangkok), studies show HIV prevalence increased from 17% in 2003 to 28.3% in 2005.¹²
- HIV prevalence of 17% in India (Mumbai) and 20% in Colombia (Bogotá) has been found among men who have sex with men.¹³

¹ Men who have sex with men” refers to any man who has sex with a man, thus accommodating a variety of sexual identities as well as those who do not self-identify as homosexual or gay. In some contexts, “masles who have sex with males” may be a more accurate definition, since programming may be directed at males who are not yet adults (individuals under 18 years of age). Sexual orientation is not to be regarded as a disorder (World Health Organization, International Classification of Diseases (10), 2005).

² US Centers for Disease Control and Prevention at <http://www.cdc.gov/hiv/pubs/faq/faq22.htm>

³ UNAIDS (2001). *I care...do you?* World AIDS Campaign.

⁴ Men who have sex with men may also acquire the infection from their female partners if they are infected.

⁵ Nieng C et al. (2002). Meeting the sexual health needs of men who have sex with men in Senegal. *Horizons Report*. New York: Population Council.

⁶ Liu H et al. (2005). Men who have sex with men and human immunodeficiency virus/sexually transmitted disease control in China. *Sexually Transmitted Diseases*, 33, 2, 66–76.

⁷ Haines F, Downs A (2003). HIV in Central and Eastern Europe. *Lancet*, 361, 1035–1044.

⁸ Ryan C, Futterman D (2001). Lesbian and Gay Adolescents: Identity Development. *The Prevention Researcher*, 8, 1, 1–5.

⁹ Cáceres CF et al. (2005). Estimating the number of men who have sex with men in low and middle income countries. *Sexual Transmission Infection Journal*, 82 (Suppl III).

¹⁰ *Ibid*.

¹¹ UNAIDS (2006). *Report on the global AIDS epidemic*. Geneva, Joint United Nations Programme on HIV/AIDS.

¹² Van Griensven F et al. [to be presented]. Surveillance of HIV prevalence among populations of men who have sex with men in Thailand, 2003–2005. XVI International AIDS Conference, Toronto, Canada, August 12–18, 2006. [Abstract number MOAC0101].

¹³ Montano et al. (2005). Prevalence, genotypes and risk factors for HIV transmission in South America. *Journal of Acquired Immunity Deficiency Syndromes*, Volume 40, Number 1.

UNAIDS POLICY BRIEF : HIV and SEX BETWEEN MEN

Denial and stigma drive the epidemic

Many governments fail to acknowledge that sex between men happens and that unprotected anal sex contributes to the transmission of HIV. Even if they recognize that it happens, there may often be insufficient political will, funding and programming to address it. Experience shows that recognition of the rights of people with different sexual identities, both in law and practice, combined with sufficient, scaled-up HIV programming to address HIV and health needs are necessary and complementary components for a successful response. Countries may choose to prioritize one or the other component but both have to fall into place to effectively deal with the epidemic as it relates to sex between men.

A number of UN human rights mechanisms have noted that sexual identity or orientation is prohibited as grounds for discrimination and that laws that criminalize homosexual acts between consenting adults violate the right to privacy.¹⁴ While some countries have legally recognized some form of same-sex partnership, in many countries sexuality is still a taboo subject for discussion and sex between men is socially disapproved of, legally prohibited and criminalized.¹⁵ In such places, health-care workers, other service providers and employers often discriminate against men who have sex with men, and police may harass or arrest them or those trying to provide HIV and sexually transmitted infections services.¹⁶ Discrimination prevents men who have sex with men from disclosing their sexual orientation, or reporting for HIV services. Consequently their vulnerability to infection is increased, and national data do not reflect the size of the HIV epidemic that is linked to same-sex behaviour involving men.

Fulfilling the rights of men who have sex with men is not only intrinsically valuable, it is also a critical means for improved health outcomes for them and the broader community. In many countries where sex between men is not criminalized and where stigma and discrimination have been reduced, men who have sex with men are more likely to take up HIV prevention, care and support and treatment services. In such contexts, historically men who have sex with men have successfully mobilized

community-based HIV prevention strategies, promoted the rights and needs of people living with HIV and created enabling environments for behaviour change.

- Globally, less than one in 20 men who have sex with men have access to the HIV prevention, treatment and care services they need.¹⁷
- A study in 20 Latin American countries revealed that men who have sex with men were the biggest, single group of people living with HIV, yet spending on prevention among this group was disproportionately low and most of it was coming from external sources.¹⁸
- In Kenya, while men who have sex with men were among the clients at voluntary counselling and testing clinics, the curriculum used to train the counsellors did not include specialized advice for sex between men—a missed opportunity for prevention.¹⁹

Policy position

The 2001 UN General Assembly Special Session (UNGASS) Declaration of Commitment on HIV/AIDS adopted by all UN Member States emphasized the importance of “addressing the needs of those at the greatest risk of, and most vulnerable to, new infection as indicated by such factors as [...] sexual practices.” At the 2006 High Level Meeting on AIDS, the Member States and civil society members reiterated the commitment, underlining the need for “full and active participation of vulnerable groups [...] and to eliminate all forms of discrimination against them [...] while respecting their privacy and confidentiality”²⁰.

In 2005, 22 governments from different regions, along with representatives of nongovernmental organizations and people living with HIV as members of the UNAIDS governing board, called for the development of programmes targeted at key affected groups and populations, including men who have sex with men, describing this as “one of the essential policy actions for HIV prevention”²¹. Since then, country and regional consultations have confirmed that the stigma, discrimination and criminalization faced by men who have sex with men are major barriers to the movement for universal access to HIV prevention, treatment, care and support.²²

¹⁴ Committee on Economic, Social and Cultural Rights (2000). General comment No. 14: Human Rights Committee, Toonen Decision (1994) and comments to a number of States to repeal laws criminalizing same-sex sexual activity, see also the Report of the Special Rapporteur on the Right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt, Document E/CN.4/2004/49, Para. 38.

¹⁵ As of 2005, nearly 70 countries had legal prohibitions against sex between individuals of the same sex. SIDA (2005). LGBTI issues in the world. A study on Swedish policy and administration of lesbian, gay, bisexual, transgender and intersex issues in international development cooperation. Stockholm: Government office of Sweden.

¹⁶ Mansell H, Pachery M (2002). HIV/AIDS prevention in men who have sex with men. In Cáceres CPM, Terto V, eds. AIDS and male-to-male sex in Latin America and the Caribbean: vulnerabilities, strengths and proposed messages. Lima, UPCH and UNAIDS, 99–132.

¹⁷ UNAIDS (2006). Report on the global AIDS epidemic. Geneva, Joint United Nations Programme on HIV/AIDS.

¹⁸ Alvarado F et al (2002). Mapeo político y análisis de redes institucionales para VIH/SIDA en HSH en tres países latinoamericanos. Fundación Mexicana para la Salud (FUNSA/LID)/Iniciativa sobre SIDA para América Latina y El Caribe (SIDALAC) and Itzola JA (2002). HIV/AIDS expenditures and political mapping of MSM policies in LAC, a presentation at the UNAIDS CRIS meeting.

¹⁹ Horizons Report, HIV Operations Research, Reaching out to the Vulnerable, December 2005 at [http://www.popcouncil.org/Horizons/newletter/horizons\(1\)_3.html](http://www.popcouncil.org/Horizons/newletter/horizons(1)_3.html)

²⁰ Paragraph 64 of 2001 Declaration of Commitment on HIV/AIDS and Paragraphs 20 and 29 of the 2006 Political Declaration on HIV/AIDS.

²¹ UNAIDS (2005). Intensifying HIV Prevention. Geneva, Joint United Nations Programme on HIV/AIDS. Available at http://data.unaids.org/publications/ircpub05/jc1165-intensif_hiv_newstyle_en.pdf

²² United Nations A/60/737 Assessment by UNAIDS to the General Assembly on Scaling up HIV Prevention, Treatment, Care and Support, March 24, 2006.

In this context, UNAIDS recommends the following:

Actions for governments:

- Empirically assess the role that sex between men is playing in the national HIV epidemic.
- Respect, protect and fulfill the rights of men who have sex with men and address stigma and discrimination in society and in the workplace by amending laws prohibiting sexual acts between consenting adults in private; enforcing anti-discrimination; providing legal aid services, and promoting campaigns that address homophobia.
- Prioritize strategies and budgets to address HIV prevention, care and treatment needs of men who have sex with men in national health and AIDS plans.
- Engage men who have sex with men, especially those living with HIV, in the design, implementation and monitoring of programmes as well as in National AIDS Councils.
- Tailor national, state and local HIV strategies²³ for men having sex with men to epidemiological and social data, taking into account the diversity of men who have sex with men and the specific sociocultural circumstances and risks that they face.²⁴
- Promote programmes for men who have sex with men who may be especially vulnerable to HIV infection, such as sex workers, injecting drug users and those in settings such as military facilities and prisons where violence and sexual coercion may take place.
- Support nongovernmental and community based organizations, including organizations of people living with HIV, addressing issues related to sex between men.

In China, local nongovernmental organizations are promoting HIV prevention and fighting discrimination against sexual minorities in large cities across the country. Outreach workers, many of whom are themselves men who have sex with men, distribute free condoms, lubricants and educational materials and conduct HIV prevention sessions in gay bars, discos, bathhouses, brothels and parks. This includes work especially addressing the needs of men who sell sex. Advocacy by local nongovernmental organizations has persuaded proprietors of some gay establishments and brothels to distribute condoms. Some 300 gay-oriented websites exist in China, with approximately seven million users. Gay hotlines exist in major cities and these provide anonymous counselling on HIV, psychological support and legal aid. Stigma and discrimination related to sex between men and HIV remain an issue and programmes are therefore carried out discreetly. As a result of the non-confrontational approaches used, local officials have not restricted these efforts and tensions with the police are easing.

²³ These strategies should: promote safer sex behaviours; ensure availability of condoms and water-based lubricants; ensure health-care staff are educated to overcome prejudices and make health facilities more accessible; promote access to voluntary HIV counselling and testing and screening for other sexually transmitted infections; promote sexuality education including the respect for sexual diversity; ensure access for HIV-positive men who have sex with men to treatment and care and promote responsible sexual behaviours towards their partner. For a more complete list please consult the report of a UNAIDS stakeholder consultation, Geneva, 10-11 November 2005 at http://data.unaids.org/pub/Report/2006/JC1233-MSM-MeetingReport_en.pdf. For Best Practice examples, please refer to the International HIV/AIDS Alliance website at <http://www.aiaalliance.org/ww29365.asp>.

²⁴ Programming for men who have sex with men may raise their visibility with adverse consequences for their interpersonal and community relationships and personal safety.

Actions for civil society:

- Deliver programmes that promote access to HIV prevention, treatment and care for men who have sex with men.
- Challenge stigma and discrimination against men who have sex with men and advocate legal and policy reforms to promote their human rights and access to health services.
- Increase networking and information exchange with organizations working on behalf of men who have sex with men.

Actions for international partners:

- Advocate government commitment to the actions outlined above and promote strategic alliances between civil society groups working on this issue including labour unions, employers, universities and other organizations.
- Provide funding for programmes that address the health needs and human rights of men who have sex with men, as well as support for civil society groups, especially those comprised of men who have sex with men.
- Support systematic surveillance of HIV infection occurring in the context of sex between men, particularly in low- and middle-income countries.
- Increase support for strategic information and research, including ethnographic research, to better understand the occurrence, contexts and risk behaviours associated with sex between men, including its implications for women partners.
- Ensure that international norms, standards and tools address the specific HIV needs of men who have sex with men.

UNAIDS POLICY BRIEF : HIV and SEX BETWEEN MEN

Policy-makers' voices:

Dr Jorge A Saavedra, Executive Director, Mexico's National AIDS Programme (CENSIDA)

In Mexico, the HIV prevalence among men who have sex with men is about 15%, compared to 0.3% in the general population. Addressing HIV among men who have sex with men is, therefore, a critical priority of the government.

Social discrimination makes people vulnerable and less likely to access health services. How can a patient trust his doctor if he cannot talk openly about his sexually transmitted disease because it may reveal his sexual orientation? Social discrimination also leads to low self-esteem, which increases a patient's chances of giving up treatment and eventually acquiring drug-resistance. Protection of human rights and public health are greatly interrelated.

In 2001, Mexico's constitution outlawed discrimination based on sexuality. However, men who have sex with men still face stigma and discrimination. In 2005, we launched a nationwide mass media campaign with a simple, key message: "It is homophobia, not homosexuality that we should fear." The campaign is accompanied by specific HIV interventions such as distribution of information and condoms in places where men who have sex with men meet and a wider offering of public voluntary counselling and testing sites.

I fully understand the challenge for policy-makers in other countries. Some of them are men who fear that if they promote activities addressing men who have sex with men, their sexual identity may be confused by others. However, that is a risk we need to take. Where homophobia is prevalent and laws forbid homosexual behaviour, the data are biased and the epidemic is likely to be interpreted as being driven by heterosexual behaviour. The men who got infected by other men would rather declare that they got infected through heterosexual sex.

In Mexico, we were able to overcome the political barriers mostly with the support of nongovernmental organizations and our current Minister of Health who is a scientist, and by providing large amounts of data and evidence on where our HIV epidemic is concentrated and how to maximize health outcomes for every dollar invested.

Mr Neil Blewett, former Health Minister of Australia (1983 to 1990)

Australia was one of the first western countries affected by AIDS. Through much of the 1980s, the number of cases per capita was greater than comparable countries but [the epidemic] was soon controlled, and from 2500 new diagnoses in 1984, the numbers were brought down to 750 new diagnoses in 1988. Even today, the cases per capita in Australia are one third to one sixth of comparable countries.

When the disease first became visible during my tenure, nearly all the HIV positive people were men who have sex with men. While sex between men was legal in the early 80s in over half the Australian states, homosexuals were still a somewhat marginalized group in society. There was additional discrimination against men known or suspected of carrying the virus.

Our response was a policy of partnership with medicos at the front line and with the well-organized gay community. Representatives of the gay community were included in most of the advisory bodies to the National and the State governments. Gay groups were funded to deliver advertising and educational programmes. This enabled much more adventurous advertising—explicit and erotic—and more uninhibited educational programmes than would have been possible if done by government. It also kept government at arms length from actual products.

To achieve these measures, we had to build social and political support to fight the discrimination. In several of our states, homosexual activities were illegal under state law and one of the results of the disease itself was to make governments decriminalize homosexual behaviour because they simply found it easier to carry out the health work if they didn't have this impediment.

I recognize things are far more difficult in many developing countries. Frankness is important and taboos have to be challenged: discussing anal intercourse was never easy for us. Explaining to likely critics in private non-confrontational situations the necessity of the policies being pursued will often diffuse or dissipate opposition. I cannot stress too much the desirability of circumnavigating rather than bashing through barriers.

SECTION VII: Developing Advocacy Messages and Methods

Activity 5 — Written Communication (Policy Briefs)

“Advocacy in Action” Card

Advocacy in Action Card 2

Preparing a briefing note/
position paper



ALLIANCE

Advocacy in Action Card 2: Preparing a briefing note/position paper

Introduction

A briefing note and a position paper are both documents that clearly state the position or opinion of an organisation (or a coalition of organisations) about a particular issue. The message of these documents is: ‘This is what we think about this topic, and this is what we recommend’. They are different from a press release, which is written specifically for a media audience.

There are different definitions, but this toolkit makes the following distinction between the two, based on who the audience is:

A **position paper** is written to be read by a target, not an ally. It is a formal written record of the position (opinion) of an organisation or coalition, for an external audience. Position papers can:

- Be left with an individual decision-maker at the end of a face-to-face meeting, to summarise the main points of your message
- Be sent to local and national governments during consultation exercises
- Be sent to people in influence, in response to a policy or action, to explain an alternative or supporting position
- Summarise the resolutions of a conference or workshop
- Show that a coalition of many different allies supports your advocacy objective
- Be given to delegates or members of a committee at the beginning of a meeting or conference – whether or not you are allowed to speak at the meeting.

A **briefing note** is written for an ally, not a target. It is similar to a speaker’s notes, to help someone who is speaking publicly in support of your advocacy objective. Often a briefing note is a position paper with additional advice to the speaker – for example, how to answer questions, or key points to emphasise. A briefing note can:

- Be written by a programme officer involved in advocacy work, to assist the executive director in supporting the advocacy objective at a high-level meeting
- Summarise the agreed advocacy objectives and messages of a coalition, to ensure that all members of the coalition give a consistent message.

Advantages

- ✓ Briefing notes and position papers are a good way to provide clear documentation of our points for external audiences.
- ✓ They reduce distortion or misinterpretation of our positions.
- ✓ They are a way of contributing to decision-making processes – for example, as a way of delivering your analysis of policies or legislation to people in positions of influence.
- ✓ They help to identify allies based on the reaction to your position paper/briefing note.
- ✓ They can build consensus on policies inside the organisation.

Disadvantages

- ✗ Briefing notes and position papers commit the organisation to a certain position; an organisation can change its mind – but it cannot deny what its position was in the past.
- ✗ They are only as up-to-date as the last time they were edited/written, but they may still be in use long after you have changed your position.
- ✗ It is sometimes difficult and time-consuming to involve beneficiaries in writing position papers – but not doing so can make our work less representative.
- ✗ They can be misinterpreted if you are not there to explain them.
- ✗ They can be ignored.

Example: Preparing briefing note and position paper**Headings for a position paper on compulsory HIV testing of sex workers (SWs)**

- 1 Statement of main recommendation:** Compulsory testing does not promote public health and violates human rights and civil liberties.
- 2 Background:** Explanation of why the position paper has been written. List of laws, international treaties, policies, etc., that support the recommendation.
- 3 Evidence supporting the recommendation:**
 - a) Quantitative evidence:** Facts and figures showing that compulsory testing:
 - does not reduce HIV transmission
 - can increase transmission through negative impact on health care and education of sex workers.
 - b) Qualitative evidence:** Case studies, personal testimonies, anecdotes or examples describing the negative impact of compulsory testing on individual SWs and clients.
- 4 Our position:** Logical explanation of how the evidence leads to the recommendations. Answers to possible questions or objections.
- 5 Recommendations:** Specific, realistic actions that the decision-maker can take, i.e., stop compulsory testing, increase education and access to health care.
- 6 Organisations and individuals supporting this position paper.**

Reference: Adapted from an advocacy workshop, the International HIV/AIDS Alliance, Philippines, November 1998.

Example: Using position papers to influence government policy, Kenya

In Kenya, recommendations from position papers prepared by the Kenya AIDS NGO Consortium (KANCO) were incorporated into the government's 1997 Sessional Paper on AIDS, the country's first comprehensive national policy on HIV/AIDS.

KANCO's position papers made eight policy recommendations, based on issues, opinions and experiences developed in a national consultation exercise. NGO personnel, religious leaders, civil servants and policy-makers were all consulted.

The position papers were given to members of the government-appointed subcommittees who drafted the Sessional Paper. As a result of this collaboration between KANCO and the Ministry of Health, all eight priority issues were addressed in the final document.

Reference: Making Prevention Work, Global Lessons Learned from the AIDS Control and Prevention (AIDSCAP) Project 1991-1997.

Advice

- ✓ Try to use appropriate language for your target audiences.
- ✓ Try to tailor your position paper/briefing note to a particular audience for a particular reason.
- ✓ Try to give full references of any research or information quoted.
- ✓ Try to be brief and to the point.
- ✓ Try to ask others for ideas before writing.
- ✓ Try to make sure the appropriate people have been consulted.
- ✓ Try to ensure that everyone in the organisation understands the position the organisation is taking.
- ✓ Try to read it carefully for mistakes before sending or using it.

- ✗ Try not to distribute a position paper that contradicts what you have said.
- ✗ Try not to include the words 'advocating' or 'advocacy'.
- ✗ Try not to include irrelevant information.
- ✗ Try not to waffle – make clear points and highlight them with bullet points.
- ✗ Try not to quote people without their permission or break confidentiality in case studies.
- ✗ Try not to use abbreviations unless necessary.

How to...produce a briefing note/position paper

Alliance

Advocacy in Action Card 2 Preparing a briefing note/position paper

Position paper

Ideally a position paper should be written in full sentences and typed neatly. Follow the format for policy documents used in the target organisation, if you know it. Otherwise, use the format below. It should include:

- 1 Statement of main recommendation:** One to two sentences.
- 2 Background:** Explanation of why the position paper has been written. List of laws, international treaties, decrees, policies, etc., which support the recommendation.
- 3 Evidence supporting the recommendation:** (see Step 2 of planning framework.)
- 4 Quantitative evidence:** Facts and figures.
- 5 Qualitative evidence:** Case studies, personal testimonies, anecdotes or examples supporting the recommendation. Ask for permission from individuals quoted, to protect confidentiality.
- 6 Our position:** Logical explanation of how the evidence leads to the recommendations. Answers to possible questions or objections.
- 7 Recommendations:** Specific, realistic actions that the decision-maker can take.
- 8 Organisations and individuals supporting this position paper.**
- 9** The name of your organisation or coalition, and logo if appropriate.
- 10** The date.
- 11** A contact name, address, telephone and fax number, and e-mail address, where available.
- 12** The mission/goals of your organisation or coalition.

Briefing note

This document will only be seen by individuals within your organisation, or within your advocacy alliance, to assist them in delivering advocacy messages. Therefore it is acceptable to write notes instead of full sentences, and to use bullet points. Follow the same format as above, but also:

- Emphasise the most important points – for example, using bold type/underline or a coloured pen.
- Suggest possible strategies, tactics, minimum demands that cannot be compromised.
- Include possible questions that might be asked, and suggested answers.
- Include problematic issues that might arise, and suggest how to deal with them.

General advice

- Briefing notes and position papers should be as short as possible. People are less likely to read them if they are too long.
- Do not assume that the reader knows the subject well – make sure that sufficient background information is included for the reader to understand the issue without needing to carry out additional research. Try to keep this information concise.
- Separate fact from opinion. Provide supporting evidence to back up facts, and write opinions as quotes where appropriate.

SECTION VIII: Using the Mass Media for Advocacy

- Content:** ■ Activity 1 — Using Mass Media as an Advocacy Tool
- Purpose:** ■ To familiarize participants with the essential skills for working with the mass media on an advocacy issue.
■ To provide practical opportunities to practice and refine the use of these skills.
■ To enable participants to consider the inclusion of appropriate mass media activities in advocacy workplans.
- Objectives:** ■ To understand key skills needed to work with the media.
■ To apply these skills in framing advocacy messages for various mass media.
■ To practice planning for the use of media in HIV/AIDS advocacy campaigns.

Background Notes:

Information and education often play an important role in an advocacy campaign by generating support for an issue among the public, which then can influence a primary target audience. For example, voters may demonstrate their support for an issue covered in the mass media, which then influences elected representatives, such as government ministers, to take the action sought by an advocacy group, coalition, or network. Using the mass media effectively in an advocacy campaign requires skill and careful planning. There are numerous training workshops devoted exclusively to working with the mass media, and it is not possible to give in-depth coverage of all aspects of working with them in this training curriculum. However, participants should be aware of the various ways of working with the mass media and the skills required for each. This session provides information and resources that can be used as the basis for developing the skills required to work with the mass media on advocacy campaigns.

Why Use the Mass Media for Advocacy?

Using the media for advocacy can be important to

- Get your advocacy issue onto the political agenda;
- Make your issue credible and visible in policy debates;
- Inform the public about your issue and proposed solution;
- Recruit allies and supporters for your advocacy campaign;
- Influence decisionmakers and opinion leaders;
- Shape policies, programs, and the conduct of public and private agencies; and
- Raise money for your cause.

Are There Challenges in Using Mass Media for HIV Reporting?

In the context of HIV in South Africa, news reporting has focused at times on wild speculation about the origins of the virus, the political conflict among different stakeholders, the inadequacy of government strategies, and the sheer devastation caused by the disease. It has been claimed that these issues appeal to media audiences; however, misleading and false information can produce fear and confusion. Many journalists in this country find HIV difficult to confront because of the relationship between HIV infection and social and political inequalities. The

effects of HIV on poor and vulnerable communities are more visible, and journalists find it challenging to report on HIV while avoiding stigmatizing such communities. Reorienting media professionals to use non-alarming, non-discriminatory, and non-moralistic language in HIV reporting can lead the media to promote hope and acceptance and to reduce stigma. Partnerships with advocates in HIV journalism can create solidarity and hope and can be achieved by training journalists and reviewing editorial policy on the quality of HIV reporting.

Is it Always Wise to Use the Media?

In some situations, the most effective strategy may be to keep your issue out of the media. Think carefully about possible negative effects on your advocacy efforts before using the media in your advocacy efforts. Highly controversial and complex public health issues may be served better by no coverage at all. Advocates need to consider carefully whether running high-profile, mass-media campaigns are useful and, in the end, helpful. In some cases, such as when a government has adopted new policies or a regional meeting has made recommendations pertaining to HIV prevention among vulnerable populations, it might be useful to stimulate mass-media coverage. Also, the results of a rapid assessment or other important research could be sent to specific journals or newspapers.

There are other cases, however, in which working quietly in the background is better. These can include the opening of a drop-in center for people living with HIV (PLHIV), which has the potential to provoke opposition from local residents or compromise the confidentiality of service users or other controversial programs, such as outreach work with the populations most at risk. Too much attention can impede program implementation and jeopardize the confidentiality of activities. Decisions on whether to express criticism of government officials or institutions through the mass media also need to be considered carefully. This can create ill-will between advocates and their primary target audience, and advocates generally find that government agencies are much more powerful than advocacy groups when it comes to dealing with the mass media and usually more skilled. Cultural factors also may make it inappropriate to express public criticism of the government or to involve the mass media in an advocacy campaign at all.

Adapted from:

Bray, R. "Spin Works! A Media Guidebook for Communicating Values and Shaping Opinions." Independent Media Institute, USA.

Burrows, D. "Advocacy Guide: HIV/AIDS Prevention Among Injecting Drug Users." Web-accessible at www.who.int/hiv/pub/advocacy/en/advocacyguideen.pdf.

"Every Voice Counts: A Grassroots Advocacy Manual for the HIV/AIDS Community." Accessible at www.sfaf.org/policy/grassroots/grassroots200103.pdf.

Van Kampen, J. "Dealing with the Media: A Practical Guide." Accessible at www.asia-initiative.org.

Activity 1 — Using Mass Media as an Advocacy Tool

Total Time: 1 hour, 30 minutes

Materials: Pens, flipchart, tape, markers, computer, projector, display screen

Prepared Materials:

PPT: Using the Mass Media for Advocacy

Flipchart:

- List of advocacy issues and objectives selected by participants
- Questions for the introduction (one question per page)
- Questions for the report and discussion

Other: N/A

Handouts: Background Notes; PowerPoint presentation; Media Planning for Your Advocacy Issue; “Advocacy in Action” Card: Writing and Using a Press Release; “Advocacy in Action” Card: Carrying Out a Media Interview; “Advocacy in Action” Card: Preparing a Press Conference

- Objectives:**
- To understand key skills needed to work with the media.
 - To apply these skills in framing advocacy messages for various mass media.
 - To practice planning for the use of media in HIV and AIDS advocacy campaigns.

- Introduction:**
- At this point, participants should have a good grasp of the benefits of including data in advocacy activities to achieve advocacy goals.
 - Participants will now learn more about how the mass media may play a role in advancing their advocacy issues and objectives.
 - There are various forms of mass media that should be used, depending on the audience you are trying to target (refer to the session on Target Audiences).
 - There are many resources in the public domain that provide guidance on how to work with the media in implementing advocacy campaigns. This session is no more than an introduction to how mass media may be incorporated into advocacy activities.

Activity Instructions:

Step 1: Discussion on Participants’ Context

Time: 15 minutes

1. **Begin** this activity with a brief set of questions that will stimulate the participants to think about various ways that the mass media can be a tool in disseminating information about an advocacy issue or goal. Facilitate a group discussion using the prepared flipchart questions.

Prepared Flipchart: Prior to the start of the session, write the questions (see #3) on three separate pieces of flipchart paper.



2. **Record** their responses on the corresponding flipchart paper.
3. **Ask** participants the following:
 - Based on your experience in working in the HIV field, what do you see as the advantages and disadvantages of promoting an advocacy issue through the mass media?

Then ask the participants to take a moment to think of some examples of HIV-related media they have seen. Ask the following questions:

- Could you give me some examples of media coverage of HIV advocacy campaigns that you view as successes or failures? More specifically, do any of you have experience in trying to get the mass media to cover your issue? If yes, would you be able to provide any tips for working successfully with the mass media?
- Thinking about A² (or any other type of program area in which you work), what sorts of advocacy or research-related information do you see as “newsworthy”?

Step 2: PowerPoint Presentation

Time: 15 minutes

1. **Present** the PowerPoint presentation, “Using the Mass Media for Advocacy,” and distribute the handouts. Save the last PPT slide until step 3.
2. **Note** that, to increase the chances of informing the population through the mass media successfully, the groups must identify which medium is most appropriate for their issue. **Emphasize** that not all forms of media may be appropriate for the messages they are trying to convey to the public and that the most appropriate media channels may change as their advocacy plans and context evolve. For this reason, it is extremely important that analysts and advocates evaluate the various forms of media available in their country, choose one that can aid them successfully in their cause, and create an effective forum for the advocacy group or network to broadcast their issue and broaden their base of support.

Step 3: Developing a Media Plan

Time: 30 minutes



Facilitator Note: Use the advocacy issues and objectives that the participants already have identified and have been using throughout the training.

1. **Distribute** the “Media Planning for Your Advocacy Issue” handout and display its counterpart PowerPoint slide at the same time (last slide of PPT presentation).
2. **Divide** the participants into the same groups in which they have worked on developing advocacy issues, goals, and objectives.
3. **Explain** the task to all of the groups—to think about their chosen advocacy issue, goal, and objectives. Ask participants to complete the “Mass Media Planning for Your Advocacy Issue” chart for one of their advocacy objectives, so that they can think about concrete ways to present their advocacy issues in the mass media, as well as the various concerns/barriers they may face in using them to advance their advocacy objective.

4. **Tell** each group that they will present their advocacy objective to the larger group and show how they filled out their respective charts.

Step 4: Report and Discussion

Time: 30 minutes

Prepared Flipchart: Write all of the discussion questions on two pieces of flipchart paper—for the small and full group questions.



1. **Ask** each group the following questions to prompt discussion:
 - Why did you choose this particular mass media strategy?
 - What are some obstacles or barriers that you may face while carrying out your mass media advocacy plan? How will you address these challenges or barriers?
2. **Ask** the entire group of participants the following questions:
 - How much overlap or difference is there between media strategies targeting specific decisionmakers and those targeting broader allies?
 - What does this suggest in terms of developing a media plan?
 - What does this suggest for developing an overall advocacy communication plan?
 - If the issue you are discussing is too controversial to disseminate through the mass media, what would be some other effective ways to build support for your issue?

SECTION VIII: Using the Mass Media for Advocacy

Activity 1 — Using Mass Media as an Advocacy Tool

Background Notes

Information and education often play an important role in an advocacy campaign by generating support for an issue among the public, which then can influence a primary target audience. For example, voters may demonstrate their support for an issue covered in the mass media, which then influences elected representatives, such as government ministers, to take the action sought by an advocacy group, coalition, or network. Using the mass media effectively in an advocacy campaign requires skill and careful planning. There are numerous training workshops devoted exclusively to working with the mass media, and it is not possible to give in-depth coverage of all aspects of working with them in this training curriculum. However, participants should be aware of the various ways of working with the mass media and the skills required for each. This session provides information and resources that can be used as the basis for developing the skills required to work with the mass media on advocacy campaigns.

Why Use the Mass Media for Advocacy?

Using the media for advocacy can be important to

- Get your advocacy issue onto the political agenda;
- Make your issue credible and visible in policy debates;
- Inform the public about your issue and proposed solution;
- Recruit allies and supporters for your advocacy campaign;
- Influence decisionmakers and opinion leaders;
- Shape policies, programs, and the conduct of public and private agencies; and
- Raise money for your cause.

Are There Challenges in Using Mass Media for HIV Reporting?

In the context of HIV in South Africa, news reporting has focused at times on wild speculation about the origins of the virus, the political conflict among different stakeholders, the inadequacy of government strategies, and the sheer devastation caused by the disease. It has been claimed that these issues appeal to media audiences; however, misleading and false information can produce fear and confusion. Many journalists in this country find HIV difficult to confront because of the relationship between HIV infection and social and political inequalities. The effects of HIV on poor and vulnerable communities are more visible, and journalists find it challenging to report on HIV while avoiding stigmatizing such communities. Reorienting media professionals to use non-alarming, non-discriminatory, and non-moralistic language in HIV reporting can lead the media to promote hope and acceptance and to reduce stigma. Partnerships with advocates in HIV journalism can create solidarity and hope and can be achieved by training journalists and reviewing editorial policy on the quality of HIV reporting.

Is it Always Wise to Use the Media?

In some situations, the most effective strategy may be to keep your issue out of the media. Think carefully about possible negative effects on your advocacy efforts before using the media in your advocacy efforts. Highly controversial and complex public health issues may be served better by no coverage at all. Advocates need to consider carefully whether running high-profile, mass-media campaigns are useful and, in the end, helpful. In some cases, such as when a government has adopted new policies or a regional meeting has

made recommendations pertaining to HIV prevention among vulnerable populations, it might be useful to stimulate mass-media coverage. Also, the results of a rapid assessment or other important research could be sent to specific journals or newspapers.

There are other cases, however, in which working quietly in the background is better. These can include the opening of a drop-in center for people living with HIV (PLHIV), which has the potential to provoke opposition from local residents or compromise the confidentiality of service users or other controversial programs, such as outreach work with the populations most at risk. Too much attention can impede program implementation and jeopardize the confidentiality of activities. Decisions on whether to express criticism of government officials or institutions through the mass media also need to be considered carefully. This can create ill-will between advocates and their primary target audience, and advocates generally find that government agencies are much more powerful than advocacy groups when it comes to dealing with the mass media and usually more skilled. Cultural factors also may make it inappropriate to express public criticism of the government or to involve the mass media in an advocacy campaign at all.

Adapted from:

Bray, R. 2000. *Spin Works! A Media Guidebook for Communicating Values and Shaping Opinion*. Independent Media Institute.

Burrows, D. 2004. *Advocacy Guide: HIV/AIDS Prevention Among Injecting Drug Users*. Geneva: World Health Organization.

Aragon, R. and S. Johnson. 2001. "Every Voice Counts: A Grassroots Advocacy Manual for the HIV/AIDS Community." San Francisco: The San Francisco AIDS Foundation.

Van Kampen, J. No date. "Dealing with the Media: A Practical Guide." Hannover, Germany: German Foundation for World Population and EC UNFPA Initiative for Reproductive Health in Asia/Information and Communication Network (RHI/ComNet).

SECTION VIII: Using the Mass Media for Advocacy

Activity 1 — Using Mass Media as an Advocacy Tool

Media Planning for Your Advocacy Issue

Advocacy Issue:					
Who is your target audience?	What is your key advocacy message?	What is the purpose of using the media for this message? To: -Inform? -Persuade? -Move to Action?	What forms of mass media would be most effective in addressing this issue?	What are the key steps involved?	At what stage of your advocacy action plan would you use this form of media to disseminate your message?

SECTION VIII: Using the Mass Media for Advocacy Activity 1 — Using Mass Media as an Advocacy Tool

“Advocacy in Action” Card

Advocacy in Action Card 7 Writing and using a press release



ALLIANCE

Advocacy in Action Card 7 Writing and using a press release

Introduction

NOTE: In some countries a ‘press release’ is a paid advertisement. This Advocacy in Action Card refers to press releases that are not paid for and that are sent to journalists on newspapers, magazines, radio and TV, to assist them in producing stories.

A press release (or news release) is the standard method of distributing a story to the media (it is also possible to telephone a journalist to suggest a story, if you are sure that it is an interesting story and that it cannot easily be distorted).

Using the mass media is also an information, education and communication (IEC) method. It only becomes an advocacy method when:

- The general public has been identified as an ‘indirect target’ who will go on to influence a direct target – for example, voters who will influence a minister
- Influential people are the targets of the article or broadcast item – for example ministers reading a newspaper.

The aim of a press release is usually to do one or more of the following:

- Outline an organisation’s response to an event/action
- Draw attention to an issue
- Provide background information on an issue/event or action
- Give advance notice of an event
- Announce new campaigns and provide progress reports
- Provide a report of a meeting
- Report decisions taken by organisations/groups
- Circulate speeches in advance.

Media organisations receive hundreds of press releases each day, most of which are never used. In order to get the attention of the media, a press release needs to be well written and interesting.

Advantages

- ✓ It is a very public form of advocacy which can increase pressure on decision-makers to take action.
- ✓ You can offer your selection of facts and opinions.
- ✓ You can decide when to give the information.
- ✓ A press release is more permanent than an interview – you have a permanent record of what you said.
- ✓ You have time to think before giving your message to a journalist.
- ✓ It makes the job of the journalist easier, therefore your views are more likely to be covered by the media.

Disadvantages

- ✗ Journalists receive too many press releases, so yours will be thrown away if it is not interesting or if a big news story ‘breaks’.
- ✗ Journalists can still distort your story, even if it is clear in a press release.
- ✗ A good press release requires a good level of literacy, and some understanding of how journalists work.
- ✗ It is difficult to involve many people in writing a press release.

Example: Writing and using a press release**When to involve the media in advocacy work**

- When you are making gains on your issue.
- When there is a burning issue.
- When other methods are not working.
- When looking for allies.
- When you have begun your advocacy work.

When not to involve the media in advocacy work

- When you do not know how the media works.
- When there are disagreements within the organisation on the issue.
- When the timing is not right – for example, due to political circumstances.
- When bigger issues are dominating the media, preventing your issue from getting the attention you think it deserves.

Reference: Adapted from an advocacy skills-building workshop for HIV/AIDS, International HIV/AIDS Alliance, Zimbabwe, July 2001.

Alliance

Advocacy in Action Card 7 Writing and using a press release

Advice for writing a press release

- ✓ **Try to** be clear about what you are trying to achieve when using the media in your advocacy work.
- ✓ **Try to** research the most relevant journalist(s) and send the release directly to them, using the correct contact details.
- ✓ **Try to** co-ordinate all your media work through one person so that there is one person for journalists to contact.
- ✓ **Try to** provide a 24-hour contact phone number on the press release if possible, so that you are contactable at all hours.
- ✓ **Try to** consult people directly affected by the issue or problem.

- ✗ **Try not to** hand write a press release.
- ✗ **Try not to** include jargon – if in doubt, explain technical words, abbreviations, initials.
- ✗ **Try not to** assume that the journalist knows about your issue – explain the key concepts or attach additional notes.
- ✗ **Try not to** quote someone without their permission.

Advice for working with journalists

- ✓ **Try to** provide the media with information they need in forms that they can use.
- ✓ **Try to** develop good relationships with journalist and be as helpful as possible.
- ✓ **Try to** understand the pressures and limitations under which journalists work – and respect their deadlines.
- ✓ **Try to** work with, rather than against, journalists whenever possible.

- ✗ **Try not to** dictate terms – any good journalist will resent being told what to think or write.
- ✗ **Try not to** be defensive, even if challenged, just state your position clearly.

How to...write and use a press release

Alliance

Advocacy in Action Card 7 Writing and using a press release

Content of the press release

Write a simple and interesting headline – this helps the journalist understand the story immediately.

The first sentence should summarise the most important facts of the story, i.e.:

- ? **Who** is involved?
- ? **What** is happening?
- ? **Where** is it happening?
- ? **When** is it happening?
- ? **Why** is this happening?

The main part of the press release should then explain these points in further detail. This information helps to persuade the journalist of the facts and importance of the subject, and why it is of interest.

Quotes can often make a press release more interesting and appealing to the journalist, because they may not have access to the relevant people or perhaps because the event has passed. Direct speech quotations from people involved in the issue or activity:

- should express an opinion, fact, or be able to support the view you have expressed in your press release
- allow you to give strong opinions that would look wrong in ordinary text
- give a human dimension to the story
- are better than indirect quotations.

Gain permission from a person affected by the issue, if you are quoting them.

Style

- Short sentences, maximum 20 words.
- Short paragraphs, maximum two to three sentences.
- Copy the format and story structure from a newspaper article.
- Use a good case study or anecdote as evidence to support your point of view.

Presentation

- Use headed paper so that it looks official and professional.
- Make sure that it is well laid out and easy to read.
- Type it, using double spacing, on one side of the paper only.
- Include the date and the name of the organisation.
- Provide a contact name, telephone and fax number, and e-mail address as available.
- Give an embargo time (the day/time when the journalists are allowed to use the information). This should include the day, date and time.

Photographs

- Include photographs of key people, places or action mentioned in the press release if you have them.

NOTE: Once a press release has been written it should be distributed to selected journalists and press associations by fax or e-mail – you can telephone them to ask for these numbers/addresses. Once the journalists receive the press release they will consider whether to include the story in their media work. They may also contact you for further information.

SECTION VIII: Using the Mass Media for Advocacy Activity 1 — Using Mass Media as an Advocacy Tool

“Advocacy in Action” Card

Advocacy in Action Card 8

Carrying out a media interview



ALLIANCE

Advocacy in Action Card 8 Carrying out a media interview

Introduction

A media interview is a conversation between a reporter and a person who has an interesting story that can be used as the basis for publication or broadcast. Although interviews are usually used by NGOs/CBOs for education and awareness-raising work, media interviews can be used for advocacy work too.

Media interviews are an advocacy method when:

- The general public has been identified as an 'indirect target' who will go on to influence a direct target – for example, voters who will influence a minister
- Influential people are the targets of the article or broadcast item – for example, ministers reading a newspaper.

In this way, the journalists are merely a means to an end. They will usually ask the questions that they think their audience might want them to ask.

Interviews may be reactive or proactive. A reactive interview is when a reporter approaches a person for an interview, particularly if there is large public interest in an issue they are involved with. This kind of interview often takes place when an issue arises which is related to your work or the work of your organisation. A proactive interview is one in which a person or organisation approaches a journalist directly about an issue that they think is important and would be of interest to the media. A proactive interview requires greater preparation. However, it is an important method for doing advocacy work.

The key to giving a good interview is knowing your subject well and preparing carefully for the questions that you may be asked.

Advantages

- ✓ It can help you get your information to the public, which will help you address the issue.
- ✓ It can provide profile for yourself and/or your organisation.
- ✓ You can reach a wide audience with relatively little effort with your key messages.

Disadvantages

- ✗ All exposure can potentially go wrong and expose the person or organisation to problems.
- ✗ It is important that the person being interviewed knows and uses the organisation's point of view as the basis of their answers – otherwise the organisation may be discredited.
- ✗ Those inexperienced at being interviewed or badly prepared can be caught out by being asked difficult or unrelated questions; this can lose support for our organisations and our advocacy work.

Example: Carrying out a media interview

Participants attending an advocacy workshop held in India practise giving advocacy radio interviews at a local radio station. The interviews were recorded and played back to the other participants and facilitators who provided feedback.

Reference: Photo taken at an advocacy skills-building workshop for HIV/AIDS Work, India HIV/AIDS Alliance and International HIV/AIDS Alliance, India, November 2001.

Advice

- ✓ **Try to** practise responding to questions; role-play with your colleagues!
- ✓ **Try to** show some emotion for radio – it shows you care – but keep it under control!
- ✓ **Try to** sit upright with your hands on your lap for a TV interview.
- ✓ **Try to** sit still and make sure you do not fidget or swing in your chair.
- ✓ **Try to** look happy to be there, and try not to look nervous.
- ✓ **Try to** answer the interviewer's questions wherever possible – it is their interview.
- ✓ **Try to** be respectful and patient with the interviewer; they will not necessarily know the subject well – but then neither, perhaps, will the audience.
- ✓ **Try to** make sure you get your key messages across; if you are not asked relevant questions, add your key messages to the end of one of your most relevant replies.

- ✗ **Try not to** bluff! If you don't know the answer to a question – say so or avoid it.
- ✗ **Try not to** agree to interviews that could stray off topic that might lead you to make statements about issues you do not know about.
- ✗ **Try not to** get angry if a journalist tries to unnerve you – your message will become unclear and the audience will assume you are in the wrong!
- ✗ **Try not to** let a journalist 'put words in your mouth' – say firmly, "That is not what I am saying..."
- ✗ **Try not to** look at the camera during a TV interview – look at the interviewer.
- ✗ **Try not to** use extreme facial expressions during a TV interview.
- ✗ **Try not to** wear jewellery or glasses if possible as these can distract the audience from what you are saying.
- ✗ **Try not to** try to cover too many points or give too much new information.
- ✗ **Try not to** wear patterned clothes on TV.

How to...carry out a media interview

Alliance

Advocacy in Action Card 8 Carrying out a media interview

Preparing for the interview

- Find out the answers to the following kinds of questions before any interview:
 - ✓ Where and when will the interview take place?
 - ✓ How long will the interview be?
 - ✓ Who else, if anyone, is being interviewed?
 - ✓ Will the discussion or interview follow a film or be linked to another story?
 - ✓ Why have they chosen the subject to address and selected you for the interview?
 - ✓ Will the interview be broadcast live?
- Find out about the journalist *who* will be interviewing you and:
 - ◆ Investigate their audience – *who* are the targets amongst their audience and what kind of information do you need to get across?
 - ◆ Contact them and agree the subject to be discussed. Remember that the interview starts as soon as you begin talking to a journalist. There is no such thing as 'off the record'. Define the issues clearly. Ask the journalist what kind of questions they will ask and whether they will be supportive or argumentative. Prepare appropriate information beforehand – for example, statistics, facts, a personal story, etc.
 - ◆ Make a list of key messages you want to get across with three or four key points for each.
 - ◆ Prepare catchy sentences ('sound-bites') that summarise your message.
 - ◆ Check that you have up-to-date information on your issue.
 - ◆ Work closely with your colleagues to develop a draft list of possible questions. Prepare answers to these and practise developing responses to them.

What to do during the interview

- Try and keep calm and composed.
- Remember that the journalist is not your advocacy target – the target will either be influential people listening or watching or the general public as indirect targets.
- Remember that you have the facts you need and that you know more than the journalist does about your area. Keep your answers concise and short, using simple language, without jargon or acronyms. Do not get side-tracked – keep to your key points. If a question strays from your topic, try to move back to the area you want to talk about – for example, "I think what you are asking about is important but the main issue is..."
- If you need time to think about a response, repeat the question before responding.
- Always bring the journalist back to your key messages/points, repetition is a way of getting your message across.

Differences between media

Press interviews tend to be more relaxed than radio or TV interviews. If you make a mistake, say so and answer again.

Radio interviews: In a studio, the studio manager will give you specific instructions about where to sit, how to use the microphone, etc. Sometimes this is done with little time to spare. However, take your time and be sure you understand the instructions. Ask what the first question will be to help you concentrate. You can take notes with you – but try not to rustle the pages. (Brief notes on postcards are often more helpful.) If you make a mistake during a recorded interview, you can ask to try the answer again. If it is live you can say, "Perhaps I might explain that answer", and continue.

TV interviews: The same rules apply as for the radio interview but you can be seen! TV interviews are usually shorter than radio interviews. The interview may be pre-recorded or live.

SECTION VIII: Using the Mass Media for Advocacy Activity 1 — Using Mass Media as an Advocacy Tool

“Advocacy in Action” Card

Advocacy in Action Card 9 Preparing a press conference



Alliance

Advocacy in Action Card 9 Preparing a press conference

Introduction

The aim of a press conference is to gain media coverage for an issue. It is a meeting held by an organisation, or group of organisations, when journalists listen to speakers and ask questions. It usually includes statements by up to three speakers followed by questions from the journalists. So the format is similar to a panel discussion, although the purpose is not to discuss, but to gain publicity for the advocacy issue.

A press conference demands careful organisation. Press conferences are expensive and time-consuming to organise, therefore they should only be used if it is the best option. It is also necessary to think carefully about confidentiality, especially when discussing or involving people living with HIV/AIDS, as they may not wish their HIV status to be made public.

Advantages

- ✓ It brings many journalists together in one place at one time.
- ✓ It encourages all media to publicise a similar message.
- ✓ It is a chance to meet journalists face-to-face and learn about their opinions and attitudes to the issue.
- ✓ It makes the job of journalists easier therefore the issue is more likely to be covered by the media.
- ✓ It allows the journalists to ask questions from a panel of speakers.
- ✓ It provides an opportunity to correct misunderstanding before journalists write their articles.
- ✓ It can save the time of key people in the organisation who would otherwise have to talk to each journalist in turn.
- ✓ It can make the issue more important.

Disadvantages

- ✗ It requires a lot of logistical organisation.
- ✗ There is always the risk that a bigger story ‘breaks’, so the journalists do not attend.
- ✗ Journalists may turn against your campaign if the press conference is badly focused or unconvincing.
- ✗ Time is needed to prepare speakers for a press conference to make sure that everyone agrees and reinforces the key messages and yet everyone contributes something different.
- ✗ You cannot predict the questions that the journalists will ask or how your issue will be presented positively by the media.

Example: Preparing a press conference

Participants practising holding a press conference during an advocacy workshop held in Mongolia.

Reference: Photo taken at an advocacy skills-building workshop for HIV/AIDS/STI work. National AIDS Foundation and International HIV/AIDS Alliance, Mongolia, February 2002.

Advice

- ✓ **Try to** make sure that your press conference does not coincide with an important event that will prevent the journalists or speakers from attending.
- ✓ **Try to** call to check whether the announcement has been received – use this as an opportunity to encourage journalists to attend.
- ✓ **Try to** choose speakers carefully – they should be interesting, confident speakers and show the human face of the issue/problem.
- ✓ **Try to** ensure that each speaker knows your key messages and co-ordinate each speaker to say something different.
- ✓ **Try to** capture attention with quotes, comparisons, examples or visual aids such as photographs or graphs.
- ✓ **Try to** respond to questions clearly and simply.
- ✓ **Try to** make sure that the person chosen to deal with the media is clearly identifiable.
- ✓ **Try to** make clear why the different organisations or people are involved if this is a joint press conference.
- ✓ **Try to** involve a journalist in advising you on how to organise and plan the press conference.

- ✗ **Try not to** have too many speakers – the message can get confused!
- ✗ **Try not to** allow speakers to talk for more than 10 minutes.
- ✗ **Try not to** start late – journalists have deadlines!
- ✗ **Try not to** allow the speakers to answer the questions at great length – warn the chair of this as appropriate.
- ✗ **Try not to** let the press conference overrun in time.
- ✗ **Try not to** allow the speakers to make conflicting statements – try to rehearse the key points with the speakers before the conference.
- ✗ **Try not to** organise a press conference if there is a cheaper, more effective way to publicise the issue.
- ✗ **Try not to** hold a press conference if you predict the majority of the journalists will disagree with you or present negative coverage.

Alliance

Advocacy In Action Card 9 Preparing a press conference

How to...organise a press conference

ALLIANCE

Advocacy in Action Card 9 Preparing a press conference

Preparing for the press conference

- Give two to seven days' notice of the conference to relevant journalists (consider reporters, columnists, newscasters, editors) and send them an announcement including:
 - ✦ The purpose of the press conference
 - ✦ Date, time and where it will be held
 - ✦ Who will speak at/present/chair it.
- Choose a suitable venue including the following as required:
 - ✦ Easy location, access and adequate parking space
 - ✦ Low noise levels
 - ✦ Enough capacity – power points for TV lights, space, layout
 - ✦ Audio/audio visual equipment
 - ✦ Room for individual interviews
 - ✦ Helpful staff with experience of hosting press conferences and with technological expertise.
- Choose an appropriate time of day for the majority of media, i.e., so that they can write the story before their deadlines (but you will not be able to fit in with everyone's deadlines).
- Select and brief a chairperson and appropriate speakers. Work with them to identify and practise answering questions from the journalists – especially the difficult ones!
- Select a press officer/key contact person for the press to deal with.
- Prepare a press pack for journalists, including:
 - ✦ Press release (see Press Release Advocacy in Action Card 7)
 - ✦ Background on your organisation/coalition
 - ✦ A list of the key points you are making and sample quotes
 - ✦ Recommendations for future action
 - ✦ A list of contacts whom journalists can contact to discuss the issue
 - ✦ Any relevant photographs, statistics, graphs, etc. Take special care concerning confidentiality, and brief the chairperson and speakers about these issues where necessary.

Format of a press conference

- 1** Welcome, refreshments and distribution of the press pack.
- 2** Chairperson:
 - ✦ Introduces the speaker/s
 - ✦ Explains arrangements and proceedings
 - ✦ Points out the press officer/key contact person for all enquiries
 - ✦ States whether interviews are available afterwards
 - ✦ Stresses confidentiality issues where appropriate.
- 3** First speaker.
- 4** Second speaker, etc.
- 5** Chairperson takes questions from journalists who then gives them to one of the speakers to answer; other speakers may also add remarks.
- 6** Chair thanks the press for attending and closes the press conference.
- 7** Individual interviews with speakers.

After the press conference

- Send the press pack to the journalists who did not attend.
- Make a list of attendees and update your database where appropriate.
- Note down the names of journalists who asked particularly important questions/appeared sympathetic to your cause.



USAID | HEALTH POLICY INITIATIVE
FROM THE AMERICAN PEOPLE



Using the Mass Media for Advocacy



Using the Mass Media for Advocacy • Slide 1

Why Use the Mass Media?

- Get your issue on the political agenda
- Make the issue credible and visible in policy debate
- Inform the public about your issue and proposed solution
- Change public opinion and behavior



Why Use the Mass Media?

- Recruit allies and influence decisionmakers and opinion leaders
- Shape policies, programs, and the conduct of public/private agencies
- Raise money for your cause



Tips for Mass Media Success

- Establish your goals
- Identify your target your audience
- Identify your message
- Craft the message for maximum media impact



Tips for Mass Media Success

- Create a media plan
- Practice delivering your message
- Ensure spokespersons are effective through appropriate training
- Remember the advocacy communication model:
Inform → Persuade → Move to action
- Craft your message to do at least one of these steps



Ways to Increase Mass Media Coverage of Your Issue

I. Choose your media wisely

To successfully convey your message, choose an appropriate communication tool to reach the target audience

II. Build effective media contacts

Do your homework and identify reporters covering your issue for the various media outlets identified in the media advocacy plan



Ways to Increase Mass Media Coverage of Your Issue

III. Organize events and plan for maximum impact

Plan how to increase the media impact of the event—from notifying media in advance to including strong visual elements that directly communicate your message



Example of PLHIV Media Advocacy: AIDS Coalition to Unleash Power (ACT UP)

Advocacy Strategies

- Theatrical and confrontational style
- Use of media to deliver the message
- Internal/external approach: participation in policymaking forums as well as independent public media events to gain media coverage of an issue



Using the Mass Media for Advocacy • Slide 8

FACILITATOR NOTES:

Advocacy Focus and Strategy

One of the founders of ACT UP New York is Eric Sawyer, who has been an HIV/AIDS activist since the early 1980s, when the first statistics were publicized about a strange illness afflicting gay men. During the mid-1980s, as people who became sick often lost their housing, Sawyer began to develop his skills in creating housing for and advocating for the housing needs of people living with HIV (PLHIV). He partnered with a housing developer in Harlem and began talking to the New York City Department of Housing Preservation and Development about establishing a skilled-nursing facility. At this point, he decided to focus his advocacy on addressing the housing needs of PLHIV and pressuring the U.S. government to invest in more research on HIV/AIDS. In a telephone conversation, Larry Kramer, ACT UP's founding father, shared with Sawyer his idea of starting an advocacy group that would draw attention to the lack of funding, research, and support services for PLHIV. Kramer invited Sawyer to attend a meeting to discuss the formation of such a group. At the meeting, Sawyer was asked to help stage the first of many civil disobedience demonstrations against HIV and AIDS. It was 1987, and ACT UP was born.

Theatrics Generates Media Coverage

ACT UP held its first demonstration on March 24, 1987, on New York City's Wall Street, the financial capital of the world. The demonstration highlighted the fact that even though the government had allocated funds to HIV and AIDS research, a hiring freeze at the National Institutes of Health meant that none of the money was finding its way to research. The demonstration also demanded that pharmaceutical companies invest more in clinical trials to investigate and develop effective drugs against the virus.

For the organization's first demonstration, Joseph Papp, one of New York City's leading theater directors, directed his theater staff to develop life-size puppets of the director of the U.S. Food and Drug Administration, which hung in effigy from a lamppost. The gay movement brought to HIV/AIDS advocacy the recognition that highly staged, theatrical antics could attract the attention of the media and thus the general public. Drawing from lessons on how the media covered the civil rights, antiwar, and gay rights movements of the 1960s and 1970s, ACT UP believed that the only way to get noticed and reach the public was to stage provocative, media-friendly events. It also learned that newspapers often misrepresent events, making it especially important for demonstrators to carry a banner

Page 30 Facilitator notes continued

bearing the group's message. The banner in the photograph would tell the story even if the news coverage did not.

Timing and Press Releases Boost Coverage

ACT UP's advocacy style also involved the staging of a "scene/demonstration," again in New York City's financial district but in front of the New York City Department of Housing Preservation and Development. To ensure coverage on the 5:00 and 7:00 p.m. news broadcasts, ACT UP scheduled the demonstration for 4:00 p.m. It notified and briefed the media via a press release accompanied by a list of issues and demands. Citing the number of PLHIV probably living in the subway system or city shelters and the potential public health disaster if PLHIV were housed with people with untreated tuberculosis, the press materials demanded government funding of medically appropriate housing for PLHIV. As for the "scene/demonstration," ACT UP set up a stage representing a squatter's camp of homeless PLHIV, while 20 activists chained themselves to old, beaten furniture that they scattered in the middle of the street as part of the camp. The demonstration caused major traffic delays. In response, the city brought in garbage trucks as police and fire department personnel tried to cut the activists from the furniture in an attempt to end the demonstration. By this time, however, the demonstration, the issues, and the demands had been broadcast on the news for hours.

Shortly after the demonstration, officials in the New York City Department of Housing and the New York State Homeless and Housing Assistance Program announced the formation of a \$50 million capital fund to build medically appropriate housing for PLHIV. The advocacy had been a success. Such theatrical demonstrations came to be a driving force and characteristic style of ACT UP's advocacy.



Using the Mass Media for Advocacy • Slide 9

Questions for Discussion

- What led ACT UP to develop its signature media style of provocative demonstrations?
- What were its benefits?
- What were its limitations?
- What are some specific issues that your project could successfully disseminate through the media in your country?



Questions for Discussion

- What type of media would be the most appropriate for these issues?
- What strategies would be most effective to gain the media attention you want?
- At what point in time would it be most/least effective to seek media coverage?



Advocacy Issue:					
Who is your target audience?	What is your key advocacy message?	What is the purpose of using the media for this message? To: -Inform? -Persuade? -Move to action?	What forms of mass media would be most effective in addressing this issue?	What are the key steps involved?	At what stage of the advocacy action plan would you use this form of media to disseminate your message?





USAID | HEALTH POLICY INITIATIVE
FROM THE AMERICAN PEOPLE



Using the Mass Media for Advocacy



Using the Mass Media for Advocacy • Slide 1

NOTES:

Why Use the Mass Media?

- Get your issue on the political agenda
- Make the issue credible and visible in policy debate
- Inform the public about your issue and proposed solution
- Change public opinion and behavior



Using the Mass Media for Advocacy • Slide 2

NOTES:

Why Use the Mass Media?

- Recruit allies and influence decisionmakers and opinion leaders
- Shape policies, programs, and the conduct of public/private agencies
- Raise money for your cause



Using the Mass Media for Advocacy • Slide 3

NOTES:

Tips for Mass Media Success

- Establish your goals
- Identify your target your audience
- Identify your message
- Craft the message for maximum media impact



Using the Mass Media for Advocacy • Slide 4

NOTES:

Tips for Mass Media Success

- Create a media plan
- Practice delivering your message
- Ensure spokespersons are effective through appropriate training
- Remember the advocacy communication model:
Inform → Persuade → Move to action
- Craft your message to do at least one of these steps



Using the Mass Media for Advocacy • Slide 5

NOTES:

Ways to Increase Mass Media Coverage of Your Issue

I. Choose your media wisely

To successfully convey your message, choose an appropriate communication tool to reach the target audience

II. Build effective media contacts

Do your homework and identify reporters covering your issue for the various media outlets identified in the media advocacy plan



Using the Mass Media for Advocacy • Slide 6

NOTES:

Ways to Increase Mass Media Coverage of Your Issue

III. Organize events and plan for maximum impact

Plan how to increase the media impact of the event—from notifying media in advance to including strong visual elements that directly communicate your message



Using the Mass Media for Advocacy • Slide 7

NOTES:

Example of PLHIV Media Advocacy: AIDS Coalition to Unleash Power (ACT UP)

Advocacy Strategies

- Theatrical and confrontational style
- Use of media to deliver the message
- Internal/external approach: participation in policymaking forums as well as independent public media events to gain media coverage of an issue



Using the Mass Media for Advocacy • Slide 8

NOTES:

THE NEW YORK TIMES, WEDNESDAY, MARCH 25, 1987



Homosexuals Arrested at AIDS Drug Protest

Police officers removing demonstrators from the intersection of Broadway and Wall Street yesterday. Seventeen homosexual-rights protesters were arrested outside Trinity Church during a rally to demand quicker Government approval of drugs that might combat acquired immune deficiency syndrome. Hundreds of protesters stayed behind police lines, but some crossed the barricades and sat in the street to block traffic. They were arrested, charged with disorderly conduct and released.

A² ANALYSIS & ADVOCACY

Using the Mass Media for Advocacy • Slide 9

NOTES:

Questions for Discussion

- What led ACT UP to develop its signature media style of provocative demonstrations?
- What were its benefits?
- What were its limitations?
- What are some specific issues that your project could successfully disseminate through the media in your country?



Using the Mass Media for Advocacy • Slide 10

NOTES:

Questions for Discussion

- What type of media would be the most appropriate for these issues?
- What strategies would be most effective to gain the media attention you want?
- At what point in time would it be most/least effective to seek media coverage?



Using the Mass Media for Advocacy • Slide 11

NOTES:

Advocacy Issue:					
Who is your target audience?	What is your key advocacy message?	What is the purpose of using the media for this message? To: -Inform? -Persuade? -Move to action?	What forms of mass media would be most effective in addressing this issue?	What are the key steps involved?	At what stage of the advocacy action plan would you use this form of media to disseminate your message?

A² ANALYSIS & ADVOCACY

Using the Mass Media for Advocacy • Slide 12

NOTES:

SECTION IX: Working with People Living with and Affected by HIV and AIDS

- Content:**
- Activity 1 — Learning from People Living with and Affected by HIV and AIDS
 - Activity 2 — Challenges to GIPA
- Purpose:**
- To familiarize participants with the GIPA principle, its relevance to HIV advocacy, and the benefits and challenges of working with people affected by HIV and AIDS.
- Objectives:**
- To understand the Greater Involvement of People Living with HIV and AIDS (GIPA) principle and its relevance to HIV and AIDS advocacy work.
 - To identify the particular benefits and challenges of working with PLHIV and most-at-risk populations.
 - To understand the features of an enabling environment for the involvement of people living with HIV (PLHIV) and most-at-risk populations and how to foster such an enabling environment.

Background Notes:¹

Adoption of the GIPA Principle 1994

At the 1994 Paris AIDS Summit, 42 national governments declared that the principle of GIPA is critical to ethical and effective national responses to the epidemic. Those countries were Argentina, Australia, Bahamas, Belgium, Brazil, Burundi, Cambodia, Cameroon, Canada, China, Côte d'Ivoire, Denmark, Djibouti, Finland, France, Germany, India, Indonesia, Italy, Japan, Mexico, Morocco, Mozambique, Netherlands, Norway, Philippines, Portugal, Romania, Russian Federation, Senegal, Spain, Sweden, Switzerland, United Republic of Tanzania, Thailand, Tunisia, Uganda, United Kingdom, United States of America, Viet Nam, Zambia, and Zimbabwe.

Defining GIPA

At its most basic level, GIPA means two important things:

- Recognizing the important contributions that people living with or affected by HIV and AIDS can make in response to the epidemic; and
- Creating space within society for their involvement and active participation.

¹ Adapted from: (1) UNAIDS. 1999. From Principle to Practice: Greater Involvement of People Living With or Affected by HIV/AIDS. Geneva: UNAIDS. (2) Asia-Pacific Network of People Living with HIV/AIDS (APN+) and Asia-Pacific Council of AIDS Service Organizations (APCASO). No Date. Valued Voices: GIPA Toolkit—A Manual for the Greater Involvement of People Living with HIV/AIDS. Bangkok: APN+.

These contributions can be at all levels, from the individual to the organizational, and in all sectors, from the social and cultural to the economic and political. In particular, the Paris declaration emphasizes the role of networks of PLHIV and community-based organizations (CBOs). CBOs are organizations controlled by the communities they represent, rather than by, for example, a government department, donor, or foreign organization. CBOs provide a means for members of affected communities to meet, share experiences, provide mutual support, debate, and develop positions on policy and program responses, among other activities.

People Living With or Affected by HIV and AIDS

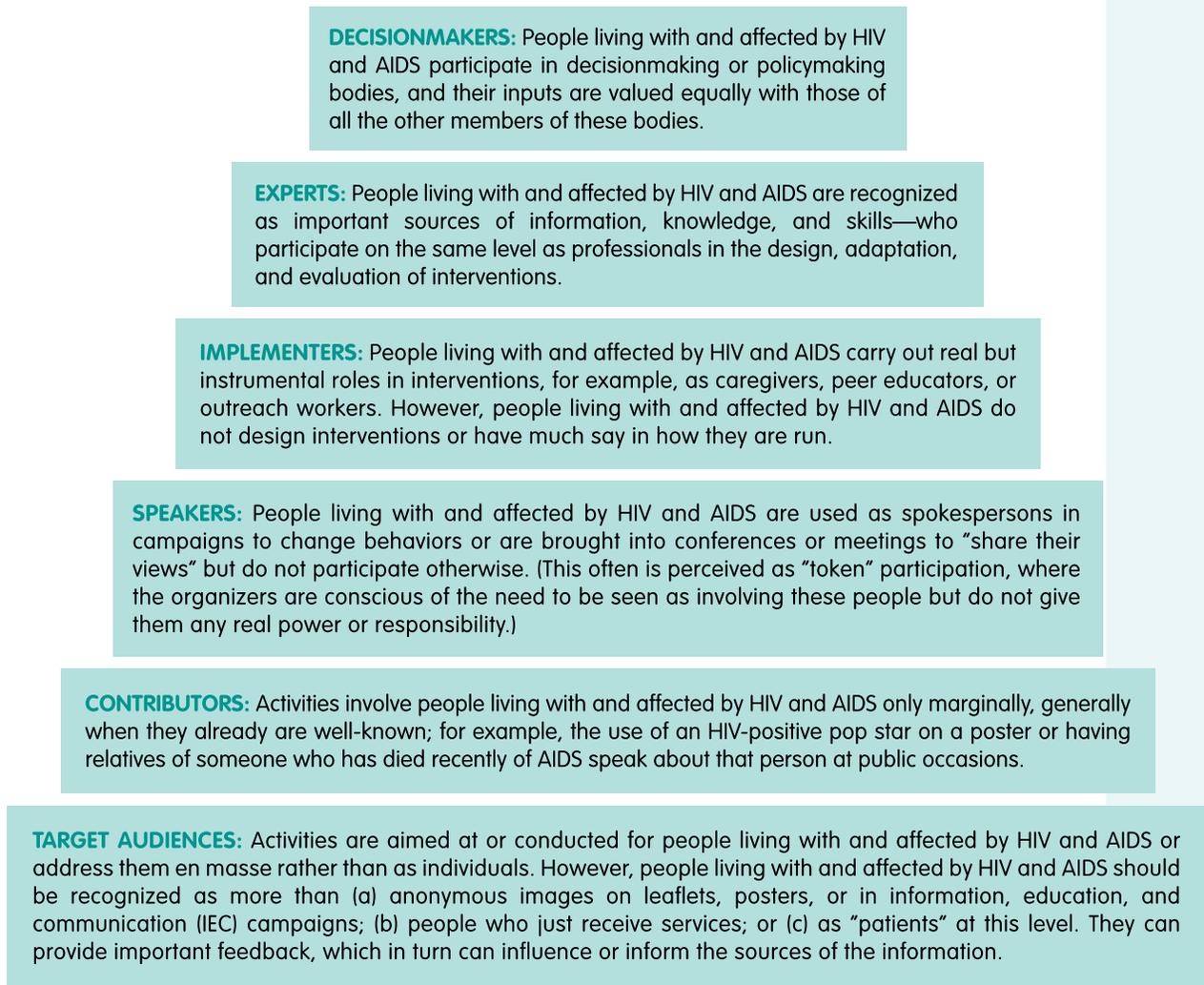
The original term used in the declaration, “people living with HIV and AIDS,” has been expanded, by broad consensus, to the term “people living with or affected by HIV and AIDS.” Note that this term does not represent a single category of persons but rather a continuum. The continuum runs from individuals living with the symptoms of AIDS, to asymptomatic HIV-positive people, to HIV-negative partners, family members, close friends of HIV-positive people, to the most at-risk populations.

What Do We Mean by Greater Involvement?

Involvement should include a variety of roles at many different levels. We do not foster the “greater involvement” of people living with and affected by HIV and AIDS when their roles are limited to observer or educational functions. Figure 1 provides a model for ways in which people living with or affected by HIV and AIDS can play a much broader range of roles. Although not part of any formal arrangement or structure, a significant portion of the worldwide response to HIV and AIDS is the work of individual people caring—in many different ways—for their HIV-positive family members and friends. It is also the work of individuals who, by “living positively” or openly interacting with PLHIV, act as examples to others, thereby countering both the denial and stigma that attend the epidemic in many communities.

It should be stressed, however, that GIPA does not mean necessarily disclosing one’s HIV status or membership in an at-risk population. Creating an “enabling environment” (which is considered in more detail later in this module) means giving people a genuine choice as to whether they will disclose their HIV status or their membership in an at-risk population, to their colleagues and community. People living with and affected by HIV and AIDS also have the right to choose to be involved without making their status public. In other words, GIPA cannot be reduced to “no visibility = no involvement.”

Figure 1. A pyramid of involvement by people living with and affected by HIV and AIDS



This pyramid models the increasing levels of involvement advocated by GIPA, with the highest level representing complete application of the GIPA principle. Ideally, GIPA is applied at all levels.

Why Is GIPA Important?

There are many reasons why GIPA is important. People with direct experience of the epidemic have expertise that adds value to the design, implementation, and evaluation of interventions at all levels of the response to the epidemic. Who better to advise on the design and delivery of appropriate and sensitive services? Who can understand better the challenges of HIV prevention than those who have become infected, or are engaged in activities that carry a risk of HIV infection? The meaningful involvement of affected communities is essential in developing better responses.

People living with and affected by HIV and AIDS have a right to be involved in solving the problems posed by the epidemic. Contributing expertise and experience can also remind people from affected communities just how valuable and productive they are and can lessen internalized feelings of stigma or low self-worth. At the societal level, publicly acknowledged involvement helps reduce stigma and discrimination and reminds us that people living with and affected by HIV and AIDS are an essential part of the response.

GIPA—It Was a Reality Before it Was a Policy

The involvement of affected communities was the basis of the first and most effective HIV prevention strategies. Long before international summits adopted formal resolutions on the subject, people directly affected by HIV and AIDS had already brought about some of the most important advances in tackling the epidemic. It was communities of gay men in Western countries who invented the concept of “safe sex.” The first wave of safe sex education took place in gay bars. There were no paid workers, no public health specialists, and no expert panels assembled by the United Nations, and yet it remains one of the most successful public health campaigns in history. No country in the world has managed to reduce the spread of HIV without promoting safe sex.

People living with HIV and AIDS have led the way in increasing access to life-saving antiretroviral therapy (ART). The Treatment Action Campaign in South Africa fought to provide ART for everyone who needed it. In a developing country with almost 5 million people living with HIV and AIDS, this goal could be achieved only through the use of generic drugs, which can be purchased for a fraction of the cost of the same drugs from brand name manufacturers. The victory of the Treatment Action Campaign was based on a series of public campaigns and court cases; following this victory, other countries began importing generic drugs and some even developed their own ARV manufacturing capability.

Activity 1 — Learning From People Living with and Affected by HIV and AIDS

Time: 2 hours 20 minutes

Materials: Computer, projector, display screen, flipcharts, Post-It notes in three different colors

Prepared Materials:

PowerPoint: GIPA Principle

Flipchart: Timeline from 1984 to the present (use several sheets of flipchart paper connected horizontally, with each year marked)

Other: N/A

Handouts: PowerPoint presentation, Background Notes

Objective: ■ To understand the GIPA principle and its relevance to HIV and AIDS advocacy.

Introduction:

Time: 5 minutes

- Briefly **review** key points from the earlier session on what is peculiar to the HIV and AIDS advocacy process. Note that HIV and AIDS advocacy has these features:
 - Effective advocacy, involving overcoming stigma and discrimination associated with HIV and AIDS and the behaviors that can transmit HIV;
 - A high level of fear and denial associated with individual responses to the epidemic, based on the perception of AIDS as an incurable, terminal illness;
 - The promotion and protection of the human rights of people living with and affected by HIV and AIDS.
 - The active involvement of people living with and affected by HIV and AIDS in all activities; and
 - Consideration of the risks associated with the disclosure of a person's HIV-positive status or membership in a most-at-risk population. The decision whether to disclose publicly their status should always be made by the person themselves, in light of the risks and benefits of such an action.
- **Explain** that this session will introduce the GIPA principle and its relevance to HIV and AIDS advocacy.

Activity Instructions:

Step 1: Learning from People Affected by HIV and AIDS

Time: 10 minutes

1. **Divide** the group into pairs.
2. **Tell** the groups that each person has up to 5 minutes to ask their partner the following questions:
 - When did you first hear about HIV?
 - When did you first meet a person you knew was living with HIV?
 - Give an example of a situation where you learned something from a person who was living with HIV or who was from a population most at risk of HIV infection.
 - When was it?
 - How did it affect you personally?

Step 2: Sharing Experiences

Time: 30 minutes

1. **Ask** participants to take Post-It stickers and place them on the timeline at the front of the room. **Have** three different colored packs of Post-It stickers ready to represent:
 - When the person first heard about HIV;
 - When the participant first met a person who he/she knew was living with HIV; and
 - When the participant first learned something from a PLHIV or someone who was from a population most at risk of HIV infection.
2. Once everyone has marked their experiences on the timeline in this way, invite them to share some of their experiences in meeting and learning from people living with or at risk of HIV infection. **Use** some or all of the following questions as prompts:
 - In what context did you first meet a person you knew was living with or most at risk of HIV infection?
 - How did the experience affect you?
 - In what context did you learn something from a person you knew to be living with or at risk of HIV infection?
 - How did the learning experience affect you?
 - How did these experiences affect you professionally (if at all)?

Step 3: Brainstorming

Time: 15 minutes

1. **Ask** participants to brainstorm activities in which PLHIV might choose to be involved or be asked to take on. Record the responses on flipchart paper.
2. After 10 minutes, **review** the responses generated against the following list. Add activities to the list that were not elicited from the brainstorming session:
 - Represent PLHIV on the National AIDS Committee
 - Provide a PLHIV commentary on a government report

- Coordinate a PLHIV network
- Interview PLHIV about their experiences for a research project on coping with stigma
- Write a letter to a newspaper responding to an article that perpetuates misunderstanding and prejudice about HIV
- Review a research protocol for an ethics committee requesting a PLHIV perspective
- Organize a demonstration to protest against compulsory testing
- Work as a volunteer in a PLHIV network office
- Provide peer outreach education for HIV prevention
- Provide counseling for ART literacy
- Represent PLHIV in a television interview on World AIDS Day
- Write a guide to implementing the GIPA principle

Step 4: Brief Lecture on GIPA—PowerPoint Presentation

Time: 15 minutes

1. **Use** the PowerPoint presentation to summarize the key content of the background notes. Reinforce those points made in the general discussion, and discuss in more detail any points not made previously.
2. **Remind** participants that they will be developing specific advocacy plans in the later stages of the training course. Ask them to consider, as they progress through the training curriculum, how the GIPA principle can be implemented at each stage of the advocacy process.

Activity 2 — Challenges to GIPA

Time: 1 hour

Materials: Flipcharts

Prepared Materials:

PowerPoint: NA

Flipchart: Challenges to Implementing GIPA, and How to Overcome Them

Other: N/A

Handouts: Background Notes; Worksheet—Challenges to Implementing GIPA

Objective: ■ To understand challenges to implementing the GIPA principle, and how these can be overcome.

Background Notes:²

As well as promising a range of potential benefits, GIPA faces a number of challenges, particularly at the higher levels of organizations:

Difficulty of Acknowledging HIV Status Publicly

Openness about one's own HIV-positive status or risk behavior, to family, community, or in the workplace can be difficult due to the pressures created by HIV- and AIDS-related stigma and discrimination. In some cases, precautions are needed to protect people who disclose their positive HIV status, because this can create serious repercussions. Discrimination shows up in different ways, from almost invisible types of social behavior at one end of the spectrum to physical violence at the other. PLHIV or members of most-at-risk populations may feel the need to conceal such aspects of their lives out of fear of stigma or discrimination, whether or not such reactions are likely.

Lack of Organizations Prepared to Involve PLHIV

Currently, there are few organizations involving or collaborating with PLHIV and affected communities in their day-to-day work. This may be because of a lack of awareness or information among those in charge of the organizations, or it may be because of active discrimination or unconscious prejudice. Lack of awareness or information is a particular problem within the private sector: management is often entirely unaware of the possible impacts of the epidemic on their economic performance and may not understand the potential benefits of GIPA.

Lack of Support for and Preparation of PLHIV

Lack of relevant skills can create a variety of obstacles. First, not everybody is born with the natural capacity to speak about issues such as sexuality and health; it is a skill that most often has to be learned. Second, facing a possibly hostile or uncomprehending environment can lead to “burnout” unless a person is either very strong to start with or has been through an

² Adapted from the following resources: (1) UNAIDS. 1999. From Principle to Practice: Greater Involvement of People Living With or Affected by HIV/AIDS. Geneva: UNAIDS. (2) Asia-Pacific Network of People Living with HIV/AIDS (APN+) and Asia-Pacific Council of AIDS Service Organizations (APCASO). No Date. Valued Voices: GIPA Toolkit—A Manual for the Greater Involvement of People Living with HIV/AIDS. Bangkok: APN+.

empowerment process. For both of these reasons, communication and personal empowerment counseling should be part of a generic training package for people participating in GIPA initiatives. Also, such training must be reinforced by ongoing support for PLHIV if their effectiveness is to remain high and their motivation strong. Third, special job-specific training or orientation may be required to compensate for the lack of particular technical skills or knowledge. To deliberately hire a person who is living with or affected by HIV and AIDS puts the emphasis on the virus rather than on the person's character and abilities. At the same time, those responsible for hiring should recognize the value of the experience-based expertise of PLHIV and consider this in their hiring decisions. As stated earlier, direct experience of the epidemic provides expertise that can add significant value to HIV and AIDS work. Affirmative action employment policies can be implemented in ways consistent with merit-based appointment.

Lack of Proper Conditions for HIV-positive People within Organizations

Organizations may not have a satisfactory policy for the employment or involvement of PLHIV. They also may lack the sort of environment and facilities that are necessary or helpful to HIV-positive people, such as healthcare facilities, medical insurance, and psychosocial support.

Questions of Addressing Employer Concerns about Absenteeism and Productivity

HIV-positive people may fall sick because of their infection and related illnesses, and some of them will die. This poses an obstacle to hiring PLHIV—particularly in the private sector—if employers feel they may have to reduce working hours as a result. Obviously, the risk of falling sick or dying exists for all employees or members of organizations, whatever their serostatus, but the odds are greater (and certainly more highly publicized) for PLHIV than for many other groups of people. This issue should not be avoided, because it is real. Instead, it needs to be discussed for employers to be able to anticipate difficulties related to sustainability.

Experience has shown that there are a variety of effective ways to deal with these obstacles to implementing or improving GIPA initiatives:

Document Experiences and Build on Lessons Learned

The results of many successful GIPA-related interventions have been published. These are very useful in helping to explain the concept and its benefits, as well as providing concrete examples of how interventions can be implemented. Prominent examples include the following:

- *The AIDS Service Organization (TASO), Uganda.* Much of the organizing drive that created and shaped TASO was provided by a woman whose husband had died of AIDS. Her major “competence” was not formal training but rather her strong motivation, which resulted from her personal experience of caring for a person with AIDS and her exposure to HIV-related stigma. From its beginnings in 1988, TASO developed into one of the most internationally prominent and innovative groups in the AIDS field.³
- *Asia Pacific Network of People living with HIV/AIDS (APN+).* This advocacy organization had its beginnings in February 1994 when 42 PLHIV from 8 countries in the Asia Pacific region met in Kuala Lumpur, Malaysia. They agreed to lobby for the betterment of PLHIV in the region and to work against stigma and discrimination. APN+ now includes 10 countries.

³ For more information, see: Hampton, J. 1990. “Living Positively with AIDS: The AIDS Support Organization (TASO), Uganda.” Strategies for Hope No 2. London: ActionAID.

⁴ See www.fdp.org.

- *UNV Support to People Living with HIV/AIDS Project.* This is a collaborative pilot project between the United Nations Development Programme (UNDP), United Nations Volunteer Program (UNV), UNAIDS, and the Network of African People Living with HIV and AIDS (NAP+). Currently in its second year of operation in Malawi and Zambia, and soon to be extended to Asia, the project recruits, trains, and supports HIV-positive persons whom it places as National UN Volunteers in various host institutions.⁵
- *Involvement of affected communities in country coordination mechanisms (CCMs).* The *Guidelines for Improving CCMs through Greater PLHIV Involvement* were developed by a large group of PLHIV who have first-hand experience of the challenges and obstacles to PLHIV involvement on CCMs. The guidelines led to the publication of a handbook *Challenging, Changing, and Mobilizing: A Guide to PLHIV Involvement in Country Coordinating Mechanisms* in 2005. The handbook aims to equip PLHIV who are members of CCMs with the skills, knowledge, and experience to be an effective CCM member; and to enable PLHIV members to move from tokenism to meaningful involvement on CCMs. The guidelines make provision for at least 10 percent PLHIV membership of CCMs, with a minimum of two PLHIV members. Selection of PLHIV CCM members should be through an inclusive and democratic process independent of the CCM. The guidelines state that all CCM members should receive HIV orientation and awareness training, including discussion of the GIPA Principle, UNGASS, and the Three Ones. Where necessary, PLHIV and other CCM members should have the right to seek outside guidance in specific areas, such as policy, finance, and legal issues; and CCMs should support PLHIV in acquiring the relevant skills and capacity they require to fully participate on the CCM.⁶

Create a More Enabling and Supportive Environment

GIPA cannot be fully effective or widely applied unless there are changes in society at large, with discrimination and stigma transformed into tolerance and acceptance by information and awareness campaigns. Political, traditional, and religious leaders have a major role to play in bringing about these social changes. Parliamentarians, for example, can help draw up antidiscrimination laws and national policies on AIDS and the workplace. At a different level, law enforcement officers in some societies can do much to curtail physical violence and other forms of intimidation against PLHIV. Such official activities by these prominent individuals, as well as less formal participation in local initiatives dealing with AIDS in their communities, can have a considerable impact on overall social attitudes to people living with or affected by HIV and AIDS. Social change must be matched by institutional change in international, national, or local organizations. A variety of initiatives (see below) can be taken to enable HIV-positive individuals to participate in the response to the epidemic. However, as mentioned under the challenges, it is the absolute right of people to choose not to disclose their HIV status or their relationship to somebody infected by HIV.

Involve the Private Sector

In parts of the world hardest hit by the epidemic, many businesses have significant numbers of employees infected or affected by HIV and AIDS. For this reason, the private sector has both a strong interest and a major role to play in the response to the epidemic. It is therefore extremely important for businesses and their leaders to understand that while AIDS among employees and

⁵ UNAIDS. 2000. "Enhancing the Greater Involvement of People Living with HIV and AIDS (GIPA) in sub-Saharan Africa: A UN Response: How Far Have We Gone?" *UNAIDS Best Practice Collection: Key Material*. Geneva: UNAIDS.

⁶ POLICY Project. 2004. *Guidelines for Improving CCMs through Greater PLHIV Involvement and Challenging, Changing, and Mobilizing: A Guide to PLHIV Involvement in Country Coordinating Mechanisms*. Washington, DC: Futures Group/POLICY Project.

the general public can affect productivity and profitability, constructive measures can be taken that will mitigate such adverse effects. GIPA is at the core of such measures. A crucial message for business leaders is that PLHIV can be ideal partners to plan for comprehensive prevention, care, and support interventions at the workplace. For instance, peer education by someone infected with HIV or someone “with AIDS in the family” can be part of a corporate action plan. Other GIPA-related activities that can be done or supported by the private sector include posting advertisements stating that HIV-positive people are welcome to apply for employment with the company; providing counseling services at the workplace; having senior management collaborate regularly and publicly with PLHIV in creating HIV and AIDS workplace plans; and providing training for and adapting the workloads of PLHIV involved in the workplace plan. All such activities have costs that must be included in the budget, but none is highly expensive and the cost-benefit ratios are generally very favorable.

Training and Ongoing Support for Individuals

GIPA activities cannot count indefinitely on individuals’ motivation or charisma, however. It is of utmost importance to provide training and support for PLHIV actively involved in the response to the epidemic. International organizations and associations for PLHIV can help to provide a generic package for those individuals wanting to disclose their personal relation to AIDS. In addition to training for specific jobs, GIPA training packages for PLHIV should include the following:

- Personal empowerment
- Communication and presentation skills
- HIV and AIDS knowledge
- Legal aspects of HIV and AIDS
- Skills for organizing and conducting policy dialogue

If the employee is to take on any administrative responsibility for GIPA activities, training also should include the basics of program planning and monitoring.

Training and Orientation for Organizations

It is equally important that people in organizations—top executives, as well as supervisory staff—receive the benefit of training and orientation regarding the GIPA concept. Among other issues, host organizations must be aware that by hiring PLHIV, they take on an added responsibility with ethical consequences. This responsibility is not a difficult one to assume, however, with proper preparation. This training should include at least three components:

- Challenges and benefits of instituting GIPA and recruiting PLHIV, including policy formulation;
- Responsibilities of and implementation strategies for host organizations; and
- Lessons learned from existing GIPA efforts (best practices).

All training should be aimed at creating supportive environments and organizational structures that allow full application of GIPA at the highest levels.

Introduction:

Time: 5 minutes

- **Remind** participants of the benefits and reasons for supporting GIPA:
 - People with direct experience of the epidemic can share their experiences to enhance the effectiveness of policies and programs.
 - People affected by HIV and AIDS have the right to be involved in responses to the epidemic.
 - The involvement of people living with and affected by HIV and AIDS promotes respect for HIV- and AIDS-related human rights—this enhances the public health response and reinforces a respect for the human rights to which all affected communities and human beings are entitled.
 - GIPA was a reality before it was a formally recognized policy. We should acknowledge the contributions made by people living with and affected by HIV and AIDS to the global response to the epidemic.
- Having considered the benefits of GIPA, **ask** participants to look at the challenges in implementing it.

Activity Instructions:

Step 1: Considering the Challenges

Time: 50 minutes

1. **Tell** participants they will be divided into four groups. Each group will be asked to consider the challenges to implementing GIPA with one of the populations most often affected by HIV and AIDS in Asia: PLHIV, sex workers, drug users, and men who have sex with men (MSM).
2. **Allow** people to self-select for the groups and to move to one of four designated areas in the training room. If needed, ask some people to select a different group so that there are approximately equal numbers of people in all of the groups.
3. **Go** through the prepared flipchart, giving an example of an identified challenge, any experiences people have in overcoming the challenge, and proposals for it could be overcome in future.

Prepared Flipchart: Challenges to Implementing GIPA and Solutions

Challenge to Implementing GIPA	Experience Overcoming This Challenge?	How to Deal With This Challenge If It Arises in Future
<p>PLHIV wanted to participate in advocacy activities, but did not want to disclose their identity publicly, due to possible stigma and discrimination.</p>	<ul style="list-style-type: none"> ● We formed a coalition of PLHIV, people from most-at-risk populations, and staff of organizations working on HIV issues. ● We were able to represent the voices of PLHIV without disclosing the identities of individual PLHIV. 	<ul style="list-style-type: none"> ● PLHIV can use pseudonyms in printed material. ● PLHIV can prohibit publication of pictures or other material which allow them to be identified. ● PLHIV who have experienced personal empowerment or leadership training may choose to disclose their identity publicly.



4. **Ask** each group to identify a person responsible for recording information on the flipchart, and a person responsible for reporting back to the larger group.
5. **Allow** groups 20 minutes to discuss and enter information on their flipcharts. **Remind** people that they may not have time to complete every section of the flipchart, and are not required to.
6. **Allow** each group 5 minutes to report back on their discussions and information recorded on flipcharts. **Note** similarities and differences between the four groups in the challenges and solutions identified for each affected population.

Step 2: Recap/Wrap-up

Time: 5 minutes

1. Briefly **review** the challenges and solutions identified during the small group work.
2. **Refer** to those issues in Background Notes that were not raised during the group discussions and feedback session, and ask people to read this document on their own time.

SECTION IX: Working with People Living with and Affected by HIV And AIDS

Activity 1 — Learning from People Living with and Affected by HIV and AIDS

Background Notes¹

Adoption of the GIPA Principle 1994

At the 1994 Paris AIDS Summit, 42 national governments declared that the principle of GIPA is critical to ethical and effective national responses to the epidemic. Those countries were Argentina, Australia, Bahamas, Belgium, Brazil, Burundi, Cambodia, Cameroon, Canada, China, Côte d'Ivoire, Denmark, Djibouti, Finland, France, Germany, India, Indonesia, Italy, Japan, Mexico, Morocco, Mozambique, Netherlands, Norway, Philippines, Portugal, Romania, Russian Federation, Senegal, Spain, Sweden, Switzerland, United Republic of Tanzania, Thailand, Tunisia, Uganda, United Kingdom, United States of America, Viet Nam, Zambia, and Zimbabwe.

Defining GIPA

At its most basic level, GIPA means two important things:

- Recognizing the important contributions that people living with or affected by HIV and AIDS can make in response to the epidemic; and
- Creating space within society for their involvement and active participation.

These contributions can be at all levels, from the individual to the organizational, and in all sectors, from the social and cultural to the economic and political. In particular, the Paris declaration emphasizes the role of networks of people living with HIV and AIDS and community-based organizations (CBOs). CBOs are organizations controlled by the communities they represent, rather than by, for example, a government department, donor, or foreign organization. CBOs provide a means for members of affected communities to meet, share experiences, provide mutual support, debate, and develop positions on policy and program responses, among other activities.

People Living With or Affected by HIV and AIDS

The original term used in the declaration, “people living with HIV and AIDS,” has been expanded, by broad consensus, to the term “people living with or affected by HIV and AIDS.” Note that this term does not represent a single category of persons but rather a continuum. The continuum runs from individuals living with the symptoms of AIDS, to asymptomatic HIV-positive people, to HIV-negative partners, family members, close friends of HIV-positive people, to the most at-risk populations.

What Do We Mean by Greater Involvement?

Involvement should include a variety of roles at many different levels. We do not foster the “greater involvement” of people living with and affected by HIV and AIDS when their roles are limited to observer or educational functions. Figure 1 provides a model for ways in which people living with or affected by HIV and AIDS can play a much broader range of roles. Although not part of any formal arrangement or structure, a significant portion of the worldwide response to HIV and AIDS is the work of individual people caring—in

¹ Adapted from: (1) UNAIDS. 1999. From Principle to Practice: Greater Involvement of People Living With or Affected by HIV/AIDS. Geneva: UNAIDS. (2) Asia-Pacific Network of People Living with HIV/AIDS (APN+) and Asia-Pacific Council of AIDS Service Organizations (APCASO). No Date. Valued Voices: GIPA Toolkit—A Manual for the Greater Involvement of People Living with HIV/AIDS. Bangkok: APN+.

many different ways—for their HIV-positive family members and friends. It is also the work of individuals who, by “living positively” or openly interacting with PLHIV, act as examples to others, thereby countering both the denial and stigma that attend the epidemic in many communities.

It should be stressed, however, that GIPA does not mean necessarily disclosing one’s HIV status or membership in an at-risk population. Creating an “enabling environment” (which is considered in more detail later in this module) means giving people a genuine choice as to whether they will disclose their HIV status or their membership in an at-risk population, to their colleagues and community. People living with and affected by HIV and AIDS also have the right to choose to be involved without making their status public. In other words, GIPA cannot be reduced to “no visibility = no involvement.”

Figure 1. A pyramid of involvement by people living with and affected by HIV and AIDS

DECISIONMAKERS: People living with and affected by HIV and AIDS participate in decisionmaking or policymaking bodies, and their inputs are valued equally with those of all the other members of these bodies.

EXPERTS: People living with and affected by HIV and AIDS are recognized as important sources of information, knowledge, and skills—who participate on the same level as professionals in the design, adaptation, and evaluation of interventions.

IMPLEMENTERS: People living with and affected by HIV and AIDS carry out real but instrumental roles in interventions, for example, as caregivers, peer educators, or outreach workers. However, people living with and affected by HIV and AIDS do not design interventions or have much say in how they are run.

SPEAKERS: People living with and affected by HIV and AIDS are used as spokespersons in campaigns to change behaviors or are brought into conferences or meetings to “share their views” but do not participate otherwise. (This often is perceived as “token” participation, where the organizers are conscious of the need to be seen as involving these people but do not give them any real power or responsibility.)

CONTRIBUTORS: Activities involve people living with and affected by HIV and AIDS only marginally, generally when they already are well-known; for example, the use of an HIV-positive pop star on a poster or having relatives of someone who has died recently of AIDS speak about that person at public occasions.

TARGET AUDIENCES: Activities are aimed at or conducted for people living with and affected by HIV and AIDS or address them en masse rather than as individuals. However, people living with and affected by HIV and AIDS should be recognized as more than (a) anonymous images on leaflets, posters, or in information, education, and communication (IEC) campaigns; (b) people who just receive services; or (c) as “patients” at this level. They can provide important feedback, which in turn can influence or inform the sources of the information.

This pyramid models the increasing levels of involvement advocated by GIPA, with the highest level representing complete application of the GIPA principle. Ideally, GIPA is applied at all levels.

Why Is GIPA Important?

There are many reasons why GIPA is important. People with direct experience of the epidemic have expertise that adds value to the design, implementation, and evaluation of interventions at all levels of the response to the epidemic. Who better to advise on the design and delivery of appropriate and sensitive services? Who can understand better the challenges of HIV prevention than those who have become infected, or are engaged in activities that carry a risk of HIV infection? The meaningful involvement of affected communities is essential in developing better responses.

People living with and affected by HIV and AIDS have a right to be involved in solving the problems posed by the epidemic. Contributing expertise and experience can also remind people from affected communities just how valuable and productive they are and can lessen internalized feelings of stigma or low self-worth. At the societal level, publicly acknowledged involvement helps reduce stigma and discrimination and reminds us that people living with and affected by HIV and AIDS are an essential part of the response.

GIPA—It Was a Reality Before it Was a Policy

The involvement of affected communities was the basis of the first and most effective HIV prevention strategies. Long before international summits adopted formal resolutions on the subject, people directly affected by HIV and AIDS had already brought about some of the most important advances in tackling the epidemic. It was communities of gay men in Western countries who invented the concept of “safe sex.” The first wave of safe sex education took place in gay bars. There were no paid workers, no public health specialists, and no expert panels assembled by the United Nations, and yet it remains one of the most successful public health campaigns in history. No country in the world has managed to reduce the spread of HIV without promoting safe sex.

People living with HIV and AIDS have led the way in increasing access to life-saving antiretroviral therapy (ART). The Treatment Action Campaign in South Africa fought to provide ART for everyone who needed it. In a developing country with almost 5 million people living with HIV and AIDS, this goal could be achieved only through the use of generic drugs, which can be purchased for a fraction of the cost of the same drugs from brand name manufacturers. The victory of the Treatment Action Campaign was based on a series of public campaigns and court cases; following this victory, other countries began importing generic drugs and some even developed their own ARV manufacturing capability.

SECTION IX: Working with People Living with and Affected by HIV And AIDS

Activity 2 — Challenges to GIPA

Background Notes¹

As well as promising a range of potential benefits, GIPA faces a number of challenges, particularly at the higher levels of organizations:

Difficulty of Acknowledging HIV Status Publicly

Openness about one's own HIV-positive status or risk behavior, to family, community, or in the workplace can be difficult due to the pressures created by HIV- and AIDS-related stigma and discrimination. In some cases, precautions are needed to protect people who disclose their positive HIV status, because this can create serious repercussions. Discrimination shows up in different ways, from almost invisible types of social behavior at one end of the spectrum to physical violence at the other. PLHIV or members of most-at-risk populations may feel the need to conceal such aspects of their lives out of fear of stigma or discrimination, whether or not such reactions are likely.

Lack of Organizations Prepared to Involve PLHIV

Currently, there are few organizations involving or collaborating with PLHIV and affected communities in their day-to-day work. This may be because of a lack of awareness or information among those in charge of the organizations, or it may be because of active discrimination or unconscious prejudice. Lack of awareness or information is a particular problem within the private sector: management is often entirely unaware of the possible impacts of the epidemic on their economic performance and may not understand the potential benefits of GIPA.

Lack of Support for and Preparation of PLHIV

Lack of relevant skills can create a variety of obstacles. First, not everybody is born with the natural capacity to speak about issues such as sexuality and health; it is a skill that most often has to be learned. Second, facing a possibly hostile or uncomprehending environment can lead to “burnout” unless a person is either very strong to start with or has been through an empowerment process. For both of these reasons, communication and personal empowerment counseling should be part of a generic training package for people participating in GIPA initiatives. Also, such training must be reinforced by ongoing support for PLHIV if their effectiveness is to remain high and their motivation strong. Third, special job-specific training or orientation may be required to compensate for the lack of particular technical skills or knowledge. To deliberately hire a person who is living with or affected by HIV and AIDS puts the emphasis on the virus rather than on the person's character and abilities. At the same time, those responsible for hiring should recognize the value of the experience-based expertise of PLHIV and consider this in their hiring decisions. As stated earlier, direct experience of the epidemic provides expertise that can add significant value to HIV and AIDS work. Affirmative action employment policies can be implemented in ways consistent with merit-based appointment.

¹ Adapted from the following: (1) UNAIDS. 1999. *From Principle to Practice: Greater Involvement of People Living With or Affected by HIV/AIDS*. Geneva: UNAIDS. (2) Asia-Pacific Network of People Living with HIV/AIDS (APN+) and Asia-Pacific Council of AIDS Service Organizations (APCASO). No Date. *Valued Voices: GIPA Toolkit—A Manual for the Greater Involvement of People Living with HIV/AIDS*. Bangkok: APN+.

Lack of Proper Conditions for HIV-positive People within Organizations

Organizations may not have a satisfactory policy for the employment or involvement of PLHIV. They also may lack the sort of environment and facilities that are necessary or helpful to HIV-positive people, such as healthcare facilities, medical insurance, and psychosocial support.

Questions of Addressing Employer Concerns about Absenteeism and Productivity

HIV-positive people may fall sick because of their infection and related illnesses, and some of them will die. This poses an obstacle to hiring PLHIV—particularly in the private sector—if employers feel they may have to reduce working hours as a result. Obviously, the risk of falling sick or dying exists for all employees or members of organizations, whatever their serostatus, but the odds are greater (and certainly more highly publicized) for PLHIV than for many other groups of people. This issue should not be avoided, because it is real. Instead, it needs to be discussed for employers to be able to anticipate difficulties related to sustainability.

Experience has shown that there are a variety of effective ways to deal with these obstacles to implementing or improving GIPA initiatives:

Document Experiences and Build on Lessons Learned

The results of many successful GIPA-related interventions have been published. These are very useful in helping to explain the concept and its benefits, as well as providing concrete examples of how interventions can be implemented. Prominent examples include the following:

- *The AIDS Service Organisation (TASO)*, Uganda. Much of the organizing drive that created and shaped TASO was provided by a woman whose husband had died of AIDS. Her major “competence” was not formal training but rather her strong motivation, which resulted from her personal experience of caring for a person with AIDS and her exposure to HIV-related stigma. From its beginnings in 1988, TASO developed into one of the most internationally prominent and innovative groups in the AIDS field.²
- *Asia Pacific Network of People living with HIV/AIDS (APN+)*. This advocacy organization had its beginnings in February 1994 when 42 PLHIV from 8 countries in the Asia Pacific region met in Kuala Lumpur, Malaysia. They agreed to lobby for the betterment of PLHIV in the region and to work against stigma and discrimination. APN+ now includes 10 countries.³
- *UNV Support to People Living with HIV/AIDS Project*. This is a collaborative pilot project between the United Nations Development Programme (UNDP), United Nations Volunteer Program (UNV), UNAIDS, and the Network of African People Living with HIV and AIDS (NAP+). Currently in its second year of operation in Malawi and Zambia, and soon to be extended to Asia, the project recruits, trains, and supports HIV-positive persons whom it places as National UN Volunteers in various host institutions.⁴
- *Involvement of affected communities in country coordination mechanisms (CCMS)*. The *Guidelines for Improving CCMs through Greater PLHIV Involvement* were developed by a large group of PLHIV who have first-hand experience of the challenges and obstacles to PLHIV involvement on CCMs. The guidelines led to the publication of a handbook *Challenging, Changing, and Mobilizing: A Guide to PLHIV Involvement in Country Coordinating*

² For more information, see: Hampton, J. 1990. “Living Positively with AIDS: The AIDS Support Organization (TASO), Uganda.” Strategies for Hope No 2. London: ActionAID.

³ See www.fdp.org.

⁴ UNAIDS. 2000. “Enhancing the Greater Involvement of People Living with HIV and AIDS (GIPA) in sub-Saharan Africa: A UN Response: How Far Have We Gone?” UNAIDS Best Practice Collection: Key Material. Geneva: UNAIDS.

Mechanisms in 2005. The handbook aims to equip PLHIV who are members of CCMs with the skills, knowledge, and experience to be an effective CCM member; and to enable PLHIV members to move from tokenism to meaningful involvement on CCMs. The guidelines make provision for at least 10 percent PLHIV membership of CCMs, with a minimum of two PLHIV members. Selection of PLHIV CCM members should be through an inclusive and democratic process independent of the CCM. The guidelines state that all CCM members should receive HIV orientation and awareness training, including discussion of the GIPA Principle, UNGASS, and the Three Ones. Where necessary, PLHIV and other CCM members should have the right to seek outside guidance in specific areas, such as policy, finance, and legal issues; and CCMs should support PLHIV in acquiring the relevant skills and capacity they require to fully participate on the CCM.⁵

Create a More Enabling and Supportive Environment

GIPA cannot be fully effective or widely applied unless there are changes in society at large, with discrimination and stigma transformed into tolerance and acceptance by information and awareness campaigns. Political, traditional, and religious leaders have a major role to play in bringing about these social changes. Parliamentarians, for example, can help draw up antidiscrimination laws and national policies on AIDS and the workplace. At a different level, law enforcement officers in some societies can do much to curtail physical violence and other forms of intimidation against PLHIV. Such official activities by these prominent individuals, as well as less formal participation in local initiatives dealing with AIDS in their communities, can have a considerable impact on overall social attitudes to people living with or affected by HIV and AIDS. Social change must be matched by institutional change in international, national, or local organizations. A variety of initiatives (see below) can be taken to enable HIV-positive individuals to participate in the response to the epidemic. However, as mentioned under the challenges, it is the absolute right of people to choose not to disclose their HIV status or their relationship to somebody infected by HIV.

Involve the Private Sector

In parts of the world hardest hit by the epidemic, many businesses have significant numbers of employees infected or affected by HIV and AIDS. For this reason, the private sector has both a strong interest and a major role to play in the response to the epidemic. It is therefore extremely important for businesses and their leaders to understand that while AIDS among employees and the general public can affect productivity and profitability, constructive measures can be taken that will mitigate such adverse effects. GIPA is at the core of such measures. A crucial message for business leaders is that PLHIV can be ideal partners to plan for comprehensive prevention, care, and support interventions at the workplace. For instance, peer education by someone infected with HIV or someone “with AIDS in the family” can be part of a corporate action plan. Other GIPA-related activities that can be done or supported by the private sector include posting advertisements stating that HIV-positive people are welcome to apply for employment with the company; providing counseling services at the workplace; having senior management collaborate regularly and publicly with PLHIV in creating HIV and AIDS workplace plans; and providing

⁵ POLICY Project. 2004. Guidelines for Improving CCMs through Greater PLHIV Involvement and Challenging, Changing, and Mobilizing: A Guide to PLHIV Involvement in Country Coordinating Mechanisms. Washington, DC: Futures Group/POLICY Project.

training for and adapting the workloads of PLHIV involved in the workplace plan. All such activities have costs that must be included in the budget, but none is highly expensive and the cost-benefit ratios are generally very favorable.

Training and Ongoing Support for Individuals

GIPA activities cannot count indefinitely on individuals' motivation or charisma, however. It is of utmost importance to provide training and support for PLHIV actively involved in the response to the epidemic. International organizations and associations for PLHIV can help to provide a generic package for those individuals wanting to disclose their personal relation to AIDS. In addition to training for specific jobs, GIPA training packages for PLHIV should include the following:

- Personal empowerment
- Communication and presentation skills
- HIV and AIDS knowledge
- Legal aspects of HIV and AIDS
- Skills for organizing and conducting policy dialogue

If the employee is to take on any administrative responsibility for GIPA activities, training also should include the basics of program planning and monitoring.

Training and Orientation for Organizations

It is equally important that people in organizations—top executives, as well as supervisory staff—receive the benefit of training and orientation regarding the GIPA concept. Among other issues, host organizations must be aware that by hiring PLHIV, they take on an added responsibility with ethical consequences. This responsibility is not a difficult one to assume, however, with proper preparation. This training should include at least three components:

- Challenges and benefits of instituting GIPA and recruiting PLHIV, including policy formulation;
- Responsibilities of and implementation strategies for host organizations; and
- Lessons learned from existing GIPA efforts (best practices).

All training should be aimed at creating supportive environments and organizational structures that allow full application of GIPA at the highest levels.

SECTION IX: Working with People Living with and Affected by HIV And AIDS

Activity 2 — Challenges to GIPA

Worksheet: Challenges to Implementing GIPA

Challenge Identified	How to Resolve It	Who Is Responsible for Resolving It?	What Resources are Required to Resolve It?



USAID | HEALTH POLICY INITIATIVE
FROM THE AMERICAN PEOPLE



GIPA: The Greater Involvement of People Living with and Affected by HIV/AIDS



**GIPA: The Greater Involvement of People
Living with and Affected by HIV/AIDS • Slide 1**

Paris AIDS Summit 1994

- The Greater Involvement of People Living with HIV/AIDS (GIPA) declaration is critical to supporting ethical and effective national responses to HIV and AIDS
- 42 countries adopted the declaration, including Cambodia, China, Indonesia, Philippines, Thailand, and Viet Nam



GIPA: The Greater Involvement of People Living with and Affected by HIV/AIDS • Slide 2

“Living with” or “Affected by” HIV/AIDS?

- Original declaration since widened by broad consensus (UNAIDS 1999)
- Not a category but a continuum:
 - People with AIDS
 - Asymptomatic HIV-positive people
 - Their close associates
 - People at risk or believed to be at risk of HIV infection

What Does GIPA Mean?

- Recognize the important contribution that people living with or affected by HIV and AIDS can make to effective responses to the epidemic
- Create space for their involvement and active participation



GIPA: The Greater Involvement of People Living with and Affected by HIV/AIDS • Slide 4

Why “Greater” Involvement?

- Involvement should include a variety of roles at all levels of the response to HIV and AIDS
- Involvement is not genuine if limited to observational or educational functions
- Should extend to decisionmaking at the highest levels



GIPA: The Greater Involvement of People Living with and Affected by HIV/AIDS • Slide 5

GIPA or Confidentiality?

- GIPA does not require disclosure
- People have the right to choose whether to disclose
- An “enabling environment” will accommodate involvement as well as confidentiality, where necessary



GIPA: The Greater Involvement of People Living with and Affected by HIV/AIDS • Slide 6

An “Enabling Environment”

- Laws and policies prohibiting stigma and discrimination
- Laws and policies protecting confidentiality
- Capacity building and support for members of affected communities
- Capacity building of organizations to understand the benefits of GIPA and implement GIPA effectively



GIPA: The Greater Involvement of People Living with and Affected by HIV/AIDS • Slide 7

Why is GIPA Important?

- People affected by the epidemic offer valuable direct experience
- People affected by the epidemic have a right to be involved in the response
- Involvement helps build feelings of self-worth, and reduces stigma and discrimination



GIPA: The Greater Involvement of People Living with and Affected by HIV/AIDS • Slide 8

GIPA: Action Came First

- Affected communities were the first to respond with HIV prevention programs
- People living with HIV have led the way in promoting access to antiretroviral drugs
- Adoption of the policy gave official recognition to the importance of the work already being done



GIPA: The Greater Involvement of People Living with and Affected by HIV/AIDS • Slide 9



USAID | HEALTH POLICY
FROM THE AMERICAN PEOPLE INITIATIVE



GIPA: The Greater Involvement of People Living with and Affected by HIV/AIDS



**GIPA: The Greater Involvement of People
Living with and Affected by HIV/AIDS • Slide 1**

NOTES:

Paris AIDS Summit 1994

- The Greater Involvement of People Living with HIV/AIDS (GIPA) declaration is critical to supporting ethical and effective national responses to HIV and AIDS
- 42 countries adopted the declaration, including Cambodia, China, Indonesia, Philippines, Thailand, and Viet Nam



GIPA: The Greater Involvement of People Living with and Affected by HIV/AIDS • Slide 2

NOTES:

“Living with” or “Affected by” HIV/AIDS?

- Original declaration since widened by broad consensus (UNAIDS 1999)
- Not a category but a continuum:
 - People with AIDS
 - Asymptomatic HIV-positive people
 - Their close associates
 - People at risk or believed to be at risk of HIV infection



GIPA: The Greater Involvement of People Living with and Affected by HIV/AIDS • Slide 3

NOTES:

What Does GIPA Mean?

- Recognize the important contribution that people living with or affected by HIV and AIDS can make to effective responses to the epidemic
- Create space for their involvement and active participation



GIPA: The Greater Involvement of People Living with and Affected by HIV/AIDS • Slide 4

NOTES:

Why “Greater” Involvement?

- Involvement should include a variety of roles at all levels of the response to HIV and AIDS
- Involvement is not genuine if limited to observational or educational functions
- Should extend to decisionmaking at the highest levels



GIPA: The Greater Involvement of People Living with and Affected by HIV/AIDS • Slide 5

NOTES:

GIPA or Confidentiality?

- GIPA does not require disclosure
- People have the right to choose whether to disclose
- An “enabling environment” will accommodate involvement as well as confidentiality, where necessary



GIPA: The Greater Involvement of People Living with and Affected by HIV/AIDS • Slide 6

NOTES:

An “Enabling Environment”

- Laws and policies prohibiting stigma and discrimination
- Laws and policies protecting confidentiality
- Capacity building and support for members of affected communities
- Capacity building of organizations to understand the benefits of GIPA and implement GIPA effectively



GIPA: The Greater Involvement of People Living with and Affected by HIV/AIDS • Slide 7

NOTES:

Why is GIPA Important?

- People affected by the epidemic offer valuable direct experience
- People affected by the epidemic have a right to be involved in the response
- Involvement helps build feelings of self-worth, and reduces stigma and discrimination



GIPA: The Greater Involvement of People Living with and Affected by HIV/AIDS • Slide 8

NOTES:

GIPA: Action Came First

- Affected communities were the first to respond with HIV prevention programs
- People living with HIV have led the way in promoting access to antiretroviral drugs
- Adoption of the policy gave official recognition to the importance of the work already being done



GIPA: The Greater Involvement of People Living with and Affected by HIV/AIDS • Slide 9

NOTES:

SECTION X: Making Advocacy Plans and Next Steps

- Content:** ■ Activity1 — Action Plans
- Purpose:** ■ To present a model for developing advocacy action plans, and to give participants the opportunity to develop action plans based on their prioritized goal and objectives.
- Objectives:** ■ To understand the process of developing an advocacy action plan and then develop such a plan, including indicators for monitoring and evaluation.

Background Notes:

Advocacy action planning puts the analysis and strategy choices of participants into a plan for taking action. Up to this point, the workshop has focused on building technical skills in the various stages of the advocacy process—defining issues, setting goals and objectives, assessing support and opposition, researching target audiences, developing and disseminating messages, collecting data, and raising funds. In the process of honing their skills, participants have made choices and taken action toward the development of their network’s advocacy strategy. The work done along the way has a real—not just a theoretical—application.

Now it is time for participants to pull together all the pieces of work they have completed thus far and then compile the products into one implementation plan to guide their advocacy group through the campaign. The implementation plan also includes a monitoring and evaluation (M&E) plan.

The implementation plan is presented in a simple format. Based on a selected advocacy objective, participants design specific activities for implementation to achieve the network’s objective. Members of the advocacy group provide details describing needed resources, responsible person(s), and an appropriate timeframe for each activity.

It is important to remember that the planned advocacy actions are designed to lead to the desired advocacy objective—that is, the key decisionmaker or institution you wish to persuade takes the action that will achieve your objective. Thus, many of the key steps in an advocacy action plan target the key audiences who need to be persuaded to support your advocacy objective. Other activities often include background or preparatory work that must be accomplished to build support, such as information campaigns to raise awareness of or support for the advocacy objective.

Developing the action plan provides an excellent opportunity for advocates to work as a team. The implementation plan should be developed with input from and the consensus of the entire group of involved advocates—and in consultation with their constituents, so as to create a sense of shared ownership and commitment to the plan and the strategy. After all, participants are nearing the end of the planning stage and soon will be called upon to act together to make their advocacy strategy a reality.

Activity 1 – Action Plans

Time: 3 hours, with a break

Materials: Markers, flipchart, tape, computer, projector, display screen

Prepared Materials:

PPT: Action Plans: Implementation and Monitoring and Evaluation

Flipchart: N/A

Other: N/A

Handouts: Background Notes, PowerPoint presentation, Indicators for Monitoring and Evaluating Advocacy Campaigns, Sources for Monitoring and Evaluating Advocacy Campaigns, Advocacy Implementation Plan

Objective: ■ To understand the process of creating an advocacy action plan and actually developing such a plan, including indicators for monitoring and evaluation.

Introduction:

Time: 5 minutes

Introduce this session by reviewing the objectives. State that this activity will focus on the steps involved in developing an advocacy action plan. The following are key points to include in your overview:

- This unit represents the action planning phase of the workshop. Up to this point, the workshop has focused on building technical skills in the various stages of the advocacy process—defining issues, setting goals and objectives, assessing support and opposition, researching target audiences, developing and disseminating messages, and collecting and analyzing data.
- This session begins by building the skills necessary to develop action plans for a specific advocacy issue. Here you will review a simple action planning process and apply it to your identified advocacy issue. You will have a chance to brainstorm sample advocacy activities, as well as to describe needed resources, responsible person(s), and an appropriate timeframe for each activity.
- The process then moves on to refine the advocacy action plans. A² country teams should consider how best to further integrate both advocacy and the lessons from this training into your current A² country workplan.

Activity Instructions:

Time: Up to 3 hours

Note to Facilitator:

The advocacy implementation plan is organized around an advocacy goal and associated objectives that each team has developed during the workshop. Depending on the extent to which participants are ready to begin implementing advocacy activities after the training, the action planning session may be shortened and used just as a skills-building exercise. However, if participants are preparing real action plans that they intend to implement, then the full three hours should be allocated to action planning.





Activity Option:

There are several options for how to adapt this exercise:

- In Step 1 (Introduction to Action Plans), there are two options: facilitated brainstorming or a PowerPoint presentation.
- In Step 2 (Practice Developing an Implementation Plan), there also are two options. If the purpose of the activity is only to introduce the idea of action plans, 30 minutes is sufficient to review the key elements and facilitate a small sample of group work. If participants are to develop an advocacy implementation plan that actually will guide implementation, up to 2.5 hours should be allocated.

Step 1 (Option A): Introduction to Action Plans— Facilitated Group Brainstorming

Time: 25 minutes

1. **Remind** participants that they have completed several steps in the advocacy process. They have
 - Identified an advocacy issue;
 - Set the advocacy goal—a long-term change they hope to play a role in achieving;
 - Set specific advocacy objectives that will contribute to achievement of the goal;
 - Assessed the support and opposition and identified primary and secondary target audiences;
 - Developed and practiced delivering advocacy messages to key members of their target audience; and
 - Reviewed data collection and analysis techniques to support their advocacy messages.
2. **Explain** that developing an advocacy implementation plan is a key tool for translating their objectives and other learning into action.
3. **Ask** if any participants have developed implementation plans for any kind of project; if so, ask them to identify some of the key elements of such a plan.
4. **Solicit/write** elements as column headers on a flipchart to match the Advocacy Implementation Plan handout. Anticipate the following points and prompt with questions if they do not arise:
 - Goal/Objectives
 - Activities
 - Timeframe
 - Who is responsible
 - Resources (human and financial)
5. **Ask** participants to call out a few activities that might help them achieve the advocacy objective identified by their group during the workshop.
6. **Fill** in several boxes of the Advocacy Implementation Plan interactively to demonstrate how it is done.

7. **Ask** if there might be additional elements to plan or track when developing an advocacy implementation plan.
8. **Solicit/write** the responses on the table. Anticipate the following points, and prompt with questions if they do not arise:
 - Target audiences for individual activities
 - Expected results/evaluation plans
 - Indicators for monitoring and evaluation: actual results and how they are documented
9. **Hold a general conversation** about the points above, noting the specific aim of an advocacy objective (and its goal of achieving the making of a particular change by a policymaker or decisionmaker), as well as the importance of specific target audiences to help build support and action to bring about this change.
10. **Remind** participants that they will need to identify a specific target audience for each of their activities.
11. **Note** that, based on the review of needs assessments in the applications completed prior to the training, it seems that many participants are familiar with some of the basic issues of monitoring and evaluation.

As a brief review, **ask**:

 - What do we monitor? (activities)
 - What do we evaluate? (results)
12. **Discuss** with participants possible examples of results, as well as the evidence or documentation, in the context of advocacy.
 - **Ask:** Based on the sample issue and activities looked at above, what might be some different levels or stages of evaluating advocacy? (For example, determine whether you have been able to inform, persuade, or move to action a person or target audience). Record “inform,” “persuade,” and “move to action” on a flipchart.
 - **Ask:** What might be the evidence or documentation of those different levels of evaluation? (Inform, persuade, move to action). Record some of their responses specific to each of these levels.
13. **Facilitate** a brief discussion about why we monitor and evaluate our work. Donors request it. Bosses request it. But more important, for advocates and advocacy networks, it is an effective means of documenting the impact of your work.
14. **Ask** participants: Do you have additional thoughts or considerations about advocacy action plans as a result of doing advocacy or other project management work?

Step 1 (Option B): Introduction to Action Plans – PowerPoint Presentation

Time: 25 minutes

1. **Review** advocacy implementation plans and monitoring and evaluation by using the PPT presentation.

Step 2: Small Group Work to Develop Action Plans

Time: 2 hours 30 minutes

1. **Explain** that, for participants to proceed with developing an advocacy implementation plan, the country team or other grouping must decide whether to approach its advocacy objectives consecutively or simultaneously. If the former, participants must agree on the logical order.
2. **Divide** participants into country teams or other groupings. If possible, ensure that people remain working with the same participants with whom they worked with previously to identify advocacy issues, goals, and objectives. Ask the groups to discuss which advocacy objectives members want to address first in the campaign. Provide the groups with the following questions to guide the discussion:
 - Is there a logical and obvious sequence? What is it, and why?
 - Will any of the objectives make a greater contribution to the broader advocacy goal than others?
 - Does the group feel better prepared and qualified to undertake one objective over the others?
3. Once each group has decided on the sequence of the advocacy objectives, it is ready to develop an implementation plan.
4. **Distribute** the Advocacy Implementation Plan handout and explain the following task:
 - **Write** the relevant advocacy objective at the top of the worksheet.
 - Next, **identify** each of the activities necessary to achieve that objective. Activities should be fairly detailed. For example, include information about message development and methods.
 - For each activity,
 - Identify the target audience;
 - Indicate who is responsible for undertaking the activity;
 - Assign an appropriate timeframe or due date for each activity;
 - Determine the resources needed to support the activity. Resources may be material, financial, human (e.g., technical expertise), or technological; and
 - Consider what results the activity will achieve, and how they can be documented.
 - **Note** to participants that, for each activity, there also are usually a number of steps that must be completed. For instance, to hold a press conference, some of the following steps may be crucial: contacting the media, securing a venue, making a banner, preparing and distributing a press release, preparing a background sheet, identifying speakers, and practicing delivering advocacy messages. Explain that groups often use another worksheet to plan the details of each activity, but note that it does not make sense to get into this level of detail until the overall plan is developed.
5. **Allow** the groups 2 hours (see comments above) to complete the worksheet and to transfer their plans to flipchart paper or PowerPoint slides.
6. **After** the working groups have completed their assignments, ask one representative from each group to present the group's plan.

7. Discuss each plan in turn:

- Are the activities comprehensive? Are the target audiences clear for each activity?
- Is the timeframe achievable and realistic given the schedules and responsibilities of network members? Are there special dates toward which you should orient your activities?
- Do you have the data you need? If not, have you considered the feasibility of taking steps to collect the data and whether the collection can be accomplished within your timeframe?
- Look at “responsible persons.” Does the group agree with the task distribution? Is the workload shared appropriately?
- Are the required resources accurate? Is it practical to think that the group can secure the resources needed?
- Review the hoped-for results—do these seem realistic and precise?
- Are there adequate plans to document the results? Have appropriate indicators been identified for documentation of results?
- Overall, is the plan missing any key activity?
- Is the plan too complicated? Can it be simplified?
- Does the plan indicate next steps to be taken after the conclusion of this training workshop?

8. Conclude by checking for final questions or comments about the implementation plans from the group.

The implementation plan makes the campaign come alive. By considering the myriad activities needed to reach each of the advocacy objectives, a group can sense the amount of work and energy required to achieve a policy victory. The plan details the activities of the campaign in a logical and timely order, and maps the country team’s next steps.

Distribute remaining handouts.

SECTION X: Making Advocacy Plans and Next Steps

Activity 1 — Action Plans

Background Notes

Advocacy action planning puts the analysis and strategy choices of participants into a plan for implementing action. Up to this point, the workshop has focused on building technical skills in the various stages of the advocacy process—defining issues, setting goals and objectives, assessing support and opposition, researching target audiences, developing and disseminating messages, collecting data, and raising funds. In the process of honing their skills, participants have made choices and taken action toward the development of their network’s advocacy strategy. The work done along the way has a real—not just a theoretical—application.

Now it is time for participants to pull together all the pieces of work they have completed thus far and then compile the products into one implementation plan to guide their advocacy group through the campaign. The implementation plan also includes a monitoring and evaluation (M&E) plan.

The implementation plan is presented in a simple format. Based on a selected advocacy objective, participants design specific activities for implementation to achieve the network’s objective. Members of the advocacy group provide details describing needed resources, responsible person(s), and an appropriate timeframe for each activity.

○ It is important to remember that the planned advocacy actions are designed to lead to the desired advocacy objective—that is, to the key decisionmaker or institution you wish to persuade to take a specific action. Thus, many of the key steps in an advocacy action plan are directed to targeting the key audiences who need to be persuaded to support your advocacy objective. Other activities often include background or preparatory work that must be accomplished to build support.

Developing the action plan provides an excellent opportunity for advocates to work as a team. The implementation plan should be developed with input from and the consensus of the entire group of involved advocates—and in consultation with their constituents, so as to create a sense of shared ownership and commitment to the plan and the strategy. After all, participants are nearing the end of the planning stage and soon will be called upon to act together to make their advocacy strategy a reality.

SECTION X: Making Advocacy Plans and Next Steps

Activity 1 — Action Plans

Indicators for Monitoring and Evaluating Advocacy Campaigns

As a result of an advocacy activity, what happened?

Inform:

Did the target audience receive information?

- If yes, what is the evidence?
- If no, why not? What did we learn? What next?

Persuade:

Did the target audience change its attitude?

- If yes, what is the evidence?
- If no, why not? Did we offend them? What did we miss? What next?

Did the target audience decide to support the advocacy objective?

- If yes, what is the evidence?
- If no, why not? What else is necessary? What next?

Move to Action:

Did the target audience do something that helps you meet your objective?

- If yes, what is the evidence?
- If no, why not? What is the barrier? Who can help?

AND FINALLY

Was the advocacy objective achieved? Did policies, laws, or financing change?

- If yes, what is the evidence?
- If no, is it time to reevaluate the strategy? What next?

SECTION X: Making Advocacy Plans and Next Steps Activity 1 — Action Plans

Sources for Monitoring and Evaluating Advocacy Campaigns

Inform:

- Agendas and attendance lists for advocacy forums
- Documentation of dissemination lists
- Letters transmitting documents to target audience
- Stamps or notes acknowledging receipt of information
- Network activity logs (documents members' activities, large or small, regarding efforts to support advocacy campaign by providing information to others)

Persuade:

- Database of supportive nongovernmental organizations
- Documentation of policymakers' statements of support
- Requests for additional information

Move to Action:

- Articles published by journalist who attended a seminar
- Changed legislation or policy
- Documented changes in funding allocation



USAID | HEALTH POLICY INITIATIVE
FROM THE AMERICAN PEOPLE



Action Plans: Implementation and Monitoring and Evaluation



**Action Plans: Implementation and
Monitoring and Evaluation • Slide 1**

Steps in the Advocacy Process

- Identify advocacy issues, goals, and objectives
- Determine target audience
- Develop advocacy messages
- Build support
- Choose communication channels
- Raise funds
- **Implement** advocacy plans
- Monitor and evaluate results



Action Plans: Implementation and Monitoring and Evaluation • Slide 2

Implementation

- Move from developing skills...
- ...to planning for action



Action Plans: Implementation and Monitoring and Evaluation • Slide 3

What Is an Action Plan?

A set of orchestrated activities specifically designed to achieve the advocacy objective.



Action Plans: Implementation and Monitoring and Evaluation • Slide 4

Components of an Action Plan

- **Who** is responsible?
- **What** is the objective and what are the activities that meet the objective?
- **How** will the work be carried out?
(resources needed)
- **When** will it take place?
- **What** is the expected outcome?



Specific Components of Advocacy Action Plans

- Advocacy objective
 - Inform
 - Persuade
 - Move to action
- Target audiences
- Monitoring and evaluation, including indicators



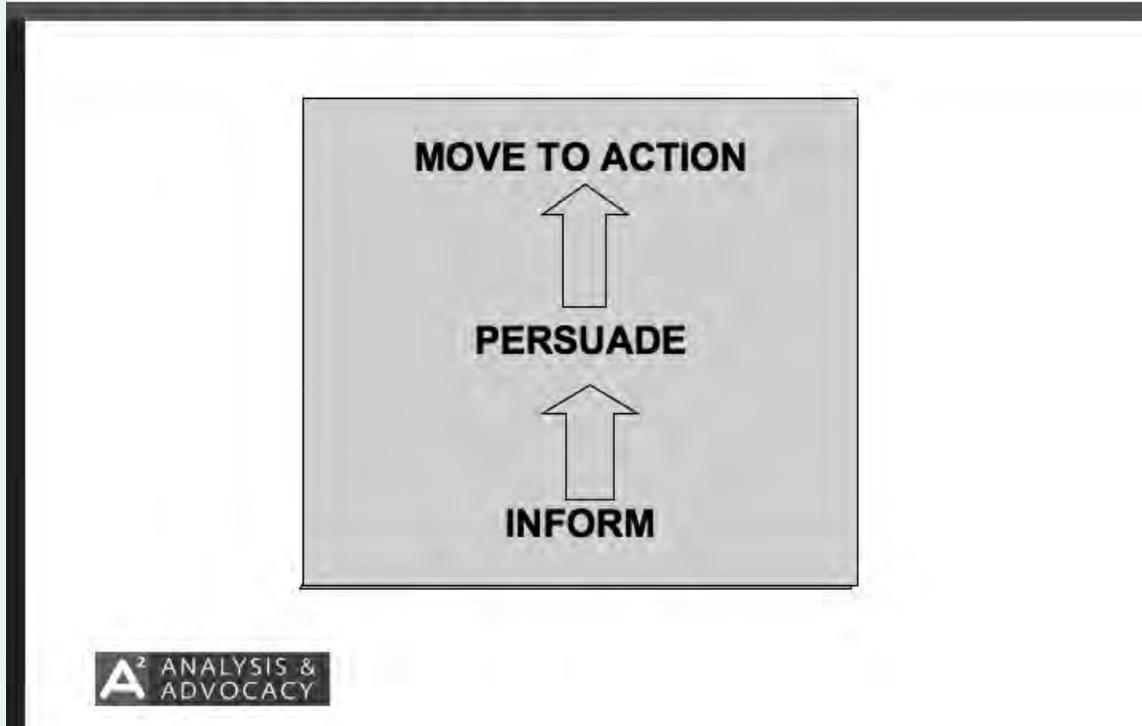
Action Plans: Implementation and Monitoring and Evaluation • Slide 6

Advocacy Outcomes, Indicators, and Evidence



**Action Plans: Implementation and
Monitoring and Evaluation • Slide 7**

Three Levels of Advocacy Outcomes, Indicators, and Evidence



Action Plans: Implementation and Monitoring and Evaluation • Slide 8

A² Action Plan Goal: Policy Change

	Inform	Persuade	Move to Action
Indicators	Target Audience Receives Message: ✓ Information received by audience ✓ Use of information by audience	Target Audience is Supportive: ✓ Absence of opposition to issues/actions ✓ Stated support for issue ✓ Request for issue (policy proposal, budget request)	Target Audience Changes or Develops: ✓ Legislation ✓ Policy ✓ Decree ✓ Program ✓ Budget allocation
Evidence	Documentation of Activity (message delivery): ✓ Meeting agendas and attendance lists ✓ Documents distributed to target audience/Dissemination lists ✓ Cover letter transmitting documents ✓ Stamped receipt notices ✓ Network advocacy log	Documentation of Support (support demonstrated): ✓ Public statements of support ✓ Written statements of support ✓ Database of supportive nongovernmental organizations (NGOs)	Documentation of Advocacy Result (changes made): ✓ Legislation ✓ Policy ✓ Decree ✓ Program ✓ Budget allocation



Advocacy Implementation Plan

Advocacy Objective: In the next budget, Ministry of Health (MOH) increases funding for HIV prevention programs for men who have sex with men (MSM) by 50 percent

Target Audience	Activities	Person Responsible	Resources Needed	Time-frame	Monitoring & Evaluation		
					Expected Outcome	Indicator	Documentation
25 Journalists	Training on MSM and HIV issues for media	Suneeta Bijay	Project staff Media consultant	June	Increase awareness of gap between need and funding	Reporting on need for increased funding	Copies of print articles Record of TV or radio reporting
(1) NGOs (2) Key program planners in MOH	Meetings to disseminate results to key stakeholders	Bhoraj Bijay	Project staff Writer Designer	June	Increase awareness of gap between need and funding Agreement that additional funds are needed	NGOs plan advocacy activities MOH advises they agree	Minutes of meetings Documented advocacy activities Minutes of meetings, letter advising agreement
MOH members of Budget Committee	Meetings with key MOH decisionmakers	Bijay Etna	NGO allies Supportive MOH staff	August	Persuade to increase funding for MSM programs by 50%	Increase in budget	Budget figures Announcement by MOH Media reports of additional expenditure, etc.



Section X

Action Plans: Implementation and Monitoring and Evaluation • Slide 10

An Important Reminder

- An Action Plan may be complete after you conduct the activities, however...
- The Advocacy Objective is achieved only after the targeted policymaker acts



Advocacy for Policy Change

“Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it is the only thing that ever has.”

~ Margaret Mead



Action Plans: Implementation and Monitoring and Evaluation • Slide 12



USAID | HEALTH POLICY INITIATIVE
FROM THE AMERICAN PEOPLE



Action Plans: Implementation and Monitoring and Evaluation



Action Plans: Implementation and Monitoring and Evaluation • Slide 1

NOTES:

Steps in the Advocacy Process

- Identify advocacy issues, goals, and objectives
- Determine target audience
- Develop advocacy messages
- Build support
- Choose communication channels
- Raise funds
- **Implement** advocacy plans
- Monitor and evaluate results



Action Plans: Implementation and Monitoring and Evaluation • Slide 2

NOTES:

Implementation

- Move from developing skills...
- ...to planning for action



Action Plans: Implementation and Monitoring and Evaluation • Slide 3

NOTES:

What Is an Action Plan?

A set of orchestrated activities specifically designed to achieve the advocacy objective.



Action Plans: Implementation and Monitoring and Evaluation • Slide 4

NOTES:

Components of an Action Plan

- **Who** is responsible?
- **What** is the objective and what are the activities that meet the objective?
- **How** will the work be carried out?
(resources needed)
- **When** will it take place?
- **What** is the expected outcome?



Action Plans: Implementation and Monitoring and Evaluation • Slide 5

NOTES:

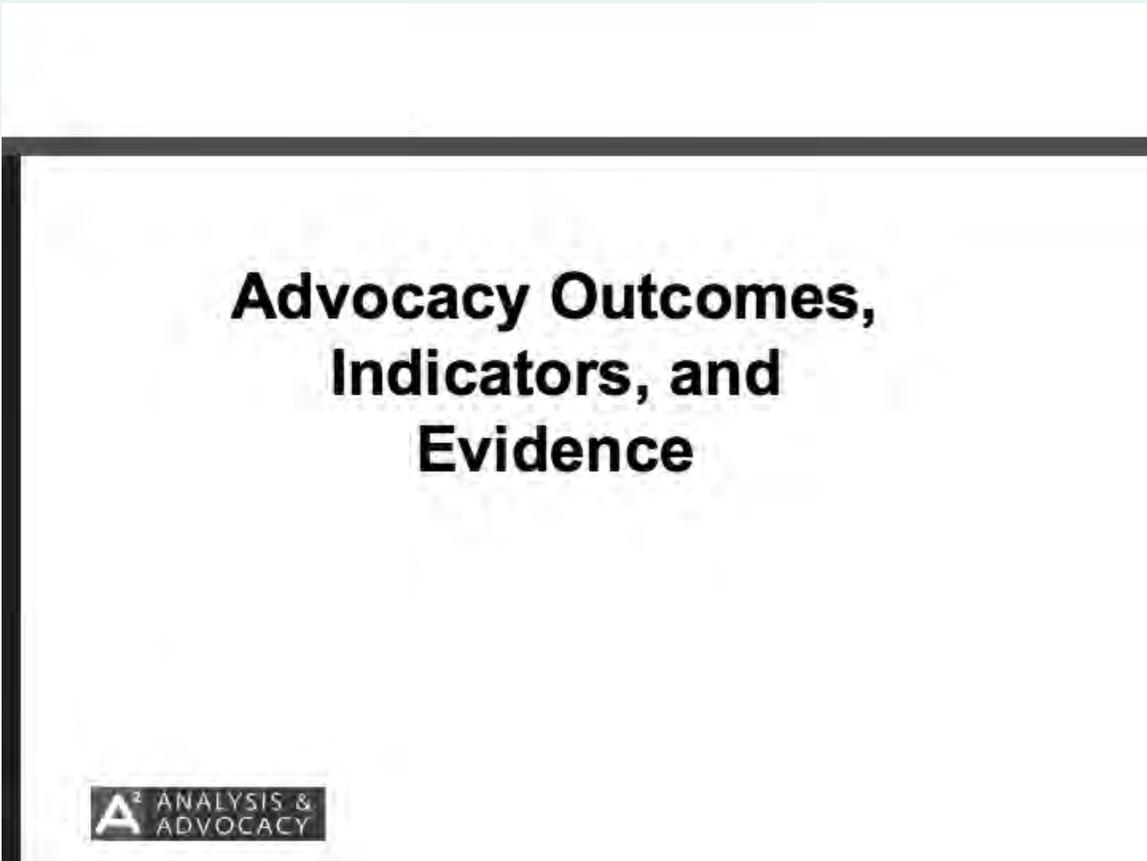
Specific Components of Advocacy Action Plans

- Advocacy objective
 - Inform
 - Persuade
 - Move to action
- Target audiences
- Monitoring and evaluation, including indicators



Action Plans: Implementation and Monitoring and Evaluation • Slide 6

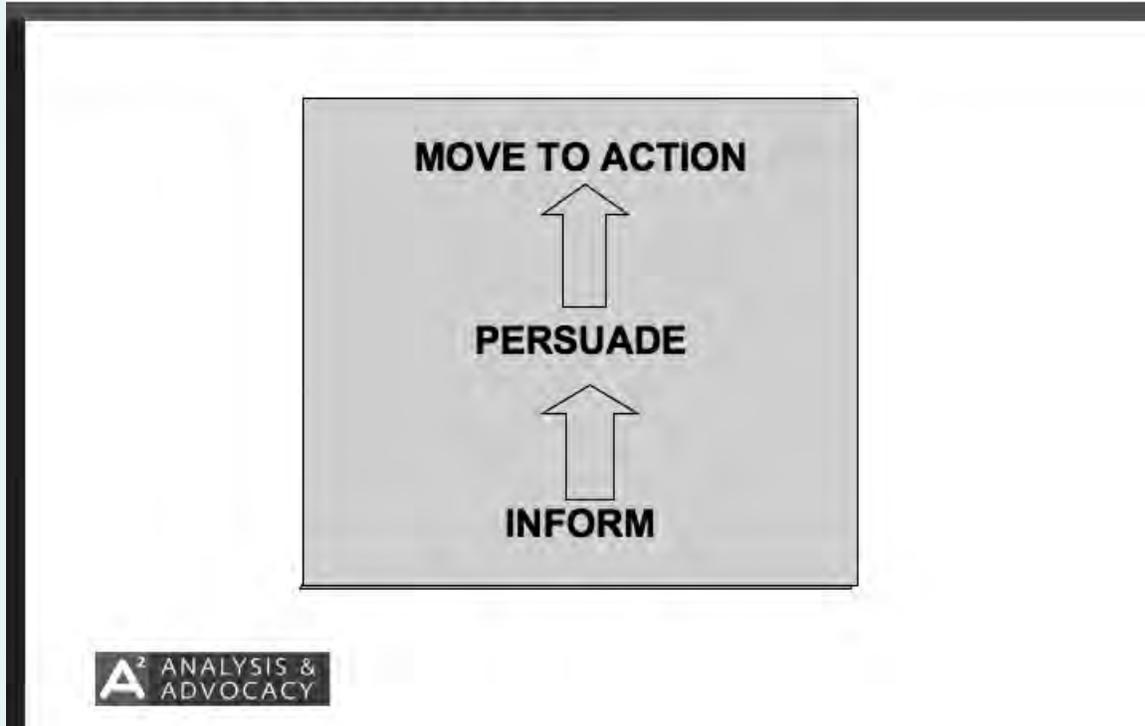
NOTES:



Action Plans: Implementation and Monitoring and Evaluation • Slide 7

NOTES:

Three Levels of Advocacy Outcomes, Indicators, and Evidence



Action Plans: Implementation and Monitoring and Evaluation • Slide 8

NOTES:

A² Action Plan Goal: Policy Change

	Inform	Persuade	Move to Action
Indicators	Target Audience Receives Message: ✓ Information received by audience ✓ Use of information by audience	Target Audience (is Supportive): ✓ Absence of opposition to issues/actions ✓ Stated support for issue ✓ Request for issue (policy proposal, budget request)	Target Audience Changes or Develops: ✓ Legislation ✓ Policy ✓ Decree ✓ Program ✓ Budget allocation
Evidence	Documentation of Activity (message delivery): ✓ Meeting agendas and attendance lists ✓ Documents distributed to target audience/Dissemination lists ✓ Cover letter transmitting documents ✓ Stamped receipt notices ✓ Network advocacy log	Documentation of Support (support demonstrated): ✓ Public statements of support ✓ Written statements of support ✓ Database of supportive nongovernmental organizations (NGOs)	Documentation of Advocacy Result (changes made): ✓ Legislation ✓ Policy ✓ Decree ✓ Program ✓ Budget allocation



Action Plans: Implementation and Monitoring and Evaluation • Slide 9

NOTES:

Advocacy Implementation Plan

Advocacy Objective: In the next budget, Ministry of Health (MOH) increases funding for HIV prevention programs for men who have sex with men (MSM) by 50 percent

Target Audience	Activities	Person Responsible	Resources Needed	Time-frame	Monitoring & Evaluation		
					Expected Outcome	Indicator	Documentation
25 Journalists	Training on MSM and HIV issues for media	Suneeta Bijay	Project staff Media consultant	June	Increase awareness of gap between need and funding	Reporting on need for increased funding	Copies of print articles Record of TV or radio reporting
(1) NGOs (2) Key program planners in MOH	Meetings to disseminate results to key stakeholders	Bhoraj Bijay	Project staff Writer Designer	June	Increase awareness of gap between need and funding Agreement that additional funds are needed	NGOs plan advocacy activities MOH advises they agree	Minutes of meetings Documented advocacy activities Minutes of meetings, letter advising agreement
MOH members of Budget Committee	Meetings with key MOH decisionmakers	Bijay Etna	NGO allies Supportive MOH staff	August	Persuade to increase funding for MSM programs by 50%	Increase in budget	Budget figures Announcement by MOH Media reports of additional expenditure, etc.



Action Plans: Implementation and Monitoring and Evaluation • Slide 10

NOTES:

An Important Reminder

- An Action Plan may be complete after you conduct the activities, however...
- The Advocacy Objective is achieved only after the targeted policymaker acts



Action Plans: Implementation and Monitoring and Evaluation • Slide 11

NOTES:

Advocacy for Policy Change

“Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it is the only thing that ever has.”

~ Margaret Mead



Action Plans: Implementation and Monitoring and Evaluation • Slide 12

NOTES:

ANNEX: Additional Resources

- Content:**
- Guest Speaker Invitation – Advocacy Methods
 - Guest Speaker Invitation – Policy Process

Invitation: Advocacy Methods



[Insert name and title of recipient]

[Insert name of organization]

[Insert address]

[Insert date]

Dear [Insert name of recipient],

A² Advocacy Workshop [INSERT DATE]

Invitation to speak on practical experiences of advocacy in [INSERT LOCATION]

Workshop session [INSERT DATE, TIME, and LOCATION]

The A² Project is a joint regional project of Family Health International, the East-West Center, and the USAID |Health Policy Initiative (a project of Constella Futures). The overall objective of the A² Project is to develop a clear understanding of the HIV epidemic at program implementation sites (currently Bangladesh, Thailand, Yunnan and Guangxi provinces in China, and Ho Chi Minh City in Vietnam) and to translate that understanding into effective policies and appropriately targeted and resourced programs. Countries and donors can then make evidence-based decisions, using this evidence to strengthen political commitment, and ensure that resources dedicated to HIV truly make a difference.

The A² Project will be holding an intensive five-day advocacy training workshop for approximately 20 participants from international, national, and local organizations working on HIV/AIDS policymaking in [INSERT LOCATION]. The workshop will be held in [INSERT LOCATION AND DATES OF WORKSHOP]. We would like to invite you to contribute your expertise to the workshop by giving a 30–45 minute presentation on the topic of “Practical Experiences of Advocacy: A Focus on Advocacy Messages and Methods,” followed by 30 minutes of questions and discussion with workshop participants. The presentation is tentatively scheduled for [INSERT TIME AND DATE] and will lead into sessions during which workshop participants develop advocacy action plans using the various skills-building exercises of the previous four days of training.

The overall goal of the workshop is to build participants’ capacity to integrate and carry out HIV/AIDS advocacy activities in their work, with a particular focus on promoting the use of evidence to inform HIV/AIDS policy and program development processes. The goal of the session in which we hope you will participate is to give participants an understanding of real-life experiences of advocacy in the context of [INSERT LOCATION].

If you are available to make the presentation suggested, we would invite you to focus on sharing a specific example of a successful advocacy activity you have been involved in—with an emphasis on the particular advocacy methods and messages used. It might be helpful to address the following questions.

1. What was the problem?
2. What was the advocacy objective?
3. Who decided to advocate to address the problem (who was involved)?
4. Who did you advocate to?
5. What were your key messages? And what methods did you use? (main focus)
6. What difficulties did you face, and how did you overcome these?
7. What were the results of your advocacy?
8. What sources of support did you find most useful?
9. What did you learn from this advocacy activity?

We hope to have the opportunity to benefit from your valuable experience. Please do not hesitate to contact the workshop organizers if you have any questions:

[INSERT CONTACT DETAILS]

Yours sincerely,

Country Director

Invitation: Policy Process

To:

From:

Re: Speaker Invitation for “The HIV/AIDS Policymaking Process in [INSERT LOCATION]” Session, A² Advocacy Training Workshop on [INSERT DATE]

Date:

The POLICY Project China will be holding an upcoming, intensive five-day “A² Squared Advocacy Training Workshop” for approximately 25 participants from international and national organizations working on HIV/AIDS policymaking in [INSERT LOCATION]. This workshop is part of a USAID-funded collaboration among the POLICY Project, Family Health International (FHI), and the East West Center. In China, the A² Project aims to strengthen HIV/AIDS data collection and analysis in [INSERT LOCATION] and to use the results of enhanced data analysis more effectively in advocacy.

We are hoping that you might be able to contribute your expertise to the workshop by giving a 20–30 minute presentation titled “The HIV/AIDS Policymaking Process in [INSERT LOCATION],” followed by 30 minutes of questions and discussion. The presentation would be scheduled in the afternoon of the first day of the workshop: [INSERT TIME, DATE AND LOCATION OF TRAINING] (exact time to be reconfirmed).

The overall training workshop goal is to strengthen participants’ understanding of the role of advocacy in ensuring that appropriate data is used to inform policy development processes and to build participants’ practical skills to integrate and carry out advocacy in their work. The goal of your invited 20–30 minute presentation on “The HIV/AIDS Policymaking Process in [INSERT LOCATION]” and 30 minutes of discussion is to increase participants’ understanding of the policymaking process at the provincial level so that they can better engage in the process.

If you were available to make a 20–30 minute presentation on the “The HIV/AIDS Policymaking Process in [INSERT LOCATION],” we would suggest that the presentation focus on the specific steps by which policy decisions are made in [INSERT LOCATION]. We also suggest that it might be helpful address the following questions:

1. Where do policies get made (i.e., key committees, taskforce, etc.)?
2. How are ideas or issues generated for new or revised policies?
3. How is a proposed issue introduced into the formal decisionmaking process?
4. What is the process for discussing, debating, and, perhaps, altering the proposal? Who are the players involved?
5. How is the proposal approved or rejected?
6. If approved, what are the steps to move the proposal to the next level of decisionmaking?

It may also help to increase participants' understanding if you include a simple diagram of the policymaking process at the provincial level (two samples are attached).

We hope that we will be able to benefit from your valuable experience and time. Please do not hesitate to call if you have any questions. We will also call you to follow-up on this invitation.

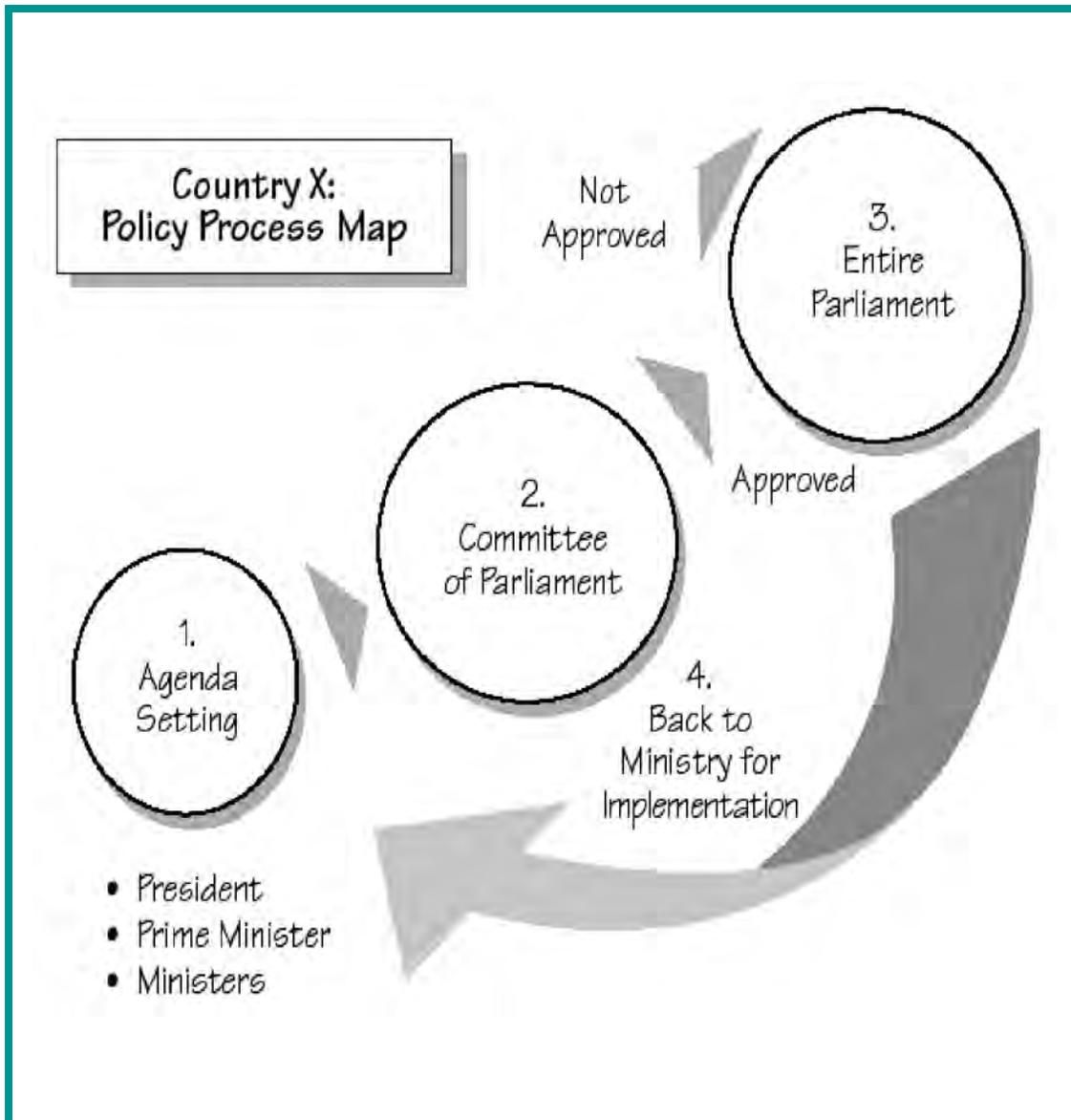
[INSERT CONTACT DETAILS]

Yours sincerely,

Country Director

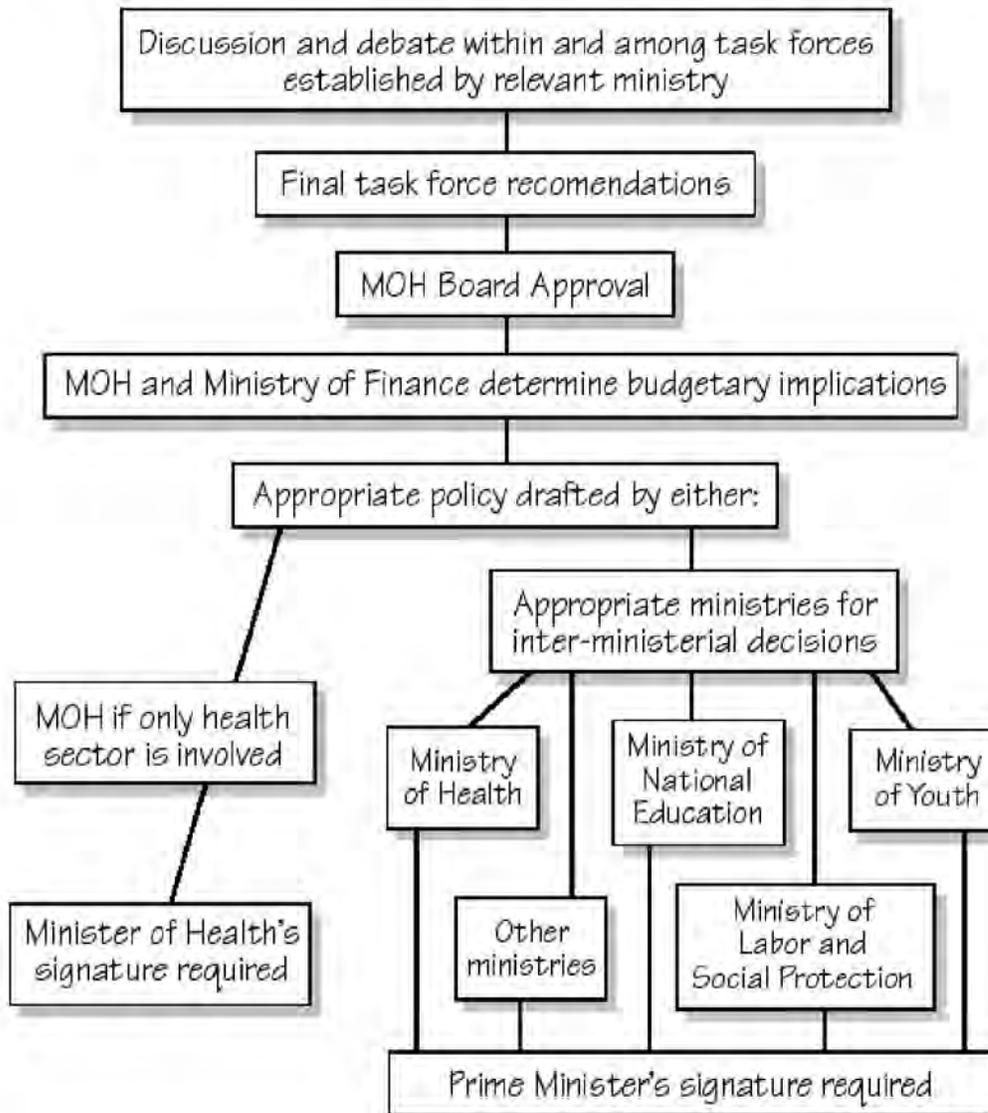
Attachments: Overall Policy Process Map; Specific Policy Process Example

Overall Policy Process Map



Specific Policy Process Example

Regulatory Stage of the Process of Health Care Reform in Romania



Bibliography

- Aragon, R. and S. Johnson. 2001. "Every Voice Counts: A Grassroots Advocacy Manual for the HIV/AIDS Community." San Francisco: The San Francisco AIDS Foundation.
- Asia-Pacific Network of People Living with HIV/AIDS (APN+) and Asia-Pacific Council of AIDS Service Organizations (APCASO). No Date. Valued Voices: GIPA Toolkit—A Manual for the Greater Involvement of People Living with HIV/AIDS. Bangkok: APN+.
- Bobo, K., J. Kendall, and S. Max. 1991 (reprinted 1996). *Organizing for Social Change: A Manual for Activists in the 1990s*. Santa Ana, CA: Seven Locks Press.
- Bray, R. 2000. *Spin Works! A Media Guidebook for Communicating Values and Shaping Opinion*. Independent Media Institute.
- Buhler, M., D. Wilkinson, J. Roberts, and P. Catalla. 2004. *Turning the Tide. Cambodia's Response to HIV & AIDS 1991-2005*. New York: UNAIDS.
- Burrows, D. 2004. *Advocacy Guide: HIV/AIDS Prevention Among Injecting Drug Users*. Geneva: World Health Organization.
- East-West Center (EWC). 2004. "Tackling the HIV/AIDS Epidemic in Asia." *Asia-Pacific Population and Policy No 68*. Honolulu: EWC, Population and Health Studies.
- Essential Advocacy Project (EAP). 2007. *The Power to Change: A Training Manual for Building Advocacy Capacity for India's HIV/AIDS Response*. New Delhi: Constella Futures/EAP.
- Hampton, J. 1990. "Living Positively with AIDS: The AIDS Support Organization (TASO), Uganda." *Strategies for Hope No 2*. London: ActionAID.
- International HIV/AIDS Alliance. 2002. *Advocacy in Action—A Toolkit to Support NGOs and CBOs responding to HIV/AIDS*. London: International HIV/AIDS Alliance.
- Maasdorp, A. 1998. *Positive Development: Setting Up Self-help Groups and Advocating for Change—A Manual for People Living with HIV*. Amsterdam: Global Network of People Living with HIV/AIDS (GNP+).
- Pisani, E. 2004. *AIDS in Asia: Face the Facts—A Comprehensive Analysis of the AIDS Epidemics in Asia*. Washington, DC: Monitoring the AIDS Pandemic (MAP) Network.
- POLICY Project. 1999. *Networking for Change: An Advocacy Training Manual*. Washington, DC: Futures Group/POLICY Project.
- POLICY Project. 2003. *Moments in Time: HIV/AIDS Advocacy Stories*. Washington, DC: Futures Group/POLICY Project.
- POLICY Project. 2004. *Guidelines for Improving CCMs through Greater PLHIV Involvement and Challenging, Changing, and Mobilizing: A Guide to PLHIV Involvement in Country Coordinating Mechanisms*. Washington, DC: Futures Group/POLICY Project.

Sharma, R. 1997. *An Introduction to Advocacy: Training Guide*. Washington, DC: Academy for Educational Development/Support for Analysis and Research in Africa (SARA) Project.

United Nations Programme on HIV/AIDS (UNAIDS). 1997. *Community Mobilization and AIDS: UNAIDS Technical Update*. Geneva: UNAIDS.

UNAIDS. 1999. *From Principle to Practice: Greater Involvement of People Living With or Affected by HIV/AIDS*. Geneva: UNAIDS.

UNAIDS. 2000. "Enhancing the Greater Involvement of People Living with HIV and AIDS (GIPA) in sub-Saharan Africa: A UN Response: How Far Have We Gone?" *UNAIDS Best Practice Collection: Key Material*. Geneva: UNAIDS.

UNAIDS. 2004. *Report on the Global AIDS Epidemic*. Geneva: UNAIDS.

Van Kampen, J. No date. "Dealing with the Media: A Practical Guide." Hannover, Germany: German Foundation for World Population and EC UNFPA Initiative for Reproductive Health in Asia/Information and Communication Network (RHI/ComNet).

VeneKlasen, L., and V. Miller. 2002 (reprinted 2007). *A New Weave of People, Power & Politics: The Action Guide for Advocacy and Citizen Participation*. Washington, DC: Just Associates.

Resourceful Websites

Aidsmap	www.aidsmap.com/en/default.asp
amFAR	www.amfar.org
Association of South East Asian Nations	www.aseansec.org
Constella Group	www.constellagroup.com
Family Health International	www.fhi.org
Fondation du Présent	http://www.fdp.org
International Council of AIDS Service Organizations	www.icaso.org
International HIV/AIDS Alliance	www.aidsalliance.org/sw1280.asp
Joint United Nations Programme on HIV/AIDS	www.unaids.org
POLICY Project	www.policyproject.com
The Cochrane Collaboration	www.cochrane.org
USAID Health Policy Initiative	www.healthpolicyinitiative.com
World Health Organization	www.who.int

