Invisible Men: Constructing Men Who Have Sex with Men as a Priority at UNAIDS and Beyond

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Invisible Men:
Constructing Men Who Have Sex with Men as a Priority at UNAIDS and Beyond

A dissertation submitted in partial satisfaction of the requirements for the degree Doctor of Philosophy in Sociology

by

Tara Ailinn McKay

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ABSTRACT OF THE DISSERTATION

Invisible Men: Constructing Men Who Have Sex with Men as a Priority at UNAIDS and Beyond

by

Tara Ailinn McKay

Doctor of Philosophy in Sociology

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Professor Stefan Timmermans, Chair

In the last decade, gay men and other men who have sex with men (MSM) have come to the fore of policy debates about AIDS prevention. In stark contrast to global AIDS policy during the first two decades of the epidemic which excluded MSM from policy outside the West, UNAIDS now identifies MSM as “marginalized but not marginal” to the global AIDS epidemic. This dissertation provides an account of this controversial reversal of global AIDS policy and uses it as a point of departure for understanding the role of intergovernmental organizations (IGOs) like UNAIDS in the formation of global health priorities. In contrast to the emergence of other health and social policy issues, various studies observe that efforts to establish a global agenda for addressing HIV and AIDS have been highly concentrated within intergovernmental organizations. How and in whose interests do new priorities emerge within AIDS IGOs? Health policy researchers argue that IGOs have considerable influence in the formation and dissemination of health policies around the world. However, there is a particularly rich debate among sociologists and political scientists about whether and how IGOs can act autonomously and pursue policy priorities that are not supported by states. Because these organizations generally lack enforcement power and are dependent on states for financial resources and
legitimacy, IGOs have traditionally been conceived as lacking autonomy to pursue their own policy interests independent of the interests of states. Yet, recent interventions by sociologists have shown how IGOs strategically navigate the demands of states and even attempt to reconfigure the external environment to promote alignment with the policy interests of the IGO. Nonetheless, concerns about resources continue to plague IGOs and often constrain their agency.

In this dissertation I argue that a key limitation of existing studies on the autonomy and influence of IGOs is their narrow focus on the decision-making and agenda-setting stages of policy making. I extend sociological research on the influence and autonomy of IGOs by addressing how concerns about implementation shape the particular structures and strategies that AIDS IGOs adopt in order to pursue their own policy interests. Many of these strategies are not easily understood by existing theories of IGO behavior which argue that as bureaucracies, IGOs will seek to expand their autonomy and influence in a sector. In contrast, I argue that IGOs with limited power to enforce policy implementation by states are highly sensitive to an implementation-autonomy trade off and may actually give up some autonomy in decision-making in order to facilitate broader implementation by states. IGOs also face additional barriers to implementation due to decentralization of the organization at the regional- and country-level and competition from other IGOs, nongovernmental organizations, and bilateral and private donors. Using archival data from World Health Organization’s Global Programme on AIDS and its successor, the Joint United Nations Programme on HIV/AIDS (UNAIDS), two IGOs mandated by the United Nations to coordinate a global response to AIDS epidemic, I show in Chapter 1 how concerns about implementation have shaped decisions about the organizational structure of these IGOs. In addition, I show how implementation concerns have promoted the adoption of particular strategies – organizational inreach, interorganizational cooperation,
evidence-based advocacy, and bidirectional pressure – to align policy preferences among states, other organizations, and even their own staff.

The use of these strategies by AIDS IGOS has had consequences beyond the decision-making phase of policy development. Drawing on a novel dataset compiled from five waves of UN Country Progress Reports on HIV/AIDS (2003, 2006, 2008, 2010, and 2012), I show in Chapter 2 that the use of these strategies has promoted the alignment of national AIDS programs with UNAIDS policies on MSM over time. On the ground, IGO interest in HIV among MSM has also provided new technologies for seeing MSM in hostile political contexts. As I show in a country-case study presented in Chapter 3, claims for the recognition of same-sex sexualities in Malawi have had the most institutional success within the national AIDS programs which increasingly identifies MSM as a key target for public health intervention. Additionally, links between Malawian organizations and transnational research and advocacy networks have provided a context in which (male) same-sex sexualities have become statistically visible and institutionalized, providing a basis for future grassroots mobilization.

At the same time, however, IGO interest in MSM has reinvigorated opposition to homosexuality among Malawian political elites and ordinary citizens. In Chapter 4 I introduce original household survey data collected in Malawi in 2012 (N=1491). Building on qualitative findings from Chapter 3, I use these data to quantitatively examine the effects of variation in aid allocations across Malawi’s administrative districts on attitudes toward homosexuality. Results show that in districts with higher levels of annual aid per capita, individuals hold more negative views of homosexuality. Thus while IGOS have had a substantial effect on state-level and donor-level adoption of policy priorities, they have had much less success in changing public views toward homosexuality on the ground. These results suggest that models of global diffusion that
utilize policy change as an indicator for cultural change may be greatly overestimating cultural change on contentious issues like homosexuality.

In sum, IGOs have become central actors in the formation, diffusion, and implementation of AIDS policy concerning same-sex sexualities. They develop new policy ideas and set priorities that may diverge substantially from the interests of member states, both rich and poor. However, IGOs also face considerable barriers to implementing their policy priorities: from reluctant states to the decentralization of staff across dozens of country offices to competition from other organizations and private donors. In this dissertation I show how barriers to implementation shape the structures and strategies of IGOs. As such, this work contends that IGOs are not simply disinterested forums in which states pursue their own interests or passive collections of rules and norms, but autonomous, influential, and self-interested actors that shape the policymaking process and the world around them, sometimes in unexpected and undesirable ways.
The dissertation of Tara McKay is approved.

Patrick Heuveline

Abigail Saguy

Susan Cotts Watkins

Stefan Timmermans, Committee Chair

University of California, Los Angeles

2013
For my dad, who never finished,

my mom, who made sure I did,

and Vincent, who never doubted I would.
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List of Abbreviations

amfAR American Foundation for AIDS Research
CDC United States Centers for Disease Control and Prevention
CEDEP Center for the Development of the People, Malawi
DfID Department for International Development, United Kingdom
ECOSOC United Nations Economic and Social Council
GPA Global Program on AIDS
IDU Injection drug user
IGO Intergovernmental organization
INGO International nongovernmental organization
LGBT Lesbian, gay, bisexual, and transgender
LGMM Lesbian and Gay Movement of Malawi
MHRRRC Malawi Human Rights Resource Centre
MSM Men who have sex with men
MSMgf Global Forum on MSM and HIV
NAC National AIDS Commission
NGO Nongovernmental organization
ODA Official Development Assistance
OECD Organisation for Economic Cooperation and Development
PCB Programme Coordinating Board, UNAIDS
PEPFAR President’s Emergency Plan for AIDS Relief, United States
UNAIDS Joint United Nations Programme on HIV/AIDS
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<tr>
<th>Acronym</th>
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<tr>
<td>UNDP</td>
<td>United Nations Development Program</td>
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<tr>
<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organization</td>
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<tr>
<td>UNGASS</td>
<td>United Nations General Assembly Special Session</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>WHO</td>
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Acknowledgements

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2007  Graduate Summer Research Mentorship, Graduate Division, UCLA

2007  Research Training Fellowship, California HIV Research Program

2006  Graduate Fellowship, Sociology, UCLA
Introduction: Invisible Men

At the most basic level, what we know about HIV and AIDS – in the form of statistics on prevalence, incidence, and transmission route – is strongly influenced by where, among whom and how hard governments, researchers, and clinicians look for disease. In his book, The Will to Live, João Biehl (2007) identifies the various “technologies of invisibility” through which early AIDS cases among Brazil’s poor and marginalized populations went undiagnosed, unregistered, and unacknowledged by official accounts of the epidemic. Poor patients with AIDS, Biehl observed, were systematically denied access to public hospitals that restricted admission to a narrow group of infectious diseases in order to avoid overpopulation. Even when hospital policies began to change in the early 1990s, many facilities still lacked the capacity to keep pace with patient demand. Denied care, many of Brazil’s poor died untested and thus unrecognized as AIDS cases. Among those who were tested by clinicians, incomplete forms, disagreements about the medical criteria needed to establish an AIDS diagnosis, overworked data entry staff, and a lack of political will to prioritize AIDS continued to undermine epidemiological surveillance efforts, ensuring that recognized cases still went unacknowledged by the state. In similar ways, various clinical, political, and bureaucratic practices have created durable blind spots in our knowledge of HIV and AIDS among diverse population groups around the world, including the population at the center of this dissertation: gay men and other men who have sex with men (MSM).¹ Such blind spots are important because what we know about HIV and AIDS has

¹ The use of men who have sex with men or “MSM” as a classification was initially employed in the early 1990s by public health researchers in the US in response to growing awareness of the inappropriateness of assuming
profound implications not just for how we understand the disease but also for our responses to it (Lee and Zwi 1996:362).

This is perhaps best demonstrated by the distinct epidemic paradigms that emerged in the mid 1980s to explain differences in the number and types of people being affected by HIV and AIDS in Western, high-income countries compared with African and other low- and middle-income countries. When AIDS was first described in 1981 and early 1982 in the US, high rates of infection among homosexual men fueled constructions of the new disease as a “gay plague” (Kayal 1993). Research and policy on the new disease, originally identified as GRID (gay-related immune deficiency), promoted negative stereotypes of gay men’s sexual behavior, linking the disease to sexual promiscuity and the effects of drug use on immune system functioning. The perceived isolation of cases to homosexuals and other socially marginalized groups (e.g., injection drug users and Haitian immigrants) and uncertainty about the epidemiology of the disease limited the extent to which government officials aspired to or felt they could intervene to prevent more deaths (Shilts 1987). In the face of reluctance from government officials to organize a response to the mounting epidemic, gay communities mobilized to generate prevention strategies and provide care for scores of gay men who were dying (Shilts 1987). Within gay communities, AIDS activists also educated themselves in homosexual identity given male-male sexual behavior (Doll et al. 1992) and the stigma attached to both AIDS and gay and lesbian identities in some communities. The adoption of MSM was concurrent with a broader shift in public health to focus on specific behaviors that could be connected to health outcomes rather than identities or groups of people. Although the decoupling of behavior and identity through the use of MSM has been widely contested (Young and Meyer 2005) and the meaning of MSM has transformed over time (Boellstorff 2011), it remains widely used especially in international work where the use of “gay” and “bisexual” is politically problematic or, alternatively, not socially meaningful.

2 Throughout this dissertation, I use “Western” or “the West” as they are commonly applied to refer to Northern America and Western Europe. Beyond the spatial reference, however, “Western” is often used as analogous to developed, modern, or civilized, and as antonym to developing, traditional, or uncivilized. As Ferguson (2006) argues for the concept of “Africa,” notions of “the West” reflect both a location in space and a rank in a system of hierarchical social categories.
epidemiology and medical research practices. These new self-educated experts within gay communities challenged the authority of government officials and clinicians to define the disease and worked to ensure gay men’s access to treatment and prevention technologies (Epstein 1996).

However, the strength of the initial framing of AIDS as a gay disease in the US and Western Europe presented a challenge to conducting and disseminating early research on AIDS in Africa. The first descriptions of AIDS in Zaire revealed that, while the clinical manifestations of the disease were "similar to the disease in Europe and the United States and Haiti," the "strong indication of heterosexual transmission in Zaire implies a different and important epidemiological pattern compared with that of AIDS in other areas” (emphasis added, Piot et al. 1984:67ff). Yet, it still took over a year to convince the American government that heterosexual transmission was occurring in Africa and needed attention (Iliffe 2006). Prominent American medical journals, The Lancet and The New England Journal of Medicine, initially rejected manuscripts documenting heterosexual transmission of AIDS in Africa, with reviewers citing such studies as “only of local interest” or contrary to existing evidence: "It's a well-known fact,” one reviewer wrote to Dr. Peter Piot, a Belgian microbiologist working in Zaire, “that AIDS cannot be transmitted from women to men" (NIH 2008:18). Despite mounting deaths, African officials too were reluctant to recognize AIDS given its associations with homosexuality and sexual promiscuity.³

As research from Africa began to accumulate, findings continued to suggest that women were just as likely as men to be infected and that African patients with AIDS generally did not

³ For example, in Botswana in 1984, an official declared: “It [AIDS] is not a problem in Botswana. AIDS is primarily a disease of homosexuals and there is no homosexual in Botswana” (as quoted in Iliffe 2006: 38)
report same-sex sexual contact or injection drug use as in the US and Europe (Biggar 1986; Serwadda et al. 1985). Importantly, while most AIDS patients in these early studies conducted in Central Africa denied same-sex practice, some did not. In several countries outside of the US and Western Europe the first reported AIDS cases were diagnosed among homosexual men, including in Botswana (1984), Brazil, Chile (1984), Mexico, Thailand (1984), and South Africa (1982). In addition, although at first denying sex with men, several of the first male Haitian AIDS patients in the US later acknowledged that they had had sex with men in Haiti, a tourist destination of US gay men in the 1970s (Smallman 2007: 26ff). In a review of African patients with HIV/AIDS living in Europe, Quinn and colleagues (1986) report that 6% of African male patients reported homosexual behavior and several others reported no known risk factor, suggesting that some of these early AIDS patients may have engaged in same-sex sex but not reported it to clinicians. Nonetheless, the overwhelming burden of AIDS among Africans led researchers at the US Centers for Disease Control and Prevention (CDC) and National Institutes of Health (NIH), some of whom had begun their work on AIDS with homosexual patients in the US, to define AIDS in Africa as following a distinct epidemiological paradigm: "African AIDS" (Quinn et al. 1986).

This conceptual division between African AIDS and AIDS in the West led to more formal divisions in AIDS policy and prevention programs within the World Health Organization (WHO). In Western, high-income countries, the AIDS epidemic was identified as following “Pattern I,” characterized by (predominantly) homosexual transmission, while African and most other low- and middle-income countries were identified as following "Pattern II" characterized by (predominantly) heterosexual transmission (Mann et al. 1988; Chin and

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4 See 1996 oral history interview with Thomas Quinn conducted by NIH (1996).
Mann 1988). As new cases emerged in India, China, and Russia, a third epidemic pattern, called "Pattern III" or "Asian AIDS" (Erni 1997), was delineated to account for still more epidemiological anomalies as infections quickly spread among injection drug users and sex workers (Chin, Sato, and Mann 1990).

In all three epidemic paradigms, various populations and behaviors were relegated to the margins of AIDS programs and policy. In the US, a Pattern I country, the locus of AIDS prevention in gay communities and prevailing assumptions that AIDS was a gay disease affecting predominantly white men, rendered women and racial minorities with the disease invisible. Work by Paula Treichler (1999) is notable for its line-by-line deconstruction of how women were written out of the US Center for Disease Control and Prevention’s (CDC) early Morbidity and Mortality Weekly Reports describing AIDS through ambiguity and overgeneralization. "Despite documented cases of AIDS in women from almost the beginning of the epidemic," Treichler writes, "AIDS was assumed by most of the medical and scientific community to be a ‘gay disease’ and a ‘male disease’ – assumed, that is, to be different from other sexually transmitted diseases" (42ff). Many women with AIDS, especially poor women and women of color, faced substantial barriers to accessing medical care, leading to "late detection, early death" (MAC 1992). Even when women were able to access medical care, they were less likely to be tested for HIV or diagnosed with AIDS as clinical diagnostic criteria excluded common manifestations of the disease in women, such as the presence of cervical cancers and other opportunistic vaginal infections.

Importantly, marginalized groups in the US epidemic managed their invisibility to researchers, clinicians, and policymakers differently. Concern about the visibility of women with AIDS grew throughout the late 1980s among women's and AIDS groups across the
country. One of these groups was the AIDS Coalition to Unleash Power (ACT UP), a prominent national AIDS social movement organization. From 1990 to 1992, ACT UP, together with other women's and AIDS organizations, mobilized to increase the visibility of women with AIDS, demanding that the CDC amend its list of AIDS-defining illnesses to include women-specific illnesses (Brier 2009). In 1993, when the CDC headed these demands and added cervical cancers to its list of AIDS-defining illnesses, women became radically more visible as victims and thus “at risk” of AIDS. In contrast, as high rates of infection became visible among African Americans, work by Cohen (1999) shows how members of the African American community actively distanced themselves from marginal groups like black gay men and downplayed the extent of the epidemic in order to avoid the anticipated costs of AIDS, drug use, and sexual promiscuity being associated with African Americans.

Outside of the US, very different blind spots emerged. In African and other low- and middle-income countries categorized as Pattern II, research on same-sex sex and injection drug use, the principal risk behaviors of American and European AIDS patients, was abandoned. From 1984 to 2007 same-sex sexual behavior was only measured in 14 of 118 (12%) epidemiological studies on AIDS in sub-Saharan Africa in which individual behavioral risk factors

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5 While ACT UP was among the most visible organizations advocating for the inclusion of women in AIDS treatment and research at the time, they were certainly not the only organization conducting this work. Importantly, other organizations, such as the Multicultural AIDS Coalition (MAC), a community-based organization that had been founded in 1988 to connect "women of all colors" affected by AIDS and conduct AIDS advocacy on their behalf, found ACT UP’s focus on the inclusion of women-specific diseases to be too narrow a platform for reform. In collaboration with the University of Massachusetts, MAC (1992) identified several other "holes in the surveillance system" that contributed to the invisibility of AIDS among low income women and women of color, including, "lack of: access to medical care, underdiagnosis of ‘indicator’ diseases where women are seen by physicians, underreporting of cases that actually fit the definition, and the exclusion of certain conditions from the definition" (25).

6 At the time, the CDC estimated that the inclusion of women-specific illnesses in the clinical definition of AIDS would increase the number of women living with AIDS by 61 percent (OTA 1992:II-25).
for contracting HIV among men were assessed (Smith et al. 2009). Instead, African AIDS came to be defined among epidemiological and social science researchers, doctors, policymakers and Western media through racial and cultural difference (Cerullo and Hammonds 1988; Austin 1989; Patton 1999; Kitzinger and Miller 2003 [1992]; Packard and Epstein 1991; Treichler 1991; Sabatier 1988). Researchers suggested that African AIDS was the result of exotic cultural and sexual practices (Hrdy 1987) and "monstrous passions" (Watney 1989) that drove Africans to have a high number and frequency of change in heterosexual partnerships (Johnson and Laga 1988; Piot et al. 1987; Piot and Carel 1988; Serwadda et al. 1985).

As a result of this focus, various populations were rendered invisible as at risk of HIV infection. The concentration of early research on sex workers and other individuals with multiple sex partners delayed recognition of the substantial transmission taking place within marriage and obscured continued transmission through medical injections and blood transfusions, especially in rural settings where blood storage and screening capacity remained limited through the 1990s (Brewer et al. 2003). The focus of prevention activities on mitigating the effects of extreme poverty on risk, a paradigm exported from the West and reinforced by concerns about development, inequality, and the vulnerability of women, has similarly made it difficult to translate mounting epidemiological evidence of high rates of

7 The cultural practices that Hrdy (1987) includes run the gamut from female circumcision, ritual scarification, group circumcision of boys at adolescence, to shared medical injection paraphernalia and contact with nonhuman primates.
8 See Epprecht (2008) for in-depth discussion of how these constructions of African AIDS were based on entrenched understandings of African sexuality that had solidified much earlier in colonial racial projects and African nationalism.
infection among educated and employed Africans into prevention activities. ¹⁰

Finally, the almost exclusive focus on heterosexual transmission in research and prevention programs has rendered same-sex sex and injection drug use invisible as risk behaviors for HIV infection in African and other low- and middle-income countries. In Johannesburg, South Africa, where same-sex sexual transfer among white homosexual men existed alongside a large generalized epidemic among heterosexual black Africans, early HIV prevention campaigns were so narrowly targeted that a survey of attitudes among Africans exposed to the campaign found that many believed that there were "two totally different kinds of AIDS. The one that only affected blacks was acquired through sexual and ritual contact with baboons in central Africa. The other was acquired by sexual contact with homosexuals—white AIDS" (Seftel 1988:21). Across the continent, AIDS prevention was integrated with existing family planning programs (WHO 1986; GPA 1988), reinforcing the invisibility of same-sex sexual transmission and having a durable effect on the priorities and practices of AIDS prevention programs on the ground. For example, research by Esacove (2010) reveals how AIDS programming in Malawi has promoted heteronormative and “modern” (read: Western) understandings of sex and relationships, emphasizing condom use for penile-vaginal sex, monogamy, gender equality within loving sexual partnerships, and, at its most prescriptive, abstinence in the absence of

¹⁰While AIDS has become universally understood as a disease of the poor and marginalized through strong health and human rights advocacy (Farmer, Connors, and Simmons 1996; Farmer 2005), as early as 1993 there has been evidence that the expected negative relationship between socioeconomic status and health may not hold in some African contexts, perhaps due to the prevalence of patron-client ties (Swidler and Watkins 2007). For example, both Over and Piot (1993) and Dallabetta et al (1993) report higher rates of HIV among individuals with higher -- not lower -- socioeconomic status in certain African contexts. Similar findings have been produced using increasingly complex empirical models by authors who conclude that targeting the very poor is unlikely to be effective in preventing AIDS in sub-Saharan Africa (Gregson, Waddell, and Chandiwana 2001; Hargraves and Shelton 2002; Shelton, Cassel, and Adetunji 2005; Bärnighausen et al. 2007; Fortson 2008). Yet, a strong focus on empowerment and poverty reduction, especially among "vulnerable women," has minimized the extent to which such results can be incorporated into existing prevention activities.
marriage.

As the disease has spread to Pattern III countries, so have assumptions about who is at risk of infection. Work by Buckley (2008) examines the social influences on epidemiological knowledge in the Southern Caucasus (Armenia, Georgia, and Azerbaijan) where HIV is widely believed to be transmitted primarily through injection drug use, and the contributions of other transmission vectors, such as same-sex sex, are generally believed to be low. Such beliefs, Buckley finds, are reinforced through the active management of the testing encounter. In Azerbaijan, where testing of incarcerated populations is mandatory, HIV is more likely to be found among injection drug users and sex workers who represent a greater proportion of arrests compared with men engaging in same-sex sex. Moreover, in interviews with HIV testing counselors conducting voluntary testing, Buckley finds that counselors frequently rely on gender and ethnic stereotypes about who participates in what kinds of behaviors to avoid asking offensive or embarrassing questions about same-sex sexual behaviors, injection drug use or sex work during the testing encounter. In many cases in Azerbaijan, no mode of transmission is even recorded in order to avoid offending the patient.

These various blind spots in our epidemiological knowledge of HIV reveal that what we know about the disease – who it affects, where it is, where it’s going, and how best to address it – are based not on objective measurements of disease in the population, but highly structured by these various technologies of invisibility that render some populations and behaviors unseen and uncounted, sometimes for decades. These technologies are employed at various levels of society, circumscribing the kinds of policy, research and prevention that are possible, shaping how new information and discrepant findings are interpreted and integrated into existing knowledge.
Yet, ways of seeing are not static. In the US, social movement activism was successful in challenging the dominant disease paradigm and expanding diagnostic criteria to include women-specific illnesses. Similarly, in the last decade the exclusive focus of prevention policy on heterosexual transmission in African and other low- and middle-income countries has begun to change. In stark contrast to global AIDS policy during the first two decades of the epidemic, which largely discounted the possibility of same-sex sexual transmission outside of the US and other western countries, international organizations have since identified MSM as “marginalized but not marginal” to the global AIDS epidemic (UNAIDS 2010b:35). Despite decades of “normal science” (Kuhn 1970), where HIV research and interventions have been carried out in African and other low- and middle-income countries without challenging overall assumptions about the appropriate objects and methods of intervention, a small but growing research enterprise has been mobilized to count and categorize same-sex sexual behaviors the world over. In addition to expanding policy and research interest, civil society and LGBT groups in low- and middle-income countries increasingly demand national and global attention to HIV among MSM. By 2012, almost every country (88%) identified a need to address MSM in their national AIDS policy. Ten years earlier, less than one quarter of countries did so. However, the cost of decades of invisibility has been great. Worldwide, MSM are now estimated to be 19 times more likely to be infected with HIV compared with the general population (Baral et al. 2007). Even in contexts where there are high levels of infection among the general population, such as sub-Saharan Africa, MSM are still 10 times more likely to have the disease.

Given the breadth of practices that reinforce the invisibility of same-sex sexual transmission of HIV, this sea change in global AIDS policy concerning MSM is quite unexpected. This dissertation endeavors to account for this contentious reversal of global AIDS
policy, for the *technologies of visibility* through which MSM have been brought from margins to the fore of global and national responses to AIDS. In the chapters that follow, I address how and in whose interests MSM have emerged as an AIDS priority, how the prioritization of MSM among officials in Geneva has influenced national AIDS policies and other forms of local mobilization, and the implications of seeing MSM as a *global prevention priority* rather than a *Western problem* for same-sex sexualities around the world.

In addressing these questions, this study takes the historical emergence of MSM as a global AIDS priority as a point of departure for understanding how new global health policy priorities are formed, disseminated, and implemented. Although various actors, interests, and institutions influence health policy over the course of its “life cycle,”\(^{11}\) I pay particular attention to the role of intergovernmental organizations (IGOs) in identifying and promoting MSM as an AIDS priority. I do so for several reasons. First, the response to AIDS has been largely directed by IGOs that control the majority of financial, technical, and human resources for prevention, treatment and care (Lieberman 2007:61-109). Second, while these IGOs remain vulnerable to external interests and pressures, the usual suspects of health and social policy change -- social movement activists and organizations, researchers, government officials, and other private interests -- have largely been constrained, uninterested, or opposed to addressing HIV among MSM until very recently, *after* IGOs had already asserted their interest in MSM as a global AIDS priority. Thus, in contrast to the emergence of other health and social policy issues, these actors cannot easily be used to explain the increase in attention to HIV among MSM. Rather,

\(^{11}\) In particular, sociological research has concentrated on the influence of social movement activism (Brown 1995; Brown 2007; Brown and Zavestoski 2004; Epstein 1996; Epstein 2007), doctors and clinicians (Epstein 2010; Timmermans and Oh 2010), researchers and experts (Haas 1992; Saguy and Riley 2005), corporate interests (Quadagno 2005; Timmermans and Kolker 2004), government officials, and structural factors (Timmermans and McKay 2009) on the formation, implementation, and provision of health policy.
efforts to establish a global agenda for addressing HIV among MSM have been highly concentrated within IGOs. Third, with few exceptions (Chorev 2012b; Inoue and Drori 2006), sociological studies of IGOs primarily focus on the development and diffusion of political and economic policy, neglecting the role of IGOs in the formation, dissemination, and implementation of health policy. By contrast, health policy researchers note the considerable influence of IGOs in the formation and dissemination of national health systems and policies (Buse and Walt 2000; Deacon 1997; Deacon and Kaasch 2008; Kickbush 2003; Ruger 2005); however, the agency of IGOs has largely been taken for granted by this literature. Bringing insights from these two literatures together provides opportunities of refining and extending understandings of IGOs in both fields.

**The Influence and Autonomy of Intergovernmental Organizations**

Social science research on organizations and institutions identifies several barriers to IGOs formulating, disseminating and implementing policy according to the organization's own interests, especially when those interests run counter to those of member states as in the case of HIV policy on MSM. First, IGOs are dependent on member states for financial resources. As such, IGOs are subject to the interests of wealthy member states who may withdraw financial support if their demands are not met. AIDS IGOs are especially dependent on the support of wealthy states for funds. In 2011, the US provided more than a quarter (26.8%) of the $16.8 billion spent on AIDS (Kates et al. 2012: 11). This dependence ostensibly gives very wealthy countries substantial power over the policymaking process. The second barrier that IGOs encounter is that they are dependent on states for policy approval. IGOs thus become subject to the interests of coalitions of poor states who may organize to veto policy initiatives advanced by wealthy states or Secretariat staff. This kind of coalition vetoing has been a consistent problem
for various UN agencies attempting to advance initiatives concerning the protection of same-sex sexualities (Correa and Parker 2004; Saiz 2004; Sanders 1995). Finally, IGOs are dependent on member states and other external actors for legitimacy, which IGOs might lose if they pursue policies that appear politically biased, lack the necessary technical expertise, veer wildly from their mandate, or fail to conduct their work consistent with global norms. Given these various constraints, IGOs have been traditionally conceived as unable to pursue independent policy interests and, at times, even insignificant to the policymaking process (Keohane and Nye 1972; Keohane and Nye 1974).

Nonetheless, recent research demonstrates that IGOs frequently behave in ways that are unanticipated and even counter to the interests of member states (Goldman 2005; Reinalda and Verbeek 1998; Weiss and Thakur 2010). Challenging dominant views of IGOs as disinterested forums in which states pursue their own interests (Keohane and Nye 1972) or passive conveyors of world culture norms (Boli and Thomas 1997), this work understands IGOs as autonomous, influential, and self-interested actors in the policymaking process. Yet, given the above constraints, how IGOs acquire and maintain this autonomy and influence is a recurring question in this literature.

A number of studies point to the strategies used by IGOs to respond to external demands and reconfigure relationships with states. This work demonstrates that IGOs strategically resist, comply, avoid, reinterpret and transform the demands of states in order to preserve the autonomy of the organization (Barnett and Coleman 2005; Barnett and Finnemore 2004; Chorev 2012b). For example, in chronicling the development of WHO policies on investments in the health of the poor, AIDS drug patent protections, and tobacco regulation, Chorev (2012b) demonstrates that WHO engaged in “strategic resistance” to state demands, transforming neoliberal policies
and practices that conflicted with the organization’s own material interests and ideational goals. However, IGOs become more vulnerable to external demands when financial resources are scarce or threatened (Barnett and Coleman 2005; Chorev 2012b). Thus, while IGOs may generally seek to increase their decision-making autonomy, expanding autonomy is evaluated against resource constraints. Barnett and Coleman (2005) understand this as the “resource-autonomy trade off” wherein IGOs may give up autonomy to states in order to gain or maintain access to resources when they are scarce or opt to pursue organizational autonomy at the expense of resources when they are more plentiful.

In addition to examining interactions between IGOs and states, organizational scholars consider how the internal structures and dynamics of an organization might convey or limit autonomy and shape an organization’s policy priorities. Conceiving of IGOs as self-interested bureaucracies, Barnett and Finnemore (2004) show how IGOs protect and increase their autonomy from states through the implementation of various procedural rules that limit how and under what circumstances states can initiate action or new policies within the organization. Although these rules can hinder action leading to “pathological behavior,” IGOs also exhibit agency and creativity in reimagining organizational goals and altering internal bureaucratic structures when they are constrained by procedural rules and technical capacity (Barnett and Finnemore 2004). Within the organization, internal structures, rules and procedures, and personnel configurations are seen as exerting significant influence over an organization’s views. Through the shared professional orientations of staff, technical capacities, and hiring practices, IGOs develop an organizational culture that is resistant to change (Barnett and Finnemore 2004; DiMaggio and Powell 1983; Hall 1993). However, these same internal characteristics also provide opportunities for new ideas to emerge "from within" through entrepreneurship.
(Finnemore and Sikkink 1998), interdisciplinary and intergenerational personnel interactions, and new recruitment practices (Chwieroth 2008a; Chwieroth 2008b).

In addition to reconfiguring IGO-state relationships and the internal structures and capacity of the organization, IGOs also proactively and creatively work to transform policy preferences outside the organization (Barnett and Coleman 2005; Barnett and Finnemore 2004; Finnemore 1993). Barnett and Coleman argue that IGOs engage in manipulation, social influence, and persuasion to “try to convince others of the necessity or desirability of a particular course of action or way of seeing the world, in hopes of recruiting converts to its organizational world view” (602). In health and other sectors, IGOs have also invested heavily in knowledge production as a way to promote particular understandings and solutions to a policy issue. Today, the WHO, UN, and World Bank all boast massive longitudinal datasets for a majority of the world’s countries on topics ranging from development and economic policy, to agriculture and education, human rights and governance, and health. Indeed, “quantifying the world” is noted among the UN’s greatest achievements in the history of the organization (Jolly, Emmerij, and Weiss 2009). Not only do these organizations accumulate massive amounts of data on member countries, but they increasingly interpret these data, disseminating seminal reports on sector priorities and "best practices." The content of this knowledge is incredibly strategic: as research on the World Bank demonstrates, knowledge production is carefully controlled through hiring practices, the privileging of individuals and research that "resonate" with the current development paradigm, discouraging dissonant discourse, and even manipulating data to align it with the organization's lending and policy prerogatives (Goldman 2005; Broad 2006). While the motives and practices of knowledge production at IGOs need not be so insidious, knowledge claims about the status or course of the AIDS epidemic are socially produced (Biruk 2012) and
are often mobilized to support particular reforms or interventions into social realities or behavior (Esacove 2013). Through their strategic data collection and research, IGOs set the terms of policy debates by defining what things like “health” and “AIDS” are through the types of data they collect.

A key limitation of these studies on the autonomy and influence of IGOs, however, is their narrow focus on the decision-making and agenda-setting stages of policymaking. Where diffusion and implementation are considered, they are generally conceived of as separate theoretical and empirical problems to be addressed once policy decisions have already been made. In the next section of the introduction, I theorize three additional barriers to autonomy and influence that IGOs encounter in attempting pursue their own interests past the decision-making stage. These barriers primarily constrain an IGO's ability to consistently implement the policy decisions it makes at headquarters. In particular, AIDS IGOs have few formal means to enforce policy implementation among member states. Additionally, AIDS IGOs face substantial competition for legitimacy, authority, and resources from other IGOs and private donors. Even within AIDS IGOs, decentralization of the organization at the regional- and country-levels poses a substantial barrier to implementing a singular policy across all offices. Yet, as barriers to implementation, they have largely been examined separate from research on the decision-making process. In contrast, in the next section I argue that concerns about diffusion and implementation are not negligible or separate from decisions about the content of policy; rather, these concerns shape the particular decision-making strategies and policy priorities adopted by an organization.

**How Concerns about Implementation Shape Policy Decisions**

By expanding our view of the policymaking process to include concerns about implementation, three additional barriers to autonomy that IGOs encounter become apparent. These barriers
include state sovereignty, organizational decentralization, and fragmentation of the policy priorities due to crowding and/or competition from other organizations. First, I examine how AIDS IGOs navigate the issue of state sovereignty. With the exception of the UN Security Council, IGOs generally lack the ability to use force to compel states to honor policy decisions. In the absence of formal enforcement power, contested policies, such as those governing weapons accumulation (Weiss and Thakur 2010), international water rights (Conca 2006) or human rights protections (Hafner-Burton and Tsutsui 2005), may never be adopted or fully implemented by states. Even when they are, they often exist as “window dressing” and may exacerbate rather than attenuate policy violations by states (Hafner-Burton and Tsutsui 2005).

Yet, enforcement problems are generally examined separate from the decision-making practices of IGOs. As such, organizational scholars have yet to consider how concerns about policy implementation might shape the particular decision-making strategies and policy priorities adopted by an organization. I argue that in addition to concerns about resources, IGOs with less power to enforce policy implementation by states are highly sensitive to an implementation-autonomy trade off, wherein IGOs may give up autonomy in decision-making in order to ensure broader implementation by states. Whereas WHO’s Global AIDS Programme had the ability to enforce AIDS policy decisions through funding allocations and opted to consolidate decision-making power among a small group of experts largely inaccessible to states, UNAIDS, an organization with no formal or financial leverage over states, explicitly opted for a unique decision-making structure that made the organization accountable to states but promoted greater implementation once a policy has been adopted.

Second, focusing on intra-organizational dynamics, I examine how IGOs attempt to actively construct and manage staff preferences. As various authors acknowledge, policy
preferences of IGOs are not universally held within an organization. As Scott writes, “Organizations are opportunistic collections of divergent interests” (1967:23). These divergent interests may form subcultures within an organization, each with its own particular ways of understanding policy problems and their solutions. Organizational subcultures are generally conceived as bifurcating along professional lines within an organization (Chwieroth 2008b; Sarfaty 2009). However, IGO programs and staff are also frequently decentralized, with substantial decision-making and resource allocation authority concentrated in regional bureaus and country offices. Decentralization is widely cited by economists as a means of improving efficiency and aligning policy preferences with local needs (World Bank 1993:12). However, because the policy preferences of in-country staff are shaped by local conditions and demands, decentralization also poses a substantial challenge to ensuring consistent understandings and implementation of policies across all offices.12 Organizations vary in the extent to which decentralization threatens internal continuity. For example, as of 2012 only 10 percent of all staff and just 23 percent of professional staff employed by the Office of the United Nations High Commissioner for Refugees (UNHCR) work at the organization’s headquarters in Geneva; the remaining general service and professional staff are distributed among 5 regional bureaus and field offices in 125 countries. In contrast, several of the specialized UN agencies, such as the United Nations Educational, Scientific, and Cultural Organization (UNESCO), employ a majority (60%) of their staff at headquarters in Geneva. The two organizations of primary concern in this dissertation, the WHO and UNAIDS, fall in between, employing two thirds of their total staff (68 and 67%, respectively) and just under half of their professional staff (49 and

41%, respectively) in regional and country offices.13 Since policy decisions do not reflect a single decision made at one point in time, but rather are composed of a sequence of decisions made by different actors who are increasingly in different physical locations, understanding how IGOs grapple with decentralization remains an important yet under theorized issue.

In the chapters that follow, I show how organizations with highly decentralized staff attempt to shape policy preferences within the organization through an array of practices that constitute “organizational inreach.” Readers will be familiar with various organizations that conduct some kind of outreach to educate constituents or bring attention to a particular issue among an external audience. In contrast, organizational inreach, an informal term used within some policy and advocacy circles, refers to practices of raising awareness within an organization through the development of trainings or materials to educate employees about an event or policy. Here, I expand the definition of this term, using it to describe practices through which IGOs actively manage organizational culture and staff preferences not only to ensure continuity across the organization but also to transform organizational culture. Thus, beyond a general “raising of awareness,” the organizational inreach conducted by UNAIDS and partner organizations aimed to ensure that staff had the “appropriate knowledge, skills and attitude to undertake and promote” prioritization of MSM. This involved formal staff trainings, the creation of new staff positions to “champion” MSM across agencies and offices, new hiring and rotation guidelines for country-level staff, revisions to funding guidelines and grant proposal review guidelines used by technical staff to make it easier for local MSM groups to access funding, and the

13 All personnel statistics are reported in Table 1A of the 2013 report on UN personnel by the United Nations Chief Executive Board for Coordination (UNCEB 2013).
establishment of antidiscrimination policies and lesbian and gay (LGBT) support groups within the organization.

Third, I extend research on the strategies through which IGOs attempt to bring the external environment, including the preferences of states, in line with IGO policy interests. For UNAIDS and other IGOs involved in health policy, the external environment is increasingly saturated with other organizations. Over the past two decades the magnitude of initiatives, number of stakeholders, and networks through which stakeholders configure and exert their influence over global health policy have grown rapidly, forming an increasingly complex, interdependent and adaptive system of global health governance (Hill 2011). In the AIDS sector, these dense networks present both opportunities and challenges that largely have been unaddressed by the organizations and institutional literatures: an IGO working on AIDS competes with more than a dozen other IGOs, various bilateral and multilateral donors, a handful of large private foundations, and scores of nongovernmental organizations (NGOs) for resources, legitimacy, and authority to set the AIDS policy agenda. While some scholars understand these organizations as promoting a consistent message on health policy priorities and practices that disproportionately reflects the interests of powerful states (Lieberman 2007:61-109; Kickbusch 2002), these organizations have more often been criticized for coordination problems and promoting overlapping, competing, and even conflicting agendas, the result being fragmentation rather than unification of health and AIDS policy (Lee et al. 1996; Walt 2001; Buse and Walt 2002). Some authors go so far as to argue that contestation – or a constant “war of positions” and mandates (Deacon 2007:171) -- is the “inherent” state of interactions among global policy actors and IGOs. As a case in point, encroachment by the World Bank into the fields of health and
AIDS is widely cited as a contributing factor in the failure of the WHO’s Global AIDS Programme (Chorev 2012b:151-156; Center for Global Development 2009; UNAIDS 2008).

However, Kaasch (2013) contends that understandings of IGOs as competitive actors have been derived primarily from studies of economic development IGOs. Presenting IGOs active in health systems reform as a point of comparison, Kaasch demonstrates that while IGOs may not necessarily hold entirely harmonious policy positions or justify their engagement in specific issues in the same way, interactions among IGOs active in health systems reform are also characterized by collaboration, cooperation and common concerns across organizations. Similarly, in the case of MSM and other so-called vulnerable groups, UNAIDS has been able to rein in competing IGOs and donors, over which UNAIDS has no formal authority, and promote the alignment of policy preferences with its own through the formation of voluntary multiparty collaborative agreements. But why would IGOs, bilateral and private donors, and other organizations voluntarily cede autonomy and delegate authority to another IGO? Existing theories of organizations as bureaucracies, as the servants of powerful states, and as autonomous, self-interested actors do not provide strong explanations for identifying when and why IGOs might give up autonomy to pursue collaboration instead of contestation as a policymaking strategy. Here, insights from the health policy literature are instructive. In an increasingly congested field, the influence of any single IGO, bilateral donor, or NGO has become much more diffuse. With various options for funding, states have more room to reject politically sensitive or socially undesirable policies initiated by IGOs. In this context, interorganizational coordination has emerged as a strategy among IGOs for increasing the leverage of the aid community over national governments (Buse and Walt 1997). Thus, while IGOs must cede some autonomy to engage in such collaborative agreements, they do so in order to gain leverage over
national governments to pursue specific policy priorities. In the next chapter I show how this strategy became important for IGOs active in AIDS not only as this sector became congested but also as IGOs became concerned with policy issues that states were reluctant to address on their own, such as the rights of women, MSM, and other marginalized groups.

In addition to brokering collaborative agreements to increase the influence of top-down initiatives, IGOs have also been shown to directly manage and transform the policy preferences of states through persuasion, manipulation, and issue framing. More broadly, IGOs shape understandings of policy issues across a range of external actors through strategic knowledge production. These strategies generally understand the influence of IGOs as originating within the organization and radiating outwards to states and the external environment. For IGOs, however, there are costs to adopting these direct strategies of shaping external preferences. As demonstrated in Goldman’s (2005) portrayal of the World Bank, these strategies are frequently interpreted by states and other external actors as promoting biased rather than neutral policy positions, and bias is a strong threat to the legitimacy of the organization. In order to appear less biased, I argue that IGOs attempt to transform state policy preferences indirectly through intermediaries using what I call “evidence-based advocacy” and “bidirectional pressure.” Through these approaches, I show how UNAIDS strategically facilitated the formation of external transnational research and advocacy networks and the emergence of local social movement activism in order to promote the prioritization of MSM in national AIDS policies without threatening organizational legitimacy.

In studies of the policymaking process, scientific consensus is traditionally conceived as a precursor to rather than an outcome of policy. Work by Haas (1992) on epistemic communities – networks or groups made up by an array of experts on a particular policy issue -- highlights the
formative role of researchers in generating policy concerns. Similarly, Meyer and colleagues (2003) contend that policy “diffusion among nation-states is heavily mediated by scientists and professionals who define virtuous instances, formulate models, and actively support their adoption,” and “the models of national development or human rights carried by international organizations have their roots in scientific and legal knowledge” (115ff). In their examination of UN policy development Weiss and Thakur (2010) further emphasize the role of scientific consensus formation as a precursor to policy development. Across these works, scientists and professionals are conceived as generating new policy interests which are then conveyed to states via IGOs. But what happens when IGO policy priorities emerge prior to scientific consensus or, in the case of HIV among MSM, before scientists even have any interest in an issue?

As I demonstrate in Chapter 1, when UNAIDS began pursuing MSM as a global AIDS priority there was very little epidemiological or social science research outside of the US, Western Europe and Australia. While there was some research on gay and bisexual men in Latin America, and Brazil in particular, there remained almost no information on MSM in Africa, the Middle East and parts of Asia and Central Europe. In these contexts, debates about the recognition and inclusion of same-sex sexualities frequently devolved into opposing agonistic campaigns, with UNAIDS and its rights-based claims on one side and government officials with their political, cultural, and religious objections on the other. Thus, in the mid 2000s, UNAIDS moved to supplement their human rights and legal advocacy for groups like MSM through evidence-based advocacy. Building on the insights from sociological studies of evidence-based medicine and evidenced-based policy movements, I conceive of evidence-based advocacy as an array of intersecting practices through which IGOs strategically facilitate research, assemble and disseminate scientific knowledge, and interpret scientific evidence in order to promote the
standardization of policy at the global and national level. In order to facilitate research, UNAIDS approached donors to promote new funding streams for research on MSM at the local, national, and regional levels and actively facilitated the institutionalization of research and advocacy networks among MSM groups through international conferences. In so doing, UNAIDS formed a dense transnational network of researchers and advocates external to the organization that could 1) put additional pressure on states, 2) advance stronger demands without compromising organizational legitimacy, and 3) reframe debates in scientific rather than political or religious terms. Here, UNAIDS has adopted less a position as knowledge producer than a position of knowledge broker, linking donors to researchers, researchers to organizations, organizations to policymakers. This view of IGOs as intermediaries pursuing indirect strategies of influence on the external environment is in sharp contrast to views of IGOs as targets of scientific and research activism or the World Bank alternative: IGOs as unscrupulous and strategic producers of “knowledge.” In chronicling the various practices through which UNAIDS facilitated the emergence of a new epistemic community and research agenda among donors, I show how relationships among IGOs, knowledge, and researchers are more dynamic than traditionally conceived and provide insight into the ways in which IGOs attempt to maintain legitimacy by promoting contentious policy positions through intermediaries.

In addition to indirectly shaping policy preferences through evidence-based advocacy, UNAIDS has also attempted to supplement the top-down pressure gained through interorganizational cooperation with bottom-up pressure from local civil society groups. Although MSM advocates and organizations existed at the local level, when UNAIDS began pursuing MSM as a global AIDS priority these local groups faced substantial barriers to accessing policymakers and, in many countries, were actively excluded from government AIDS
coordinating bodies. By supporting community groups and NGOs on the ground while continuing its advocacy work among its own staff and across UN and donor agencies, UNAIDS could put bidirectional pressure on governments to address AIDS among socially and culturally excluded groups such as MSM. Again, UNAIDS used its networks with donors and other international organizations to mobilize resources for amplifying the voice of civil society and building local capacity. New funding streams were developed to increase NGO’s access to regional and national awards. Because these smaller organizations lacked the technical capacities of states, the technical review guidelines for proposals in this new funding stream were also relaxed. In addition to mobilizing resources, UNAIDS also directly advocated for community, human rights and HIV groups to address MSM, facilitated their engagement in national AIDS policy formulation and review, and provided technical support to improve the funding stability of grassroots organizations. Together, UNAIDS’ use of evidence-based advocacy and bidirectional pressure poses several challenges to other theories of policy formulation which emphasize the role of social movement activism, state interests, and researcher-experts in generating the policy concerns of IGOs and directing the policymaking process. Rather, in the chapters that follow I show how social movement activism and transnational research networks concerned with HIV among MSM are an outcome of the needs of IGOs to appear neutral in their policy preferences.

The Implications IGO Strategies for Diffusion and Implementation

Above I have outlined how concerns about the diffusion and implementation of a policy theoretically shape the particular strategies and priorities that IGOs adopt. In the next chapter I show how these strategies have been implemented by WHO's Global Programme on AIDS and its successor at the United Nations, UNAIDS, to promote the prioritization of MSM at the global, national and local levels. Following my analysis of WHO’s Global Programme on AIDS and
UNAIDS, I turn to the implications of IGOs adopting these various strategies for understandings of how new and contentious policy ideas diffuse through global system and interact with local environments. In Chapter 2 I examine how effective these strategies have been in aligning national AIDS programs with IGO policy positions on MSM. Drawing on a novel dataset compiled from five waves of Country Progress Reports on HIV/AIDS (2003, 2006, 2008, 2010, and 2012) submitted to the United Nations General Assembly, this chapter traces the diffusion of MSM as an AIDS policy priority through transnational and local channels over time. Given the arguments above, I pay particular attention to the effects of exposure to IGOs, research on HIV among MSM within a given region, and links to transnational advocacy networks on states’ prioritization of MSM in national AIDS policies. I test these effects against those suggested by other prominent theories of policy diffusion, namely coercion of economically dependent states through aid conditionalities and regional patterns of policy transfer through learning or mimicry of neighboring states (DiMaggio and Powell 1983). To assess the extent to which policy adoption is structured by the national context, I also include variables to control for political and cultural barriers to policy adoption within countries, such as the legal status of same-sex sex and population demographics which have been shown to affect public support for homosexuality (Loftus 2001).

From these analyses, I show that HIV priorities and practices have changed substantially among low- and middle-income countries. In 2001, a majority of low- and middle-income countries had not initiated HIV surveillance or prevention programs targeting MSM. By 2012, just under half (46%) of these countries had planned or initiated surveillance and/or pilot prevention programs for MSM. Additionally, the proportion of countries prioritizing MSM and expanding HIV surveillance and prevention programs also increased each year. At the same
time, however, countries have been slow to move out of the initial data gathering and pilot program stage to begin expanding prevention programs for MSM. Consistent with the theoretical arguments above and the empirical evidence presented in Chapter 1, the analyses in Chapter 2 demonstrate that participation in IGOs, links to transnational advocacy networks and the supply of research but not aid flows significantly increase the likelihood of a country prioritizing MSM in their national AIDS policy. Criminalization and other demographic composition factors also present significant obstacles to prioritization of MSM by national AIDS programs.

In the final empirical chapters of the dissertation, I take a closer look at the ways in which the strategies adopted by IGOs to promote the prioritization of MSM intersect with local contexts. As discussed above and elaborated on in Chapter 1, IGOs strategically facilitate the formation of transnational research networks and target local organizations in order to put additional pressure on the governments of low- and middle-income countries. IGOs and donors also increasingly direct funding to civil society groups, including NGOs and other nonstate actors such as community groups and churches, based on assumptions that this will avoid misuse of funds by recipient governments, extend service delivery beyond the capacity of the state and private markets, and promote local ownership and innovation.

Whether or not local NGOs achieve these goals — and social science researchers generally conclude that they have not (Cambell 2003; Igoe and Kelsall 2005; Swidler and Watkins 2009) — the influx of donor funds has dramatically reconfigured social life in local contexts. Geographically, established NGOs and individuals seeking to start or be employed by an NGO are concentrated in locations within the country that facilitate access to donors (Brass 2012). NGOs that are dependent on or hoping to acquire external funding adopt the goals, language and technologies of donors in order to access donor funds (Watkins and Swidler 2013; Watkins,
Strong donor interests in governance and development, for example, have facilitated the proliferation of local organizations across the African continent looking to educate “backwards” villagers on their new rights under democracy and empower the poor (Englund 2006; Green 2000). As donor interests shift from one issue to the next, existing NGOs rapidly reinvent themselves and new NGOs form to meet demand (Watkins and Swidler 2013; Morfit 2011).

Donor interests have also unwittingly impelled new individual subjectivities (Nguyen 2010; Frye 2012). As Watkins and Swidler (2013) show, the international AIDS enterprise in Malawi has impelled new identities, motivations and aspirations among individuals, new understandings of possible careers, and new social structures that facilitate and impede the realization of these imagined futures, all despite failing to achieve its primary objective of preventing HIV. In Chapter 3, I use newspaper and interview data from Malawi to show how debates about homosexuality in Malawi have been employed by diverse actors in order to manage the emergence of these new subjectivities, even those that did not directly concern gender and sexual deviance. As I continue my examination of how IGOs reconfigure external environments, I also show how the expansion of transnational research and advocacy networks has created new opportunities for seeing and articulating same-sex sexualities in Malawi. In Chapter 4, I extend these findings using quantitative data from an original, nationally representative household dataset collected in Malawi in 2012 to gauge how variation in donor activity across districts has affected individuals’ attitudes toward homosexuality. I conclude with a discussion of the theoretical implications of this work for understanding the autonomy and influence of IGOs in determining health policy and the policy implications for globalizing MSM as an AIDS priority.
Chapter 1. From Marginal to Marginalized: Prioritizing Men Who Have Sex with Men in the Global Response to AIDS

In this chapter I examine the role of IGOs in establishing MSM as a global HIV prevention priority in just under a decade. Drawing on primary source documents from WHO and the UN, including published reports, policy position papers, and original research, as well as meeting minutes, budget reports, and speeches, I demonstrate a persistent effort among WHO’s first Global Programme on AIDS (GPA) and its successor, UNAIDS, to establish and implement AIDS policies despite opposition from member states, including policies concerning the inclusion of MSM. Like other IGOs, however, GPA and UNAIDS have encountered substantial barriers to consistently implementing policy decisions across states, its own staff, and an increasingly congested field of IGOs active in AIDS. In contrast to existing theoretical and empirical work on IGOs which largely examines enforcement and implementation problems as separate from policy decision-making, I argue that IGO concerns about implementation are not negligible or easily separated from decisions about the content of policy. Rather, IGOs have adopted particular strategies to divert power away from member states and reshape relationships of power within the organizations and across other IGOs and private donors in order to facilitate policy implementation. In this chapter, I demonstrate how IGOs have employed these strategies to navigate barriers to consistent implementation of MSM as a global AIDS priority by states, their own staff, and other organizations. Additionally, by comparing the structures and strategies of GPA and UNAIDS, I am able to show how differences in enforcement power between the two organizations have compelled UNAIDS to adopt very different strategies from GPA.
Given the dependence of both GPA and UNAIDS on wealthy member states for funding and, for UNAIDS, the additional oversight of the six cosponsoring agencies, these two organizations should have very little power to set and pursue their own policy goals. Yet, as I show below, both GPA and UNAIDS have pursued their own policy objectives that conflicted with member states and the broader WHO and UN systems, respectively. In the next section I introduce the organizational structure, challenges and strategies of the Global Programme on AIDS, the first IGO program with a mandate to address the growing pandemic. Subsequently, I examine the very different structure and challenges of UNAIDS. In contrast to GPA, which retained some enforcement power through the use of funding contingencies, UNAIDS had no formal or financial leverage over states, and even more puzzlingly, its first director advocated for greater accountability to states when the organization was formed. These structural differences have not only promoted the adoption of very different strategies across the two organizations, but also provide evidence of an implementation-autonomy trade off, wherein IGOs that are generally theorized as desiring to increase autonomy from states may instead opt to cede autonomy to states in order to promote broader implementation. I conclude with discussion of how UNAIDS engaged in three additional strategies, what I call organizational inreach, evidence-based advocacy, and bidirectional pressure, to increase consistent implementation of policy decisions across states, staff working in field offices, and other organizations.

**Held hostage: MSM and the WHO Global Programme on AIDS**

In 1985 WHO drafted the first global strategy for the prevention and control of AIDS. As part of this strategy, WHO established the Special Programme on AIDS, later renamed the Global Programme on AIDS (GPA), under the leadership of Dr. Jonathan Mann who had been conducting research on the emergence of this new disease in Zaire. As part of its mandate, GPA
was to direct a "coherent and rational plan for prevention and control of AIDS" (GPA 1988: 6) and provide technical and financial assistance to countries for developing a comprehensive national AIDS program for the provision of information and education, health and social services, humane care, and epidemic monitoring. In its first year of operation, GPA had a substantial influence on the global response, providing technical and financial assistance to over 130 countries for the development of national AIDS programs and training laboratory workers from 103 countries in HIV antibody testing procedures. The program quickly became the largest program at WHO in terms of both total staff and budget. With early contributions from the United States and many European countries, GPA's budget grew from a meager $5 million in 1986 to $90 million by 1989, accounting for roughly 10% of the total WHO budget (Gibbons 1990). The program had begun with just three staff; by the end of the decade, GPA staff numbered in the hundreds.

In order to bypass opposition from states and to facilitate a rapid response to new information, GPA had been specifically designed to have substantial autonomy over organizational policies and practices during its first few years, especially in the areas of human rights and NGO participation. "Respect for human rights of HIV-infected people and people with AIDS, and members of population groups" had been deemed "vital" to the success the national implementation of the global strategy (World Summit of Ministers of Health 1988). At the meetings of various international and intergovernmental organizations, including the UN General Assembly, GPA voiced strong opposition to the implementation of discriminatory policies and practices towards people with HIV/AIDS, gay men, women, and racial minorities in order to promote effective HIV prevention programs. While most country delegations agreed in principle, many governments, including GPA's largest donors, continued to pursue discriminatory policies
in areas such as HIV testing, housing, education, travel and employment. To ensure compliance with the human rights frame, GPA integrated this principle of nondiscrimination into its support for national AIDS programs by refusing to fund certain activities within country programs, such as laboratory support for mandatory screening activities (Mann and Kay 1991).

Additionally, GPA sought to support innovative civil society responses to local epidemics, especially in country contexts where political will to address AIDS was weak. To accomplish this, GPA invited the International Lesbian and Gay Association and other human rights and AIDS NGOs to participate in the various HIV/AIDS conferences organized by WHO and sponsored the first international meeting of AIDS Service Organizations held in Vienna in 1989. GPA also commissioned research on structural impediments to NGO development and functioning at the country level and rerouted funds directly to national NGOs instead of passing them through government AIDS programs where they "risked becoming hostage to national and local politics" (Mann and Kay 1991: S227).

Despite political barriers to doing so, researchers in GPA’s Social and Behavioural Research Unit also pursued their interests in expanding research on sexual behavior (Carballo 1990). The unit's interests in this area were developed in consultation with researchers and clinicians and broadly reflected the needs of GPA as a whole. First, there was a growing need for country-specific data to facilitate the development of national AIDS strategies. In addition, collecting concrete data on sexual behavior was seen as the primary way for GPA to minimize the reliance of national planners and policymakers on assumptions or stereotypes about sexual behavior. Second, the Social and Behavioural Research Unit aimed to provide a basis on which GPA could conduct cross-country comparisons, projections, and global monitoring of the epidemic. A substantial amount of this research was devoted to measuring HIV-related
knowledge, attitudes, and risk behavior (Cleland and Ferry 1995). However, the unit also maintained an independent interest in furthering quantitative and qualitative research on homosexuality, bisexuality and AIDS around the world. To this end, the unit conducted stakeholder meetings, briefings and trainings. In collaboration with GPA's High-Risk Behaviour Unit, research and prevention projects for MSM were funded and implemented in Latin America and Asia. The Social and Behavioural Research Unit also facilitated interdisciplinary and international exchange among researchers, encouraged national AIDS programs to collect data on same-sex sexual transmission, and catalyzed the dissemination of an edited volume on bisexuality and AIDS in from Costa Rica to Papua New Guinea (Aggleton 1996).

Nonetheless, several organizational elements impeded GPA from fulfilling its mandate to implement a coherent approach to AIDS across countries and, in turn, from developing programs for gay, bisexual and other MSM in low- and middle-income countries. The first of these issues was how GPA decided on policy. As Mann explains in detail:

the mechanism most favored by GPA was the technical consensus meeting, adapted for rapid and broad dissemination of meeting conclusions. Often at relatively short notice, GPA would assemble between 10 and 50 experts on a specific topic, selected with regard to disciplinary and geographical diversity, for a 1-5 day meeting. These meetings produced short consensus statements and usually held a post-meeting press briefing; the full reports were completed and distributed in record time, often within weeks after the meeting. (Mann and Kay 1991)

This strategy was well suited to GPA's needs to assess, develop, revise, and disseminate policy as various political debates and new scientific data concerning HIV emerged. From 1986 to
1989, GPA conducted 67 policy-related consultations on a range of issues, including the imposition of bans on international travel of HIV positive individuals, blood screening and transfusion practices, occupational exposures to HIV, requirements for the notification of sexual partners, tuberculosis coinfection, breastfeeding practices, and the presence of HIV positive individuals in sports.

However, while this technical consensus strategy ensured a rapid response to new information and events, it was not responsive to interests of member states. As a result, the policies developed in GPA expert consultations often encountered substantial friction from national and local actors responsible for their implementation who felt policies did not reflect local interests, needs, or capacity. Additionally, for a policy issue in which consensus was not easily established given available research, as in the case of internal GPA recommendations for preventing HIV among bisexual men, GPA experts were hesitant to make definitive policy recommendations:

Overall, available evidence derives from somewhat disparate and isolated studies which have not arisen from any unified set of concerns or research agenda. It is therefore difficult to build up any authoritative picture of bisexual behavior and inferences about its role in HIV transmission must at present be tentative.  

(Boulton and Weatherburn 1990)

Outside of the consensus meeting, GPA also faced substantial hurdles in disseminating program priorities to individual countries due to a lack of enforcement power. Although GPA had a clear mandate to establish a unified international response, this mandate was in tension with the necessity to respect state sovereignty. The primacy of national integrity and decision-
making within WHO ensured that each country remained free to "develop its own detailed programme" (GPA 1988: 3) -- or not. As such, national AIDS strategies could deviate dramatically from GPA policy recommendations and had substantial latitude to avoid socially or politically contentious groups or behaviors such as homosexuals and same-sex sex. A handful of countries, including a few African countries believed to have very high rates of HIV infection, refused to establish a national AIDS strategy all together.

This tension between GPA and member states tempered GPA demands that national AIDS programs address HIV among MSM despite GPA’s knowledge of the importance of same-sex sexual transmission to HIV epidemics in developing countries, especially the emerging Asian epidemics. In the early 1990s, GPA continued to conduct and review research on MSM, leading to an informal consultation on interventions to prevent HIV transmission among behaviorally bisexual men in 1992. At this consultation, then-GPA Director Michael Merson, who had replaced Mann in 1990, opened the meeting with an acknowledgement that while "the prevalence of homosexual behavior is extremely difficult to estimate with any accuracy...there is sufficient evidence to conclude that homosexual and bisexual behavior may be relatively common in some regions of the world" (GPA 1992: 1). Similarly, the 8 researchers and 6 GPA program managers in attendance acknowledged that "Where surveys of sexual practices in the general population have been conducted, recruitment strategies usually exclude sub-populations having a greater likelihood of being involved in homosexual contacts...[T]he contribution of bisexual behavior to HIV transmission is certain to be greater than the existing data indicate" (GPA 1992: 3). Recommendations developed by the consultation were careful not to pathologize MSM or treat them as purely a vector of transmission and demonstrated a nuanced understanding of the social contexts in which MSM live. The consultation concluded with a confirmation of
inadequacy of current interventions for MSM and "the need to encourage policy-makers and programme planners to consider the role of bisexual behaviour in the transmission of HIV" (GPA 1992:10).

Yet, GPA continued to avoid the issue of MSM at the global and country levels, adopting instead the narrative of a heterosexually transmitted epidemic in developing countries in order to be "culturally sensitive" and ensure government commitment to other programs. Ceding autonomy in order to promote implementation and maintain organizational legitimacy, GPA did not take a strong policy stance on the global need for HIV prevention or human rights protections among MSM despite knowledge of their exclusion from national AIDS programs, surveillance infrastructure, and expected high rates of infection (see for example GPA 1994: 9ff).

The internal bureaucratic structure of WHO served to further limit the power of GPA to pursue its own policy interests. As a program within WHO, GPA had to contend with direction from the World Health Assembly, the body of member states that approve and review the policies of the WHO, as well as from the Regional Directors and the Director-General. Internal conflict with the policy interests of the Regional Directors and then-Director-General, Hiroshi Nakajima, repeatedly thwarted GPA progress on a number of issues. Within WHO, country offices remain under the oversight of Regional Directors who are elected by the Ministries of Health in that region. For example, PAHO, the Pan American Health Organization, serves as the Regional Office for the Americas of the World Health Organization. The PAHO Director is elected by the Ministers of Health of the region, of Latin America and North America, and the Caribbean. This internal bureaucratic structure created substantial barriers to establishing a truly global program on AIDS by promoting a regional basis for coordinating the response, thereby reifying the various geographic, cultural, and economic divisions between epidemics.
Additionally, individual Regional Directors can and did undermine the implementation of WHO and GPA initiatives coming from Geneva that were seen as unnecessary or politically undesirable (Godlee 1994). In particular, GPA’s first Director, Dr. Jonathan Mann, frequently butted heads with Dr. Gottlieb Lobe Monekosso who served as the Director for WHO’s African Regional Office from 1985 to 1995. Throughout the late 1980s, Monekosso challenged the priorities set by GPA, especially around the need prioritize AIDS over other public health issues such as maternal and infant mortality, malaria, and basic health care (Third World unable to join war on AIDS 1987).

WHO Director-General Nakajima voiced similar concerns, stating that "too much attention [is being] paid to AIDS compared to other diseases" and that GPA occupied too high a percentage of WHO time, money, and staff relative to other programs and diseases, including malaria and diarrhea (Gibbons 1990; New York Times 1990). To balance the GPA with other health initiatives, Nakajima, with the support of many African countries, promoted decentralization of GPA programs and staff to regional offices where regional and national directors would have greater control over priorities and implementation (Selby 1990). Constant internal bureaucratic struggles between GPA Director Jonathan Mann and WHO Director-General Nakajima delayed implementation of GPA projects until Mann’s resignation in 1990 (Mann and Kay 1991). Following Mann's departure, Nakajima “left the GPA virtually unstaffed and in chaos” (Orkin 1990).

Although Merson had been hired to replace Mann, donors became increasingly dissatisfied with WHO management over the early 1990s and wanted more direct control over multilateral aid mechanisms (Center for Global Development 2009). International funding for GPA declined in 1991 for the first time since the program’s inception (WHO 1992:15-16). The
US, GPA’s largest donor, moved away from multilateral support towards administration of its own bilateral aid programs. Meanwhile, both WHO and the decimated GPA had lost their leadership role in health and AIDS policy. WHO faced increasing competition from other organizations, especially the World Bank, UNDP and UNICEF, that established their own AIDS policies and programs to bypass what they saw as WHO ineffectiveness.

**Restructuring the global response at UNAIDS**

In 1994, members of the GPA Management Committee -- the United Nations Children’s Fund (UNICEF), United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA), United Nations Educational, Scientific, and Cultural Organization (UNESCO), and the World Bank -- agreed to dismantle GPA and replace it with a new organization, the Joint United Nations Programme on HIV/AIDS (UNAIDS). The formal objectives of UNAIDS were largely similar to the GPA: to provide global leadership in response to the HIV/AIDS epidemic, toward the end of achieving *global consensus on policy and programmatic approaches*. Like GPA, UNAIDS was also tasked with strengthening the capacity of national governments to develop and implement comprehensive national strategies for monitoring, care, and prevention. In addition, UNAIDS was tasked with strengthening the capacity of the United Nations system to monitor trends and ensure that appropriate as well as effective policies and strategies were implemented at the country level and advocating greater political and financial commitment in responding to the HIV/AIDS epidemic at the global and country levels.

At the outset, UNAIDS already had several structural advantages over GPA that would aid UNAIDS in implementing a global framework for HIV prevention and policy where GPA had failed. First, UNAIDS was to be situated within the UN system in order to coordinate a system-wide response. As such, UNAIDS was intended to work with rather than compete with
its cosponsors -- UNICEF, UNDP, UNESCO, UNFPA, WHO, the World Bank -- and other organizations that had developed AIDS programs.

Second, while these organizations would be able to provide input into the policies and strategies of UNAIDS, the program’s first Director, Dr. Peter Piot, and his allies within the UN system pushed for UNAIDS to be accountable to member states rather than to the cosponsoring agencies. Thus, the governing body on all programmatic issues concerning policy, strategy, finance, and evaluation of UNAIDS would be a newly formed Programme Coordinating Board (PCB) made up of delegations from member states (ECOSOC 1996). The implementation of the PCB was and remains unique to UNAIDS within the UN system. After substantial discussion concerning the makeup of the PCB, the UN Economic and Social Council decided that the PCB would be comprised of 22 country delegations: five African states, five Asian states, three Latin American and Caribbean states, two Eastern European states and seven Western European states (ECOSOC 1995). While the inclusion of member delegations on the PCB could very well impede policy development if member states were in conflict, their inclusion would also ensure that local interests, needs, and capacities were taken into consideration as policies were developed thereby increasing the likelihood of implementation.

In discussions of the composition of the PCB, Piot also pushed for the inclusion of civil society groups. Prior to his move to UNAIDS, Piot had worked for a year and a half at GPA and already become frustrated with the policymaking process there:

I got really irritated when I was in WHO when they would call in a few experts sitting in a room in Geneva, usually a room without windows like this one, and define policy for the rest of the world and try to shovel it down people's throats. And then they would be surprised that the policy didn't work. So I believed that
we need to involve the people. (NIH 2009:6)

The inclusion of civil society groups would increase the representation of people with HIV and AIDS, people whom Piot believed had much more at stake in the response to AIDS than government officials, and would promote the accountability of both the UNAIDS Secretariat and member states to citizens. Thus, in addition to 22 voting member delegations, five seats for NGOs were eventually included on the PCB. These seats were split to ensure representation from NGOs in developed as well as developing countries. However, which NGOs gained a seat was left up to the NGOs themselves. Although NGO delegations could not vote on PCB decisions, they were granted power to bring agenda items to the PCB, leaving room for UNAIDS to address NGO concerns not brought to the PCB by member states.

Directional decisions made by the PCB were implemented by the UNAIDS Secretariat in Geneva. At the outset, there was substantial opposition from some of the cosponsoring agencies to the Secretariat being more than just a coordinating body (Center for Global Development 2009). Threatening to resign if his demands were not met, Piot again pushed for the Secretariat to not just coordinate cosponsor activities but also have the power to initiate new activities. To this end, he hired an initial staff of individuals based on their dedication to AIDS and ability to organize rather than based on technical, scientific or bureaucratic expertise (NIH 2009: 8, 12). The need for a strong UNAIDS Secretariat was supported by some member states, including the delegate from Brazil, who noted in his support for the establishment of the PCB that "while the [UNAIDS] Programme could not be carried out without the full participation of the six Co-sponsoring Organizations, it should not be limited to the inter-agency coordination of activities but should serve as a catalyst for mobilizing resources to combat that terrible pandemic" (ECOSOC 1995: 17). In the end, although the Secretariat had less financial clout than any of its
cosponsors or the former GPA, it retained substantial power to direct the day-to-day activities of UNAIDS, develop and advocate new policies, and identify priority policy issues beyond those brought to the PCB by member states.

UNAIDS also developed a substantial Secretariat presence at the country level despite opposition from member states, especially the UK which advocated for no country-level structure. In 81 priority countries, a newly appointed UNAIDS Country Programme Advisor\textsuperscript{14} would direct activities. The Country Programme Advisor, representatives of the cosponsoring agencies, representatives of other non-cosponsoring UN agencies, such as the International Labour Organization (ILO) or the United Nations International Drug Control Programme, and representatives of the national government would meet to form the host country's United Nations Theme Group on HIV/AIDS. Theme Groups were to facilitate the coordination of in-country activities, sharing of information, and distribution of funding to major government and nongovernment activities. As of mid-April 1996, 90 theme groups covering 107 countries had been formally established, compared with 35 at the end of 1995. As I discuss below, these in-country Theme Groups were later strategically mobilized in order to align national and donor policies with the position of UNAIDS.

Like GPA, UNAIDS has, since its inception, sought to include gay men and MSM into global and national AIDS policies despite opposition from member states. In the program's first operations report in 1995, the program explicitly identified same-sex sexual transmission of HIV as a "major route of HIV spread" globally and insisted that "gay men living in a community where their sexual orientation is stigmatized" were a key driver of the global epidemic because of their lack of access to "life-saving information about safer sex" (UN 1995). This focus was

\textsuperscript{14}This position was later renamed the Country Coordinator.
retained as the program was scaled up. In 1997, UNAIDS developed and disseminated the first technical guidelines for HIV surveillance and prevention among MSM (UNAIDS 2000 [1997]) and repeatedly encouraged "donor and cosponsoring agencies...to include outreach to men who have sex with men when designing and funding national AIDS programmes" (UNAIDS 1999:40ff). Given the "inadequate or unreliable epidemiological information on HIV transmission through male-male sex...[and] lack of interest among donor agencies in supporting and sustaining prevention programs among men who engage in same-same sex behavior," the UNAIDS Secretariat stressed the need to "strengthen groups representing self-identified gay men, enabling them to promote HIV prevention and care programmes" throughout the world, and to review "with the aim of abolishing laws that criminalize certain sexual acts between consenting adults in private" (UNAIDS 2000 [1997]:2ff). These guidelines were updated by the Secretariat in 2000 and the importance of expanding efforts to address the needs of MSM was included in the 2001 Global Strategy Framework on HIV/AIDS produced by UNAIDS (2001) and in the United Nations System Strategic Plan adopted in the same year (UN 2001c).

However, also like GPA, UNAIDS conducted its work in an inherent state of tension. On the one hand, UNAIDS was tasked with promoting and achieving global consensus on policy and programmatic approaches, while on the other hand the organization was to respect the decisions of national policymakers. Like most other UN bodies with the exception of the Security Council, UNAIDS had limited power to locally enforce the policies it adopted. Thus, like GPA, the official position of UNAIDS was that "there can be no universally valid blueprint for tackling HIV/AIDS" (emphasis added). Rather, national AIDS programs continued to be responsible for identifying the mode(s) of HIV transmission most relevant in the area(s) in which they conduct treatment and prevention activities and would "need to select...a 'package' of
strategies, interventions and activities that is *best suited to its local context*, and then tailor the approaches to the needs of individuals and communities" (emphasis added, UN 1995:para 46). As such, UNAIDS policy recommendations, especially those concerning MSM, were frequently dismissed or ignored by national policymakers.

Within the broader forum of the United Nations, dissenting states continued to wield substantial power over the content of global AIDS policy, as demonstrated by the outcome of the 2001 United Nations General Assembly Special Session on HIV/AIDS (UNGASS). Following several calls from member states as well as UNAIDS and its cosponsoring agencies for greater political attention and financial contributions to fight HIV and AIDS from all states, the UN General Assembly decided to convene the first ever Special Session on HIV/AIDS, conduct a review of global progress on AIDS, and establish a global agenda, the *Declaration of Commitment on HIV/AIDS*, that would be adopted by all states. After "20 years of embarrassing international under-response to this pandemic" (opening remarks by the American representative, (UN 2000), UNGASS was widely seen as a watershed moment in galvanizing political support for HIV prevention and treatment and establishing a global agenda. Among the key concerns raised at the Special Session and highlighted in the *Declaration* were the gross inequalities limiting access to treatment in the global South, the need to mainstream HIV concerns into development, poverty, and security sectors, the mobilization of new funding resources,¹⁵ and the continued need for prevention activities to ensure the health and human rights of vulnerable groups.

But countries disagreed on who these vulnerable groups were and what should be done to protect them. While country delegations unanimously supported the adoption of women and

¹⁵ In particular, the creation of the Global Fund to Fight HIV/AIDS, TB, and Malaria was announced at this meeting.
children as vulnerable groups in the Declaration, other more stigmatized practices, such as same-sex sex, sex work, and injection drug use faced substantial opposition to explicit inclusion in the final version of the document. To the disappointment of several member states and various NGOs observing the meeting, the final draft of the Declaration failed to specifically identify MSM as a vulnerable group. On June 25, 2001, Speaker of the UN General Assembly, Harry Holkeri of Finland, opened the Special Session meeting with his regrets that a consensus on MSM had not been reached and were thus excluded from the Declaration. Following Holkeri, Kofi Annan, then-Secretary General of the United Nations, also expressed his dissatisfaction with the stalemate on the inclusion of MSM in the Declaration, reiterating in his key-note speech that progress on AIDS would not be furthered by:

- making moral judgments or by refusing to face unpleasant facts, and still less by stigmatizing those who are infected and making out that it is all their fault. We can only [deal with AIDS] by speaking clearly and plainly about the ways that people become infected and about what they can do to avoid infection. And let us remember that every person who is infected -- whatever the reason -- is a fellow human being, with human rights and human needs. (UN 2001b:3)

Nonetheless, the Declaration did encourage a "comprehensive approach to prevention" that included the expansion of human rights and prevention efforts among populations "at greatest risk of and most vulnerable to new infection as indicated by such factors as...sexual practices" (UN 2001a). While this language did not specifically identify MSM, it remained open to interpretation, establishing enough latitude for other organizations such as the WHO to specifically identify the development of interventions targeting MSM as a priority in their 2002 follow-up report to the UNGASS meeting (2002).
Further, the Declaration established universal targets for scaling up prevention and reducing infections that were endorsed by all 189 member countries. Countries were, for the first time, required to report on their progress on a number of issues including surveillance infrastructure, access to prevention and HIV testing as well as progress on enacting legal protections to prohibit discrimination of people with HIV/AIDS and vulnerable groups. The Declaration also established a standardized set of indicators so that efforts to increase the quantity and quality of services could be compared across states. Additionally, an electronic Country Response Information System was designed to strengthen UN machinery for systematically and regularly monitoring the activities and outcomes of member states, including country reporting of the HIV/AIDS indicators of the Declaration of Commitment on HIV/AIDS. Through these changes, countries became more accountable than ever to UNAIDS, the UN system, and their constituents. Two years later, UNAIDS used the data from the first Country Progress Reports on the targets outlined in the 2001 Declaration to highlight the continued absence of MSM to country-level surveillance, research and prevention activities "even when evidence points to the prominence of this mode of transmission in the epidemic" (UNAIDS 2003a:5).16

From Many, One: Brokering Consensus among UN and Donor Organizations

Concurrent with adoption of the 2001 Declaration, UNAIDS began pursuing various informal and formal initiatives to consolidate agenda-setting power and reduce friction from member states. Building on interests within the UN system to "broker consensus on best practice and to develop common approaches to problem solving" (UN 2001c), the Secretariat produced 45 best

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16 See also the Follow-up to the 2001 United Nations General Assembly Special Session on HIV/AIDS (UNAIDS 2003b: 47, 50)
practice guidelines between 2001 and 2003 identifying core strategic and programmatic areas for intervention, consolidating information on "the practices around the world that work in responding to AIDS," and specifying the roles of different actors in providing access to care, treatment and support; human rights, including stigma and discrimination; HIV/AIDS in the workplace; prevention; strategic planning; private sector/business response; people living with HIV/AIDS; voluntary counseling and testing; vulnerable groups and young people. By 2005, the total number of best practice guidelines had more than tripled to 156. This dramatic policy expansion was explicitly conducted to solidify the reputation of UNAIDS among other organizations and donors as the global resource for information on how to respond to the epidemic.\(^\text{17}\)

Additionally, UNAIDS pursued formal multiparty agreements to coordinate HIV/AIDS strategies and activities across the UN system, international and national organizations, and donors. These initiatives began with the development of the *Global Framework* (UNAIDS 2001) and the *United Nations System Strategic Plan* (UN 2001c), and evolved into a series of bilateral coordination agreements between UNAIDS and donors\(^\text{18}\) and the Three Ones agreement initiated between UNAIDS, other UN agencies, the US, the UK and other key donors in April 2004. Taken together, these formal coordination initiatives were a testament to the success of UNAIDS in galvanizing donor support for AIDS in its first five years of operation (see Figure 1). With the mobilization of the UN system and development partners, especially United States Agency for International Development (USAID) and the United Kingdom's Department for International Development (DfID), and the advent of the Global Fund for HIV/AIDS, TB and Malaria (2002)

\(^{17}\) For an extended discussion of progress towards this aim, see the mid-term review of the *UN System Strategic Plan* (UNAIDS 2003c: 3-4).

\(^{18}\) See for example MOU between UNAIDS and the Global Fund (UNAIDS 2004b).
and the US President’s Emergency Plan for AIDS Relief (PEPFAR) (2003), and various other private foundations, such as the Bill and Melinda Gates Foundation, developing countries were flooded with volunteers, personnel, missions, offices, and programs to provide AIDS prevention, care, and treatment. However, these activities were largely uncoordinated with UNAIDS and with each other, resulting in the fragmentation of priorities, the duplication of service provision in some areas and the wholesale neglect of other areas. In addition to the massive influx of organizations and aid activities, donors each had their own monitoring and evaluation requirements. “In the end,” explains Piot, “people who were in charge of AIDS programs or ministers of health, they started complaining. They said, ‘Look, we have no time to do our job. People are here, generally polite, our foreigners are well-received and treated and so on, but that leaves little time to do the program work’” (NIH 2010:24). To increase coordination and decrease the burden on local officials, the 2004 Three Ones agreement stipulated that all donors would support one strategy for a country that rather than each having its own strategy; one
coordinating body to set up target goals; and one country-level monitoring and evaluating system.\textsuperscript{19}

However, formal agreements among UN organizations and donors to coordinate activities were not merely driven by logistical concerns. In effect, these agreements consolidated power within the UN -- and UNAIDS in particular -- by establishing a unified agenda that would be followed by UN and non-UN organizations alike and a global network of organizations could be mobilized to put concentrated \textit{top-down pressure} on individual countries to address UNAIDS priority issues. As summarized in the \textit{United Nations System Strategic Plan}, "Improved partnership and coordination within the UN system is not an end in itself. Rather, it is an essential means to \textit{focus independently managed efforts along shared strategic lines}" (emphasis added, UN 2001c:9). A coordinated and concentrated effort was sorely needed to address issues that governments were reluctant to address on their own, such as the health and human rights of women and vulnerable populations.

Thus in the early 2000s, alongside the mobilization of the UN system, development partners, and donors to integrate HIV among women and girls into all activities (USAID 2004; WHO 2002; UNIFEM 2006), another multisectoral effort was strategically implemented across the UN system to address HIV among vulnerable populations, which included MSM, injection drug users, sex workers, migrants, refugees, and women and children affected by trafficking and violence. As part of this effort various UN organizations collaborated to strengthen capacity to monitor the epidemic among vulnerable populations, develop and disseminate "strategic information" on HIV among vulnerable populations, advocate for the legal protection of

\textsuperscript{19} This was later adopted as the "Four Ones" throughout the UN system, specifying that all in-country programs act as "one programme with one leader, one budget and, where appropriate, one office." In the 2007, the "Four Ones" was repackaged as the "Delivering as One" system-wide initiative.
vulnerable populations to government officials and human rights organizations, and mobilize financial resources for supporting emerging local programs addressing HIV and human rights among vulnerable populations. ILO and UNDP developed policy guidelines for nondiscrimination against MSM in the workplace (ILO 2002: 6) and in governance (UNDP 2001), respectively. New legal and policy guidelines were developed on the human rights and prevention of HIV among injection drug users and prisoners in conjunction with WHO and the UN Office on Drugs and Crime (WHO 2004c; WHO 2004d; WHO/UNAIDS/UNODC 2004c; WHO/UNODC/UNAIDS 2004b). The formal role of UNAIDS in expanding these multipartner initiatives at the country level was to "recruit partners—especially key donors—to champion efforts in 'showcase' countries," promote the inclusion of "civil society including service providers, the private sector, communities and vulnerable groups," and "build consensus on methods of operationalization, in particular with critical multilateral partners including the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank and other Cosponsors" (UNAIDS 2004a:2ff).

Despite these efforts, the mid-term review of the UN system-wide effort to address vulnerable populations still found that very little had been done within the UN or at the country level to address the HIV-related needs of MSM, sex workers, prisoners and institutionalized people (UNAIDS 2003c: 12). Because "advocacy and programming on behalf of these population groups are often politically sensitive," additional strategies would be needed to address HIV among these groups. Below I introduce three strategies – evidence-based advocacy, organizational inreach, and bidirectional pressure -- used by UNAIDS and its partners to promote the prioritization of MSM at the global level, among their own staff, and on the ground.
Evidence-Based Advocacy

UNAIDS and partners moved to supplement their human rights and legal advocacy for groups like MSM with evidence-based advocacy. Using scientific research and epidemiological data to advocate for the protection of MSM was seen as a way to legitimize and depoliticize their inclusion in national AIDS programs and circumvent strong cultural and religious objections to the recognition of same-sex sexualities. David Wilson, the World Bank’s Lead HIV Specialist,\(^{20}\) summarized the rationale for adopting an evidence-based advocacy approach:

> [F]or years, we used epidemiology as battering rams and grappling hooks to scale the ramparts of denial towards injecting drug users and sex workers, globally. But we haven’t yet done that for men who have sex with men, and we need to... We need concerted campaigns, using surveillance, research and analysis, to convince major funders that MSM are the missing pillar of the global AIDS response.... the World Bank is committed to working with partners to undertake the policy analysis, to show ourselves and others how we’ve missed this major challenge.

(Wilson 2008)

There was just one problem.

Despite multiple reports by UNAIDS calling for epidemiological and social science research on vulnerable populations like MSM, there continued to be a lack of information on these groups in most national contexts, and in some cases, for entire regions. Moreover, funding to conduct research on MSM remained scarce. A 2005 stakeholder consultation on MSM conducted at UNAIDS in late 2005 concluded that:

\(^{20}\) Wilson was appointed the Director of the World Bank's Global AIDS Program in 2010.
Across all regions, a core problem was identified as hampering the development of HIV prevention, treatment and care with men who have sex with men. Put quite simply, there is lack of funding because there is a lack of evidence; and there is a lack of evidence because there is a lack of funding. (UNAIDS 2005:11)

And finally, the isolation of researchers working with MSM in different countries and regions precluded the mobilization of a global evidence base.

A multifaceted effort was employed to promote the strategic collection and dissemination of data on MSM. Drawing on the expertise of the World Health Organization and social science researchers, new guidelines for epidemiological and behavioral surveillance were revised to better capture transmission among MSM (UNIADS/WHO 2000; WHO 2004). UNAIDS and its various partners also disseminated aggressive policy briefs (UNAIDS 2006), established prevention guidelines on MSM for all countries (Parker et al. 2002; UNAIDS 2005; WHO/UNDP 2009), commissioned research estimating HIV infection and examining the legal obstacles to accessing prevention for MSM in various contexts (Cáceres et al. 2008; Caceres et al. 2008; Anyamele et al. 2005), and funded local and regional dissemination of reports on MSM (MAP 2005).

To facilitate the formalization of international and interregional research networks, UNAIDS sponsored the first-ever two-day satellite conference concerning HIV among MSM at the 2008 International AIDS Conference. This satellite conference, entitled “The Invisible Men: Gay Men and other MSM in the Global HIV/AIDS Epidemic,” presented an overview of MSM in the global context highlighting the neglect of MSM in global, regional, and local HIV planning, prevention, and treatment and strategies used to engage MSM in the host country, Mexico, as well as in the Caribbean, Central and South America, Eastern Europe,
Asia and Africa. In addition to promoting linkages among researchers at the International AIDS Conference, UNAIDS organized and sponsored various regional conferences on HIV among MSM in Southeast Asia, Eastern Europe, and sub-Saharan Africa. From these conferences, new regional and global epistemic communities concerned with the health and human rights have formed, such as the Asia Pacific Coalition on Male Sexual Health (APCOM), a regional coalition of MSM and HIV community-based organisations, government officials, donors, technical experts and UN representatives, and the Global Forum on MSM and HIV (MSMGF), a transnational advocacy organization that acts as a clearing house for research on the health and human rights of HIV and fosters links among civil society groups, researchers, advocates, and policymakers. UNAIDS has also continued to pursue institutional partnerships, including a formal collaboration with MSMGF (UNAIDS 2011).

As part of this evidence-based advocacy approach, UNAIDS also mobilized donors to promote new funding streams for research on MSM at the local, national, and regional levels. While private foundations like the Ford Foundation and the Bill and Melinda Gates Foundation, and other development organizations such as Family Health International and Population Services International had used their general mandates to improve health and prevent HIV to make several individual awards to local and national NGOs working with MSM, the first organization to establish a programmatic response to HIV among MSM was the American Foundation for AIDS Research (amfAR), a private foundation that had been conducting research on HIV since 1985. Following mobilization of research among MSM in Asia in 2005 and 2006, amfAR established *The MSM Initiative* in 2007, a program that aimed to support grassroots HIV

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21 In particular, the organization fosters web-based networking among researchers and advocates as well as "'twinning' partnerships between MSM and HIV organisations or regional networks across the globe with complementary capacities, expertise, and skill sets" (MSMGF 2009: 13)
prevention, care, and advocacy for men who have sex with men (MSM) around the world. In addition to support from UNAIDS and development partners, amfAR enlisted private partners to fund *The MSM Initiative*, including the Open Society Institute, GlaxoSmithKline, and several other private foundations to launch the initiative in 2007. Between 2007 and 2011, *The MSM Initiative* provided more than $2.5 million in small grants for research, prevention, and advocacy work with MSM in low- and middle-income countries (amfAR 2011). Complementing *The MSM Initiative*, between 2002 and 2010 the Global Fund committed an additional $349 million, or about 10% of total funding for HIV prevention, to addressing HIV prevention in most-at-risk populations, including MSM, sex workers, and injection drug users (Avdeeva et al. 2011).

Additionally, despite its conservative and ideologically-driven beginnings, PEPFAR has attempted to reinvent itself as a "data-driven" funder. In the original bill authorizing PEPFAR (US Congress 2003), HIV/AIDS was framed as a public health, security, and gender issue and contained several contentious restrictions limiting the use of funds. In particular, the PEPFAR strategy asserted that "the reduction of HIV/AIDS behavioral risks shall be a priority of all prevention efforts in terms of funding, educational messages, and activities by promoting abstinence from sexual activity and substance abuse, encouraging monogamy and faithfulness, promoting the effective use of condoms, and eradicating prostitution, the sex trade, rape, sexual assault and sexual exploitation of women and children" (§ 101/A/4). As part of this mandate, countries and organizations receiving PEPFAR funds were required to spend more than 50% of program funds on abstinence-based education, allowed to opt-out of providing comprehensive information and prevention in the case of religious or moral objection, and were barred from conducting HIV prevention with sex workers or using funds to support needle-exchange programs. In 2008, however, the PEPFAR bill (US Congress 2008) was redrafted to include
MSM as a specific target population on grounds that evidence on HIV among MSM in some PEPFAR countries showed disproportionate rates of infection and were likely high elsewhere. Under this second PEPFAR bill, the US Congress explicitly authorized the use of funds to "(i) gather epidemiological and social science data on HIV; and (ii) evaluate the effectiveness of prevention efforts among men who have sex with men, with due consideration to stigma and risks associated with disclosure" (§ 301/C/3/F) and support partner countries by providing "assistance for appropriate HIV/AIDS education programs and training targeted to prevent the transmission of HIV among men who have sex with men" (§ 301/C/1/K). Three years later, PEPFAR administrators developed technical guidance to inform countries about the epidemiology of HIV among MSM and the types of prevention programs that PEPFAR funding would support for MSM (PEPFAR 2011). Through these changes in legislation and the dissemination of technical guidance documents on MSM, PEPFAR has diverged from its previous model of earmarked allocations for ideologically-determined programs to a model that, at least the sake of appearances, espouses research data and epidemiological trends.

Organizational Inreach

In addition to drawing global and national attention to HIV among MSM via evidence-based advocacy, the UNAIDS Secretariat staff at the country level needed to be strengthened and

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22 Unfortunately, PEPFAR does not report specifically on program expenditures targeting MSM, and tracking the flow of resources from U.S. agencies tends to be extremely difficult due to the number of sub-contracts to other international, national, and government organizations. Still, evaluations of PEPFAR note progress in targeting MSM through PEPFAR-funded and community-led activities in some countries, for example in China, Côte d’Ivoire, Ukraine, and Vietnam (see amfAR’s (2011) evaluation of PEPFAR). In Asia, PEPFAR also supports the Purple Sky Network, a transnational advocacy organization which works to reduce HIV among MSM by strengthening MSM community groups, improving clinical services, and engaging with governments to establish a supportive environment for HIV prevention.

23 amfAR and others continue to criticize PEPFAR for its neglect of MSM and a lack of transparency in where funds go once they get in-country (amfAR 2011; Grosso et al. 2012)
educated on how to monitor and include MSM. The PCB summarized the problem in a 2003 meeting: "The greatest challenge is at the country level to transform the UNAIDS response from loosely organized coordination through the UN Theme Groups on HIV/AIDS, to genuine joint and cosponsored UN programmes on AIDS." Despite the Three Ones agreement which aimed to align donor priorities and the establishment of the Theme Groups which promoted interaction among IGOs, donors, and governments, country level programs were perceived by Geneva-based staff as fragmented and handicapped by their lack of knowledge on how to incorporate MSM at the country level. Thus, substantial inreach efforts were conducted specifically to teach UNAIDS Country Coordinators that the inclusion of MSM and vulnerable groups was important to national AIDS programs. Country Coordinators also had to be taught how to facilitate mobilization and partnerships with MSM and vulnerable groups. As decided by the PCB, "the UNAIDS Secretariat is increasing both the number of UN Country Coordinators and the capacity of its country offices in three areas: monitoring and evaluation, social mobilization and partnerships, and resource mobilization." Changes were made to the initial hiring, training, and rotation of Secretariat staff, including the "introduction of competency-based recruitment and training beginning with the new UNAIDS Country Coordinators and country-based monitoring and evaluation posts." While these changes were in line with broader reform processes taking place within UNAIDS and the UN system, they were also motivated by a particular interest in ensuring the inclusion of MSM and other vulnerable groups in national policy programs and planning.

In 2009, in the UNAIDS Action Framework developed for MSM and transgender people identified the continued need for inreach and capacity building within all UN and donor agencies to ensure program staff could and would address MSM:
Ensuring sufficient capacity in intergovernmental, governmental and nongovernmental organizations to appropriately address diverse sexuality and HIV is vital if men who have sex with men and transgender people are to get universal access to HIV-related services. This includes not only organizations responsible for developing policies and delivering programmes, but donors and other stakeholders…To ensure that UN staff members have the necessary knowledge, skills and attitude to undertake and promote this work, training materials will be developed and training will be provided. (emphasis added, UNAIDS 2009b:9)

At the country and regional levels, trainings and new hiring practices were also developed to “ensure UNAIDS-supported regional knowledge hubs and technical support facilities are able to deliver timely support and strategic information on male-to-male sex, transgender people and HIV” (UNAIDS 2009b:9).

Organizational inreach was also implemented at donor organizations to increase internal prioritization on MSM. At its Sixteenth Meeting in November 2007, the Global Fund Board\(^\text{24}\) recognized the importance of addressing gender issues in the fight against AIDS, Tuberculosis, and Malaria, placing a "particular focus on the vulnerabilities of women and girls and sexual minorities" (Global Fund 2007). At that meeting, Global Fund’s Executive Director, Michel Kazatchkine stressed that the Fund "become more 'people-centered' in its model and approaches. The Fund needs to more systematically consider whether its resources are being effectively used to reach those most in need: the poor, women and girls in many regions of Africa and the most

\(^{24}\) The Board is comprised of representatives from select donor and recipient countries, NGOs, and private donors (e.g., the Bill and Melinda Gates Foundation).
vulnerable, including injection drug users and men who have sex with men" (Global Fund 2007: 28). At the same meeting, the Board authorized the Global Fund Secretariat to develop a strategy to ensure gender equitable responses to AIDS, TB and malaria, open three new staff positions including a senior-level "Champion for Gender Equality," and to provide technical guidance and encourage grant applicants to submit proposals addressing the vulnerabilities of women, girls and sexual minorities.25 Within a year, the Global Fund had also developed a parallel strategy on Sexual Orientation and Gender Identity (SOGI) and appointed new SOGI staff to increase the ability of MSM transgender people, and female, male, and transgender sex workers to access and benefit from Global Fund grants (Global Fund 2007).

The Gender Equality and SOGI strategies adopted by the Global Fund identified organizational inreach and capacity building as the primary means of improving the Fund's inclusion of women, MSM and other vulnerable populations. In particular, these groups were deemed to have limited access to the country-level decision-making bodies (the Country Coordinating Mechanism, or CCM) that develop and submit the country’s grant proposal to the Global Fund, identify the country’s principal grant recipient, and supervise implementation of funded proposals. Thus, the Gender Equality and SOGI strategies outlined concrete actions to redress this exclusion at the country-level by educating CCMs on the importance of incorporating women and MSM groups and conducting technical consultations with CCM members on how to do so effectively throughout the grant process. Importantly the Fund would also provide political, legal and mentorship support to CCM members representing the needs of MSM and other groups.

25 In contrast to almost all other agencies discussed in this chapter, the Global Fund is the only organization that incorporates MSM in their programs on gender.
But it wasn't just the CCMs that were the problem. David Winters, an out gay man who oversaw the Fund's 133 CCMs and was a former human rights program officer in sexual and reproductive health at the Ford Foundation, was among those in favor of inreach further up the line. Speaking at a 2008 satellite conference to the International AIDS Conference on HIV among MSM, Winters argued for organizational inreach at the level of proposal review as well:

There’s an increasing amount of very good data that shows the disproportionate impact of men having sex with men in this epidemic within these 'larger heterosexual epidemics.' I think that our technical review panel needs to be educated about that. But we should also look at other types of data, at other types of information that the technical review panel could review in the proposals, so I wouldn’t just limit ourselves to epidemiological data, but looking at human rights-based data, other sociological data that will convince the TRP that these programs are, in fact, necessary and important. (Winters 2008)

In the final strategy, inreach and capacity building were also undertaken at the funding approval level. As outlined in the Gender Equality and SOGI strategies, the Fund's own Technical Review Panel that evaluated proposals needed to be educated on the needs of women and sexual minorities. Criteria for evaluating proposals from civil society organizations would be adjusted to ensure that they were not immediately rejected. Additionally, the membership of the Technical Review Panel would be reviewed and experts added to ensure its capacity to properly evaluate intervention proposals for women, MSM and other groups. Beyond the Technical Review Panel, the Global Fund Secretariat would also "recruit, retain, train and manage personnel to maximize its capacity to address barriers presented by gender inequality and SOGI issues," (Global Fund 2007: 22), establish an LGBT employee resource and support group, and review the Fund's
human resource policies to ensure their conformity with international standards on
nondiscrimination in relation to sexual orientation and gender identity. Together, these inreach
practices reflect a substantial effort to educate staff, reorient institutional culture and build
capacity for addressing MSM and other groups at the Global Fund.

In turn, the participation of MSM and other groups in CCMs increased. Compared with
Round 8 (2008), representation of MSM and other vulnerable groups in CCMs tripled for all
proposals in Round 9 (2009) following the implementation of the SOGI strategy (Global Fund
2011). The proportion of funded proposals targeting prevention, treatment, care and support
activities to MSM and fighting stigma/rights promotion activities for MSM also increased. In
Rounds 6 (2006) and 7 (2007) MSM and/or transgender people were targeted beneficiaries in
21% of funded proposals (UNDP/Global Fund/UNAIDS 2010). This increased to 40 percent in
Round 8 (2008) to 58 and 54 percent in Rounds 9 (2009) and 10 (2010) respectively (Global
Fund 2011).

**Bidirectional Pressure**

Finally, in the context of strong government reluctance to target MSM, "cultivating partnerships
with community groups or NGOs that are already effectively reaching particular population
groups" became a high priority (UNAIDS 2003c:12). Interests in the participation of NGOs in
policy planning was certainly not new to UNAIDS at this stage; the inclusion of NGOs in the
policy making process had long been a priority for Piot and others going back to the initial
debates on the composition of the PCB in 1995 and 1996. These groups, Piot felt, represented the
people whose lives were on the line and were the key to formulating innovative responses to the
epidemic. Pushback from NGOs could also promote internal alignment with initiatives made by
the Secretariat. As Piot explains:
Sometimes it was actually even helpful that [NGO activists] were accusing me of not doing enough because I could use that with my bosses, and with industry, saying to them, “Look, there's even worse than me!” I was already putting pressure on them, and I could then argue that if we didn't come to a deal, they would have to confront activist anger in a more direct fashion, and they would be more vulnerable. (NIH 2010:3)

In the end, these would also be the groups implementing policies and programs on the ground and it was crucial to have them on board.

Following the mobilization around vulnerable populations, however, the active participation of NGOs working with MSM in every region of the world acquired a new strategic advantage for UNAIDS. By supporting community groups and NGOs on the ground while continuing its advocacy work among its own staff and across UN and donor agencies, UNAIDS could put bidirectional pressure on governments to address AIDS and vulnerable groups. At the outset, much of this work was financial. UNAIDS used its networks with donors and other international organizations to mobilize resources for amplifying the voice of civil society and building organizational capacity. For example, between 2002 and 2004, the Organization of Petroleum Exporting Countries (OPEC) Fund for International Development, with support from the Global Fund Secretariat, made grants totaling approximately US$ 14 million to support the prevention activities of NGOs and UNAIDS Cosponsors. The Global Fund also provided US$ 4 million to support a joint OPEC Fund/UNAIDS Global Initiative on HIV/AIDS to strengthen civil society leadership in AIDS through trainings and technical support in the Middle East, North Africa, Asia and Latin American Countries.

At the Global Fund, revisions of the eligibility requirements were undertaken to increase
access to Global Fund grants for civil society groups that had been excluded from the CCMs. As Winters explained:

> [O]n the one hand, the Global Fund very much says, ’The country coordinating mechanism is the form in which proposals are developed. It’s the form in which multi-stakeholder partners come together and influence that proposal development.’ But, it’s a catch-22 for MSM community groups, or communities, when they can’t get access to the CCM. We realize that there’s this tension and we need to address that. (Winters 2008)

In addition to the evidence-based advocacy and organizational inreach work described above, in 2010 the Global Fund established a separate stream of funding for single country and multicountry proposals from national and regional civil society groups addressing HIV among MSM, transgender people, sex workers, and injection drug users. Within this separate funding stream, 95% of proposals focused on addressing the prevention needs of MSM, transgender people and sex workers as compared with 55% of funded proposals in the general funding category (Gurkin, Graham, and Seale 2011).\(^{26}\) The creation of this separate funding stream for vulnerable groups may have indirectly promoted in the prioritization of interventions focused on those that are more at risk of being infected in the general funding pool (Global Fund 2010b). According to the report of the Technical Review Panel on Round 10 funding recommendations, proposals submitted to the general funding category in Round 10 also had a strong focus on MSM, transgender people, and sex workers, suggesting that Round 10 applicants were made more aware by the Board’s emphasis on vulnerable populations and that the Secretariat

\(^{26}\) Notably, however, funded proposals in the reserve funding stream were 50% less likely to provide for treatment or care activities.
information notes and other funds of support offered to Round 10 applicants had been useful.\textsuperscript{27}

In addition to mobilizing resources, UNAIDS also directly advocated community, human rights and HIV groups to address MSM and provided technical support to improve the funding stability of grassroots organizations. From Cambodia and Lebanon to Lesotho and Ukraine, UNAIDS established partnerships with HIV organizations and community leaders and encouraged their “informed advocacy and direct provision of HIV and health services for men who have sex with men and transgender people” (UNAIDS 2010b). As new funding resources became available, especially through the Global Fund, UNAIDS provided technical support to MSM groups and facilitated the formation of multicountry and regional MSM groups that would be eligible for Global Fund grants.

**AIDS IGOs as Interested, Strategic Actors**

The two AIDS IGOs examined in this chapter, the WHO Global Programme on AIDS and its successor UNAIDS, conduct their work in an inherent state of tension with member states, other organizations, and even their own staff who are dispersed across various regional and national offices. This chapter extends research on the autonomy and influence of IGOs by looking at how concerns about implementation shape the strategies IGOs adopt to pursue policy priorities. Across GPA and UNAIDS, different organizational structures present different constraints on these organizations' abilities to pursue and implement independently determined policy priorities. Using the case of HIV among MSM, I show how IGOs actively navigate these constraints by

\textsuperscript{27} A further comparison of trends across Rounds 8, 9, and 10 conducted by Gurkin, Graham and Seale (2011) conflicts with this conclusion of the Technical Review Panel, revealing that the proportion of proposals in the general funding pool addressing MSM and other vulnerable groups actually decreases slightly between Rounds 9 and 10. However, the authors suggest this may be due to fluctuations in the cohort of applicant countries.
adopting various strategies to increase their influence over states, other organizations and donors, and their own staff.

Puzzlingly, both UNAIDS and other organizations have, at certain times, opted to decrease their autonomy in ways that are not easily understood by theories of IGOs as bureaucracies (Barnett and Finnemore 2004), which generally seek to expand rather than contract their organizational goals and mandates, or theories of IGOs as the agents of states (Hawkins et al. 2006), where states have the power to delegate or constrain the autonomy of IGOs. I argue that these decisions are more easily understood if concerns about implementation are incorporated into the policymaking process and not treated as separate, secondary problems for IGOs once policies have already been decided. For organizations with no formal or financial power to enforce policy decisions, such as UNAIDS, tradeoffs between implementation and autonomous decision-making were highly salient at the outset. In contrast to GPA, which adopted a highly-autonomous decision-making structure and which had the ability to impose aid conditionalities, UNAIDS opted for increased accountability to states in order to ensure that policy decisions that were made were more likely to be implemented. Additionally, as more donors and international organizations committed resources to AIDS, global policy and programming priorities were increasingly fragmented and states had greater space to avoid contentious or undesirable programs and policies without substantial financial costs. Without any formal or financial authority to enforce policy and program recommendations in national contexts where governments were reluctant to address AIDS or vulnerable groups, UNAIDS undertook several strategic efforts to consolidate agenda-setting power and coordinate the program activities and policies across UN and donor agencies. This coordination of policies and
programs among international organizations facilitated an aggressive top-down response to countries’ lack of attention to HIV among MSM.

In order to get countries to prioritize MSM and other vulnerable groups, UNAIDS and its partners also mobilized a substantial effort to increase and improve research on MSM around the world. Increasing and improving scientific knowledge on MSM was crucial to organization’s ability to conduct evidence-based advocacy alongside its already strong human rights advocacy work. Next, organizational inreach was conducted within UN and donor agencies to educate staff about MSM and transform institutional culture at the organization's headquarters and at the country-level to ensure that policies targeting MSM were consistently implemented across regional and national field offices. Finally, UNAIDS directly supported in-country and regional grassroots HIV and LGBT organizations working with MSM. By directly supporting grassroots initiatives while also coordinating a unified agenda at the international level, UNAIDS used its resources to put bidirectional pressure on governments to adopt HIV among MSM as a prevention priority. In the next chapter, I empirically examine how effective these strategies have been in promoting the alignment of national AIDS policies with UNAIDS policy on HIV among MSM.
Chapter 2. The Diffusion of Men Who Have Sex with Men to National AIDS Programs

In the previous chapter, I have shown how UNAIDS engaged in strategic efforts increase its influence over member states and promote the prioritization of MSM in national AIDS policies and programs. The use of interorganizational coordination, evidence-based advocacy and support of local MSM groups was integral to these efforts. Drawing on a novel dataset compiled from five waves of United Nations Country Progress Reports on HIV/AIDS (2003, 2006, 2008, 2010, and 2012), this chapter presents a quantitative analysis examining how effective IGOs have been in changing national AIDS policies and practices towards MSM in low- and middle-income countries. Given findings from the previous chapter, I focus on the effects of a country’s participation in IGOs, links to transnational advocacy networks, and research production on MSM on states' prioritization of MSM by national AIDS programs. I test these effects against those suggested by other prominent theories of cross-country policy diffusion, namely coercion of economically dependent states through aid conditionalities and regional patterns of policy transfer through learning. To assess the extent to which policy adoption is structured by variation in national contexts, I also include variables to control for political and cultural barriers to policy adoption within countries, such as the government’s respect for political and civil rights, the legal status of same-sex sexualities, and population demographics which have been shown to affect public support of homosexuality in high- and middle-income countries (Loftus 2001; Gerhards 2010).

Results suggest that UNAIDS and its cosponsors have been very effective in increasing attention to HIV among MSM by national AIDS programs. At the start of the monitoring period
in June 2001, a majority of low- and middle-income countries that submitted progress reports had not initiated HIV surveillance or prevention programs targeting MSM. By 2012, 46% of these countries had planned or initiated surveillance and/or pilot prevention programs for MSM. The proportion of countries expanding HIV surveillance and prevention programs targeting MSM also increased each year. At the same time, however, countries have been slow to move out of the initial data gathering and pilot stage and expand prevention programs for MSM.

Consistent with findings from the previous chapter, government participation in IGOs, links to transnational advocacy networks, and research on HIV among MSM within the region significantly predicted increased prioritization of MSM while explicit coercion by donor countries through aid flows did not predict increased prioritization of MSM. Criminalization of same-sex sex and other demographic composition factors also present obstacles to prioritization of MSM by national AIDS programs.

**HIV/AIDS UNGASS Country Progress Reports**

To assess a country’s level of prioritization of MSM in national AIDS programs, I use data culled from five waves of HIV/AIDS UNGASS Country Progress Reports. As discussed in the previous chapter, in 2001 the UN General Assembly convened a Special Session on HIV/AIDS (UNGASS). At this special session, 189 UN member countries recognized and agreed to meet specific goals for the provision of HIV prevention and universal access to treatment set forth in the *Declaration of Commitment on HIV/AIDS* (UN 2001a). The 2001 Declaration was significant in that it replaced vague commitments with specific goals and timetables for reducing

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28 Reports are publicly available for 2008 an onwards at data.unaids.org. I previously obtained all reports from 2003 and 2006 which are no longer publicly available on the UNAIDS website.

29 These goals were subsequently reaffirmed and updated in the 2006 Political Declaration on HIV/AIDS and the 2011 Political Declaration on HIV/AIDS, both adopted by the UN General Assembly.
HIV transmission and increasing access to care and prevention that would apply to all countries, for example “to reduce by 2005 HIV prevalence among young men and women aged 15 to 24 in the most affected countries by 25 per cent and by 25 per cent globally by 2010” and to “enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups” by 2003.

At the same time, UN member countries also agreed to prepare a follow-up report documenting the country’s progress towards these goals two and five years later, in 2003 and 2006 respectively. Continued biennial follow-up reports were agreed to at the second UNGASS meeting in 2006. From 2003 to 2012, 196 out of 201 recognized countries and territories submitted at least one report. The mean number of reports submitted per country was 3.6. While progress reports are required by all UN-member countries, there are no consequences identified in the 2001 Declaration for not submitting a report and five countries did not submit a report in any of the five waves. Fourteen countries and territories only submitted one report across all five waves.

Progress reports were typically drafted by a national Ministry of Health or a national AIDS coordinating body over the course of several months and draw on national and subnational

30 Four additional countries became UN member states after 2001 increasing membership to 193 countries. These include Switzerland and Timor-Leste in 2002, Montenegro in 2006, and South Sudan in 2011. Additionally, the following UN recognized territories submitted independent progress reports: Anguilla, 2008; Aruba, 2008; Cook Islands, 2003; Kosovo, 2008; Palestine, 2010 and 2012; South Sudan, 2008; Turks and Caicos, 2008; The Vatican, 2003; and Zanzibar, 2006, 2008 and 2010.
31 These include Iceland, Liechtenstein, Monaco, San Marino, and Turkmenistan.
32 Countries that only submitted one report between 2003 and 2012 include Andorra, Anguilla, Aruba, Bhutan, Cook Islands, Democratic People's Republic of Korea, Iraq, Italy, Kiribati, Kosovo, Liberia, Nauru, Turks and Caicos, and the Vatican.

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data collected through national HIV case reporting systems, behavioral surveillance studies, and/or other small-scale research studies as available. For each report, governments were requested to supply data on specific indicators requested by UNAIDS and to write a narrative report describing the status of the epidemic; the national response in areas of testing, treatment, and prevention; the legal context in which the HIV program operates; current challenges faced by the country in terms of addressing HIV; details of the monitoring and evaluation procedures; and funding allocations. In later years, reports may also include additional data and input from civil society, community stakeholders, and development partners, such as UNAIDS, the Global Fund, the WHO and smaller regional organizations. These progress reports form the basis of the Secretary-General’s report to the General Assembly as well as the annual Reports on the Global AIDS Epidemic produced by UNAIDS.

In addition to these internal uses, two prior research studies have utilized the UNGASS Country Reports to study HIV prevention activities engaging MSM. Data from 2008 UNGASS reports were used by Adam and colleagues (2009) to estimate the extent and impact of efforts to prevent HIV among MSM in low- and middle-income countries. Additionally, the narrative content of the 2010 progress reports was analyzed by Persson and colleagues (2011) to assess engagement of MSM and injection drug user (IDU) populations in local epidemics. Both Adam and Persson find that monitoring and prevention responses targeting MSM are insufficient relative to need and that the protection of human rights for same-sex sexualities lags far behind commitment. Both Adam and colleagues and Persson and colleagues only utilized reports from a single year (2008 and 2010, respectively) and limited their analyses to reports available in English, which excludes 34% of 2008 reports and 32% of 2010 reports.
While the aim of this study is not an evaluation of need versus commitment, this study extends the use of these data in two ways. First, I use all five waves of UNGASS country progress reports to construct a novel longitudinal dataset of a state’s acknowledgement and targeting of same-sex sexual transmission in HIV programming and policy (N=728). Second, all available reports have been translated and coded for inclusion in the final data set. Reports not available in English (N=196) were initially electronically translated by Google Translate document translating service (Google Translate 2011) and then coded. Subsequently, a subset of documents that were electronically translated was coded again in the original language (French, Spanish, Russian, or Portuguese) by a native speaker to ensure both the validity of the electronic translation as well as the reliability across coders. This duplicate coding exercise yielded few discrepancies between the coding of the original and electronically translated reports. In the event that the coding of the original and electronically translated reports differed, the value for the original report was maintained.

**Coding**

Report narratives were coded to reflect the adoption of MSM as an HIV prevention priority. Coding categories were developed to differentiate between countries that explicitly identify MSM as a programming priority and those that do not as well as to discern the extent to which the country has engaged MSM as a priority along two dimensions: epidemiological surveillance activities and prevention programs targeting MSM. Broadly, surveillance is used to identify changes in the nature or extent of health problems. Although surveillance data are intended to objectively reflect the pattern of HIV transmission in the population, epidemiological knowledge of HIV is strongly influenced by where, among whom and how hard governments look for disease and social and cultural assumptions about transmission (Biehl 2007; Buckley
2008). Thus, whether a country seeks to identify and measure HIV among MSM serves as an initial indicator of priority adoption. The second aspect of implementation is the provision and reach of HIV prevention programs targeting MSM.

Countries were grouped into three categories: (1) no acknowledgement of MSM as an HIV programming concern and no reported surveillance or prevention targeting MSM; (2)

Table 1. HIV/AIDS UNGASS Country Progress Report coding scheme

<table>
<thead>
<tr>
<th>Acknowledgement</th>
<th>MSM Surveillance</th>
<th>MSM Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) No Prioritization</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>2) Weak Prioritization</td>
<td>Yes</td>
<td>Yes but limited, pilot only, or planned and not yet in place</td>
</tr>
<tr>
<td>3) Strong Prioritization</td>
<td>Yes</td>
<td>Yes, active, in place beyond planning or pilot stage in multiple municipalities</td>
</tr>
</tbody>
</table>

acknowledgement of MSM as HIV programming concern, a small number of prevention programs (i.e., one or two) targeting MSM may be in planning phase or in place but only serving
a single municipality, and national surveillance activities of MSM are passive,\textsuperscript{33} limited or in planning phase; and (3) acknowledgement of MSM as HIV programming concern, an active surveillance program that regularly (i.e., at least every three years) collects prevalence data among MSM, and state-sponsored prevention programs targeting MSM are in place beyond pilot stage and available in more than one municipality or subnational unit of administration. The three categories can generally be conceived as composing an ordinal scale from 1 "No prioritization of MSM," to 2 "Weak prioritization of MSM," to 3 "Strong prioritization of MSM" (see Table 1).

The 2006 progress report by the Central African Republic represents a typical example of no prioritization in the coding scheme. The government notes that no surveillance targeting either MSM or the general population has been conducted since 1995 due to political instability. Additionally, despite the absence of such data, the report asserts that "[t]he principal mode of contamination with HIV in [the Central African Republic] is by the hetero-sexual route...The prevention programmes (sic) in the CAR did not take into account the part linked to the consumption of injecting drugs, similarly those aspects linked to male homosexuality" (Government of the Central African Republic 2005:8).\textsuperscript{34} Similarly, in Micronesia, where passive surveillance technologies are in place for the general population, the 2008 report notes that:

\textsuperscript{33} Surveillance methods can be divided into four general categories: passive, active, sentinel and special systems. In general, passive and active systems are based on conditions reportable to the health jurisdiction. The term “passive” refers to the idea that health authorities take no action while waiting for report forms to be submitted. This generally refers to the use of HIV/AIDS case reporting systems by healthcare providers or laboratories. As case reports are frequently incomplete and unlikely to be representative of the population, active, sentinel and special systems surveillance methods are also employed to directly collect additional information from "watch post" healthcare providers like antenatal clinics, blood screening labs, and hard-to-reach populations.

\textsuperscript{34} Note that a country’s political instability need not determine their response to MSM. For example, Iraq’s 2012 report similarly notes that no systematic surveillance has been conducted due to the American occupation of Iraq, but speculates that HIV among sex workers, MSM, and injection drug users" are severely underrepresented in the national HIV/AIDS statistics" and in need of attention (Republic of Iraq 2012: 12).
Most stakeholders were aware of men who had sex with other men in Kosrae [one of the four island states in Micronesia], although estimates of numbers were less than 20 and there was a generally feeling expressed by stakeholders that this practice is not acceptable to Kosraean culture and religion. No healthcare workers were aware of any of their patients being men who had sex with other men.

(Federated States of Micronesia 2008:26)

Even in countries where HIV surveillance is conducted among the general population, the importance of collecting data on same-sex sexual transmission of HIV is frequently minimized among reports in the "no prioritization" category. For example, the 2006 report from Rwanda, a country that conducts surveillance of the general population, notes that, "[h]omosexuals are not among the most-at-risk groups in Rwanda,” and speculates that, “[t]his is because this group is still small and they do not appear to have many partners. In our country it is also a hidden practice which makes it difficult to implement a strategy for them even if one were developed” (Government of Rwanda 2006: 41). 35 Country Progress Reports in this lowest category may also make no mention of MSM, same-sex sex, or homosexuality and in response to UNGASS indicator items on MSM simply report "Not Applicable" or "Not Relevant”36 if these indicators are included in the report at all.37

The 2008 report from Ecuador represents a typical weak prioritization in the coding scheme, where MSM are conceived as a priority but little to no data has been collected on HIV

35 Importantly, it is beyond the scope of this paper to determine whether and how much MSM might actually contribute to HIV transmission dynamics in a given country. Rather, my concern is with the uptake of global AIDS prevention priorities in national contexts. In the case of countries coded in the lowest adoption category, MSM are omitted or dismissed as irrelevant, signaling little to no penetration of global norms.

36 "Not Applicable" and "Not Relevant" are seen as different from "Not Available" due to a lack of data.

37 In earlier years it was more common for a country to omit an indicator that was deemed irrelevant to the national context rather than list the indicator and identify it as "Not Applicable."
prevalence among MSM and the reach of prevention programs remains limited to a single municipality. In the Government of Ecuador’s 2008 report, MSM are identified by the as disproportionately affected by HIV and notes that the National Program for Prevention and Control of HIV/AIDS/STI "está trabajando para desarrollar servicios dirigidos a HSH [is working to develop services aimed at MSM]" (Gobierno del Ecuador 2008: 11). Similarly, the Government of Barbados reports in 2012:

The current trends [in HIV surveillance] suggest a mixed epidemic--that is, a generalized HIV epidemic with probable higher HIV prevalence in key populations. There is anecdotal evidence to suggest that some of the groups most at risk groups are men who have sex with men (MSM), sex workers (SW) and prisoners. However, validation of this assumption is yet to occur through the conduct of specific research studies. The Ministry of Health has commenced a behavioural and sero-prevalence survey for MSM and a similar study is slated to begin for sex workers by 2013." (Government of Barbados 2012:15)

Countries in the weak prioritization category may have begun collecting data, as in the case of Madagascar which began collecting behavioral surveillance data on MSM in 2010 and used this data to establish new targeted prevention programs by 2012 (Repoblikan'i Madagasikara 2012:10) or may receive external support to initiate programs, as in the case of Afghanistan where the 2012 report indicates that:

While there is no reliable data on HIV prevalence among MSM in Afghanistan, information suggests there are high HIV-risk networks of MSM that are not being addressed...Afghanistan is a part of a GFATM [Global Fund] regional project Round 9 on men who have sex with men (MSM). Despite the need to adapt HIV
prevention outreach approaches to the context, this has allowed a focus on MSM programming." (Islamic Republic of Afghanistan 2012:19)

Australia's report in 2012 provides an example of strong prioritization in the coding scheme. The Australian Government conducts regular sentinel surveillance of HIV infection and annual behavioral studies among MSM populations and:

- has funded effective social marketing initiatives that have engaged both broad and specific audiences of MSM, including HIV positive men. The material is comprehensive in terms of both the diversity and volume of education material and in the range of different MSM to whom it speaks. It is also integrated with other interventions (e.g. a comprehensive range of community development and group support programs, sexual health testing and treatment, mental health and self-esteem and drug harm initiatives). (Government of Australia 2012:10).

Countries where sexual minority communities are less organized or where HIV prevalence among MSM was low relative to other groups could also be coded as strong prioritization in the context of ongoing surveillance and active prevention campaigns targeting this group. For example, the 2012 Bangladesh report notes that in a 2011 surveillance study:

[N]one of the MSM or MSW [male sex workers] tested was positive for HIV.

Among the transgendered community (hijra) the HIV prevalence was 1%

...Though there were no changes in the rates of active syphilis in MSM, MSW and hijra, large proportions of MSM and MSW, report STI symptoms (MSW more than MSM), as well as multiple sex partners (including women), group sex (often associated with violence and without condoms) and very low condom use with all
types of partners. MSMs are highly networked, so if HIV were to emerge, it could spread very rapidly in this population. (Government of Bangladesh 2012:6)

In addition to ongoing surveillance activities to monitor HIV infection among MSM, the Government of Bangladesh also supports multiple prevention programs throughout the country on its own and in collaboration with the Global Fund, UNAIDS and other UN agencies, the South Asia Regional HIV/AIDS Programme, and local civil society organizations that aim to "increase access and use of quality targeted interventions for the most vulnerable groups" such as MSM. Active behavioral surveillance of MSM in Bangladesh is conducted biennially.

In the analyses that follow, the population of reports is restricted to those submitted by low- and middle-income countries.\(^{38}\) In total, 135 (18.3\%) reports from low- and middle-income countries were coded as no prioritization of MSM, 365 (49.3\%) as weak prioritization of MSM, and 66 (8.9\%) as strong prioritization of MSM. A small number of reports submitted by low- and middle-income countries (N=5) could not be coded due to insufficient information or corrupted files.\(^{39}\) In general, countries proceeded from no prioritization to weak prioritization and from weak prioritization to strong prioritization on the coding scale. Given the relatively short period

\(^{38}\) I use the World Bank country classifications based on gross national income (GNI) per capita.

\(^{39}\) Incomplete information and corrupted files are concentrated in the first wave for low- and middle-income countries. Country-years with missing data include: Benin, 2003; Côte d'Ivoire, 2003; Honduras, 2003; Macedonia, 2003; and Turkey, 2003.
Table 2. Descriptive statistics for all country progress reports, by year

<table>
<thead>
<tr>
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</tr>
</thead>
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</tr>
<tr>
<td>N (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of pages (M, SD)</td>
<td>19.3 (13.5)</td>
<td>37.8 (21.6)</td>
<td>60.2 (39.8)</td>
<td>73.2 (54.0)</td>
<td>71.2 (55.3)</td>
<td>56.1 (47.2)</td>
</tr>
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<td>Report language</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<td>87 (58.4)</td>
<td>74 (50.3)</td>
<td>85 (57.8)</td>
<td>84 (58.7)</td>
<td>393 (53.2)</td>
</tr>
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<td>2 (1.3)</td>
<td>24 (16.3)</td>
<td>24 (16.3)</td>
<td>25 (17.5)</td>
<td>89 (12.0)</td>
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<tr>
<td>Spanish</td>
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<td>4 (2.7)</td>
<td>17 (11.6)</td>
<td>18 (12.2)</td>
<td>18 (12.6)</td>
<td>64 (8.7)</td>
</tr>
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<td>1 (0.7)</td>
<td>2 (1.4)</td>
<td>1 (0.7)</td>
<td>6 (0.8)</td>
</tr>
<tr>
<td>Russian</td>
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<td>0 (0.0)</td>
<td>5 (3.4)</td>
<td>6 (4.1)</td>
<td>6 (4.2)</td>
<td>18 (2.4)</td>
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<td></td>
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<td>Europe</td>
<td>11 (7.2)</td>
<td>11 (7.4)</td>
<td>18 (12.2)</td>
<td>18 (12.2)</td>
<td>16 (11.2)</td>
<td>74 (10.0)</td>
</tr>
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<td>14 (9.2)</td>
<td>15 (10.1)</td>
<td>14 (9.5)</td>
<td>17 (11.6)</td>
<td>18 (12.6)</td>
<td>78 (10.6)</td>
</tr>
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<td>Latin America and Caribbean</td>
<td>20 (13.1)</td>
<td>27 (18.1)</td>
<td>32 (21.8)</td>
<td>31 (21.1)</td>
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<td>Sub-Saharan Africa</td>
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<td>34 (22.8)</td>
<td>42 (28.6)</td>
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<td>44 (30.8)</td>
<td>194 (26.3)</td>
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<tr>
<td>Middle East and North Africa</td>
<td>6 (3.9)</td>
<td>4 (2.7)</td>
<td>9 (6.1)</td>
<td>15 (10.2)</td>
<td>16 (11.2)</td>
<td>50 (6.8)</td>
</tr>
<tr>
<td>Oceania</td>
<td>3 (2.0)</td>
<td>4 (2.7)</td>
<td>6 (4.1)</td>
<td>11 (7.5)</td>
<td>11 (7.7)</td>
<td>35 (4.7)</td>
</tr>
<tr>
<td>Prioritization</td>
<td>1) No prioritization</td>
<td>2) Weak prioritization</td>
<td>3) Strong prioritization</td>
<td>Unable to be coded</td>
<td>Subtotal</td>
<td>Did not submit report</td>
</tr>
<tr>
<td>-------------------------</td>
<td>----------------------</td>
<td>------------------------</td>
<td>--------------------------</td>
<td>-------------------</td>
<td>----------</td>
<td>-----------------------</td>
</tr>
<tr>
<td></td>
<td>44 (28.8)</td>
<td>32 (20.9)</td>
<td>4 (2.6)</td>
<td>5 (3.3)</td>
<td>85 (55.6)</td>
<td>63 (41.2)</td>
</tr>
<tr>
<td></td>
<td>38 (25.5)</td>
<td>51 (34.2)</td>
<td>6 (4.0)</td>
<td>0 (0.0)</td>
<td>95 (63.7)</td>
<td>54 (36.2)</td>
</tr>
<tr>
<td></td>
<td>26 (17.7)</td>
<td>83 (56.5)</td>
<td>12 (8.2)</td>
<td>0 (0.0)</td>
<td>121 (82.3)</td>
<td>26 (17.7)</td>
</tr>
<tr>
<td></td>
<td>18 (12.2)</td>
<td>101 (68.7)</td>
<td>16 (10.9)</td>
<td>0 (0.0)</td>
<td>135 (91.8)</td>
<td>12 (8.2)</td>
</tr>
<tr>
<td></td>
<td>8 (5.6)</td>
<td>98 (68.5)</td>
<td>28 (19.6)</td>
<td>0 (0.0)</td>
<td>134 (93.7)</td>
<td>9 (6.3)</td>
</tr>
<tr>
<td></td>
<td>135 (18.3)</td>
<td>365 (49.3)</td>
<td>66 (8.9)</td>
<td>5 (0.7)</td>
<td>570 (77.1)</td>
<td>164 (22.2)</td>
</tr>
</tbody>
</table>

*Note: Columns may not add to 100 due to rounding.*
between reports, no countries proceeded from no prioritization to strong prioritization. Occasionally, countries explicitly stated that a transition had occurred, as in the case of Tuvalu in 2012, which notes that, "[I]n the 2010 UNGASS report men to men sex (MSM) was not identified as a risk population. In 2011, anecdotal evidence suggests that MSM is becoming prevalent. At this stage there has been no specific programs (sic) targeted at this population" (Government of Tuvalu 2012:9). Due to changes in funding resources and/or social or political changes within countries over time, however, it was possible for countries to revert from strong prioritization to weak prioritization or from weak prioritization to no prioritization, though this was rare (N=5).  

Table 2 presents the distribution of prioritization of HIV among MSM across the five report years alongside descriptive statistics for region, language and report length which vary over time. From 2001 to 2012 the number of countries that did not prioritize MSM at all decreased from 29% to 6%. Both weak and strong prioritization increased dramatically from 21% to 69% and 3% to 20%, respectively. Because the composition of countries submitting reports varies each year, the percentage of countries at each level of prioritization should be read

40 Romania serves as an example of a reversal. In the 2012 report the country notes that, "[A]ccess to harm reduction programmes for groups vulnerable to HIV infection diminished, in 2011 more than half of the service providers closed their operations due to lack of funds and no future prospects for reopening the following period of time. Despite consistent advocacy efforts to MoH [Ministry of Health], no funds were allocated for prevention programmes for vulnerable groups, in the context of HIV increase among IDUs and MSMs" (Government of Romania 2012:7). This event is foreshadowed in Romania’s 2010 report, which states that, "[w]hile the HIV/AIDS treatment is one of the key success stories of Romania in HIV field (sic), the achievements recorded in prevention field are very fragile, because most of the HIV prevention programs are funded exclusively from international grants and they have limited financial support from Romanian governmental authorities" (Government of Romania 2010:9).  

41 Notably, the story of the diffusion of HIV programming and policy targeting MSM is as much a story of the diffusion of policy norms as it is of the diffusion of reporting standards. In 2003, the average report length was 19 pages (range 2 to 76 pages) wherein countries responded to largely pre-formatted questions with a narrative response. Between 2003 and 2012 the average report increased in length 275%; by 2012, the average report included an average of 71 pages (range 1 to 302) of narrative, tables, indexes and appendices.
as demonstrating a general trend toward stronger prioritization rather than absolute gains or losses over time.

Table 3 presents the probabilities of transiting from one category to another for all countries and territories that submitted at least 2 reports. As shown in Table 3, countries that changed status generally proceeded in an orderly fashion from no prioritization to weak prioritization to strong prioritization; however, transiting from weak prioritization to no prioritization did occur for three countries. Two countries also transited from strong prioritization to weak prioritization. Slightly less than half (46%) of countries that did not prioritize MSM at time $t$ evinced weak prioritization at time $t+1$, where $t+1$ represents the next report submitted rather than a unit change in year. Movement from weak to strong prioritization

<table>
<thead>
<tr>
<th>Prioritization (t)</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No prioritization</td>
<td>67 (54)</td>
<td>56 (46)</td>
<td>0 (0)</td>
<td>123 (100)</td>
</tr>
<tr>
<td>Weak prioritization</td>
<td>3 (1)</td>
<td>243 (87)</td>
<td>35 (12)</td>
<td>281 (100)</td>
</tr>
<tr>
<td>Strong prioritization</td>
<td>0 (0)</td>
<td>2 (2)</td>
<td>78 (98)</td>
<td>80 (100)</td>
</tr>
<tr>
<td>Total</td>
<td>70 (15)</td>
<td>301 (62)</td>
<td>113 (23)</td>
<td>484 (100)</td>
</tr>
</tbody>
</table>

Source: UNGASS Country Progress Reports on HIV/AIDS

Note: Countries that did not submit any report and countries that only submitted one report are excluded from the matrix.
was substantially more limited however; only 12% of countries in the weak prioritization category transited to strong prioritization.

**Primary Pathways of Diffusion**

*Participation in IGOs*

Given the results of the previous chapter, participation in IGOs is expected to be positively associated with a country experiencing an increase in the prioritization of MSM. The data used to measure participation in IGOs come from the KOF Index of Globalization for 207 countries from 1970 to 2010 (Dreher 2006; Dreher, Gaston, and Martens 2008) and reflect membership in IGOs, participation in UN Security Council missions, ratification of international treaties, and the number of embassies in the country.

*Research production on MSM and HIV*

To assess the role of research production on the prioritization of MSM, I compiled a database of peer-reviewed original research and review articles addressing HIV and MSM in nonwestern contexts published in English between 1989 and 2012 (N=237).42 Articles were included in the database based on searches of social science, public health and medical databases with configurations of the keywords, “MSM”, “men who have sex with men”, “gay”, “bisexual” and “HIV”, “AIDS” and “low- and middle-income countries”, “LMIC”, “developing”, “low income”, "third world”, “nonindustrial” or proper names for each country designated as low- or

42 This figure is consistent with Baral et al (Baral et al. 2007) who are able to locate 83 studies describing HIV prevalence among MSM in 38 low- and middle-income countries between 2000 and 2006. Since I include social science research that may not provide HIV prevalence estimates, my figure is somewhat higher.
middle-income by the World Bank. Additional articles were obtained by tracing the references and new citations of articles already included in the database as well as policy documents sourced for analyses conducted in Chapter 1. I also examined the CV’s of researchers included in the database for additional articles. All articles identified through these preliminary searches were screened to ensure that they addressed HIV among MSM in a low- and middle-income country or countries.

Figure 2 presents the cumulative distribution of peer-reviewed articles concerning MSM and HIV in nonwestern contexts, by region of study. Most notably, Figure 2 illustrates the presence research on MSM in South American and the Caribbean countries prior to 2000 with an increase in production beginning in 2002 (primarily Brazil, but also Argentina, Ecuador, Jamaica, and Peru). Additionally, there is consistent annual growth in research beginning in 2004 among MSM in Asian countries (primarily China and India, but also Indonesia, Mongolia, Malaysia, Myanmar, Nepal and Vietnam), as well as the emergence of a substantial amount of research on MSM in sub-Saharan Africa from 2008 forward (primarily Kenya, Nigeria, Senegal and South Africa, but also Botswana, Cameroon, Malawi, Namibia, Tanzania, and Uganda). From 2008 forward, there is also a substantial increase in the number of articles produced that conduct meta-analyses or provide reviews for multiple regions or low- and middle-income countries as a group. Research production on MSM in Eastern European and Central Asian countries as well as in Middle Eastern and North African countries has been initiated but remains limited. No peer-reviewed original research or review articles on MSM and HIV in Oceania could be found.

The cumulative number of articles on MSM and HIV in a given region, as a percent of the total cumulative number of articles, is used in the analysis. While a country-level measure is
possible with these data, a regional-level measure is used because countries that have yet to conduct their own research or surveillance study frequently refer in their country progress reports to research that has been conducted in nearby countries as an indication of the likely level of infection among MSM in their own country.

**Links to transnational advocacy networks**

In the previous chapter I showed how UNAIDS strategically facilitate the formalization and institutionalization of transnational advocacy groups for MSM. Transnational advocacy networks
connecting organizations and activists in the global South with their counterparts in the global North rely heavily on the internet for communication and information exchange, especially in less developed countries where postal services may be slow, unreliable or subject to government censorship (Keck and Sikkink 1998). Where access to the internet and other digital communication is limited, local organizations are at a substantial disadvantage (Keck and Sikkink 1998:98). Sexualities scholars have also commented on the importance of the internet to the international diffusion of sexual diversity/sexual identity discourses (Altman 2001) and the connection of individual MSM and small community-based organizations for gay and bisexual men both within and across countries, especially in contexts where there are legal or social barriers to public assembly. Data on internet users per 100 people are used to reflect information flows from human rights, health, and sexualities transnational advocacy networks to local NGOs and populations. These data reflect any internet access, including via cellular phone, and are available annually from the World Bank (2012).

**Official development assistance**

Theories of coercive diffusion highlight the role of explicit and implicit coercive pressures used by powerful states and international organizations to induce conformity among economically-vulnerable or otherwise dependent states. To assess the role of donors' monetary influence on low- and middle-income countries, I include net official development assistance (ODA) received from select bilateral and multilateral donors. The Organisation for Economic Cooperation and Development (OECD) collects detailed time-series data available annually on flows of ODA to
all eligible\textsuperscript{43} countries and recognized territories disaggregated by source (OECD 2012). First, I include net ODA received from the United States and the United Kingdom, the two largest bilateral donors for AIDS accounting for 72\% of total government disbursements for international AIDS assistance in 2011 (Kates et al. 2012:6). In recent years, the Obama administration and UK Prime Minister David Cameron have taken a strong stance on the provision of aid to countries that did not acknowledge or respect human rights generally and of sexual minorities in particular (BBC 2011; Clinton 2011; Obama 2011). USAID and DfID, the country’s respective development organizations, were also identified in the previous chapter as contributing to and participating in coordinated multisectoral initiatives to address HIV among MSM at the country-level. Splines at 2008 (when Obama was elected to office and PEPFAR restrictions were relaxed) and 2010 (when David Cameron was elected to office) were tested and are included in the results for both donors.

Second, I include aid for AIDS from multilateral donors, including UNAIDS and the Global Fund to Fight HIV, Tuberculosis, and Malaria\textsuperscript{44} and the World Bank. As discussed in the previous chapter, these donors have been particularly active in promoting the adoption of MSM as a national HIV prevention priority through coordinated, multisectoral initiatives. Due to the later prioritization of MSM at the Global Fund and the World Bank I test and include splines at

\textsuperscript{43} ODA eligibility is extended to all low and middle income countries based on gross national income (GNI) per capita as published by the World Bank, with the exception of G8 members, EU members, and countries with a firm date for entry into the EU. The list of ODA eligible countries is revised every three years. Countries that have exceeded the high-income threshold for three consecutive years at the time of the review are no longer eligible to receive ODA. Some ODA recipient countries also provide ODA to other countries, e.g., Turkey and Thailand (OECD 2013).

\textsuperscript{44} OECD data for the Global Fund aggregate aid commitments for all projects, including projects for Malaria and Tuberculosis prevention and control. To assess whether this overestimated the effect of Global Fund aid, I also obtained data directly from the Global Fund (2013) on all grants disaggregated by year, country, and project type (e.g., HIV/AIDS, TB, Malaria). OECD data are preferable since they are all in constant 2011 US dollars and report commitments annually while Global Fund data report total per-project commitments. Nonetheless, similar results were obtained using both measures.
<table>
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<tr>
<th>Country-level characteristics</th>
<th>All countries (N=146)</th>
<th>Aid receiving countries only (N=115)</th>
<th>Source</th>
</tr>
</thead>
<tbody>
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<td>Number of progress reports submitted (M, SD)</td>
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<td>4.5</td>
<td>UNGASS Country Progress Reports</td>
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<tr>
<td></td>
<td>(0.88)</td>
<td>(0.75)</td>
<td></td>
</tr>
<tr>
<td>Population, in 100,000s (M, SD)</td>
<td>44.9</td>
<td>49.1</td>
<td>UNGASS Country Progress Reports</td>
</tr>
<tr>
<td></td>
<td>(156)</td>
<td>(174)</td>
<td></td>
</tr>
<tr>
<td>GNI per capita, in 1000s (M, SD)</td>
<td>8.7</td>
<td>3.2</td>
<td>World Bank</td>
</tr>
<tr>
<td></td>
<td>(14.0)</td>
<td>(3.3)</td>
<td></td>
</tr>
<tr>
<td>ODA eligible country (N, %)</td>
<td>115</td>
<td>115</td>
<td>OECD</td>
</tr>
<tr>
<td></td>
<td>(75.0)</td>
<td>(100.0)</td>
<td></td>
</tr>
<tr>
<td>Adult HIV prevalence (M, SD)</td>
<td>2</td>
<td>2.5</td>
<td>World Bank; Country Progress Reports</td>
</tr>
<tr>
<td></td>
<td>(4.6)</td>
<td>(5.1)</td>
<td></td>
</tr>
<tr>
<td>Political/Civil Rights Index (M, SD)</td>
<td>9.6</td>
<td>8.7</td>
<td>Freedom House</td>
</tr>
<tr>
<td></td>
<td>(3.6)</td>
<td>(3.2)</td>
<td></td>
</tr>
<tr>
<td>Same-sex legal (N, %)</td>
<td>88</td>
<td>53</td>
<td>International Lesbian and Gay Association, 2012</td>
</tr>
<tr>
<td></td>
<td>(59.5)</td>
<td>(47.8)</td>
<td></td>
</tr>
<tr>
<td>University enrollment, % gross (M, SD)</td>
<td>29.6</td>
<td>20.5</td>
<td>UNESCO</td>
</tr>
<tr>
<td></td>
<td>(25.1)</td>
<td>(18.5)</td>
<td></td>
</tr>
<tr>
<td>Total fertility rate (M, SD)</td>
<td>2.9</td>
<td>3.3</td>
<td>World Bank</td>
</tr>
<tr>
<td></td>
<td>(1.5)</td>
<td>(1.5)</td>
<td></td>
</tr>
<tr>
<td>Percent of population living in urban areas (M, SD)</td>
<td>52.6</td>
<td>46.0</td>
<td>World Bank</td>
</tr>
<tr>
<td></td>
<td>(22.4)</td>
<td>(20.2)</td>
<td></td>
</tr>
<tr>
<td>Global Integration Indices</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participation in IGOs</td>
<td>68.9</td>
<td>64.6</td>
<td>Dreher 2006; Dreher, Gaston and Martens 2008</td>
</tr>
<tr>
<td></td>
<td>(19.0)</td>
<td>(17.9)</td>
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<td>Links to transnational advocacy networks</td>
<td>61.3</td>
<td>55.0</td>
<td>World Bank</td>
</tr>
<tr>
<td></td>
<td>(18.8)</td>
<td>(15.6)</td>
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Table 4. Descriptive statistics and data source for country-level characteristics, by year

<table>
<thead>
<tr>
<th>Country-level characteristics</th>
<th>All countries (N=146)</th>
<th>Aid receiving countries only (N=115)</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Largest religion, by proportion of population (N, %)</td>
<td></td>
<td></td>
<td>ARDA, Cross-National Socio-Economic and Religion Data, 2011; CIA World Factbook</td>
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<tr>
<td>Catholic</td>
<td>48 (32.4)</td>
<td>32 (28.8)</td>
<td></td>
</tr>
<tr>
<td>Other Christian</td>
<td>44 (29.7)</td>
<td>29 (26.1)</td>
<td></td>
</tr>
<tr>
<td>Muslim</td>
<td>40 (27.0)</td>
<td>37 (33.3)</td>
<td></td>
</tr>
<tr>
<td>Buddhist/ Hindu</td>
<td>10 (6.8)</td>
<td>10 (9.0)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>6 (4.0)</td>
<td>3 (2.7)</td>
<td></td>
</tr>
<tr>
<td>Region (N, %)</td>
<td></td>
<td></td>
<td>Recode of World Bank, Region</td>
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<tr>
<td>Europe</td>
<td>44 (30.1)</td>
<td>16 (13.9)</td>
<td></td>
</tr>
<tr>
<td>Asia</td>
<td>17 (11.6)</td>
<td>15 (13.0)</td>
<td></td>
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<tr>
<td>Americas</td>
<td>29 (19.9)</td>
<td>28 (24.4)</td>
<td></td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td>38 (26.0)</td>
<td>40 (34.8)</td>
<td></td>
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<tr>
<td>Middle East and North Africa</td>
<td>13 (8.9)</td>
<td>11 (9.6)</td>
<td></td>
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<tr>
<td>Oceania</td>
<td>5 (3.4)</td>
<td>5 (4.4)</td>
<td></td>
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</table>
Table 4. Descriptive statistics and data source for country-level characteristics, by year

<table>
<thead>
<tr>
<th>Country-level characteristics</th>
<th>All countries (N=146)</th>
<th>Aid receiving countries only (N=115)</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net official development assistance, as % government expenditure (M, SD)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>From USA</td>
<td>--</td>
<td>3.05 (6.94)</td>
<td>numerator: net ODA by source, Organisation for Economic Cooperation and Development</td>
</tr>
<tr>
<td>From UK</td>
<td>--</td>
<td>1.18 (4.43)</td>
<td>denominator: total government expenditure, International Monetary Fund</td>
</tr>
<tr>
<td>From UNAIDS</td>
<td>--</td>
<td>0.02 (0.03)</td>
<td></td>
</tr>
<tr>
<td>From Global Fund to Fight HIV/AIDS, TB and Malaria</td>
<td>--</td>
<td>0.83 (2.30)</td>
<td></td>
</tr>
<tr>
<td>World Bank, AIDS only</td>
<td>--</td>
<td>0.26 (0.89)</td>
<td></td>
</tr>
</tbody>
</table>
2008, when both agencies identified MSM as an official priority. Since UNAIDS has promoted MSM as an HIV prevention priority since before the first reporting period (2003), no splines are used to transform this term.

All net ODA values are expressed as a percentage of government expenditure, obtained from the International Monetary Fund (IMF 2013), and have been logged for all analyses below.

**Other Country-Level Covariates Predicting Prioritization**

The effects of the four primary variables identified above are evaluated against other prominent understandings of policy change and diffusion in the sociological and international relations literatures. In their review of the global diffusion literature, Dobbin, Simmons and Garrett (2007) lament that the various mechanisms of diffusion are typically evaluated separately, thereby neglecting potential for overlap and interaction. In adopting a global AIDS policy concerning MSM, the concurrent influences of multiple mechanisms of diffusion deserve attention, especially since much of the attention of sexual rights activists has been focused on low- and middle-income countries that have not only undergone substantial social, economic, and political change since the 1980s, but have also received large amounts of foreign aid for development projects and AIDS in particular. To control for this variation across countries and the potential influence of other mechanisms of diffusion, I have merged the data from the country progress reports with additional country-level time-series data from several publicly available datasets. **Table 4** presents descriptive statistics and the data source for all country-level characteristics.
across report years for all countries and for low- and middle-income countries receiving any aid. All time-series country-level data have been lagged one year\textsuperscript{45} in analyses to adjust for autocorrelation and because both donor and recipient countries are unlikely to have more recent data available at the time they compile progress reports and make funding decisions.

\textit{Country resources}

Two variables are included to control for variation in country resources to develop HIV surveillance and prevention programs prior to receiving any aid: country wealth and HIV in the general population. To measure country wealth, I use (GNI) per capita in US dollars, adjusted for fluctuation in exchange rates. If a country's wealth generally restricts that country's ability to develop surveillance and prevention activities, the effect of country wealth on prioritization of MSM is expected to be positive. Alternatively, in the presence of normative influences, a null relationship between country resources and prioritization is expected, while coercive influences would produce a significant negative relationship between country wealth and prioritization. The population prevalence of HIV infection in adults aged 15 to 49 is used to control for the likelihood that officials in low- and middle-income countries allocate scarce resources where they are expected to produce the greatest net benefit to the population. In countries with higher HIV prevalence in the general population, resources are expected to be allocated to general instead of highly targeted prevention programs, decreasing the likelihood of prioritization of MSM. Both indicators are available annually from 2001 to 2011 from the World Bank (2012).

\textsuperscript{45} Analyses were also conducted using two year lags. This had no substantive effect on the results presented below but is not preferred due to an increase in missing data at the beginning of the time series, especially for Global Fund allocations which are not available prior to 2003.
Political opportunity structure

To the extent that previous research has considered the issue of same-sex sexual transmission of HIV in global AIDS programming at all, the focus has been on explaining the historical neglect of this issue due to widespread homophobia and heterosexism which has resulted in the criminalization of same-sex sex (Epprecht 2008). Among HIV/AIDS policymakers and public health officials, the criminalization of same-sex sex is routinely pointed to as an explanation for the lack of targeted AIDS programming efforts in low- and middle-income countries. To the extent that this is true, recent changes in the legal status of same-sex sexual relationships globally may have created a political opportunity structure (Kitschelt 1986; McAdam 1999) in which it is increasingly possible to identify and target same-sex sexualities with HIV prevention programs and decreasingly legitimate to avoid, ignore, harm or detain individuals on the basis of sexual orientation or behavior. In their study of state policies on same-sex sexual relations between 1984 and 1995, Frank and McEneaney (1999) observe that 24 of 86 countries changed their laws concerning same-sex sex in this period, almost all of them towards liberalization. Notably, this trend has continued: from 1996 to 2010, 24 countries legalized same-sex sexual behavior; 46 enacted legislation prohibiting discrimination in employment based on sexual orientation; 10 ratified constitutional amendments prohibiting discrimination based on sexual orientation; 16 recognized sexual orientation as an aggravating circumstance in hate crimes legislation; and 33 recognized same-sex marriage or civil unions (ILGA 2012)

Such changes should facilitate collective action concerning the health of sexual minorities and decrease opportunities for challengers through the state’s acknowledgement and support of same-sex sexualities. Thus, countries that have a lower propensity for repression and that have legalized same-sex sex should be more likely to adopt MSM as an HIV prevention
priority. Reflecting two of the four components of McAdam’s (1999) operationalization of political opportunity structures, I include two country-level time-series variables to measure the extent to which state repression or facilitation of collective mobilization around the health of same-sex sexualities translates into the prioritization of MSM. These two variables capture: 1) the state’s respect for individual political rights and civil liberties, and 2) the legal status of same-sex sex.

Data on countries respect for individual political rights and civil liberties are collected annually by Freedom House for more than 190 countries and territories (Freedom House 2013). Political rights and civil liberties scores are based on expert surveys assessing the extent to which a country effectively provides for political rights and civil liberties, both measured on a 1 (best) to 7 (worst) scale. Ratings focus on seven areas drawn from the Universal Declaration of Human Rights, including an individual’s ability to: participate freely in the political process; vote freely in legitimate elections; have representatives that are accountable to them; exercise freedoms of expression and belief; be able to freely assemble and associate; have access to an established and equitable system of rule of law; enjoy social and economic freedoms, including equal access to economic opportunities and the right to hold private property. A combined political/civil rights index was created by adding the two variables so that the index ranges from 2 to 14, which was then reversed so that a higher value on the index indicates greater respect for political and civil rights. Unstandardized means and standard deviations are presented in Table 3. Standardized scores are used in all analyses, where a 1-point increase reflects a 1 standard deviation increase in the political/civil rights index score. This measure is used to reflect the relative openness or closure of the political system to collective action and the state’s capacity for repression.
The second measure – the legal status of MSM -- captures the state’s capacity for repression of sexual dissidents in particular. The year of decriminalization of same-sex sex was obtained from the International Gay and Lesbian Association (ILGA 2012) and a dummy variable was constructed from these data indicating whether same-sex sex was legal in a given country during a given year. Although it is theoretically important for a country implementing HIV prevention programs for sexual minorities to also decriminalize same-sex sexual behavior, it is not entirely clear whether the legal context of same-sex sexual behavior independently affects this decision. For example, a country’s response to AIDS may include prevention or harm reduction programs addressing other illegal behaviors, such as commercial sex work or injection drug use. Further, several multilateral donors, such as UNAIDS and the Global Fund have implemented programs targeting MSM, sex workers and injection drug users in countries despite legal barriers to doing so. Thus, while decriminalization of same-sex sex is expected to have a positive effect on prioritization of MSM, a negative or null effect is also possible.

**Cultural opportunity structure**

Over several works, Frank observes the erosion of public and political support for various laws regulating sex that were designed to protect collective entities, including the expansion of sex laws that prioritized individual consent to participate in sex (e.g., in cases of rape and child abuse) (Frank, Camp, and Boutcher 2010; Frank, Hardinge, and Wosick-Correa 2009), and increasing pressure on states to deregulate same-sex sex by gay and lesbian social movements (Frank and McEneaney 1999). Frank argues that these shifts in sex laws and legitimization of same-sex sexual relationships are driven by broader cultural transformations that are also likely to affect the adoption of HIV prevention and policy targeting MSM. In particular, Frank and
McEneaney (1999) highlight the effects of individualization and gender equality on legitimizing same-sex relations over and above a country’s economic expansion and democratization.

This argument is consistent with a long tradition of demographic research examining the links between demographic change and cultural change. More than half a century ago, Notestein (1945) observed that industrialization and urbanization produced changes in the economic opportunities of individuals. These economic opportunities, Notestein argued, had consequences for the importance of family and family structure by creating a “shift in social goals from those directed toward the survival of the group to those directed toward the welfare and development of the individual” (41). Similarly, Goode (1970 [1963]) observed that industrial societies had a strong preference for conjugal families characterized by fewer kinship ties, geographic mobility, and greater emphasis on the nuclear family unit. Additionally, Thornton and Fricke (1987) show how industrialization, urbanization, migration, and increases in educational attainment have affected individual opportunities for mobility and changed how individuals interact with families and cultural institutions.

In particular, changes in individual opportunities have shifted the locus of primary activities away from collective entities (e.g., the family, nation, or race) and toward the individual, thereby increasing individuals’ autonomy in decisions about where to live, who to marry and when, how many children to have, and who they are obliged to support. Lesthaeghe (1995) and others (van de Kaa 1987) conclude that individualistic orientations coupled with new economic opportunities have released individuals from the social constraints that once kept fertility rates high and have substantially decreased the demand for marriage and children. These sweeping social and economic changes have not only affected individual aspirations, but have also influenced the symbolic and cultural meanings people assign to behaviors, especially sexual
behaviors. As individuals have increasingly become the focal point of societies, the cultural meanings of sex have also shifted from procreation to individual pleasure (Giddens 1993), facilitating the emergence of dissident (homo)sexual identities and communities (D'Emilio 1983; Weeks 1998).

To examine the extent to which cultural opportunity structures facilitate the prioritization of MSM independent of other mechanisms, I include three measures: education attainment, total fertility rate (TFR, average births per woman), and the percent of the population living in urban areas. Since cross-country time-varying data for educational attainment have substantial missing data (see extended discussion of missing data below), I use the university gross enrollment ratio, obtained from UNESCO (2013), which corresponds to the number of students enrolled in tertiary education, regardless of age, expressed as a percentage of the 5-year age cohort leaving secondary school. TFR and the percent urban were obtained from the World Bank for the years 2001 to 2011 (World Bank 2012).

**Region**

Various scholars assess the role of geography on adoption of an innovation, frequently revealing the geographic clustering of policy adoption. According to Berry and Berry (1990), geographic or "regional diffusion models emphasize the influence of nearby states, assuming that states emulate their neighbors when confronted with policy problems" (396). To control for likelihood that countries fashion policies after those of neighboring states, I include a fixed effect for region. Due to a smaller number of countries in some regions, region is represented as the World Bank regional categorizations collapsed to the continent-level.
Missing Data

Data quality issues in the UNGASS, World Bank, OECD and UNESCO archives are compounded by the fact that countries are not obligated to provide information. Consequently, there is a considerable amount of missing data, though it varies by indicator, year, country, and region of the world. In particular, cross-national analyses frequently suffer from a lack of comparable data on education attainment. In the present data, tertiary education enrollment data are missing in all years for 13 countries that submitted progress reports. For this reason, a second indicator – the estimated average years of education compiled by Barro and Lee (2012) for 140 countries and extended to 166 countries by Nardulli, Payton, and Bajjalieh (2010) – was also used to test the robustness of results. Although the pattern of missing values for estimated average years of education differs from tertiary education enrollment, results were substantively the same (data not shown). Additionally, five territories that submitted Country Progress Reports (Anguilla, the Cook Islands, Nauru, the Vatican, and Zanzibar) are consistently missing data on a majority of country-level characteristics due to aggregation or exclusion in the source data and thus could not be included in analyses. See Appendix A for a full list of countries and territories excluded due to missing data.

Multiple data sources

For some indicators, comparable indicators are available from other sources. For adult HIV prevalence, for example, the World Bank data\textsuperscript{46} serve as the primary data and missing observations are replaced with the adult HIV prevalence cited in the country progress report. In a small number of cases, country splits created substantial missing data for territories that

\textsuperscript{46} These data are identical to several other sources, including UN data.
submitted independent reports prior to the split. For example, South Sudan submitted reports in 2008 and 2012 but only gained independence and began proving demographic data separate from (North) Sudan in 2011. Here, demographic and economic indicators for the whole of Sudan are used prior to 2011 for South Sudan.

**Interpolation**

For missing data that could not be replaced using other data sources, missing values are interpolated where possible. For countries missing data between two observed data points on GNI or a demographic indicator, I use linear interpolation to estimate missing values. In some countries missing data exist for the initial year or years in their time-series. For these countries data from earlier waves of the source dataset (e.g., for a nonmissing year between 1990 and 2000) are used where available to interpolate missing data at the beginning of a country's time series.

**Analyses**

I employ a series of nested probit regression models predicting a change in the level of prioritization in a given country-year, where $\Delta$ prioritization is measured as $y_{i,t} - y_{i,t-1}$. Since it is possible to reverse adoption ($y_{i,t} = -1$), countries remain in the risk set after transiting to the next level of prioritization. For countries where no change is observed in all years, $y_{i,t} = 0$ regardless of whether the country is in category 1, 2 or 3. All models include a fixed effect for year to control for shocks that may exert a general influence prioritization among all countries (e.g., the financial crisis beginning in 2008 which negatively impacted donor funding and country resources). For this analysis, the sample is restricted to ODA-eligible countries receiving any aid and without missing data on independent variables (N=113). I report robust, clustered standard
errors to account for the fact that observations within each country are not independent.

Additionally, following Torfason and Ingram (2010), I include prioritization (lagged) in order to account for autocorrelation in the dependent variable, or the fact that countries where MSM are already a priority are less likely to experience a positive change in prioritization.

**Results**

Table 5 presents the results of the probit regression models estimating the probability of an ODA-eligible country experiencing a positive change in the level of prioritization of MSM. In all models the dependent variable is the change in prioritization between time \( t-1 \) and \( t \), while the independent variables are lagged by one year and measured at \( t-1 \).

Models 1 serves as the baseline model controlling for earlier levels of prioritization and country resources. In this model, the coefficient for prioritization (lagged) is negative and significant as expected given that countries that have already prioritized MSM are less likely to experience a positive change in the level of prioritization. The effect of prioritization (lagged) is consistent across all models. In Models 1 through 7, the effect of country wealth is nonsignificant, suggesting no relation between country resources and prioritization. This finding is consistent with expectations that other social and organizational pathways of diffusion are more important for promoting policy adoption than country resources. In Model 1, higher adult HIV prevalence significantly reduces the likelihood that a country will experience a positive change in the level of prioritization of MSM (\( p < .001 \)); however, this effect is attenuated when other variables are included in later models. The effect of adult HIV prevalence speaks to the decreased likelihood that national policymakers prioritize MSM in countries where there is a high burden of HIV in...
Table 5. Probit models estimating change in prioritization of MSM, aid receiving countries only

<table>
<thead>
<tr>
<th></th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
<th>Model 5</th>
<th>Model 6</th>
<th>Model 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prioritization (lagged)</td>
<td>-1.680 ***</td>
<td>-1.862 ***</td>
<td>-2.214 ***</td>
<td>-2.339 ***</td>
<td>-2.467 ***</td>
<td>-2.936 ***</td>
<td>-2.971 ***</td>
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<tr>
<td></td>
<td>(0.200)</td>
<td>(0.219)</td>
<td>(0.275)</td>
<td>(0.326)</td>
<td>(0.335)</td>
<td>(0.485)</td>
<td>(0.513)</td>
</tr>
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<td>Country Resources</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>GNI per capita (logged)</td>
<td>0.131</td>
<td>0.098</td>
<td>0.080</td>
<td>0.096</td>
<td>0.077</td>
<td>-0.340</td>
<td>-0.449 †</td>
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<tr>
<td></td>
<td>(0.076)</td>
<td>(0.113)</td>
<td>(0.112)</td>
<td>(0.202)</td>
<td>(0.207)</td>
<td>(0.241)</td>
<td>(0.258)</td>
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<tr>
<td>Adult HIV prevalence</td>
<td>-0.056 ***</td>
<td>-0.046 **</td>
<td>-0.042 *</td>
<td>-0.051 *</td>
<td>-0.037</td>
<td>-0.040 †</td>
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<tr>
<td></td>
<td>(0.015)</td>
<td>(0.018)</td>
<td>(0.019)</td>
<td>(0.023)</td>
<td>(0.023)</td>
<td>(0.023)</td>
<td>(0.028)</td>
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<td></td>
<td></td>
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<td>Participation in IGOs</td>
<td>0.019 ***</td>
<td>0.022 ***</td>
<td>0.019 **</td>
<td>0.021 **</td>
<td>0.024 **</td>
<td>0.029 ***</td>
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<td>(0.005)</td>
<td>(0.006)</td>
<td>(0.006)</td>
<td>(0.009)</td>
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<td>Links to transnational advocacy networks</td>
<td>0.009</td>
<td>0.014</td>
<td>0.023 *</td>
<td>0.024 **</td>
<td>0.022 *</td>
<td>0.026 *</td>
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<td>(0.008)</td>
<td>(0.009)</td>
<td>(0.009)</td>
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<td>(0.010)</td>
<td>(0.010)</td>
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<td>Research Production</td>
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<td></td>
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<tr>
<td>Articles per region, % of total</td>
<td>0.032 ***</td>
<td>0.035 ***</td>
<td>0.034 **</td>
<td>0.038 **</td>
<td>0.082 **</td>
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<td></td>
<td>(0.010)</td>
<td>(0.012)</td>
<td>(0.012)</td>
<td>(0.014)</td>
<td>(0.028)</td>
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<td>Official Development Assistance</td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>United States, before 2008</td>
<td>0.142</td>
<td>0.119</td>
<td>0.141</td>
<td>0.142</td>
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<tr>
<td></td>
<td>(0.119)</td>
<td>(0.121)</td>
<td>(0.130)</td>
<td>(0.127)</td>
<td></td>
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</tr>
<tr>
<td>United States, 2008 and later</td>
<td>0.153 *</td>
<td>0.122 †</td>
<td>0.114</td>
<td>0.101</td>
<td></td>
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<tr>
<td></td>
<td>(0.057)</td>
<td>(0.068)</td>
<td>(0.073)</td>
<td>(0.078)</td>
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<td>-0.037</td>
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<td>(0.057)</td>
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<td>(0.060)</td>
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<td>-0.030</td>
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<td>Table 5. Probit models estimating change in prioritization of MSM, aid receiving countries only</td>
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<td>-0.210 **</td>
<td>-0.256 **</td>
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<td>Same-sex sex legal</td>
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<td>0.460 †</td>
<td>0.328</td>
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<tr>
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<td>Cultural Opportunity Structure Variables</td>
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<td>University enrollment, % gross</td>
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<td></td>
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<td>(0.011)</td>
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<tr>
<td>Total fertility rate</td>
<td>-0.404 **</td>
<td>-0.404 *</td>
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<td></td>
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<td>(0.160)</td>
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<tr>
<td>Percent of population living urban areas</td>
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<td>0.012</td>
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<td></td>
<td>(0.009)</td>
<td>(0.011)</td>
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<td>Religion, largest by proportion of population</td>
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<td>Muslim</td>
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<tr>
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Table 5. Probit models estimating change in prioritization of MSM, aid receiving countries only

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<th>Region</th>
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<th>Model 5</th>
<th>Model 6</th>
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<td>Latin America &amp; Caribbean</td>
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<td>Middle East and North Africa</td>
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<td>Oceania</td>
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<tr>
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<tr>
<td>LL</td>
<td>-135.38</td>
<td>-128.47</td>
<td>-122.49</td>
<td>-114.34</td>
<td>-111.68</td>
<td>-104.98</td>
<td>-101.36</td>
</tr>
</tbody>
</table>

Note: Level 1=time, Level 2=Country. Independent variables lagged one year. Robust clustered standard errors shown in parentheses.
†p < .1; * p < .05; **p < .01; ***p < .001
the general population.\textsuperscript{47}

\textit{IGO participation} and \textit{links to transnational advocacy networks} are introduced in Model 2. Across all models, the coefficient for \textit{IGO participation} is positive and highly significant ($p < .001$). \textit{Links to transnational advocacy networks} also increase the likelihood of a country experiencing a transition in the level of prioritization of MSM, suggesting that both kinds of links to international organizations have promoted greater prioritization of MSM in national AIDS programs. These results are consistent with results from the last chapter which describe the mobilization of a substantial effort to coordinate policy from the top-down across the UN system as well as from the bottom-up through direct support of local organizations and advocacy networks.

In addition to the effects of participation in IGOs and links to transnational advocacy networks on AIDS priority diffusion, a key concern of this chapter is examining the extent to which research and donor interests contribute to the adoption of AIDS priorities. The accumulation of social science and public health research on MSM and HIV within each region is introduced in Model 3 and has a consistent positive effect on the likelihood of a country experiencing a positive change in the level of prioritization of MSM across all subsequent models ($p < .01$). As research accumulates on MSM and HIV within a region, countries are more likely to experience a positive change in the level of prioritization of MSM. Conversely, the coefficients for the percent of government expenditure provided through development assistance, introduced by source in Model 4, are generally nonsignificant with the exception of aid from the

\textsuperscript{47} Additionally, in countries with a higher HIV prevalence in the general population, penile-vaginal sex is likely to have been viewed as the primary transmission vector. The decreased likelihood of experiencing a change in the prioritization of MSM in these countries suggests that expanding the paradigm of prevention to include other vectors of transmission (e.g., penile-anal sex) has proved more difficult in countries that have been historically identified as “Pattern II” countries.
US after 2008 (positive) and the World Bank prior to 2008 (negative). Only the negative effect of receiving aid for AIDS from the World Bank prior to 2008 remains significant in the final Model. For other aid sources, the alignment of policy priorities with UNAIDS on MSM has had little measurable effect on a country's level of prioritization of MSM in their national AIDS program.

The positive effects of IGO participation, links to transnational advocacy networks and research production remain after controlling for variation in political and cultural opportunity structures across countries. In Model 5, the coefficient of the legalization of same-sex sex is positive and significant, suggesting that favorable political structures promote prioritization. However, the broader measure of the openness of the state is nonsignificant, suggesting that experiencing a positive change in the level of prioritization is unrelated to a country’s broader protection of political and civil liberties. Cultural opportunity structure variables are included in Model 6 and demonstrate additional effects of demographic composition on the likelihood of experiencing a positive change in the level of prioritization of MSM. Within this cluster, only TFR is significant, but the effects of tertiary enrollment and urbanization are in the expected direction (positive). As clusters, the political opportunity variables and cultural opportunity variables are jointly significant ($p < .01$ and $p < .05$, respectively) and significantly improve model fit ($p < .01$ and $p < .05$, respectively).

Finally, to control for similarities within geographical regions in the level of prioritization of MSM, I include dummy variables for region in Model 7. In this model, low- and middle-income countries in Asia and Latin American and the Caribbean are less likely to have experienced a positive change in the level of prioritization of MSM between 2003 and 2012 compared with low- and middle-income European counties. Contrary to expectations, low- and
middle-income countries in sub-Saharan Africa and the Middle East are not less likely to have experienced a positive change in the level of prioritization of MSM compared with low- and middle-income European countries. Given strong patterns of same-sex legalization by region, the effect of the legalization of same-sex sex is attenuated in this model. As a group, the coefficients for the six regions are significantly different from zero (p < .05); however, including region dummies does not significantly improve model fit (p = .122).

Discussion
In this chapter, I examine how effective the organizational strategies adopted by UNAIDS to promote prioritization of MSM have been in changing national AIDS policies. Using multiple data sources, I demonstrate that IGO participation, links to transnational advocacy networks, and research production play a significant role in a state increasing its level of prioritization of MSM over time. In the previous chapter I argued that the convergence of donor priorities on HIV among MSM and the formation of transnational research and advocacy networks targeting MSM are an outcome of purposeful and strategic action by IGOs to increase leverage over states and appear neutral in their policy preferences. Together with the results presented here, I have shown that IGOs make substantial efforts to reconfigure their external environments in accordance with their policy interests and that, in the case of HIV among MSM, these efforts have been highly successful.

As a result of strong coordination of policies across IGOs, I observe a positive association between levels of IGO participation and a state’s likelihood of increasing its prioritization of MSM. As I discuss in the previous chapter, UNAIDS has made a substantial effort to fund, formalize, and build the capacity of transnational advocacy networks. Here I demonstrate how local links to such transnational advocacy networks significantly increase the
likelihood that a state will add MSM to its national AIDS policy. Finally, above I demonstrate the dramatic effect of efforts by UNAIDS to document HIV among MSM, formalize networks of researchers, and mobilize funding for research have had on research production throughout the 2000s. The availability of research on MSM and HIV within a region creates a context in which evidence-based advocacy can be conducted and assumptions about transmission in a given country can be contested, thereby promoting prioritization in national AIDS programs. Research also creates the potential for more research and funding addressing MSM and HIV within country and regional contexts, making it a cumulative and less easily reversed process, as compared with grassroots activism and policy implementation. The inclusion of research production and researcher collaboration with IGOs has not been widely incorporated into quantitative analyses of policy diffusion\(^48\) and may be particularly relevant for the diffusion of organizational forms and policies in areas such as education, health, environmental protections, and, given the present results, government attention to rights for stigmatized social groups.

Importantly, the results presented here are limited in the extent to which they measure actual change in state behavior and not just text in a report to appease the UN General Assembly. While the stringency of the coding criteria were designed to suss out imposters, as we know from other work, ratification of formal treaties and agreements between countries does not guarantee convergent behavior. In the context of HIV prevention targeting MSM, the late Shivaji Bhattacharya, who was the HIV and Human Rights Advisor for the regional South African office of the UNDP, complained in 2008, “HIV policy statements and frameworks pay lip service to the rights of sexual minorities and…in fact there is very little evidence of actions taken to ensure

\(^48\) As an exception, Meyer and colleagues (1997) examine the effects of an expansion of scientific activity on the diffusion of environmentalism. However, here “scientific activity” is measured in standard world polity fashion as the number of publications but as the number of international science associations and memberships in the International Council of Scientific Unions (ICSU).
access to HIV-related services to members of sexual minorities. Most countries lack specific HIV prevention, care and support services targeting members of sexual minorities.” While this may remain true even as states add MSM to their national AIDS policies, Conca (2006) has also posited that behavior may change when government actions become more transparent through monitoring and reporting requirements. As the Declaration of Commitment on HIV/AIDS has been revisited and revised over the years and as countries have collected and submitted more data, their actions – and inactions – have become much more apparent. Thus, governments have become more accountable to other governments, IGOs and INGOs, and their constituents. Further, researchers have shown how the ratification of human rights treaties, even those that a state lacks the will or capacity to implement, may promote a state’s alignment with the treaty over time by creating a context in which other actors, especially civil society actors, can legitimately challenge state actions (Hafner-Burton and Tsutsui 2005). As I have argued, research production may similarly be effective on increasing the prioritization of MSM not because it convinces government officials of the need to address MSM, but rather because it increases the ability of local actors to challenge state representations of policy needs within the country. In the next chapter, as I continue my examination of how IGOs reconfigure external environments, I show the expansion of transnational research and advocacy networks has benefitted local NGOs and impelled new understandings and articulations of same-sex sexualities.

As policies and practices circulate around the globe, through layer upon layer of intermediaries and interaction, they also promote new articulations and understandings of social groups and social location (Tsing 2005). These understandings become inscribed in material practices and institutional forms (Collier and Ong 2004), creating new "kinds of people" and ways of being in the world (Franklin and Roberts 2006; Nguyen 2010; Rofel 2004; Swidler and Watkins 2009). In the chapter that follows, I turn to an analysis of how global policy prescriptions generated in the offices of AIDS IGOs in Geneva have intersected with local contexts and shaped local understandings and articulations of same-sex sexualities. Using newspaper and qualitative interview data from Malawi I trace changes in understandings and debates about homosexuality over time, attending to the ways in which AIDS IGOs and research production have shaped these understandings. This work builds on observations and discussions with Malawian colleagues conducted in Malawi during the summers of 2007 and 2010 through my attachment as a graduate research assistant for a larger household survey of rural Malawians. 49 In the next chapter, I augment this qualitative analysis with original household survey data of attitudes toward homosexuality in Malawi collected in 2012.

Malawi is an excellent country in which to study the implications of seeing MSM as a global AIDS priority for same-sex sexualities around the world. As a very poor African country with a high prevalence of HIV, Malawi has routine interactions with various AIDS IGOs and

49 For more information on the Malawi Longitudinal Study of Families and Health (MLSFH), see http://malawi.pop.upenn.edu/.
donor organizations. Although Malawi is among the countries that has initiated prevention and HIV surveillance activities targeting MSM, the inclusion of MSM in Malawian AIDS programs and policy remains widely contested. As I show in this chapter, popular and political opposition to homosexuality has deep roots in Malawi, though not just for obvious religious reasons as is frequently argued by Western gay activists. I argue that power inequities between global and national actors have strongly shaped local understandings of homosexuality in Malawi’s recent past. These understandings have been employed by a diverse range of actors in different contexts for different purposes (Foucault 1990).

Following Malawi’s independence from Britain in 1964, Malawi’s first president, Hastings Kamuzu Banda, advocated a return to traditional Malawian values and imposed substantial constraints on citizens’ self-expression and mobility. Under Banda’s increasingly authoritarian regime, gender and sexual deviance were cast as the result of Western imposition, as not only unMalawian but antiMalawian (cf Phillips 1997). Within this context of censorship, abuse of power, and the manipulation of tradition that Banda employed to legitimate his dictatorship, new ways of being emerged. Malawians “were forced to find alternative strategies for survival, alternative metaphors for the expression of our feelings and ideas” that allowed people to blend into the background to avoid persecution and detention (Mapanje 1974: 76, as quoted by Chirambo 2007). Like chameleons, as they were described by Malawian poet Jack Mapanje (1981), Malawians adopted strategies to navigate social contexts with distinct normative codes and to negotiate ties of dependence and patronage.

In the early 1990s, amidst the political turmoil of Banda’s last years in power, Malawians encountered a growing economic crisis, an exploding HIV/AIDS epidemic, and fluctuations in development aid that increased the urgency to obtain economic and other resources for oneself
and one's relatives and friends, while at the same time transforming the landscape of available resources (Anders 2007). The ability to navigate disparate social contexts and relationships during this time proved particularly rewarding for political elites who were able to draw support from multiple networks of patronage and jump from one favored party to the next (Englund 2002) as well as for civil servants who used these skills to embezzle public funds (Anders 2007). The “culture of chameleons” also benefited other less skilled Malawians who, in the almost total absence of opportunities for formal employment, gained status and resources by fashioning themselves as “local experts” for the country's many foreign donors (Englund 2006; Watkins and Swidler 2013; Biruk 2011). In this social context, I show how accusations of homosexuality, already framed by Banda as outside the limited discourse of what constituted “Malawianness,” were employed by villagers to regulate these new subjectivities and give voice to Malawians’ feelings of social and economic vulnerability. In these accusations, homosexuality came to be synonymous with foreign exploitation, corruption, and abuses of power by local officials.

Throughout the late-1990s and early 2000s, understandings of homosexuality as exploitation were appropriated by Malawi’s increasingly congested civil society sector. At this time, NGOs that had emerged to meet donor demand earlier in the decade now faced high levels of economic insecurity as donors shifted their priorities and competition from new individuals and organizations that wanted to gain access to donor funds. In such a context, more established organizations have attempted to limit the penetration of undesirable external interests in same-sex sexualities and manage the emergence of new organizations that threaten the status quo by actively policing the boundaries of “authentic” Malawian concerns. While existing human rights, development, and health organizations conceivably could have expanded their goals to include same-sex sexualities and thereby gained access to new donor funds in this area, donor interests in
same-sex sexualities lack a strong “cultural match” (Swidler 2006) with existing Malawian institutions. Additionally, given that same-sex sex is criminalized in Malawi, adopting same-sex sexualities as a priority would put existing organizations in direct conflict with the state and other faith-based civil society organizations. Instead of expanding their goals and mandates to include same-sex sexualities, I show how established organizations attempted to limit the penetration of donor interests in same-sex sexualities by publicly discrediting innovators as unMalawian, out of touch with the true needs of poor Malawians, and opportunistically exploiting alliances with donors for personal gain.

While understandings of homosexuality as exploitation and opportunism continue to color debates on the subject in Malawi, new understandings of homosexuality as a health issue and a human rights issue have emerged within a segment of Malawian civil society and government following the intense mobilization of donor organizations around HIV among MSM in the mid-2000s. In particular, local links to transnational research and advocacy networks have provided a context in which (male) same-sex sexualities have become visible and institutionalized, providing a basis for future social movement efforts. However, in contrast to arguments that HIV has provided a much needed “in” for sexual rights promotion in Africa (Epprecht 2012), I find that these changes have been largely limited to Malawian civil society elites and a few government officials tasked with addressing AIDS and keeping donor monies flowing.

Moreover, I find that growing international pressure to protect the human rights and health of sexual minorities has prompted increasingly oppositional and repressive action from
political and religious elites. As I discuss below, in December 2009, Malawian police arrested Tiwonge Chimbalanga, a transgender woman, and Steven Monjeza, a man, at their engagement party on suspicion of committing sodomy. Activists and officials from South Africa and Western nations called on Malawian officials to abandon the prosecution of Chimbalanga and Monjeza and repeal the country’s antisodomy statute. However, as a public demonstration of the country’s so-called cultural sovereignty from donors, the Malawian Court found both Monjeza and Chimbalanga guilty of sodomy and sentenced each to fourteen years in prison in May 2010. Additionally, throughout the trial and the remainder of 2010 government officials moved to strengthen enforcement and extend the reach of the antisodomy statute rather than repeal it.

Many villagers supported this oppositional stance which gave voice to longstanding concerns about the country’s vulnerability of foreign exploitation and the arbitrariness of donor priorities. Further, emboldened by the Court’s opposition to donor demands, many Malawians began to consider a future of cultural sovereignty from the West. Among these groups, longstanding debates about homosexuality in Malawian society were reinvigorated to marshal a social critique of global power inequalities and Western aid politics.

In Malawi, as elsewhere (Ferguson 2006; Nguyen 2010), donor initiatives – even those that fail to achieve their goals of development or aids prevention -- have had a profound impact on local subjectivities, reconfiguring individual behaviors, motivations, aspirations, and models of the self (Swidler and Watkins 2009; Watkins and Swidler 2013; Frye 2012). Various actors have a stake in what forms new subjectivities take and seek to manage their course (Rofel 2004). In this chapter, as I continue my examination of how IGOs reconfigure external environments, I

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50 A similar argument is made by Long (2009) in a discussion of how the tactics of Western gay rights organizations have provoked more extreme reactions from conservative states. Vorhölter also presents evidence of political pushback on the topic of same-sex sexualities in Uganda (2012).
show debates about homosexuality in Malawi have been employed by diverse actors in order to manage the emergence of these new subjectivities, even those that did not directly concern gender and sexual deviance. Nonetheless, the expansion of transnational research and advocacy networks concerned with HIV among MSM has benefitted local NGOs and created new opportunities for articulating and seeing same-sex sexualities in Malawi. Additionally, even as the government has pursued stronger regulation of same-sex sexualities, some Malawians used debates about homosexuality to redirect attention to the government's failure to deliver on the promise of democratization and its general lack of transparency on civil rights issues, foreshadowing a period of civic unrest that began shortly after the trial of Monjeza and Chimbalanga and continued into 2012 (Camack 2012). I conclude with a discussion of the implications of these developments for same-sex sexualities in Malawi.

Data and Analysis

In the analysis that follows, I draw primarily from Malawian news media. News media data were collected from Malawi's two daily print papers, The Nation and The Daily Times,51 and a weekly print paper, The Chronicle,52 through the Cooperative Africana Materials Project (CAMP). Articles were also collected from the archives of an electronic Malawian paper, The Nyasa Times. Articles were selected that were printed in English, published between 1997 and 2012, and referenced homosexuality, gays and lesbians, same-sex sex, same-sex marriage, and sexuality more broadly in order to document debates about homosexuality in contemporary Malawi (N=400). These data are supplemented with articles appearing in other Malawian and

51 Including the bulkier, weekend edition The Sunday Times.
52 The Chronicle was first printed in 1993 as a small, weekly "opposition paper" and ran for over a decade. It is no longer in circulation.
African presses found through searches of the allAfrica news database and the ProQuest historical newspapers database. Inclusion in the dataset was limited to articles published between 1980 and 2012\(^53\) in English and which contained the words "Malawi" and "homosexual*", "gay," "lesbian," "same-sex," "sexual orientation," or "men who have sex with men." For comprehensiveness and to assess circulation in Western media of particular cases, follow-up searches were also conducting using the names of public figures identified in articles in *The Nation*, *Daily Times*, or *Chronicle*. Select articles from Western presses are also referenced below to provide context as needed or a comparison to Malawian coverage of the same event.

These data are supplemented with government and organizational documents that provide context for the news media articles as well as 58 qualitative interviews with Malawian civil society leaders at LGBT, AIDS, women’s and human rights and law NGOs that did and did not conduct work with MSM or LGBT populations, volunteers who worked as peer educators with MSM who were largely MSM themselves, and other key informants such as government officials at the Malawi National AIDS Commission, Ministry of Health and UN offices, and Malawian academics and news media reporters. The majority of these interviews were conducted in English between June and July of 2012 in collaboration with Dr. Ashley Currier of Texas A&M University. Eight interviews were conducted by me in 2010 during the trial of Monjeza and Chimalanga. For civil society leaders and volunteers, respondents were asked to detail the history of the organization, its scope of work, and its interests in MSM. Respondents were also asked to discuss any material or ideological partnerships with other organizations in Malawi or abroad, controversy with other organizations as well as the group's relationship with Malawian

\(^{53}\) Although, no articles were found meeting the specified criteria until 1987. Between 1987 and the late 1990s, all co-occurrences of homosexuality and Malawi are from articles about HIV/AIDS making a comparison between epidemiologic patterns of transmission in Africa versus the West.
government, religious groups, and media. For groups that did not work explicitly with MSM, leaders were asked to discuss whether MSM had ever been an area of concern for the organization, if they perceived MSM to be an issue that donors were interested in, and, if so, how the organization has responded to or navigated those interests.

All data were managed in NVivo, an electronic database package designed for qualitative analysis. A subset of the news media data were first coded using open-coding techniques to identify emerging inferences from the data (Corbin and Strauss 2008). Following Timmermans and Tavory (2007) who advance a modified grounded theory and analytical-induction approach, open-coding was conducted alongside a close reading of salient themes in the literatures on sexualities, HIV/AIDS, NGOs and donor investment in African and other nonwestern contexts. Throughout the initial coding process, I developed a conceptual model relating homosexuality to concerns about AIDS, state sovereignty, and economic insecurity to discourse among diverse actors. As this model developed, I engaged in selective-coding of themes in all data to further elaborate and refine this model. In the results that follow, all names of individuals and locations from field notes and interviews have been changed. Names and locations from public sources, however, have been maintained.

**Freer but Poorer**

Understandings of homosexuality in Malawi prior to substantial investments in AIDS and human rights were strongly shaped by experiences of isolation and cultural engineering under the country’s first president, Hastings Kamuzu Banda. Under Banda, Malawi became a police state. Banda’s party thugs ensured allegiance throughout the country’s vast rural areas by imposing beatings, arrests, and disappearances (Africa Watch 1990). Abuses of power by the ruling party were commonplace, the greatest beneficiary being Banda himself whose party slogans included
"zonse zimene nza Kamuzu Banda," everything belongs to Kamuzu Banda. Opportunities for education and advancement were few for those falling outside Banda’s networks of patronage.54 For the duration of his 30 year rule, the vast majority of Malawians remained peasants, wholly dependent on subsistence agriculture and small trade.55 In addition to controlling the material lives of Malawians, Banda also sought to direct their "moral development" by promoting “traditional” Malawian values and criminalizing social elements that might promote sexual promiscuity, including birth control, discussion of sexual matters in public, and various elements of "modern dress."56 Visitors were expelled from the country for noncompliance (Morton 1975, as cited in Chimbwete, Watkins, and Zulu 2005). Though Banda did not take an explicit stance on homosexuality, he spoke often of gender and sexual deviance as the problematic result of foreign, especially Western, influence and deeply offensive to the “traditional” morals of Malawian society. “Civilization” in the West, Banda remarked frequently, "is going to the dogs" (Hansard 24 March 1970, as quoted in Short 1974: 281).

Malawi did not emerge from Banda's repressive regime until 1994, following several months of civic unrest (van Donge 1995; Kaspin 1995). At the time, the country's transition from dictatorship to multiparty democracy was popularly regarded as a hopeful "new dawn" for the country (Posner 1995). A new social contract prioritizing personal accountability and the common good was drafted alongside a new constitution imposing presidential term limits and guaranteeing human rights. However, following the 1994 presidential election, Malawians were

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54 Levels of primary school completion for the entire population are stable at about 35% from 1980 to 1993 when Banda begins to lose his grip on power (World Bank 2013).
55 In 1980, more than 90% of the Malawian population lived in rural areas. In contrast to other countries in the region which underwent massive rural-to-urban migration in this period, the proportion of Malawians living in rural areas decreases only slightly to 87% by 1993 (World Bank 2012).
56 The Decency in Dress Act was passed in 1971 and prohibited women from wearing trousers and mini-skirts and men from wearing bell-bottomed trousers.
more regionally and ethnically divided than ever (Posner 1995; Kaspin 1995; van Donge 1995). In May 1992, following two years of drought, the World Bank and Western donors temporarily froze development aid to Malawi to put pressure on Banda's repressive regime (Riding 1992). Through the early 2000s Malawians continued to experience rapid inflation,\(^{57}\) sharp economic decline,\(^{58}\) and a widening of the gap between rich and poor.\(^{59}\) For all their talk promoting human rights and civic participation, efforts by politicians, donors and NGOs to "educate" and "assist" poor Malawians in claiming their new rights only served to reinscribe inequality and silence the concerns of the poor majority (Englund 2006).

After years of inaction under Banda, AIDS was also ravaging the country. Population prevalence among adults aged 15-49 was estimated at over 11% in 1994 and continued to rise to almost 14% by 2003 (World Bank 2013). By 1998, 96% of rural Malawians knew someone who had died of AIDS and 50% had known 5 or more; sixty percent of women and 50% of men in rural areas reported being "very worried" about getting AIDS (Smith and Watkins 2005). Within this context, rumors and accusations of exploitation, abuses of power, and witchcraft were widespread (Englund 2006).

These material conditions created a context in which accusations of engaging in homosexuality, already associated with Western promiscuity and non-traditional Malawian values, emerged as a powerful critique of global and local regimes of inequality. Between 1998 and 2001, several stories and editorials conveying an understanding of "homosexuality as exploitation" circulated throughout Malawi. In April 1998, police in Lilongwe were called to

\(^{57}\) The average level inflation from 1994 to 1998 was 39% annually, with inflation as high as 83% in 1995 (Chira, Patel, and Kanyongolo 2003).

\(^{58}\) Malawi's GDP per capita declined 7.5 percent in 1992 and by more than 10 percent in 1994 (World Bank). GDP per capita continued to decline through 1995 when it rises slightly before plummeting to levels consistent with the last years of the Banda regime in 1998 through 2002 (World Bank 2013).

\(^{59}\) In 1998, 42% of all income is controlled by the top 10% (World Bank 2013).
investigate a series of reports of a "thriving sex slave trade ring involving unscrupulous business people who, posing as benefactors, sell innocent girls and boys to contacts in Germany, Holland, and South Africa to be sexually humiliated and abused." Foreigners posing as "Good Samaritans" were reported to be visiting villages as tourists where they "make friends with the prospective captive then introduce themselves to the parents or guardians," ultimately offering to pay for the "prospective captive" to travel to Europe and continue their schooling (AllAfrica News 1999). A few months later, following "complaints from parents of strange behaviour among young men in the area," foreign tourists were accused by a women's community organization in Mangochi, a relatively poor area frequently visited by Western tourists along the lake shore, of "tak[ing] advantage of the young men's poverty and illiteracy and woo[ing] them into sex." "Some of these tourists have actually built houses for these boys," a spokesperson for the women's organization stated. As in the first case, fears of child abduction were paramount: "Some of the boys, according to the [tourism] ministry, have found themselves in European capitals being used by paedophile rings" (Tenthani 1999).

Rumors of widespread predatory victimization by foreigners were perceived by many to be confirmed when, in September 2000, a third case drew national attention and briefly circulated in Western presses. The case involved the alleged sexual abuse of Francos Kamiza, a 19-year-old Malawian young man, by Wolfram Stolz, a German national working for a German development organization in Malawi. Ralph Kasambara, a well know Malawian human rights lawyer, represented Kamiza in the case. Kasambara alleged that Stolz had invited Kamiza to his house on several occasions, offered him drinks that were laced with drugs, and sexually abused him. Police found no drugs when they searched Stoltz' residence but did find photographs of Stolz and Kamiza together. Although Stolz had successfully fled the country with the help of his
employer, the German Agency for Technical Cooperation (GTZ), Kasambara insisted that he would continue to pursue the case against Stolz in his absence. However, without a defendant and without the cooperation of the German government, the case was not pursued further. In a press interview, Kasambara concluded with a warning to donors, "We appreciate development aid given by these international organisations but the people who are sent to administer them must keep their abnormal sexual habits to themselves" (AllAfrica News 2000). In identifying foreigners and donors with money as untrustworthy, likely to exploit Malawian children for personal gain, and beyond the reach of Malawi's legal system, these stories stood in stark contrast to the stern rejection, if not outright expulsion, of unwelcome donor activity by Banda's authoritarian regime and gave voice to poor Malawians' feelings of economic insecurity and vulnerability to wealthy foreign interests.

Malawians' feelings of vulnerability extended into the domestic arena as well. In the absence of Banda's authoritative presence and his band of enforcers, petty crime increased dramatically after multiparty elections in 1994, especially in times of drought and food shortage. Despite judicial and economic reforms intended to promote a “pro-poor” environment, insecurity in rural areas was identified by government officials as the key impediment to poverty reduction initiatives: “[I]nsecurity makes it too risky for the poor to accumulate assets or wealth, particularly in a rural setting, as any assets or wealth are likely to be stolen. This undermines the ability of the poor to generate their own incomes and reduce their own poverty…For the ultra-poor, the only means of survival may be stealing food or assets from other poor people” (Government of Malawi 2002). In a household survey fielded in 2002 by the International Crime Victims Survey (ICVS) of the United Nations Interregional Crime and Justice Research Institute (UNICRI), just under half of all respondents (43.5%) reported experiencing one or more crimes
in the past year, a majority of which had been the victim of crop theft, livestock theft, or personal property theft (Pelser, Burton, and Gondwe 2003). In the survey, satisfaction with police was reported to be incredibly low and most believed that police involvement was very unlikely to result in the return of property whether or not an arrest was eventually made.

Between 1994 and 1998, the country’s prison population rose almost 40%; it doubled in less than a decade (International Centre for Prison Studies 2012). At the turn of the century, one in 1600 Malawians were in prison, a majority of whom were being held for robbery, theft, fraud, and fatal accidents. Almost all (98%) of them were men. At the time, there were reported to be only 28 legal aid attorneys and eight prosecutors with law degrees to service the entire population of just over 11 million (Wines 2005). Cases dragged on one year to the next. Many spent years in prison before their case was finally heard in court, if it was ever heard (Wines 2005). In a 2000 report on Malawi’s prison system conducted by Penal Reform International and UNICEF (2000), overcrowding was identified as a fundamental, system-wide problem which "lead inter alia to...high promiscuity and spread of diseases" (Chirwa 2001). Malawi’s prison system had exceeded capacity back in 1997 and many of the smaller prisons (e.g., Zomba prison) had long been operating at 200% capacity. The report noted several incidents of prison rape, widespread sexual abuse by young and vulnerable inmates by both inmates and guards, and the presence of perianal abscesses and STDs, including high rates of HIV infection, among adult and juvenile inmates. In several prisons, rates of inmate death were as high as 1 in 30 to 1 in 20 annually.\footnote{The comparable figure for the US at this time is 1 death for every 330 prisoners.}\footnote{A comprehensive report compiled by the Open Society Initiative for Southern Africa (OSISA) conducted in 2010 confirms these descriptions by earlier reports and adds that detainees "face intimidation and abuse, and are particularly prone to coerced confessions and guilty pleas. It was also found that pre-trial detainees are spending inordinately long periods of time in detention on expired warrants. Access to relatives and courts depends on the
Shortly after the report was released, several personal accounts of abuse and homosexual activity in prisons circulated. One such story that appeared in the news media in June 2000 chronicled the plight of Mabvuto Banda who had just been released from prison. In the story, Mabvuto was identified as 19 years old. He had been detained in the Zomba prison for five years. Mabvuto is described as being not very healthy, likely to have HIV, and likely to have acquired it following sexual abuse while in prison. Like many poor Malawians without the ability to pay for tests or medicines, "he cannot go for a voluntary check up until when he is seriously ill and admitted to a hospital." Describing a typical encounter with Malawi's medical system overburdened by AIDS and unable to offer any treatment, the article continues:

If he has the virus, it will be detected by the medical personnel in a checkup which he will not know about. If things get worse he will be discharged and told he should go and recuperate at home. He might get better, but the chances are he will die from AIDS. He will just be another statistic of the millions of people who die from HIV/AIDS in this country ranked as one of the poorest and mostly hit by HIV/AIDS in the region and in the world. His relatives will never know where he got the disease from. No one in his home will ever know that he contracted the virus in prison. Mabvuto is a pawn caught up in a dehumanising organised prostitution racket currently running in Malawian prisons, organised by Prison Officers where male juvenile prisoners are being sodomised and being exposed to whims of the police and prison warders. Not only do detainees often lack awareness of their rights in a criminal justice context, there is also no clarity in general about many key issues, including the powers of the police to arrest and detain a person, the role of police officers in releasing a person with or without bail, and in which cases, when and under what circumstances is recourse to a magistrates court to challenge a detention introduction necessary. The procedures for applying for bail are incomprehensible to many accused people as well as the general public" (OSISA 2013)

62 Mabvuto is not the boy’s real name but is a common Malawian name and literally translates to "problems" or "trouble."

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HIV/AIDS. Adult prisoners bribe the POs [prison officers] for as little as 30 USA Cents to have a juvenile prisoner smuggled into the adult block. (Phiri 2000)

The story conveyed the extreme vulnerability of rural and poor Malawians who, when not being abused by the country's failed economic and justice reforms, were condemned to die for being poor. The author concludes on a pessimistic note: the victimization of juvenile inmates is well-established and very unlikely to change without extreme state or donor intervention given guards' low salaries, a history of inaction on behalf of the government, and the continued growth of the country's incarcerated population. Until then, HIV in prisons - and in the poor villages to which inmates eventually returned - would only increase. Unable to talk about the sexual abuse he suffered, Mabvuto and others like him were destined to die alone by the hand of a guard who profited from his exploitation.

In the years immediately following the country's emergence from Banda’s repressive and isolationist regime, feelings of vulnerability to exploitation in global contexts where Malawians felt they had little power to refuse donor demands and in local contexts where corruption and opportunism emerged as a strategy to combat extreme poverty strongly shaped poor Malawians' understandings of and responses to homosexuality. Accusations of sexual deviance and homosexuality among foreigners and local elites gave voice to popular concerns about widespread corruption and abuse and served as a means of policing individual abuses of power for personal gain as material conditions for a majority of Malawians deteriorated in the 1990s and early 2000s.

Betrayals, Authenticity and Interorganizational Policing

At the same time that Malawians' economic conditions were deteriorating, civil society was growing by leaps and bounds due to the increasing availability of donor funds. The government
was also growing, as new parties and officials vied for power in the new multiparty democracy. In this section I show how civil society organizations and political elites appropriated understandings of homosexuality as exploitation in order to regulate the new subjectivities that were emerging in the new Malawi.

In 2003, after almost two 5-year terms as President, Banda's elected successor, Bakili Muluzi, started to have second thoughts about leaving office. He proposed an amendment to the country’s constitution that would allow him a third term. Malawians quickly equated Muluzi's pursuit of a third term with Banda's claim to Life President. Following substantial mobilization by Malawi's members of Parliament (MPs), judiciary and civil society, Muluzi abandoned the amendment and promoted as his successor Bingu wa Mutharika, a Western educated economist who had returned to the country during the fall of the Banda regime. In 2004, Mutharika won the presidency by popular vote and quickly severed ties with Muluzi by forming his own political party. Shortly thereafter, Mutharika established the Special Law Commission (SLC) and tasked the commission with reviewing and recommending improvements to Malawi's hastily drafted 1994 Constitution in order to avoid further abuses of power by the executive and legislative branches of government. In addition to soliciting expert and public sentiment, the SLC also reviewed the constitutions of neighboring African countries, France, Britain, and the United States. Here, Mutharika evoked a Banda trope, insisting that the SLC only take from outside what suited the country but otherwise rely on Malawian culture and practices to guide the way.

In early February 2005, amidst activists' demands to legalize same-sex marriage in South Africa, the Malawi Human Rights Resource Centre (MHRRC) approached the newly formed

63 He also later pursued criminal charges against Muluzi for corruption.
64 SLC membership included representation from the judiciary, the civil service, civil society, gender interest groups, the Law Society, religious groups, academia and eminent citizens.
SLC and requested the Commission review the conflicts between the new Constitution and the penal code, much of which had been directly carried over from British rule. In particular, MHRRC wanted the SLC to uphold principles of nondiscrimination in the new Constitution by legalizing same-sex sex and protecting the rights of gays and lesbians. Immediately, other civil society organizations actively distanced themselves from MHRRC. MHRRC was accused of "playing Judas Iscariot of our culture," and receiving financial support from "influential homosexuals the world over" to promote "crazy imported ideologies" (Nation 2005). In response, another civil society organization, the Task Force on Participation of Women in Politics and Decision-making, issued a public statement "asking the Law Commission and government to disregard the proposal. We are also questioning the Malawi Human Rights Resource Centre for not consulting with other NGOs and stakeholders on the matter before taking it head on" (Nation 2005). Public outcry further condemned MHRRC, insisting the organization had "run out of ideas...and to avoid closing down their organisations, they are running wild, championing useless and unheard of motions or causes that are in direct conflict with not only our culture by also biblical precepts" (MHRRC Under Fire 2005). Out of touch with the true needs of Malawians and without the support of other civil society organizations, commentators suggested MHRRC "find a better way of spending donor money (Nation 2005). "The fact that [homosexuality] is practised in Western countries does not mean it is something good," members of the clergy cautioned. "Not everything from the West is good" (Kumwenda 2005).

Accusations of inauthenticity and disingenuousness were further bolstered a few months later when the Lesbian and Gay Movement of Malawi (LGMM), an underground organization linking Malawian gays and lesbians in Malawi and in diaspora, also lobbied for a revision of the penal code on grounds that Sections 153 and 156, the sections that criminalize same-sex sex,
were discriminatory. This time, the organization put the issue before Parliament. The organization, operating from South Africa where same-sex marriage was gaining traction in the Constitutional Court, had sent letters to MPs on the Legal Affairs Committee, requesting that they table a new Sexual Orientation Discrimination Bill to amend the penal code and reverse the social, cultural and economic marginalization of the country's gays and lesbians. Compared with initial efforts by MHRRC, the LGMM scored a minor victory in that MPs did not dismiss the group's concerns outright and suggested that a meeting regarding the organization's petition may be called when the Parliament was back in session. While news coverage highlighted the organization's South African roots in order to discredit them, the more disconcerting issue for multiple MPs was the lack of adherence to democratic procedure, a major concern in the SLC's Constitutional review. Atupele Muluzi, Member of Parliament and Chairman of the Legal Affairs Committee, reminded LGMM and Malawian citizens, "[A]s a committee we have no jurisdiction to propose an amendment." However, other organizations remained active in the policing of civil society priorities. Imran Shareef, Vice Chairman of the Public Affairs Committee (PAC), an influential civil society organization that had worked to oust President Banda and protect the rights of Malawians, urged MPs and citizens to recognize that, "Democracy should go with morals and respecting the rights of other people," meaning the majority of Malawians who did not practice same-sex sex (emphasis added). Here, Shareef conveyed a common understanding of rights and homosexuality present in interviews with rural villagers: after a decade of rampant corruption and abuses of power under Muluzi, the many should not be made to suffer at the hands of a few. Turning the human rights claims made by LGMM on their head, Shareef concluded that legalizing same-sex sex was, in fact,
discriminatory against heterosexuals because same-sex sex could not be equally enjoyed by both sexes at the same time (Khunga 2005).

In December of 2006, just weeks after South Africa had legalized same-sex marriage, MHRRC advanced a second request for the legalization of same-sex sex in Malawi. Now in collaboration with the Students Law Society of Malawi, MHRRC attempted to reorient Parliament's attention to the conflict between Malawi's penal code, which criminalized same-sex sex, and Section 20 of the Constitution which guaranteed equal and effective protection against discrimination (Government of Malawi 1994). Yet, the continued invisibility of gay men and lesbians within this movement was an easy target for MPs. "We cannot rush into making provisions for things that we do not have in Malawi," argued MP Benjamin Banda. "If we do not see homosexuality in Malawi then it does not happen and should not be created." In response to assertions that there was no evidence of homosexuality in Malawi and thus no need to extend rights to gays and lesbians, MHRRC argued that homosexuality was indeed practiced in Malawi among "middle to upper class people because of their interaction with people of other cultures." However, the ability of gay men and lesbians to be visible, the coalition argued, would be continue to be impossible as long as same-sex sex was criminalized. On hearing that "other cultures" were again to blame, MP Adden Mbowani redirected questions to the authenticity of the movement: "We have Muslims and Christians in Malawi and in both religions it is sinful, so where is this coming from? We are not going to let this into our laws" (Muhariwa 2006).

Despite mobilization around same-sex sexualities, efforts to recast homosexuality as a human rights issue remained hamstrung by the invisibility of LGBT Malawians.
AIDS Interventions

In contrast to human rights and LGBT organizing, understanding same-sex sexualities within the context of Malawi’s HIV/AIDS epidemic enjoyed increasing success throughout the mid- to late-2000s for two primary reasons. First, same-sex sexualities were increasingly a focus of intergovernmental and donor organizations. Through this focus, several new funding mechanisms emerged creating an incentive for several heavily aid-dependent countries like Malawi, at the very least, begin identifying same-sex sex as a potential target in national AIDS prevention policies and programs. Second, bolstered by UNAIDS efforts to expand research and advocacy networks, Western HIV/AIDS researchers forged direct partnerships with Malawian civil society. The immediate impact of these partnerships was to provide access to funding, information, and networks for civil society organizations. The long term, more durable impact, however, was to render Malawi’s invisible LGBT population visible, a noted problem of all earlier attempts to persuade officials to recognize same-sex sexualities in Malawi.

Same-sex sex had been on the radar of Malawian AIDS officials since the late 1990s following the reports of HIV transmission in prisons and, in 2003, the Malawi National AIDS Commission added "persons engaged in same sex sexual relations" to its list of vulnerable populations in the National HIV/AIDS Policy (Government of Malawi 2003). Compared with the responses to human rights and LGBT activist’s demands examined above, which were rejected as inauthentic and disingenuous, the inclusion of same-sex sexualities in the 2003 policy was lauded for its openness and honesty in taking “a giant step towards addressing and acknowledging that things do happen in our midst.” In the past,” an editorial commented, “it was easy for us all to bury our heads in the sand like thoughtless ostriches, and make believe that there are no same-sex relationships or sex in prisons being practised. But to face the facts and put
in place mechanisms that will protect people from becoming infected with HIV is really a giant leap in the right direction” (Chronicle 2004).

This support was short lived, however, as later documents sought to reassert the irrelevance of same-sex sexual transmission to Malawi’s AIDS epidemic. Contrary to the 2003 National AIDS Policy which highlights the unequal burden of HIV among several vulnerable populations, the 2005-2009 National HIV/AIDS Action Framework (NAF) drafted a year later describes transmission dynamics as follows:

Unprotected heterosexual contact with an infected partner accounts for 88% of new infections. Mother-to-child transmission (MTCT) accounts for about 10% of cases. Other modes of HIV infection are insignificant and together account for about 2%. These include use of infected blood, infected needles and health care waste handling, intravenous drug use and homosexual sex. (emphasis added, Government of Malawi 2005:4)

Under this framework, no HIV prevention programs were implemented by the Malawi National AIDS Commission (NAC) targeting same-sex sexualities between 2005 and 2009.65

But, as described in Chapter 1, the donor landscape was changing. Despite decades of distinguishing between transmission dynamics in Africa and the West and being careful not to push government officials so hard that they reject AIDS prevention wholesale,66 in the mid-2000s UNAIDS and its cosponsoring organizations began a coordinated push for the inclusion of MSM in national AIDS programs in all countries. As part of a call to establish global prevention policy, in June 2005 the UNAIDS PCB resolved that “issues such as men who have sex with

66 Interview, National AIDS Commission, 19 August 2010.
men, drug use, sex work, gender vulnerability, and prison populations must be incorporated into prevention plans in all regions” (emphasis added, Programme Coordinating Board 2005). Linked developments among donors created a financial incentive for heavily aid-dependent countries like Malawi to, at the very least, begin identifying MSM as a potential target population. Organizational inreach to country-level staff also played a key role in increasing pressure on government officials. As a Malawian civil society leader explained:

[W]ithin Global Fund they are pushing the human rights agenda in the forefront. So, the language is if you don’t recognize sexual minorities, the rights of sexual minorities, within your HIV prevention programming, then you may not get these funds. So, UNAIDS is of the same opinion. Some of the key Global Fund partners are also of the same opinion. And, again, if I’m not wrong, our Ministry of Health is also heavily funded by donors. They have got a pool of funds, like a basket. Even those funders, they also have got their own agendas towards [MSM]. They also, I think, are propagating the same philosophy...[the Malawian President] was anti-MSM in the public (sic). But, I think he was being cornered in private to, kind of, open up.67

Thus, despite laws criminalizing same-sex sex, MSM were being increasingly considered within African government and nongovernment initiatives to decrease HIV transmission during the mid- to late-2000s. By 2008 the United Nations Commission on HIV/AIDS and Governance in Africa (CHG) explicitly identified the need for research on HIV among MSM and the expansion of services targeting MSM in Africa as key priorities (CHG 2008). Additionally, CHG reiterated that the core principle of equity should “govern national plans and efforts” ensuring access to

67 Interview, CEDEP officer, 29 June 2012.
care and treatment "to all regardless of gender, wealth, ethnicity or any other non-medical
criteria; groups such as commercial sex workers, men who have sex with men and injection drug
users must be included" (111).

Through evidence-based advocacy, UNAIDS, the Global Fund, and other donor
organizations also facilitated the expansion and institutionalization of research, policy and INGO
networks to support to local organizations seeking to address same-sex sexualities where
commitments from the state were not forthcoming. In late 2005, a Malawian human rights
organization was formed in Blantyre, Malawi’s commercial capital in the heavily populated
Southern region. The organization was established by a small group of Malawian men, some of
whom identified as homosexual or bisexual, and expats who had prior experience in AIDS and
human rights organizations, to directly respond to the “sidelining” of sexual minority issues not
just by government, as MHRRC and LGMM had argued earlier, but also by mainstream AIDS
organizations in Malawi. As one cofounding member explained:

There were some insinuations from the [AIDS] program implementers saying that
they cannot implement programs targeting MSM because the people do not exist,
so they took that as an excuse of not doing anything…so [CEDEP] thought ‘How
can they say that people do not exist when we know. Some of them are our
friends. Some of them are amongst us. So let’s come up with something to
mobilize the community.’

As the different cofounding members of the organization met to establish a strategic plan,
the group decided that in order to make any headway, they first had to register the organization
to obtain legal status and gain access to government and donor funds. Within the organization, it

6 Interview, CEDEP cofounder 28 June 2012.
was felt that the organization should be registered as a human rights organization and not an LGBT or sexual minority organization given the hostile political context and homophobia in Malawi. To avoid additional scrutiny, the group adopted a nondescript name for the organization: the Center for the Development of the People (CEDEP). Once established as a human rights organization, the group decided it had a responsibility to not just sexual minorities but also to educate and empower other vulnerable communities, such as sex workers and prisoners. Like other Malawian organizations, the group focused on funding proposals, education, and outreach, and relied heavily on networks of volunteers to conduct its work outside the office (Watkins and Swidler 2013). Founding members’ prior experience in AIDS organizations also promoted CEDEP’s alignment with public health practices and technologies. As one of the founding members explained:

Most the politicians have been arguing to say homosexuality does not exist in Malawi. ‘Where are the people?’ and blah, blah, blah. So, we thought the best way to bring this to them is by conducting research. So, just in 2006, the first activity that we did was to do a research (sic) on what we call a KAP study: knowledge, attitude, and practices of men who have sex with men in Malawi …because there was no (sic) any other data around in Malawi, not anywhere. So, that was the first data. That was the first statistics (sic). That was the first evidence that people [homosexuals] exist.  

69 Interview, CEDEP cofounder, 2 July 2012.  
70 Interview, CEDEP cofounder, 27 June 2012.
In collaboration with Malawian researchers at the University of Malawi and a Zambian researcher at the University of Zambia, the KAP study identified just less than 100 MSM within a period of a month in the Southern district and Lilongwe (Ntata, Muula, and Siziya 2008).

By establishing the "real" presence of (male) homosexuality in Malawi, this initial, small-scale study executed by CEDEP reinvigorated debate about the criminalization of same-sex sex (Nkhata and Mambulasa 2007) and created a context in which personal, albeit anonymous, testimonials of gay Malawians became possible and more frequent. Three months after CEDEP released a press release on the study findings, one such testimonial by a self-described 43 year old, married Malawian who engaged in same-sex sex concluded "Nothing stays the same forever. I know it will take time but things will certainly change at some point. Gay life is here and in greater proportion that people can imagine" (Mpaka 2007b). And the results of CEDEP's survey proved it (Mpaka 2007a).

This first study also led to CEDEP's partnership with researchers from Johns Hopkins School of Public Health and receipt of funding and technical support from the Sexual Health and Rights Project at the Open Society Institute to conduct a larger study of sexual networks and HIV among MSM in Malawi, Namibia, and Botswana (Baral et al. 2009). In 2008, Gift Trapence, the current Director of CEDEP, presented preliminary results of the study for Malawi at the International AIDS Conference in Mexico City and the Malawi NAC Quarterly Review and Dissemination Workshop held in August and October, respectively. Despite citing the same figures -- 201 Malawian MSM surveyed, 21% tested HIV positive, 95% unaware of their infection, many had experienced physical and sexual violence -- the two presentations could not have been received more differently. While Trapence was lauded for revealing the urgent need
for HIV prevention and care among an invisible population in Mexico City, back in Malawi he introduced the acronym "MSM" to his audience amidst laughs and disbelief (Biruk 2011). As ethnographic work by Biruk notes, Trapence's presentation in Malawi marked a significant "departure...from prior, accepted knowledge held in common by audience members" who had never "seen or heard of" MSM (Biruk 2011:229ff).

Despite initial rejections of the study findings in Malawi, however, the results of the collaborative study gained substantial traction in global North and continue to be widely cited in policy briefs on HIV among MSM. Additionally, the organization's partnership with international researchers resulted in strengthening the local, regional, and global voice of CEDEP, who continued to work with NAC to develop prevention programs for MSM, engage researchers and advocates at the biennial International AIDS Conference, and establish connections with myriad advocacy and policy organizations to promote sexual health among MSM in Malawi and Africa more broadly.72

Importantly, the study data also provided same-sex sexualities a certain visibility through numbers, the primary way that AIDS is "seen" by researchers and policy makers in Africa (Biruk 2011). As Trapence explained, "Politicians don't understand things. This is a rights issue. We work with them -- rather than competing with them -- and use the data to make them understand what we are talking about" (as quoted in van der Westhuizen 2009). This statistical presence, while initially dismissed at the NAC meeting in 2008, provided a context in which Malawi’s

71 Field notes, MSM Pre-Conference to the 2008 International AIDS Conference, 1 August 2008.
72 In addition to ties with researchers at Johns Hopkins School of Public Health, CEDEP currently also boasts strong collaborative relationships with various human rights, LGBT, and HIV/AIDS organizations, including Boston’s Fenway Institute, Denmark’s AIDS Fondet, AIDS & Rights Alliance for Southern Africa (ARASA), the International Gay and Lesbian Human Rights Commission (IGLHRC), Human Rights Watch, amFAR, Open Society Initiative of Southern Africa (OSISA), UNAIDS, UNDP and Population Service International (PSI).
73 as opposed to a personal presence through "coming out" or social movement activism.
largely invisible (male) LBGT population became increasingly visible within the context of national and international HIV prevention efforts. In contrast to earlier attempts by MHRRC and LGMM, CEDEP was able to provide numerical evidence contesting officials' claims that sexual minorities "do not exist" in Malawi. By 2009, when funding for projects targeting MSM became more widely available through the Global Fund and the results of CEDEP's second study of MSM had been published (Baral et al. 2009), the Malawi National HIV/AIDS Policy included a full paragraph on the need to address HIV among MSM (Government of Malawi 2009). On various occasions, the country's Secretary for HIV, AIDS, and Nutrition in the Ministry of Health, Dr. Mary Shawa, publically acknowledged the need to respect the human rights of MSM in order for the country's HIV response to be effective (Nation 2009a; Nation 2009b; Nation 2009c).

**Between money and morals**

On the Monday after Christmas, 2009, just a few months after Malawi's first conference on "Most-at-Risk" populations organized by CEDEP, The Nation featured a dramatic, full page cover story telling of a *chinkhoswe* ceremony\(^{74}\) between Steven Monjeza and Tiwonge Chimbalanga in Blantyre, Malawi's largest city in the South (Somanje 2009). While homosexuality had been in and out of the news for over a decade, most Malawians had remained relatively isolated from LGBT social movement activism and the gay marriage debates occurring on the international stage. At the *chinkhoswe*, hundreds of nearby villagers gathered to witness the "rare occasion," which the press identified as the “first public activity of homosexuals in the country.” Amidst interruptions in the venue's electricity and a jeers from spectators, however, the ______________________________

\(^{74}\) a traditional engagement ceremony.
couple was growing frustrated. As if in anticipation of debates to come, Chimbalanga cried out, "Ndisanyozedwe ine. Siine wolaula [Don't ridicule me. I am not unusual\textsuperscript{75}]" (Somanje 2009:2). Two days after the chinkhoswe, however, Malawian police decided otherwise; both Chimbalanga and Monjeza were arrested and charged with gross indecency and carnal knowledge against the order of nature (Bottoman 2009).

Responses to the engagement of Monjeza and Chimbalanga and the events that unfolded for months afterwards once again exposed Malawians' individual and collective vulnerability of foreign exploitation and local opportunism. In 2010, as the trial of Monjeza and Chimbalanga began, Malawi remained one of the poorest nations in the world with a gross national income (GNI) per capita of $350 and half (50.7\%) of the population living below the national poverty line (World Bank 2013). Throughout Malawi, the presence of substantial foreign investments in health, development, and education was ubiquitous. Along the few tarmac roads connecting the country's urban centers, roadside signs announce USAID agricultural projects, women’s health clinics maintained by the World Bank, Swedish and Japanese water reclamation projects, road projects funded by the European Union, and, in the capital, even a new Parliament building erected with Chinese funds. Receiving more than $1 billion US dollars in net official aid and development assistance in 2010 (World Bank 2013), roughly half of Malawi's development budget and almost the entire health budget was paid for by foreign donors.

Immediately following the arrest of Monjeza and Chimbalanga, international human rights campaigners began lobbying government officials in the United Kingdom, one of Malawi's primary donors, to review aid allocations to Malawi.\textsuperscript{76} As the trial progressed through the early

\textsuperscript{75} Wolaula has a negative connotation, wherein "unusual" is considered "strange" or "indecent."

\textsuperscript{76} This resulted in a motion ratified by 67 members of Parliament in mid-January calling on the President of Malawi to "ensure that they [Monjeza and Chimbalanga] are released from jail and that all charges against them for
months of 2010, Malawian government officials were subject to increasing international pressure and criticism. In-country diplomats put pressure on the President and his Cabinet to redress the situation. With each additional day Monjeza and Chimbalanga were detained, more and more representatives of international organizations, including regional partners such as the African Development Bank and Western journalists (Khanje 2010a), seemed to be arriving in Lilongwe to condemn the government. Feeling bombarded and coerced, Members of Parliament considered adopting even tougher penalties for homosexuality and debated the likelihood of donors making good on their threats to withdraw aid (Khanje 2010b). Monjeza and Chimbalanga as well as several Malawian organizations, including CEDEP which had taken on a substantial burden in advocating for and ensuring the rights and safety of Monjeza and Chimbalanga while in police custody, were widely accused of taking money from international NGOs to lobby for gay rights (Mizere 2010). In February, two months into the trial, Malawi police launched a "hunt for gays" during which the CEDEP office was raided and two of its officers arrested (Nyasa Times 2010).

Despite donor threats to revoke aid, on May 18, 2010, after more than 5 months of proceedings, the Magistrate pronounced Monjeza and Chimbalanga guilty and delivered the maximum sentence: 14 years in prison with hard labor. Throughout the country, many Malawians celebrated the outcome and supported Usiwa-Usiwa in his decision to not allow

homosexual relations are dropped," adding that the government of Malawi should "decriminalise homosexuality in accordance with the equality and non-discrimination clauses of the Malawian constitution and the African Charter on Human and People's Rights, and...ensure the human rights of all its citizens, regardless of sexual orientation or gender identity" (House of Commons 2010).

77 A series of confidential cables between the US Ambassador to Malawi and the US State Department address new developments in the trial of Monjeza and Chimbalanga, including discussions between the President and his Cabinet with several foreign ambassadors. In one instance, the German and Irish ambassadors voiced strong concerns to the President about the potential for repealing Malawi's laws on homosexuality and the implications of the outcome of the case for continued aid (US Government 2010).

78 Interview, Government official, 10 May 2010.
donor influence to sway his ruling, proclaiming, “Donors must know that we are a sovereign country. Our Judicial system must be respected…We will lose our identity as a nation if we follow everything donors say” (Nation 2010). The conviction of Monjeza and Chimbalanga, as many understood it, was an opportunity for the country to make progress in asserting Malawi's independence from donors. As Ephraim Chirwa, a spokesperson for the Economics Association of Malawi stated, the "time has come for Malawi to start using its resources effectively so that it can fund its own budgetary needs. Of course, we can survive without donors... It is high time Malawi put its house in order to wean itself from donor dependence" (Sabola 2010).

For some, issues of donor dependence and Malawi's vulnerability were secondary to the failed promises of democratization. Like Banda and Muluzi before him, then-President Mutharika had been applauded by donors during his first term for promoting democracy in Malawi. However, in his second term international observers began to question Mutharika’s commitment to democratic leadership. As early as 2008, prior to his re-election to a second term, Mutharika was described as showing “familiar signs of impatience with due legal process and open debate” (Africa Confidential 2008). Within this context, Malawi's judicial system had become unreliable, subject to corruption, and in some cases was seen as protecting criminals from the community rather than the community from criminals (Englund 2006). The conviction of Monjeza and Chimbalanga served to highlight these longstanding popular concerns about the country's biased and unreliable justice system, and in the context of secular increases in education and income throughout the country (World Bank 2012), became actionable.

Pointed concerns about fairness in sentencing also emerged following the Magistrate's pronouncement. A handful of editorials openly criticized the necessity of giving Monjeza and Chimbalanga such a long sentence as compared to those handed down for other crimes. Outside
of Blantyre, where Monjeza and Chimbalanga were arrested, one man wrote to *The Nation*:

“Rapists, murderers, and other criminals roaming our streets…if such people go to court they will only be given a few years in jail, yet they violated other people’s lives, but the gay people practiced sodomy in the confines of their homes and did not disturb anyone’s life” (Chileka 2010). A second editorial by an older woman further questioned the efficacy of the sentence:

I look at these two consenting adults, the crime they committed, and the sentence they got and compare it to sentences defilers [rapists] are getting in our courts. I am at a loss for words. Something is wrong somewhere with our justice system…What, I ask, would a 14-year jail term achieve to someone like Aunt Tiwo? The man practically thinks he is a woman, dresses and acts like a lady and is gender disoriented…How would confining such a man to 14 years in an environment where homosexuality is said to be ripe suppose to help solve anything? (Onaliyera 2010)

These editorials and several others like it were clear to state agreement with the judgment that homosexuality is wrong, but argued that the sentences delivered to Monjeza and Chimbalanga were unjust and failed to hold people responsible for other crimes deemed more serious.

News of the judgment and sentence was met with harsh criticism from several international actors. Malawi’s principal donors – the US, UK, EU, Germany, Sweden, Norway, and Denmark – all issued statements condemning the judgment. Official statements by the US and UK were accompanied by pressure to reduce or reevaluate aid allocations to Malawi if international human rights laws were not upheld. Donors also invoked health and HIV transmission specifically as key concerns in the outcome of the case. On May 25th, a week after

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79 "Aunt Tiwo" is the nickname of Tiwonge Chimbalanga.
the sentencing, Michel Sedibé and Michel Kazatchkine, the Executive Directors of UNAIDS and the Global Fund, respectively, arrived to meet with the President. At this meeting, Sedibé and Kazatchkine both emphasized how damaging the conviction and sentencing of Monjeza and Chimbalanga would be for AIDS prevention in Malawi. Citing research studies from Kenya and Nigeria, where MSM had recently been shown to account for as much as 30% of national HIV epidemics and a recent study showing that MSM in Malawi had an HIV prevalence of 21% (Baral et al. 2009), Sedibé cautioned the President:

The danger is that when [MSM] are criminalized, they go underground and continue to be a vector of transmission because they don’t have access to services, treatment, or preventative measures. So we are trying to explain the health aspect of these issues and why it is important to address these issues globally and of course here in Malawi. (Khunga 2010c)

Kazatchkine similarly identified the judgment as a threat to AIDS programming in the region and called on Mutharika to be “a champion for...health in development” and reminded him that continued persecution of MSM would be detrimental to Malawi’s development aid flows as well as the stability of the Global Fund as a whole (Khunga 2010c). These claims were reiterated by CEDEP in international and national interviews.

Ten days after the sentencing, the President, who had privately expressed his disapproval of homosexuality but remained largely outside public debate, gave way to donor pressure. On May 28th, Mutharika received UN Secretary General Ban Ki-moon in Lilongwe. A day later, 

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80 Mutharika was questioned by the German Ambassador to Malawi in January 2010 regarding Malawian laws prohibiting same-sex sex and is reported by US Ambassador Peter Bodde as stating, “If God had wanted men to have sex with men, he would not have created Eve. He would simply have duplicated Adam!” Bodde summarizes: "the President stated his belief that homosexuality was unnatural and should not be sanctioned under Malawian law. That said, he noted that the matter was now before the Malawian courts, which would come to their own conclusion concerning the constitutionality of current proscriptions” (US Government 2010).
following a speech by Ki-moon applauding Malawi’s many successes towards achieving the Millennium Development Goals and adopting the "modern principle of non-indifference" to abuses of power and the denial of rights to people on the basis of "race or faith, or age or gender, or sexual orientation" (Nation 2010), Mutharika officially pardoned the couple before Parliament. Despite Mutharika's stated agreement with the Magistrate that the acts of Monjeza and Chimbalanga were “unMalawian” and “totally wrong” (BBC 2010), Mutharika explained his decision to release Monjeza and Chimbalanga as a legitimate use of him Executive power with humanitarian intentions: "Now that they have been sentenced, I as President of this country have the powers to pronounce on them. I have thus decided that with effect from today, they are pardoned and they will be released. Not because the law allows them, not because the religion of this country allows them, but from a humanitarian point of view. They are pardoned and released forthwith” (Khunga 2010b). In subsequent interviews, Mutharika repeatedly denied allegations that he had pardoned the two men to meet the demands of donors, emphasizing instead that he found forgiveness to be the more appropriate path and because, as President, he must be ever mindful of the country’s "democratic reputation" (Khunga 2010a).

Nevertheless, Malawians publicly attacked Mutharika for kowtowing to Western governments and honoring the desires of foreign donors over those of Malawians. Although Mutharika's pardoning attenuated criticism of human rights abuse from donors, Mutharika was scorned for disrupting democratic procedure and overstepping the division between the Executive and Judicial branches of government (Chalira 2010). Moreover, the pardon was widely misunderstood as constituting a change the law without the approval of the Legislative branch (Nation 2010). Mutharika had broken the law by intervening in the court proceedings while the decision of the court to punish Monjeza and Chimbalanga was seen as reflecting the
"real" cultural and religious values of Malawians. Mutharika received so much criticism that, within three days of the pardon, he banned government officials and the Malawian press from further discussing quote “the gay issue.” Whereas earlier in the proceedings Mutharika had been praised for his appreciation and openness to dialogue on homosexuality (Khunga 2010c), he now declared: “The matter should end there. I don’t want to hear anyone, especially from the government and the party, just leave it alone” (Khunga 2010a).

This ban was maintained for just under a week when Monjeza and Chimbalanga again became the focus of international media attention amid rumors of a breakup, allegations by Monjeza that he and Chimbalanga had been paid to be a “test case” and news of Monjeza’s new engagement to a woman. Although Monjeza was denounced as quote “eating from both sides” throughout the countryside, for many it proved far easier to believe that Monjeza had been “gay for pay” from Western organizations all along, even as rumors circulated that Monjeza’s bride-to-be was a prostitute he had met just a few days earlier. Whether Monjeza’s engagement to Chimbalanga was fact or fiction, a popular opinion columnist for The Nation still condemned Monjeza for tarnishing the reputation of Malawi: “We must admit that as a country we were embarrassed by the saga. We were labeled as the cruel type that violates minority rights” (Kasakula 2010).

Throughout the remainder of 2010, understandings of homosexuality as foreign exploitation re-emerged in full force among poor Malawians and political elites when the UK and US governments threatened to restrict on aid to countries that do not protect the rights of gays and lesbians (Obama 2011:§ 4; Clinton 2011; BBC 2011). Monjeza and Chimbalanga, and

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81 Field notes, 9 June 2010.
82 Field notes, 11 June 2010.
the civil society organizations supporting them, were widely suspected of having been paid to pursue donors’ "gay agenda." However, ideas about how Malawi should respond to foreign pressure to release Monjeza and Chimbalanga and repeal the sodomy statute were inconsistent.

Among the political elite, allowing donors to dictate domestic policy was a violation of political and cultural sovereignty and officials in Parliament and the Malawi police moved to strengthen enforcement of the antisodomy statute. Mixed results on the international stage emboldened Malawi’s political elite. Uganda had been embroiled in debates about a new "Anti-Homosexuality Bill" that strengthened existing legislation criminalizing same-sex sex for over a year. Gay men had been arrested in Kenya and were facing trial in Cameroon. There was talk of strengthening legislation against homosexuals in Nigeria and Ghana. Late in 2010, just after the French parliament rejected yet another bill to legalize same-sex marriage, Malawi Attorney General Jane Ansah reaffirmed her government’s refusal to decriminalize sodomy. Ansah asserted, “If Malawians want to make any changes on this issue, they will do so on their own, but not because of [international] pressure, especially when the whole world cannot agree one thing on gay rights” (Nyasa Times 2010).

In January 2011, a year after the arrest of Monjeza and Chimbalanga, Mutharika signed into law a legislative amendment rendering sex between women a criminal act punishable with five years in prison (Nyasa Times 2011; Nyasa Times 2011). Affirming gender equality while attacking sexual rights, the Minister of Justice and Constitutional Affairs George Chaponda stated that lawmakers had amended the antisodomy law in order to guarantee the law’s gender

83 Leading up to the passage of the "Marriage for All" bill by the French Assembly in February 2013, same-sex marriage had been repeatedly denied in France. A law to legalize gay marriage was first shot down in October, 1998 (BBC 1998). In January of 2011, the French constitutional court upheld a gay marriage ban when challenged by a lesbian couple with four children (BBC 2011). Gay marriage was again denied in June of 2011 when the national assembly voted down a bill to legalize gay marriage (AFP 2011).
neutrality. The original antisodomy law applied only to men and the “government wanted to include women to ensure that homosexuality is criminalized without discrimination” (Nyasa Times 2011). “In as far as we cannot run away from the fact that we need their aid,” said a spokesperson for the President, “it is absurd for these countries to be forcing the country to embrace immoral cultures. We are a sovereign state and we deserve to be treated as such, aid or no aid” (Nyasa Times 2011). 84

Among some Malawians, however, donor threats to withdraw aid were meaningful and disconcerting. The trial provided an important arena in which some Malawians sought to understand and draw attention to the government's failure to deliver on the promise of democratization. When the court convicted Monjeza and Chimbalanga of sodomy and sentenced the pair to 14 years in prison with hard labor, several specific concerns arose related to the arbitrariness of the country's laws and fairness in sentencing across different kinds of crimes. Despite higher than expected support for the pardon, 85 many Malawians perceived Mutharika as disrupting official, democratic procedures and overstepping the division between the Executive and Judicial branches of government. Similarly, for civil society organizations, the persecution of Monjeza and Chimbalanga was exemplary of the state's general lack of transparency on civil rights issues, foreshadowing a period of civic unrest that began shortly after the trial and continued into 2012 (Camack 2012).

84 This oppositional stance caused substantial friction with donors and by mid-2012 was deemed unsustainable and reversed by new leadership. Under Joyce Banda (no relation to Kamuzu Banda), the former Vice President who was promoted to the Presidency following the death of Mutharika in April 2012, reconciling with donors has been a primary concern and, towards this end, she has repeatedly promised a repeal of the sodomy statute. As of November 2012, Banda had imposed a moratorium on enforcing sections 153 and 156 of the penal code, which like the trial has drawn mixed responses from political elites, civil society, and poor Malawians.

85 In national household survey data collected in 2012 and discussed in the next chapter, 33% of Malawians supported the presidential pardon despite 96% strongly agreeing that homosexuality is always wrong (Attitudes toward Identity Survey 2012).
What does this all mean for understandings of same-sex sexualities in Malawi?

Donor interest in HIV among MSM has provided new technologies for seeing MSM in hostile political contexts. With strong support from international HIV, LGBT, and human rights networks, CEDEP has continued to pursue the implementation and expansion of HIV prevention programs and policy for men who have sex with men. In contrast to efforts by earlier organizations, rights claims for the protection of sexual minorities in Malawi have had the most institutional success within the national AIDS program which increasingly identifies MSM as a key prevention target.

However, the view of sexual minorities that is propagated within AIDS research in Malawi and other low- and middle-income countries leaves some reasons for concern. In Malawi, MSM have been made visible but primarily as sites of scientific research, as new objects for interrogation and betterment through public health. Additionally, the technologies through which Malawian NGOs and the small professional class that has emerged through transnational research partnerships engage MSM remain largely constrained by the data collection needs of public health research. Since this research only recognizes individuals and groups as “at risk” of some health problem or another, lesbian women are frequently unidentifiable as rights-bearing subjects in global AIDS policy (e.g., there is no global movement to expand HIV prevention among lesbians or women who have sex with women). Not surprisingly, lesbian women also remain largely invisible and marginalized by Malawian human rights, development and women’s organizations86, including CEDEP, though the organization is moving to redress this issue. As a case in point, in 2011 when Malawian lawmakers amended the

86 Interview, Malawian journalist, 25 June 2012; Interview, officer at Malawian women's organization, 25 June 2012.
antisodomy law in order to guarantee the law’s gender neutrality by extending it to women, neither the global AIDS enterprise nor Malawian civil society marshaled a substantial challenge to government actions.

Further, in order to convince countries of the importance of HIV prevention among MSM, researchers have frequently pointed to a high prevalence of MSM who are also married to or have sex with women. Although some of this research promotes more nuanced understandings of such findings as the result of heterosexism and homophobia, they nonetheless invoke the discourse of the "dreaded bisexual" infecting "unsuspecting women" (Cohen 1999: 220), a discourse that conceives of MSM as primarily as a threat to the public good, as a transmission vector rather than a subject worthy of intervention, suggesting that perhaps we have learned nothing from the visibility struggles that have characterized the first thirty years of the epidemic. As such, the public health discourse on HIV transmission among MSM in low- and middle-income countries may not only contribute to the stigmatization of homosexuality but also fail to provide a basis for broader mobilization around sexual diversity.

Additionally, as shown by responses to the trial in 2010, gains through HIV organizing have been largely limited to civil society and government officials who work directly with donors on HIV/AIDS programs and policies. As yet, it remains unclear whether changes in understandings of homosexuality among civil society will spillover, promoting tolerance among constituents. Among most political elites, the opposite appears to be true: government officials responded to increasing international pressure and criticism by moving to strengthen the enforcement and extend reach of the antisodomy statute. Many villagers supported this oppositional stance which gave voice to longstanding concerns about the country’s vulnerability

87 see Treichler (1999) for similar discussion of women in early writings about AIDS.
of foreign exploitation and the arbitrariness of donor priorities. Further, in the context the Court’s opposition to donor demands, many Malawians began to consider a future of cultural sovereignty from the West. Yet, the trial also provided an important point at which the Malawian government became accountable to the poor majority. After years of “the same thing over again,” some Malawians used the trial to draw attention to inconsistencies in regulation, enforcement, and sentencing, while other villagers drew attention to the fact that opposing donors would have disastrous consequences for Malawians. Thus, the strong oppositional stance characteristic of the political elite during and after the trail may have inadvertently generated some support for Monjeza and Chimbalanga.

88 Interview, Villager, 9 June 2012.
Chapter 4. The Effects of Aid on Individual Attitudes toward Homosexuality in Malawi

In this final empirical chapter, I assess the impact of international donor organizations on local attitudes toward homosexuality in Malawi. As I have argued, international organizations strategically seek to shape the preferences of states by engaging local actors and facilitating various kinds of transnational research and advocacy activities. These strategies also reconfigure local realities by creating new structures of opportunities, constraints, and incentives. In the previous chapter I show how AIDS IGOs and transnational research networks have created new opportunities for seeing and articulating same-sex sexualities in Malawi. Building on these findings, in this chapter I employ nationally representative household data to quantitatively gauge how variation in donor activity across districts has affected individual attitudes toward homosexuality.

Although studies of attitudes toward homosexuality in Africa are very limited compared to other parts of the world, two previous cross-national surveys suggest that Malawians are likely to have strongly negative views of homosexuality. In 2006, the Pew Research Center began examining attitudes toward homosexuality in ten\textsuperscript{89} of the continent’s 54 countries. Pew asked respondents to indicate whether "homosexuality should be accepted by society or homosexuality should not be accepted by society." Overall, the average nonacceptance rate of homosexuality in the ten African countries was 92%, although acceptance of homosexuality ranged from 28% in

\textsuperscript{89} These countries were Ethiopia, Ghana, Ivory Coast, Kenya, Mali, Nigeria, Senegal, South Africa, Tanzania and Uganda.
South Africa to 1\% in Mali (Pew Research Center 2007).\textsuperscript{90} As elsewhere (Lewis 2003; Loftus 2001), Africans’ acceptance of homosexuality varied across demographic characteristics. For example, among middle-class South Africans, 37\% percent accepted homosexuality compared with 23\% of lower-income respondents. A follow-up survey conducted in 2013 that included more affluent African countries -- South Africa, Kenya, Uganda, Ghana, Senegal, and Nigeria -- found that, unlike countries in the Americas and Europe, these attitudes had generally not improved substantially over time (Pew Research Center 2013)

Questions concerning the acceptance of homosexuality were also collected in twelve African countries\textsuperscript{91} by the World Values Survey in 2000-2001 and again in 2005-2008. The World Values Survey asked respondents to indicate whether homosexuality "can always be justified, never be justified, or something in between" on a scale from 1 (never justified) to 10 (always justified). Attitudes toward homosexuality are more positive in these data compared with the Pew data. For example, between 2001 and 2007, the proportion of South Africans reporting that homosexuality was never justified decreased from 60\% to 49\%. In the Pew data, acceptance of homosexuality in South Africa actually decreased during this time, from 33\% acceptance in 2002 to 28\% in 2007. By 2013, acceptance in South Africa was still slightly lower than in 2002 in the Pew data, holding at 32\%. Similarly, while acceptance of homosexuality outside of South Africa lingered in the single digits in the Pew data, World Values Survey data from Zambia, the country immediately to the West of and which shares several cultural characteristics with Malawi, report that just 59\% of respondents reported that homosexuality was never justified in 2007.

\textsuperscript{90} The comparable percentage in the US is 49\% in 2006.
Importantly, the Pew and World Values surveys differ methodologically and have asked substantially different questions. Sociologically-informed public opinion research on attitudes toward homosexuality demonstrates that there are substantial question wording and priming/framing effects in existing surveys of attitudes toward homosexuality and related issues like same-sex marriage (Perrin and McFarland 2011). Differences in wording and the framing of items, for example by asking about same-sex sex, gays and lesbians, or homosexuals, or by presenting homosexuality as a social concern, civil rights issue, or morality issue, can result in important differences in results across question items and could easily explain the differences across the Pew and World Values Survey results. Additionally, both surveys primarily collect data from Africa’s most urbanized settings; in contrast, 80% of the African population lives in rural areas. Thus while these two surveys provide a guide for gauging popular attitudes toward homosexuality in Malawi, the absence of nationally-representative data outside of South Africa and urban areas significantly greatly constrains the ability or researchers, politicians and advocates to assess what individuals' attitudes toward homosexuality, much less how these attitudes might have changed over time. Moreover, in the absence of data on popular attitudes in most countries, the strong, negative positions of a few African political leaders are often taken as representative of their constituents’ views.

Work by Anderson and Fetner (2008), which finds that those who benefit least from economic development tend to be less tolerant of homosexuality regardless of the wealth of the society in which they live, would predict that poor Africans in particular hold strong, negative attitudes toward homosexuality. However, such assumptions are problematic for several reasons. First, donor priorities have been a strong force in reconfiguring local realities (Green 2012; Morfit 2011; Nguyen 2010; Swidler and Watkins 2009; Watkins and Swidler 2013). As I have
shown in the previous chapters, donor interests in HIV among MSM have shaped the preferences of states and the goals and strategies of Malawian civil society organizations. Additionally, in recent years, donors have increasingly directed aid straight to civil society organizations rather than channeling it through a state intermediary, potentially increasing donor influence on the ground through civil society organizations. It remains unknown how these donor interests may have directly shaped individual attitudes or provided new opportunities and incentives for attitudinal change through state and civil society intermediaries.

Second, political homophobia does not necessarily emerge from citizens’ anti-homosexual sentiments. Some state leaders deliberately use political homophobia to achieve specific goals, such as deflecting attention away from undemocratic activities like corruption or suppressing social movements (Currier 2010; Currier 2012). Additionally, as observed by Vorhölter (2012) in Uganda, understandings of homosexuality in southern Africa take on different meanings for actors that are differently situated in national and global networks. Whereas Ugandan political elites have taken very strong oppositional stances to homosexuality, frequently identifying it with Western imperialism, ordinary Ugandans hold ambivalent views, employing Westernization as means to understand broader social changes and not necessarily condemning homosexuality in the process.

Third, ordinary Africans increasingly recognize and contest their marginalization from the global community through claims to global citizenship (Ferguson 2006). In Malawi, challenging the status quo has been increasingly possible in recent years due to secular increases educational attainment, urbanization, the expansion of civil society, evolving indigenous understandings of human and civil rights (Englund 2011), and gains in the economic status of most households in mid-2000s (World Bank 2012) following good rains and the introduction of
fertilizer subsidies. As I show in the previous chapter, various elements have converged in Malawi to promote social activism around human rights which may coincide with the adoption of other more liberal values. All of these factors may introduce variation into Malawian’s attitudes toward homosexuality. Thus, it is important to empirically examine Malawians’ attitudes towards homosexuality and understand how donor pressure for reform may have differentially shaped attitudes toward homosexuality. The questions I address here straightforward: To what extent do individual attitudes toward homosexuality vary in Malawi and how has exposure to aid-supported projects, through which donors disseminate their priorities and practices, shaped those attitudes? In the next section I introduce the data and analyses.

Data and Methods

Nationally representative household survey data were collected in Malawi in 2012 by Tara McKay (UCLA) and Drs. Kim Yi Dionne and Ashley Currier (Texas A&M University). The survey was specifically designed to gather data on Malawian's attitudes toward homosexuality as well as religion, ethnic groups, donors, and government. Interviews were administered by eight trained Malawian staff under the supervision of the author and Malawian research staff at the Invest in Knowledge Initiative, a Malawian research organization with substantial experience fielding household surveys in Malawi. Data collection and analysis procedures were approved by the UCLA and Texas A&M University Institutional Review Boards for the protection of human subjects.

92 For more information on IKI, see http://investinknowledge.org/.
Figure 3. Map of sampled districts, Malawi

**Sampling**

There are aid-supported projects in all of Malawi’s 28 administrative districts (Ministry of Finance [Malawi] 2011:12). Five of Malawi’s 28 districts were sampled across the three regions of Malawi: Mzimba district in the Northern region, Mchinji and Lilongwe districts in the Central region, and Zomba and Mangochi districts in the Southern region (see Figure 3). Districts were
purposefully selected based on population size and representativeness. In all districts, 2
Traditional Authorities (TAs) and one urban area were randomly selected. Within TAs, 3
Census Enumeration Areas (EAs) were randomly selected proportional to population size.
Within urban areas, 1 to 2 residential wards were randomly selected proportional to size using
the same procedure. This yielded 36 Census Enumeration Areas (EAs).

Within selected EAs and urban wards, households were sampled based on a random walk
procedure. At each new EA, interviewers would begin at the center of the village or ward and
radiate outwards in a circle, sampling every fourth household and alternating male and female
respondents. Households were defined as buildings with living quarters and excluded other
outbuildings within the same compound. EAs often contained several distinct villages with
farmlands or sparsely populated areas in between. For efficiency, in such cases the team would
relocate via minibus to the center of the next village and resume the random walk procedure until
there were no more households. In most EAs, all villages within the EA were sampled. In a few
EAs, mountainous terrain and/or lack of passable roads restricted access to the most remote
villages; however, interviewers proceeded on foot as far as possible in these conditions.

Within each EA, 20 to 40 households were sampled, with an oversample of households in
urban areas and in the Northern Mzimba district. One adult from each household was randomly
selected and invited to participate in a short interview. A total of 1584 randomly selected adult
respondents were selected for interview and 1569 consented to participate. Of the 1569 adults
that consented to be interviewed, 1559 completed the interview. The interviews of 68

93 Districts are divided into multiple administrative areas which are governed by an appointed traditional authority
(TA). Chiefs of individual or group villages govern under the authority of the TA. Civil disputes that cannot be
settled by the village chief are heard by the TA for resolution. However, generally the TA’s primary role is to serve
as a liaison between villages and elected district officials.
respondents are excluded from analyses due to missing data on dependent or independent variables, yielding an analytic sample of 1491 respondents.

Survey administration

Once respondents had consented to participate, interviewers asked respondents a series of questions about their demographic background, economic status, and attitudes toward homosexuality, donors, government, and other ethnic groups. A copy of the complete survey instrument with item translations can be found in Appendix B. Data were collected by Malawian interviewers in one of the three primary languages (Chichewa, Chiyao, and Chitumbuka) on iPads using the iSurvey application (iSurveySoft 2013). While the use of iPads to collect survey data was novel to many respondents, all surveys were interviewer administered. Additionally, the Invest in Knowledge Initiative (IKI) research organization which was contracted to hire and train interviewers has consistently fielded studies using android phones to collect data in remote areas since 2011. While piloting the study, we were sensitive to administration effects due to the use of the iPads but generally did not find that their use presented a substantial distraction for respondents. At the end of each day, data were uploaded to a central database and reviewed for consistency and other interviewer errors by Kim Dionne, Tara McKay, and the IKI field supervisor Augustine Harawa.

Attitudes toward homosexuality

In order to get at how variation in question wording and framing affect measurements of attitudes toward homosexuality, the survey contains a variety of standard and original items measuring individual attitudes toward homosexuality, including the two standard attitudinal questions used in cross-national research to gauge attitudes toward homosexuality. The first of
these questions is used by the World Values Survey and regional spinoff surveys such as the European Values Survey (Gerhards 2010). This question presents homosexuality as a moral issue -- the most likely form to elicit negative attitudes toward homosexuality (Perrin and McFarland 2011). The item asks respondents to rate various actions including homosexuality, abortion, spousal abuse, accepting a bribe, having sex before marriage, divorce, cheating on your taxes, and others on a scale from 1 to 10, where 1 is "never justifiable" and 10 is "always justifiable. Response categories may also take a categorical form, presented as "always wrong," "almost always wrong," "sometimes wrong," or "never wrong" in some surveys, as in the General Social Survey in the US (Loftus 2001). In the survey, this question is presented with the categorical responses among a series of items measuring respondents' attitudes toward sex before marriage and extramarital affairs.

A second widely used question gauges the stigma of homosexuality and other groups such as drug users, immigrants, and racial minorities by asking respondents whether they would like to have members of these groups as neighbors, yes or no. We present this question as it appears in its usual form with slight revisions to ensure local understanding:

*I will read you a list of various groups of people. Could you please mention any that you would NOT like to have as neighbors:*

1). People who smoke *chamba* [marijuana]
2). People of a different ethnic group/tribe
3). People who have AIDS
4). Immigrants/foreign workers
5). Homosexuals
6). People of a different religion
7). Heavy drinkers
8). Unmarried couples living together
9). People who speak a different language

In the survey, these questions are juxtaposed with additional questions presenting homosexuality as a legal rights issue, asking respondents whether they favor or oppose laws making same-sex sex among men and same-sex sex among women illegal. A third attitudinal question related to the legal rights of homosexuals asks respondents to rate their agreement with the item:
"Homosexuality is a private matter and should not be regulated."

In addition to framing homosexuality as a legal rights issue, an additional question is used to gauge the political salience of homosexuality relative to other social and economic concerns Malawians may have by asking respondents to rate the priority of series of issues from 1 (lowest, not important for the government to address) to 10 (highest, very important for the government to address). These issues were derived from other research on public policy preferences in Malawi (Dionne, Gerland, and Watkins 2013) and were presented to respondents as follows:

1) increasing fuel in the country
2) increasing access to clean water
3) keeping the price of household commodities low (e.g., sugar, oil)
4) improving the delivery of electricity in the country
5) making laws to deal with witchcraft
6) making laws to deal with polygamy
7) making laws to deal with sexual relations between two adults of the same sex
While other items gauge the strength of individual attitudes for or against homosexuality, this item allows for a relative ranking of the salience and importance of government action on homosexuality for respondents.

Next, given various threats from donors to withdraw aid on grounds of violating minority rights discussed in the previous chapter, the survey includes a question linking homosexuality to donor interest and Westernization. These questions ask respondents to rate their level of agreement with the statements, "Homosexuality is a donor concern so I have to support it" and "Homosexuality is a Western invention."

Finally, a key concern in social psychological research on attitudes is that individual attitudes, especially those toward stigmatized groups or behaviors, are frequently argued to be too abstract and thus not representative of individuals' actual opinions or behavior. In order to address some of this bias, the survey includes two questions regarding concrete events in Malawi: the conviction and Presidential pardoning of Steven Monjeza and Tiwonge Chimbalanga discussed in the previous chapter. After being asked if they were familiar with the defendants and how closely they followed the trial, respondents were asked to rate their level of approval with the Courts conviction of Monjeza and Chimbalanga and the subsequent Presidential pardon of Monjeza and Chimbalanga.

**District-level characteristics**

To assess how variation in donor investment across districts affects residents' attitudes toward homosexuality, I merged the household data with district-level demographic characteristics from the 2008 Malawi Census (Government of Malawi 2010). Primary characteristics include the proportion of the population over age 5 with no education, the proportion of the population under
age 5, and the proportion of the population over age 55. Higher proportions of uneducated individuals in an area would typically be expected to be negatively associated with tolerance towards homosexuals. At the same time however, individuals with no education in Malawi are very likely to be subsistence farmers living in rural areas with very different concerns that are directly related to their livelihood, making predictions of the direction of this effect difficult. In contrast, parents’ concerns about their young children’s exposure to homosexuals has ignited various sex panics around the world in the last few decades (Rubin 1984; Irvine 2008) and, as such, areas with high concentrations of children – and thus high concentrations of parents -- should be more likely to prioritize making laws about homosexuality. Additionally, areas with higher concentrations of individuals over age 55 who lived under the socially conservative and politically anti-Western Banda regime are expected to be more likely to prioritize making laws about homosexuality.

In order to examine the effects of donor investment, I have also merged the household survey data with geocoded aid activity data compiled by the Malawi Geocoding project, a joint venture between AidData and the Robert S. Strauss Center's Climate Change and African Political Stability (CCAPS) program (Peratsakis et al. 2012). Aid data are based on aid information reported by donors to the Malawi Ministry of Finance and supplemented with data from project documents and reports gathered from in-country donor offices. Data contain the committed dollar amounts\textsuperscript{94} and locations of 548 projects initiated from 2000 to 2011 by 30 of the 31 donor agencies active in Malawi. The data represent $5.3 billion US dollars in aid

\textsuperscript{94} Across various sources, including OECD Credit Reporting Database used in Chapter 2 and project administration data from multilateral, bilateral and private foundations, aid commitment data are generally more complete than actual aid disbursement data which may be adjusted over the course of the project. For this reason, I use commitment data in the present analysis, however, because actual disbursements are more likely to be adjusted downwards rather than upwards, the analysis may somewhat overestimate the effects of aid.
commitments, or approximately 80% of all official external funding that the country has received since 2000. From these data, I construct a 5-year average of aid per capita per district (in thousands of $US). Because household survey data were collected in 2012, I limit the inclusion of aid projects to those that were active during the 5 years prior to the survey, or since 2008. I also limit the inclusion of projects to those with locations geocoded at the district-level or smaller. Roughly 6% of all projects are coded at the national level which cannot be easily disaggregated, although since these awards primarily go to government ministries, it is highly likely that these aid commitments end up in the capitol and other urban district centers.

Additionally, a small number of projects do not include geocoded location data or data on the start or end year of the project. Without such data, aid commitments cannot be adequately allocated by district or year and these projects must be dropped from the analysis. Fortunately, in a recent paper using these data to examine predictors of districts receiving aid (Dionne, Kramon, and Roberts 2013), aid commitment data were more likely to be missing in earlier years (1998-2003) compared with the more recent years used in the present analysis.

Descriptive statistics for all district-level characteristics are presented in Table 6.

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95 While new projects are not included in the data past 2011, many projects are commissioned for multiple years. As such, several projects initiated in 2011 or earlier continue to be active in 2012, giving a sense of baseline aid investments active in 2012. For projects where aid commitment amounts reflect multiyear projects, the allocation per year is obtained by dividing the total commitment by the number of years.
Table 6. Descriptive statistics for district-level characteristics

<table>
<thead>
<tr>
<th>District-Level Characteristics</th>
<th>Southern</th>
<th></th>
<th>Central</th>
<th></th>
<th>Northern</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mangochi</td>
<td>Zomba</td>
<td>Lilongwe</td>
<td>Mchinji</td>
<td>Mzimba</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>Urban</td>
<td>Rural</td>
<td>Urban</td>
<td>Rural</td>
<td>Total</td>
</tr>
<tr>
<td>Percent of the population under age 5</td>
<td>19.1</td>
<td>16.1</td>
<td>18.5</td>
<td>17.2</td>
<td>18.6</td>
<td>19.5</td>
</tr>
<tr>
<td>Percent of the population over age 55</td>
<td>7.3</td>
<td>3.4</td>
<td>7.8</td>
<td>3.1</td>
<td>7.1</td>
<td>6.0</td>
</tr>
<tr>
<td>Percent of population living more than 30 minutes from nearest tarmac road</td>
<td>24.7</td>
<td>8.4</td>
<td>30.2</td>
<td>8.8</td>
<td>21.2</td>
<td>72.6</td>
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<tr>
<td>Number of aid projects active in district</td>
<td>109</td>
<td>129</td>
<td></td>
<td>190</td>
<td>45</td>
<td>144</td>
</tr>
<tr>
<td>Annual aid per capita, 5 year average (in thousands $US)</td>
<td>.462</td>
<td>.713</td>
<td>.217</td>
<td>.480</td>
<td>2.004</td>
<td></td>
</tr>
</tbody>
</table>
Individual covariates

In addition to district characteristics, individual-level covariates various individual covariates are included in the analysis described above to control for variation in demographic and other individual characteristics across districts. Individual characteristics include: sex, age, ethnic group/tribe, marital status, urban residence, highest level of education attained, an index of socioeconomic status composed from assets found in the household, frequency of mobile phone use, and political party. Descriptive statistics for the sample are presented with data from the 2008 Malawi Census as available in Table 7.

Analysis

In the analyses presented below, I briefly compare responses to the different questions measuring attitudes toward homosexuality, demonstrating the effects of wording on measured attitudes toward homosexuality. Because the items use different scales, I standardize all items so that 0 represents the lowest approval of same-sex sexualities on the scale and 1 represents the highest approval of same-sex sexualities possible on the scale. Using a two-tailed t-test, I test for differences in the means across items, comparing each item to the most widely used item "Same-sex sexualities are always wrong."

Next, I present a two-level (level 1 = individuals, level 2 = district) random intercept regression model with maximum likelihood estimation (Rabe-Hesketh and Skrondal 2008) to estimate the effects of aid on respondents' prioritization of making laws to regulate same-sex sex. The two-level model uses level 1 and level 2 weights calculated for all randomly selected adults. Weights are used to adjust for over-sampling by district, the EA selection probabilities by TA, the household selection probabilities by EA, and the EA specific rates of over-sampling urban
Table 7. Descriptive statistics for 2012 Malawi Household Survey data (N=1491)

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>% unweighted</th>
<th>% weighted</th>
<th>2008 Census</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Region</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>North</td>
<td>278</td>
<td>14.1</td>
<td>12.9</td>
<td></td>
</tr>
<tr>
<td>Central</td>
<td>639</td>
<td>45.4</td>
<td>44.9</td>
<td></td>
</tr>
<tr>
<td>South</td>
<td>574</td>
<td>40.5</td>
<td>42.2</td>
<td></td>
</tr>
<tr>
<td><strong>District</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mzimba</td>
<td>278</td>
<td>14.1</td>
<td>18.4</td>
<td></td>
</tr>
<tr>
<td>Mchinji</td>
<td>331</td>
<td>2.4</td>
<td>9.7</td>
<td></td>
</tr>
<tr>
<td>Lilongwe</td>
<td>308</td>
<td>42.9</td>
<td>40.6</td>
<td></td>
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<tr>
<td>Mangochi</td>
<td>296</td>
<td>21.2</td>
<td>17.0</td>
<td></td>
</tr>
<tr>
<td>Zomba</td>
<td>278</td>
<td>19.3</td>
<td>14.2</td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>448</td>
<td>20.2</td>
<td>15.3</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>739</td>
<td>49.7</td>
<td>51.4</td>
<td></td>
</tr>
<tr>
<td><strong>Age Group</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>18-24</td>
<td>418</td>
<td>27.5</td>
<td>27.6</td>
<td></td>
</tr>
<tr>
<td>25-34</td>
<td>461</td>
<td>30.9</td>
<td>30.7</td>
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<tr>
<td>35-45</td>
<td>271</td>
<td>19.4</td>
<td>16.9</td>
<td></td>
</tr>
<tr>
<td>45-54</td>
<td>167</td>
<td>10.4</td>
<td>9.8</td>
<td></td>
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<tr>
<td>55+</td>
<td>185</td>
<td>11.8</td>
<td>15.0</td>
<td></td>
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<tr>
<td><strong>Socioeconomic status (mean, SD)</strong></td>
<td>.46</td>
<td>(.03)</td>
<td>--</td>
<td></td>
</tr>
<tr>
<td><strong>Highest Level of Education Completed</strong></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Some Primary</td>
<td>884</td>
<td>61.0</td>
<td>73.0</td>
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<tr>
<td>Completed Primary</td>
<td>225</td>
<td>14.2</td>
<td>11.0</td>
<td></td>
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<tr>
<td>Some Secondary</td>
<td>222</td>
<td>13.6</td>
<td>7.0</td>
<td></td>
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<tr>
<td>Completed Secondary or higher</td>
<td>171</td>
<td>11.2</td>
<td>7.0</td>
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<tr>
<td><strong>Frequency of Mobile Phone Use</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Never</td>
<td>456</td>
<td>28.9</td>
<td>--</td>
<td></td>
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<tr>
<td>Less than once a month</td>
<td>94</td>
<td>6.5</td>
<td>--</td>
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<tr>
<td>A few times a month</td>
<td>108</td>
<td>5.8</td>
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</tr>
<tr>
<td>A few times a week</td>
<td>208</td>
<td>12.7</td>
<td>--</td>
<td></td>
</tr>
<tr>
<td>Everyday</td>
<td>702</td>
<td>46.2</td>
<td>--</td>
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<td><strong>Marital Status</strong></td>
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<td></td>
<td></td>
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<tr>
<td>Never Married</td>
<td>193</td>
<td>8.4</td>
<td>--</td>
<td></td>
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<tr>
<td>Married</td>
<td>1161</td>
<td>80.7</td>
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<tr>
<td>Separated/Divorced/Widowed</td>
<td>148</td>
<td>10.9</td>
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<td><strong>Ethnic Group/Tribe</strong></td>
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<td>Chewa</td>
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<td>33.6</td>
<td>32.6</td>
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<tr>
<td>Lomwe</td>
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<td>17.6</td>
<td></td>
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<tr>
<td>Ngoni</td>
<td>122</td>
<td>11.1</td>
<td>11.5</td>
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<tr>
<td>Tumbuka</td>
<td>220</td>
<td>9.5</td>
<td>8.8</td>
<td></td>
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</table>
Table 7. Descriptive statistics for 2012 Malawi Household Survey data (N=1491)

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>% unweighted</th>
<th>% weighted</th>
<th>2008 Census</th>
</tr>
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<tr>
<td></td>
<td></td>
<td>2012</td>
<td>2012</td>
<td>2008</td>
</tr>
<tr>
<td>Yao</td>
<td>223</td>
<td>13.3</td>
<td>13.5</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>184</td>
<td>15.6</td>
<td>16.0</td>
<td></td>
</tr>
<tr>
<td>Foreign Born</td>
<td>40</td>
<td>3.0</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Subsistence agriculture</td>
<td>640</td>
<td>39.6</td>
<td>--</td>
<td>--</td>
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<tr>
<td>Market work, sales</td>
<td>369</td>
<td>23.7</td>
<td>--</td>
<td>--</td>
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<tr>
<td>Agriculture wage-labor</td>
<td>117</td>
<td>9.5</td>
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<tr>
<td>Salaried employment</td>
<td>119</td>
<td>8.7</td>
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<tr>
<td>Fishing</td>
<td>25</td>
<td>2.3</td>
<td>--</td>
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<tr>
<td>Student</td>
<td>30</td>
<td>2.0</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Other cash activity</td>
<td>98</td>
<td>8.8</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>(Handicraft, alcohol</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>production, carpentry,</td>
<td></td>
<td></td>
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<tr>
<td>domestic activities)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never worked, not seeking work</td>
<td>14</td>
<td>0.7</td>
<td>--</td>
<td></td>
</tr>
<tr>
<td>Never worked, seeking work</td>
<td>59</td>
<td>3.0</td>
<td>--</td>
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<tr>
<td>Religion</td>
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<td></td>
</tr>
<tr>
<td>Christian</td>
<td>1248</td>
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<td>82.7</td>
<td></td>
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<td>Catholic</td>
<td>330</td>
<td>19.8</td>
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<td>--</td>
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<td>Protestant</td>
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<td>39.3</td>
<td>--</td>
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<td>Evangelical/Charismatic</td>
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<td>--</td>
<td>--</td>
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<tr>
<td>African Independent</td>
<td>199</td>
<td>12.0</td>
<td>--</td>
<td>--</td>
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<tr>
<td>Muslim</td>
<td>236</td>
<td>15.5</td>
<td>13.0</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>18</td>
<td>2.4</td>
<td>2.5</td>
<td></td>
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<tr>
<td>Political Party</td>
<td></td>
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<tr>
<td>Democratic Progressive Party</td>
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<tr>
<td>Malawi Congress Party</td>
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<td>7.9</td>
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<td>--</td>
</tr>
<tr>
<td>People's Party</td>
<td>273</td>
<td>16.1</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>United Democratic Front</td>
<td>197</td>
<td>13.3</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>None, Undecided, Other</td>
<td>475</td>
<td>34.8</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

a Census data on education attainment reflect receipt of leaving certificates for which a test is required.

b Census occupation categories differ substantially from those used here and levels of aggregation do not permit formal comparisons. However, census data confirm that the vast majority of Malawians engage in subsistence agriculture, forestry, fishing, market work or other cash activity for their primary income (94%). Very few are formally employed in other sectors.
households. See Appendix C for a description of the procedure used to construct sampling weights. All analyses are conducted using STATA 12.1.

The two-level analysis proceeds in three stages. First, I fit a two-level (level 1 = individuals, level 2 = district) random intercept model with maximum likelihood estimation with no covariates and only a random intercept for each district. Second, I test the fit of this model against a model that includes all individual-level characteristics identified above and a random intercept for each district. Third, I test the fit of the second model with only individual characteristics against a model that includes individual and district characteristics and a random intercept for each district. The full model is represented as:

\[ y_{ij} = \beta_0 x_{0ij} + \beta_1 x_{1ij} + \ldots + \beta_k x_{kij} + u_{0j} + e_{0ij} \]

where the outcome \( y \) for individual \( i \) living in district \( j \) is predicted by \( \beta_0 x_{0ij} + \beta_1 x_{1ij} + \ldots + \beta_k x_{kij} \), the fixed portion of the model; \( u_{0j} \), which allows each district \( j \) to have a unique intercept \( u \); and \( e_{0ij} \), the level 1 residual. The inclusion of a random intercept for district allows me to adjust for unobserved characteristics across districts that may affect attitudes towards homosexuality. At each step in the analysis, I test the model against a one-level model without the random intercept for district. Results are only presented below where the full model with district characteristics fit the data significantly better than the model with only individual characteristics and where the inclusion of the random intercept for district significantly improved the fit of the base and individual-level models. The variance of the random intercept is presented for each model at the bottom of each results table.

**Historical effects**

Household survey data were collected in Malawi June and July of 2012. This point in Malawi's history was particularly tumultuous in ways that may potentially affect the data and thus require
brief but explicit acknowledgement. As described in the previous chapter, Malawi’s relations with donors became increasingly tenuous leading up to the trial of Monjeza and Chimbalanga and continued to deteriorate substantially through 2011 and 2012. As the government led by former President Bingu wa Mutharika became increasingly authoritarian following his successful reelection in 2009, donors began to question their support of the regime. Mutharika's economic policies, especially fixing the currency value so that it could not fluctuate against the dollar, crippled local foreign currency reserves and exacerbated economic decline (Camack 2012; Dionne and Dulani 2013; Wroe 2012). Following the government's criminalization of same-sex sex among women and the passage of legislation, Germany reduced its aid to the country by half (Resnick 2012). Additional concerns regarding Mutharika violation of IMF conditions by fixing the currency prompted the IMF to suspend aid to the country beginning in July 2011 (Resnick 2012). In April 2012, President Mutharika died and was succeeded by Vice President Joyce Banda. Under pressure from the IMF, one of Banda’s first moves in office was to devalue the currency by 40%. It had been pegged at 151 kwacha to the dollar under President Mutharika. After the IMF adjustment the value of the kwacha continued to fall, reaching an all-time low in April 2013 of 415 kwacha to the dollar, just 36% of its 2011 value. In order to redress donor concerns about human rights abuses in the country, Banda also stated in her first state address on May 18, 2012, a month prior to fielding the survey, that she would repeal anti-homosexuality laws (Banda 2012; BBC 2012) and, after a bit of wavering, installed a moratorium on police enforcement of the country's sodomy laws in November 2012 (Juma 2012).

Thus, data represent a snapshot of public attitudes in the midst of ongoing and often contentious debates about the homosexuality, donor investment, democracy, and economic decline. If we had fielded the study slightly earlier or later in 2012, it is conceivable that
individuals' attitudes to homosexuality, especially where we have asked respondents to rank the importance of making laws against same-sex sex against other social and economic issues, we may have gotten somewhat different responses. While the dynamic and reactive nature of public opinion is a problem for all public opinion research, in our case, historical effects limit the extent to which these data are generalizable beyond a certain time period in Malawi's history, but nonetheless capture Malawian's attitudes for the first time and provide a baseline for future studies.

Malawians’ Attitudes toward Homosexuality

Overall, a majority of Malawians hold negative attitudes toward same-sex sex; however, as expected there are substantial differences across questions. The distributions of each item are presented in Table 8. On questions that framed homosexuality as a moral issue, respondents were the most negative. Perceptions that homosexuality is "always wrong" were almost universal (97%). This result is consistent with perceptions of the presence of substantial public disapproval of homosexuality discussed in the previous chapter but is higher than expected. In World Values Survey data using a variant of the same question collected in 2007 in Zambia, the country immediately to the West of and which shares several cultural characteristics with Malawi, 59% of respondents reported that homosexuality was "never justified."

Using this item as a baseline, I tested the means of all other items against this standard question. For all other items, the mean scores are significantly higher than the base line item at the level of $p < .01$ with the exception of laws making sex between women illegal, which is
Table 8. Items measuring attitudes toward homosexuality

<table>
<thead>
<tr>
<th>Items</th>
<th>% weighted</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Same-sex sex is</strong></td>
<td></td>
</tr>
<tr>
<td>Always wrong</td>
<td>97.7</td>
</tr>
<tr>
<td>Almost always wrong</td>
<td>1.0</td>
</tr>
<tr>
<td>Sometimes wrong</td>
<td>0.5</td>
</tr>
<tr>
<td>Never wrong</td>
<td>0.1</td>
</tr>
<tr>
<td><strong>Homosexuals as neighbors</strong></td>
<td></td>
</tr>
<tr>
<td>Do not want</td>
<td>94.5</td>
</tr>
<tr>
<td>Can have</td>
<td>5.5</td>
</tr>
<tr>
<td><strong>Favor/Oppose law making same-sex for men illegal</strong></td>
<td></td>
</tr>
<tr>
<td>Strongly favor</td>
<td>92.6</td>
</tr>
<tr>
<td>Favor</td>
<td>4.8</td>
</tr>
<tr>
<td>Oppose</td>
<td>1.0</td>
</tr>
<tr>
<td>Strongly oppose</td>
<td>1.6</td>
</tr>
<tr>
<td><strong>Favor/Oppose law making same-sex for women illegal</strong></td>
<td></td>
</tr>
<tr>
<td>Strongly favor</td>
<td>93.6</td>
</tr>
<tr>
<td>Favor</td>
<td>3.7</td>
</tr>
<tr>
<td>Oppose</td>
<td>1.0</td>
</tr>
<tr>
<td>Strongly oppose</td>
<td>1.7</td>
</tr>
<tr>
<td><strong>Homosexuality is a private matter and should not be regulated.</strong></td>
<td></td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>61.6</td>
</tr>
<tr>
<td>Disagree</td>
<td>23.7</td>
</tr>
<tr>
<td>Don't Know</td>
<td>3.7</td>
</tr>
<tr>
<td>Agree</td>
<td>5.2</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>5.5</td>
</tr>
<tr>
<td><strong>Prioritization of: (mean (SD))</strong></td>
<td></td>
</tr>
<tr>
<td>keeping the price of household commodities low</td>
<td>8.9</td>
</tr>
<tr>
<td>(SD) 0.09</td>
<td></td>
</tr>
<tr>
<td>increasing access to clean water</td>
<td>8.5</td>
</tr>
<tr>
<td>(SD) 0.13</td>
<td></td>
</tr>
<tr>
<td>increasing fuel in the country</td>
<td>8.3</td>
</tr>
<tr>
<td>(SD) 0.12</td>
<td></td>
</tr>
<tr>
<td>improving delivery of electricity in the country</td>
<td>7.5</td>
</tr>
<tr>
<td>(SD) 0.15</td>
<td></td>
</tr>
<tr>
<td>making laws to deal with sexual relations between two adults of the</td>
<td></td>
</tr>
<tr>
<td>same sex</td>
<td>7.4</td>
</tr>
<tr>
<td>(SD) 0.23</td>
<td></td>
</tr>
<tr>
<td>making laws to deal with polygamy</td>
<td>6.1</td>
</tr>
<tr>
<td>(SD) 0.23</td>
<td></td>
</tr>
<tr>
<td>making laws to deal with witchcraft</td>
<td>5.8</td>
</tr>
<tr>
<td>(SD) 0.20</td>
<td></td>
</tr>
</tbody>
</table>
Table 8. Items measuring attitudes toward homosexuality

<table>
<thead>
<tr>
<th>Items</th>
<th>% weighted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homosexuality is a primary concern of donors so I have to support it.</td>
<td></td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>66.5</td>
</tr>
<tr>
<td>Disagree</td>
<td>18.9</td>
</tr>
<tr>
<td>Don't Know</td>
<td>5.4</td>
</tr>
<tr>
<td>Agree</td>
<td>3.2</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>6.0</td>
</tr>
<tr>
<td>Homosexuality is a Western invention. (reverse coded)</td>
<td></td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>7.2</td>
</tr>
<tr>
<td>Disagree</td>
<td>4.2</td>
</tr>
<tr>
<td>Don't Know</td>
<td>13.3</td>
</tr>
<tr>
<td>Agree</td>
<td>19.5</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>55.9</td>
</tr>
<tr>
<td>Approve/Oppose conviction of Steven Monjeza and Tiwonge Chimbalanga</td>
<td></td>
</tr>
<tr>
<td>Opposed conviction</td>
<td>13.6</td>
</tr>
<tr>
<td>Don't Know</td>
<td>3.0</td>
</tr>
<tr>
<td>Approved conviction</td>
<td>83.4</td>
</tr>
<tr>
<td>Approve/Oppose Presidential pardon of Steven Monjeza and Tiwonge</td>
<td></td>
</tr>
<tr>
<td>Opposed pardon</td>
<td>62.9</td>
</tr>
<tr>
<td>Don't Know</td>
<td>3.9</td>
</tr>
<tr>
<td>Approved pardon</td>
<td>33.2</td>
</tr>
</tbody>
</table>
significant at $p < .05$. Although in some cases these differences are small, especially for the legal rights items, these results indicate greater approval of same-sex sexualities when items are not framed as moral concerns but rather as legal and social issues. Additionally, the two items that request opinions about concrete events -- the conviction and pardoning of Monjeza and Chimbalanga -- present a very different picture of attitudes toward homosexuality. Compared with the baseline item in which 97% of Malawians identify homosexuality as "always wrong," I find that significantly fewer (83%; $p < .001$) approved of the conviction and one-third actually approved the President's pardon of the two men (this difference is also significant at $p < .001$). Given these results, expectations of universally negative attitudes towards homosexuality in Africa which have been largely drawn from World Values Survey data using the morally-framed item are likely to be overestimated. Compared to this standard item, those framing homosexuality as a legal/rights concern and those asking respondents to report their opinion on actual events demonstrate significantly greater approval of same-sex sexualities. Finally, examining respondents' ratings of the importance of various issues the government could be attending to (see Table 9), making laws to deal with homosexuality comes in fifth of the seven priorities. Respondents' ratings of the extent to which the government should prioritize making laws to deal with homosexuality ($M = 7.4$, $SD = .23$) come in a full point and a half lower than the need for government to prioritize keeping the price of commodities low ($M = 8.9$, $SD = .09$; $t = 17.45$, $p < .001$).

**Effects of Aid on Attitudes?**

In this section, I examine how variation in aid allocations across districts affects individuals' prioritization of making laws to deal with same-sex sex. Above I have shown how ratings of this
Table 9. Means and standard deviations of citizens’ priority preferences

<table>
<thead>
<tr>
<th>Prioritization of...</th>
<th>Rank Order</th>
<th>Overall Mean (SD)</th>
<th>Southern District (Mean, SD)</th>
<th>Central District (Mean, SD)</th>
<th>Northern District (Mean, SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Zomba</td>
<td>Mangochi</td>
<td>Mchinji</td>
</tr>
<tr>
<td>keeping the price of household commodities low</td>
<td>1</td>
<td>8.9 (.09)</td>
<td>9.3 (.18)</td>
<td>8.7 (.21)</td>
<td>9.0 (.07)</td>
</tr>
<tr>
<td>increasing access to clean water</td>
<td>2</td>
<td>8.5 (.23)</td>
<td>9.0 (.18)</td>
<td>8.3 (.21)</td>
<td>8.1 (.17)</td>
</tr>
<tr>
<td>increasing fuel in the country</td>
<td>3</td>
<td>8.3 (.12)</td>
<td>9.2 (.18)</td>
<td>7.9 (.21)</td>
<td>7.9 (.12)</td>
</tr>
<tr>
<td>improving delivery of electricity in the country</td>
<td>4</td>
<td>7.5 (.15)</td>
<td>8.6 (.44)</td>
<td>7.1 (.14)</td>
<td>6.9 (.15)</td>
</tr>
<tr>
<td>making laws to deal with sexual relations between two adults of the same sex</td>
<td>5</td>
<td>7.4 (.23)</td>
<td>9.0 (.21)</td>
<td>7.4 (.39)</td>
<td>6.6 (.18)</td>
</tr>
<tr>
<td>making laws to deal with witchcraft</td>
<td>6</td>
<td>5.8 (.20)</td>
<td>6.9 (.32)</td>
<td>5.8 (.29)</td>
<td>5.1 (.19)</td>
</tr>
<tr>
<td>making laws to deal with polygamy</td>
<td>7</td>
<td>6.1 (.23)</td>
<td>7.6 (.37)</td>
<td>6.0 (.44)</td>
<td>5.3 (.26)</td>
</tr>
</tbody>
</table>
item present a different picture of the salience of homosexuality compared with the standard item that asks respondents to rate whether same-sex sex is always or never wrong. As shown in Table 10, individual ratings of this item are also affected by the level of aid allocated to the district and the proportion of children under the age of 5. As average annual aid increases, individuals rate the need for the government to make laws against same-sex sex higher. A thousand dollar difference in aid translates to almost a full point increase on the 1 to 10 scale measuring prioritization. Similarly, as the proportion of children under age 5 in a district increases, adults increase their prioritization of regulating same-sex sex. There were no significant effects of other district characteristics. At the individual-level, Malawians with higher socioeconomic status, as measured by an index of household items, were surprisingly more likely to prioritize regulation of same-sex sex. In contrast with other surveys which find that higher socioeconomic status is associated with greater acceptance or approval of same-sex sexualities, these data show the inverse relationship is present in Malawi. Similarly, individuals who completed primary education are more likely than individuals who did not complete primary to prioritize making laws to deal with same-sex sex. Together these results suggest that donor priorities have had an effect on Malawian attitudes toward homosexuality, but not necessarily in the expected direction of liberalization. Rather, greater donor presence in some districts appears to have increased concern about homosexuality.
Table 10. Multilevel random intercept regression coefficients and standard errors of model predicting prioritization of making laws to deal with same-sex sex

<table>
<thead>
<tr>
<th></th>
<th>Level 1 Only</th>
<th></th>
<th></th>
<th>Full</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>β</td>
<td>(SE)</td>
<td>p</td>
<td>β</td>
<td>(SE)</td>
<td>p</td>
</tr>
<tr>
<td><strong>District-Level Characteristics</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aid per capita, 5 year average</td>
<td>0.885</td>
<td>0.360</td>
<td>0.014</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent population with no education</td>
<td>-0.013</td>
<td>0.010</td>
<td>0.201</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent population under age 5</td>
<td>0.568</td>
<td>0.153</td>
<td>0.000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent population over age 55</td>
<td>0.101</td>
<td>0.111</td>
<td>0.365</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Individual-Level Variables</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>-0.116</td>
<td>0.239</td>
<td>0.627</td>
<td>0.618</td>
<td>0.424</td>
<td>0.145</td>
</tr>
<tr>
<td>Female</td>
<td>0.220</td>
<td>0.187</td>
<td>0.238</td>
<td>0.224</td>
<td>0.191</td>
<td>0.240</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-24 (reference)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25-34</td>
<td>0.198</td>
<td>0.258</td>
<td>0.442</td>
<td>0.217</td>
<td>0.243</td>
<td>0.371</td>
</tr>
<tr>
<td>35-44</td>
<td>0.150</td>
<td>0.121</td>
<td>0.217</td>
<td>0.203</td>
<td>0.126</td>
<td>0.108</td>
</tr>
<tr>
<td>45-54</td>
<td>-0.933</td>
<td>0.491</td>
<td>0.057</td>
<td>-0.889</td>
<td>0.513</td>
<td>0.083</td>
</tr>
<tr>
<td>55+</td>
<td>0.652</td>
<td>0.400</td>
<td>0.103</td>
<td>0.671</td>
<td>0.381</td>
<td>0.078</td>
</tr>
<tr>
<td>Asset Index</td>
<td>0.781</td>
<td>0.177</td>
<td>0.000</td>
<td>0.761</td>
<td>0.192</td>
<td>0.000</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some Primary (reference)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completed Primary</td>
<td>0.396</td>
<td>0.126</td>
<td>0.002</td>
<td>0.438</td>
<td>0.110</td>
<td>0.000</td>
</tr>
<tr>
<td>Some Secondary</td>
<td>0.476</td>
<td>0.286</td>
<td>0.096</td>
<td>0.464</td>
<td>0.282</td>
<td>0.100</td>
</tr>
<tr>
<td>Completed Secondary</td>
<td>0.189</td>
<td>0.284</td>
<td>0.506</td>
<td>0.185</td>
<td>0.280</td>
<td>0.510</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never married (reference)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>-0.143</td>
<td>0.248</td>
<td>0.565</td>
<td>-0.153</td>
<td>0.253</td>
<td>0.545</td>
</tr>
<tr>
<td>Divorced, Separated, Widowed</td>
<td>-0.684</td>
<td>0.461</td>
<td>0.137</td>
<td>-0.729</td>
<td>0.448</td>
<td>0.103</td>
</tr>
<tr>
<td>Ethnic Group/Tribe</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chewa (reference)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lomwe</td>
<td>-0.647</td>
<td>0.196</td>
<td>0.001</td>
<td>-0.548</td>
<td>0.203</td>
<td>0.007</td>
</tr>
<tr>
<td>Ngoni</td>
<td>-0.209</td>
<td>0.138</td>
<td>0.130</td>
<td>-0.072</td>
<td>0.218</td>
<td>0.743</td>
</tr>
<tr>
<td>Tumbuka</td>
<td>-0.908</td>
<td>0.339</td>
<td>0.007</td>
<td>-0.747</td>
<td>0.251</td>
<td>0.003</td>
</tr>
<tr>
<td>Yao</td>
<td>-0.734</td>
<td>0.656</td>
<td>0.263</td>
<td>-0.579</td>
<td>0.730</td>
<td>0.428</td>
</tr>
<tr>
<td>Other</td>
<td>-1.072</td>
<td>0.474</td>
<td>0.022</td>
<td>-0.980</td>
<td>0.562</td>
<td>0.081</td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catholic (reference)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protestant</td>
<td>-0.232</td>
<td>0.185</td>
<td>0.210</td>
<td>-0.219</td>
<td>0.188</td>
<td>0.244</td>
</tr>
<tr>
<td>Muslim</td>
<td>-0.837</td>
<td>0.889</td>
<td>0.346</td>
<td>-0.832</td>
<td>0.892</td>
<td>0.351</td>
</tr>
<tr>
<td>Evangelical/Charismatic</td>
<td>-0.421</td>
<td>0.111</td>
<td>0.000</td>
<td>-0.406</td>
<td>0.104</td>
<td>0.000</td>
</tr>
<tr>
<td>African Independent</td>
<td>0.702</td>
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Table 10. Multilevel random intercept regression coefficients and standard errors of model predicting prioritization of making laws to deal with same-sex sex

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Conclusion

*How could it be that the AIDS world at large only just seems to have rediscovered yesterday that there is an HIV epidemic amongst [men who have sex with men] and trans people in the global South as well as the global North?*

Jeff O’Malley, Director, HIV/AIDS group, UNDP

2008 International AIDS Conference

Over the course of a decade, HIV among MSM has become politically salient and been integrated into global AIDS policy in ways that were unthinkable at the beginning of the epidemic. Yet, the inclusion of same-sex sexualities remains widely contested. To the extent that AIDS policies on MSM are converging across national boundaries, that process has been driven by the efforts of intergovernmental organizations. IGOs have become central actors in formation, diffusion, and implementation of AIDS policy concerning same-sex sexualities. They develop new policy ideas and set priorities that may diverge substantially from the interests of member states, both rich and poor. As such, IGOs have shown that they are not simply disinterested forums in which states pursue their own interests or passive collections of rules and norms, but autonomous, influential, and self-interested actors that shape the policymaking process and the world around them. However, IGOs also face considerable barriers to implementing their policy priorities: from reluctant states to the decentralization of staff across dozens of country offices to competition from other organizations and private donors. Getting policy results and convincing states to take collective action requires the capacity to disseminate and implement that policy
across a variety of contexts. While IGOs cannot compel states to act in most cases, they exercise agency and influence in choosing the policy priorities they advocate and in adopting various strategies to directly and indirectly promote implementation in potentially hostile political contexts.

Because existing theories of IGO autonomy and influence focus rather narrowly on the agenda-setting and decision-making phase of policy formation, scholars have yet to consider how concerns about implementation shape the particular decision-making strategies and policy priorities adopted by an organization. This dissertation expands existing social science research on IGO behavior by providing theoretical and empirical support for why implementation concerns matter and what IGOs do to navigate them. I argue that IGOs, especially those with limited enforcement power, are highly sensitive to these implementation barriers and adopt particular organizational structures and strategies to navigate them. Using WHO's Global Programme on AIDS and its successor, UNAIDS, I show how concerns about implementation at both agencies promoted the adoption of particular structures and strategies to increase the organization's leverage over states. A primary goal of both the WHO Global Programme on AIDS and UNAIDS was to broker a consensus among governments on the policies and practices that needed to be implemented in order to prevent new infections and care for people with AIDS. Nonetheless, both programs also pursued policy issues on which there was substantial disagreement among states, such as the appropriate implementation of testing, the level of participation of NGOs, and the inclusion of women, MSM, and other vulnerable groups. At times both GPA and UNAIDS lacked the power to enforce the adoption and implementation of policy frameworks on national governments. In order to promote the alignment of national AIDS programs with GPA recommendations, GPA employed aid conditionalities and restricted
Regional Directors’ budgetary control over projects. However, in 1990, the frustrated Regional Directors gained the support of the WHO’s new Director General and, as a coalition, they were able to greatly reduce the autonomy of GPA until it was formally dismantled in 1995.

When GPA was replaced by UNAIDS, UNAIDS adopted very different strategies to shape the policy preferences of states, other organizations, and even its own staff. At the outset, UNAIDS opted to decrease its autonomy by increasing state participation in decision-making, a move that is not easily explainable within existing theories of IGO behavior and decision-making. Additionally, as more donors and international organizations committed resources to AIDS, global policy and programming priorities were increasingly fragmented, diluting the influence of UNAIDS. Without any formal or financial authority to enforce policy and program recommendations in national contexts where governments were reluctant to address AIDS or vulnerable groups, UNAIDS undertook several strategic efforts to consolidate agenda-setting power and coordinate the program activities and policies across UN and donor agencies. This coordination of policies and programs among international organizations facilitated an aggressive top-down response to countries’ lack of attention to HIV among MSM. In order to get countries to prioritize MSM and other vulnerable groups, UNAIDS and its partners also mobilized a substantial effort to increase and improve research on MSM around the world. Increasing and improving scientific knowledge on MSM was crucial to organization’s ability to conduct evidence-based advocacy alongside its already strong human rights advocacy work. Next, organizational inreach was conducted within UN and donor agencies to educate staff about MSM and methods for reaching them and promote an institutional culture at the country-level in which MSM were a valued element of the policy planning process. Finally, UNAIDS supported in-country and regional grassroots HIV and LGBT organizations working with MSM. By
directly supporting grassroots initiatives while also coordinating a unified agenda at the international level, UNAIDS has used their resources to put bidirectional pressure on governments to adopt HIV among MSM as a prevention priority. Thus, while IGOs are typically understood as the targets of international and national social movement activism, researchers, member states and even private-sector donors, I use the case of HIV among MSM to show how IGOs actively construct the interests of these external actors rather than vice versa.

As I show in Chapters 2 and 3, the influence of IGOs on AIDS policy and the external environment doesn’t stop here. The mobilization of donors, transnational researchers and local civil society groups has initiated a substantial transformation of national AIDS policies. Governments all over the world have increasingly prioritized HIV surveillance and prevention among MSM in their national AIDS plans. On the ground, IGO interest in HIV among MSM has provided new technologies for seeing MSM in hostile political contexts. With strong support from transnational research networks, local organizations have advocated for the expansion of HIV prevention programs and policy for men who have sex with men. As I show in the case study of Malawi, claims for the recognition of same-sex sexualities in Malawi have had the most institutional success within the national AIDS programs which increasingly identifies MSM as a key prevention target. Additionally, links between Malawian organizations and transnational research and advocacy networks have provided a context in which (male) same-sex sexualities have become statistically visible and institutionalized, providing a basis for future social movement efforts.

Beyond Malawi, the mobilization of new funding opportunities, research, and advocacy for same-sex sexualities by IGOs is indeed “creating new actors, tasks, and goals that transform the character of global politics itself” (Barnett and Finnemore 2004:157). Organizations that
emerged through IGO efforts to facilitate transnational research and advocacy for MSM have since taken on new, independent roles. For example, the Global Forum on MSM and HIV, established in 2008 with support from UNAIDS to promote connections among researchers and advocates around the world and provide a clearing house for research on MSM, now sits on the NGO delegation of Programme Coordinating Board at UNAIDS and routinely challenges aid allocations the Global Fund and PEPFAR, demanding the organizations give more money and attention to HIV among MSM. amfAR, the AIDS research organization started The MSM Initiative in 2007 has also consistently sought to expand its mission to include the promotion of human rights for same-sex sexualities outside of health:

[I]t would be a missed opportunity if the refocusing of HIV/AIDS responses on MSM would mean a focus only on issues related directly to HIV or on the human rights only of those people judged to be at the highest clinical risk of HIV. We have a chance to go beyond AIDS and contribute to a larger movement for promotion, protection, and fulfillment of human rights in this sphere. (amfAR 2008:15)

In these examples, it becomes clear that the strategies adopted by UNAIDS to perpetuate its influence and promote prioritization of MSM by national AIDS programs have had substantial effects beyond the AIDS sector. Indeed, early mobilization by UNAIDS around MSM has facilitated broader initiatives across the UN system to extend rights protections on the basis of sexual orientation despite substantial disagreement among member states. In 2011 - sixty three years after the adoption of the Universal Declaration of Human Rights and ten years after mobilization around HIV and MSM by UNAIDS - the United Nations Human Rights Council
was able to finally pass, by the narrowest of margins,\textsuperscript{96} the first UN resolution specifically recognizing the rights of lesbian, gay, bisexual and transgender people.

The ability of IGOs to so dramatically reconfigure transnational and local research and advocacy priorities corroborates previous scholarship demonstrating the how IGOs have reshaped policy paradigms according to their interests (Chorev 2012b) and alter the behavior of states and other actors by changing the structure of opportunities, incentives, and constraints (Barnett and Finnemore 2004). It also raises important questions about how and with what consequences IGOs generate new norms or “universals” on contested issues while at the same time maintaining the appearance of impartiality and objectivity. As Tsing (2005) has argued, “Teaching a language of universal human rights can foreclose other trajectories. Participants may be drawn into a framework of global observation and classification in which cultural difference becomes yet another brick administrative data with which to be walled in” (14). As I have argued the view of sexual minorities that has been propagated through AIDS research in Malawi and other low- and middle-income countries leaves some reasons for concern. In Malawi, MSM are increasingly visible in ways not previously possible, however this visibility is greatly constrained by the construction of MSM as sites of public health research and the limited funding streams available to local organizations. Accessing these funds means adopting and affirming the identities and agendas of external actors over local ones. The almost complete focus on HIV and decriminalization have, as a case in point, left little room to address or even realize local concerns that don’t have anything to do with giving out condoms and lubricants to MSM, educating them on the risks of unprotected anal sex, or repealing outdated British Penal Codes. Meanwhile, the imposition of liberal sexual rights policies from outside the state rather than from

\textsuperscript{96} Resolution A/HRC/RES/17/19 was adopted by 23 countries in favor, 19 against. There were three abstentions.
within through grassroots organizations representing diverse goals and constituencies – as they have emerged in the West – has already prompted substantial backlash from political elites and potentially increased rather than alleviated threats to the health and lives of MSM in some places. While UNAIDS and the transnational research and advocacy networks it has facilitated can in some ways reign in this backlash, as the outcome of the Malawian trial of Steven Monjeza and Tiwonge Chimalanga shows, it will remain a challenge for these organizations to appreciate and recognize difference through global policy.
### Appendix A. Missing Country-Level Data

Table 11. Missing country-level data

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<th>Country</th>
<th>Commercial Trade</th>
<th>Links to TANs</th>
<th>IGO Participation</th>
<th>University enrollment</th>
<th>Total fertility rate</th>
<th>Percent urban</th>
<th>Legal Status of MSM</th>
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Appendix B. Malawi Household Survey Instrument
## Respondent ID Information

1. Respondent ID: [____] [____]
2. Location ID: [____]
3. Interviewer ID: [____]

### INTENVIEWER’S VISITS

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<th>VISIT #3</th>
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</table>
### Section 3: Demographic Background

1. **Gender:**
   - 1 = Mwamuna (male)
   - 2 = Mkaz (female)

   **how many men slept in the household last night, including the respondent?**
   - Kodini anthu a amuna angati onwe anagona pakhomo pano, kuphatikizapo oyankha malunso?

2. **Place of Birth:** Kodini munabawira Kuti?
   - a. **Village/Town**
     - Mudzi/Mzimba
   - b. **District (select from list)**
     - Boma (select)

   **If not born in Malawi, Ask: Are you a Malawian citizen?**
   - Sindime zika ya Malawi: .............................................. 0
   - Zika ya mMalawi: .............................................. 1

3. **Age:** Kodini muli ndi zaka zingati?

4. **What is your marital status?**
   - Never Married: .................................................. 1
   - Married: ......................................................... 2
   - Separated/Divorced: ........................................... 3
   - Widowed: ......................................................... 4

   **Circle the right answer**

5. **What is the highest level of education you have completed?**
   - Primary: .......................................................... 1
   - Secondary: ...................................................... 2
   - University/Tertiary: ............................................ 3

   **Circle the right answer**

6. **What is your first language?**
   - Kodini mumanka kuti chilankhula chanu?

   **Circle the right answer**

7. **what language can you speak well enough to carry conversation?**
   - Kodini chilankhulu chiti mungakwanise kulankhulu mosavalu?

   **Circle the right answer**

8. **What is your main way of earning money?**
   - Kodini guru ili yenye nyimwe mumapezera noana?

   1. Agricultural worker (incl. animal care), own field
      - Mulimw/Moikumbe: ........................................... 0 1
   2. Agricultural wage-labor, for cash or in kind
      - Ganyu yolina: .................................................. 0 1
| 3) Salaried employment | Wclembedwa ntchito ........................................ 0 1 |
| 4) Marketing work / sales | Bzmisi............................................................. 0 1 |
| 5) Handcraft production e.g., basket/ mat weaving | Zauso............................................................ 0 1 |
| 6) Alcohol production | Kudzha mowe.................................................... 0 1 |
| 7) Carpentry | Zchonaikhomba................................................. 0 1 |
| 8) Other cash activity | Nkizi za zopozela Nkakene..................................... 0 1 |
| 9) Domestic activities | Kwephunzira siku uku........................................... 0 1 |
| 10) Student | Jesi dz............................................................ 0 1 |
| 11) Fishing | Osagwira ntchito/ Osaka ntchito................................ 0 1 |
| 12) Never worked, seeking work | Osagwira ntchito/ Osa/una ntchito................................ 0 1 |
| 13) Never worked, not seeking work | Other specify ................................................. 88 |

9. Which of these goods can be found in your household?
Kodi ndi kumufedwa uti mwa uyu yemwe mula naye pakhomo pano?

| Television | Kanema............................................................. 0 1 |
| Radio | Wayiyesi........................................................... 0 1 |
| Cell phone | Laminja ya m'manja............................................. 0 1 |
| Mosquito Net | Wukucondwe wa dzudzudzu........................................ 0 1 |
| Bicycle | Njanga yakapalasa................................................ 0 1 |
| Motorcycle/Car | Njanga yamotso/Galimoso........................................ 0 1 |
| ESCOM electricity | Magetsi............................................................. 0 1 |
| Generator | Genelesta.......................................................... 0 1 |

10. How often do you get news from?
Kodi ndi mowilikiza bwanji mmene mumapezera nkhanilika.......

| a. Radio | Wayiyesi........................................................... 0 1 |
| b. Television | Kanema............................................................. 0 1 |
| c. newspaper | Newspaper.......................................................... 0 1 |
| d. friends | Azanu/oruwez anu................................................... 0 1 |
| e. neighbors | Cyanikana nawo nyumbe........................................... 0 1 |

**Interviewer refer to the codes below for Q11**

0. Never, 1. Less than one month, 2. A few times a month, 3. A few times a week, 4. Everyday,
5. Don't know, 6. Refused

11. How often do you use?
Kodi ndi mowilikiza bwanji mmene mumagwiritsira ntchito...................

| a. Mobile phone | Fonji yam'tmanja.................................................. 0 1 |
| b. Computer | Makina a Computer............................................. 0 1 |
| c. The Internet | Makina a Internet.............................................. 0 1 |

**Interviewer refer to the codes below for Q12**

0. Never, 1. Less than one month, 2. A few times a month, 3. A few times a week, 4. Everyday,
5. Don't know, 6. Refused
**Section 04. Social participation and attitudes**

Let's turn to your role in the community! Now I am going to read out a list of groups that people join or attend. For each one, could you tell me whether you are?

Tikambilane za udindo wanu pa nikani zachitukukwa m'ule lino. Ndikuvelengeri mndandanda wa magulu amene anthu amakumana kapena kupezekako. Kodi inu ndinu memba la wa?

<table>
<thead>
<tr>
<th>No.</th>
<th>Group Description</th>
<th>Your Participation Status</th>
</tr>
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<tbody>
<tr>
<td>1.</td>
<td>1) A religious group (e.g., church, mosque)?</td>
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<tr>
<td></td>
<td>2) A village/area committee (e.g., VDC, Funeral Committee)?</td>
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<tr>
<td></td>
<td>3) Some other voluntary association or community group?</td>
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<tr>
<td></td>
<td>BUngwe la a khisitu kepe a silamu.</td>
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<tr>
<td></td>
<td>BUngwe la mmuczi.</td>
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<tr>
<td></td>
<td>BUngwe la ogwera rtchito mungzipereka.</td>
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</tbody>
</table>

**Interviewer refer to the codes below for Q1**

0. Not a member, 1. An inactive member, 2. An active member, 3. An official leader.

---

2. In your opinion, what are the most important problems facing Malawi that government should address?

Kodi mmaqanano anu ndi mawu anji amene Dziko la malawi likukumana nawi ndipo boma likhoza kuchitapo kanthu mwansanga?

(Interpreter instructions: accept up to three answers. If respondent offers more than three options, ask “which three of these are the most important?”, if respondent offers one or two answers, as “anything else?”)

a).

b).

c).

---

3. If you had to choose, which one of the following things is most important?

Tikupatsani mwa wosankha, mwa izi ndi zinthu zinthu zomwe ndzofunikila kwambiri?

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<th>No.</th>
<th>Importance Description</th>
<th>Your Choice Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Maintaining order in the nation</td>
<td>Kutsa mala melumulo a Dziko.</td>
</tr>
<tr>
<td>2.</td>
<td>Giving people more say in government decisions</td>
<td>Kupereka m'iwa kw' anthu popereka m'enganiza awo.</td>
</tr>
<tr>
<td>3.</td>
<td>Protecting people's rights to live freely</td>
<td>Kusungula maulufu a anthu kuti azikhala m'masuka.</td>
</tr>
<tr>
<td>4.</td>
<td>Improving economic conditions for the poor</td>
<td>Kupindeza patiyenga chichitundizira cha chuma kwa osauka.</td>
</tr>
<tr>
<td>5.</td>
<td>None of these</td>
<td>Pali be mwa izi.</td>
</tr>
</tbody>
</table>

**Do not read >>>**

Refused to answer. 1

---

4. I will read you a list of various groups of people. Could you please mention any that you would NOT like to have as neighbors?

Ndikuvelengeri mndandanda wa magulu ena a anthu. Mungandi uzi ndi gulu litt mbwane simungasangalatsidwe. Kukutha mwayandika natio?

<table>
<thead>
<tr>
<th>No.</th>
<th>Group Description</th>
<th>Your Participation Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>People who smoke chambwa</td>
<td>Anthu amene amasuka Chamba.</td>
</tr>
<tr>
<td>2.</td>
<td>People of a different ethnic group/two</td>
<td>Anthu azikalidwe, kapena mitundu yosiyana/ia.</td>
</tr>
<tr>
<td>3.</td>
<td>People who have AIDS</td>
<td>Anthu odwa matenda a EDZI.</td>
</tr>
<tr>
<td>4.</td>
<td>Immigrants/Foreign workers</td>
<td>Amene asali zika za Malawi kapena anchiwo ochokelwa maiko en</td>
</tr>
<tr>
<td>5.</td>
<td>Homosexuals</td>
<td>M'akwati okwati anu kapena ekazi okhaokha.</td>
</tr>
<tr>
<td>6.</td>
<td>People of a different religion</td>
<td>Anthu osiyana zimpepedzo.</td>
</tr>
<tr>
<td>7.</td>
<td>Heavy drinkers</td>
<td>Zidakwa.</td>
</tr>
<tr>
<td>8.</td>
<td>Unmarried couples living together</td>
<td>Anthu osoalanima mblana kukkanila lomodzi.</td>
</tr>
<tr>
<td>9.</td>
<td>People who speak a different language</td>
<td>Anthu oyankhula zinthu zosiyana.</td>
</tr>
</tbody>
</table>

**Do not read >>>**

---

5. What is your opinion about a man having sexual relations before marriage?

Kodi maganizano anu kw'munthu wamuna wanchoridwe wawitzana asanaliwone mblana m'iwotani?

a). Is it always wrong  
Nthawi zonse ndikolakwika. 1

b). Almost always wrong  
Pafupufupu nthawi zonse ndikolakwika. 2
<table>
<thead>
<tr>
<th>6. What is your opinion about a woman having sexual relations before marriage?</th>
<th>7. What is your opinion about a married man having sexual relations with someone other than the wife?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Is it always wrong</td>
<td>a. Is it always wrong</td>
</tr>
<tr>
<td>b. almost always wrong</td>
<td>b. almost always wrong</td>
</tr>
<tr>
<td>c. wrong only sometimes</td>
<td>c. wrong only sometimes</td>
</tr>
<tr>
<td>d. not wrong at all</td>
<td>d. not wrong at all</td>
</tr>
<tr>
<td>Ntchawi zina ndikolakwika</td>
<td>Ntchawi zina ndikolakwika</td>
</tr>
<tr>
<td>Pufupfu. Ntchawi zina ndikolakwika</td>
<td>Pufupfu. Ntchawi zina ndikolakwika</td>
</tr>
<tr>
<td>Ntchawi zina ndikolakwika</td>
<td>Ntchawi zina ndikolakwika</td>
</tr>
<tr>
<td>Ntchawi zina ndikolakwika</td>
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</tr>
<tr>
<td>Ntchawi zina ndikolakwika</td>
<td>Ntchawi zina ndikolakwika</td>
</tr>
<tr>
<td>Don’t know</td>
<td>Don’t know</td>
</tr>
<tr>
<td>Refused to answer</td>
<td>Refused to answer</td>
</tr>
</tbody>
</table>

8. What is your opinion about a married woman having sexual relations with someone other than the husband?

9. What is your opinion about a married man who practices polygamy having sexual relations with someone other than his wives?

10. What is your opinion about a married woman who practices polygamy having sexual relations with someone other than the husband?

11. What about sexual relations between two adults of the same sex?

| a. Is it always wrong | a. Is it always wrong |
| b. almost always wrong | b. almost always wrong |
| c. wrong only sometimes | c. wrong only sometimes |
| d. not wrong at all | d. not wrong at all |
| Ntchawi zina ndikolakwika | Ntchawi zina ndikolakwika |
| Pufupfu. Ntchawi zina ndikolakwika | Pufupfu. Ntchawi zina ndikolakwika |
| Ntchawi zina ndikolakwika | Ntchawi zina ndikolakwika |
| Ntchawi zina ndikolakwika | Ntchawi zina ndikolakwika |
| Ntchawi zina ndikolakwika | Ntchawi zina ndikolakwika |
| Don’t know | Don’t know |
| Refused to answer | Refused to answer |
2. Do you……………… a law that would make polygamy illegal?  
Kodi inuyo……………… lamulo loetsa kuhala ndi: mkazi wosopela m’modzi?

a) strongly favor  Mukugwirizana nazo kwambiri……………………………………… 1  
b) favor  Mukugwirizana nazo…………………………………………………………… 2  
c) oppose  Mukutsutsana nazo…………………………………………………………… 3  
d) strongly oppose  Mukutsutsana nazo kwambiri……………………………………… 4  
Don’t know………………………………………………………………………………… 99  
Refused to answer………………………………………………………………………… 66

3. Do you……………… a law that would make sexual relations between adult men illegal?  
Kodi inuyo……………… lamulo loemwe likuetsa nchitidwe wogonana amuna akulu okheokha?

a) strongly favor  Mukugwirizana nazo kwambiri……………………………………… 1  
b) favor  Mukugwirizana nazo…………………………………………………………… 2  
c) oppose  Mukutsutsana nazo…………………………………………………………… 3  
d) strongly oppose  Mukutsutsana nazo kwambiri……………………………………… 4  
Don’t know………………………………………………………………………………… 99  
Refused to answer………………………………………………………………………… 66

4. Do you……………… a law that would make sexual relations between adult women illegal?  
Kodi inuyo……………… lamulo loemwe likuetsa nchitidwe wogonana akazi akulu okheokha?

a) strongly favor  Mukugwirizana nazo kwambiri……………………………………… 1  
b) favor  Mukugwirizana nazo…………………………………………………………… 2  
c) oppose  Mukutsutsana nazo…………………………………………………………… 3  
d) strongly oppose  Mukutsutsana nazo kwambiri……………………………………… 4  
Don’t know………………………………………………………………………………… 99  
Refused to answer………………………………………………………………………… 66

5. Do you think being homosexual is something people choose to be, or do you think it  
is something they cannot change?  
Kodi mukuganizana kuti Nchitidwe wogonana akazi kapene amuna okheokha ndi  
zisaniko zawo kapene mukuganiza kuti ndi nchitidwe oli sangakwani m’u kusintha?

Yes……………1  
No……………2

6. Who are Steven Monjeza and Tiwonge Chimbalanga (or Auntie Tiwo)?

1) Interviewer check if the correspondent response is correct
   Respondent gave incorrect response……………………………………… 0  
   Respondent gave correct response………………………………………………… 1  
   Respondent said “Don’t Know” (only choose this option after probing)………………… 99

7. How closely would you say you followed the trial of Steven Monjeza and Tiwonge Chimbalanga who  
were arrested in 2010?  
Kodi mbulu w:o Steven Monjeza ndi Tiwonge Chimbalanga amene adamangidawo mu chaka cha 2010  
munauta unje bwanzi?

1) Not at all  Sindikudziwapo kenhulu…………………………………………………………… 1  
2) Somewhat closely  Nkudziwe mwe aphondiapo…………………………………………………………… 2  
3) Very closely  Nkudziwe kwambiri…………………………………………………………… 3  
Don’t know………………………………………………………………………………… 99  
Refused to answer………………………………………………………………………… 66

8. Did you agree with the court ruling that Steven Monjeza and Tiwonge Chimbalanga should  
serve 14 years in prison with hard labor?  
Kodi mukugwirizana nazo zomwe kholi lidaluma kuti Steven Monjeza ndi Tiwonge Chimbalanga
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19. Did you approve of President Bingu wa Mutharika's decision to pardon Steven Monjeza and Tiwonge Chimbalanga?

Kodi munagwizana nako maganizo a president Bingu wa Muthalika pokhululukila Steven Monjeza ndi Tiwonge Chimbalanga?

1) Did not approve
Sinagwizane nazo........................................... 1
2) Approved
Ndina/magwizana nazo........................................ 2
3) Don't know Steve and Tiwonge
Sindikuwadziwa Steve ndi Tiwonge..................... 3
Don't know................................................. 99
Refused to answer.......................................... 88

19a. Do you (strongly) agree/agree/disagree/disagree (strongly) disagree) that homosexuality is ...?
Kodi mukugwizana nazo zoti nchitidwe wogona zina akazi kapena amuna oxhaokia?...

(GRID QUESTION)

1) A Western invention
ndi oti unachokera maliyo akunja?
2) A sin
ndi tahiro?
3) A private matter that should not be regulated by
kapena ndza chinsinsi zoti lamulo Isagwilepo nchito?
4) A primary concern of donors so I have no choice
kapena ndi chifuwa choti matungwe othandiza akunja amanera.
Ndikuwadinje ine mwa ngati muala ya dziko lapazi. (strongly agr)
Ndikuwizana nazo. (agree)
Sindikuwizana nazo. (disagree)
Sindikuwizana nazo kwambiri. (strongly disagree)
DON'T READ: Don't Know
DON'T READ: Refused to Answer

20. Earlier you mentioned... [fill in response from earlier open-ended question]... as the most important problem facing Malawi that government should address. Let's say that [issue paraphrased] scores a 10 on importance for government to address and something that is not important. Important at all scores a 0.

How important from 0 to 10 would the following issues be?

Paja munalankhulepo kuti.........., zamavuto eneni akulu amene dziko ia malawi likukumana nako omwe boma

Inga chiteto kanthu mwa sansanga. Tingoyeikeza kuti yankho lamunyali ili ndi malikisi kumi (10) ndi kuido ndikoyenaili
kuti boma lichiteto kanthu. Kapena osapeleka malikisi (0) pa anliwo lamulo ndipo safunikila boma kuchiteto kanthu
pa mavuto amene dziko liwagwizana nako.

Kodi pa ndandwe wa magwizano aza, mthu kupereka malikisi angati polingalina ndi mavuto omwe boma likupatira?

a) Increasing the amount of fuel in the country
Kuwonjiza Mafuta a galimo mdziko............... [ ]
Kuwonjiza kuvirera ndi madzi awukhonda/kotundizana... [ ]
Kwekanso zu zinthu zita pakhomo mungo........... [ ]
guma, mafuta opthikira, nhatha ndi zina.
Kwekanso zu zinthu zita pakhomo mungo........... [ ]
b) Increasing access to clean water
Kwekanso zu zinthu zita pakhomo mungo........... [ ]
kupatsa patsogolo mpamvu za majitsa mdziko........... [ ]
c) Keeping the price of household
Kwekanso zu zinthu zita pakhomo mungo........... [ ]
sugar, mafuta opthikira, nhatha ndi zina.
Kwekanso zu zinthu zita pakhomo mungo........... [ ]
d) Improving the delivery of electricity in
Kwekanso zu zinthu zita pakhomo mungo........... [ ]
the country
Kwekanso zu zinthu zita pakhomo mungo........... [ ]
e) Making laws to deal with witchcraft
Kwekanso zu zinthu zita pakhomo mungo........... [ ]
kupatsa patsogolo mpamvu za majitsa mdziko........... [ ]
f) Making laws to deal with polygamy
Kwekanso zu zinthu zita pakhomo mungo........... [ ]
Kupatsa patsogolo mpamvu za majitsa mdziko........... [ ]
g) Making laws to deal with sexual relations
Kupatsa patsogolo mpamvu za majitsa mdziko........... [ ]
between two adults of the same sex
Kupatsa patsogolo mpamvu za majitsa mdziko........... [ ]
Kupatsa patsogolo mpamvu za majitsa mdziko........... [ ]
21. In your opinion, how much of a democracy is Malawi today?
Kutengere miga magangano ena, kudi democracy m'malawi mukuyona bweni m'muano?

1) Not a democracy
Still mu democracy........................................... 1
2) Democracy, with major problems
Tiilu mu democracy ngakhalile ndi mavuto akulukula........ 2
3) Democracy, but with minor problems
Tiilu mu democracy ndi mavuto ochepa........................ 3
4) A full democracy
Tiilu mu democracy yeniyeni................................... 4
5) Do not understand question/do not
Sindikuwadziwa funso lamuna/sindikuwadziwa kuti democracy........ 5
understand what 'democracy' is
ndi chani
Don't know................................................. 99
Refused to answer.......................................... 88

(interviewer notes: read the question in the language of the interview, but always read 'democracy' in English.)
Translate ‘democracy’ into local language (only if respondent does not understand English term.)

22. Which of the following statements is closest to your view?
Kodi ndi maganizo ati mwa awa omwe mukugwirizana nawi?

1. Democracy is preferable to any other kind of government
Democracy ndiyo funika kwa boma ililose.......................... 1

2. In some circumstances, a non democratic government can be preferable
Nhawi zina kuthala kopa democracy ndikufunika............ 2

3. For someone like me, it doesn’t matter what kind of government we have.
Kwa muthu ngati ine sindima labada za boma lomwe ikulamulitsa
Don’t know.................................................................. 99

Refused to answer.......................................................... 88

23. Which of the following best represent what you think of as “human rights”?
Kodi ndi maganizo ati mwa awa omwe akugwirizana kwambiri ndi maganizo anu pa ma ufulu a muthu?

1. The ability to vote for whatever political party I choose
Kutengapo mbili pa chisankho cha puleziendent ndi aphungu......... 1

2. The ability to own property
Ufulu wokhala ndi zinthu katundu...................................... 2

3. Freedom from slavery
Kumusulidwa ku ukapolo.................................................. 3

4. The ability to speak freely without fear of punishment
Ufulu wolankhula mwafulu osopoe kumangidwa.................... 4

5. The ability to go to school
Ufulu wopitila maphuziro.................................................. 5

6. The ability to be treated fairly by police
Ufulu wosamali idwa ndi a Polisi........................................ 6

7. The ability to have access to food, clothing and housing
Ufulu wokhala ndi chakudya, zovula ndi nyumba.................. 7

8. The ability to receive medical care
Ufulu wolandi chthandizo chakhapata ndikadwa.................... 8

9. The ability to practice the religion I choose
Ufulu wasatila chipembozho chimene ndi kuufa.................... 9

Interviewer read the list and circle all that apply
Don’t know.................................................................. 99

Refused to answer.......................................................... 88

24. Which of these is most important to you?
Kodi ndi ganizo liti lofunikira kwa mbiiri kwa nu.................. 1

(Refer to Q21)

25. Which of these is second most important to you?
Kodi ndi ganizo liti lachwiri lofunikira kwa mbiiri kwa nu...... 1

(Refer to Q21)

26. Which of these is third most important to you?
Kodi ndi ganizo liti lachwiri lofunikira kwa mbiiri kwa nu...... 1

(Refer to Q21)

27. In 2009, the former president of Malawi, Bingu wa Mutharika, reinstated the so-called quota system. The quota system saves a certain number of places at schools and universities for individuals from each district in Malawi. Which of the following statements is closest to your view?
Mucheka cha 2009, Malumunzi puleziendent wa dziko la malawi, Bingu wa Mutharika, anakhazikitsa ‘quota system’ kakhakhwende ka ana kupitaliza maphuzilo komaseke ndi makanisotho kuthamali ndi makanisotse une boma one a mmalawi mofanana. Kodi ndi liti mwa maganizo ati mwa awa imone mukugwirizana nali?

1. The quota system should be removed, as access to education should be granted on merit alone, not based on one’s district of origin.
Quota system iyenele kudhoka ndipo mwai...................... 1

wamaphuziro uyenele kupatidwa malingani ndi
zeru za muthu osatengera boma lomwe akukhoka

2. The quota system should be maintained, as access to education should be equally distributed between individuals from each district.
Quota system iyenele kupitalira ndi po mwai................... 2

we maphuziro kwa aliyesa upetsidwe mofanana
kukhoka miboma ili rose

Do not read >>>

Don’t Know.................................................................. 99

Refused to answer.......................................................... 85

28. Do you think that each of the following has..................... amount of influence over your government?
Kodi mukanizana kuti.............................. ali ndi mphandu kapena gawo pakasendardsedi kwa boma?

a. International donors and NGOs
Ma dons (mabungwe ohanzida akunja) ndi mabugwe owme

b. Malawian businesses and investors
Makamane akunja ndi mabizimisiku

Mabungwe ophuizitsa ndi kufaititsi kkhani mmalawi

Zika za mmalawi

Don’t know.................................................................. 99

Refused to answer.......................................................... 85

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| **Interviewer, Below are code list for Q28** |  
| **1. too little, 2. too much, 3. about right** |  

| **29.** Do you think the number of immigrants from other African countries who are allowed to come to Malawi to live should be increased, decreased, or left the same as it is now?  
Kodi mukuganiza kuti chwerengelo cha anthu obwera ku Malawi kuno kudzakhara kuchokera mako ena amu Afrika, chiwonjezeredwe, chichepe kepena chikhale chimodzimodzi? |  
| **30.** Do you think the number of immigrants from non-African countries who are allowed to come to Malawi to live should be increased, decreased, or left the same as it is now?  
Kodi mukuganiza kuti chwerengelo cha anthu obwera ku Malawi kuno kudzakhara kuchokera mako akunja kwe Afrika, chiwonjezeredwe, chichepe kepena chikhale chimodzimodzi? |  
| 1. Increased (chiwonjezeredwe)  
2. Decreased (chichepe)  
3. Left the Same (chimodzimodzi)  
4. DK  
5. Refused |
### SECTION 5: POLITICAL ACTIVITIES

1. With regard to the most recent, 2009 national elections, which statement is true for you?

   **Pazisaniko za boma zimene zinachitika mu chaka cha 2009: kodi mwa izi zoona ndi zinthu?**

   1. You did not vote in the elections  
      Simunatengwa mubalipachisankho……………………………………… 1
   2. You voted in the elections  
      Munatenga nawo mubali povi pachisankho………………………… 2
      Don’t Know/I can’t remember……………………………………… 99
      Refused to answer………………………………………………… 88

   **Do not read >>**

2. Do you feel close to any particular party?

   **Kodi chilipo chifani chilichonse chimene mumachimva chifupi kuti chimakugwirani kumitima?**

   1. No  
      Ayi…………………………………………………………………… 1
   2. Yes  
      Eya…………………………………………………………………… 2
      Don’t Know/I Can’t Remember…………………………………… 99
      Refused to answer………………………………………………… 88

   **Do not read >>**

3. If Party=1 (Yes), ask: which party?

   **Kodi ndi mva a chifani chani?**

   DPP………………………………………………………………………… 1
   MCP………………………………………………………………………… 2
   UDF………………………………………………………………………… 3
   PF…………………………………………………………………………… 4
   Other specify…………………………………………………………… 5
   Refused to answer……………………………………………………… 88

4. Which party did you feel close to during the 2009 election

   **Kodi ndichipani chitichimene mumachimva chifupi kuti chimakugwirani kumitima kwano mu 2009?**

   DPP………………………………………………………………………… 1
   MCP………………………………………………………………………… 2
   UDF………………………………………………………………………… 3
   PF…………………………………………………………………………… 4
   Other specify…………………………………………………………… 5
   Don’t know/remember……………………………………………… 99
   Refused to answer……………………………………………………… 88

5. What if there were a national election tomorrow, for which party on this list would you vote?

   **Kodi nanga zisankho za dziko zita khalako mawa, Mukhoza kuvotela chifani chani pa mndandanda uwu?**

   DPP………………………………………………………………………… 1
   MCP………………………………………………………………………… 2
   UDF………………………………………………………………………… 3
   PF…………………………………………………………………………… 4
   Other specify…………………………………………………………… 5
   Don’t know/remember……………………………………………… 99
   Refused to answer……………………………………………………… 88

6. Here is a list of actions that people sometimes take as citizens. For each of these, please tell me whether you, personally, have done any of these things during the past year:

   **Apa palli mndandanda wa zochitika zomwe anthu amachita nthawi zina ngati nzika. Ndiuzeni ngati inu mbali mwa izi muchaka chatha?**

   a). Attended a community meeting  
      Kupezeka nayo misonkhano ya m’mudzi…………………………………… [______]
   b). Got together with others to raise an issue  
      Kukumana ndi anthu ena pawiriza mfuwo………………………………… [______]
      Imodzi……………………………………………………………………………… [______]
   c). Attended a demonstration or protest march  
      Kupezeka nayo pa zionezelwe…………………………………………………… [______]

   **Interviewer, read code list for Q6**
   1=eya, kawirikawiri
   2=eya, nthawi zambiri
   3=eya, kamodzi kapera kawiri
   4=eya, ndiita palaphala mwa
   5=eya, sindingalathe
   99=sindikudziwa

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### Section 6. National, Ethnic and Religious Identity

Now we would like to ask you questions about your background.

Ndikufusani mafuso okhusana ndi moyo wanu.

#### 1. Was your mother born in Malawi or is she an immigrant?

*Kodi amai anu okubelekani ndi mbadwa ya m'Malawi kapena ndi zika ya kunja?*

1. She was born in Malawi
2. She was not born in Malawi, but is a Malawi citizen
3. She was not born in Malawi, and is not a Malawian

<table>
<thead>
<tr>
<th>Option</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>She was born in Malawi</td>
<td>1</td>
</tr>
<tr>
<td>She was not born in Malawi, but is a Malawi citizen</td>
<td>2</td>
</tr>
<tr>
<td>She was not born in Malawi, and is not a Malawian</td>
<td>99</td>
</tr>
<tr>
<td>Refused to answer</td>
<td>88</td>
</tr>
</tbody>
</table>

#### 2. What about your father; was he born in Malawi or is he an immigrant?

*Kodi abambo anu okubelekani ndi mbadwa ya m'Malawi kapena ndi zika ya kunja?*

1. He was born in Malawi
2. He was not born in Malawi, but is a Malawi citizen
3. He was not born in Malawi, and is not a Malawian

<table>
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<tr>
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<tr>
<td>He was not born in Malawi, and is not a Malawian</td>
<td>99</td>
</tr>
<tr>
<td>Refused to answer</td>
<td>88</td>
</tr>
</tbody>
</table>

#### 3. How proud are you of being Malawian?

*Kodi ndinu wosangalala bwanji kuxhala zika ya malaw?*

1. Not at all proud
2. Not very proud
3. Quite proud
4. Very proud

<table>
<thead>
<tr>
<th>Option</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all proud</td>
<td>1</td>
</tr>
<tr>
<td>Not very proud</td>
<td>2</td>
</tr>
<tr>
<td>Quite proud</td>
<td>3</td>
</tr>
<tr>
<td>Very proud</td>
<td>4</td>
</tr>
<tr>
<td>Other specific</td>
<td>10</td>
</tr>
<tr>
<td>Don't know</td>
<td>99</td>
</tr>
<tr>
<td>Refused to answer</td>
<td>88</td>
</tr>
</tbody>
</table>

#### 4. What is your tribe? You know, your cultural or ethnic group?

*Kodi ndinu a mbutu uli?*

<table>
<thead>
<tr>
<th>Tribe</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chexwa</td>
<td>1</td>
</tr>
<tr>
<td>Ngoni</td>
<td>2</td>
</tr>
<tr>
<td>Lomwe</td>
<td>3</td>
</tr>
<tr>
<td>Tumbuka</td>
<td>4</td>
</tr>
<tr>
<td>Yao</td>
<td>5</td>
</tr>
<tr>
<td>Sena</td>
<td>6</td>
</tr>
<tr>
<td>Senga</td>
<td>7</td>
</tr>
<tr>
<td>Nyanja</td>
<td>8</td>
</tr>
<tr>
<td>Other specific</td>
<td>10</td>
</tr>
<tr>
<td>Don't know</td>
<td>99</td>
</tr>
<tr>
<td>Refused to answer</td>
<td>88</td>
</tr>
</tbody>
</table>

#### 5. What about your father, what is your father’s ethnic group?

*Kodi abambo anu okubelekani ndi antundu uli?*

<table>
<thead>
<tr>
<th>Tribe</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chexwa</td>
<td>1</td>
</tr>
<tr>
<td>Ngoni</td>
<td>2</td>
</tr>
<tr>
<td>Lomwe</td>
<td>3</td>
</tr>
<tr>
<td>Tumbuka</td>
<td>4</td>
</tr>
<tr>
<td>Yao</td>
<td>5</td>
</tr>
<tr>
<td>Sena</td>
<td>6</td>
</tr>
<tr>
<td>Senga</td>
<td>7</td>
</tr>
<tr>
<td>Nyanja</td>
<td>8</td>
</tr>
<tr>
<td>Other specific</td>
<td>10</td>
</tr>
<tr>
<td>Don't know</td>
<td>99</td>
</tr>
<tr>
<td>Refused to answer</td>
<td>88</td>
</tr>
</tbody>
</table>

#### 6. What about your mother, what is your mother’s ethnic group?

*Kodi amai anu okubelekani ndi antundu uli?*

<table>
<thead>
<tr>
<th>Tribe</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chexwa</td>
<td>1</td>
</tr>
<tr>
<td>Ngoni</td>
<td>2</td>
</tr>
<tr>
<td>Lomwe</td>
<td>3</td>
</tr>
</tbody>
</table>
7. How proud are you of being [Respondent's ethnic group]?
Kodi ndi ku wosangalira kwandikha ku khala [Respondent's ethnic group]?

<table>
<thead>
<tr>
<th>Response</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Not at all proud</td>
<td>Sindili wosangalala ndipang'ono pomwe</td>
</tr>
<tr>
<td>2) Not very proud</td>
<td>Sindili wosangalala kwambiri</td>
</tr>
<tr>
<td>3) Quite proud</td>
<td>Ndi wosangalala</td>
</tr>
<tr>
<td>4) Very proud</td>
<td>Ndi wosangalala kwambiri</td>
</tr>
<tr>
<td>Don't know</td>
<td>Refused to answer</td>
</tr>
</tbody>
</table>

8. Think about the condition of [Respondent's ethnic group]. Are their economic conditions worse, the same as, or better than other groups in this country?
Taganizirana mmene zinthu zili ndi [Respondent's ethnic group]. Kodi iwo salifuno pe nkhanza cha chuma, kepena ndi chimodzimodzi ndimutundu yina ya muzikizo muno?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) much worse</td>
<td>Sizili bwino kose</td>
</tr>
<tr>
<td>b) Worse</td>
<td>Sizili bwino</td>
</tr>
<tr>
<td>c) same</td>
<td>Chimodzimodzi</td>
</tr>
<tr>
<td>d) Better</td>
<td>Zili bwino kwambiri</td>
</tr>
<tr>
<td>e) much better</td>
<td>Zili bwino</td>
</tr>
<tr>
<td>Don't know</td>
<td>Refused to answer</td>
</tr>
</tbody>
</table>

9. Think about the condition of [Respondent's ethnic group]. Do they have less, the same, or more influence in politics than other groups in this country?
Taganizirana mmene zinthu zili ndi [Respondent's ethnic group]. Kodi a' ndi mphanyu zochepe, chimodzimodzi kapena zawiri pankhani za ndale kulekana ndi mtundu ina muzikizo muno?

<table>
<thead>
<tr>
<th>Influence</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) much less</td>
<td>Zochepe kwambiri</td>
</tr>
<tr>
<td>c) somewhat less</td>
<td>Zochepe lasu</td>
</tr>
<tr>
<td>d) Same</td>
<td>Chimodzimodzi</td>
</tr>
<tr>
<td>e) somewhat more</td>
<td>Zochula ukapalo</td>
</tr>
<tr>
<td>d) much more</td>
<td>Zochuluku kwambiri</td>
</tr>
<tr>
<td>Don't know</td>
<td>Refused to answer</td>
</tr>
</tbody>
</table>

10. How often are... [Respondent's ethnic group]... treated unfairly by the government?
Ndinomwikuza bwani mmene [Respondent's ethnic group].... amachiri dwa nhaza ndi boma?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Always</td>
<td>Nhawi zose</td>
</tr>
<tr>
<td>b) Often</td>
<td>Pafupupfu</td>
</tr>
<tr>
<td>c) sometimes</td>
<td>Nhawi zina</td>
</tr>
<tr>
<td>d) Never</td>
<td>Sachitili dwa nkhaza</td>
</tr>
<tr>
<td>Don't know</td>
<td>Refused to answer</td>
</tr>
</tbody>
</table>

11. Let us suppose that you had to choose between being a Malawian and being [Respondent's ethnic group].
Which of the following statements best expresses your feelings?
Tingopa zizana kuthandizidwe moata wosangalira kufunika zika ya malawi kepena... [Respondent's ethnic group].
Kodi ndi gani zikho liti mu ndandandawu limene mukuwirizana nalo ku ntima kufunika?

<table>
<thead>
<tr>
<th>Feelings</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) I feel only Malawian</td>
<td>Ndikusangalala ngati nzika ya malawi basi</td>
</tr>
<tr>
<td>b) I feel more Malawian than [Respondent's ethnic group]</td>
<td>Ndikusangalala kooswa ngati zika ya malawi kulekana</td>
</tr>
<tr>
<td>d) I feel equally Malawian and [Respondent's ethnic group]</td>
<td>Ndikusangalala chimodzimodzi ngati zika ya malawi, kepena [Respondent's ethnic group]</td>
</tr>
<tr>
<td>e) I feel more [Respondent's ethnic group] than Malawian</td>
<td>Ndikusangalala kwambiri kulekana ndikukhala zika ya malawi [Respondent's ethnic group] kulekana</td>
</tr>
<tr>
<td>f) I feel only [Respondent's ethnic group]</td>
<td>Ndikusangalala kulekana [Respondent's ethnic group] basi</td>
</tr>
<tr>
<td>Don't know</td>
<td>Refused to answer</td>
</tr>
</tbody>
</table>

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12. What religion are you?

| 1. No religion                                      | 1 |
| Catholic                                           | 2 |
| COAP                                               | 3 |
| Baptism                                           | 4 |
| Anglican                                          | 5 |
| Seventh Day Adventist                              | 6 |
| Jehovah's Witnesses/Mooni za yehova                | 7 |
| Pentecostal                                        | 8 |
| Church of Christ                                   | 9 |
| Bible Believer                                    | 10 |
| African Abraham                                    | 11 |
| Other specify                                      | 12 |
| Don't know                                         | 99 |
| Refused to answer                                  | 88 |

13. When was the last time you went to church/mosque?

| 1. Never                                           | 1 |
| 2. 6 months ago or more                            | 2 |
| 3. in the last 2-6 months                          | 3 |
| 4. in the last month                               | 4 |
| 5. in the last week                                | 5 |
| Sabata yaana                                       | 99 |
| Don't know                                         | 88 |

14. How proud are you of being [Respondent's religious group]?

| 1. Not at all proud                                | 1 |
| 2. Not very proud                                  | 2 |
| 3. Quite proud                                     | 3 |
| 4. Very proud                                      | 4 |

People have different views about themselves and how they relate to the world. How strongly do you agree or disagree with each of the following statements about how you see yourself:

15. Generally speaking, would you say that most people can be trusted, or that you can't be too careful in dealing with people?

| 1. Most people can be trusted                      | 1 |
| 2. You can't be too careful                        | 2 |
| 3. Don't know                                      | 3 |
| 4. Refused to Answer                               | 4 |

16. How much do you trust your relatives/neighbours/people from your own ethnic group/Malawians from other ethnic groups? Added: Malawians from other regions, immigrants/foreign workers, international business and investors, Western donors, the govt.

17. How much do you trust your relatives/neighbours/people from your own ethnic group/Malawians from other ethnic groups? Added: Malawians from other regions, immigrants/foreign workers, international business and investors, Western donors, the govt.

18. Koki mumawakulupirira bwanji azitaile anu, oyandikana nawi nyumba, antu antundu wanu kapena antu a mtundu yina amene alii zika ya malawi? Added 24ABCD. - Nzikia za Malawi zochoza zigawo zina (Malawians from other regions)
- Amene asi zi za Malawi kapena antu zina (immigrants/foreign workers)
- Ila akuna ndi mabizimisi akulaakulu (international business and investors)
- Ma dons (mbungwe chithandiza akuna) ndi malawina omwe Sal a boma (Western donors)

19. Boma la Malawi (Malawi govt)

20. 1. Not at all                                    | 1 |
| 2. Just a little                                   | 2 |
| 3. Somewhat                                        | 3 |
| 4. A lot                                          | 4 |

21. Even if you had to guess, what ethnic group do you think I am from?
26. Just one more question: who do you think sent us to do this interview? 
Fuso lowonjeza, Kodi inu mukuganza kuti ife aikafukufuku tatumizidwa ndindani?

<table>
<thead>
<tr>
<th>Option</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>No one</td>
<td>1</td>
</tr>
<tr>
<td>Government</td>
<td>2</td>
</tr>
<tr>
<td>National Statistics Office</td>
<td>3</td>
</tr>
<tr>
<td>Political party</td>
<td>4</td>
</tr>
<tr>
<td>NGO</td>
<td>5</td>
</tr>
<tr>
<td>Research Company</td>
<td>6</td>
</tr>
<tr>
<td>University</td>
<td>7</td>
</tr>
<tr>
<td>Azungu</td>
<td>8</td>
</tr>
<tr>
<td>Other specify</td>
<td>10</td>
</tr>
<tr>
<td>Don't know</td>
<td>99</td>
</tr>
<tr>
<td>Refused to answer</td>
<td>88</td>
</tr>
</tbody>
</table>

THE END OF THE INTERVIEW

End time (24 hour time): [   ] [   ]
Appendix C. Description of Sampling Weights for Malawi Household Survey Data

Weights were calculated to adjust for variation in the probabilities of selection across census Enumeration Areas (EAs), households within EAs, and individuals within households.

EA Selection
The probability that an EA was sampled is the product of two factors. The first factor reflects the overall rate at which we sampled EAs, which is given by the ratio of the number of households in selected EAs to the total number of households in Malawi. The second factor represents the rate at which we over- or under-sampled households from each of the five districts. It is given by the proportion of the households in the sampled EAs that were contained in the district divided by the proportion of households in Malawi that were located in the district. Thus, the EA-specific probability of being included in the sample is given by:

\[ P_1 = \frac{\text{Number of HHs in all sampled EAs}}{\text{Number of HHs in Malawi}} \times \frac{\text{Proportion of HHs in district located in sampled EAs}}{\text{Proportion of HHs in Malawi contained in district}} \]

Household Selection
The probability of sampling households within EAs is given by the following expression:

\[ P_2 = \frac{\text{Number of sampled HHs}}{\text{Total number of HHs in EA}} \]
There are two additional components that contributed to household sampling adjustment: the variation in the number of households interviewed across EAs and the over-sampling of households in urban areas. To adjust for variation in nonresponse across EAs I include:

\[ P_3 = \frac{\text{Number of HH that completed interview}}{\text{Total number of sampled HH}} \]

Additionally, weights are included to adjust for over-sampling of households in urban areas:

\[ P_4 = \frac{\text{Proportion of urban HH in district completing interview}}{\text{Proportion of urban HH in district}} \]

The household sample weight is the inverse of the product of probabilities 1 through 4.

**Individual Selection**

The adjustment for the sex-specific probabilities of individual selection within a household is given by the following expressions:

\[ P_{5m} = \frac{1}{\text{Total number of adult men who slept in the HH last night}} \]

\[ P_{5f} = \frac{1}{\text{Total number of adult women who slept in the HH last night}} \]

The final respondent sample weight is the product of the individual selection weight and the household selection weight. Sample weights were calculated for all respondents who partially or fully completed the survey. Weights were normalized to have a mean of one.

**Post-Stratification, Correction for Nonresponse, and Raking**

We used a raking procedure to match the weighted marginal distributions of important respondent characteristics with the marginal distributions of these same characteristics for all
Malawi residents from the 2008 Malawi Population and Housing Census (Government of Malawi 2010). The marginals were derived from two- or three-way cross tabulations of sex and ethnic group/tribe across district and rural/urban areas.
References


International Non-governmental Organization.” American Sociological Review 62:171- 
190.

Bottoman, Lucas. 2009. “Police Arrest Gay Lovebirds.” The Daily Times (Malawi), December 
29, pp. 1, 3.

Boulton, Mary and Peter Weatherburn. 1990. “Literature Review on Bisexuality and HIV 
Transmission.” commissioned by the Social and Behavioral Research Unit, Global 
Programme on AIDS, World Health Organization.

Bracher, Michael, Gigi Santow, and Susan C. Watkins. 2003. ““Moving” and Marrying: 
Modelling HIV Infection Among Newlyweds in Malawi.” Demographic Research 
Special Collection 1:207-246.


Brewer, Devon D., Stuart Brody, Ernest Drucker, David Gisselquist, Stephen F. Minkin, John J. 
the Epidemiology of HIV in Africa: Cry the Beloved Paradigm.” International Journal of 
STD & AIDS 14:144-147.

University of North Carolina Press.

Bank's Development Economivs Vice-Presidency (DEC).” Review of International 
Political Economy 13(3):387-419.

Brown, Phil. 1995. “Naming and Framing: The Social Construction of Diagnosis and Illness.” 

Brown, Phil. 2007. Toxic Exposures: Contested Illnesses and the Environmental Health 


the Southern Caucasus.” The National Council for Eurasian and East European Research, 
Seattle, WA.


Health Partnerships: In Search of ‘Good’ Global Health Governance.” Pp. 169-196 in 
Public-Private Partnerships for Public Health, edited by Michael R. Reich. Cambridge: 
Harvard University Press.


Deacon, Bob and Alexandra Kaasch 2008. “The OECD’s Social and Health Policy: Neo-liberal Stalking Horse or Balancer of Social and Economic Objectives.” in The OECD and
Global Governance, edited by R. Mahon and S. McBride. Vancouver: University of
British Columbia Press.

D'Emilio, John. 1983. Sexual Politics, Sexual Communities. Chicago, IL: University of Chicago
Press.

Isomorphism and Collective Rationality in Organizational Fields.” American

Succession: Malawi’s 2012 Transition in Comparative Perspective.” African Affairs
112(446):111-137.

View From Below.” AIDS and Behavior 17(3):825-831.

Dionne, Kim Y., Eric Kramon, and Tyson Roberts. 2013. “Aid Effectiveness and Allocation:
Evidence from Malawi.” Paper presented at the Conference on Foreign Aid at Princeton
University, April 26-27, Princeton.

Policies: Social Construction, Coercion, Competition, or Learning?” Annual Review of
Sociology 33:449-472.

Doll, Lynda S., Lyle R. Petersen, Carol R. White, Eric S. Johnson, and John W. a. T. B. D. S. G.
Ward. 1992. “Homosexually and Nonhomosexually Identified Men who have Sex with


Consequences. New York: Springer.

ECOSOC. 1995. “Provisional Summary Record of the 7th Meeting.” Economic and Social

Nations Program on Human Immunodeficiency Virus/ Acquired Immunodeficiency

Democracy of Chameleons: Politics and Culture in the New Malawi, edited by Harri

University of California Press.


Epprecht, Marc. 2008. Heterosexual Africa? The History of an Idea from the Age of Exploration
to the Age of AIDS. Athens, OH: Ohio University Press.


Nardulli, Peter, Buddy Peyton, and Joe Bajjalieh. 2010. “Gauging Cross-national Differences in Education Attainment: A 60 Year Look at Global Educational Trends.” Cline Center for Democracy, University of Illinois at Urbana-Champaign.


Nation. 2010a. “Donors, Rights Groups Wrong to Condemn Gay Sentence.” *The Nation (Malawi),* May 27.


NIH. 1996. “Interview of Thomas C. Quinn.” In *Their Own Words: NIH Researchers Recall the Early Years of AIDS*, December 5 & 16.


NIH. 2009. “Interview with Dr. Peter Piot.” In *Their Own Words: NIH Researchers Recall the Early Years of AIDS*, April 8.

NIH. 2010. “Interview with Dr. Peter Piot.” In *Their Own Words: NIH Researchers Recall the Early Years of AIDS*, June 16.


