



2nd PAKISTAN TRIP REPORT

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Project: World Bank Contract: 7138376
Technical assistance for strengthening interventions for HIV
and AIDS prevention, care and support services for MSM in
Pakistan

Training visit to Lahore, Peshawar and Karachi

Travel Dates: 30th June – 29th July 2006

Introduction

The National AIDS Control Programme (NACP) in Pakistan is implementing its Enhanced Programme on HIV/AIDS with World Bank financing. A key component of this enhanced programme is support for implementing MSM HIV services packages in all provinces in Pakistan, that is Baluchistan, Punjab, NWFP, and Sindh. NFI has developed a contract with the World Bank Pakistan and NACP to provide technical assistance for strengthening interventions for HIV and AIDS prevention, care and support services for MSM in Pakistan.

Key objectives of this contract are to:

- Enhance the institutional, technical and delivery capacity of organisations working with males who have sex with males on HIV prevention, care and support whether supported by the Pakistan Enhanced Programme on HIV/AIDS or not.
- Enhance the institutional and technical capacity of the Provincial AIDS Control Programmes to effectively manage, monitor and evaluate MSM and HIV prevention, care and support programmes they support.
- Develop an in-country technical support capacity in the area of appropriate service delivery on HIV prevention, care and support for MSM.
- Explore the possibility of development of MSM community-based self-help approaches to HIV prevention, care and support in the country.

Following on from the evaluation visit conducted in May 2006, where discussions were held with the three implementation agencies (where only one had begun delivering services to 'MSM'), along with the decision not to follow on with development work in Quetta (for Balochistan) due to the long delays in implementation, a two phase approach to skills building was developed. In the first phase, representatives from the agencies implementing (or soon to implement) MSM and Hijra HIV prevention, care and support projects, along with others from the Provincial AIDS Control Programmes, and those selected by the consultant, would participate in a knowledge building programme which would assist in reviewing project proposals and develop a better understanding of methodologies for effective service design and delivery to maximise outreach and risk reduction.

It had also been intended for the consultant to conduct a two-day seminar in Islamabad on working with MSM and HIV prevention, care and support for key staff from the various Provincial AIDS Control Programmes (including the Balochistan AIDS Control Programme), and the National AIDS Control Programme, towards developing a deeper understanding of the issues, needs and concerns in regard to 'MSM' and HIV risk and vulnerability. However, due to certain logistical issues, it was finally decided to delay the Islamabad seminar to the visit by the consultant in October 2006.

Further to this, each agency was also given access to a range of BCC Urdu and English resources that had been developed by NFI, along with the programme software (*InPage*) and the masters in order for them to be able to adapt these resources to local situations. A tool-kit that provides knowledge and training programme resources is currently under development in Urdu as a part of this current contract, and will be made available by the October visit. This tool-kit works on the principal of developing community-based HIV interventions as the most appropriate model for developing sustainable risk reduction amongst 'MSM'. In the meantime, English versions of this tool-kit were made available. Beyond this, participants and represented agencies were also given access to the NFI website for access to a range of other documentation and resources which they might find useful in developing and implementing their programming, as well as a copy of the powerpoint presentations for the workshop.

The participants of the three workshops were:

- Agencies contracted by the specific Provincial AIDS Control Programme (NWFP – ORA International; Punjab – Contech International; Sindh – Infection Control Society; NWFP)
- Representatives from any MSM CBOs in the province/city
- Others identified by the consultant

The workshops involved the implementing agencies to explore the issues of male-to-male sex and sexualities in Pakistan, issues of risk and vulnerability, along with understanding the diversity of the

frameworks of male-male sexualities and sexual practices. From this understanding, participants were supported in exploring appropriate strategies for implementing HIV prevention, care and support services for MSM and hujras in their target areas, and where necessary to redesign their proposed approaches in their project proposals.

As a part of this tour, a visit was made to Islamabad to discuss with the World Bank and the National AIDS Control Programme a range of issues that had arisen as a result of conducting the workshops, and the need to ensure that follow-on work would implement some of the recommendations arising within the workshops, if not all, and to suggest possible additional technical assistance and support post October 2006 when this specific contract would be completed. It is clear that such technical assistance will need to be ongoing.

Workshop goals

➤ Impact Level

Implementation of a shared set of principles for good practice and programming for MSM HIV prevention, care and support programming.

➤ Organisation/Process Level

Institutionalise knowledge and understanding within local agencies regarding male-to-male sexualities, masculinities, sexual behaviours, risk and vulnerabilities, as well as implementation of appropriate HIV programming to address the needs of MSM.

➤ Personnel/Capacity Level

A deeper understanding of differing frameworks of male-to-male sex, risks and vulnerabilities in Pakistan, and knowledge-based interventions within a framework of agreed good practice principles in regard to HIV prevention, care and support programming among a range of MSM sub-populations.

Skills and Learning Outcomes

- Have a better understanding of social constructions of masculinities and sexualities in Pakistan.
- Have a better understanding of male-to-male sexual behaviours, genders and identities, along with risks and vulnerabilities in Pakistan.
- Be able to integrate this knowledge into programme planning and design for MSM sexual health interventions
- Have access to a range of knowledge resources

Impact Evaluation

While it was clear that some of the issues and concerns highlighted in the workshop were taken on board, based on the evidence from some of the exercises conducted by the participants, it was not possible to evaluate the impact. This will be determined by whether the agencies make the appropriate changes to their service delivery model, and are supported by the PACPs to do so. However, a concern still exists about the levels of organisational stigma and discrimination towards MSM, where reference was made on several occasions to “unnatural” and “against Islam” by key participants. Unless this attitude is effectively dealt with, addressing empowerment issues and building an enabling environment will continue to be problematic.

Workshop Content

Day	Content
Day One	Assumptions, expectations, goals Talking about sex: personal sensibilities Why work with MSM What do we know about HIV and AIDS Gender, sexuality and masculinity Exploring masculinities and their impact on male-male sex Social expectations and their impact on 'MSM' Who is MSM Why do males have sex with males Male-to-male sex: natural or unnatural
Day Two	Frameworks of male-to-male sex in Pakistan Male sex work Risk and vulnerability What is sexual health? Identifying issues and needs Psychosexual issues and concerns; myths and misconception Changing behaviours: how?
Day Three	2 films on zenanas: issues, needs and concerns Developing a response to MSM and HIV risk and vulnerability Developing an enabling environment Addressing empowerment needs Key components in an 'MSM' HIV intervention: Who, What and How Designing an MSM HIV prevention, care and support intervention
Day Four	Designing a programme: group presentations on previous day's work Design implications for implementation agencies Model for implementation and key components Management organogram Organisational recommendations

Lahore, Punjab

Participants

Contech International
Executive Director HIV/AIDS
MSM Project Manager
Lahore staff
Sociologist
Support Officer
2 Project physicians
3 Project dispensers
4 Project counsellors
6 Peer educators
Faisalabad staff
Project Manager
Sociologist
2 project dispensers
2 Project counsellors

Sathi Foundation	1
Nayyab Health Project	2
PACP representatives	3
Total	31

Issues

From the consultant's trip report to the World Bank Pakistan 12th June 2006:

In Punjab, CONTECH International has been contracted to provide HIV services for MSM and Hijras in Lahore for the past two years, and in Faisalabad for the last six months by the Punjab AIDS Control Programme.

The Terms of Reference specifically identify the following as part of the service package:

- *Implement appropriate behaviour change communication (BCC) strategies*
- *Provide lubricant and condom education and distribution*
- *Provide primary healthcare curative services and services for sexually transmitted infections on syndromic management using national guidelines*
- *Provide education on sexual health and sexually transmitted infections, and access to acceptable and appropriate services for sexually transmitted infections*
- *Provide outreach services through field teams of MSM drawn from their networks*
- *Provide access to drop-in centres*
- *Provide access to Voluntary Testing and Counselling*
- *Promote an enabling environment in the project area*
- *Provide empowerment activities*

I have already pointed out my concerns in regard to the overly medicalised approach to service delivery, as well as issues of concern in terms of the absence of water-based lubricant, as well as the STI treatment package with the absence of management protocols regarding anal and oral STIs, rectal damage, haemorrhoidal treatment, as well as issues regarding castrated hijras. All these issues are also covered by the TOR, but continue to be absent in the programme.

For CONTECH, there appears to be an almost exclusive focus on hijras and visibly identifiable zenanas, with very little attention being paid to malaishas who sell sex, professional male sex workers, chavas, and other sub-categories of self-identified MSM. Thus 'peer educators' and 'counsellors' tend

to visit spaces where 'hijras', 'chelas' and 'zenanas' live, their 'debras', with less attention on other main cruising sites, such as parks, cinema halls, and so on.

Apart from this the work with hijras is also further exacerbated with the confusion between the differences between zenana and hijras, gurus and chelas, and an apparent lack of understanding of the guru/chela hijra cultural dynamics. This is leading CONTECH to make fundamental mistakes in approaches to hijras and HIV work and creates tensions and friction between the different hijra households in Lahore.

Despite having identified, drop-in centres, MSM field teams, appropriate IEC materials, empowerment activities, and so on in the Terms of Reference, CONTECH has currently either not implemented these specific elements of the service package, or to some extent inadequately so.

Further, what is referred to as Special Health Clinics (SHCs) by the implementation agency are inadequate in presentation, representation and usage as well as in service provision with regard to the specific sexual health needs of its current users. Too much investment is made in the general population using the services rather than the targeted population, which is resulting in a skewed service usage.

In addition, during the workshop, there was some evidence of continued stigmatisation of the target population by the use of the term “unnatural sex”. It was also clear that there was little involvement of the affected population being centrally involved in project design, management, implementation and delivery (there was no GIPA for MSM). This was exacerbated by a lack of clarity as to who the target population was, and the general misuse of the behavioural term ‘MSM’ as an identity term. There was a lack of clarity of the specific roles of counsellors (who were primarily non-MSM) and ‘peer educators’. Too much emphasis was placed on developing awareness and little attention appeared to be paid to community development and mobilising towards changing sexual norms and normalising safer sex behaviours.

There are also concerns about the effectiveness of Project Monitoring by the PACP and what it is monitoring based on the above issues.

This consultant believes that CONTECH needs to re-think the specific purpose of its current HIV programming and clearly identify its primary focus, which currently are hijras and allied zenanas. As a consequence it should refocus its work specifically for this subpopulation and concurrently develop an additional separate project for the other at-risk MSM sub-populations. This will require a rapid expansion of outreach activities focusing on these additional sub-populations, as well as initiating community development and mobilising strategies for these sub-populations of MSM who are all highly at risk of HIV infection.

The workshop had identified the following MSM sub-populations highly vulnerable and at risk to HIV infection as well as having the potential for increasing the risk of HIV spreading into the general community.

These sub-populations are:

- Hijras
- Zenanas
- Male sex workers (including malaishas who sell sex to men)
- Chavas who can be highly sexually active and may or may not sell sex to other males.

Key Recommendations

1. CONTECH needs to urgently consider hosting two separate and exclusive HIV projects focusing on male-to-male risk behaviours; these would be a hijra/zenana programme and a separate MSM programme focusing on male sex workers, malaishas who sell sex to other males, and chavas.
2. CONTECH should immediately develop a dialogue with leading hijra/zenana gurus and include them in the project by developing a hijra advisory group.

3. The current field team should be clearly defined as an exclusive hijra/zenana outreach team, with their skills and capacity enhanced, and that this outreach team should continue to conduct visits to all the dehras on a regular basis supported by the hijra/zenana advisory group, and these activities should be enhanced with community mobilising strategies
4. It is suggested that a mobile clinical team be developed which would visit dehras regularly to provide on-site clinical assessment and treatment to hijras and zenanas, parallel to the fixed site clinics.
5. CONTECH should also consider sub-contracting Sathi Foundation to support its work with hijras/zenanas.
6. An additional, and separate, team of outreach workers and field supervisors needs to be recruited from the above mentioned MSM sub-populations to deliver field services to the populations they come from, with separate teams working with either male sex workers, malaishas or chavas.
7. The current SHCs need to be enhanced environmentally and equipped and furnished to provide appropriate drop-in spaces for either hijras/zenanas, OR for other MSM sub-populations, such as malaishas who sell sex to other men, other male sex workers and chavas, and the clinical spaces also enhanced as well. If these centres are developed for hijras/zenanas, then additional drop-in spaces and clinics will need to be provided for the male sex workers, malaishas and chavas as a separate service provision. A temporary resolution of this could well be to make the SHCs for the MSM populations that need to be worked with, and the development of the mobile clinic team and socialising activities held in the dehras.
8. The drop-in spaces need to be equipped for vocation training, socialising and entertainment, as well as community building amongst chavas, male sex workers and malaishas.
9. In order to facilitate networking and accessing these MSM sub-population, CONTECH should sub-contract Nanyab Health Foundation to assist it in working with male sex workers, malaishas and chavas.
10. Since CONTECH has a fixed price contract to implement its HIV work, and is supposed to do this with both hijras and MSM, it will need to revisit its budget and identify where costs can be re-allocated to implement the above.
11. The Punjab AIDS Control Programme should seek to identify additional resources to support CONTECH, Sathi Foundation and Nanyab Health Project in regard to the above.
12. The Punjab AIDS Control Programme, as well as CONTECH will need to modify its indicators and monitoring procedures to take into account the above.
13. The Punjab AIDS Control Programme needs to take a much more active and consistent role in providing advocacy support to CONTECH and its partners (if CONTECH agrees to the sub-contracting process), in regard to the social, legal and judicial issues that impede effective implementation of its hijra and MSM HIV prevention, care and support programming. Local beat police need sensitising and awareness of the issues, as much as their superiors.
14. Clinical services providers within CONTECH (doctors and dispensers) need access to training and skills building in terms of medical support for hijras, zenanas, male sex workers, malaishas and chavas, including address anal, rectal and penile health problems. Both the NACP and the PACP should provide for training programmes in this area.
15. Access to water-based lubricant is a critical health concern for all types of males who have sex with males, and is included as a specific activity in the Terms of Reference. Yet, currently, no appropriately packaged water-based lubricant is available. This gap in service delivery needs to be urgently addressed by the NACP and PACP.

16. Condom procurement and distribution for all types of males who have sex with males needs urgent improvement and scaling up rapidly.
17. And finally, it is highly recommended that appropriate team members of CONTECH Hijra and MSM projects (including field team members) should be enabled to conduct a study tour to Dhaka, Bangladesh for visit Shusto Jibon (a hijra owned sexual health project), and Bandhu Welfare Society (an MSM HIV project) as soon as possible. Funding needs to be secured for such a visit.

Peshawar, NWFP

Participants

ORA International	
Executive Director	1
MSM Project Manager	1
Other staff	4
Zenana gurus	4
Dost Foundation	3
Volunteers	3
PACP representative	1

Issues

From the consultant's trip report to the World Bank Pakistan 12th June 2006:

As of the consultant's visit, no contract for service delivery for MSM and Hijras had been signed by the selected agency, ORA International. The long delay has also created significant problems for ORA's recruitment strategy because potential staff have not been willing to wait until the project can actually begin. This has had cost implications for ORA. Further the requirement of fulfilling compulsory staff positions and the need to submit three CVs for each required position are cumbersome, time-consuming and problematic, and as stated above, unnecessary.

Part of the issues regarding delay was the explicit nature of the TOR, which in the socio-political environment of NWFP created a degree of hesitancy in agreeing for the implementation. This was because of the use of terms such as MSM, condoms, and other terms that have a high significance. The consultant's suggestion was to use terms such as "vulnerable males" and a 'male health project' as substitutes.

Despite the lack of a project to review, the consultant discussed a range of issues with the potential implementing agency ORA, and its management, along with the Programme Manager who had been recruited to implement the project once funds have begun to be available.

As in Punjab with the CONTECH Project, the project design, because of the inclusion of compulsory specialist public health staff at management levels, generated an overly medicalised approach to the issues of HIV prevention care and support for the target population. Such an approach would actually hinder effective implementation and sustainability, whereas a more community development and self-help approach would be more effective.

As in the CONTECH approach, the ORA proposal reflected a strong focus on the most highly visible sub-population of 'MSM' – that is on hijras and a certain sub-set of zenanas, without sufficient attention being paid to other 'MSM' sub-populations such as malaishas who sell sex, professional male sex workers, chavas and others.

The medicalised approach indicated a focus only on clinical service delivery with education and awareness programmes, with a lack of attention to empowerment, building sustainability in risk reduction, and addressing psycho-social needs and concerns of the target sub-populations.

Because no final contract had been signed between ORA International and the NWFP PACP, no mobilisation fund advance had been given. As a consequence no project staff had been recruited, other than management.

It is clear that from the workshop there needed to be a re-design of the implementation strategy if ORA International is to fulfil the requirements of both hijra/zenana population as well as other self-identified MSM and male sex workers.

This will also mean that permission needs to be given for a budget readjustment in terms of specific line items, where expenditures may need to be shifted to accommodate these changes.

The key change will be the need to have two separate field teams to address these two very specific sub-populations.

Thus field team 1 will address the educational and social needs of hijras/zenanas, while field team 2 will address the needs of murwasis, male sex workers (including malaishas who sell sex to other males), and “college boys” along with other self-identified MSM.

While I would highly recommend that there should be separate sexual health clinics for these two sub-populations, along with separate drop-in centres providing socialising and community building, mobilising and empowerment activities, I am not sure whether the current budget can afford this.

As in Lahore, there appears to be a lack of understanding of field work methodologies (i.e. outreach workers and peer educators) but this lack of understanding also appears to include the PACP and others.

Expectation issues will need to be addressed, particularly since this contract is only for 25 months, and outputs will be limited by the length of this period. The first 6 to 9 months of the implementation will be involved in developing the infrastructure, identifying and recruiting appropriate staff, conducting skills and capacity building programmes and conducting needs assessments.

Key Recommendations

It needs to be noted that as of 18th July 2006, no official contract has been signed between ORA International and the NWFP PACP (as far as I am aware only a draft has been signed). As a consequence, no advance mobilising fund has been disbursed to the agency.

Review the proposed budget and make adjustments to line items for proposed amendments to implementation and delivery strategy.

Key components of the service delivery package would include:

Outreach Work

- To develop two separate field teams, one focusing on hijras and zenanas, the other focusing on male sex workers including malaishas who sell sex to other males, chavas and other self-identified MSM.
- These field teams would include outreach workers and site-based peer educators. There would also be a need for Field Supervisors to manage the different field teams.
- Both Outreach Workers and Peer Educators would need training programmes for capacity building and communication skills.
- The number of outreach workers and site-based peer educators will depend on the number of dehras (hijras/zenanas) and the number of “hotspots”, their size and numbers using these sites. An outreach worker could manage say five sites, each site having one or two site-based peer educators depending on its size and activity.
- Outreach Workers would also need a monthly field allowance for purchasing refreshments during their fieldwork as part of their socialising activities and networking, as well as local transport.
- All outreach staff should come from the communities/networks they will be working with.
- It is suggested that Outreach Workers are issued with identity cards signed by an appropriate person (such as a police officer), which they can use during working hours.

- Working hours will be determined when sites are active, i.e. possibly afternoons and evenings; workers will need to complete the previous day's monitoring reports before they go onto work in their sites.
- For hijras/zenanas working periods may well be from mid-morning till early evening, with perhaps some night work.

Clinic services

- There will be a need to provide sufficient space for a counselling room, clinic room, and reception area.
- Doctor need to be skilled in STI management, including anal and oral STIs; they should also have knowledge of a range of rectal concerns including fissures, fistulas, haemorrhoids; they should be able to conduct proctoscopic examinations; they should also be able to treat a range of general health concerns such as skin infections; they should also be aware of health issues arising from castration and female hormone ingestion; they should be able to deal with opportunistic infections.
- They will be a need for a dispenser/compounder, and perhaps a technician to draw blood for testing.
- A pre test/post test counsellor should also be available with an understanding of issues around male-male sex.
- Relationships need to be developed with local hospitals for minor rectal operations, and other related issues.
- Relationships with VTC centre will need to be developed for referrals.
- It may be necessary to consider having two separate clinics to address the needs of hijras/zenanas, as well as male sex workers and other MSM. These two distinct sub-populations may not use the same clinic space due to a range of issues.
- Patients would be referred through outreach work and drop-in centre (s), and by word of mouth.
- Sexual history taking will be important, and it will be necessary to have a person who can do this and who will be trusted by all users.
- The clinic service could be promoted as a male health clinic.
- If 2 separate clinics is not a viable option, then a different timetable for access will need to be developed for hijras/zenanas from other males who have sex with males.
- Necessary equipment, fittings and furnishings will need to be secured and the physical environment should be attractive and welcoming.
- Clinic openings will depend on user needs and accessibility.
- Decision needs to be taken as to whether medical treatment and medicines should be free or subsidised.

Drop-in Centre

- The Drop-in Centre needs to be located close to where the sites used by the target population exists, and so reduce the burden of travel and accessibility.
- It may be necessary to consider a separate DiC for hijras/zenanas if financially possible.
- If the budget does not make this a viable option (and this is the preferred option), then it will be necessary to develop a separate timetable for hijras/zenanas from MSW and other MSM accessing the drop in centre.
- Space required will include:
 - Large meeting room and socialising room – also can be used for education groups and training programmes
 - Counselling room for psychosexual counselling
 - Administration room
 - Room for field teams to meet and write daily reports
 - Kitchen
 - Toilet and washroom facilities
- The space should be large enough to include the clinic, but the clinic will require a separate entrance from the drop-in centre.
- Necessary equipment needs to be acquired for a range of empowerment and training activities, fittings and furnishings.

- DiC for activities should be opened from about 11am till 7pm.
- Proper monitoring records will need to be kept on users and activities on a daily basis.
- A psychosexual/psychosocial counsellor should be available in the DiC.

Other issues

- The project should not advertise itself openly, but call itself a Male HIV Project or a Male Health Project.
- Alternately it could name the two separate components (hijra/zenana and MSW and MSM) with two different names selected by the two different sub-populations through FGDs which may provide an element of empowerment and ownership.
- The location of the space (s) should be in semi-commercial areas with easy access in terms of transport
- It should be relatively close to where risky activities take place.
- Considerable advocacy work will need to be done with local police and community leaders and ORA will need the support of the PACP for this.
- Sufficient condoms and water-based lubricant need to be made available.
- Decisions will need to be taken regarding free distribution and social marketing.
- It is suggested that in the first year to two years, these should be provided for free, but there needs to be a planned movement towards social marketing
- A good referral system will need to be developed, not only to Project activities, such as the DiC and clinic, but also for VCT and ARV services, as well as in-depth counselling for depression and suicidal feelings
- This will require training and sensitisation for appropriate service providers in these areas.
- It will be useful if the Project can identify legal support as well.
- In terms of the hijra/zenana component the Project should immediately initiate a range of meetings with the leading gurus in Peshawar, and develop a Hijra/Zenana Advisory Committee or Council to support its prevention care and support activities for this sub-population.
- A small monthly remuneration for members of this council should also be considered.
- It is essential that the Project conducts a small social and needs assessment amongst the two sub-populations as an initial exercise which will also identify the range of highly active sites in the city and their users, from which potential outreach workers and site based peer educators can be recruited.
- Condom promotion messages should not only focus on infection prevention but should also explore cleanliness and hygiene issues.
- Exposure visits should be conducted to Bandhu Social Welfare Society and Shusto Jibon in Dhaka, Bangladesh.

Karachi, Sindh

Participants

<i>Infection Control Society</i>	
Karachi	17
Hyderabad	3
Sukkur	3
Pakistan National AIDS Consortium	2
Volunteer	1
<i>MSM sub-populations:</i>	
Zenanas	2
Male sex workers	2
Mailashias	2
SACP	1

Issues

While Infection Control Society (ICS) was the current preferred choice, no contract has been signed with Sindh PACP that would address MSM and HIV in Karachi, Hyderabad and Sukkur. The delay appears to be within the World Bank because of concerns regarding ICS capacity to deliver, and also the current possible strategy for implementing province-wide services that would require new TORs and re-advertising nationally and internationally. This delay is also compounded by the changes in the Sindh PACP management structure.

The consultant held a range of discussions with the ICS management team regarding its proposed service delivery package and organisational structure. Similar issues of concerns arose as in NWFP and Punjab service packages, that was whether the project designs and implementation strategies could address a broad range of ‘MSM’ sub-populations as well as hijras. However, it was also clear that ICS did have access to a broad range of ‘MSM’ and hijra networks in Karachi, and understood the needs for a community development approach to risk reduction amongst highly vulnerable populations.

Further to this, the consultant held a focus group discussion with a number of professional male sex workers, zenanas and malaishas who sell sex to other men, which was organised by ICS. Along with this, several visits were made to a number of sites where male sex work could be readily identified.

The contract between the SACP and Infection Control Society had recently been signed, but as yet ICS had not begun the implementation of the project. ICS is now committed to develop service packages in Karachi, Hyderabad and Sukkur

It is clear that from the workshop there needed to be a re-design of the implementation strategy if Infection Control Society is to fulfil the requirements of both hijra/zenana population as well as other self-identified MSM and male sex workers.

The key change will be the need to have two separate field teams to address these two very specific sub-populations.

Thus field team 1 will address the educational and social needs of hijras/zenanas, while field team 2 will address the needs of murwasis, male sex workers (including malaishas who sell sex to other males), and “college boys” along with other self-identified MSM.

Whilst I would highly recommend that there should also be separate sexual health clinics for these two sub-populations, along with separate drop-in centres providing socialising and community building, mobilising and empowerment activities, I am not sure whether the current budget can afford this.

Expectation issues will need to be addressed, particularly since this contract is only for 2 years, and outputs will be limited by the length of this period. The first 6 to 9 months of the implementation will be involved in developing the infrastructure, identifying and recruiting appropriate staff, conducting skills and capacity building programmes and conducting needs assessments.

A further issue of concern is whether the funding made available will be sufficient in regard to the need to cover three cities, along with the size of Karachi itself. This city alone will require a minimum of 5 drop-in centres and clinics to make any sort of impact. I was not able to evaluate the coverage area of Hyderabad and Sukkur as a part of this workshop.

Another issue is the proposed methodology of fund disbursement. Following a 10% advance for start-up costs, it appears that payment is in arrears. This will most likely create cash flow difficulties that would have a negative impact on staff retention, particularly those at the lower pay grades such as those involved in field work.

Key recommendations

Review the proposed budget and make adjustments to line items for proposed amendments to implementation and delivery strategy.

Key components of the service delivery package would include:

Outreach Work

- Two separate teams of field workers, one focusing on hijras and zenanas, the other focusing on male sex workers including malaishas who sell sex to other males, chavas and other self-identified MSM will need to be developed.
- These field teams will include outreach workers and site-based peer educators (numbers would depend on the number of dehras and field sites). There will be a need for a Field Supervisor for each of the field teams addressing the different sub-populations (see Annexure).
- Both Outreach Workers and Peer Educators will need training programmes for capacity building and communication skills.
- The number of outreach workers and site-based peer educators will depend on the number of dehras (hijras/zenanas) and the number of “hotspots”, their size and numbers using these sites. An outreach worker could manage say five sites, each site having one or two site-based peer educators depending on its size and activity.
- Outreach Workers should also receive a monthly field allowance for purchasing refreshments during their fieldwork as part of their socialising activities and networking, as well as local transport.
- All outreach staff should come from the communities/networks they will be working with.
- All field staff should come from the communities/networks they will be working with.
- It is suggested that Outreach Workers are issued with identity cards signed by an appropriate person, which they can use during working hours.
- Working hours will be afternoon and evenings; workers will need to complete the previous day’s monitoring reports before they go onto work in their sites
- For hijras/zenanas working periods will be mid-morning till early evening, with some night work

Clinic services

- Exploring the size of Karachi, there will need to be about 5 clinics across the city, assuming that each clinic will service both zenanas/hijras as well as malaishas and other MSW. To do this effectively, different clinic timings may be necessary.

- For each clinic there will be a need to provide sufficient space for a counselling room, clinic room, and reception area.
- Doctors will need to be skilled in STI management, including anal and oral STIs; they should also have knowledge of a range of rectal concerns including fissures, fistulas, haemorrhoids; they should be able to conduct proctoscopic examinations; they should also be able to treat a range of general health concerns such as skin infections; they should also be aware of health issues arising from castration and female hormone ingestion; they should be able to deal with opportunistic infections.
- There will be a need for dispensers/compounders, and perhaps technicians to draw blood for testing.
- Pre test/post test counsellors should also be available with an understanding of issues around male-male sex.
- Relationships need to be developed with local hospitals for minor rectal operations, and other related issues.
- Relationships with VTC centre will need to be developed for referrals.
- It may be necessary to consider having two separate clinics to address the needs of hijras/zenanas, as well as male sex workers and other MSM. These two distinct sub-populations may not use the same clinic space due to a range of issues. However, budget constraints may not make this possible.
- Patients would be referred through outreach work and drop-in centre (s), and by word of mouth.
- Sexual history taking will be important, and it will be necessary to have persons who can do this and who will be trusted by all users.
- The clinic services could be promoted as a male health clinics.
- If 2 separate clinics is not a viable option, then a different timetable for access will need to be developed for hijras/zenanas from other males who have sex with males.
- Necessary equipment, fittings and furnishings will need to be secured and the physical environment should be attractive and welcoming.
- Clinic openings will depend on user needs and accessibility.
- Decision needs to be taken as to whether medical treatment and medicines should be free or subsidised.

Drop-in Centre

- Drop-in Centres needs to be located close to where the sites used by the target population exists, and so reduce the burden of travel and accessibility, and would include the clinic services.
- It may be necessary to consider separate DiCs for hijras/zenanas if financially possible.
- If the budget does not make this a viable option (and this is the preferred option), then it will be necessary to develop a separate timetable for hijras/zenanas from MSW and other MSM accessing the drop in centres.
- For each DiC, space required will include:
 - Large meeting room and socialising room – also can be used for education groups and training programmes
 - Counselling room for psychosexual counselling
 - Administration room
 - Room for field teams to meet and write daily reports
 - Kitchen
 - Toilet and washroom facilities
- The space should be large enough to include the clinic, but the clinic will require a separate entrance from the drop-in centre.
- Necessary equipment needs to be acquired for a range of empowerment and training activities, fittings and furnishings.
- DiC for activities should be opened from about 11am till 7pm.
- Proper monitoring records will need to be kept on users and activities on a daily basis.
- A psychosexual/psychosocial counsellor should be available in the DiC.

Other issues

- The project could promote itself as a Male HIV Project or a Male Health Project
- Alternately it could name the two separate components (hijra/zenana, and MSW and MSM) with two different names selected by the two different sub-populations through FGDs which may provide an element of empowerment and ownership
- The location of the space (s) should be in semi-commercial areas with easy access in terms of transport
- DiCs should be relatively close to where risky activities take place
- Considerable advocacy work will need to be done with local police and community leaders and ICSP will need the support of the PACP for this
- Sufficient condoms and water-based lubricant need to be made available
- Decisions will need to be taken regarding free distribution and social marketing
- It is suggested that in the first year to two years, these should be provided for free, but there needs to be a planned movement towards social marketing
- A good referral system will need to be developed, not only to Project activities, such as the DiCs and clinics, but also for VCT and ARV services, as well as in-depth counselling for depression and suicidal feelings
- This will require effective training and sensitisation for appropriate service providers in these areas
- It will be useful if the Project can identify legal support as well
- In terms of the hijra/zenana component the Project should immediately initiate a range of meetings with the leading gurus in Karachi, and develop a Hijra/Zenana Advisory Committee or Council to support its prevention care and support activities for this sub-population
- A small monthly remuneration for members of this council should also be considered
- It is essential that the Project conducts social and needs assessment amongst the two sub-populations as an initial exercise which will also identify the range of highly active sites in the city and their users, from which potential outreach workers and site based peer educators can be recruited
- Condom promotion messages should not only focus on infection prevention but should also explore cleanliness and hygiene issues
- Exposure visits should be conducted to Bandhu Social Welfare Society and Shusto Jibon in Dhaka, Bangladesh

Key issues for NACP and the PACPs

The following are key issues that NACP and the Provincial AIDS Control Programmes will need to address urgently.

Water-based lubricant

This is an urgent requirement for reducing HIV infection risk amongst hijras/zenanas and MSM. However, no such appropriately packaged product is currently available in Pakistan. This significant gap in availability in health promotion products needs to be addressed through the importation of water-based lubricant packaged in sachets that are affordably priced and in sufficient quantity so that the implementation agencies can have access for onward distribution.

Condoms

The implementation agencies will need access to sufficient condom supplies for forward distribution on a regular basis.

Clinical services

Doctors and other clinical staff providing STI and general health management services for the implementation agencies urgently need to be provided with capacity building training in regard to the sexual and other health needs of hijras/zenanas and other males who have sex with males. This

includes anal and oral STIs, rectal damage, castration issues, female hormonal ingestion by males, and other concerns.

Advocacy

Because of the significant levels of stigma and discrimination focused on zenanas/hijras and other MSM, along with the illegality of the behaviour, there needs to be considerable coordination between health and home ministries, both at federal level as well as at the provincial and city levels. Considerable advocacy needs to be conducted at local, city, provincial and national levels towards developing enabling environments, particularly with local police at beat and station house levels. Implementation agencies will require on-going support to be able to conduct such activities, and it is suggested that the PACPs should take the lead in this.

Collaboration and partnerships

Developing links with other HIV programmes and projects, as well as agencies working in the fields of women's health, human rights, street children, IDUs, female sex workers, migration and mobility, and allied arenas could provide a supportive environment for implementation agencies working with zenana/hijras and other MSM. It is suggested that PACPs support such networking and enable collaboration to develop between these agencies.

National Forum

One such mechanism that could be a part of an enabling strategy is to develop a National Forum for MSM and HIV prevention, care and support, that could meet quarterly or bi-annually, and provide a platform to address a range of issues, from access to resources to advocacy. It could act as a forum for sharing of knowledge and skills as well as a forum for the exchange of information. Such a forum would consist of agencies implementing HIV programming for MSM through PACP support, or community-based interventions, donors, NACP, and as well as allies.

Conclusion

It is clear that the implementing agencies for promoting HIV prevention, care and support services for hijras, zenanas, and other MSM did not have the technical knowledge, nor a clear understanding, to design and develop effective and appropriate strategies for addressing the HIV issues, needs and concerns of these highly stigmatised and vulnerable populations.

The workshops conducted in Karachi, Lahore and Peshawar was an attempt to provide them with such a basic knowledge and understanding, exploring male-male sexualities, gender variance, methodologies of access, and effective ways of promoting HIV prevention, care and support.

At the same time, a range of BCC materials in English and Urdu were provided to the implementation agencies to adopt and adapt to their specific needs.

Further to this key individuals were identified for further skills upgrading towards developing an in-country technical resource team on HIV and MSM should funding be secured for this.

A follow-on round of workshops will be conducted in October 2006 for the same agencies, which will focus on issues of outreach methodologies as well as monitoring and evaluation. It will also create an opportunity for exploring the implementation of the suggestions and recommendations for each of the three agencies identified above.

Annexure 1

Travel Schedule

Day	Date	Dept Time	Origin	Destination	Arrival time	Airline	Flight No	nights
Friday	30/6	1105	Lucknow	Delhi	1200	IA	IC812	0
Friday	30/6	1830	Delhi	Lahore	1900	IA	IC845	10
Sunday	9/7	1400	Lahore	Islamabad	1450	PIA	PK386	4
Wednesday	12/7	1600	Lahore	Peshawar	1735	PIA	610	6
Tuesday	18/7	1450	Peshawar	Karachi	1640	PIA	PK351	7
Tuesday	25/7	1600	Karachi	Islamabad	1755	PIA	PK308	3
Friday	28/7	1400	Islamabad	Lahore	1505	PIA	PK623	0
Friday	28/7	1945	Lahore	Delhi	2115	IA	IC846	1
Saturday	29/7	0930	Delhi	Lucknow	1025	IA	IC601	31

Workshop Schedule

City	Arrival Date	Workshop Dates	Workshop conducted	Departure Date	Next stop
Friday	30/6	4 – 7/7	Lahore	9/7	Islamabad
Sunday	9/7		Islamabad discussions	12/7	Peshawar
Wednesday	12/7	13 – 16/7	Peshawar	18/7	Karachi
Tuesday	18/7	20 – 23/7	Karachi	25/7	Islamabad
Tuesday	25/7	27/7	Islamabad de-briefing	28/7	Lahore
Friday	28/7	-		28/7	Delhi
Saturday	29/7	-		29/7	Lucknow

Annexure 2

Workshop agenda

Dates:	Lahore:	4 - 7 July 2006
	Peshawar	13 - 16 July 2006
	Karachi	20 - 23 July 2006

Working with MSM and HIV in Pakistan

Workshop 1: Developing strategies for sexual health interventions focusing on male-to-male sexual behaviours and sexualities in Pakistan

Facilitator: Shivananda Khan

Time	Issue
Day 1	
9.30am – 10.00am	Registration/refreshments
10.00am – 10.15am	Welcome/introductions
10.15am - 10.45am	Assumptions/Agenda/Expectations/Goals: <i>Presentation</i> Personal sensibilities
10.45am - 11.00am	Why work with MSM? <i>presentation</i>
11.00am – 11.30am	What do we know: HIV and AIDS <i>Questionnaire and discussion</i>
11.30am – 12noon	Tea Break
12 noon – 1.30pm	What is sex Gender, Sexuality, Masculinity: What are they? Exploring masculinities and their impact on male-to-male sex <i>Working Groups</i>
1.30pm - 2.30pm	Lunch
2.30pm – 4.00pm	Social, cultural and religious expectations <i>Working Groups</i>
4.00pm - 4.30pm	Tea break
4.30pm – 5.30pm	Who is MSM? Why do males have sex with males? Same-sex behaviours: Natural or unnatural <i>Working groups</i>
5.30pm	Close

Time	Issue
Day 2	
9.30am – 10.00am	Warm up Feedback from Day 1 Questions and answers
10.00am - 11.30am	Frameworks of male-male sex Male sex work Who is at risk? Who is vulnerable Focus on groups or behaviour? <i>Working groups</i>
11.30am – 12 noon	Tea break
12 noon – 1.30pm	What is sexual health? Identifying issues and needs in this context <i>Working groups</i>
1.30pm - 2.30pm	Lunch
2.30pm - 4.00pm	Myths, misconceptions and psychosexual issues in regard to sexualities, sexual practices and STIs <i>Working groups</i> <i>Discussion: How these impede safer sex promotion</i>
4.00pm - 4.30pm	Tea break
4.30pm - 5.30pm	What are risky behaviours Changing behaviours: how? What works – what doesn't work <i>Working groups</i> <i>Discussion: what are the necessary components to address behaviour change for risk reduction</i>
5.30pm	Close

Time	Issue
Day 3	
9.30am – 10.00am	Warm up Feedback from Day 2 Questions and answers
10.00am – 11.30am	Film show: 2 1. The Unconscious 2. Avchetan Discussion on disempowerment, self-esteem, marriage Developing a response Strategies for intervention <i>Working Groups</i>
11.30am – 12noon	Tea Break
12 noon – 1.30pm	Developing an enabling environment What does empowerment mean What are key components of an MSM HIV interventions <i>Presentation and discussion</i>
1.30pm - 2.30pm	Lunch
2.30pm – 4.00pm	Designing an MSM intervention Which sub-populations to focus on What are the issues and needs How, what, where, when, who Goal, Objectives, Outputs, Activities <i>Working groups</i>
4.00pm - 4.30pm	Tea break
4.30pm – 5.30pm	Designing an MSM intervention <i>Working groups</i>
5.30pm	Close

Time	Issue
Day 4	
9.30am – 10.00am	Warm up Feedback from Day 3 Questions and answers
10.00am - 11.30am	Working group presentations <i>Discussion: What will work and what won't</i>
11.30am – 12 noon	Tea break
12 noon – 1.30pm	Working group presentations continued <i>Discussion: What will work and what won't</i>
1.30pm - 2.30pm	Lunch
2.30pm - 4.00pm	Management, Organogram, Outreach, Centre-based services, Clinical services, Advocacy, Technical Support Outputs and indicators <i>Presentation and group discussion</i>
4.00pm - 4.30pm	Tea break
4.30pm - 5.30pm	General Discussion: Question and Answers
5.30pm	Evaluation and Close

Annexure 3

NFI Position Paper

Field Staffing for self-help agencies working with vulnerable male populations in promoting sexual health

Naz Foundation International
August 2000

A Field Team consists of a Field Officer with responsibilities to cover a specific number of sites, along with a number of Site Buddies who come from these specific sites.

Depending on the size and the socio-sexual dynamics of a site, the number of Site Buddies will vary between 1 and 3. A Field Officer may be responsible for 2 or more sites depending on the size and socio-sexual dynamics of the sites and the number of Site Buddies deemed necessary to cover each site.

The Field Officer manages the Site Buddies in his Field Team. A City Project may well have several Field Teams.

Field Officers would be selected because they have:

- personal MSM behaviours and identities
- desire to do community work
- an aptitude to learn
- comfortable with personal sense of sexual/gendered identity

Criteria for Field staff selection will be based on the following

- good communication skills
- an understanding of MSM issues and sociocultural contexts
- good working knowledge of sites
- good understanding of HIV/STIs
- ability to enable people to feel at ease and comfortable
- ability to develop friendship with kothis, panthis, double-deckers and other MSM
- ability to write in local language, and if possible, English
- ability to speak openly on MSM sexualities and behaviours
- knowledge of the male and female body
- knowledge of psychosexual issues and counselling
- a proven commitment to the issues

Secondary skills

- reasonable vernacular literacy
- a minimum of education up to HSS standard

Field Officers must also be MSM themselves, and preferably come from the networks within which they are working with. It should be noted that the essential key for success in achieving the Programme's primary goal and purpose will be around community development and mobilising, and skills that are able to empower and develop such a framework are not necessarily based on educational capacity.

A Field Officer's personal style of dress, behaviour, language, and attitudes should be appropriate to the site (s) he would be working with it. He needs to be comfortable with a range of sexual choices and behaviours and partner selection, as well as different socioeconomic groups, ages, and classes.

Constant reinforcement of messages, skills, and knowledge would be undertaken for field officers by both the Field Coordinator and Centre Manager with appropriate support from the Programme management staff. This would require an on-going series of in-house training and refresher courses.

The role of the Field Coordinator is to develop the Field Teams, manage and supervise their work, ensure adequate monitoring procedures are followed, conduct regular site visits, evaluate the work of the field teams and individuals, and prepare monthly reports.

Criteria for Site Buddies selection will be based on the following

- Site Buddies must always come from the site/framework in which they have considerable knowledge. This knowledge should include
 - kothis/panthis using the site
 - local traders, assistants, transport workers, etc.
 - sexual activities at the site
 - safer sex behaviours and condom usage
 - personal friendships
 - areas of risk
- good communication skills with beneficiaries
- knowledge of MSM issues and sociocultural contexts
- proven knowledge of site
- reasonable working knowledge of HIV/STIs
- ability to enable people to feel at ease and comfortable
- ability to develop friendship with zenanas, hijras, MSW, and other MSM
- ability to speak openly on MSM sex
- knowledge of the male and female body

(Site Buddies are site-based peer educators)

Quality of Field teams and outreach skills

It must be noted that Site Buddies are much more than just peer educators. They are key to an effective community-building and development strategy for a sustainable behaviour change programme, where the population group is highly stigmatised, socially excluded and vulnerable. Further they also play a role in building an enabling environment for increasing health-seeking behaviours.

For effective outreach at the site, it is not essential that the Site Buddy is literate. What is essential is his networking and communication skills.

The site buddy is the key link between the field officer and the males utilising a specific site for sexual purposes. They provide detailed knowledge and understanding about the social and sexual dynamics, practices, relations with the police, and so on. The site buddies also distribute condoms and lubricant as well as generally sharing information and encourage their peers to practice safer sex, access STI diagnosis and treatment, as well as participate in the social groups and utilise the drop-in. Site buddies should only work at their site.

Field Officers cover more than one site, usually two or three. The field officer undertakes more intensive communication. This is based on making friends and relation building. Provision of BCC materials, information on HIV/AIDS and STIs, condoms, and so on, follow later. This is backed-up by the site buddy when the field worker is not on site.

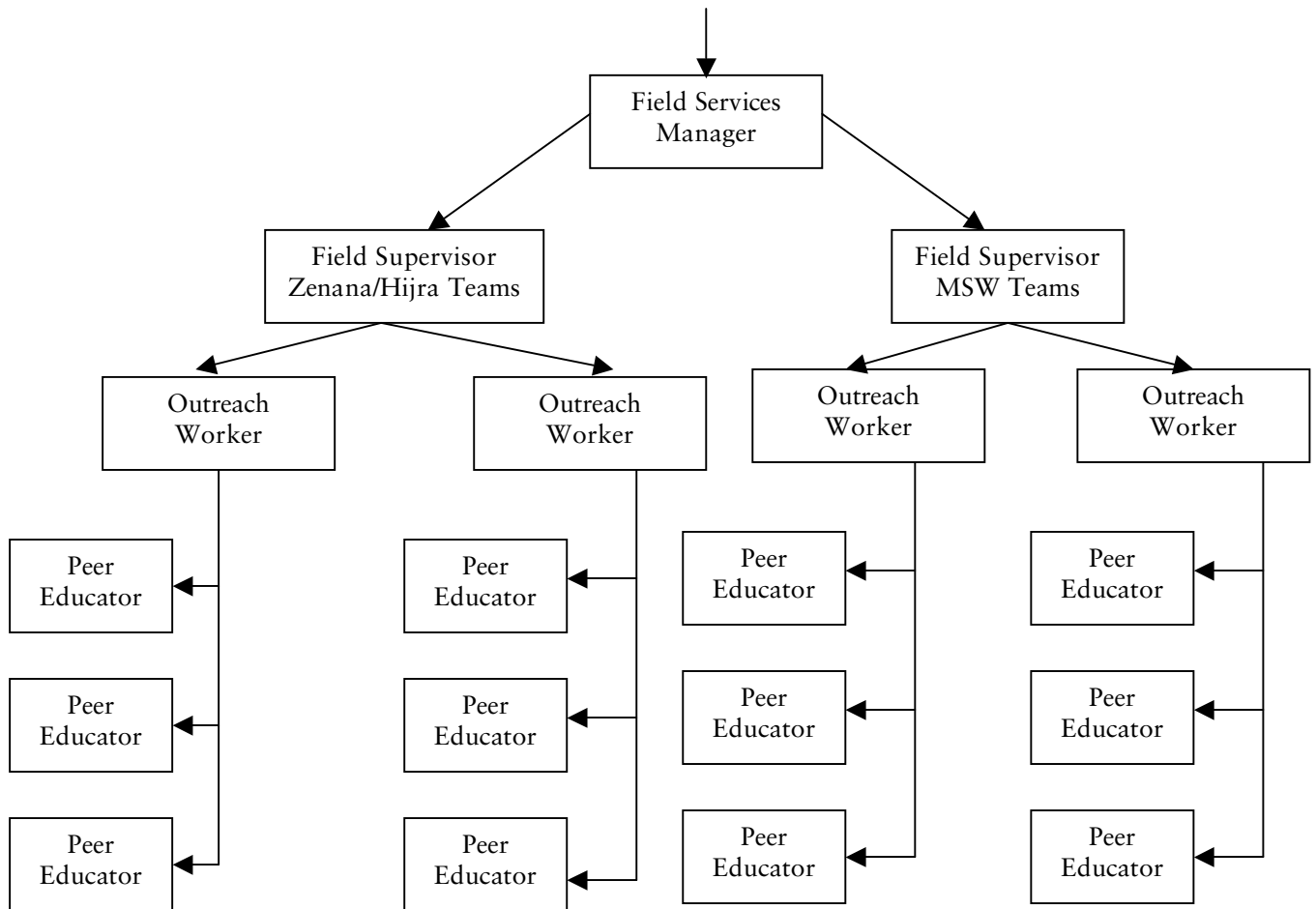
Interactions in the field include low-key counselling as well.

Building up interactions in the field encourages people to visit the office and join in the office activities thus learning more about HIV/AIDS and STIs, access STI diagnosis and treatment as well as counselling if required, and generally begin to develop a sense of community.

Annexure 4

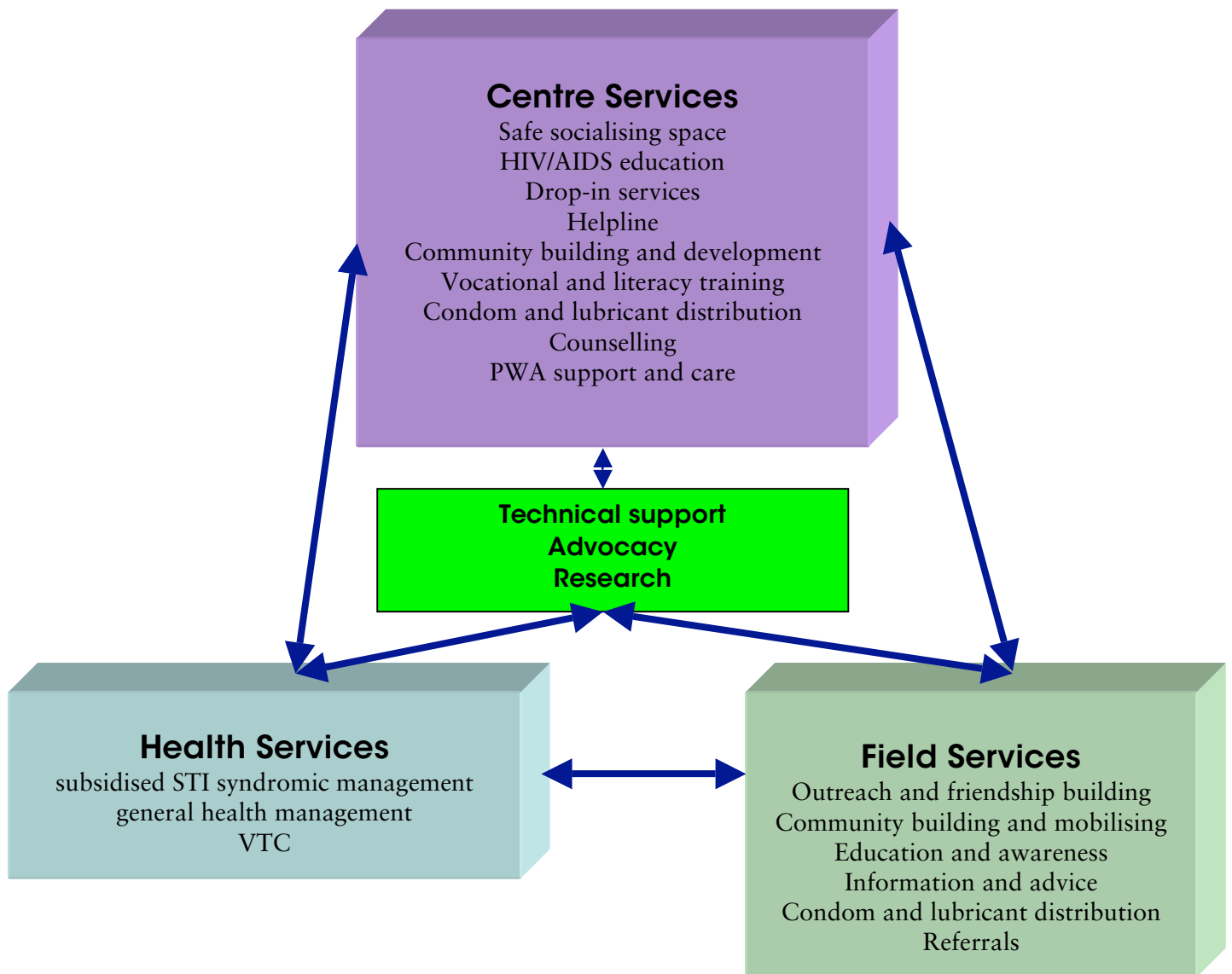
Example of Field Teams Organogram

A field team consists of an Outreach Worker and a number of site-based peer educators. The Outreach Worker will be responsible for a number of sites, while the SBPE will operate from his own site. Field services will operate from the appropriate drop-in centre.



Annexure 5

Service Delivery Model for MSM and Hijras



Annexure 6

Possible Organogram

