

Recommendations for action

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Following on from the 1st round of workshops conducted in Karachi, Lahore and Peshawar

World Bank Contract: 7138376

Technical assistance for strengthening interventions for HIV and AIDS prevention, care and support services for MSM in Pakistan

Actions to be taken by the Implementation Agencies in Karachi, Lahore and Peshawar

26th July 2006

Lahore

CONTECH International

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 Nayyab 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 Nayyab 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

ORA International

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

Infection Control Society

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.
- They 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
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 - Room for field teams to meet and write daily reports
 - Kitchen
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- 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

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- 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
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- 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

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 on 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.

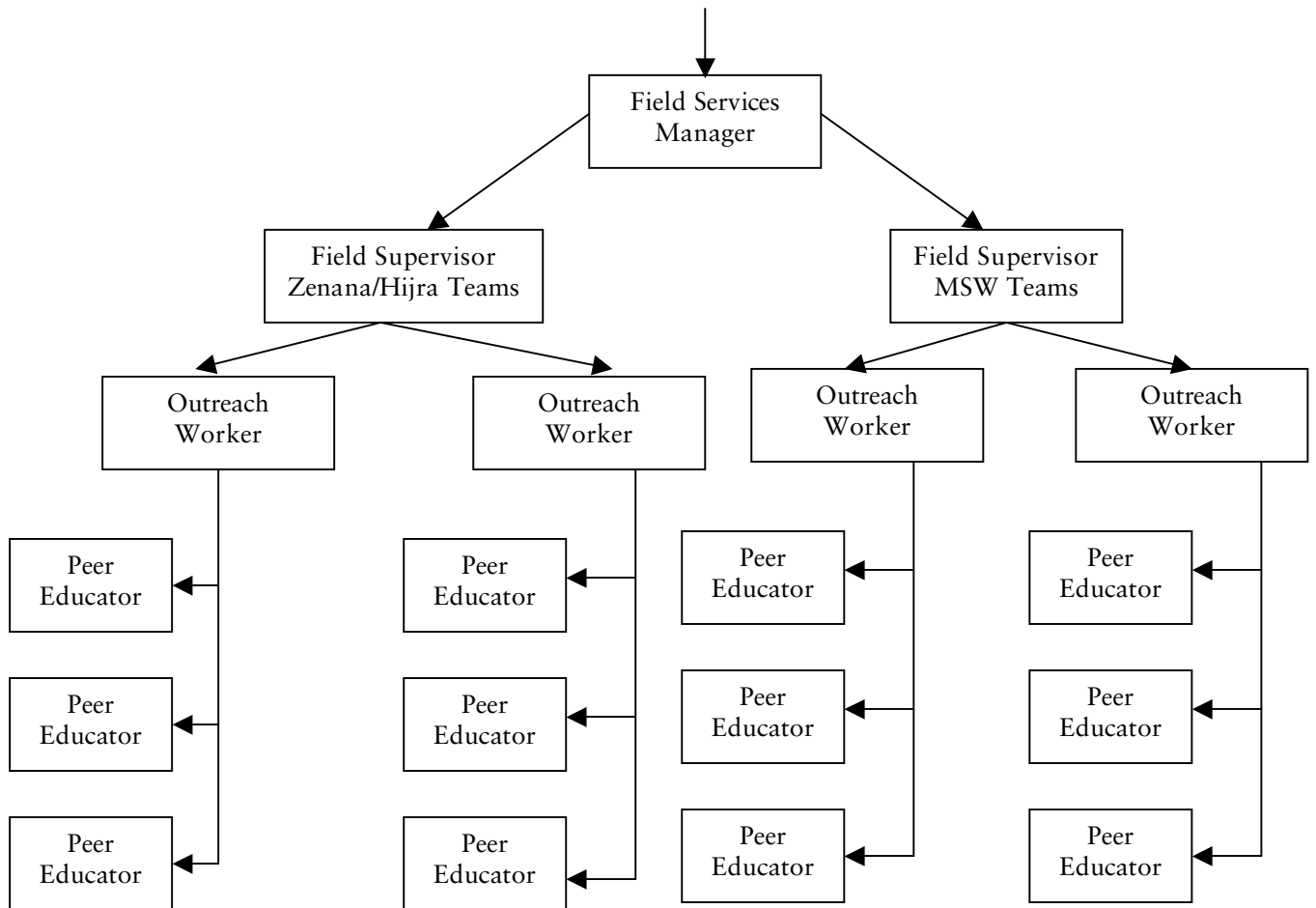
Interactions in the field include low-key counselling as well.

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 2

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 3

Service Delivery Model for MSM and Hijras

