

Report on the Training on Sexual Health for Men with High Risk Behaviours



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**Organised and conducted by PSI Myanmar TOP with
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Executive Summary

Acknowledgements

NFI would like to gratefully acknowledge Habibur Rahman, National Programme Manager, Population Services International, Myanmar, for his strong commitment, understanding and dedication towards ensuring that males who have sex with males in Myanmar have access to appropriate sexual health services, as well as ensuring that community involvement and ownership are central to such service delivery.

Special thanks also need to Guy Stallworthy, the previous Country Director of Population Services International Myanmar for his strong commitment, support and encouragement for the development of the MSM Targeted Outreach Programme and its goals and objectives, along with Sam Connor, PSI Myanmar Acting Country Director in the run up to the meeting.

We would also like to thank John Hetherington, the new Country Director of PSI Myanmar, who, despite having only just arrived in the country during the meeting, very graciously agreed to attend the closing ceremony, articulating the strong commitment of PSI Myanmar to support MSM and HIV programming in the country, as his first public statement.

And finally, our thanks go to the organising committee, co-facilitators, chairpersons, and all the participants, along with Paul Causey and Jan Wijngaarden and the collaborating partners that made this meeting so successful.

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-retroviral treatment
ARV	Antiretroviral
BCC	Behaviour, Change, Communication
CBO	Community-based organisation
DiC	Drop-in centre
FSW	Female sex worker
GO	Government organisation
HIV	Human Immunodeficiency Virus
INGO	International non-government organisation
MDM	Medecins du Monde
MSF	Medecine sans Frontieres
MSM	Males who have sex with males (sometimes known as men who have sex with men)
MSW	Male sex workers
NFI	Naz Foundation International
NGO	Non-government organisation
OI	Opportunistic infections
PLHA	People living with HIV/AIDS
PLHIV	People living with HIV
PSI	Population Services International
PSN	Purple Sky Network
SHG	Self-help group
STI	Sexually transmitted infection
TB	Tuberculosis
TOP	Targeted Outreach Programme
ToT	Training of Trainers
UNAIDS	United Nations Joint Programme on AIDS
UNFPA	United Nations Family Planning Association
VCT	Voluntary counselling and testing
WHO	World Health Organisation

Why we should work with male-to-male sex and HIV prevention, care and support?

Because:

- It is the right thing to do on humanitarian grounds.
- It is the right thing to do epidemiologically.
- It is the right thing to do from a public health perspective.

Males who have sex with males (MSM) whether their self-identity is linked to their same sex behaviour or not, have:

- The right to be free from violence and harassment;
- The right to be treated with dignity and respect;
- The right to be treated as full citizens in their country;
- The right to be free from HIV/AIDS;

MSM who are already infected with HIV have the right to access appropriate care and treatment equally with everyone else, regardless of how the virus was transmitted to them.

Sexual health

Sexual health is a state of physical, emotional, mental and social wellbeing related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

*World Health Organisation
Draft working definition, October 2002*

Executive Summary

HIV/AIDS has become a national concern in Myanmar as one of three priority communicable diseases identified by the Ministry of Health. In South-East Asia, Myanmar, as well as Thailand and Cambodia, have been identified by UNAIDS as the three highest priority countries.

UNAIDS 2004 estimates for the number of HIV positive individuals in Myanmar range from 170,000 to 620,000 (out of 54 millions habitants). Trends in official sentinel surveillance data show increasing rates of HIV infection among high-risk groups, especially sex workers. Low-risk groups like blood donors and pregnant women top respectively at 1.23 % and 1.64 %. Officially reported AIDS cases attribute 30% to intravenous drug use and 68% to heterosexual transmission. Though the men to woman ratio among reported cases is still 5:1, the number of infected women has increased in the last 5 years. Geographical mapping of officially reported AIDS cases shows that eastern states/divisions have been hardest hit. The central and delta regions had moderate rates of infection, with the lowest found on the western border.

However, data from the VCT services being offered by PSI drop-in centres indicate that the prevalence rate among MSM in Yangon is between the 25-40% range (in 2006 it was reported as 32.50% while the prevalence rate among the general adult population was 1.30%).¹

PSI Myanmar is a major international non-government organisation working in HIV prevention in the country implementing an HIV prevention programme since 1996 through social marketing and educational mechanisms of a range of sexual health products and services to the general community. In 2003 it began to develop an MSM and HIV prevention, care and support service through its Targeted Outreach Programme, and initiated drop-in services, outreach and clinical services in Yangon in 2004 and Mandalay in 2005. It began a scaling up of services to other cities in 2006, and now covers 9 cities.

At the same time, a number of other INGOs are implementing a range of HIV services for MSM on a relatively small scale, including including the HIV/AIDS Alliance in Myanmar, Artsen Zonder Grenzen (AZG/MSF Holland), CARE International, and Medecins du Monde (MDM).²

A critical element in the PSI Myanmar programme design is the need to develop community ownership of the process. Field workers are identified, selected and trained from the MSM networks themselves, and play the crucial role of establishing friendship and trust with community members and assist in community building. Their role is to provide education on HIV and STI, while providing condoms and lubricants and encourage MSM to attend the drop-in centre (DiC) where they can access STI clinical and VCT services. At the same time, the DiC provides a social non-stigmatising and mutually supportive social environment which compliments the field workers community networking towards developing a sense of community solidarity and mobilising to achieve sustained risk reduction. Thus the drop-in centre plays a key role in the process of collectivisation and self-help group formation.

However, the realities within Myanmar make the development of local independent community-based organisations problematic.

As a way of exploring strategic approaches towards scaling up coverage of appropriate MSM HIV services utilising community-based engagement in mobilising MSM to assist in this process, while recognising the gendered construction of much of male-male sexual practices and identities in Myanmar, it was decided that PSI Myanmar would host a national training meeting to discuss these issues by bring together donors, implementing agencies and MSM community(ies) representatives over three days.

¹ See Jan Wigngaarden's presentation later in this report.

² See Jan W de Lind van Wijngaarden, 2006, Scaling up the response to HIV/AIDS among males having sex with males (MSM) and transgenders (TG) in Myanmar

Scope and purpose

To bring together males who have sex with males from the whole nation either as representatives from AIDS Service Agencies, sexual networks, groups or as individuals, in a consultative process to discuss ways forward in improving access to HIV/AIDS and sexual health services appropriate to their needs, to develop collaborative work, to act as a skills building programme, and to ensure that culture specific issues around sexualities, sexual health, and STDs/HIV/AIDS are appropriately developed and addressed.

Objectives

Using a Working Group process with introductory presentations, the primary objective was to develop a number of recommendations arising from identifying the various issues of concerns and needs. This process enabled identifying what participants believed were appropriate strategies to reduce HIV risk and vulnerability amongst MSM, as well identifying gaps in current services and their availability.

Another key objective was achieved, in that, by mobilising and motivating participants from a range of MSM networks across Myanmar towards developing a national network of MSM groups, organisations and HIV services.

Participants

A total of 120 participants, drawn from the range of MSM sexual health projects in Myanmar, as well as those from a number of MSM sexual networks who had expressed interest in developing appropriate services in their cities. A number of agencies and NGOs also participated, including the International HIV/AIDS Alliance, MSF, MDM, and their supported organisations.

Technical assistance and support was provided by Shivananda Khan of Naz Foundation International, along with two UNFPA supported consultants, Paul Causey and Jan Wigngaarden.

Methodology

A Working Group methodology was followed where participants were allocated to one of nine Working Groups where each had two co-facilitators (one of which also acted as a reporter). A training day was held for these facilitators just prior to the meeting.

The meeting over three days explored:

Day 1: What are the issues of concern for MSM in regard to their sexual health, based on the WHO working definition?³

Day 2: What are sexual health needs of MSM?

Day 3: Ways forward in addressing these needs

Each day, a morning plenary session was held where a range of speakers provided presentations on relevant themes, followed by a presentation on the theme of the day to guide the Working Groups on their discussions.

³ Sexual health is a state of physical, emotional, mental and social wellbeing related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, a well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, Protected and fulfilled. World Health Organisation, draft working definition, October 2002

Following the Working Group discussions, a feedback session enabled Working Groups to report back on their deliberations each day, followed by a question and answer session. A brief presentation was also given by Shivananda Khan on days one and two on any missing elements from these deliberations.

On the final day of the meeting, Working Groups were asked to identify four key priorities from the range of recommendations that they would develop.

Key recommendations

1. Supporting MSM community building and development, along with self-help organising

It was strongly believed that the most effective way forward to providing sexual health services for MSM towards reducing their risks to STI and HIV infection, as well as addressing their vulnerabilities, and sustaining behaviour changes, was to actively support community building and development by aiding self-help organising through technical assistance and appropriate levels of funding. It is recommended therefore that donors and international NGOs should preferentially support and fund such grass roots initiatives, along with providing support for community building and development.

2. Providing a comprehensive service package that includes drop-in centres, outreach and health services

There should be a comprehensive service package being supported that involves:

- a. Safe spaces such as drop-in centres where socialising and recreational activities can be provided towards aiding community building, and where sexual health education, psychosexual counselling, vocational training, and other supportive activities can be developed.
- b. Outreach activities conducted by peer field teams who are from the same MSM networks as those they are reaching out providing education and awareness, sexual health products, inter-personal communication, referrals to appropriate services, and peer pressure towards reducing risk.
- c. Health services providing STI management and treatment, voluntary HIV counselling, general health services, treatment of opportunistic infections, sexual health education and products, and if possible, voluntary testing and access to anti-retrovirals. If this is not possible then appropriate services need to be identified ensuring that the clinic staff are trained on sexual health issues for MSM, not only in terms of STIs, but also in terms of rectal problems, as well as general health issues. Such health provision will need to be linked with TB treatment as well. This health provision should be seen as a one-stop treatment centre.

3. Ensuring that STI treatment providers have the appropriate knowledge, skills and empathy to the needs of MSM

Many low-income MSM utilise the services of street quacks for STI treatment, while others do not access government services because of stigma and discrimination, while for others, accessing private services may be too expensive if they even provide appropriate services. At the same time, many STIs services do not address anal or oral STIs, or the fact that a range of rectal problems increases the risk for STI and HIV infection, partly because of the shame involved, and partly because of their lack of knowledge and skills. Staff at STI treatment centres and clinics need to be trained on anal and oral STIs and their management, along with addressing these rectal problems, as well as in appropriate sexual history taking. Further to this, such staff will need to be sensitised to the issues, needs and concerns of MSM, particularly those with feminised identities.

It is therefore recommended that MSM sexual health agencies, in collaboration with donors, other sexual health services, and government, ensure that:

- Appropriate training is provided to medical students, maybe through accessing international expertise on these issues.
- Sensitisation and capacity-building programmes is provided to all doctors and clinicians providing STI services.

- Training of pharmacists to provide syndromic management as well as sensitise them to the issues of male to male sex and anal and oral STIs
- Training for MSM field workers on STI syndromic management for the provision of on-site counselling and referral.

Current and new MSM sexual health agencies should be encouraged to provide their own clinics which can access cheap testing facilities and reduced costs for treatment regimes through funding support, access to technical training, and appropriate equipment and medical needs. These agencies should be encouraged to provide subsidised rates for treatment.

Further, with appropriate training and capacity building, networks of STI services should be developed as referral points. Anonymity and confidentiality need to be a part of this service, and can be achieved through appropriate numbered referral cards given by field workers and/or agency drop-ins.

Other framework of providing access to appropriate STI services should be evaluated and implemented. One such example could be a mobile clinic (particularly useful in rural areas and small towns).

With TB as a co-factor and with significant rates of TB in Myanmar, links need to be established with TB treatment facilities.

Along with this, nutritional support should be provided for those MSM under-nourished, poor, or living with HIV.

4. Provision of appropriate voluntary counselling, testing, as well as access to ARVs

A comprehensive service package for MSM must include voluntary testing, counselling and treatment. MSM sexual health services should explore this issue thoroughly before they consider providing HIV testing and treatment facilities. If they do, they must provide this service under anonymous and confidential conditions, following international protocols. To provide such a services, training must be given to provide and manage such a service and these agencies must provide appropriate pre-test and post-counselling along with anti-retrovirals. Funding also should be given to sustain this service. If such a service is being provided by non-MSM agencies then staff at the services need full training and sensitisation of the specific MSM issues, needs and concerns, including factors regarding living with HIV and the necessary social and family support mechanisms that will be required. MSM groups and organisation should consider developing a “Buddy” system of support and care as a parallel process to voluntary testing and counselling.

This service provision needs to include psychosexual counselling, addressing low self-esteem and self worth, along with sexuality issues, risk reduction strategies, and other issues that will promote wellbeing. Peer counsellors need to be developed and trained so that such counselling can be offered in a variety of settings, particularly at field level.

Self-help and support groups should also be developed where psychological and emotional support can be provided.

5. Rapid scaling up of MSM service coverage across Myanmar through community-based groups and develop a national network

With the increasing HIV prevalence amongst MSM, it is essential to reach as many at risk MSM throughout the country. Not only does this mean a rapid scaling up of appropriate service coverage is an urgent necessity, preferably being provided by community-based groups and organisations. National networking and developing a sense of solidarity and community would be an essential component of this in order to build a sense of community ownership and solidarity, as well as ensuring that MSM, wherever they are can receive services.

6. Development of appropriate BCC materials

Education and literacy levels of MSM vary considerable, like any other population in Myanmar. BCC resources will need to address the range of language and literacy skills, as well as the lack of knowledge on sexual health issues. Imagery, terminologies, content, etc, will need to be explicit if such resources are to be useful and meaningful to their intended audience. This will also mean considerable advocacy with law enforcement agencies regarding such materials and their necessity to promote risk reduction.

7. Increased access to affordable (if not free) condoms and water-based lubricant

Ready access to affordable condoms and water-based lubricant is central element in a successful MSM HIV programme. Sufficient condoms and lubricant sachets should be made available, initially for free distribution, followed by gradually by social marketing efforts. A variety of methods need to be used for distribution, addressing the difficulties that many young people, especially MSM have in accessing condoms from retail outlets. This will require considerable advocacy work with local law enforcement agencies in order that project staff will not be harassed for distributing condoms and lubricant amongst MSM.

8. Develop a national MSM information resource centre and national telephone hotline

A national resource centre which provides a telephone advice and information service would enable MSM to anonymously access knowledge, not only about any HIV and sexual health concerns they might have, but also on male sexualities and related issues.

9. Address social justice needs for MSM through strengthened local and national advocacy with government, law enforcement agencies and others

To effectively address the social justice needs of MSM and their right to access appropriate sexual health services, as well as to deliver them, significant levels of advocacy need to be conducted at all levels of society. Such advocacy should not be left to the implementing MSM HIV projects themselves, but need to be taken on by government agencies, INGOs, and donors. Law enforcement personnel, lawyers, advocates, the judiciary, politicians and bureaucrats, the media and the broader community, all need to be sensitised on these issues, and reduce the significant levels of stigma, discrimination and violence which impede both access and delivery of MSM HIV services.

10. Provision of literacy and vocational training for MSM in need to address employment opportunities

Many MSM are from low-income sectors and are either unemployed, or are under employed, or are paid low wages. For such MSM, the temptation to generate income as a survival strategy through sex work is enormous. Perceived effeminacy as well as low levels of education and literacy exacerbates this. Funding should be made available for MSM HIV projects to develop literacy and vocational training programmes that can offer development of employable skills, as well as increase self-esteem and self-worth. In addition income generation schemes should be developed to support poverty alleviation.

11. Greater involvement of MSM in policy making

MSM HIV projects cannot work in isolation from other stakeholders in the field of HIV prevention, care and support. It is essential that government, INGOs, and other agencies working in this field see MSM HIV projects as equal partners and collaborators in reducing HIV prevalence across Myanmar. As such, there needs to be greater involvement of MSM in local, state and national programme and policy development.

12. Development of a National MSM and HIV Task Force or Working Group

A national MSM and HIV Task Force should be developed which brings together government, donors, INGOs and community-based representatives to coordinate activities, develop strategies, and provide advocacy.

13. Access to appropriate technical assistance and resources

Appropriate technical expertise already exists in the country and region, with a range of resources, tool-kits and training programmes specifically focused on the HIV prevention, treatment, care and support needs of MSM. Both the emergent self-help organisations and the appropriate technical support agencies should be funded, both to access and to provide such assistance as an on-going programme. A coherent and strategic response in regard to technical and capacity needs should be developed and implemented.

14. Increasing knowledge generation

In order to shed more light on the variety of male-to-male sexuality in Myanmar, aimed at the development of more effective sexual health services, additional qualitative research is called for. The current meeting was successful in bringing out group norms and values – future research should focus on individual-level data collection to explore views and ideas about male to male sex, sexual health, stigma and violence, and ways forward as a matter of urgency. It also seems that the current meeting was dominated by *apwint* identified men; the issues of *apone* and *tha nge* need to be further explored; the issues of class and ethnicity also should be further investigated.

Concluding Statement

This national consultation meeting bringing together self-identified males who have sex with males from across Myanmar, as well as representatives from implementing agencies providing services for MSM to discuss their issues, needs and concerns regarding HIV prevention, care and support, clearly identified a need for urgent action to address the growing evidence of increasing HIV infection amongst them.

This initiative was certainly a milestone activity in addressing HIV prevention, treatment, care and support needs and issues. The meeting not only was successful in bringing together MSM networks representatives to discuss the range of issues, but also in developing a strong sense of commitment and activism to address these concerns and needs and mobilising efforts towards combating the impact of HIV upon MSM themselves.

As such the outcomes of the meeting, the sense of solidarity and mutual support and concern needs to be actively supported and developed to continue what was achieved here.