

Advocacy, policy and support on male sexualities

Scaling up coverage of HIV prevention and AIDS care and support services for males who have sex with males in Asia

A workshop on good practice and the PSI Myanmar experience

Yangon, Myanmar

8 – 10 February 2006



Countries represented

- **China**
- **Lao PDR**
- **Myanmar**
- **Thailand**
- **Vietnam**

Agenda

Day One

- **Why work with MSM?**
- **The NFI perspective**
- **Country Situations (China, Lao, Thailand)**
- **Myanmar MSM Programme**
- **Community based approaches to HIV prevention, care and support**
- **Site visits**

Agenda

Day Two

- **Available PSI products in Myanmar**
Explored development, distribution, pricing, branding and sale - problems, concerns, the future
- **Research and evaluation**
Knowledge generation, surveys, mapping, size estimations
- **Policy and advocacy**
The PSI approach
- **IEC materials**
PSI Myanmar - development, distribution, results

Agenda

Day Two

- **MSM Drop-in Centre**
Rationale, objectives, design, activities - discussion with DiC social group meeting
- **MSM Clinic**
Discussions with users and clinic doctor

Agenda

Day Three

- **Group work**
Identifying gaps and lessons learnt - SWOT analysis of the Myanmar MSM programme
- **MSM Clinic**
Discussions with users and clinic doctor
- **Scaling up coverage in Myanmar**
The PSI Targeted Outreach Programme (TOP) approach
- **Improving coverage and scaling up in PSI countries**
- **Identifying consensus on good practice**

Surveillance/study location	Percent HIV-positive (Number tested)	
	MSM	Transgender
Bangladesh, Central A, 2004	0% (399)	0.2% (405)
Phnom Penh, Cambodia, 2000	12.8% (166)	36.7% (40)
Beijing China, 2002	3.1% (481)	
Dili, East Timor, 2003	0.9% (110)	
Mumbai, India, 2003	18.8% (NA)	
Jakarta, Indonesia, 2002*	3.29% (529)	
Bangkok, Thailand, 2003	17.3% (1,121)	
Thailand, 4 provinces, 2004*	9.6% (519)	
Ho Chi Minh City, Vietnam, 2004	8% (600)	
Pakistan, Karachi*/Lahore, 2004*	4% (409*)/0.5% (400*)	2% (199)/0.5% (204)
Nepal, Kathmandu, 2004MSM/MSW**	4% (275)/5% (83)	
Philippines, Manila/Baguio, 2004	0% (261)/0% (261)	

Sample design only includes male sex workers ** MSW refers to male sex workers
From the MAP 2005 report

Why work with 'MSM'

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.**

Why work with 'MSM'

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.

Gender, sexualities and masculinities an NFI perspective

This session explored:

- **Developing a common understanding of terms - gender, masculinities, sexualities**
- **Why NFI uses the term 'male' instead of 'men'**
- **Why males do sex with males**
- **Frameworks of male-to-male sex**
- **Risks and vulnerabilities**

Country presentations

China

- **PSI China - new programme, and only one staff person covering all 'at-risk' populations**
- **Estimated population between 10-20 million - very hidden**
- **Socially compulsory marriage**
- **Estimated prevalence: 1-3% in the cities**
- **Poor surveillance and low risk perception**
- **Low consistent condom use**
- **Little research**
- **Current PSI China work focuses on social marketing on condoms and lubricant through partner organisations**

Country presentations

Lao PDR

- **Few studies**
- **Significant levels of male-to-male sex**
- **Primary framework appears to be highly gendered**
- **Low condom usage and knowledge**
- **Female partners**
- **No STI/HIV surveillance data**
- **Current PSI Lao focuses on ‘transgender’ (kathoeyes) and their partners through peer educators in capital city**
- **Social marketing of condoms and lubricant**
- **Limited advocacy work with the government**

Country presentations

Thailand

- **Despite a current HIV prevalence rate of 28% among MSM in Bangkok, very few MSM services exist (Bangkok, Chiang Mai, Pattaya)**
- **Further, these services tend to ignore the needs of male-to-female transgender population and who do not identify as ‘MSM’**
- **PSI Thailand has focused on this population and is implementing in a programme in Pattaya with a DiC, outreach activities and clinical services**

Country presentations

Vietnam

- **Did not give a presentation**
- **Respresentative with MSM responsibility new to PSI Vietnam**

Country presentations

Myanmar

- Little knowledge, no community-based organisations, political difficulties
- PSI Myanmar, along with a couple of other international non-government organisations, implementing MSM HIV programming
- PSI using Targeted Outreach Programme approach in Yangon and Mandalay
- Involves:
 - Peer centred in outreach
 - MSM friendly
 - Provision of DiC (safe spaces)
 - MSM involvement in management
 - Advocacy with local police

Community-based approaches to HIV programming

Issues explored:

- **What do we mean by community?**
- **Why is a community approach more effective in HIV prevention?**
- **Does such an 'MSM' community exist where you implement an HIV intervention?**

Community-based approaches to HIV programming

What do we mean by community?

- **affiliation to a shared consensus**
- **shared/common behaviours and gender performance**
- **solidarity as a “community:**
- **mutual support mechanisms**
- **social support services**
- **shared ideologies and social characteristics**
- **shared socialising frameworks**
- **mutual concerns**
- **shared needs**
- **shared rituals**

Strengthening community

Frameworks of male-to-male sex form around social/sexual networks

There is very little sense of community

To develop a sense of community towards building a community response to HIV and AIDS and work towards changing community sexual norms will require community development and mobilising Processes.

SWOT analysis of PSI Myanmar MSM programme

Strengths

First targeted MSM programme
Motivated peer workers
Clinic has an MSM doctor – health services
Within Drop-in Centre
Good mapping (Yangon/Mandalay)
Brand recognition and competency

Weakness

Very apwint centred
Too much information given by peer educators in first meeting
Quality control – how do you measure quality
Linkage between research findings and programmes poor – a knowledge gap
Confused and unclear research segmentation
MSM/MSW segmentation

SWOT analysis of PSI Myanmar MSM programme

Opportunities

Opening government attitudes
Potential for general male sexual health programme
Strong programme
Partnership with peer (MSM) researchers
Strong research department

Threats

Costs issues - sustainability
Government insecurity/potential intolerance

Increasing coverage in Myanmar

- **Yangon MSM drop-in centre opened in August 2004**
- **Mandalay MSM drop-in centre opened in May 2005**
- **Mobile education team to work in secondary cities June 2005**
- **Following extensive field visits, available secondary data, size estimations, decision to develop fixed site programmes in 12 secondary cities in October 2005**

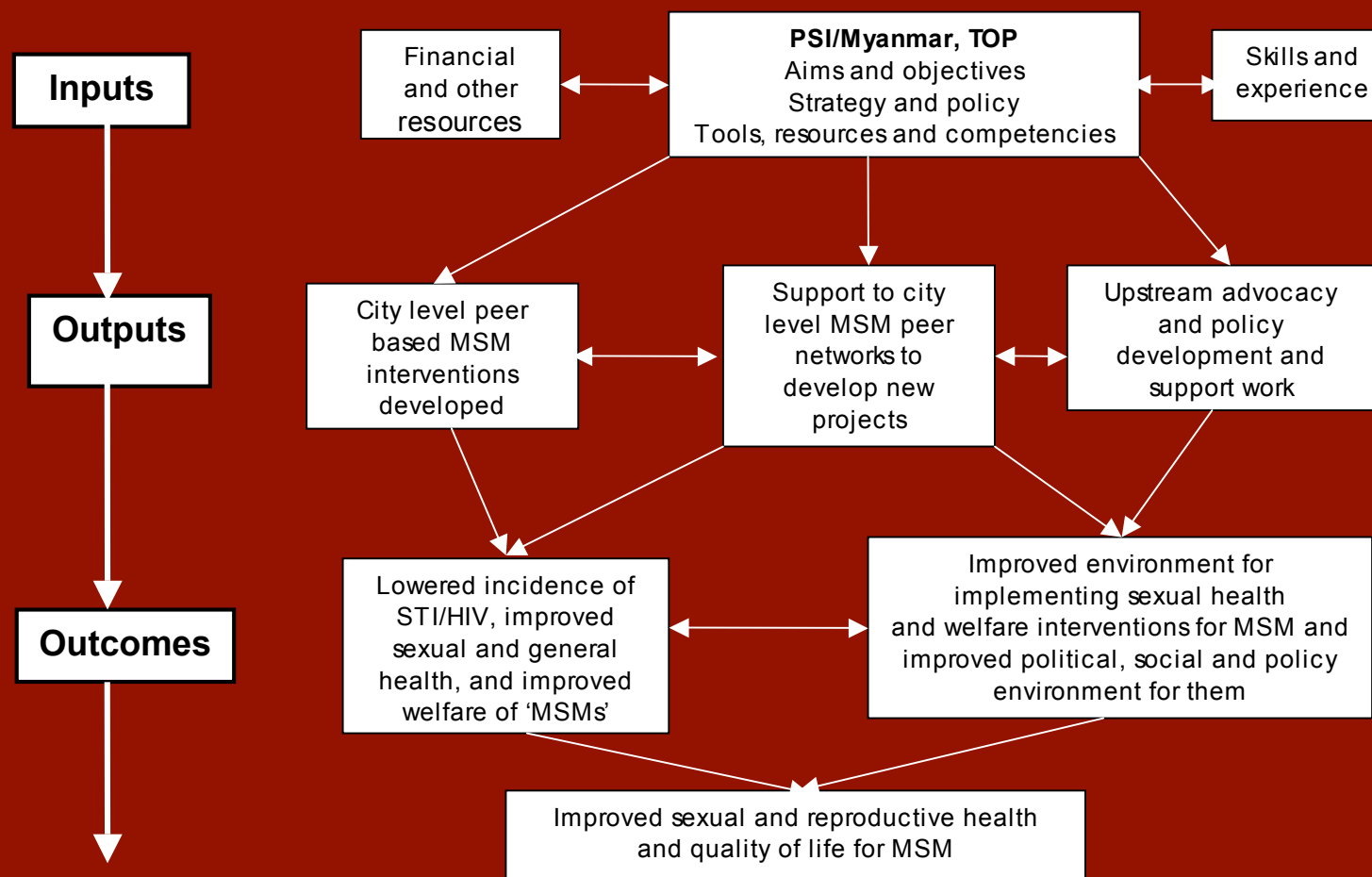
Increasing coverage in Myanmar

Scaling Up Process

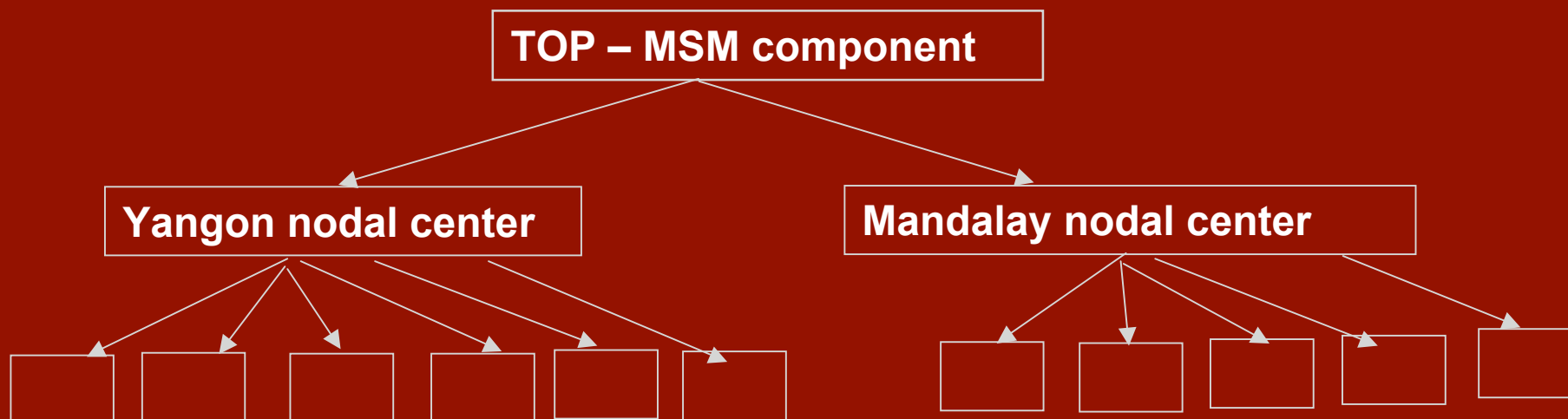
- **Conduct rapid situational assessments**
- **One day workshops in each target city with local MSM representatives**
- **Local steering committees established**
- **Establish DiC, clinical services and conduct outreach**
- **Conduct advocacy with local authorities and other stakeholders**

Currently, this has only been achieved in one city

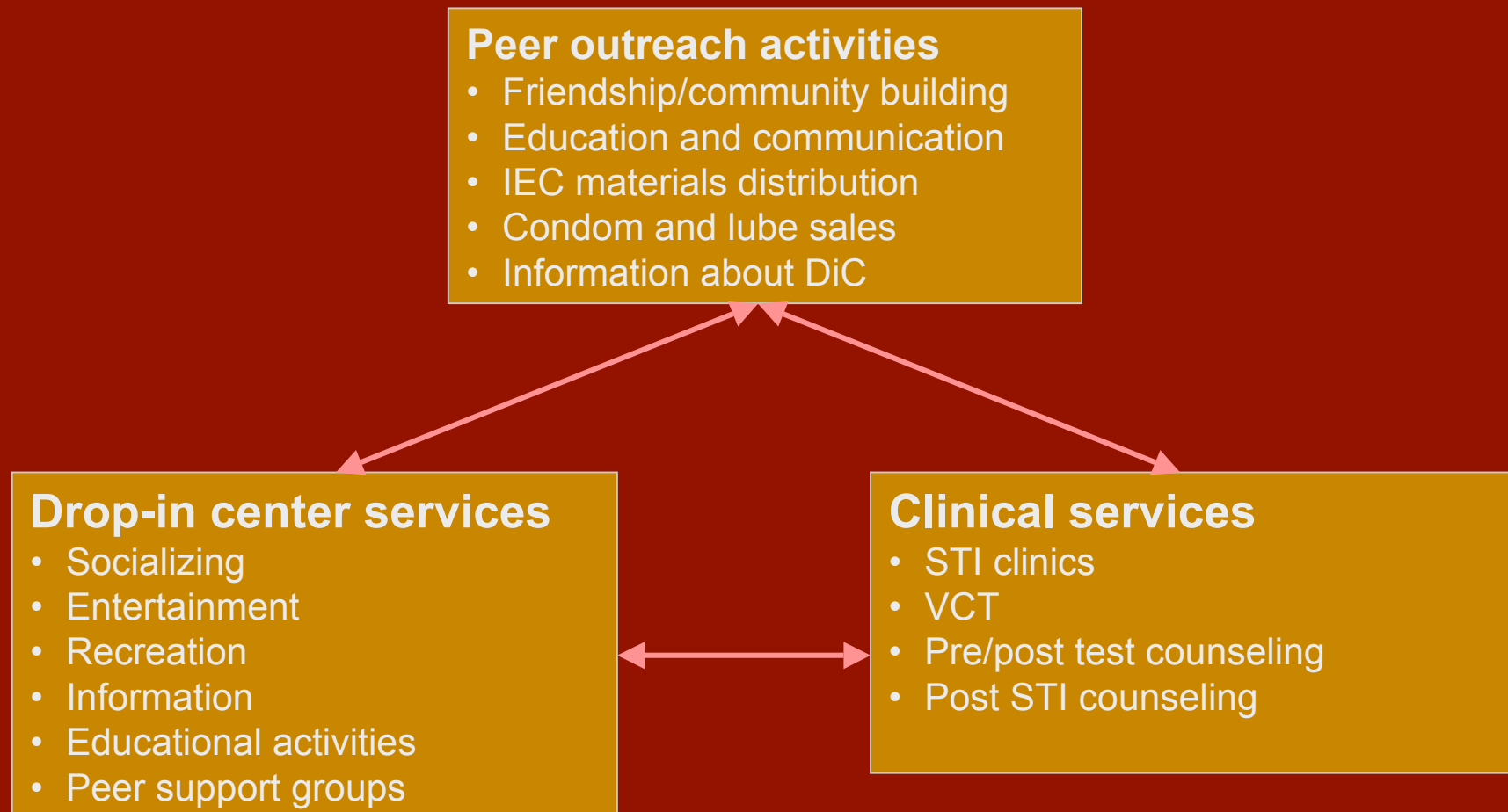
Suggested TOP Process Model



Suggested TOP Process Model



Suggested MSM Service Provision



Improving coverage

Myanmar

- **More training for peer educators**
- **More peer educators**
- **Work with clients of male sex workers**
- **Outreach to masculine partners**
- **More operational research**
- **Increase autonomy of local projects**
- **Skill up MSM staff for management responsibilities**
- **Link with projects working with general male population**

Improving coverage

China

- **Use current ‘client’ focused programme and migrant workers programme to initiate more discussion of male-to-male sex issues and risks among general male population**
- **Leverage growing gay entertainment venues to promote condoms and improve attitudes and openness**
- **Combine resources to improve research design and implementation**
- **Utilise successful CBOs to reach out to regions with no projects, but need support**
- **Improve networking of organisations working on projects for men**
- **Use PSI/Myanmar model for intervention design in Guangxi province**
- **Improve sensitivity of PSI staff on gender/sexuality issues**
- **Network with other NGOs to better identify gaps that PSI can fill (i.e. female condoms for male use in anal sex)**

Improving coverage

Lao PDR

- Developing autonomy of the current project
- Increasing access to different networks
- Develop core group of peer educators
- Develop further advocacy workshops
- Enhance existent capacity
- Develop a mobile team
- Strategic planning developed

Improving coverage

Thailand: Sisters Project

- **Develop specific IEC materials and sexual health projects for TGs**
- **Develop sustainability framework**
- **Create autonomy of project**

Improving coverage

Vietnam

The PSI Vietnam representative pointed out that she was recently recruited, and the PSI Vietnam was also recent with no current MSM focusing. However, she suggested the following for ‘starting-up’ an MSM programme:

- **Advocacy with local government**
- **Conduct Rapid Situational Assessments, identifying needs, issues and concerns for a variety of MSM sexual networks**
- **Human resource development: recruitment and training, including project manager, project officers, peer educators**
- **Training on sexuality/gender issues**

Improving coverage

Vietnam - continued

- **Access to technical assistance and support**
- **Product development and service provision, including partnership with others, and referral network development**
- **Initiate outreach activities in selected areas**
- **Development of appropriate messages, games, other activities**
- **Development of an M&E system**

Key requirements for scaling up coverage of MSM HIV interventions

1. **Address knowledge gaps and include development and utilisation of MSM peer researchers**
2. **Ensure that there is adequate coverage of ‘MSM sites’ by peer outreach**
3. **Ensure sufficient funding**
4. **Increase technical capacity for community-based interventions and involvement of ‘MSM’ at levels of decision-making**
5. **Increase availability of services and sexual health products, ensuring appropriateness and accessibility**

Key requirements for scaling up coverage of MSM HIV interventions

5. **Building sustainability of risk reduction strategies amongst MSM through community development and mobilising**
6. **Develop a set of 'GIPA' principles for MSM and ensure its implementation**
7. **Improve and extend advocacy and policy development at all levels**
8. **Address social, cultural, legal, judicial and economic impediments by addressing illegality, discrimination, stigma, harassment and violence**
9. **Develop partnerships and collaboration between community-based interventions and those that work with the general male populations**

Key requirements for scaling up coverage of MSM HIV interventions

- 10. There must be a firm commitment from government, donors, international and local non-government organisations, as well as other institutions to reduce stigma and discrimination internally and externally**
- 11. Processes and strategies to address the sexual health needs of MSM need to be institutionalised**