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Advocacy, policy and support on male sexualities

A review of the MSM Targeted Outreach Programme

PSI Myanmar

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Why we need to work with ‘MSM’

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:

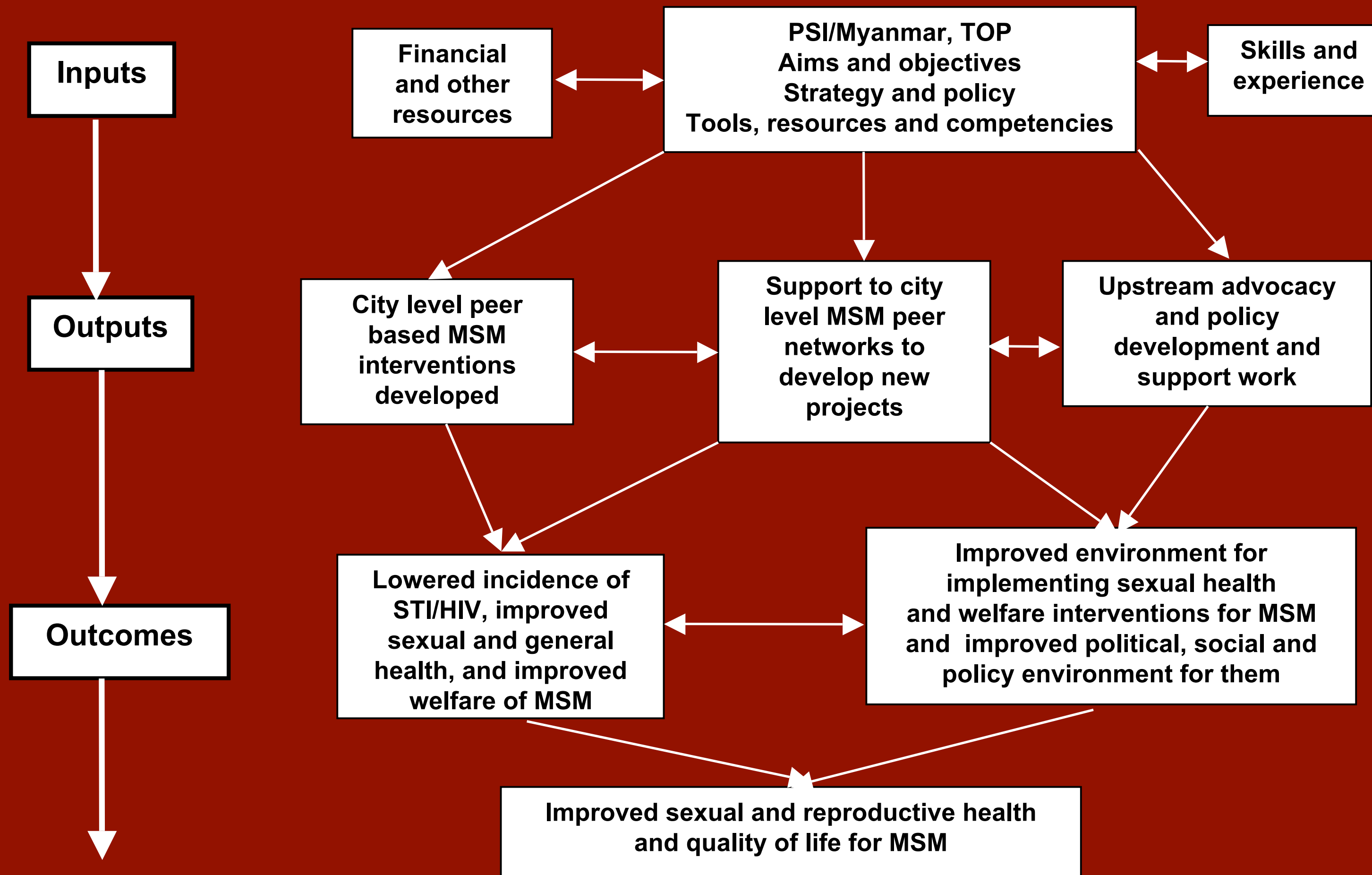
- **The right to be free from violence and harassment;**
- **The right to be treated with dignity and respect;**
- **The right to be treated as full citizens in their country;**
- **The right to be free from HIV/AIDS;**

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.

Methodology

- Formal and informal discussions with all levels of MSM staff
- Field visits (Yangon and Pathein DiCs)
- Discussions with MSM (DiC and field level)
- One day workshop with outreach staff
- Observations (DiCs, nightclub, street, attended MSGM)
- Interview with the PM and other key members
- Total time spent in Myanmar - 7 days

The TOP Process Model



Sexual health

WHO, 2002

Sexual health is a state of <u>physical</u>, <u>emotional</u>, <u>mental</u> and <u>social</u> well-being 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.

Two key objectives

1. Promoting risk reduction

1. Building sustainability and continuity of risk reduction - normalising safer sex

Why “community-based approach?

Global evidence clearly indicates that when marginalised and stigmatised communities are empowered and mobilised to take action against HIV, they are more likely to produce sustainable results to reduce risks.

In this context, MSM, as the natural owners of risk, should be recognised as key agents of change, rather than recipients and beneficiaries, as owners of the intervention.

Thus for an effective and sustainable intervention focused with vulnerable and marginalised populations, programmes should be developed from a “bottom-up” approach, rather than a “top-down” strategy.

Added value

- **Community acts as peer pressure group and can monitor its own behaviours**
- **Opportunities for normalising safer sex behaviours amongst community members**
- **Active involvement of community members rather than passive recipients increases sustainability**

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

But what community?

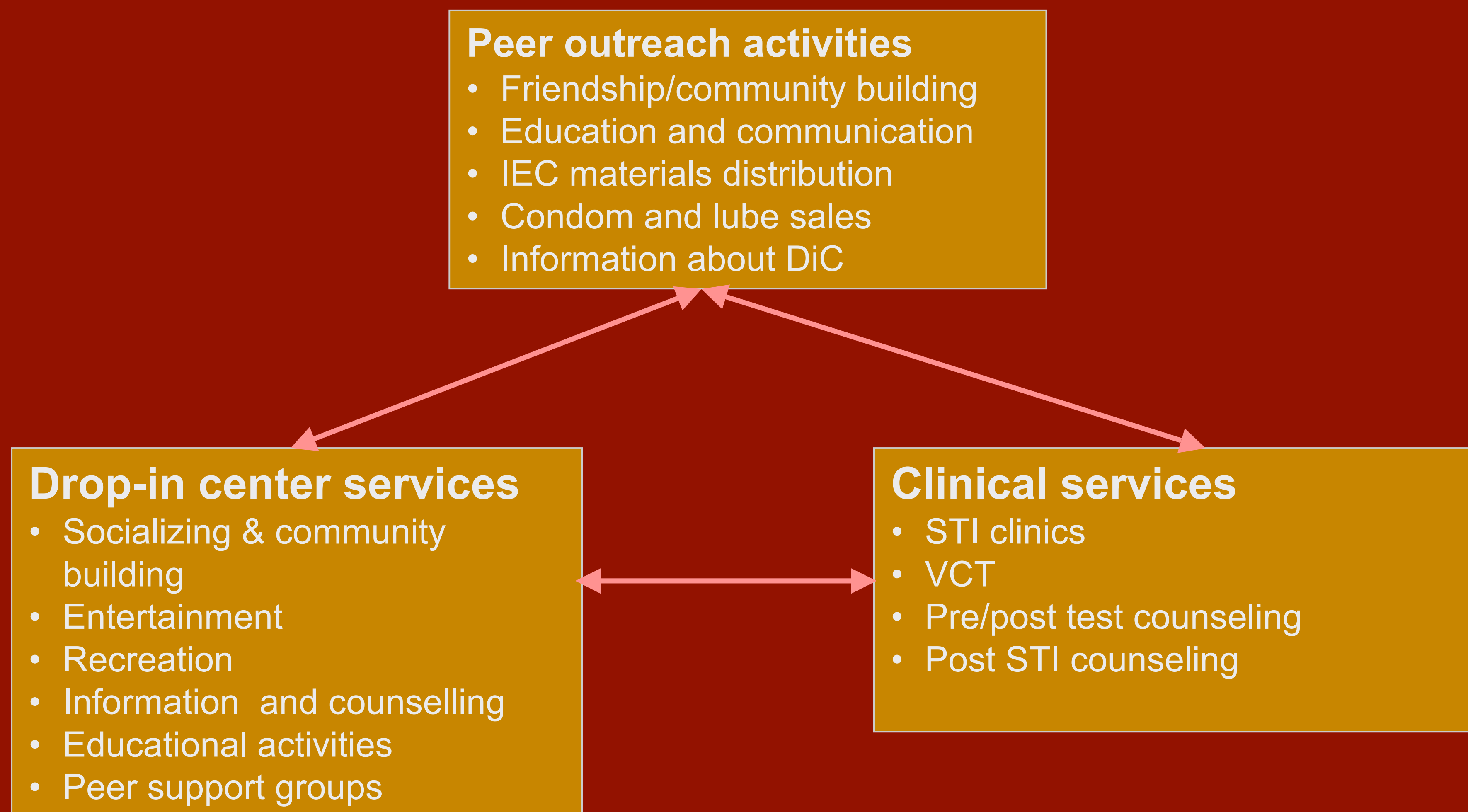
- Apwint
- Apone
- Tha Nge

There is no natural ‘MSM’ community. It needs to be built and developed.

How?

- Identifying key persons
- Transfer knowledge
- Build skills and capacity
- Develop role models and leadership
- Self-help organising
- Empower and mobilise
- Co-opt for programme management
- Active involvement in design, implementation and delivery
- No tokenism

Current Services Model



Current Strengths

- Access to a safe space ‘owned’ by MSM
- Emergent community being developed and strong involvement
- Strong outreach programme
- Strong sense of commitment and loyalty - staff group solidarity
- Good knowledge on risk reduction
- Availability of safe space - well attended
- Strong sense of community ownership

Current Strengths

- Increasing condom and lubricant distribution
- Increasing management responsibility taken on by MSM
- Strong leadership and support provided by PM
- Emergent MSM leadership
- Very good clinical support in Yangon, good in Pathein through sympathetic service providers
- Flat MSM management structure evolving leading to community ownership

Weaknesses

- Limited range of activities in the DiCs for non-apwint identified MSM
- No general health service provision - focus is only on STIs
- Lack of consistent skills building programme for service users
- DiC programme under-developed - lack of empowerment activities for service users
- Weak social support mechanisms for building community

Weaknesses

- Lack of psycho-social-sexual counselling
- Weak community involvement and community access to information and data
- Weak capacity-building process for staff
- Lack of appropriate operational and staff protocols and procedures for MSM programme
- No support and care services for positive MSM
- Lack of a clearly articulated strategy for addressing stigma and discrimination

Strengthening the programme

Community Development (DiC)

- Expand utilisation of safe spaces to include some evening and weekend activities
- Expand range of socialising and entertainment activities to include those of interest to apone and tha nge users
- Provide skills building and education programme on non-HIV issues
- Ensure that the two components of the TOP programme (MSM/FSW) are seen as autonomous from each other, each with their own spaces
- Develop social support programme for users and staff which will include:
  * psycho-social-sexual counselling and support
  * community-building programmes
  * identify and build capacity of community leaders
- Increase ownership by more self-identified MSM in management positions
- Establish an MSM advisory council

Strengthening the programme

Outreach

- Expand outreach activities to include weekends at appropriate ‘hot spots’
- Regularise training programme with refresher courses
- Include in these programmes issues relating to psycho-social-sexual counselling
- Develop a volunteer network

Strengthening the programme

Clinical services

- Expand service provision to include non-STI issues, i.e. general health for low income MSM as well as presumptive rectal examinations
- Sexual history taking by clinic assistant
- Increase capacity of clinic doctors through enhanced training to include psycho-social-sexual issues

Strengthening the programme

Living with HIV/AIDS

- Develop a care and support programme for MSM living with HIV/AIDS and address the double stigma that this incurs
- Develop an MSM +ve support group and provide a range of empowerment and self-help activities specific to their needs
- Develop leadership skills amongst appropriate +ve MSM as educators

Strengthening the programme

Scaling Up

- Develop a development tool-kit, which can be expanded as new issues and needs are identified
- Institutionalise the process and develop handbook
- Develop the required range of protocols and guidelines for implementing, management and service delivery
- Develop an MSM training and technical support team
- Develop a national MSM Advisory Group and network

Strengthening the programme

Staffing

- Key MSM need to be skilled up to take on management responsibilities and leadership within the MSM TOP programme
- Staff support group needs to be developed
- Complaints and grievance procedure for MSM staff needs to be developed
- Sexual harassment policy of PSI Myanmar should include MSM issues
- Enhance staffing structures which may require recruitment of additional programme staff

Amended model of service provision