Advocacy, policy and support on male sexualities

Naz Foundation International

Review of the MSM Targeted Outreach Programme, PSI Myanmar

Final Report

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Acknowledgements

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Executive Summary

This review of the Population Services International (PSI) Myanmar males who have sex with males (MSM) Targeted Outreach Programme (TOP) is the first following the NFI conducted workshop in partnership with PSI Myanmar held in Yangon, Myanmar between 8th – 10th February, 2006 for representatives from other PSI country affiliates in the region to explore HIV/AIDS programming issues to address the needs and concerns of MSM. It was at this workshop that PSI Myanmar TOP articulated its approach to the MSM HIV programming based on the concept of community development and involvement, and a scaling up model for increasing accessibility to sexual health services across the country, where the MSM TOP was initiated in 2004.

The Targeted Outreach Programme is for both female sex workers (FSW) and MSM, but the consultant's brief was specifically to focus on the MSM component.

The service model being implemented is based on three interlinked components. These are:

- Access to a safe space through a Drop-in Centre providing a range of community building activities
- Outreach work and service referrals through peer workers and "inter-personal communicators" working at a range of 'hotspots'
- Clinical services providing STI management and voluntary testing and counselling

Currently this targeted approach is being implemented in Yangon, Mandalay, Pathein, Henthada, Mekhtila, Kalaya and Taunggyi, where the first Drop-in Centre was opened in Yangon in August 2004.

The consultant's brief was to review the service provision for MSM provided by TOP in Yangon and Pathein, identify any weakness and gaps making recommendations to strengthen the programme, as well as review the planned expansion programme.

This was done through discussions with the MSM programme staff and management, service users, conducting a one day workshop with the staff, and observational analysis of the drop-in centre, clinic and field activities both in Yangon and Pathein.

The Drop-in Centres are well attended with a mixed population of MSM including apwint, apone and tha nge. Readily accessible and open five days a week during office hours, there was a high degree of satisfaction expressed of the space and the activities currently being offered. These activities ranged from socialising group meetings, entertainment opportunities (via television mainly), bathing and make-up spaces, discussions, group education and meditation. As a venue for social discourse and community building, the DiCs provides an excellent opportunity. Not only do the DiCs provide a non-sexualised safe space, but there was a clearly visible sense of community ownership of the spaces.

However the range of potential activities were limited, and somewhat focused on apwint identified males. Offering a broader range of activities that can draw in the apone/tha nge males, could enhance the sense of a broader MSM community as well as increase the usage of the DiCs. Such activities could include computer literacy classes, a more formal English reading, writing and speaking class, access to a range of games and musical instruments. Along with these, enhanced activities for

apwint-identified males could be classes on life-skills, fashion design, make-up and hairdressing.

Users expressed a desire for more social group meetings, rather than the once a month currently being conducted (not withstanding the 'mini' social groups that also happen on a weekly basis). These expressed needs could be met by extending opening hours of the DiCs into evenings and weekends. There was also an identified need for psychosocial support and counselling as well as on sexuality counselling.

With regard to the field teams, while knowledge was very good, the focus of information provision was only on HIV/STIs. A broader social support with perhaps limited psychosocial and sexuality counselling being offered would enhance the outreach effort and work towards enhancing community building as well. Outreach timings also need to be explored and developed to include longer periods at the relevant 'hot spots' during the week, and also outreach being conducted at weekends.

While the clinic offers STI management and voluntary testing and counselling (VCT), the 'target population' being addressed are primarily low-income males, and access to general health care would enhance programme effectiveness and make the clinic a community space as much as the drop-n centre. Sexual health includes not only addressing sexually transmitted infections, but also other physical, mental, emotional and social concerns. The clinic should be seen as a sexual health centre.

The current MSM TOP programme has many strengths towards enabling and empowering MSM to take responsibility for their own sexual health and having ownership of the virus and taking responsibility for reducing risk. In other words, moving an intervention focus from passive recipients of information and resources, to a framework of active involvement in design, management and service provision. However, there are a range of issues that need to be addressed to enhance the sustainability of risk reduction over the long haul, strengthening the sense of community development and solidarity, as well as strengthen the capacity for scaling up across the country. Further there are some gaps in service provision that urgently need to be addressed.

With the provision of voluntary testing and counselling, and with the increasing numbers of MSM who are now HIV positive and living with AIDS, there is an urgent need to develop an MSM specific support and care programme, particularly in Yangon (this may also be true in Mandalay and other centres), which can include an MSM self-help support group, developing a home care programme, and a prevention programme that addresses the needs of MSM HIV positive persons.

Strengthening MSM ownership is critical for success. This can be achieved by developing a consistent community building and development programme, enhancing MSM leadership, and incorporating more MSM into the management structure of TOP. This will require a capacity building programme for MSM, both in terms of current staff as well as service users. The capacity of outreach staff can be enhanced as they emerge as community leaders and role models. And the programme currently being offered, rather than being constrained by office hours, can be adjusted to reflect community needs and hours with extended hours and services (within the framework of the local socio-political environment).

Building sustainability and scaling up is not only about enhancing MSM staff skills and incorporating more MSM staff into management and decision making, but also requires the developmental and operational process to be well documented, a

management, training, development and process tool-kit to be developed, and the institutionalisation of the process.

Finally, the MSM TOP process needs to be clearly articulated and promoted, and it is suggested that a paper be developed which does this and widely circulated. PSI Myanmar has shown leadership, courage, and innovative skills in developing and implementing this MSM programme in difficult social circumstances, developing good practice and providing a model for others to adopt and adapt to their own particular circumstances.

Introduction

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.

Recognising the special needs of highly stigmatised and vulnerable populations, such as males who have sex with males and female sex workers, PSI Myanmar initiated a targeted approach to address the sexual health needs of these at-risk populations and began to implement its Targeted Outreach Programme (TOP), operating as a separate unit within PSI Myanmar from 2003, with the objective of reducing transmission of HIV/STIs and to improve the quality of life of MSM and FSW.

With the basic premise of community developed and peer-led intervention as the keys to successfully implementing a sustainable risk reduction strategy, PSI Myanmar opened an MSM Drop-In Centre in Yangon in August 2004 with drop-in and clinical services two days a week. (*Note: a drop-in centre for FSW was opened in July 2004, but since the consultant is focusing only MSM, this paper will only discuss MSM*). In May 2005, a similar centre was opened in Mandalay and services upgraded to five days a week.

Fieldwork is conducted by full-time MSM peer workers, and what are known as 'interpersonal communicators' (IPCs), where outreach and referrals is offered at a number of MSM 'hotspots' in the relevant cities.

Plans were developed to expand the targeted approach to a range of secondary cities in Myanmar, and initial rapid situation assessments conducted. Currently TOP is in operation with full-time staff and peer workers in Yangon, Mandalay, Pathein, Henthada, Mekhtila, Kalaya and Taungyyi.

The process model as conceptualised by TOP can be seen below (Fig 1), while service delivery model is contextualised as three basic components of Drop-in Centre Services, Field Services and Clinical Services (see Fig. 2). The components work in concert mutually supporting each other so that a wholistic approach to sexual health promotion can be achieved that acts as a development framework for community building and mobilising towards sustaining risk reduction strategies as a community responsibility. With regard to implementing a scaling up process, the management structure is perceived as Figure 3.

A critical element in the 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 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.

Figure 1: TOP Process Model

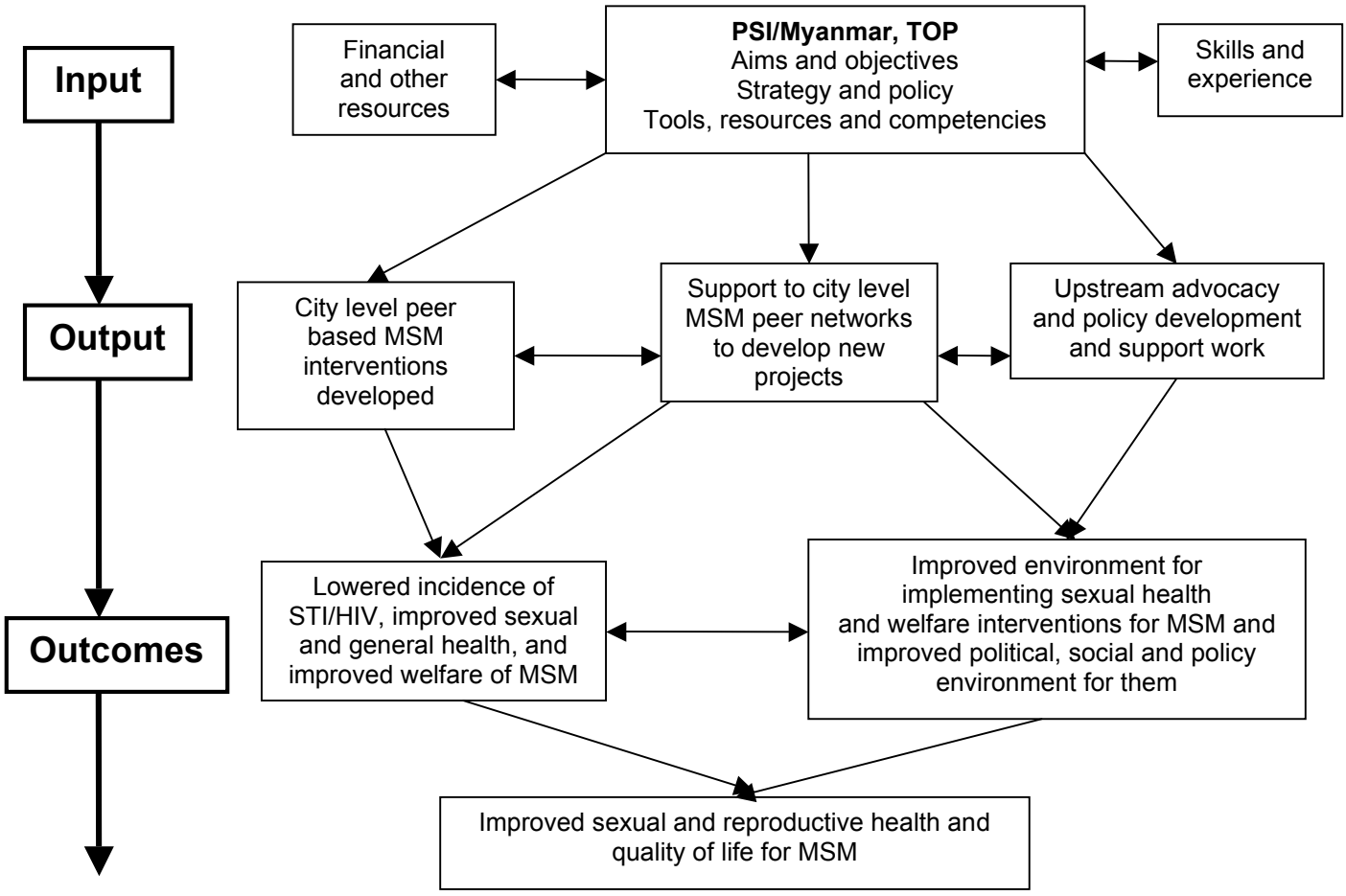


Figure 2: TOP Service Model

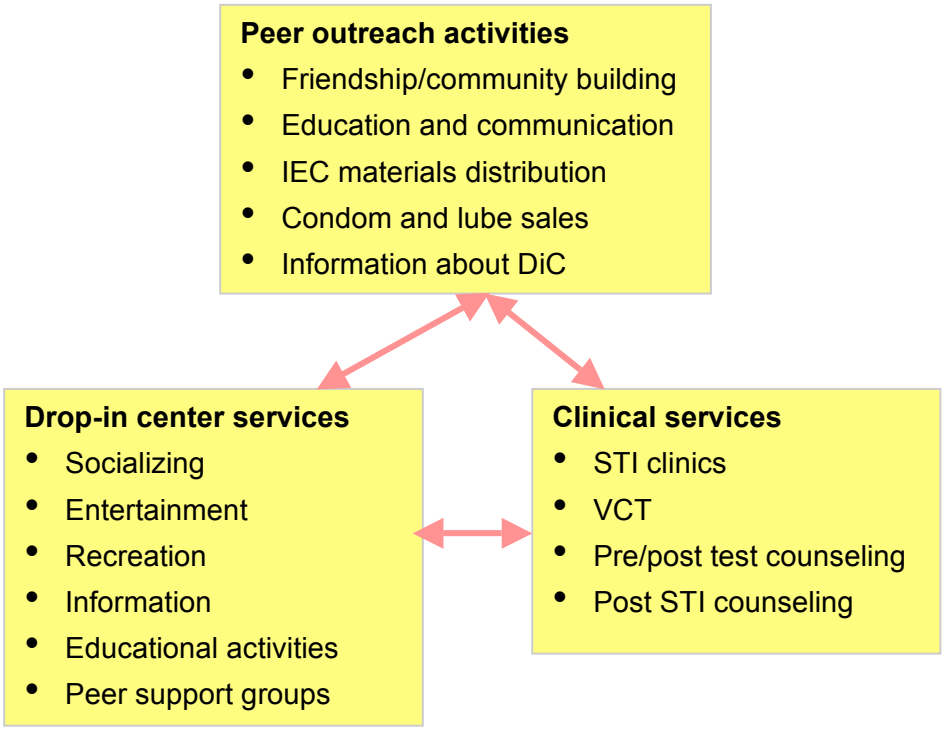
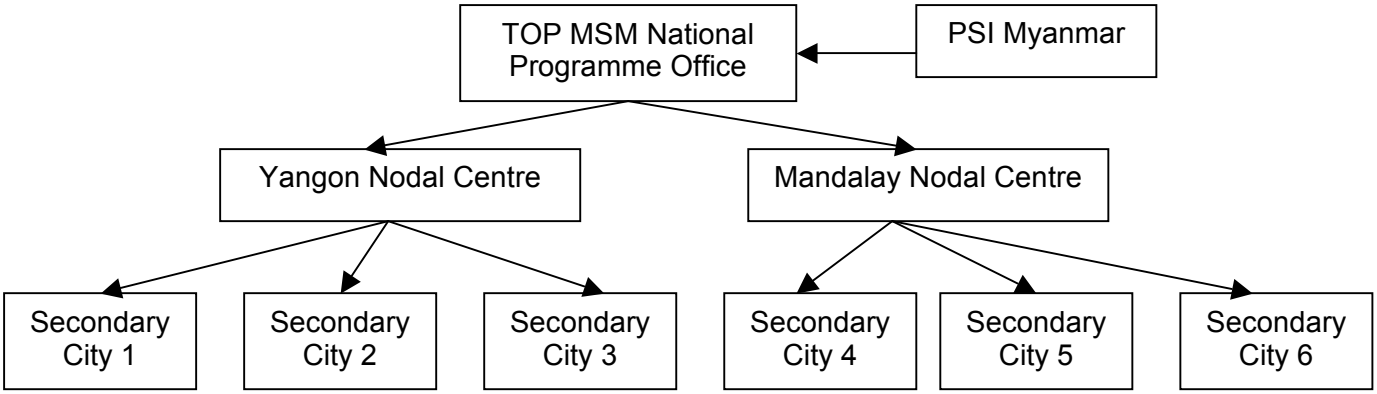


Figure 3: TOP MSM Management Model



Scope of work

In February 2006, Naz Foundation International and PSI Myanmar MSM TOP conducted a workshop in Yangon for PSI country affiliates in South East Asia exploring issues of developing MSM HIV interventions and scaling up processes, where the Programme Manager of the MSM TOP articulated the work currently underway as a model of good practice.

As the first follow-up, NFI was contracted to review the MSM TOP programme. This included:

- Review and appraise existing TOP services in Yangon
- Review and appraise expansion programme
- Undertake analysis of the TOP services and identify gaps and weaknesses, making recommendations as necessary

The methodology used included:

- Formal and informal discussions with all levels of MSM staff
- 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

A community-based model

The objectives of MSM TOP are:

- To provide STI/HIV/AIDS prevention information and services to males who have sex with males through a team of outreach workers as a means to influence behaviour change in the target 'community'.
- To increase condom and water-based lubricant use among the target community and their partners and clients by making available and accessible to them.
- To reduce STI incidence through promoting quality STI management services to MSM and their partners in addition to enhancing condom utilisation amongst them.

An additional component has been that of the provision of voluntary testing and counselling to MSM and their partners.

To achieve this, the TOP strategic approach, based on sound global evidence, is focused on community building, development and mobilisation as the key policy of such a targeted intervention. The framework of this approach is to assist MSM networks to develop a sense of community solidarity, and enable them to take control over the own bodies and health, and to empower them to mobilise their peers to follow the same practices, enabling a change in sexual norms in the MSM networks and community. This is being achieved through identifying key individuals in the networks, providing capacity building programmes to empower them as educators and communicators to reach out to their peers, and to provide a safe space for socialisation and community building, as well as clinical services and other resources to address the sexual health needs of MSM.

Why a "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.

In such a strategic approach, such a community identified response develops as a way of sustaining peer pressure towards a sustained risk reduction, and can monitor its own behaviours, providing enhanced opportunities for normalizing safer sex behaviours amongst its own networks, as well as the active involvement of community members rather then as passive recipients of information.

What do we mean by community?

The word 'community' is often poorly understood and misused in the context of developing responses to HIV. In the context of TOP, the word community can be defined by:

- Affiliation to a shared consensus and social norms
- Shared/common behaviours and understanding gender performance
- A sense of solidarity as a "community:
- Mutual support mechanisms
- Social support activities
- Shared ideologies and social characteristics
- Socialising frameworks and friendship networks
- Mutual concerns
- Shared and common needs
- Shared rituals and beliefs

Where these are under-developed, community-building and development activities can be used to strengthen a sense of community and enhance community solidarity towards achieving common goals.

But what community?

In Myanmar, historically there has never been an 'MSM community', but rather a range of sexual and friendship networks, limited in scope and reach and primarily focused on apwint-identified MSM.

The existence of HIV and the urgent need to respond to the health and social challenges that this raises has created the necessity to develop a more sustainable and comprehensive approach to HIV prevention, care and support, one that requires a more community focused sense of responsibility and support, not only towards changing sexual norms, but also in terms of the provision of support and care for this living with AIDS.

In Myanmar, there are three distinct sub-populations of MSM:

Apwint	Men who openly show their same-sex orientation in public, wear make-up, cross-dress and behave in an effeminate manner. Preference for the receptive role in MSM sexual relationships.
Apone	Men who are less open about their same-sex orientation in public (but do acknowledge it among peers) and do not cross-dress or behave effeminately. Play both a receptive and insertive role in MSM sexual relationships.
Tha nge	Potential sex partners (casual, paid and unpaid/regular) of apwint and apone, of the same age or younger. These men do not acknowledge a same-sex orientation and see themselves (and are usually perceived

as such) as ‘real men’. Preference is for the insertive role in MSM sexual relationships.

Both the terms ‘apone’ and ‘tha nge’ are apwint labels.

However, with the development of safe meeting and socialising spaces, an outcome of the TOP approach, these terms are also becoming self-identifying terms, creating the framework of the emergent ‘MSM community ‘where desire and sexual preference for other males is the unifying bond.

To further strengthen this process, and to enable this emergent community to take on ownership and responsibility in addressing HIV/STI risk and its management, key steps forward include:

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

Strengths and Weaknesses

While there appears to be very little material available to TOP regarding the theoretical foundations of this community-based approach and core principles of interventions which guides various processes and steps in implementing HIV prevention and care activities amongst MSM, there have been some studies conducted which indicate that the community based approach to working with stigmatised, marginalised and highly vulnerable populations to HIV appears to be the most affective methodological approach to build sustainable risk reduction. (See Carol Jenkins paper *Preventing HIV infection among males who have sex with males in the Asia-Pacific region*, a background paper produced for International Consultation on Male Sexual Health and HIV in Asia and the Pacific titled “Risks and Responsibilities” held in New Delhi, India 23-26 September 2006.)

Such an approach is usually defined as a *second generation of targeted interventions*, where attention is put as much on process as that on outputs to address at-risk population where stigma, discrimination and social exclusion are primary co-factors for such risks and vulnerability. The process involves the principle of ‘co-option’ as partners in the intervention, where the population is conceived not as an ‘object’ of the intervention, but a subject who has all the potential power and ability to males changes in their life and the social environment in which they live.

In the context of the MSM TOOP, MSM are the perceived as the natural owners of risk and have the capacity to reduce their own risks,

From NFI’s perspective, the MSM TOP is seen to have strongly adopted the Guidelines of Good Practice as declared and adopted that the Delhi Asia Pacific consultation meeting mentioned above, where community stands at the centre of any such intervention and instead of just being seen as passive recipients of service are active providers of those services. It was on this basis that the MSM TOP was reviewed.

This is rightly perceived as the major strength of the MSM TOP, along with its comprehensive and inclusive strategy and provision of services, and from a process point of view this project is highly successful. Evidence for this is clearly indicated in the data with the increasing take-up of condoms and lubricant, the increasing utilisation of drop-in services and sociability, as well as the increased use of STI management services.

Active involvement of a broad range of MSM in the social group meetings, and other socialising activities clearly indicates the growing strength of the emergent community and the effectiveness of the outreach programme, and with the staff solidarity and respect given by services users also provide an indication of the emerging peer network of community leaders.

Along with appropriate MSM being involved in management, these all show an increasing sense of community development and ownership, essential components for a successful outcome and for building sustainability.

Central to the success of the growing success of the TOP approach is because of the vision, dedication and support of the Programme Manager, who through knowledge, experience and understanding has been able to replicate a community-based approach within the contexts of Myanmar and PSI itself. This is a remarkable achievement, and needs to be clearly documented and promoted.

However, despite this glowing picture of a successfully developed project, there are several issues of concern, as well as gaps in he service provision, which could weaken this programme and its sustainability over time.

For example, the DiCs only provide a limited range of socialising and entertainment activities and these are primarily focused on apwint-identified MSM who do all actively participate in them but offer limited options to non-apwint identified MSM. Along with this is a need to increase the level of empowerment activities for DiC users along with a skills enhancement and development programme towards building self-esteem and socialising skills. Such activities would provide an environment for greater community building and begin to address a range of social concerns. In conjunction with this would be the provision of psychosocial-sexual counselling that would address personal issues, such as internalised stigma, family and partner issues, sexual myths and misconceptions with the psychological and behavioural issues that arise from them, and so on. All of these activities would develop a social support mechanism for building a sense of community.

Currently the focus of the sexual health services is around STI management. It would enhance service provision if presumptive rectal screening was a standardised feature of the clinical services (this is only happening in the Yangon clinic), along with a general health service provision. With oral sex being one of the primary sexual behaviours amongst apwint-identified males (as providers) and with the observed poor oral hygiene amongst many of them, a dental hygiene programme is urgently needed to help reduce STI/HIV transmission risks, where condom use maybe difficult to promote.

A weak community involvement and community access to information and data relevant to them reduces the sense of ownership and management of the programme, and with this, staff development through capacity building needs to be addressed to enhance their skills and active participation.

There is a lack of operational and staff protocols and procedures for MSM programme development which would strongly assist in providing a framework for effective and sustainable scaling up as well as address the institutionalization of the process. Along with this is the inadequate documentation system that outlines the process of developing and implementing the TOP process (including the development of key process indicators), and there is not clearly articulated strategy for addressing stigma and discrimination issues, particularly for apwint-identified MSM, either socially of within families, or among law enforcement agencies. Further to this, a training and skills building manual needs to be developed which would outline the skills and knowledge needs of MSM staff at different levels.

Finally, while TOP provides VCT services, there is no support and care programme for those MSM who are living with AIDS, and who increasingly are becoming more visible and would be doubly stigmatized because of their HIV status and their sexual preferences.

Strengthening the programme

The following are being recommended for strengthening the MSM Targeted Outreach 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
- Institute a dental hygiene programme as part of a health service delivery
- Increase ownership by more self-identified MSM in management positions
- Establish a national MSM advisory group for 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 in each city

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

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

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 along with an appropriate MSM identified training manual/tool-kit
- Develop a national MSM Advisory Group and network

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 MSM programme staff

Additionally, as a key step forwarded it is suggested here that a National MSM Strategy Consultation Meeting is held early in 2007 which will bring together MSM staff and peers from each of the cities where service provision is being implemented, or will be implemented, which will enable a deeper sense of ownership to develop, and where issues, needs and ways forward can be discussed.

From a management point view, the TOP Project Manager needs to build up management support for the MSM programme as a priority, by skilling up appropriately identified MSM to take on more responsibility for implementing and managing the programme.

Further, the process of developing and implementing the MSM TOP process needs to be well documented and publicised as an example of good practice in the region as well as globally.

Conclusion

In conclusion, while it can be clearly stated that the MSM Targeted Outreach Programme is clearly successful in developing and implementing an MSM community-based approach within the socio-political constraints of Myanmar, as well as within the framework of an international non-government organisation, there are several weaknesses that need to be addressed. These areas need to be tackled effectively in parallel to the scaling up process.

PSI Myanmar, and the Project Manager of TOP need to be congratulated for taking the bold step of building the community-based approach to HIV in Myanmar, and for enabling and empowering MSM to take the lead on this issue and address their own responsibility.

Figure 4: Amended service programme