Second country consultation and training meeting on male sexual health in Myanmar

A PSI/Myanmar workshop

10th – 12th September 2008

Final Technical Report

Shivananda Khan
Naz Foundation International

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 John Hetherington, 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.

And finally, thanks must also go to the organising committee, facilitators and co-facilitators, chairpersons, all the participants, and the collaborating partners that made this meeting so successful.

This National Workshops was supported by UNFPA and USAID.

Contents

Why we must 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 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.

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	Medecin 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
PLHIV	People living with HIV
PSI	Population Services International
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

Executive Summary

Introduction

HIV/AIDS has become a national priority in Myanmar, as one of three priorities 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 HIV 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, while the realities within Myanmar make the development of local independent community-based organisations problematic.

In April 2007, PSI Myanmar organised the First National Workshop on Male Sexual Health, bringing together some 120 MSM participants from across the country to explore their issues, needs and concerns, while developing a number of recommendations for ways forward. One of the key recommendations that arose from that meeting was the felt need for process of national consensus and community networking and mobilising through regular national meetings of this nature. It was believed that such national meetings also provided an opportunity to representatives from local projects to share knowledge, experience, and skills, while developing a common framework of understanding, as well as ensuring appropriate replicability as a means of rapid scaling up of coverage.

The Second National Workshop on Male Sexual Health is an outcome of that meeting.

Objectives

To enable the sharing of knowledge, experience and skills amongst the various local MSM and HIV projects in Myanmar towards ensuring good practice.

To continue to strengthen the national network towards building a common purpose in addressing the growing HIV epidemic among MSM

[1] See Jan Wigngaarden's presentation to the First National Consultation Meeting on Male Sexual Health

This meeting was funded by UNFPA and USAID.

Participants

A total of 148 participants, drawn from the range of PSO/Myanmar TOP MSM sexual health projects (12 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, LIGHT, HELP, MDM, MSI, Save the Children, and AZG.

Methodology

Nine one-day workshops (repeated, making 18 workshops in total) were provided):
1. Fieldwork methodologies
2. Community building and mobilising
3. Social marketing
4. Developing educational materials
5. PLHIV – care and support
6. Peer Counselling
7. Female partners of MSM
8. Empowerment strategies
9. Male sex work

Facilitators and co-facilitators were provided a training programme on the day prior to the consultation meeting by the technical consultant from NFI.

The process used during these workshops was based on group work and discussion, identifying specific issues and needs, along with ways to address these needs. Groups presented their findings in the afternoon of each day, where meeting participants had the opportunity to ask questions to clarify issues, or seek further information from the group.

Each day of the meeting began with a number of presentations on specific issues, which provided added value to the added value to the workshops.

With Opening and Closing sessions that brought in key speakers from PSI Myanmar, UNFPA, UNAIDS, and NFI, each other evening various community-building programmes were also provided.

Conclusions

Bringing together so many representatives from MSM networks and projects across Myanmar presented its own unique challenges, but ultimately exceeded expectations in terms of achieved outputs because of the considerable development work over the last three years. These include the development of local MSM sexual health projects that included the availability of safe spaces for various types of MSM to meet and socialise, ready access to sexual health products and STI treatment, the provision of VCT services and psychosocial counselling, along with the considerable networking and community building that has occurred within cities where such projects exist, as well as within those townships and other cities where PSI Myanmar TOP hopes to scale up its MSM interventions.

PSI Myanmar TOP does recognise that currently MSM and HIV service coverage in Myanmar is only reaching perhaps some 30 percent of at risk MSM, and that more work needs to be done. In order for this to happen though it needs to increase its pool of skilled MSM who have take responsibility for scaling up service coverage in the future. This second national workshop on skills and capacity building for MSM was a key component of this strategy.

The workshop on male sexual health, brought together self-identified males who have sex with males from across Myanmar, as well as representatives from implementing agencies providing prevention,

treatment, care and support services for MSM to share their knowledge, experience and skills, building a consensus on good practice.

During this meeting, nine workshops were held and repeated, so that each participant could attend three different workshops, bringing the total number of one-day workshops to eighteen. This report summaries the content of these workshops and identifies key recommendations that arose from these workshops.

This second meeting can certainly be defined as another milestone activity towards ensuring Universal Access to HIV prevention, treatment, care and support services for MSM, strengthening the national networks of MSM and those MSM living with HIV, and sustaining the outcomes of the first national meeting. It clearly demonstrated the value of using community-building and mobilising approaches towards implementing risk reduction strategies, and increasing take-up of sexual health products and access to STI treatment, VCT and demonstrated the urgent need to increase access to ARVs as a matter of priority.

Key recommendations

1. Fieldwork methodologies

1.1 Additional skills building for outreach staff of communication, psychosexual and psychosocial counselling, along with networking and listening skills
1.2 Increase outreach to *apone* and *tha nge* types of MSM
1.3 Involve local traders and shopkeepers surrounding specific sites as part of an outreach programme
1.4 More educational materials that reflect different key messages other than just on HIV and STIs
1.5 Better communication links between field staff and DiC staff

2. Community building and mobilising

2.1 Strengthen networking capacity within individual cities and townships and develop links with rural based MSM
2.2 Increase the levels of community building activities, and include those that are more appropriate for *apone* and *tha nge* types of MSM
2.3 Develop activities that can bring different types of MSM into one community sensibility, i.e. utilising religious and community festivals, invent new ones, etc.
2.4 Institutionalise the MSM national network and establish secretariat
2.5 Establish a National Task Force on MSM and HIV which can work with the National AIDS Programme
2.5 In-country regional meetings held regularly (i.e. Upper and Lower Myanmar)
2.6 Annual MSM national meeting to discuss strategy and development

3. Social marketing

3.1 Greater involvement of key MSM community leaders in terms of design, production and delivery of sexual health products focusing on the needs of MSM
3.2 Knowledge generation in regard to barriers to consistent condom use by MSM that can then be addressed by specific campaigns
3.3 Exploring non-HIV messages to increase condom and lubricant use
3.4 Developing campaigns focusing on desire, pleasure, and fun
3.5 Increase level of training on marketing skills of MSM field workers

4. Developing education materials

4.1 Greater involvement of key MSM educators in terms of design, production and delivery of education materials
4.2 Increased use of language terms used by MSM in education materials

4.3 Greater use of rituals, performing arts, festivals
4.4 Different types of MSM will need different types of education materials, as one size does not fit all
4.5 Greater use of entertainment mediums for distribution and message development
4.6 Coherent development that works with the different services being offered for MSM
4.6 Other messages to promote condom use developed such as genital and anal hygiene
4.7 Materials developed to address drug and alcohol use
4.8 More interactive materials

5. Living with HIV and AIDS

5.1 Recognise that the term MSM does not describe a monolithic community, and that there will be different types of MSM (at the least *apwint, apone*, or *tha nge*) who may be HIV positive and that these sub-populations will have different issues, needs and concerns from each other.
5.2 There is an urgent need to scale up access to ARVs for MSM who are positive; PSI Myanmar needs to explore sources of funding that could support such a scale up of access, including the Global Fund for AIDS TB and Malaria.
5.3 Access to clean potable water and appropriate nutritional requirements for poor MSM needs to be addressed

6. Peer counselling

6.1 More specific skills-building workshops on counselling for local projects and field staff
6.2 More availability of reference materials and information made available in local
6.3 More networking between projects to share experiences and skills
6.4 Protocols and guidelines developed for peer counselling
6.5 Develop frameworks for telephone counselling and protocols for local projects
6.6 Need to explore relevant issues and needs for MSM in small towns and villages

7. Female partners of MSM

7.1 Local projects should have a well developed support strategy for
- married MSM
- female partners of MSM

7.2 Married MSM and those MSM who have sex with female partners as well should be encouraged to have their partners tested should they themselves be found to have an STI or HIV
7.3 Participants suggested that perhaps services should be developed for female partners of MSM, and that female doctors should be utilised for this
7.4 MSM with female partners should be given skills to negotiate condom use with these partners (along with male partners)
7.5 Education programme (sex education) that develops knowledge on females reproductive and sexual health issues and needs, including sexual pleasure and desires
7.6 Training of field workers to positively communicate to family, friends and society
7.7 Psychosocial support and counselling needs to be offered to married MSM, along with family counselling

8. Empowerment strategies

8.1 Peer counselling offered to address low self-esteem and self-worth
8.2 Greater involvement of MSM in decision-making processes and management
Life skills training offered
8.3 Increased advocacy initiatives at the community and social level to address stigma and discrimination
8.4 Address stigma and discrimination with MSM networks against different types of MSM, i.e. *tha nge* against *apwint*, *apwint* against *apone*, stigma against male sex workers, class-based stigma

8.5 Activities within DiCs appropriate for different types of MSM
8.6 Vocational training and skills building for MSM to improve their own employment opportunities

9. Male sex work

9.1 Greater integration of male sex workers into the evolving MSM community, that will also address stigma and discrimination within this emergent community
9.2 Vocational training for increasing employment opportunities
9.3 Provide assistance in job seeking
9.4 Support for integrating male sex workers into the MSM community(ies) and networks
9.5 Assist in the development of self-help groups specifically supporting male sex workers
9.6 Psychosocial and psychosexual support for male sex workers

PSI Myanmar is to be congratulated for this key work in the Asia region, and for developing models of community-based initiatives within the limitations of a country like Myanmar.

Background

The Independent Commission on AIDS in Asia in its March 2008 report, *Redefining AIDS in Asia: crafting an effective response* speaks with concern about MSM and the growing HIV epidemics among MSM in the various countries in the region.

In the majority of the countries in the Asia-Pacific region, there is general discomfort among the government and national AIDS program leadership, and others, with the existence of males having sex with males (MSM) including transgenders (TG)[2] as well as the realities of male-to-male sexual activity. This discomfort has led to a lack of HIV interventions for MSM which strategically focus on prevention, treatment, care and support. A 2006 survey of the coverage of HIV interventions in 15 Asia-Pacific countries estimated that targeted prevention programs reached less than 8% of MSM,[3] woefully short of the 80% coverage that projective modelling states is needed for effective results.[4] Highly concentrated HIV epidemics among men who have sex with men (MSM) in urban areas in some countries are already well documented (e.g., HIV prevalence in: Bangkok – 30.7%[5]; Phnom Penh – 8.7%[6]; Mumbai – 9.6%[7]; Beijing – 5.8%[8]), yet the investment on HIV programming for MSM ranges from 0% to 4% of the total spending for HIV programming region-wide.[9]

Myanmar is no exception. Data from the VCT services being offered by PSI drop-in centres indicate that the HIV 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%).[10]

The Commission's report clearly confirms that high risk behaviours during sex among men is one of the three major driving forces of HIV in Asia-Pacific, along with risk behaviours during sex work by females and injection drug use. Without an increase in effective, comprehensive and carefully targeted HIV interventions, the highest number of new infections will soon be among MSM which will outnumber other single sub-population groups in Asia. That number will increase dramatically until 2020, at which time nearly 50% of all new infections in Asia will be among men who have sex with men, as illustrated below from the AIDS Commission Report:[11]

[2] 'Men who have sex with men' (or MSM) is an inclusive public health term used to define the sexual behaviours of males having sex with other males, and does not refer to an identifiable community or gender identification. Within this context it is understood that the word 'man'/'men' is socially constructed; as well, within the framework of male-to-male sex, there are a range of masculinities along with diverse sexual, gender and transgender identities, communities and networks.

[3] Men who have sex with men: the missing piece in national responses to AIDS in Asia and the Pacific. Geneva: UNAIDS (2007).

[4] Executive Summary- *Redefining AIDS in Asia - Crafting an Effective Response* (2008). Commission on AIDS in Asia. Oxford University Press, New Delhi, India (2008):4.

[5] Pliplat T, Kladsawas K, van Griensven, Wimonsate W. 2008. *Results of the HIV surveillance among men who have sex with men (MSM) in Bangkok, Chiangmai and Phuket*. Proceeding for the Department of Disease Control Annual Conference, Ministry of Public Health, 11-13 February 2008, Bi-Tech Convention Centre (in Thai).

[6] Neal JJ, Morineau G, Phalkun M et al. HIV, sexually transmitted infections and related risk behavior among Cambodian men who have sex with men. Abstract presented at the 8th International Congress on AIDS in Asia and the Pacific, Colombo, Sri Lanka, August 19-23, 2007 [#1469]

[7] Palwade P, Jerajani H, Ashok RK, Shinde S, Vivek A; International Conference on AIDS (15th : 2004 : Bangkok, Thailand). Int Conf AIDS. 2004 Jul 11-16;15: abstract no. C10822.

[8] Ma X, Zhang Q, He X, et al. Trends in prevalence of HIV, Syphilis, Hepatitis C, Hepatitis B and sexual risk behavior among men who have sex with men: Results of 3 consecutive respondent-driven sampling surveys in Beijing, 2004 through 2006. J Acquir Immune Defic Syndr 2007;45:581-87.

[9] *HIV expenditure on MSM programming in the Asia Pacific region*. Constella Futures/USAID (2006), available at www.healthpolicyinitiative.com.

[10] See Jan Wigngaarden's presentation to the First National Consultation Meeting on Male Sexual Health

[11] Figure 2.16 - *Redefining AIDS in Asia - Crafting an Effective Response* (2008). Commission on AIDS in Asia. Oxford University Press, New Delhi, India (2008):57.

Illustration of increasing share of HIV among MSM in the HIV epidemics in Asia

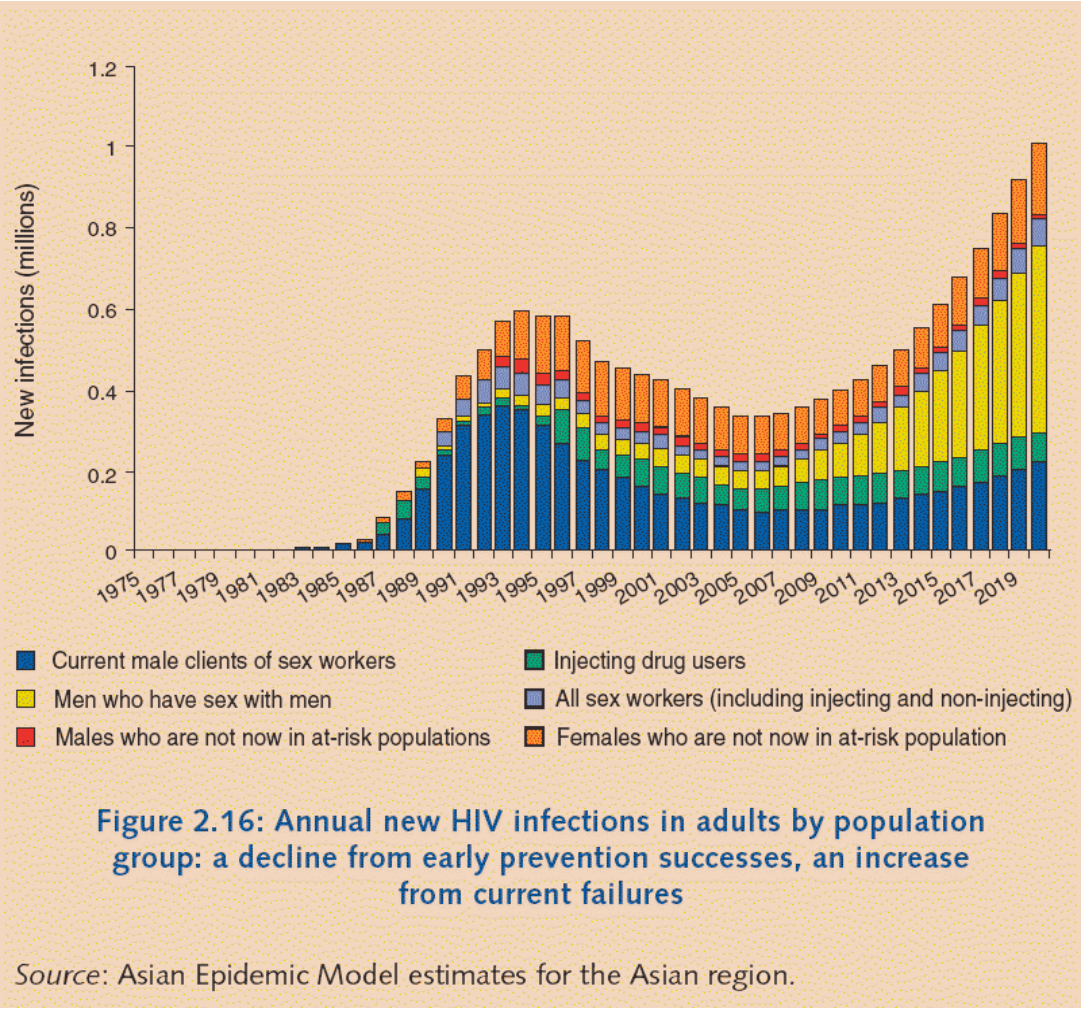

Figure 2.16: Annual new HIV infections in adults by population group: a decline from early prevention successes, an increase from current failures

Source: Asian Epidemic Model estimates for the Asian region.

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 and marginalised 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. In May 2005, a similar centre was opened in Mandalay and services upgraded to five days a week. Between March 2006 and March 2007, the PSI MSM TOP expanded to include 7 more cities.

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.

Other international agencies are also implementing HIV prevention and care work with MSM in the country, including the HIV/AIDS Alliance in Myanmar, Artsen Zonder Grensen (AZG/MSF Holland), CARE International, and Medecins du Monde (MDM).[12]

Following a review of the PSI Myanmar MSM TOP services in Yangon and Pathein, in November 2006 by Shivananda Khan,[13] discussions were held with the TOP Manager and it was recommended that a national MSM consultation meeting should be held in order to support TOP's scaling up strategy and develop a national framework for MSM and HIV prevention, treatment, care and support. This consultation meeting is an outcome of those discussions.

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Technical advisor: Shivananda Khan, Naz Foundation International, providing technical assistance during the meeting.

Methodology

Nine one-day workshops (repeated, making 18 workshops in total) were provided):

- Fieldwork methodologies
- Community building and mobilising
- Social marketing
- Developing educational materials
- PLHIV – care and support
- Peer Counselling

[12] 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

[13] See Shivananda Khan, NFI, 2006, Review of the MSM Targeted Outreach Programme, PSI Myanmar

- Female partners of MSM
- Empowerment strategies
- Male sex work

Facilitators and co-facilitators were provided a training programme on the day prior to the consultation meeting by the technical consultant from NFI.

The process used during these workshops was based on group work and discussion, identifying specific issues and needs, along with ways to address these needs. Groups presented their findings in the afternoon of each day, where meeting participants had the opportunity to ask questions to clarify issues, or seek further information from the group.

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This meeting was funded by UNFPA and USAID.

The programme

All presentations and speeches were translated into Myanmar.

Opening day: *9th September*	**Registration**
Opening Ceremony	
Opening remarks:	John Hetherington, Country Director, PSI/Myanmar Daniel Baker, Country Representative, UNFPA/Myanmar Brian Williams, Country Coordinator, UNAIDS/Myanmar Dr Tin Maung Win, Deputy Country Director, PSI/Myanmar Shivananda Khan, NFI
Cultural Performance	Yangon Night

Day One *10th September*	
Morning Presentations	Chairperson, Nikki Charman PSI/Myanmar
Than Naing Oo PSI TOP	Overview of the First National Consultation
Dr Kyaw Thu HIV/AIDS Alliance	Alliance working with MSM in Myanmar
Thiha Lu Lin PSI TOP	DiCs as tools for community development
Questions and Answers	
Shivananda Khan NFI	Purpose of the Second National Consultation
Workshops	Fieldwork methodologies Community building and mobilising Social marketing Development of education materials PLHIV – care and support Peer counselling
Afternoon Feedback	Chairperson: Dr. Ne Win Presentations from the workshops
Shivananda Khan	Responding to Gaps
Cultural programme	Yangon Night

Day Two *11th September*	
Morning Presentations	Chairperson, Dr Nyo Nyo Minn PSI Myanmar

Nay Oo Lwin PSI TOP	The Female Condom and Lubricant for MSM
Kyaw Naing Win PSI TOP	Living with HIV – a personal story
Addy Chan HIV/AIDS Alliance	HIV positive MSM – developing a response in Myanmar
Moe Zaw LIGHT	LIGHT - working for MSM
Questions and Answers	
Shivananda Khan NFI	Bridging the gaps
Workshops	Female partners of MSM Empowerment strategies Male sex workers Fieldwork methodologies Community building and mobilising Social marketing
Afternoon feedback	Chairperson: Dr Hia Myo Kyaw Presentations from workshops
Shivananda Khan NFI	Responding to gaps
Cultural programme	Mr MSM Mandalay Night

Day Three

12th September

Presentations	Chairperson, Dr Tin Aung PSI Myanmar
Nay Oo Lwin PSI TOP	A global view of MSM and HIV
Dr Myo Thant Lwin PSI TOP	MSM and STI treatment
Thet Mon Pyo HELP	HELP - working for MSM
Questions and Answers	
Shivananda Khan NFI	Universal Access and Ways Forward
Workshops	Female partners of MSM Empowerment strategies Male sex workers Developing educational materials

	PLHIV – care and support Peer counselling
Afternoon Feedback	Chairperson: Maung Maung Nyine Chan Presentations from workshops
Shivananda Khan	Responding to gaps
Closing ceremony	
Closing remarks	John Hetherington, Country Director, PSI/Myanmar Shivananda Khan, NFI
Cultural Performance	Ms Myanmar

The Workshops

1. Field work methodologies

Facilitator: Thiha Lulin
Co-Facilitator: Kyaw Ko ko Zin

Questions: What are the goals and objectives of fieldwork?
What are the most effective methodologies to achieve these goals?

Primary goals defined as:
To promote sustained safer sex and condom and lubricant use
Reduce risks and vulnerabilities for STI/HIV transmission amongst MSM and their partners

Question: How is PSI TOP defining MSM in the context of fieldwork? How would the project reach them?
Apwint
Apone
Tha nge

Strategy: To use existent social/sexual networks at a range of sites towards building a sense of community

Purpose: To utilise peer pressure to change behaviours and sustain that change through developing and extending peer networks and forming self-help groups

Questions: Does giving only condoms and leaflets change behaviour?
What does change behaviour, and sustain that change without further input?
What would promote lifetime change in risk behaviour?

Methodologies: Community building and mobilising strategies
Providing education and awareness on HIV/STI
Sex education
Promoting condom and water-based lubricant use for: safer sex
cleanliness
Building MSM networks and networking of networks
Referrals to appropriate services at DiC
Field counselling on: condom use and safer sex
eroticising non-penetrative sex
STIs and HIV/AIDS
pre-test counselling
psychosexual counselling
personal issues

Promoting behaviour change: sexual
social
partner reduction

Primary importance: befriending and socialising
developing friendship and support
building self-esteem

Outreach activities then consist of:
- accessing individuals across the whole site, not only *apwint, apone, tha nge*, and male sex workers and their clients, but also perhaps the local shops, stall, other individuals at a site
- forming friendships across the specific site

- providing information, advice and appropriate BCC resources
- providing emotional and practical support wherever possible and as such needs arise
- identifying issues and problems that affect individuals and networks across a site
- referring individuals to specific Centre-base services
- monitoring sexual practices and choices at a site
- providing data to the Centre
- being there .....

A range of sites where MSM congregate or utilise:
- Beauty parlours
- Cruising points
- Bus stop/station
- Toilets
- Teashops
- Gamily rooms such as billiard halls
- Social gatherings
- Festivals

Fieldwork is a key part of a broader strategy that incorporates the provision of safe spaces for group meetings, community building along with VCT and clinical support for treatment of ST1s, as well as general health questions. Appropriate information resources would be necessary that are both entertaining and factual, as well as meaningful, to MSM and relevant to their behavioural choices.

In the field, MSM are identified through:
- eye contact
- direct contact
- actual behaviours
- personal networks

Approaches to field work:
- using appropriate individuals as key informants who already use the site and are well known to others at that site... a regular user
- building peer support mechanisms within specific sites and across sites
- utilising already existent friendship AND sexual networks

Advantages of this approach:
- issues are known
- personal experience
- existent rapport within site
- existent levels of trust
- existent degree of confidentiality

Disadvantages:
- possible police harassment of site buddies and field workers
- problems with local thugs and violence
- possible breaking of confidentiality outside a network
- jealousy
- soliciting for sex

It was suggested that these issues would need to be addressed through local advocacy, training and empowerment towards personal behaviour change.

Recommended that Field Teams be developed for each site consisting of:
1. Field Officer providing primary skills and information
2. “Site Buddies” providing localised knowledge, networking and support
3. Volunteers and Friends providing additional knowledge and support

Qualities and skills of field workers:

- should be MSM themselves
- good communication skills with beneficiaries
- good knowledge of MSM issues and sociocultural contexts
- good knowledge of HIV/STDs
- ability to enable people to feel at ease and comfortable
- ability to develop friendship with a range of MSM with differing identities and behavioural choices
- ability to speak openly on MSM sex without shame
- good working knowledge of the male and female body
- knowledge of psychosexual issues and counselling
- a proven commitment to the issues

Qualities of "site buddies"

Site Buddies must always come from the site/framework in which they have considerable knowledge. This knowledge should include:

- differing types of MSM using the site
- local traders, assistants, transport workers, etc.
- sexual activities at the site and areas of risk
- condom usage
- personal friendships

2. Community building and mobilising

Facilitator: Aung Min Thein
Co-Facilitator: Aung Kyaw Moe

What is community? How do we build a community when none exists? How do we mobilising these communities around risk reduction? What do we need to do?

It was recognised that education and condom promotion was insufficient to build sustainable behaviour change in the socio-cultural context of Myanmar where so much sexual behaviour is based on gender identification, and where certain sexual roles are highly stigmatised. Poverty, low self-esteem, gendered sexual identities, shame, and cultural-social pressures, create a dynamic that makes it difficult to enable sustainable behaviour change to be developed and maintained.

Building a sense of community with a shared sensibility of risk and vulnerability can create a common purpose to reduce such risks and vulnerabilities.

Question: Who is MSM?
Apwint
Apone
Tha nge
Male sex workers and their clients

Other labels
England (looks top but wants to be penetrated by feminised male))
Offer (male sex worker)
Ah Chit Taw (non-feminised MSM who wants sex with other non-feminised MSM)

Differing identities, gender performance, sexual networks, and sexual practices frame these identities Can all these differing frameworks be brought together into one community?

What makes an MSM community?

Does an MSM community exist? To some extent the answer is yes, but this tends to be focused as localised social and sexual networks that may cut across each other. Primarily these networks are made up *apwint* identified males.

Recognising the strengths of community affiliations as they already exist, this requires ensuring that *apwint* and *apone* and their partners as a behavioural group/network are specifically targeted to draw them into an emergent community where affiliation is based upon behavioural and emotional characteristics as well as on personal friendships. Mobilising networks, encouraging network development, and networking of networks is feasible under current social realities and should be used as first entry points into networks.

Characteristics of a community:
- affiliation to a shared consensus
- solidarity as a "community"
- mutual support mechanisms
- social support services
- shared ideologies and social characters
- socialising frameworks
- mutual concerns
- shared needs
- shared rituals

In this situation, community is not defined by some geographical space or locality, but rather as a

sensibility, a psychological realm of shared concerns, sexual behaviours, needs, histories and desires.

It is recognised *apwint* are stigmatised as feminised and penetrated males. In many ways the *apwint* is gendered as not-woman/not-man. Such characteristics enable *apwint* to recognise themselves as a "gender" apart, and to also recognise each other with shared characteristics of desire, behaviour and sexuality. However, it should be noted that for many *apwint*, this gender play and practice is locational, and does not carry over into other situations and locations, i.e. in the home, with one's wife, or at work, and so on.

But what unites *apwint* with *apone* and *tha nge*? A shared male-to-male sexual desire? Shared stigma and discrimination, shared risks and vulnerabilities?

Since the primary community frameworks and social identities within Myanmar revolve around family (the joint and extended family system), rural origins, i.e. shared village experiences, locational (where you live), work affiliations (truck-driver, student, etc.), and marriage and children, making shared behaviour characteristic a basis for community building becomes a major initiative and a challenge to the social basis.

In terms of community building and development, *apwint* represent the most effective opportunity form changing behaviour practices. Their sexual choices enable them to access *tha nge* from different socio-occupational communities, as well as a cross-section of society. They are already, for the most, embedded within behavioural and identity social frameworks, and their shared characteristics can be the basis for community building.

MSM identified as *apone* can also be approached in a similar through accessing their sexual networks at a range of "cruising sites".

A safe space where people can meet, socialise, discuss personal issues, receive appropriate and needful services and act as a focal point for an emergent community is an essential element in the process of community-building. A drop-in centre providing a range of services is a necessary component for any such programme.

The fieldwork would promote the drop-in centre and its activities as a part of its programme. While field work promotes friendship building and provides on-site emotional and practical support, this is insufficient on its own. Community building and mobilising requires an empowered sensibility from an individual as well as group standpoint.

Building community ownership

a. Drop-in service
A safe, non-sexual environment providing entertainment (such as TV, games, etc.), community building activities such as shared festivals and religious activities, as well as access to individual psychosexual counselling, instruction on condom use, and information and advice on STIs/HIV/ AIDS, as well as a safe space to meet each other.

b. Socialising meetings
A variety of social groups developed meeting specific sexual/social needs. These groups act as a space within which personal friendships and community-building can be developed, experiences shared, and common purposes evolve. It develops as a community bonding process.

c. Sexual health education classes
Providing information and education on sexual health issues in group situations

d. Personal skills development
A range of educational classes should be offered including literacy, cosmetics, fashion design, social skills, life skills, health seeking knowledge, vocational skills, income generation skills, and so on.

Such Centre-based activities address:
i. personal and emotional needs including
sexual abuse and violence
personal hygiene
friendship
identity and desire
emotional support
empowerment
personal skills development
personal health issues
support and care for those living with HIV

ii. social needs
education
employment
economic development
human rights
family
marriage and children
vocational skills
socialising spaces

iii. sexual health needs
access to quality condoms
access to appropriately packaged water-based lubricant
appropriate STI treatment
psychosexual and psychosocial counselling
voluntary testing and counselling
knowledge
empowerment
negotiating skills
female partners and wives of MSM

These activities lead towards
- the overcoming of fear and shame
- building a shared sense of common purpose and self
- developing confidentiality and trust
- working together towards common goals and purposes
- building self-esteem and self-worth
- providing mutual support and comfort

In others words - a community.

Building alliances
Developing relationships and building alliances with non-MSM groups and agencies is believed to be critical for strengthening MSM networks and community(ies). This includes FSW groups and organisations, NGOs, INGOs, government organisations, and such like.

Recommendations
1. Institutionalise national network and establish secretariat
2. Establish a National Task Force on MSM and HIV which can work with the National AIDS Programme
3. In-country regional meetings held regularly
4. Annual MSM national meeting to discuss strategy and development

3. Social marketing

Facilitator: Than Naing Oo
Co-Facilitator: Kyaw Min Khine

This workshop explored approaches to empowering MSM to purchase their own condoms from as a regular practice, and to sustain such a practice.

Goal
To link sex and condoms in a similar way that we often link cold drink with coca-cola, or jeans with Levis, or salt with pepper.

The objective is to persuade increasing numbers of MSM to
a. purchase their own condoms and lubricant on a regular basis
b. to make condom and lubricant use a normative behaviour among MSM
c. to promote safer sex

Why?
a. distributing free condoms - costings prohibitive
b. often misuse of free condoms
c. more likely to personally use condoms and lubricant if self-purchased

Condom use issues: reproductive sex
recreational sex

Question: Whose life will the condom save?
- both partners involved in the penetration
- other sex partners
- lovers
- sex friends
- clients and sex workers
- wives, children
- families - economic issues

Question: What are the barriers for condom use?
- accessing condoms in the right place and right time
- shame of purchasing
- reaction of shop-keepers
- public spaces
- masculinity attitudes
- incorrect use
- condom price
- belief in reduction of pleasure
- condoms stigmatised as for family planning
- belief that condoms are not suitable for anal sex
- lack of a habit for condom use
- condom use stigmatised as disease prevention

Question: Can these barriers be overcome?
- accessing condoms on site
- establishing MSM distribution network
- education of shop-keepers to promote condom sales
- promote condoms as pleasure and not for family planning
- eroticise condom use
- destigmatise condoms
- increase condom habit through practice

- masculinise condom use
  find new ways of promoting condom use - not focusing on disease prevention i.e. genital/anal hygiene
- reduce cost of condoms
- market condoms with lubricant sachets
- more direct education on condom use
- more openness in discussions on sex
- addressing sexual myths directly through psychosexual counselling and education
- peer pressure on regular condom use

Selling an idea: condom use

The following issues were also explored in terms of determining best marketing strategies:
- protection from disease
- potential for stigmatisation
- protect your family - stronger sense of family than individual
- increase your pleasure?
- sex lasts longer
- keeping clean

Different processes were explored including:
- one-on-one education towards change
- role modelling behaviour change
- community mobilising
- generating desire for using condom through cultural frameworks, i.e. cleanliness, or as a form of masculinity

Sustainability of behaviour change towards regular condom use was explored through
- sustained peer and community-based pressure
- ensuring regular access to condoms
- sufficient availability of condoms
- ensuring affordability
- ensuring quality
- locational availability
- teaching preparedness

Condoms should be readily available at the point of need.

Marketing skills of peer workers
- Good communication skills
- Knowledgeable
- Respect
- Flexible
- Good organisational skills
- Patient
- Need to demonstrate interest in marketing and able to spend time with beneficiaries

Issues of water-based lubricant were also explored in terms of packaging, accessibility, price, and user friendliness. Participants urgently expressed the need for readily available, appropriately packaged, and cheap water-based lubricant.

Question: Why social marketing?

Following an explanation of what social marketing means, participants looked at how such a programme would be implemented.

Condom Distribution: 1st phase increase condom awareness

2nd phase increase condom usage through initial free distribution
3rd phase build condom use habit
4th phase initiate subsidised sales
5th phase persuade to purchase directly

Access:
Wide availability, including rural areas
MSM information centres
Distribution at all festivals
Cruising points, and locations where MSM congregate and/or meet

4. Developing education materials

Facilitator: Kyaw Myint
Co-Facilitator: Soe Moe

What do you need to ensure when you are designing a new information booklet, video, leaflet, or poster for MSM and HIV and AIDS?

When developing appropriate education resources, the following questions should always be asked:

- how appropriate is the framework of education resources for the target group?
- what language are these education resources in?
- what terminology and images are being used? Are they appropriate for the target group?
- what methodology is being used?
- is it appropriate to the cultural frameworks and context of delivery for the target behaviour/group?
- who controls the agenda for the development of these education resources?
- who produces the information and resources?
- who is intended to receive the information?
- who delivers the information?
- how is this information delivered?
- can we differentiate between culturally sensitive and culturally appropriate resources?
- do services exist to cater for expressed and felt needs that such information may generate?
- who staffs these services?
- what do they deliver?
- how do they deliver services?
- how are appropriate are they?
- what skills do they have and are they appropriate?
- what messages are being delivered?
  - don't do it?
  - do it safely?
- what is the objective of these resources?
  - to inform?
  - to change behaviour?
  - to reduce the rate of HIV transmission?
  - to halt the spread of HIV?
  - to increase reproductive health of women? Of men?
- how will this be achieved?

It is only when these questions can be answered satisfactorily can effective resources be developed.

Objective:
- sensitise general public
- educate general public
- targeting MSM behaviours
- targeting MSM networks
- increase awareness
- build self-esteem

How?
- leaflets for distribution
- newspaper/magazine adverts
- street theatre
- word of mouth
- posters
- internet
- wall graffiti
- public transport slogans

Note:
- keep in mind who will be seeing/reading these images/messages
- social class/caste/religion/locality
- Needs to be appropriate for local area/region
- should have a visual impact
- creating imagery which are culturally simple and specific in appropriate language and terminology

What are we trying to say?
- practice safer sex
- promote condom use
- promote non-penetrative sex
- other messages?
- moral message?
  -"don't do it" or "do it safely"

Address:
Injecting drug use
Recreational drug and alcohol use
Risky sexual practices
Health seeking behaviours
Personal hygiene
Basic health knowledge
Nutritional needs
Positive living

Building sustainability in risk reduction.

Such materials need to recognise that MSM is not a monolithic "community", and that there are several different types of MSM with differing identifies, gender performance, and sexual practices. Messages need to be appropriate for each of these differing frameworks, i.e. kothis, panthis, gay men, other MSM.

One suggestion was the possibility of developing the use of *apwint* language.

Also the need to explore alternative mediums, rituals, and frameworks, such as the utilisation of the *nat ka daws*, older *MSM and* "aunties", and the performing arts.

It should be remembered that passing on information does not equal to a change in behaviours.

Messages must be followed through with one on one and group support.

Also development of education materials must involve those for whom the message is being targeted at.

Messages should be:
- short,
- clear
- meaningful
- understandable
- within context
- appropriate
- make sense
- cost-effective

Who:
- Different media – journals, newspapers, movies, radio, hoardings
- Internet

- Leaflets and booklets
- Human interest messages distributed by community leaders and key informants
- Use of various artists
- Social networks
- Teachers
- Religious leaders
- Schools, colleges, universities
- Work places
- Armed forces
- Police

Mass campaign versus one-on-one/small groups

Mass campaign

- Mass population coverage but not quality
- Can deliver the message for mass people in short time
- Need less human and financial resources
- Less effort

    No interactive
    No feedback
    Not assure effectiveness

One-on-One/small groups

- Coverage is low but high quality
- More interactive
- Can get feedback
- More human and financial resources
- More time consuming
- More effort

5. Living with HIV and AIDS – treatment, care and support

Facilitators: U Chit Ko Ko
Co-Facilitators: Myo Min Win
Ko Ko Myo

What do you need to ensure that those living with HIV can obtain the appropriate treatment, care and support in a resource poor environment?

Participants were briefed on
- HIV infection and its consequences
  - physical
  - emotional
  - psychological
  - family
  - community
  - economic
- symptoms
- AIDS
- death and dying

Question: Are there specific issues around living with HIV and MSM? Which MSM? *Apwint*? *Apone*? *Tha nge*?

Issues for MSM
- sexual behaviour and choices
- impact of MSM transmission of HIV
- double jeopardy: HIV infection and MSM, particularly *apwint*
  anal transmission/penile transmission
  social and family consequences

Question: What is needed?
- appropriate counselling
  - personal
  - partner
  - family
- support mechanisms
  - medical
  - treatment
  - nutritional
  - personal
  - partner
  - family
- confidentiality of both HIV status and MSM behaviours/identities
- access to treatment - ART and OI
- addressing poverty and basic care issues
- addressing stigmatisation
  -MSM
  -HIV status
- appropriate training for
  - those MSM living with HIV
  - medical profession on both MSM and HIV
  - family

Objectives
- developing a pathway to appropriate care and support

- understanding the importance of care and support
- linkages of care, support and prevention of HIV transmission
- organisational and individual levels of support and care

Obstacles to care and support

Note: Significant levels of MSM are poor, and lack access to basic needs
- shelter
- nutritious food
- clean water
- medicine for opportunistic infections and ART

- lack of proper voluntary testing facilities
- lack of appropriate counselling facilities
- lack of facilities for STI management for MSM in particular anal STIs
- lack of networking
- invisibility of the issues
- very little information on appropriate care and support for MSM
- lack of appropriate home-based care systems

Issues

As *apwint*
Double discrimination
(as feminised males, as receptive in anal sex p but may have better chances to get VCT and treatment at several DiCs)

As *apone* and *tha nge*
Lesser discrimination
(since these men tend to hide their sexualities and practices and are more afraid to become visible by attending DiCs for VCT and treatment)

Need to address:
- stigmatisation: - of MSM behaviours - of *apwint* - of living with HIV
- pathways to infection
- developing positive attitudes towards people living with HIV
- developing positive attitudes by those living with HIV
- self-esteem around sexual identities/behaviours
- acknowledgement of differences between HIV and other diseases
- stigmatisation by media and medical profession
- discrimination

Need:
- to promote condoms, safer sex and safer blood programmes
- address injecting drug use and MSM
- address female partners of MSM
- reduce partner rates
- risk reduction
- partner notification
- appropriate BCC materials
- MSM friendly counselling
- voluntary testing and counselling
- confidentiality
- access to treatment
- poverty alleviation
- medication for opportunistic infections
- voluntary testing sites
- appropriate information in appropriate formats

- challenge "quack cures" and promotion of "false cures"

Services
Specialist doctors
More resources for DiCs
Internet access
Increased availability of condoms and lubricant
Flexible opening hours
ARV distribution
Counselling services (living with HIV, psychosocial and psychosexual counselling, health counselling)
Prevention education
Living positively

Development of self-help groups with access to:
Training of trainers
Peer counselling skills
Increased access to resources
Home-based care
Nutritional supplies
Motivational meetings

Public advocacy through:
Media and public relations
Representatives and skilled speakers bureau established
World AIDS Day events
Fund raising events

6. Peer Counselling

Facilitator: Dr Myo Thant Lwin
Co-facilitator: Tun Htuk Myoe

What are the essential components to appropriate counselling in terms of
- psychosexual concerns
- psychosocial concerns
- STIs and HIV

Issues to address
- What is counselling?
- What are appropriate methodologies for South Asian MSM?
- What is the differences between Optional or Directive counselling?
- What is the difference between Counselling and Advice/support?
- What skills are necessary?

What is needed
- Pre-test/post-test counselling
- Counselling on risk reduction
- Counselling on sexualities, masculinities and MSM
- Counselling on faith, family, marriage and children

It is necessary to develop "grass-roots" methodologies of counselling on all these issues, appropriate to the needs of MSM.

Framework of counselling
- develop a friendly and support environment
- non-judgemental
- complimentary attitude and speech
- show concern through eye contact, body language, position
- share experiences and knowledge content
- avoid physical barriers (such as a desk)
- regular feedback
- focusing on client's issues
- provide options if possible
- avoid personal involvement

Skills
- good at rapport building
- empathic
- a good listener
- good knowledge of the issues
- able to provide advice and information
- able to summarise and recap the issues
- able to prioritise issues
- must be non-judgemental
- good voice modulation

Other areas
- confidentiality must be assured. A verbal assurance should be given
- counsellor should maintain records of clients and follow up
- differences between open-ended and closed questions
- power dynamics
- information vs advice
- counsellors''s power
- ownership

- ethical issues
- providing incomplete information
- directive versus optional

The use of role-play can be a very effective methodology in dealing with issues such as police harassment at cruising sites, and initiation of counselling sessions.

Peer counselling advantages

- Friendship
- Intimacy
- Interpersonal relationship
- Free negotiation
- Help and support
- Empathy
- Good Understanding
- Respect
- Non-judgmental
- Confidentiality
- Tailoring
- Good listening
- No suggestion
- Partner counseling
- Persuading
- Be patient
- Basic knowledge
- Role model
- No decimation
- Open ended question
- Simple words
- Same language
- Refer to DiC & VCCT
- Family counseling
- Pre marital and marital counseling
- PLHIV Counseling

Recommendations

- more specific skills-building workshops on counselling for local projects
- source and reference materials and information made available
- networking to share experiences
- protocols and guidelines developed
- developing frameworks for telephone counselling
- explore relevant issues and needs for MSM in small towns and villages

7. Female partners of MSM

Facilitator: Thura Aung
Co-facilitator: Htun Htun Naing

Many MSM will be married, get married, and/or have sex with other women, particularly *apone* and *tha nge*.

Ensuring that MSM do not infection their female partners, nor become re-infected, requires developing appropriate sexual health services that can also address the needs of female partners of MSM.

Issues
- family and marriage context in Myanmar
- *tha nge*, masculinity and sex with females
- what concerns regarding cross infection?
- male to male to female to male transmission risks
- partner notification? Why not?
- how can this be addressed
- treatment issues regarding STIs infection for female partners
- HIV infection of female partners
- wives and children
- support mechanisms and methodologies

The workshop was participant orientated based on sharing experiences and ideas. It focused on married MSM.

Question: Why do MSM get married to women?
- traditional social structures in Myanmar may require marriage, usually arranged by family
- continuing the family line
- support, companionship and security for old age
- sexual pleasure and falling in love
- pressure from friends
- to avoid loneliness

MSM activities outside marriage
- usually married MSM avoid emotional encounters with other men, keeping the sexual encounter physical
- if there is an emotional involvement can create difficulties in marriage
- requires psychological demarcation of love
- tend to access male sex workers with no emotional involvement
- impacts on risk reduction strategies

Some issues
- wife may get more disturbed if she knows that her husband is having sex with women
- wife may also suffer guilt and blame herself as she may think she is not satisfying her husband
- how do you tell your wife that you are having sex with other men?

If the wife comes to know
- shame
- perhaps lead to broken marriage and divorce
- may have disastrous results with family and community
- possible traumatised children
- may have to try and give up MSM activities to save children which could have a psychological impact

Participants believed that “no woman wants to share her husband”, and that they will keep quiet about this because of the social security that marriage provides. Divorced women are always

considered to be of "loose" character.

Participants believed that if the MSM is STI or HIV infected then
- tell the truth (but will need considerable support to do so)
- if this is not considered possible then they should always use a condom, stating that he enjoys using a condom because it takes a longer time to do sex

Protecting female partners
- always practising safer sex
- spend quality time with wife and children
- balance MSM activity with family life
- reducing number of partners

Other trauma of married MSM
- dual life style often producing psychological stress
- keeping secret
- potential of threats and blackmail
- constant fear of wife and children finding out
- conditioning of family members to cope with phone calls, messages, and meetings
- can't invite MSM friends home
- can't do sex with other male in personal home
- difficulty in satisfying wife after having sex with other male
- need to fantasise
- Economic issues – spending money on male partners
- Possible demand for divorce and breakup of the family
- Possible blackmail
- Possibilities of HIV/STI transmission to wife
- Depression and suicidal feelings

Is it necessary to tell your female partner that you are MSM? This will be a personal decision, but ensure support systems are available.

Recommendations
- projects should have a well developed support strategy for
  - married MSM
  - female partners of MSM
- female doctors for female partners
- condom negotiation skills for males and females
- learn more about female partners
- families should not force MSM to marry
- sensitise people in general about MSM
- promote communication skills of married MSM to counsel their female partners
- training of field workers to positively communicate to family, friends and society
- forming self-help groups of married MSM for mutual support and peer counselling

Other actions
- give wife a lot of love and respect and time
- balance your roles
- act diplomatically
- ensure that she is treated if you have disease
- non-vaginal sex should be experimented with (with permission)
- don't let her feel bad
- adopt a child if you don't have your own child
- proper maintenance should be provided

8. Empowerment strategies

Facilatator: Nay Oo Lwin
Co-facilitator: Thet Mon Phyo

Disempowerment

- Stigma, discrimination, violence and social exclusion affects the ability of vulnerable MSM to protect themselves from HIV
- It disempowers them from support and care.
- It disenfranchises them from accessing what services may be available.
- It reduces opportunities to develop appropriate services.

To enable: Authorise, empower, supply with means to take action.
To provide with adequate power, means opportunity, or authority.

Equity: A system of justice founded on principles of natural justice and fair conduct.

Thus to develop an enabling environment means to create systems of empowerment, social justice, and equity for the most marginalised populations.

To empower

- Giving power
- Capacity building
- Building solidarity and sense of belonging
- Address low self-esteem and self-worth
- Provide skills and knowledge
- Provide resources, technical, financial, institutional
- Advocate on their behalf
- Create and enabling environment
- Assist in self-help organizing

Frameworks

- Link to counseling
- Peer support
- Can be able to talk
- Leadership skills
- Psychological support
- Better linkage between organization
- Safer sex practice
- Solidarity
- No discrimination
- Equal chance
- Building up life skills

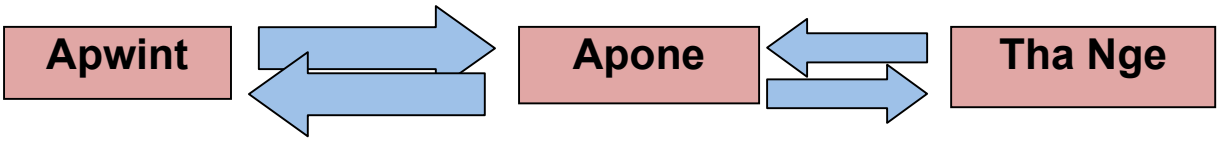
Strengthening responses to life's situation

- Develop sense of self-respect and self worth
- Income generation and development of life skills
- Negotiate with family/boyfriend/friend
- Provide support to family
- Be able to influence family
- Support each other
- To live as ideal person
- Self motivation and encouragement
- To have good relationship with the family
- Have support from friends and colleagues
- Be flexible and empathic with others

- Respect others (as you ask for their respect)
- Be positive
- Offer leadership and positive decision making
- Show positive attributes and office support to others

Building community as a process of empowerment

- Develop supportive environment to self-disclosure
- Understanding each other
- Friendship building
- Social gatherings to develop a sense of unity
- Mutual respect
- More confidentiality
- Should not gossip
- Understand each other
- Network of groups



Strategies

- Networking
- Provision of safe space
- Socialising activities
- Upscaling community activities
- Activities for differing types of MSM
- Use of all types of media

Advocacy work

- Within own networks and social spaces
- General population
- Government sector
- Medical and NGO sectors

Suggestions

- Should not use the word MSM or gay but as men's health network
- Have to link with each organization
- Have to have the meeting twice a year by city focal point.
- Newsletter by quarterly
- Should have SHG in each city and share the information
- Should have the MSM health web site.
- Technical assistance
- Resources from INGOs and other donors

9. Male sex work

Facilitator: Kyaw Zayar Swe
Co-facilitator: Swan Pyae Phyo

Issues and questions
- Who is selling sex?
- Who is buying sex?
- Why?
- Where does this take place?
- What is the currency of exchange?

How are we defining sex work?
- Cash transactions
- Gift exchange
- Resources exchange
- Employment opportunities
- Access to food and shelter
- Family support

Sex work as a survival strategy
- Addressing poverty: personal and family
- Supporting family needs
- Supporting personal needs
- For food and shelter

Perceived economic needs
- College and university expenses
- Pocket money
- To be a part of a social group (good clothes, mobile, etc)

For criminal gain, i.e. to be able to rob clients

Many male sex workers also provide free sex for pleasure and enjoyment.

Many male sex workers also have sex with females.

What type of sex is being sold?
- Receptive anal sex
- Penetrative anal sex
- Oral sex
- Masturbation

The more masculine male workers will often only provide penetrative anal sex or will be recipients of oral sex, and are thus able to maintain the fiction of their "heterosexuality" and masculinity. Others will provide only receptive sex as *apwint* identified males and feminised roles they perform for their clients. Some others will provide both receptive and penetrative anal sex depending on the choice of their clients.

Buyers
- Older men who have less chance in finding sexual partners because they are perceived to be unattractive
- Married men who want anonymous sex for fear of discovery, or do not wish any emotional attachments
- Situational opportunities where females may not be readily available at the time of perceived sexual need

- Behavioural preferences, such as desire for anal or oral sex, where wives/girlfriends cannot be asked for this.
- Desire for males but do not want to be discovered

Perception is that it is easier to get sex from males than from females, that they are less costly since you don't have to "date" male partners, and that male partners are perceived to provide more support.

Needs of MSW

- Provide vocational training and life skills training to improve their sense of self-worth and possibilities of better employment opportunities
- Assistance in job seeking
- Peer counselling on a wide range of issues
- Integration into MSM networks and community building
- Self-help support
- Regular health checkups and access to VCT, treatment and STI management programmes
- Anti discrimination and emotional/social support
- Ready availability of sexual health products

Special thanks

1. The Organising Committee

Habib Rahman
Kathy Win
Who Yee Win Mg
Kyan Swar Htwe Nyut

2. Participating organisations

International HIV/AIDS Alliance
Healthy Living Society
Light
MDM
MSF-Holland
UNFPA
PSI Myanmar

3. Guest Speakers

Opening session	John Hetherington, Country Director, PSI Myanmar Daniel Baker, Country Representative, UNFPA Myanmar Brian Williams, Country Director, UNAIDS Myanmar Dr Tin Maung Win, Deputy Country Director, PSI Myanmar
Day One	Than Naing Oo, PSI Myanmar Dr Kway Thus, Alliance Myanmar Thiha Lu Lin, PSI Myanmar
Day Two	Nay Oo Lin, PSI Myanmar Kyaw Naing Win, PSI Myanmar Addy Chan, Alliance Myanmar Moe Zaw, LIGHT
Day Three	Nay Oo Lwin, PSI Myanmar Dr Myo Thant Lwin, PSI Myanmar Thet Mon Phyo, HELP

4. Chairperson

Day One	Morning – Nikki Charman, PSI Myanmar Afternoon – Dr Ne Win, UNFPA Myanmar
Day Two	Morning – Nyo Nyo Min, PSI Myanmar Afternoon – Dr Hla Myo Kyaw, PSI Myanmar
Day Three	Morning – Dr Tin Aung, PSI Myanmar Afternoon – Maung Maiung Nyine Chan

5. Facilitators

Fieldwork Methodologies	Thiha Lulin Kyaw Ko Ko Zin
Community Building	Aung Min Thein Aung Kyaw Moe

Social Marketing	Than Naing Oo Kyaw Min Khine
Education Materials	Kyaw Myint Soe Moe
PLHIV care and support	U Chit Ko Ko Myo Min Win Ko Ko Myo
Peer Counselling	Dr Myo Thant Lwin Tun Htuk Myo
Female partners	Thura Aung Htun Htun Maing
Empowerment	Nay Oo Lwin Thet Mon Phyo
Male sex work	Kyaw Zayar Swe Swean Pyae Phyo

6. Official photographers

Ko Yoe
Min Aker

7. Technical assistance and support

Shivananda Khan, OBE, Naz Foundation International