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The Humsafar Trust, Mumbai, India

Empowering Communities of Men Who Have Sex with Men to Prevent HIV



Courtesy of the Humsafar Trust

This painting is on display at many community activities sponsored by Humsafar.

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In 1990, three men in Mumbai, India, wondered aloud to each other, “What will happen to us in old age? Who will take care of us?” As Indians, each felt a strong sense of responsibility to his own family, and each expected to care for his parents as they aged. But these men also knew that they were unlikely to have children of their own or build a family in the traditional sense. As part of the emerging gay rights movement in India, they recognized a need to develop an alternative support system rather than accept the limitations of a marginalized and criminalized existence. With this aspiration in mind, these men founded the Humsafar Trust, named for the Hindi word meaning “companions on a journey.”

Humsafar created a safe haven and provided support for Mumbai’s emerging community of men who have sex with men (MSM) and transgender people (TG), too often the victims of familial rejection, social discrimination, and violence. But new challenges lay ahead. HIV loomed as a growing threat, particularly in a city as diverse as Mumbai, whose tolerance has made it a magnet for sexual minorities. Like the handful of organizations in India with similar mandates, Humsafar quickly recognized that it needed to take up the challenge of HIV since, at that point early in the country’s epidemic, the Government of India typically neglected the prevention needs of MSM in its programming.

Although the syndrome that would eventually be called AIDS was first identified among clusters of gay men in the United States in the early 1980s, the vulnerability of MSM has all too often been ignored in program design and implementation. In many parts of the developing world, HIV programming for MSM is inadequate or nonexistent. In some places, fledgling rights movements for sexual minorities have provided a vital and often the only platform for MSM to respond to their vulnerability to HIV in the absence of governmental or other support (Anyamele et al. 2005).

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THE HUMSAFAR TRUST: SUMMARY OF RECOMMENDATIONS FOR EFFECTIVE HIV PROGRAMMING FOR MSM

- Leverage MSM community knowledge and involvement
- Undertake formative research
- Increase resource investment in MSM HIV programming
- Develop service options that reflect MSM community diversity
- Collaborate with government health systems
- Integrate and link services as possible
- Balance necessary advocacy with service provision

For nearly two decades, the Humsafar Trust has worked with MSM and TG in Mumbai and successfully linked community advocacy and support activities to the development of effective HIV prevention and health services (see the box to the left). Using its firsthand knowledge of MSM and TG in this metropolitan area, the organization has tailored its HIV and health programming to respond to the diverse needs of these populations in a sometimes difficult cultural and political environment. Beyond Mumbai, Humsafar has become one of a small group of Indian organizations working with sexual minorities that influence the development of HIV policies and programming at home and around the world.

MSM and the Indian Response to HIV

Though often hard to reach and frequently neglected in national public health strategies and programming, MSM should be a priority for HIV prevention worldwide. Recent studies show that MSM are at significantly greater risk for HIV infection than other adults of reproductive age, due to such biological, behavioral, and structural factors as unprotected anal intercourse, multiple sex partners, and criminalization of sexual relations between men. Even in regions with medium to high HIV prevalence, MSM are on average nine times more vulnerable to infection than the general population (Baral et al. 2007). Adult HIV prevalence in India is estimated by the government to be 0.34 percent (NACO 2008: 21). However, recent sentinel surveillance identifies 11 states with HIV prevalence among MSM higher than 5 percent (NACO 2008: 12). If left unchecked, these levels are likely to increase.

The urgency of the situation has prompted the National AIDS Control Organization (NACO), an Indian government agency, to make MSM and TG, along with female sex workers and injecting drug users (IDUs), a priority in its third national strategy, the National AIDS Control Program III (NACP-III, 2006-2011). NACO's concern about MSM is based on research showing that some subpopulations of MSM, including TG, have high rates of multiple as well as concurrent sexual partners and often engage in unprotected anal sex. Significantly, many most-at-risk MSM have both male and female sexual partners. Thus, NACO has determined that targeting interventions for MSM is strategically critical to controlling the HIV epidemic in India.¹

¹According to NACO's 2002 national behavioral surveillance survey, "31% of MSM reported having sexual intercourse with a female partner in the 6 months prior to the survey, and the mean number of female partners was 2.4" (NACO 2007: 13).

Community-based organizations (CBOs) have been an important part of the Indian response to HIV. For MSM, a number of CBOs emerged to support efforts in different parts of the country. While the Humsafar Trust focuses its services in and around Mumbai, it also contributes meaningfully to the national discourse about rights for sexual minorities. Humsafar is not alone in this role and has been joined most prominently by the Naz Foundation International, which promotes a sexual health and rights agenda for MSM in South Asia. For the most part, Naz functions as a capacity builder, using its experience and resources to strengthen smaller CBOs in India and other countries in the region.²

As part of the community engagement process that was integral to the development of NACP-III, Humsafar served in an advisory capacity, helping to craft the MSM component of the national strategy. The organization’s success in this effort reflects its sophisticated understanding of the political and cultural sensibilities involved and the careful advocacy necessary to gain buy-in for MSM programming. For example, NACP-III targets its MSM activities to “most-at-risk MSM,” a category promoted by Humsafar specifically for MSM who take a receptive role during anal sex and who have multiple partners.

NACP-III estimates that there are 2.35 million most-at-risk MSM in India. While this may be an underestimation, it represents a rational goal for program development and resource allocation in a political and cultural environment that has little sympathy for the needs of sexual minorities. By establishing a more focused target for MSM activities both in terms of behavior and size, NACO has defined a manageable scale for MSM programming. The use of a sub-category of “most-at-risk MSM” helps NACO

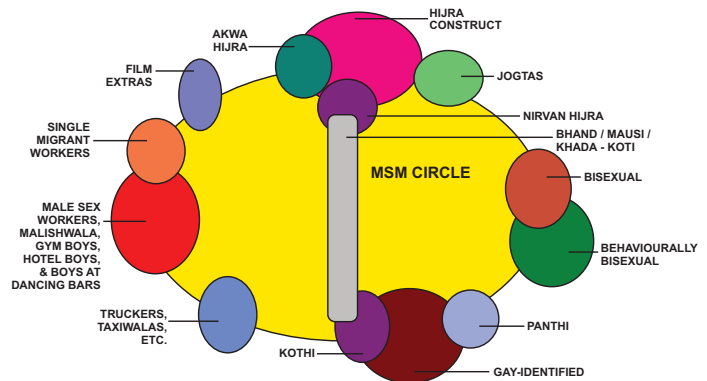


Figure 1: The MSM Circle (courtesy of the Humsafar Trust).

signal its intention to make MSM a priority without triggering a debate on the more thorny challenge of quantifying the actual number of MSM in India.

The term “MSM” itself presents its own challenges for the field of public health in India and elsewhere. In NACP-III, MSM are defined as “men who have sex with other men as a matter of preference or practice, regardless of their sexual identity or sexual orientation and irrespective of whether they also have sex with women or not” (NACO 2007:12). The term was first used in the early 1990s by social scientists to avoid often unclear identity terms, such as “gay” or “straight,” when discussing sexual behavior that might increase a man’s risk for HIV. In fact, recent research in the United States shows that even when men describe themselves as “straight,” it may be an inaccurate or incomplete description of their sexual behavior or HIV risk (Pathela et al. 2006). This disconnection between identity and behavior among MSM appears to be a global dynamic that manifests itself in different ways, depending on the country or culture.

To better understand the complexity of the contexts in which sex between men occurs in Mumbai and to some extent in India generally, Humsafar devised the MSM Circle (see Figure 1), which illustrates the range of sub-groups and indigenous typologies—such as *hijra*, *kothi*, and *panthi*—within and around the city’s MSM community. The sub-groups on top

² Despite some common priorities and goals, the relationship between Humsafar and Naz was strained for some time. Given the importance of a unified effort to support MSM and other sexual minorities in India, a rapprochement was undertaken several years ago in which both organizations agreed to collaborate with other stakeholders such as the Lawyers Collective on broader domestic and international advocacy issues while continuing to work separately in their respective spheres.

Mapping the sexual dynamics of MSM provided Humsafar with a useful advocacy tool as well as essential information to determine priorities and guide the development of its HIV programming.

of the circle are based on gender; at the bottom, on sexual behaviors; on the left, on vulnerability due to workplace situations; on the right are bisexual or potential bridge populations. Some Indian MSM also describe themselves as “gay,” using the term common in industrialized countries. Although the MSM Circle is specific to Mumbai, the process of mapping the sexual dynamics of MSM provided Humsafar with a useful advocacy tool as well as essential information to determine priorities and guide the development of its HIV programming.³

Humsafar’s MSM Circle illustrates the challenge that programmers often face in assessing the nature and diversity of MSM in order to design and implement interventions that maximize lean resources. It shows that MSM are not a homogeneous and easily identifiable group but a distinctly heterogeneous population that often resists social expectations or cultural norms. This is true not only in Mumbai but throughout India and across the world.

The complexity is exacerbated by the near invisibility of many MSM communities. Sex between men occurs in many different venues and contexts and, while it defines the identity of some, there are many for whom it is simply a behavior that, like most sex, is hidden from view. Marginalized and stigmatized, sex between men is frequently either relegated to the outskirts of social discourse or obscured entirely. As a consequence, HIV prevention programs struggle to identify men who need services. The

social networks that Humsafar has nurtured through community building provide useful (though by no means complete) access to the more hidden sexual networks of MSM who remain at risk.

The Humsafar Trust

The Humsafar Trust focuses its efforts on sexual minorities in and around Mumbai by advocating for their rights and providing HIV prevention, care, and support services, as well as general health care. Although some of its advocacy activities—such as supporting the development of the NACP-III MSM strategy—have a broader geographic reach, Humsafar has endeavored to remain community-based, primarily serving the needs of MSM and TG in India’s most populous city. However, to support the growing number of organizations in India working with MSM, TG, and other sexual minorities, Humsafar initiated the establishment of the India Network for Sexual Minorities (INFOSEM) in 2003, which works with more than 80 groups across the country. As one informant noted, “Now every donor wants to work with MSM,” and since the availability of new funding has prompted the establishment of new CBOs working with MSM and TG, Humsafar’s ability to serve as a capacity builder is especially valuable.⁴

A large part of Humsafar’s value as a partner in HIV prevention is its close connection to populations targeted as most-at-risk for HIV acquisition and transmission. Leveraging this expertise has been a core element of Humsafar’s own success in providing HIV services in an environment sometimes hostile to MSM. The organization’s development of solid governance, management, and finance systems has established Humsafar as a credible recipient of donor funding. Humsafar has attracted support from NACO, most significantly through the Mumbai District AIDS Control Society, and from such international donors as the U.S. Agency for International Development

³ For further discussion of the classification of MSM in India and its impact on HIV prevention, please see Boyce 2007 and Cohen 2005.

⁴ Some critics, though, worry that Humsafar’s influence has become too great and that its involvement in so many organizations might stifle innovation or reduce competition for resources.

(USAID) through Family Health International (FHI) and the Avert Society, the Bill & Melinda Gates Foundation through Avahan, UNAIDS, the U.N. Development Programme (UNDP), and the U.K.'s Department for International Development (DFID).

Program Offerings

Humsafar recognized early on that the HIV epidemic would be both a great challenge and an opportunity for the organization. By promoting the rights of sexual minorities alongside access to health and HIV services, the organization has moved both agendas forward in a mutually beneficial manner. The organization's mission articulates this dual and symbiotic purpose: "[T]o strive for the human rights of sexual minorities and [to provide] quality health services to MSM and *tritiya panthi* [TG]." This approach has also allowed the organization to identify funding from broader sources, and it has particularly benefited from the expansion of funding for HIV-related activities.

Humsafar currently reaches more than 12,000 clients annually with HIV and health services at three clinics and drop-in centers as well as through its street outreach and other prevention programming. The organization has two professional counselors and seven community counselors, who are trained MSM and TG personally familiar with many of the issues clients face. The clinical services are supported by seven part-time doctors, a nutritionist, and three lab technicians. A pioneer in HIV-related service provision to sexual minorities in Mumbai, Humsafar has built an impressive range of prevention, treatment, care, and support services that connect clients to a continuum of care, as the box on page 6 shows. In 1999, Humsafar was accredited as a Voluntary Counseling and Confidential Testing Center (VCCTC) for Mumbai, and it has subsequently built its clinical component alongside its prevention and support activities, integrating and strengthening services as appropriate.

Philosophically and as a point of policy, Humsafar avoids replicating existing services or taking over the

With its mandate to support a marginalized community that receives inadequate care, Humsafar seeks to create services that fill critical gaps in what the formal health system offers.

fundamental responsibility of the government to provide health services, including those related to HIV. With its mandate to support a marginalized community that receives inadequate care, Humsafar seeks to create services that fill critical gaps in what the formal health system offers. Humsafar has worked closely with a number of government health facilities, most extensively Sion Hospital, to provide sustained training and sensitization programs for health care workers, clinical staff, and policymakers on the needs of MSM and TG patients and people living with HIV and AIDS. Client referrals to more complex medical care complement Humsafar's in-house clinical services.

A significant portion of Humsafar's programmatic work has focused on HIV prevention, particularly street outreach and condom promotion activities. Cruising sites such as parks, public toilets, cinemas, truck stops, and beaches provide an opportunity to reach MSM looking for sex partners. At these sites, outreach workers may use a series of encounters over several weeks to "introduce" themselves and identify those men who are MSM. Street outreach in Mumbai is not easy. Although outreach workers carry identification cards, they are frequently harassed by the police, though seldom charged with a crime.

Even in designing its outreach materials, Humsafar has found it necessary to be careful how it represents sexual behavior. One example is the instruction leaflet Humsafar distributes with condoms (see Figure 2 on page 6). While Humsafar specifically developed the leaflet for its work with MSM, there is nothing in the leaflet that mentions MSM or describes the use of condoms for anal sex. The images obscure the sex

HUMSAFAR PROGRAM COMPONENTS

- Community work
- Counseling services
- Condom promotion
- Street outreach
- VCCTC and STI services
- Care and support
- Behavior Change Communication strategies and tools
- Advocacy
- Networking
- Research
- Training
- Project management

of the receptive partner, and the language (in this English version) even implies that the partners are of different sexes. Given the criminalized status of sex between men at the time of the leaflet’s design, Humsafar decided to remove any reference to anal sex to protect its outreach workers from accusations of distributing pornography and encouraging criminal acts. Of course, this leaflet is given out during HIV prevention discussions with MSM that are more explicit about the risk of unprotected anal sex.

In truth, there is no simple way to reach sexual populations who—by virtue of context or choice—are secretive or hidden. Humsafar continues to struggle with such issues in its outreach activities and recognizes that it does not reach all MSM in Mumbai, particularly because so many MSM hide their sexual orientation. This has led the organization to redouble its efforts at cruising hot spots that may attract men who would not otherwise approach Humsafar. Telephone helpline and email counseling that complement the services available at Humsafar’s drop-in centers are particularly appealing to men who want to maintain their anonymity. Humsafar’s Gaurav Aastha Project specifically focuses on male sex workers who do not self-identify as MSM and provides another access point to reach the customers of these men with prevention messages.

What Worked Well

Creating and sustaining a support system for MSM: Many MSM and TG who rely on Humsafar’s services and social support feel that the organization has been indispensable in developing the community and responding to HIV. One MSM informant observed that without Humsafar, “half the MSM in Mumbai would be dead.” At Humsafar drop-in centers and Friday Community Workshops, it is clear that the organization has been effective in creating and sustaining a support system for the MSM community and addressing the unique needs of TG. The organization has also made progress in providing health and HIV-related services for MSM and TG and has consequently increased health-seeking behavior within the community.

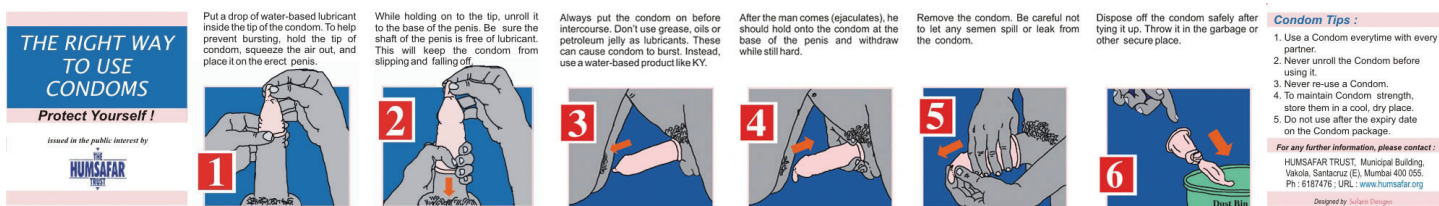


Figure 2: Condom leaflet (courtesy of the Humsafar Trust).

Collaborating with health care providers:

Consistent with its identity as a community-based organization that avoids replicating existing government services, Humsafar has developed clinical components that allow clients access to an integrated menu of health and HIV-related services at its clinics or by referral to targeted facilities in the government system. By training government health care providers to respond to the health needs of MSM and TG appropriately and without discrimination, Humsafar has been able both to address the stigma that is commonplace in the government health system and to provide a fuller range of MSM- and TG-friendly services to its clients.

Promoting prevention: Even as the organization has expanded its clinical services, HIV prevention continues to be the “bread and butter” of Humsafar’s HIV programming. The promotion of condoms and lubricant remains essential to successful prevention. Street outreach brings condoms and prevention messages directly to men at cruising sites. These efforts reach MSM who would otherwise not attend Humsafar’s clinics or drop-in centers because they are afraid to reveal their sexual orientation or may not even recognize themselves as potential clients. Condom promotion and distribution have worked well for Humsafar, but the high cost and poor availability of lubricant continues to be a concern. NACP-III mandates the availability of condoms but not lubricant, despite its importance to safer sex, particularly during anal intercourse.

Advocating through the media: From the start, Humsafar has embraced an advocacy role in promoting the rights and interests of MSM and TG. The organization has worked closely with the news media to reach a broad public audience and with institutions such as NACO and UNAIDS to influence policy. One of Humsafar’s earliest advocacy tools was India’s first registered gay publication, *Bombay Dost*. Its editor was one of Humsafar’s founders, and this newsletter and a later magazine helped organize the community and raise a collective consciousness about the rights of sexual minorities.

(In 2009, with the support of UNDP, *Bombay Dost* was relaunched after a seven-year hiatus.) Over the years, Humsafar has employed a variety of media to advance its advocacy agenda. Benefiting from its proximity to Bollywood, India’s film industry based in Mumbai, the organization has developed several film projects such as training and documentary films, as well as a feature-length film that explores the stigma and marginalization experienced by sexual minorities. Humsafar has also learned to use such tools as the Internet and research data to influence opinion and policy.

Undertaking research: Formative research can play a vital role in describing distinct characteristics of the populations of MSM that may drive the epidemic in a particular geographic area. Research can also provide valuable evidence to present to stakeholders to encourage the initiation, design, and scale-up of programming for MSM. As Humsafar’s CEO Vivek Anand observes, “Prevention is not just about promoting condoms; it’s about understanding why people are not using them.” As Humsafar has matured, its research efforts have become more sophisticated, supported by donors and coordinated by the organization’s in-house research department. Over the past five years, the Boston-based Fenway Institute has collaborated with the organization to develop the infrastructure for community-based research, including the establishment of Humsafar’s own institutional review board to approve and monitor research activities. By building its research capacity, Humsafar has taken an active role in identifying questions of local relevance that have direct and immediate value to its institutional goals. Under the auspices of the Fenway Institute and the National AIDS Research Institute in Pune, India, and with funding from the National Institutes of Health in the United States, Humsafar recently initiated a study of married MSM in Mumbai. Using respondent-driven sampling, the study will evaluate the characteristics of the social and sexual networks of most-at-risk MSM who are married to women. Humsafar intends to use the results to design future prevention interventions targeting these hard-to-reach MSM.



James Robertson/JSI

Humsafar prevention outreach workers at a railway station in Mumbai.

Encouraging organizational evolution and growth: As they grow, many CBOs struggle to address changing needs and priorities. In a little less than 20 years, Humsafar has evolved from an idea among three friends to an established organization with more than 200 employees (10 full-time and the remainder part-time on different projects), an international reputation, experienced leadership and staff, diverse funding streams, robust programming, effective monitoring systems, and strong community involvement. As it has grown, it has remained grounded within the community it serves and focused on Mumbai, even while it has strengthened its management and financial systems and otherwise maintained an ambitious agenda for institutional growth. The organization has benefited from decisions to professionalize its management, bringing in a CEO with MBA training and establishing a program management unit to systematize decision making. Recognizing the need to better manage its institutional work streams, the organization established the Humsafar Center for Excellence (CeFE), separate from its service delivery arm, to coordinate its advocacy, research, and capacity-building activities, including the organization’s work through INFOSEM. These restructuring efforts have

provided new opportunities to support the professional growth of staff and increase Humsafar’s management capacity.

Challenges

Social marginalization: Since MSM are a core most-at-risk population in NACP-III, Humsafar has received HIV funding from government entities. While this support reflects changing attitudes, there continues to be a high degree of discomfort about MSM and TG, even among health officials, who must choose their words carefully to deal with sensitivities in the government and in Indian society more broadly. The identifiable progress over the past two decades—including a July 2009 court ruling to decriminalize homosexuality⁵—does not reverse entrenched attitudes about sexual minorities that permit discrimination in employment, limit access to services, and encourage police harassment, violence, and threats of exposure and public humiliation. Similarly, this progress will not cure the pain that many in this population have endured and that continues to contribute to their vulnerability to HIV.

Reach: By Humsafar’s own assessment, the organization’s prevention efforts do not reach all vulnerable MSM who might benefit from their services. “One of the biggest challenges is reaching married and bisexual men,” Humsafar’s Anand readily admits. “Humsafar is easier to access if you’re openly ‘gay.’” While resource constraints are partly responsible, the organization continues to struggle to identify and serve certain MSM even while it otherwise achieves some diversity within its client population. For example, there appear to be

⁵ In July 2009, the High Court in New Delhi ruled that the prohibition on homosexual sex between consenting adults under Section 377 of the Indian Penal Code—a legacy of British colonial rule—was unconstitutional. If this judgment holds, India will have removed a basic barrier to equality for sexual minorities. This has significant symbolic value, although the decision alone will not end social marginalization and discrimination for sexual minorities. But it is likely to have a meaningful practical effect on the lives of sexual minorities by making some aspects of HIV prevention outreach easier and easing some of the fear that many MSM have about seeking out services they need.

few older MSM accessing services, and most street outreach makes contact with men in their 20s or 30s, reflecting the age of most Humsafar peer educators. The hidden nature of sexual expression will continue to limit successful outreach to vulnerable MSM, even as the organization continues to refine its strategies to increase the diversity of contacts.

Knowledge gaps: One of the more remarkable phenomena observed in Mumbai and elsewhere is the disconnect between awareness about HIV and AIDS and actual condom use. MSM who take part in Humsafar's prevention programming often report that before they received MSM-specific education, they thought condom use was only necessary during vaginal sex. Put another way, most HIV prevention messaging for the general population tends to discuss sexual behavior in broad and often vague terms, reflecting acceptable social norms. Unfortunately, this lack of specificity often gives people incomplete information and, as a consequence, they may engage in more risky sexual behavior thinking that they are, in fact, avoiding HIV. The absence of discussion about anal sex in the general HIV prevention discourse puts not only MSM at risk but also women who might consider anal sex as an option to protect their virginity or avoid conception.

Recommendations

The Humsafar Trust offers a model that has been particularly vital in India but is nonetheless instructive for programmers in other places. The marginalization and criminalization of sexual minorities in India led to the founding of the Humsafar Trust to provide a safe social space and support network for MSM and TG. While Humsafar grew as an advocacy organization, the growing HIV-related needs of the community it serves required the organization to build services, particularly because the government health system failed to adequately respond to the needs of this population. A number of useful lessons emerge from the Humsafar experience.

Leverage MSM community knowledge and involvement: Although there may not always be a visible indigenous CBO working to address the needs of MSM, careful research and networking can usually provide access to community members and advocates who can be indispensable partners in developing HIV programming for MSM.

Undertake formative research: Decision makers are often unaware of the need for HIV programming for MSM. Research can provide the data necessary to convince skeptics, motivate action, and design responsive interventions.

Increase resource investment in MSM HIV programming: To gain traction against these challenges, HIV-related activities need more funding to address the specific prevention and service needs of MSM and other sexual minorities.

Develop service options that reflect MSM community diversity: Programs need to recognize the multiple contexts in which sex between men occurs as well as the heterogeneity of MSM themselves. It is unlikely that a single strategy or program will effectively reach a population as demographically diverse as MSM.

Collaborate with government health systems: Few health care providers are prepared to address the specific health- and HIV-related problems of MSM. Programs should collaborate with government health systems to train clinical personnel and facility staff to treat MSM and other sexual minorities without bias and with care that addresses their needs.

Integrate and link services whenever possible: CBOs doing prevention outreach to MSM are likely to be good candidates for developing a broader menu of HIV services for their clients. More complex services such as antiretroviral therapy will usually require referrals to government systems.

Balance necessary advocacy with service provision: In many places where MSM are most in need of HIV-related services, governments

are frequently antagonistic to their rights and unsupportive of efforts to develop suitable service offerings. When required, advocacy must be undertaken to address these challenges.

For international donors who work with host governments in bilateral relationships, there are legitimate legal and cultural issues that should be addressed in designing and implementing HIV-related interventions for MSM. Some program planners may find that a lack of technical experience will slow progress in developing appropriate responses for MSM. However, local MSM and TG communities will often provide the initial expertise and spark necessary to build successful programs.

Future Programming

Even in light of evolving attitudes about homosexual behavior and a movement toward its full decriminalization, social barriers for MSM, both visible and hidden, continue to test India's HIV programs. NACP-III's inclusion of MSM among the most-at-risk populations it targets has provided a foundation to build upon, although activities need to be expanded to reach an appropriate scale. At current levels, coverage is inadequate. International agencies and donors will continue to have valuable contributions to make to these efforts.

Research programs need to be encouraged and sustained to increase our understanding of MSM and TG populations and inform the development of effective interventions. Programming is needed to

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build the capacity of government as well as private health care providers to better serve MSM and TG individuals. Strengthening the CBOs and NGOs that work with these populations should also be a priority.

MSM and TG themselves continue to be essential partners in government and donor efforts to expand HIV services for these groups, providing experience and insight that are not available outside their communities. Of course, no single organization can be expected to support the full range of services required. The Humsafar Trust's integrated approach addresses part of the current need in Mumbai, but by the nature of its mandate and resource limitations, the organization is unable to serve all who might benefit. In India as elsewhere, the development of responsive programming and service options for MSM and other sexual minorities will help reduce their vulnerability to HIV and the other challenges they face. ■

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www.nacoonline.org/NACO

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Naz Foundation International
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