Sexual risk behaviors among male sex workers in Ho Chi Minh City, Vietnam - Implications for HIV prevention

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Sexual Risk Behaviors Among Male Sex Workers In Ho Chi Minh City, Vietnam - Implications For HIV Prevention

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2011

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DEDICATION

This thesis is extremely dedicated to my family, colleagues and close friends who have supported me materially and spiritually during my studies in Umeå, Sweden. Their continuous contributions during my work become a fantastic inspiration on my way to success in life.
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<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
</tr>
<tr>
<td>CDC</td>
<td>US Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>FHI</td>
<td>Family Health International</td>
</tr>
<tr>
<td>FSW</td>
<td>Female Sex Worker</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HCMC</td>
<td>Ho Chi Minh City</td>
</tr>
<tr>
<td>IBBS</td>
<td>HIV/STI Integrated Biological and Behavioral Surveillance</td>
</tr>
<tr>
<td>IDU</td>
<td>Injecting Drug User</td>
</tr>
<tr>
<td>ILGA</td>
<td>The International Lesbian, Gay Bisexual, Trans and Intersex Association</td>
</tr>
<tr>
<td>ISDS</td>
<td>The Institute for Social Development Studies</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MOLISA</td>
<td>Ministry of Labor, Invalids and Social Affairs</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have Sex with Men</td>
</tr>
<tr>
<td>MSMGF</td>
<td>The Global Forum on MSM and HIV</td>
</tr>
<tr>
<td>MSW</td>
<td>Male sex worker</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organisations</td>
</tr>
<tr>
<td>NIHE</td>
<td>National Institute of Hygiene and Epidemiology</td>
</tr>
<tr>
<td>PE</td>
<td>Peer educator</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>US President’s Emergency Plan for AIDS Relief</td>
</tr>
<tr>
<td>PLWH</td>
<td>People Living with HIV</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother to Child</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infections</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>The Joint United Nations Program on HIV/AIDS</td>
</tr>
<tr>
<td>USAID</td>
<td>US Agency for International Development</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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ABSTRACT

Background: HIV and same-sex among men exist in every society globally. In Vietnam, social stigma and prejudices trigger male sex workers (MSW) at high risk to HIV and STI transmission. Surveys and researches on MSW in Vietnam are rare. MSW is regarded as a bridge to HIV transmission and STI to their partners by their bisexual behavior.

Objective: The overall aims were to explore sexual risk behavior in addition to HIV knowledge and awareness among MSW in Ho Chi Minh City (HCMC), as well as to understand how cultural gender beliefs may influence sex risk behavior among MSW.

Methods and material: Data collection was between July and August 2009. Data from a baseline survey, consisting of mapping, quantitative and qualitative interviews were used. 200 MSW took part in questionnaires and 27 MSW in in-depth interviews on male sex work, HIV knowledge, sexual behavior and condom use, etc. The quantitative data were analyzed by SPSS and using descriptive analysis. Thematic analysis was used to analyze the in-depth interviews.

Results:
The median age of MSW was 25. 51% of MSW were from HCMC and about a half (48.7%) from other provinces. 62.5% reported drinking alcohol, 13.5% reported using ecstasy and 5.5% used heroin. 36% had unprotected anal intercourse (UAI) with all partners and 22% had UAI with male client partners. 90% reported they had ever known of STI. 46.5% reported ever had tested for HIV, and three were HIV positive. Older MSW (aged ≥25) had HIV test more than younger MSW (aged15-24), 64% and 35%, respectively. Low salary, family support and earning extra income were showed to be major reasons to be engaged in sex work. Trust to intimate partners, physical smell and negotiation skills affect safe or risky behavior. Most of MSW show good knowledge too HIV/STI transmission. Hegemonic masculinity is involved in risky sexual behavior among MSW as well. Special meeting venues or network for MSW were classified in various hierarchies of dichotomous areas: the young-the old, the rich-the poor, the national-the foreign, etc.

Conclusions: MSW in HCMC are a subgroup of MSM who are at very high risk for acquiring HIV and for transmitting it to their male and female partners. New and expanded projects are needed to focus on this high-risk population.

Key words: MSM, MSW, knowledge, attitude, HIV/STI, risk sexual behavior
1 INTRODUCTION

1.1 Background. HIV/AIDS and sex between men - globally and in Vietnam

There were 33.4 million of people living with HIV/AIDS (PLWA) in 2008 all over the world. Asia accounted for 4.7 million and 350,000 who became newly infected in 2008 [1]. Since the first detection of HIV case in Vietnam in 1990, the HIV prevalence in Vietnam in 2010 was 254,000 and is estimated to 280,000 in 2012 based on the medium scenario. In 2009, the AIDS cases rose from about 5,000 in 2000 to 16,000, a tripling rise compared to that 10 years ago [2].

Worldwide, it’s estimated that sex between men accounts for between 5 and 10% of HIV infections [3]. In the context of the global AIDS epidemic, same-sex among men becomes more crucial since it gets engaged with unprotected anal sex, which leads to higher risk for HIV transmission than unprotected vaginal sex. Globally, MSM are 19 times more likely to be infected with HIV than the general population in low and middle income nations [4]. However, only one in ten MSM all over the world has access to HIV-related services [5]. UNAIDS estimated same-sex between men might account for up to 10% of the total global infections. Men who have sex with men (MSM) is a term “that includes all men who engage in consensual male-male sex, including those who identify as gay, bisexual, or heterosexual, and including men who are sex workers. Some MSM have concurrent sexual relationships with both men and women” [6].

Studies in Asia suggest that 1% to 3% of the male population aged 15 and older has practiced same-sex behavior in the last year. Findings reveal that there is a rising number of HIV transmissions among MSM; however, there is a limited data on them, including male sex workers, in spite of some completed researches. Besides, data mainly focus on general MSM, not covering other MSM sub-populations such as transgender and male sex workers [7].

In East and South-east Asia, recent HIV prevalence in MSM ranged from the lowest (0.0% in Manila) to the highest (30.8% in Bangkok). HIV prevalence in Bangkok dramatically increased from 7.3% in 2003 to 30.8% in 2007. In other Eastern Asia cities, this figure is smaller, ranging from 2.9% in Tokyo to 5.8% in Beijing. In South Asia, Karnataka (India) is the area with the highest level of HIV prevalence (19.5%) compared to smallest one with only 0.2% in Dhaka (Bangladesh). In Australia, during 2003–2007, MSM accounted for 64% of newly diagnosed HIV infections. In Amsterdam, the Netherlands HIV incidence among MSM accessing to STD clinics was supposed to vary from 1.8% in 1998 to 3.8% during
1999-2005. In Northern European countries, the figure is lower with Sweden and Finland (0.1%) and Italy (0.4%) and Spain (0.5%), respectively. About 48.1% of MSM living with HIV of the total 1.1 million people in USA was reported by the US Centers for Disease Control and Prevention (CDC). The epidemiological data of HIV prevalence among MSM was also reported in Africa. There was 21.8% of MSM with positive HIV in Senegal in 2004 and 24.6% in Kenya in 2005. HIV surveillance in Egypt discovered 6.3% of MSM infected with HIV[8].

Promiscuity is one of the most prevalent sexual trends among MSM. This varies from many sorts of male and female sexual partners in diversified types such as regular, casual, and commercial (paid). The mean number of non-commercial male partners of MSM over one month was between from 1.7 to 13.9 in India (2006), 3.9 (one month) in Bangladesh. In Indonesia, the median number of male partners of MSM ranged from 2 to 10 (last month) while the high mean number of commercial male partners of MSM ranged from 3.6 to 25.2 (last 6 or 12 months) in India. Notably, a significant proportion of MSM in South-East Asia revealed having sex with female partners. It varied from 22.3% in Thailand (6 months) to 93.8% in Timor-Leste (12 months). One important note is inconsistent condom use with male partners during anal sex which is associated with HIV transmission of HIV/STI. In addition, condom use at last sex with casual female partners was 32% in Indonesia in 2007 [9].

Despite that fact that male-to-male sex is legal, MSM has neither been prioritized nor viewed as a part of HIV surveillance in national strategies in Vietnam. The prevalence of HIV among MSM was high during 2004-2006, ranging from 5.8% (in HCMC) to 9.4% (in Hanoi). Compared to Vietnam, most of Asian countries prioritize MSM in their HIV surveillance and prevention. The illustration below would present how settings had taken account on MSM-related issues.
Table 1. Epidemiology and legal environment to MSM in Asia

<table>
<thead>
<tr>
<th>No.</th>
<th>Province/City</th>
<th>Country</th>
<th>Year</th>
<th>HIV Pre. (%)</th>
<th>No. of MSM enrolled</th>
<th>Male-to-male sex legal</th>
<th>MSM prioritized for HIV pre.</th>
<th>MSM part of HIV surveillance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Hanoi</td>
<td>Vietnam</td>
<td>2006</td>
<td>9.4</td>
<td>397</td>
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<td>No</td>
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</tr>
<tr>
<td>2</td>
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<td>2005</td>
<td>0</td>
<td>295</td>
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<td>No</td>
<td>No</td>
</tr>
<tr>
<td>3</td>
<td>Ho Chi Minh</td>
<td>Vietnam</td>
<td>2000</td>
<td>5.8</td>
<td>208</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2004</td>
<td>7.8</td>
<td>600</td>
<td>Yes</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2006</td>
<td>5.3</td>
<td>397</td>
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<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>4</td>
<td>Phnom Penh</td>
<td>Cambodia</td>
<td>2005</td>
<td>8.7</td>
<td>299</td>
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<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>5</td>
<td>Vientiane</td>
<td>Laos</td>
<td>2007</td>
<td>5.4</td>
<td>540</td>
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<td>Yes</td>
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<td>6</td>
<td>Kuala Lumpur</td>
<td>Malaysia</td>
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<td>3.9</td>
<td>517</td>
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<td>7</td>
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<td>Thailand</td>
<td>2007</td>
<td>31</td>
<td>401</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td>8</td>
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<td>Indonesia</td>
<td>2002</td>
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<td>Yes</td>
<td>Yes</td>
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<td>9</td>
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<td>Myanmar</td>
<td>2007</td>
<td>24</td>
<td>200</td>
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<td>Yes</td>
<td>Yes</td>
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<td>2006</td>
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<tr>
<td>12</td>
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<td>Singapore</td>
<td>2008-09</td>
<td>3.2</td>
<td>960</td>
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<tr>
<td>13</td>
<td>Tokyo</td>
<td>Japan</td>
<td>2000</td>
<td>2.9</td>
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<td>Yes</td>
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<td>Yes</td>
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<td>Nepal</td>
<td>2007</td>
<td>3.3</td>
<td>265</td>
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<td>Yes</td>
<td>Yes</td>
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<td>16</td>
<td>Karnataka</td>
<td>India</td>
<td>2007</td>
<td>19.5</td>
<td>210</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Source: A review of the epidemiology of HIV infection and prevention responses among MSM in Asia (van Griensven et al., 2010) and UNAIDS data.

Like other countries in Asia-Pacific, there are some subgroups of MSM in Vietnam labeled as self-identified gay, bisexual, transgender, or heterosexual [10] & [11]. Many researchers agree to use two common labels to depict MSM in Vietnam: “bong kin” and “bong lo”. Indeed, bong kin (hidden MSM) refers to men who wear men’s clothing, showing a masculine appearance, being closed in everyday life and not really like to be identified as same-sex attracted men”. While bong lo (unhidden MSM) refers to men wearing female clothes, possessing a feminine appearance and presenting themselves as women. A survey of 600 MSM in HCMC disclosed that 79% identified themselves as bong kin, 13% as bong lô, and 9% as others who have sex with both men and women [12].

1.2 Attitudes towards men who have sex with men

Despite efforts and action plans to MSM, a myriad of socially hostile actions such as ridicule, harassment, violence, bullying, sex work and drug use towards this marginalized population lead to unfair stigma and discrimination, both perceived and internalized to them.
Even worse, a report entitled *Social Discrimination Against Men Who Have Sex With Men (MSM)* published in July 2010 by The Global Forum on MSM and HIV (MSMGF) revealed that 76 countries and entities in the world criminalize “same-sex acts between consenting adults, with penalties ranging from fines to imprisonment, and in seven nations, death”. More than 20 Asian countries where Islam is a predominant religion still have criminalized homosexuality even though a high prevalence of HIV has hit this continent compared to other regions worldwide. Israel and Taiwan issued anti-discrimination laws and only Israel recognizes same-sex union [13]. The detailed map in figure 1 clearly presented this current discrimination toward homosexuality worldwide.

*Figure 1. Lesbian and gay rights in the world*

![Figure 1](image.png)

In Vietnam, information on homosexuality was still limited and largely ignored by the society until 1990 [14]. Traditionally, homosexuality is not accepted as a normal lifestyle in Vietnamese culture and society. The invisibility of homosexual groups in Vietnam is probably explained by the Confucianism. The Chinese ideological system stated that a man will get married and have offspring while homosexuality is likely to be an obstacle to maintain the virtue of a man [15]. Even though Vietnamese legislation has not regarded
homosexuality as illegal explicitly, men who have sex with men are exposed to unfair prejudice and negative thoughts due to their sexual acts. As a result, they often attempt to hide their sexual identities [12].

In a national plan by Vietnam Ministry of Health in 1990, homosexual behavior was depicted as a “possible phenomenon like in most other countries, not appearing in formal meetings and other organized homosexual groups. Homosexuals were not listed as a significant factor in the spread of HIV/AIDS in Vietnam” [16]. A common belief about MSM spread by one of the most famous sexologists in Vietnam, Dr. Tran Bong Son was repeated in many articles and researches and implied that homosexuals in Vietnam just impermanent followed a Western fashion. He divided homosexuals in Vietnam into two types: true but rare in quantity and fake but more popular in size. His perspective implied homosexuality as an ebullience and imitation of some young people and that these “fake” homosexuals could go back to their heterosexual orientation. Though these perspectives were his personal opinions, much mass media and mainstream population accepted this despite lack of strong scientific researches or facts to confirm that [16]. In a study in 2005, Blanc noted that “Vietnamese society is very normative and based on a strict sexual dimorphism (female/male, yin/yang)”. That’s why homosexual men are really viewed as abnormal compared to traditional norms in Vietnam context.

In Vietnam, mass media have been presented much negative attitude against homosexuals. Even worse, homosexuals were labeled as “social evils” to be eradicated or to get re-educated in mind at detention and rehabilitation centers. For example, 30 men were sent to one of these rehabilitation centers because of their sexual acts at a massage parlor in November 2002. A popular newspaper named Thanh Nien (Youngsters’ Newspaper) said “this was a really abnormal and monstrous phenomenon and foreign to Vietnam cultural tradition” when hundreds of gays gather in a beach of Vung Tau, Southern Vietnam in 2004 [15]. The bias toward MSM was also depicted in a meta-analysis of total 2,077 published news on MSM issues conducted by Sarah during 2006-2009. In her study, she showed how MSM were unfairly viewed by Vietnamese printed newspapers. According to this study, there was a misrepresentation on MSM in Vietnam’s printed publications when they failed to define MSM but concluded that 1% of MSM population engaged inborn sex-related problems. Even though MSM is really one of the most-at risk populations in HIV/AIDS transmission in Vietnam, most of Vietnamese newsprints ignore this trend and showed unreasoned opinions on MSM. The majority of articles did not mention the existence and risk of men who sell sex to other men. Only 1.68% (35 out of 2,077) of articles on HIV/AIDS specifically mentioned MSM [17].
In Vietnam, a ceremony of homosexual wedding can really triggers a stir to the community. Internet information on a lesbian couple was spread in Hanoi late 2010 and followed by a gay couple in HCMC in June, 2011. In recent years, opener and more positive trends on homosexuality is capturing much public’s attention. The National Assembly deputy, Prof. Nguyen Minh Thuyet suggested that same-sex marriage should be accepted in Vietnam. This could lead to a possible change in the Law on Marriage, 2000. Indeed, two articles from this current law were against marriage of the homosexuals in Vietnam. Article 10, clause 5 prohibited the so-called same-sex marriage together with Article 8, clause 2 described getting married is “an act whereby a man and a woman establish the husband and wife relation according to the law provisions regarding conditions for getting married and marriage registration”.

1.3 Male sex workers and HIV risk

The vast majority of the literatures on commercial sex workers focus on female workers, whilst there are limited published reports on male sex workers who serve other male clients. In a study conducted in 1990 on 50 MSW aged 14-27 years old in New York City, Pleak and Meyer-Bahlberg discovered that these respondents frequently experienced condom use and avoided anal sex [18]. A high proportion used condom (85%) when engaged in anal sex. However, they had safest sex acts with their male customers, not with other male encounters and had least safe sex (i.e. unprotected) with female partners. Besides, in a San Francisco-based survey on 150 call men and hustlers in 1991, Waldorf and Lauderback [19] found that about three-quarters of the workers had used condoms in the last week. Condom use for anal sex among hustlers was reported less frequently. The rate of condom use with intimates was lower than that with customers for both two groups.

A study of male sex workers in three areas of Thailand was implemented in 1988 including Bangkok, Hat Yai, and Chiang Mai [20]. In these areas, MSW meet clients through gay bars, bath houses, and public locations. The findings indicated less than 50% in Chiang Mai engaged in anal sex, 71% in Bangkok and 86% in Hat Yai. Another survey by Sittitrai et al. in 1989 on 141 male bar workers in Bangkok showed that respondents had a large number of sexual contacts and more than 50% engaged in insertive and receptive anal sex without condoms [21]. These workers have had sex with multiple types of partners including male clients, non-client males, non-client females before the interview. With a proportion of 13% in sex acts among MSW with a variety of sex encounters, it really put an alarming rate of risk for HIV infection and potential spread among the mainstream populations.

Being a target population in action plans and programs funded by domestic and international organizations, female sex workers (FSW) received numerous concerns in
HIV/STI activities and interventions. There are numerous published reports about Vietnamese commercial female sex workers (CSWs) including risk behavior and HIV prevalence, VCT services and condom use [22],[23],[24], etc. On the contrary, there is a limited amount of data on male sex workers (MSW) in Vietnam. The reason derives from MSW who have been considered as social evils in government crackdown campaigns to be eradicated while male counterparts have not been focused and even ignored [16]. Besides, oriental cultures among Vietnamese people to homosexuality as a taboo remained unchanged, provoking social exclusions to MSM. Reports on population size, seroprevalence of MSM in general and MSW in particular in sentinel surveillance fuel barriers to address this vulnerable groups in programs and intervention nationwide.

In June 2011, at an implementation workshop on anti-prostitution 2011-2015, Minister of Ministry of Labor, Invalids and Social Affairs, Mrs. Nguyen Thi Kim Ngan officially voiced her proposal not to regard sex work as a social evil. Some sociology experts, law policy makers and activists agreed to the opinion that the entire society should be more tolerant of sex workers and sex work should be decriminalized. One unpublished report by Donn Colby confirmed that it was a lack of job chances and low salary from unskilled jobs that male sex workers engaged in their work [25].

Due to economic hardship, some MSM left their home for big cities such as Hanoi, Ho Chi Minh City (HCMC) or tourist cities to earn their living. Little salary and social inequalities may influenced MSM's choice to male sex work. Distinct sexual behavior and sexual orientation provoke an endless circle in labor market and that MSM choose sex work to pursuit their dream and desire which are different from other males.

Negotiation on condom use is becoming a concerned issue when most of MSW refuse to use a condom so as to satisfy their clients or from regular sexual partners. Due to this, MSM are likely to suffer from vulnerable risk behavior including HIV/STI. Moreover, MSW become a bridging factor to risk behavior with either i) married MSM clients and their wives or ii) married woman clients and their husbands.

Stigma and discrimination toward MSM and MSW comes from exaggerated fears of HIV infection, misperceptions about HIV transmission, and negative representations of PLHIV in the media [26]. Due to discrimination, MSW can be ignored, reluctant or denied to access of health care services. Stigma and discrimination catalyze PLWA hide their status, not to test for HIV/STI. This increased their infection toward their clients. Even worse, male sex workers are easily subjected to suffer a double stigma and discrimination because of their
HIV status and their sexual orientation.

Due to these reasons, less than ten previous surveys or researches on MSW have been found in Vietnam. One qualitative survey about male sex work by Doussantousse et al. [27] was conducted in Hanoi in 2002 which collected data of 15 male sex workers, clients, and intermediaries, ranging from 18 to and 25. Its findings indicated there were about 100 MSW in Hanoi; money was the most common reason accounting for their engagement in sex work. This survey revealed that one MSW had an average of 10 clients a week. The respondents also reported that half of their sexual encounters involved only masturbation and oral sex, but anal sex was also common. Vietnamese clients preferred not to use condoms: the majority seemed oblivious to the risk for STDS and HIV. The unavailability of suitable lubricants was also a major issue. A survey carried out by Donn Colby [28] in HCMC in 2001 collected information of 54 MSW among a sample of 219 MSM. It showed the median number of sexual encounters was five in one month (range = 1-70) and the median amount of time working as an MSW was 2 years. Averagely, each MSW received U.S.$7 or less per encounter. The finding from the survey showed a low consistent condom use for oral sex (15%) and anal sex (42%), respectively [16]. In 2005, another survey on MSW and injecting drug users done in Hanoi by Clatts et al. [29]. The mean age of sex workers is 22.8 years. Over half (n=45, 57%) reported continued and current male sex work during the last 30 days. They had more than three different sex partners in the past 30 days and approximately one-third (31.1%) reported having receptive anal sex. About 71.4% did not use a condom. All MSW ever used heroin, ever injected (68.4%). Smoking and injection are the most frequent mode of administration.

In 2005-2006, an integrated HIV/STI biological and behavioral surveillance (IBBS) was done among selected population groups in 7 provinces/cities in Vietnam including Hanoi, Quang Ninh, Hai Phong, Da Nang, Ho Chi Minh City, An Giang, and Can Tho [30]. This new survey utilized a community-based sampling to estimate the HIV prevalence and other STI aimed to obtain indicators of risk behaviors and intervention exposure among most-at-risk population groups. One notable key-point of this method was including MSM together with two traditional groups, female sex workers (FSWs) and injecting drug users (IDUs), respectively. There were total 3,547 FSWs and 2,032 IDUs in 7 provinces, and 790 MSM in two provinces recruited into the program. Behavioral and other data were collected through individual face-to-face interviews, while the prevalence of HIV and STI were selectively measured by blood, urine, and rectal swab samples. In 2009, another IBBS program continued to implement to get data of FSW and IDU in 10 provinces and 4 provinces to MSM [31]. A comparison of results key affected populations in two surveys of
2006 and 2009 is demonstrated in figure 2. The number of recruits from the 2009 IBBS has not officially been published.

**Figure 2.** Percentage of key affected populations that received an HIV test in 2006 and 2009

![Figure 2: Percentage of key affected populations that received an HIV test in 2006 and 2009](image)

Source: HIV and AIDS Hub for Asia-Pacific, 2011

This figure indicates that the percentage of MSM receiving HIV test in 2009 was 3% higher compared to that in 2006. That inferred MSM were well aware of the risks of their sexual risk behavior to themselves and to their partners. It’s likely to have had a positive impact from peer education which encouraged more MSM and its sub populations to seek for health services.
1.4 Rationale of the thesis

There is a lot of knowledge of MSM issues in since MSM become a concerned subgroup of most-at risk populations in HIV epidemic in Vietnam. However, stigma and discrimination toward MSM make them reluctant or denied to an access to health care services. Besides, double stigma and discrimination toward male sex workers (MSW) arises when they have to suffer from being both a MSM and a MSW. Also, MSW have multiple sex partners with other different types of sex partners. Despite vulnerabilities to this marginalized group, researches that specifically focus on MSW in Vietnam are very limited. There have been so far less than four surveys/studies on MSW in Vietnam, focusing on large cities such as Ho Chi Minh and Hanoi. No typical studies on MSW have been conducted in small cities such as Nha Trang, Da Nang, Hai Phong, Can Tho, etc. although MSM studies, interventions and programs are ongoing. MSW groups are embedded into larger MSM surveys since MSW topic are still sensitive to most of Vietnamese norms. The data used in this thesis were derived from the baseline survey specifically addressing 200 MSW in some targeted districts in Ho Chi Minh City.

1.5 The aim

1.5.1 The overall aim

The overall aims of this thesis are to explore sexual risk behavior in addition to HIV knowledge and awareness among MSW in HCMC, as well as to understand how cultural gender beliefs may influence sex risk behavior among MSW.

1.5.2 The specific objectives:

The specific objectives are:

1) To identify socio-demographic and social characteristics for MSW in HCMC.
2) To investigate the magnitude of sexual risk behavior among MSW.
3) To explore the level of awareness and knowledge about HIV risk among MSW.
4) To analyze how cultural beliefs about gender may influence sexual risk behavior among MSW in HCMC.
5) To come up with suggestions for reduction of sexual risk and promote HIV/AIDS interventions among MSW in the future.
2 THEORETICAL FRAMEWORK

2.1 Sexuality and gender

A definition on sexuality by WHO in 2002 stated sexuality as “a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors”. Thus, sex and sexual activity are regarded as indispensable aspects of human life.

Gender is an institutional system of social practices for constituting people as two significantly different categories, men and women, and organizing social relations of inequality on the basis of that difference [32]. In addition, Hirdman defined that gender is the organizing principle underlying other system. According to her, there is a distinct separation of almost all areas of life into male/female categories. Gender is perhaps one of the most crucial factors contributing to vulnerability to HIV/AIDS and its impact [33].

The first thing is to conceptualize different notions of the term “men’, ‘male’ and ‘masculinity’ relating to gender. ‘Men’ links closely to biological sex and ‘male’ describes the traits, characteristics and attributes typically shared by ‘men’ within a given culture, while ‘masculinity’ is far more complex. It is, “simultaneously, a place in gender relations; the practices through which men and women engage that in gender; and the effects of these practices for bodily experience, personality and culture” [34].

Gender underpins most of the epidemiological models we use in describing HIV/AIDS. It is loosely used to describe the epidemics in Asia [35]. In a male-dominated world, it means that women are placed in the situation of heightened vulnerability to infection [33]. The World AIDS Campaigns (WAC) coordinated by UNAIDS adopted a theme which indicated men in two years in a row. Under the theme ‘Men Make a Difference’ and ‘I Care – Do You?’, UNAIDS really prioritizes that men become the main factors to promote awareness, consideration and motivation in the fight against HIV/AIDS.

In terms of gender issues and its interaction with male sex workers, there are some key concepts listed here as a manifestation to understand further how gender operates in the male sex work context [36]&[37].

- **Homosexual or Same-sex sexual behavior**: Sexual acts between people of the same sex.
- **Sexual Orientation**: an enduring pattern of emotional, romantic, and/or sexual attractions...
to men, women, or both sexes. Frequently, sexual orientation is discussed in terms of three categories: heterosexual (having emotional, romantic, or sexual attractions to members of the other sex), gay/lesbian (having emotional, romantic, or sexual attractions to members of one’s own sex), and bisexual (having emotional, romantic, or sexual attractions to both men and women)

- **Sexual behavior**: manners or activities including but not limited to caressing, masturbation, touching, kissing, and intercourse with an aim to express and enjoy sex.
- **Gender identity**: Gender identity refers to a person’s basic sense of being male, female, or transgender and may or may not be the same as one’s assigned gender at birth. Gender identity is how we feel about and express our gender.
- **Social gender role**: the cultural norms that define feminine and masculine behavior

Here, men who have sex with men imply sexual behaviors between people of different sexual orientations and identities, consisting of male homosexuals/ gays, heterosexual men and transgender. The figure 3 below shows an interlacing relationship in sexual behavior between homosexual men with other sexual partners.

**Figure 3.** Interaction on sexual encounters between homosexual men and other groups

Source: *Understanding and reducing stigma related to MSM and HIV, ISDS, Hanoi, 2010*

### 2.2 Masculinities

Masculinities are configurations of social practices produced not only in relation to femininities but also in relation to another. Hegemony is regarded as “winning and holding
Hegemonic masculinity is defined by Connell [39] as the idealized form of masculinity at a given place and time. It is the socially dominant gender construction that subordinates femininities as well as other forms of masculinity, and reflects and shapes men's social relationships with women and other men; it represents power and authority [40]. There are three reasons why homosexuality can be viewed as counter-hegemonic: (1) hostility to homosexuality as a necessary component to male heterosexuality; (2) homosexuality is related to effeminacy; and (3) homosexual pleasure is itself destructive and controversial. Not surprisingly, therefore; heterosexuality and homophobia are the main principle of hegemonic masculinity and any surrounding understanding by nature [38].

Within any given culture or society, there are dominant and more subordinate forms of masculinity. Class, race and sexuality (among other variables) interact with gender so that not all masculinities are equal. If we consider the meaning of gender, it is important to review both relation between men and women, and between men and other men [21].

Dominant masculinities subordinate lower status, marginalized such as those of gay, rural or lower men. As Courtenay said “Gay and bisexual men may also adopt culturally sanctioned belief about masculinity to compensate for their subordinated and less privileged social position. The endorsement of hypermasculine beliefs can be understood as a means for gay and bisexual men to prove to others that, despite their sexual preferences, they are still “real” men [40].

### 2.3 Gendered health risk behavior

Unlike women, men are less likely to seek health care than women are, and they are more likely to engage in behaviors – such as drinking, using illegal substances, smoking or driving recklessly – that put their health at risk [33]. Once having unprotected sex with males, MSW is engaged in risk behavior accompanied with increasing vulnerability to HIV/STI. Seen from gender-based perspectives, hegemonic masculinity among MSW may lead them to vulnerable behavior such as refusal to use a condom or other safe sex practice. Some think they work as MSW, if getting HIV it is one way to drop off their life. Others wrongly believe that physically strong and healthy clients could not be infected with HIV. Cultural norms, social marginalization, stigma and discrimination to MSM, making them possess negative beliefs that can also expose to unprotected life. Moreover, concealment of their homosexuality among male sex workers is found to have adverse impact on physical and mental health [41].
2.4 Stigma, shame and homophobia

Oriental culture in Vietnam characterized social taboos on sex between MSM. The emergence of HIV/AIDS has associated homophobia and stigmas associated with homosexuality [41].

Stigma is typically a social process, experienced or anticipated, characterized by exclusion, rejection, blame or devaluation that results from experience, perception or reasonable anticipation of an adverse social judgement about a person or group [42]. Stigma consists of two popular categories: (1) felt stigma depicted as an internalized fear, difference, status or a condition that could be discovered by others; and (2) enacted stigma viewed as instances of discrimination against people since they are defined as different [21]. A MSW that possesses shame and suffers from spiritual miseries and hates himself as a MSW experiences felt stigma. Still, he has to encounter enacted stigma which is associated with actions and responses from surrounding people to the stigmatized people. It goes without saying that increased vulnerability to HIV is fueled by stigma from interdisciplinary consequences. Stigma itself is not naturally formulated; it is characterized from previous cultural, moral and religious prejudices.

Together with stigma, shame is a common emotion in most male sex worker. Indeed, shame is a painful feeling about oneself as a person, caused by the perception of negative evaluations of the self [43]. According to Bowles [44], guilt is a painful feeling of regret and responsibility for one’s actions, i.e. doing wrong. On the contrary, shame is a painful feeling caused by the feeling of “being wrong”. To MSW, the shame of their socially-lowered job will be accompanied with guilty expressions in the prism of social norms.

The term homophobia was coined a clinical psychologist George Weinberg in 1960s and was popularized in his book Society and the Healthy Homosexual in 1972. He defined it as a “dread of being in close quarters with homosexuals”. To some extent, homophobia could be conceived as a social illness acting as a social norm [45].

Peter Piot, former director of UNAIDS labeled homophobia as “one of the top five barriers to ending this epidemic, worldwide. The fight against the epidemic is entering a new phase, and if governments and NGOs and international organizations like my own do not take up the fight for gay rights, and the rights of all people with diverse sexuality, we will not end AIDS.” [46]. Impact from homophobia was a really great barrier which hampers disclosure of sexual and other health-related behaviors in health settings [47]. Homophobia could be viewed as two sub-terms. The first is exogenous homophobia which was called by
Malyon in 1982 as the hostility that heterosexuals aim at homosexuals. The second was known as internalized homophobia, which is further characterized by an intrapsychic conflict between experiences of same sex affection or desire and feeling a need to be heterosexual [48]. Figure 4 shows the relationship between HIV and homophobia.

**Figure 4.** Linkages between homophobia and HIV risk

Source: *Engaging with men who have sex with men clinical settings, MSMGF, 2011*
3 METHODOLOGY

3.1 Study context

Covering an area of about 2,095 km² with a population of about 7,382,287 people, Ho Chi Minh City (HCMC) is the biggest and the most populated city in Southern Vietnam. HCMC is also known as the largest economic and financial hub of Vietnam, attracting more and more immigrants from other Vietnamese provinces in recent years. There was a gross domestic product (GDP) grow rate about 10% and GDP per capita was more than 2000 USD in 2008 [49].

Figure 5. Map of Ho Chi Minh City

3.1.1 HIV situation in Ho Chi Minh City (HCMC)

HCMC had the highest HIV prevalence in Vietnam with 41,193 cases of the total HIV infections nationwide (160,019 cases) [50]. The number of people living with HIV in HCMC was expected to rise from 72,400 in 2006 to 89,900 in 2010 and 105,800 in 2015. In 2006, there would be about 4,800 new AIDS cases in HCMC, an estimated 7,700 new cases in 2010. The figure will comply with the growing 10,000 ART cases by 2020. Clearly, this will lead to a critical burden to care and treatment services and large impacts on life quality promotion of PLWA and their affected family.

Based on international and regional evidence and sexual behavior surveys in Vietnam, the number of MSM including MSW in HCMC is estimated to 36,000, representing approximately 2% of the adult male population in HCMC. This demonstrates MSM in the populations who regularly have sex with other men. If we calculate the number of MSM who
have ever had sex with other men, we always find it hard to estimate exactly since this would be a far larger population. Other surveys indicated that a high percentage of MSM engage in sex work: 22-40% of MSM reported exchanging sex for money in 4 surveys conducted in 3 cities across Vietnam [51]. Since 2001, the number of MSM with HIV prevalence in HCMC continue its increasing trend and always tripling the national level (ranging from 1.2%-2% till 2012) during 10 years [52]. The figure 6 will present how HIV prevalence among MSM in HCMC and some other cities in Vietnam.

**Figure 6.** HIV prevalence among MSM in Vietnam by regions

![HIV prevalence chart](image)

*Source: The HIV/AIDS epidemic in HCMC by A² Analysis and Advocacy*

The finding of 2005-06 IBBS revealed the proportion of HCMC-based MSM who have tested for HIV for the previous 12 months and knowing their result was about 3 times lower than that in Hanoi-based MSM (see Figure 7).

The percentage of anal sex among MSM in HCMC is high, especially among MSW (35%) (see Figure 7). Notably, a high proportion was found among MSM had anal sex with consensual male partners (61.7%). Other findings from IBS survey 2005-2006 disclosed that drug use (21%) among MSW in HCMC was 7 times higher than injecting drug (3.8%). Although using a condom in anal sex with male sexual partners (more than 54%), the figure among MSM in HCMC with MSW was 49%, showing risk behavior among MSW should link to more safe sex programs and intervention. Besides, MSW in HCM had sex with FSW (28%) while non-commercial MSM with FSW accounted for 6%.
Figure 7. Prevalence of anal sex among both commercial/non-commercial sex partners

Source: Result of IBBS 2006 by Ministry of Health

3.1.2 Study area
The study was conducted initially in 4 districts in HCMC, including Binh Thanh District, District 1, District 5 and District 8. Later, three additional districts (District Binh Tan, District 3 and District 4) were added to reach a more diversified network of MSW and to avoid actual overlap with other current HIV intervention activities to MSM in the whole project implementation.

3.2 Study design
The study was carried out in some targeted districts in HCMC, Vietnam between July and August 2009. It was a baseline survey which collected information of MSW via mapping, qualitative in-depth interviews as well as quantitative questionnaire. The survey was developed by the cooperation between two implementing organizations including Havard Medical School AIDS Initiative in Vietnam (HAIVN) and Centre for Promotion of Quality of Life. I received a written permission for utilizing the data from both leaders of these institutions; Donn Colby and Ms. Nguyen Nhu Trang.

3.2.1 Mapping:
As a first phase of the study, a mapping was performed to estimate the size, and frequency of activities of MSW via the project-oriented geographic areas.

3.2.2 Qualitative Interviews:
In-depth qualitative interviews were conducted to get detailed information of
respondents in sex work, sexual risk behaviors. These were helpful to get more information about gender-related issues such as gender, sex work, and masculinity in a HIV context.

3.2.3. **Quantitative questionnaire:**

The questionnaire was aimed to give a descriptive snapshot of MSW life via participants, and covered demographics, sexual orientation, drug use, sexual behavior, condom use, sex work experience, knowledge about HIV/AIDS, HIV testing, and exposure to HIV prevention activities.

3.3 **Study population**

The target population of the study was MSW in the selected districts in HCMC in order to develop tailor-made interventions in accordance with national strategies of preventing HIV among MSM in Vietnam context.

3.4 **Sampling procedure and sample size**

First of all, mapping, i.e. a list of venues as workplace among MSW was set up by the project staff. After that, these staff ought to get to each location to outreach and quantify the size of potential MSW at various time and weekdays or in weekends.

The sampling was probability, using time-location sampling. Thanks to a mapping of all sites having MSW in the central district of HCMC previously conducted, then the peer educators (PE) went to each site to count number of MSW. Since then, researchers decided on a sample size for each location based on the proportion of the total MSW who were at that site. The sample size was based on feasibility and logistics. The study was descriptive, so there was no hypothesis or intervention, the researchers tried to get a big enough sample size (i.e. 200 MSW) to describe the population within the resources available for the study.

All the subjects were given a written information sheet about the research and then had to verbally agree to participate since the survey was anonymous. If they had to sign, their name and signature would be exposed; thus, the survey would not be anonymous. Therefore, verbal consent was given in order to maintain anonymity without collecting any names or other identifying information. During the survey, the subjects were given condoms, lubricant and HIV prevention brochures. If patients had any symptoms or other problems they could be referred to places where free treatment was available.

In-depth interviews were done upon completing the mapping and decision of selecting sample size. There were total 27 MSW recruited by peer educators from the
program at 5 districts in HCMC to join the qualitative in-depth interviews. Inclusion criteria for participation were biological male, aged 15 years old and over, having a sex work history to clients at least once in the last month. Table 2 shows a distribution of qualitative interview.

**Table 2. Distribution of in-depth interviews by districts**

<table>
<thead>
<tr>
<th>District</th>
<th>Number of district</th>
<th>Number of case</th>
</tr>
</thead>
<tbody>
<tr>
<td>Binh Thanh</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>Tan Binh</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>27</td>
</tr>
</tbody>
</table>

The final phase of the sampling consisted of the distribution of a quantitative questionnaire. A total 200 MSW were recruited from the community from the 7 selected districts in HCMC to complete a questionnaire survey. Upon agreeing, these MSW would be offered to a nearby location to finish a paper-based questionnaire. All their confidential information would be coded and ensured for research purposes. The distribution of MSW questionnaires is listed below.

**Table 3. Distribution of 200 questionnaires by districts**

<table>
<thead>
<tr>
<th>District</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>District 1</td>
<td>45</td>
</tr>
<tr>
<td>District 3</td>
<td>14</td>
</tr>
<tr>
<td>District 4</td>
<td>14</td>
</tr>
<tr>
<td>District 5</td>
<td>39</td>
</tr>
<tr>
<td>District 8</td>
<td>38</td>
</tr>
<tr>
<td>District Tan Binh</td>
<td>10</td>
</tr>
<tr>
<td>District Binh Thanh</td>
<td>40</td>
</tr>
<tr>
<td>Total</td>
<td>200</td>
</tr>
</tbody>
</table>

Inclusion criteria for the survey were the same as with in-depth interview. Sampling of MSW was stratified by district and by type of sex worker. Based on the mapping and qualitative interviews, MSW were classified into four types: street/park based, sauna/massage based, callboy, and café/disco.

Six staff were in charge of approaching potential subjects in the field and asked them to participate in the survey. If the subjects agreed, they were taken to a nearby location to complete a written questionnaire keeping a respondent’s confidential information. An
allowance of 40,000 Vietnam dong (about 2 US$) was granted to any respondent for participation.

3.5 Study period
The data collection was performed between July and August, 2009.

3.6 Data collection
First, a team of staff from The Life Center were appointed to complete a mapping by arriving to each location to outreach and quantify the size of potential MSM at various times and weekdays or in weekends. Data on frequency, specific time and days; types and activities of MSW were observed and documented into the mapping. Furthermore, extra conversations and discussions among staff and MSW were done to get more additional new locations and hot spots for formulating a comprehensive map of MSM activities in each targeted district.

Followed by the mapping was conducting qualitative interview. Two well-trained Life Center interviewers were responsible of guiding twenty-seven MSW from five districts in HCMC to complete in-depth interviews. A guide for in-depth interview was used as assistance for participants in collecting the qualitative data. It was developed by conducting a thorough literature review and gathering input data from respondents-MSW and MSM to ensure cultural relevance of survey instrument. The guide, which was designed to get more detailed chronology and informative stories relating to participants’ sexual behavior and sex work, consisted of three sections. Section I &II aimed to obtain general data on family background, health condition and income resources among respondents. Section III focused on first sex acts, types, orientation and relations around sexual practices. Beside information on sex work, networks, safe sex, risk behaviors and HIV/STI perspectives was discussed in the interviews.

A pleasant and open context is always ensured for case-sensitive between the interviewer and respondents during the interview. Therefore, all interviews were confidentially conducted in a private location so as not to disclose the participants’ information. Major interview information included introduction to sex work, reasons for sex work, risky behavior to HIV/STI, etc. Although no interviews were recorded, the interviewer took extensive notes on the information provided by the informant.

The final step of data collection was the distribution of 200 questionnaires. Six study staff worked as assistants to guide 200 MSW in the community in filling in the questionnaire forms after receiving their informed consent. The questionnaire contained about 95
questions and consisted on three sections. Section I basically stated background information such as age, sex and type of respondents. Section II depicted collected general socio-demographic characteristics among MSW including place of residence, educational level, religion and ethnicity. Section III paid attention to specific details on history of sexual behaviors and practices, frequency of condom/lubricant using, knowledge of HIV/STI and social activity interaction.

3.7 Data analysis

3.7.1 Quantitative data

The quantitative data were computerized with software SPSS (Statistical Package for the Social Science, IBM), version 19. Variables were analyzed via descriptive command into the program. Descriptive statistics in the form of frequencies, percentages and cross-tabs were generated to analyze the data. Frequencies are the most common command to process the data. Combined with Excel tool, variables such as socio-demographics of MSW were processed to fulfill the aims and specific objectives of the thesis.

3.7.2 Qualitative data

Thematic analysis was chosen for analyzing the qualitative interviews, since it is “a method for identifying, analyzing and reporting patterns (themes) within data identifying, analyzing and reporting patterns (themes) within data” [53]. Easily explained, once data is analyzed by theme, it is called thematic analysis. One special thing from this type of analysis is highly inductive, which means the themes emerge from the data and are not imposed upon it by the researcher [54]. Besides, its simple structure make researchers do not take care so much on complicated processes such as grounded theory as “it minimally organizes and describes your data set in (rich) detail. However, frequently it goes further than this, and interprets various aspects of the research topic”. Compared to other qualitative approaches (e.g., narrative analysis, grounded theory, ethnographic research), thematic analysis is reviewed as “a very poorly branded method” [53]. Aronso, 1994 reflected in his essay that “there is insufficient literature that outlines the pragmatic process of thematic analysis”.

One of the key concepts in thematic analysis is theme. A theme is defined into different expression by many authors. A definition by Braun that “A theme captures something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set”. Themes are considered as units derived from patterns such as "conversation topics, vocabulary, recurring activities, meanings, feelings, or folk sayings and proverbs" [55]. Another definition of theme is “bringing together components or fragments of ideas or experiences, which often are
meaningless when viewed alone” [56]. The description of thematic analysis used for analyzing data of qualitative in-depth interview is presented below.

I followed the steps described by Braun [53] to process the data, despite the fact that I neither collected the raw data nor transcribed the data. Upon receiving the raw data, I had to read them, re-read to see of there any important things to take notes any ideas for further steps or analysis. Second, I pictured out an initial list of ideas within the data and consisted of making preliminary coding which organized data into meaningful groups [57]. In a study by Boyatz in 1998, he emphasized coded data is different from theme (units of analysis). Coding will based on the type of themes [58]. Here, I chose data-driven approach for coding text into meaningful groups as described by Tuckett [57]. Thereafter, I categorized a list of groups of codes into themes which were labeled as main and sub-themes. Then, I reviewed to check if sub themes could be “related” to make new themes. Finally, I decided to make a refinement of all themes to discover coherent patterns. An example of the process from moving from text to coding, making theme, choosing sub and main themes is shown in Figure 8.

**Figure 8.** Illustration of analyzing process from text to theme

<table>
<thead>
<tr>
<th>Text from dataset</th>
<th>Coding</th>
<th>Sub-theme</th>
<th>Main theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I went from a countryside area 3 months ago. I worked as a waiter but my wages was so low that I could not support my family...”</td>
<td>Low salary to support family</td>
<td>Enforced by living conditions</td>
<td>Reasons to engage in sex work</td>
</tr>
<tr>
<td>“My main work was a callboy with 6 million VND a month. I had another extra work as a hair dresser with 2 million VND a month”</td>
<td>Seek for another job</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“...When my lover went abroad, I felt depressed. I liked to have same-sex with men and then I joined sex work after that”</td>
<td>Sadness from love</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“...I liked this work, my family knew that and forced me to get rid of but I refused”</td>
<td>Pleasant to job under family forbiddance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3.8 Ethical considerations

The study was done as a baseline needs assessment for the MSW population before implementing the HIV prevention intervention. In addition, all participants gave verbal informed consent before completing the questionnaire and all data collection was confidential. The assessment which has been verified by the director of the Life Center, Ms. Nguyen Nhu Trang, was carried out in accordance with the principles of the Declaration of Helsinki of World Medical Association. In addition, I received a written ethical approval for utilizing the data from both leaders of these institutions; Donn Colby and Ms. Nguyen Nhu Trang.

3.9 Methodological considerations and limitations

As mentioned above, I did not collect the data myself. I used secondary data with an approval from the head of the two organizations whose survey was conducted. This can be seen a limitation, especially when analyzing qualitative data, where the researcher him/herself is the human research instrument for receiving valid and reliable data [21]. That’s why it was not likely to result in a perfect qualitative analysis. The interview guide did not cover specific questions relating to the diversity of stigma and discrimination connected to the life of MSW. Moreover, limited data on felt and enacted stigma to MSW during their sex work hinder a comprehensive understanding of male sex work in HCMC settings.

However, since I used to work in HIV/AIDS field and was in charge of MSM-related projects and activities for over 6 years in Vietnam, I was very familiar with the field. This means that I had previous experiences of meeting with MSM and MSW, which I could use for estimating the quality of the interviews, as well as in my interpretation and analyses of the qualitative data.

Since interview data consisted of interview notes and no transcripts of full interviews were available, they really limited the ways in which the qualitative data could be analyzed. However, the interview notes were extensive enough for a thematic analysis, which proved to be a suitable method for analyzing the qualitative interviews.

Although 200 MSW took part in the questionnaire survey, there is not a 100% response rate due to partial non-responses in some questions. However, this is low, i.e. less than 3%.

Another limitation cited here is enhancing evaluation of trustworthiness. Therefore, researchers tried their interaction with participants to make them comfortable and created a
trust to researchers. Confidentiality in personal data and interviewing in private places, comparing finding with results from other studies as ways of triangulation were also contributory factors in evaluating thesis result.

The sampling of 200 MSW in quantitative survey and 27 MSW in qualitative interviews which was done in 7 of 24 districts in HCMC could not be representative to overall MSW in HCMC.

There was a low HIV proportion reported since HIV testing is not inclusive into the survey. Therefore, it relied on respondent’s self-reporting of HIV status and it exposed that HIV prevalence is lower than the true prevalence in the population of MSW in HCMC. However, the prevalence rate of 5.6% reported by the MSW in the survey is similar to the prevalence rates of 5.3-8.0% which had been found in other recent research projects with MSM in HCMC. Although no previous reports of HIV prevalence among MSW in Vietnam have been officially published, it is certainly expected that MSW should have a higher risk for HIV infection than other MSM in HCMC.
4 RESULTS

The result section of the thesis consists of two parts: quantitative and qualitative results. The first part report results from data of 200 questionnaires while the second part reports the results from the 27 in-depth interviews. All analyzed data will supply necessary information to learn more about MSW life and their risky behavior in HCMC context.

4.1 Survey results

Information on demographic characteristics, general sex work, and sexual behavior as well perception on HIV/STI among MSW are described below.

4.1.1 Socio-demographic characteristics

a. A snap-shot of MSW in HCMC

The results of demographic data are demonstrated in Table 4. The median age was 25. There was a little variation among MSW origin when 51% of them were from HCMC and about a half (48.7%) from other provinces. MSW from other provinces had lived in HCMC for a median of 5.5 years. Almost all of the MSW reported Kinh ethnicity (93.5%). Other ethnic groups accounted for a very little (6.5%). Most of MSW are Buddhists (77%), the other are Christians (13%) and other religions (10%), respectively. About a half of MSW identified as homosexual (47%), slightly more than a half reported as bisexual and only 2 MSM (1%) identified as heterosexual. The median age when the MSW recognized their sexual orientation was 18. Almost of MSW were single (93%) while 1.5% of the rest reported other marital status including divorce, widow or other cases. Only one MSW knew that he was homosexual at the age of 6. The highest proportion of knowing their sexual orientation was at the age of 18 (22.4%) while the low proportion of knowing their homosexuality is found after the age of 22, ranging from 0.5%-8.5%. Although the majority of MSW (62.5%) reported drinking alcohol, only 11 (5.5%) reported daily use. The most common illicit drugs used were ecstasy reported by 13.5% and heroin (5.5%). Ecstasy use was found among MSW with 27 cases, accounting for 13.5%.
### Table 4. Demographic information on male sex workers in HCMC

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>n</th>
<th>Proportion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-24</td>
<td>91</td>
<td>45.5</td>
</tr>
<tr>
<td>&gt;25</td>
<td>109</td>
<td>54.5</td>
</tr>
<tr>
<td><strong>Home</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCMC</td>
<td>102</td>
<td>51.0</td>
</tr>
<tr>
<td>Other provinces</td>
<td>97</td>
<td>48.5</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Buddhism</td>
<td>153</td>
<td>76.5</td>
</tr>
<tr>
<td>Christianity/Protestantism</td>
<td>20</td>
<td>10.0</td>
</tr>
<tr>
<td>Other, none</td>
<td>26</td>
<td>13.0</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kinh</td>
<td>186</td>
<td>93.5</td>
</tr>
<tr>
<td>Other</td>
<td>13</td>
<td>6.5</td>
</tr>
<tr>
<td><strong>Sexual orientation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homosexual</td>
<td>93</td>
<td>47.0</td>
</tr>
<tr>
<td>Heterosexual</td>
<td>2</td>
<td>1.0</td>
</tr>
<tr>
<td>Bisexual</td>
<td>103</td>
<td>51.5</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>186</td>
<td>93</td>
</tr>
<tr>
<td>Married</td>
<td>10</td>
<td>5.0</td>
</tr>
<tr>
<td>Divorced/Widowed/Other</td>
<td>3</td>
<td>1.5</td>
</tr>
<tr>
<td><strong>Children</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>13</td>
<td>6.5</td>
</tr>
<tr>
<td>No</td>
<td>186</td>
<td>93</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illiterate</td>
<td>7</td>
<td>3.5</td>
</tr>
<tr>
<td>Primary School</td>
<td>38</td>
<td>19.0</td>
</tr>
<tr>
<td>Secondary school</td>
<td>66</td>
<td>33.0</td>
</tr>
<tr>
<td>High School</td>
<td>70</td>
<td>35.0</td>
</tr>
<tr>
<td>University and above</td>
<td>19</td>
<td>9.5</td>
</tr>
<tr>
<td><strong>Ecstasy use during 12 months</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>27</td>
<td>13.5</td>
</tr>
<tr>
<td><strong>Injecting drug</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>11</td>
<td>5.5</td>
</tr>
<tr>
<td><strong>Alcohol use (last month)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Everyday</td>
<td>11</td>
<td>5.5</td>
</tr>
<tr>
<td>Every week</td>
<td>54</td>
<td>27.0</td>
</tr>
<tr>
<td>At least 1/week</td>
<td>60</td>
<td>30.0</td>
</tr>
<tr>
<td>None</td>
<td>75</td>
<td>37.5</td>
</tr>
</tbody>
</table>
b. Views on sex work

As shown in Table 5, the age when first engaged in sex work is still young between from 10 to 18 year old. The age from 25 and above just accounted for 4.5% while the age from 10-18 was much more than (33%). Job unavailability and income need could possible account for this variation. 66% of MSW had been engaged in sex work between 0-5 years with the mean number of 3 years. About a half of MSW received VND 100,000-199,999 [#US 2.5-5] for every sex act. The most prevailing way in getting clients included phone contact (57%), in street/park, bar/disco (35.5%) and private house (35.5%). 93 MSW (46.5%) reported they have ever tested for HIV while 51% reported no testing. Internalized homophobia in combination to social stigma and discrimination toward MSW could result in the low HIV test proportion. Only 5% of MSW reported having sex work at hotel or at guest-house. More than a half (57%) of MSW had number of male clients from 1 to 10 people while only 11.5% had from 12-20 clients.

Table 5. Characteristics of sex work in HCMC

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>n</th>
<th>Proportion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First age of experiencing sex work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10-18</td>
<td>66</td>
<td>33</td>
</tr>
<tr>
<td>19-25</td>
<td>113</td>
<td>56.5</td>
</tr>
<tr>
<td>&gt;25</td>
<td>9</td>
<td>4.5</td>
</tr>
<tr>
<td>Years of sex work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-5 years</td>
<td>133</td>
<td>66</td>
</tr>
<tr>
<td>6-10 years</td>
<td>36</td>
<td>18</td>
</tr>
<tr>
<td>&gt;10 years</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>Payment in sex work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 50,000 VND [#US 2.5]</td>
<td>15</td>
<td>7.5</td>
</tr>
<tr>
<td>50,000 VND-99,000 VND [#$2.5-$5]</td>
<td>32</td>
<td>16.0</td>
</tr>
<tr>
<td>100,000-199,000 VND [#$5-$10]</td>
<td>91</td>
<td>45.5</td>
</tr>
<tr>
<td>&gt;200,000 VND [#&gt;$10]</td>
<td>57</td>
<td>28.5</td>
</tr>
<tr>
<td>Places meeting clients ( Frequency)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>City street/park</td>
<td>103</td>
<td>51.5</td>
</tr>
<tr>
<td>Massage/sauna parlor</td>
<td>54</td>
<td>27</td>
</tr>
<tr>
<td>Phone contact</td>
<td>115</td>
<td>57.5</td>
</tr>
<tr>
<td>Food shop</td>
<td>47</td>
<td>23.5</td>
</tr>
<tr>
<td>Bar/disco</td>
<td>71</td>
<td>35.5</td>
</tr>
</tbody>
</table>
Private house  70  35  
Other/No remembering  51  25  

Ever have HIV test

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>93</td>
<td>107</td>
</tr>
<tr>
<td>%</td>
<td>46.5</td>
<td>53.5</td>
</tr>
</tbody>
</table>

No. of male clients last month

<table>
<thead>
<tr>
<th></th>
<th>1-10</th>
<th>12-20</th>
<th>&gt;20</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>114</td>
<td>23</td>
<td>4</td>
</tr>
<tr>
<td>%</td>
<td>57</td>
<td>11.5</td>
<td>38.5</td>
</tr>
</tbody>
</table>

* 1 US = approximately 20,000 VND

4.1.2 Sexual behavior

Even though 52.5% of MSW identified their sexual orientation as bisexual or heterosexual, only 38.5% of total participants reported having sex with female partners. Clearly, the percentage of having sex with male partners was significantly more likely than that with female partners (see Table 6). Oral sex (90.5%) was the most common type of sexual behavior with other men, approximately two-thirds more than compared to reported vaginal sex. Over a half of MSW (51%) reported having anal sex with male partners.

Table 6. Number and proportion of MSW reported different kinds of sexual activities

<table>
<thead>
<tr>
<th>Type</th>
<th>Type of sexual activity</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Female vaginal</td>
<td></td>
<td>77</td>
<td>38.5</td>
</tr>
<tr>
<td>Male oral</td>
<td></td>
<td>181</td>
<td>90.5</td>
</tr>
<tr>
<td>Male anal</td>
<td></td>
<td>102</td>
<td>51</td>
</tr>
</tbody>
</table>

Table 7 shows a proportion of unprotected sex practices (i.e. without condom use) among MSW during the past month. About a half of MSW (42.5%) got engaged in unprotected sex with any sex partner, both vaginal and anal sex during the past month. Specially, more than a third (36%) practiced unprotected anal intercourse (UAI). These figures showed a diversity of sexual acts in the interaction with the sexual partners among MSW in HCMC, raising risky behavior to their partners in HIV/STI transmission.
Table 7. Number and proportion of MSW reporting having had unprotected sex during last month

<table>
<thead>
<tr>
<th>Type of sex</th>
<th>Unprotected sex</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Any sex</td>
<td>85</td>
<td>42.5</td>
<td></td>
</tr>
<tr>
<td>Anal</td>
<td>72</td>
<td>36</td>
<td></td>
</tr>
</tbody>
</table>

4.1.3 Level of awareness and knowledge of HIV/STI

a. Knowledge of HIV/AIDS

Most of respondents gave correct answers to HIV modes of transmission (more than 90%). Also, 96% agreed on using a condom in anal sex to prevent from HIV. Nevertheless, about 10% of MSW believed that HIV could be infected via sharing food with an infected person and 13.6% mistakenly thought that mosquito bites was the cause for a HIV transmission. Moreover, 23.2% did not ever know an HIV infected person could look healthy on the outside. Only 121 MSW (60.5%) answered correctly all five questions.

Table 8. Knowledge about HIV/AIDS

<table>
<thead>
<tr>
<th>No.</th>
<th>Questions</th>
<th>correctly answered (n)</th>
<th>correctly answered (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Can a person prevent HIV infection by having sex with only one uninfected partner?</td>
<td>183</td>
<td>91.5</td>
</tr>
<tr>
<td>2</td>
<td>Can we prevent HIV infection by always using a condom correctly for anal sex?</td>
<td>191</td>
<td>95.5</td>
</tr>
<tr>
<td>3</td>
<td>Can a person become infected with HIV from a mosquito bite?</td>
<td>173</td>
<td>86.5</td>
</tr>
<tr>
<td>4</td>
<td>Can a person become infected with HIV by eating with an infected person?</td>
<td>182</td>
<td>91.0</td>
</tr>
<tr>
<td>5</td>
<td>Can a person with HIV infection look normal and healthy on the outside?</td>
<td>152</td>
<td>76.0</td>
</tr>
</tbody>
</table>

Answer correctly all 5 | 121 | 60.5 |
Analyzed by age, young MSW aged 15-24 has a lower knowledge on HIV than older MSW aged 25 and above (see Figure 9). 74% of older MSW (aged 25 and above) answered all 5 questions correctly, while only 35% of the younger MSW did. It goes without saying that older MSW are well aware of their health and are afraid of the HIV transmission which could link to them.

Figure 9. Proportion of answering 5 questions correctly by age

![Proportion of answering all 5 questions correctly by age](image)

b. Knowledge of sexually transmitted infections

Along with HIV knowledge, STI is an important index to evaluate risk behavior of MSW. The vast majority (90%) reported they had ever known of STI. Only 6 answered they have experienced STI problems. Table 9 illustrated what they did when experiencing the problem.

Table 9. Awareness of STI among MSW

<table>
<thead>
<tr>
<th>What did you do when infected with pain, ulcer, warts or discharge at sexual organ or around anus?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>n</td>
</tr>
<tr>
<td>Did nothing</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Did a medical check-up at public health station</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Did a medical check-up at private health station</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Bought a treatment at a pharmacy</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Sought for a treatment from a traditional physician</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Self-treatment at home</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Tell about symptoms to a sexual partner</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Stopped having sex with sexual partners when experiencing symptom</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Used a condom to have sex while experiencing such symptom above</td>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>
A large number of MSW who reported no experience of STI symptom was likely to show that they had a high perception on STI to their health protection. However, among those who replied with STI symptoms, 5 MSW disliked to tell their partners about their health. Besides, 6 MSW continued having sex with partners when they experienced above symptoms. Although a few MSW replied their STI practices, it did not mean they had low prevalence of STI since some of STI showed no symptoms at first phrases.

c. Knowledge of homosexuality and the risk for HIV infection

Like HIV knowledge, homosexuality awareness among older MSW was better than younger MSW (See Figure 10). When being asked to voice their agreement with the statement “Homosexual men have a higher risk for HIV than other men”, three-quarters (76%) of older MSW agreed with the statement while younger MSW were less likely to agree with that (72.5%). Overall, there was no significant variation between two both groups on the relationship between HIV and homosexual men. That inferred MSW themselves well perceive their risky behavior to HIV vulnerability among their network.

**Figure 10.** Proportion of knowledge about homosexuality and its risk for HIV infection by age

<table>
<thead>
<tr>
<th></th>
<th>Proportion (Group 15-24)</th>
<th>Proportion (Group ≥ 25)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree</td>
<td>72.50</td>
<td>76.10</td>
</tr>
<tr>
<td>Disagree</td>
<td>27.50</td>
<td>23.90</td>
</tr>
</tbody>
</table>


d. Access to HIV-related services

Access to HIV-related services to the target audience reflects the coverage of HIV programs and protection rate among MSW to their risk behavior. Currently, MSM prevention and harm reduction programs in Vietnam are providing free services including materials (printed brochures specific for MSM, condoms and lubricant) VCT and STI treatment
services. MSW were asked on their HIV testing history and receiving HIV prevention materials. Results on access to HIV services among MSW were presented in Figure 11.

**Figure 11.** Receiving services by districts

![Receiving services by district](image)

About 30% of MSW received all 3 materials and 21% received all 4 services. MSW in district 1, 3 and 4 were the least likely to receive HIV services. The percentage of receiving all 3 materials ranging from 16-29% in these districts while there was a higher proportion of district 5, 8, Tan Binh and Binh Thanh.

There was a wide variation in access to HIV services by district. District 3, District 4 and Tan Binh were districts with the least proportion of receiving services. Only 5.2% and 4.8% of MSW in district 3 received a condom and lubricant. There highest percentage of all services was found in Binh Thanh. Brochures and condom use were 23.40% and 25%, respectively. Lubricant is necessary to anal sex; but its receipt was not much in 7 districts, ranging between 3.6%-29.8 %. Notably, lubricant use in District 4 was about 8 times lower than that in Binh Thanh District. Fewer MSW received MSM-based brochures and HIV testing (less than 30%). Binh Thanh has the highest proportion of receiving all 3 services, 6 times higher compared to that in district 4.

Different types of MSW had different access to HIV prevention services. MSW who were call boys or worked in brothel were significantly more likely to have accessed all 4 prevention services. The distribution of HIV services among MSW by type is listed in Figure 12.
Overall, the majority of MSW received not more than 20% of all HIV-related services. Street-based or park-based MSW had the lowest receipt to all materials. Specially, brothel and callboy MSW were likely to receive much condom or lubricant, 35.4% and 36.6% respectively due to their risk behaviors. Although they got more than other groups, the proportion was not more than 50% in all services. Only 13% of MSW (6.5%) attended MSM drop-in center or MSM network. About 1-3% of MSW knew services provided by these centers such as distributing free condom/lubricant or VCT services and STI treatment.

About a half of MSW (46.5%) reported they had ever had HIV test. Among 93 MSW having HIV test, 90 reported their results: 3 not getting back the result and 2 failed to report the result. There were 5 cases or 2.5% of HIV among the 200 MSW joining the survey. All five positive MSW were Kinh ethnic groups, aged over 25 years old and 4/5 self-identified as homosexuals. The data shows that all five HIV-positive MSW who have ever engaged in unsafe sex work and exacerbate their HIV status and trigger sexual risk behavior to themselves and their partners. 4 of 5 MSW reported unprotected anal sex intercourse with clients and vaginal sex with FSW.

The study findings showed a large variation in HIV testing by age. Older MSW aged 25 and over were much likely to use HIV testing than younger MSW (aged 15-24). About 64%
of older MSW reported they had ever tested for HIV while only about 35% of younger MSW did. The distribution of HIV testing by age was listed in Figure 13.

**Figure 13.** Distribution of HIV testing by age

![Bar chart showing the proportion of HIV testing by age](chart.png)

<table>
<thead>
<tr>
<th></th>
<th>Proportion (Group 15-24)</th>
<th>Proportion (Group ≥ 25)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever had HIV test</td>
<td>35.50</td>
<td>64.50</td>
</tr>
<tr>
<td>Not yet</td>
<td>54.20</td>
<td>45.80</td>
</tr>
</tbody>
</table>
4.2. Interview results. Cultural belief about gender and sexual risk behavior

This second section of the thesis results focuses on findings from interviews with 27 participants on issues related to their sex work engagement. The thematic analysis resulted in six themes, illustrating patterns of meaning in the data, on the relationship between sexual risk behavior among MSW and cultural aspects in the community.

4.2.1 Various feelings on being a homosexual – fear, curiosity and over excitement

The age of 27 respondents in the qualitative in-depth interview ranged from 17 to 35 years old. Most of them left their home towns and came to HCMC to seek for work. The vast majority identified either homosexual or bisexual while not more than five of them identified as heterosexual. A large amount of respondent answered their sexual orientation was clear to them between 16 to 18 years old. One MSW replied he knew his homosexuality at the age of 6. Another MSW even could not believe in his sexual orientation until when he was 26.

Some MSW reported they showed their sexual orientation during their childhood as putting on girl’s clothes or playing with girl’s toys. At school, they were more attracted to male students than female students.

“I felt I had a homosexual orientation when I was at a high school. I felt attracted to male students but dared not to identify my status”

22 year-old MSW, MSM, District 3

Participants identified their sexual orientation with curiosity and pleasure when they watched entertainment programs with their peers.

“I felt pleasant and curious to watch gay films online. Sometimes I felt myself like homosexual acts when my friends told about gay stories and their sexual practices”

MSW, bisexual, Binh Thanh District

There were variations in homosexual identification among respondents. Some felt normal, strange even over-excited.

“It sounded a little strange but later on everything was normal”

MSW, bisexual, District 5
“.... I was really over excited at that time”
31 year-old MSW, MSM, District 5

Some felt worried and scared of being known by their parents or friends. Others made a try-out with the encouragement of another male partner and even support with money.

“I was a little scary and nervous with my homosexual behavior. I was afraid if my friends could know that....”
25 year-old MSW, bisexual, District 5

Almost all respondents reported their first homosexual encounter at the ages of 16 to 21. Two answered first sexual experiences at 13 and 14 and another three interviewees replied around the age of 27. Overall, all sexual acts were consensual, not being coerced.

“When I was 13 or 14 years old, I felt bored with my family and left home. I hanged around Park 23/9 and one man invited for going around and we had sex then”
MSW, bisexual, District 1

Participants’ first sexual experience with men occurred in quite varied circumstances. Public places were the most popular venues to experience their first sex. The majority had sex after going out for a drink, joining a birthday party. Two interviewees said that they did first sex after wandering in the street around the city at late night.

“I was 21 and had no money for rent. I was wandering in Thuan Kieu Plaza in District 5 and a 30 year old gay man invited me to eat and after that we agreed to get to a hotel for sex.”
21 year-old MSW, heterosexual, District 5

4.2.2 Reasons to engage in sex work – Enforced by strained living conditions or a way to fulfill sexual pleasure

a. Enforced by strained living conditions

Involvement in sex work ranged from one week to 11 years. Almost respondents reported sex work engagement was their major source of income with an average income between 6-7 million VND (300-350 USD).
“I did farming or taking care of my cow when I was at the countryside. With this current work, I can earn every 4 million and send home 2 million to help my family”

MSW, gay, District 8

Also, the majority of participants prompted by lack of work opportunity and dissatisfaction with rural life and small towns, had entered other employment such as housing emulsion painting, hair dresser, retail shop assistants, etc. prior their entry into sex work.

“I had no money, no jobs. I tried on working at a restaurant and in a store but the salary was not good. Looking for other job was really hard”

19 year-old MSW, gay, District 1

Others accepted to work since their low salary from previous jobs could not help their family out of difficult life.

“I went from a countryside area 3 months ago. I worked as a waiter but my wages was so low that I could not support my family. ...”

18 year-old MSW, bisexual, District

b. A way to fulfill sexual pleasure

Apart from economic hardship, stress and sadness from personal break-ups and lost life orientation fuelled MSW to get involved in this work. Other chose sex work as a sexual pleasure, a way to meet the need of meeting same-sex men or make social contacts. However, feelings of earning money easily and the like of same-sex led MSW to engage in sex work. Others refused to get rid of this work even they got a prohibition from their family.

“...I did this job since I could earn more money, have same-sex with other men and could meet more friends as well as develop social relationship”

23 year-old MSW, MSM, Tan Binh District

4.2.3 The shame of degrading the reputation of own family

Psychologically, MSW had to encounter internalized stigma including inferior complexes such as low self-esteem and prohibition from family. Besides, a shame of being a male sex worker remains in his mind as if it was a sin that degraded his family's fame. Therefore, keeping the work identity to home families is one of the most important things for
MSW to tackle. It is a really stressful emotion for MSW to hide from their work. The shameful feelings together with nervous and worried emotions of “coming out” lead MSW to expose their ultimate anxiety by possibly ending their life if being revealed by their family.

“My family has not known my current work. If they knew, I would end my life…”

19 year-old MSW, MSM, District 1

4.2.4 Safe or risky sexual behavior – A matter of trust, power and pleasure

a. Trust to intimate partners

Consistent condom use is really not an easy task for MSW to do. Some MSW reported using a condom in all types of sex partners. Nevertheless, most of the MSW reported that they did not use condoms with partners, both male and female due to their relationship of trust and intimacy.

“I only used condoms with males in anal sex. I never used condoms in oral sex. Neither did I use a condom with my regular partners since I trusted them and believed they could not have any infections”

19 year-old MSW, MSM, District 1

Also, MSW are less likely to use a condom in oral sex. Some MSW replied that condom unavailability hampers their protected sex practices.

“Sometimes I could not find any condom and lubricants to have sex at late nights. All pharmacies were closed before”

22 year-old MSW, MSM, District 3

b. Power relations and negotiations

Condom negotiation was not always successful. It depended on how clients were aware of safe sex. Most of clients used a condom or lubricants with MSW. Some clients used it from time to time and a few of them refused. However, MSW always liked their customers to practice safe sex.

“Occasionally some clients forced me not to use a condom and I had to convinced them so many times before they accepted to use in the end”

35 year-old MSW, bisexual, Binh Thanh District
However, some MSW accepted not to have sex with their clients as a way to protect themselves from vulnerable infections.

“Last month, I refused to have sex with 4 clients since they did not agree to use a condom”

23 year-old MSW, MSM, District 1

c. Physical smell and sexual pleasure

Together with client's psychological problems, physical smell of condom prevented clients from condom use. That's why the vast majority reported they had disadvantages of condom use with their clients. The MSW's clients always complained that condoms made them unpleasant and uncomfortable to have sex, especially very inconvenient in oral sex. Other clients disliked bad smell of condom or believed condom reduced sexual pleasure.

“Condom smelled bad in oral sex and provoked my clients unpleasant in sex”

MSW, gay, District 5

4.2.5 Meeting clients – Hidden places, mediators, phone contacts and cyberspace or special venues

a. Hidden places for sex activities

The public sites such as coffee shops, streets, brothels, massage parlors, parks etc. were the most common for MSW to meet their clients. MSW had a close network with sex intermediaries as pimps in their work. At times, they could choose dark corners of street for sexual encounters.

“I usually met my clients at Nguyen Kim Street, Gia Dinh Park or Nguyen Binh Khiem Street. I had sex with them at dark corners of street, at hotel or at their private house for a couple of times”

19 year-old MSW, MSM, District 1

b. Mediators as bridges

Intermediaries or pimp were those introduced clients to MSW. They were regarded as bridge between MSW and their clients. Intermediaries could be friends, co-workers or any those engaged in sex work. It was likely to have a network between MSW and those pimps based on agreement on working ways and allowances about introducing of clients to MSW.
“Sometimes some of my friend introduced clients to me. I did not give them money but I invited them for a drink from time to time”

23 year-old MSW, MSM, Tan Binh District

c. **Contact via phone and cyberspace**

Chatting via Internet, phone contacts and appointment at coffee shops were regarded as common places for sexual transactions.

“Many a time my client phoned or chatted with me and sent me address of destinations”

18 year-old MSW, bisexual, District 5

d. **Special venues for MSW**

MSW had various opinions on special meeting venues for MSW and their clients gather. Some MSW believed the network in HCMC was classified in various hierarchies of dichotomous areas: the young-the old, the rich-the poor, the national- the foreign, etc. Based on socio-economic position and cultural aspects, MSW could visit these venues.

“I knew there was a brothel for male sex work in District 7. This place was divided into two sections: one for the old and the remaining for the poor. Since the old were interested in quite places while the young were fond of active and bustling settings”

MSW, bisexual, District 5

However, one-third reported they have never known the existence of such these places since MSW could go to any place with fixed prices and demand of clients.

“I did not think there existed special areas. MSW just go to places with fixed price”

17 year-old MSW, MSM, District 1

4.2.6 **Avoiding HIV – Good knowledge and safe sex strategies**

Most of the MSW respondents showed a good knowledge about HIV transmission. They voiced their ideas on measures to protect themselves from HIV such as use of antiseptic solution or use of condoms and water-based lubricant with anal sex.
“To keep away from HIV/STI, I always used a condom with all type of partners in anal sex. After oral sex, I used Listerine (a kind of antiseptic mouthwash) to keep clean my mouth”

18 year-old MSW, MSM, Binh Thanh District

MSW often received prevention materials and condom/lubricant which were provided by peer education or at VCT services in HCMC.

“I usually received packs of condom and lubricant. The lubricants were packed in small sachets, water-based type, and provided by peer educators of Blue Sky drop-in center”

23 year-old MSW, bisexual, District 4
5. DISCUSSION

This thesis aimed to give a general view about the socio-economic settings to MSW and their sexual behavior. Based on the data from a baseline survey on 200 MSW in 7 of 24 districts in HCMC, the thesis found interesting findings around MSW in HCMC and some considerations in HIV setting in Vietnam.

The thesis results bring up some thoughtful perspectives regarding male sex work. First, most of MSW reported that financial problems are major reasons for their work. Some agreed to leave their hometown due to low salary which could not cover their daily life. Others have to support their poor family as one way to show their filial piety. Some used sex work to earn their extra income besides their other work. Others thought sex work would be an easy job to earn money which other jobs could not pay well. Second, some MSW were abandoned by their families and forced to leave their home due to family and social stigma, becoming homeless and penniless children. Vietnamese cultural prejudices on male homosexuality have been improved thanks to certain success to HIV/AIDS prevention activities to MSW in Vietnam in recent years but they are still a barrier to MSW in efforts of leading to a normal life.

Sexual risk behavior

The data from the survey showed most of MSW experienced having sex with multiple sex partners, including casual partner, clients, female sex workers and even to other MSW. The same findings were found like previous studies on MSM including MSW[59],[20, 60], etc. The MSW engaged in many different sexual practices with many different types of sexual partners. The highest number of sex partners of MSW was respectively found with MSW (10 partners), non-commercial encounters (20 partners) and male clients (30 partners). Despite high amount of partners, condom use is not always consistent. 36% reported unprotected anal intercourse (UAI) with all partners in the past month and 22% reported UAI with male customers in the past month. The UAI among MSW in HCMC is higher than that from the study findings (one-quarters) based in San Francisco [19] and lower than the figure among MSW in 3 provinces in Thailand. [21]. Compared to a study on MSW in Hanoi, Vietnam by Clatts [29], the UAI from this finding is lower (36% vs 71.4%). However, a proportion of 36% of UAI is pretty dangerous since it is the primary means by which HIV is transmitted in homosexual sex. This confirmed risky behavior among MSW in previous studies [20], [59], [29], [61]. This figure showed a low proportion of condom use
and raised an alarming rate to MSW and challenged current and future HIV implementation and policy makers in formulating appropriate intervention strategies.

**Perception about HIV**

In general, MSW had good knowledge about HIV transmission and preventive measures. Almost all MSW knew that HIV could be prevented by having sex with only one uninfected partner or by always using condoms for anal sex. However, only 76.5% knew that an HIV infected person can look healthy on the outside. The proportion of answering all five questions correctly among younger and older MSW varies. 74% of older MSW answered all 5 questions correctly while only 35% of the younger one did. About 74.5% of respondents agreed with the statement “Homosexuals are at greater risk for HIV/AIDS than other people in Vietnam”. The figure is much higher than the study on 219 MSM in HCMC by Donn Colby [28] with only 31% agree with the same statement. The limited correct knowledge of HIV together could be dangerous for younger MSW to practice safe sex acts with PLWA. Still, younger MSM were less likely to know that homosexual have higher risk for HIV than other men. This could make them more exposed to engage in risk behavior since they probably underestimate the chance of risky behavior among their partners in transmission modes of HIV and STI.

**Access to preventive HIV services**

The finding of the thesis revealed a significant amount of MSW engaged in unprotected sex acts and had limited access to HIV prevention materials and services. Existing and future intervention should provide more outreaching work and provide services to street-based and sauna-based MSM. Free condom box and HIV materials and consensus with more sauna establishments should be done to reduce risk behavior for their staff and partners. Since groups of MSW in HCMC are MSM subgroups who act as bridge in HIV transmission and other risky behaviors to their male and female partners, VCT services, condom negotiation should be encouraged in new and expanded projects.

The results from the thesis showed a highest proportion of access to HIV prevention and HIV testing in Binh Thanh District. The main reason was MSM-specific drop in center named *Blue Sky Club* was based at this district and attracted more MSM and MSW to use services there. Also, other districts which are geographically distant from Blue Sky, coverage of HIV services is much less than, especially in district 3, 4 and Tan Binh. Only 5% of MSW receiving all 3 HIV materials and 6.5% of MSW ever used for HIV test. In-depth interviews showed MSW asked for providing free material and condom/lubricant from project activities. Although peer educator show their high efforts in access to MSW, not all categories of MSW
in the survey received or meet peer educators. Maybe MSW at park and street have to keep away from police crackdown or social stigma, their receipt to these materials is not high.

Like street-based and park-based MSW, massage-based MSW were less likely to have had HIV testing or received HIV prevention materials. Maybe the massage parlor owners do not allow much peer educators into their establishments due to business outcome and they were afraid that their settings could be associated with HIV risk with peer education. Anyway, efforts for programs working with MSW at these massage establishments are great and should be duplicated.

This survey also showed that younger MSW aged 15-24 years that had ever had HIV test services were less than among older MSW. Only 35.5% of younger MSW had HIV tested while this was higher among older MSW (64.5%). This can be explained that older were well aware of their risk behavior while the younger MSW could show their masculinity. Although the younger MSW can have easier access to Internet services of seeking for sex partners and protection ways of HIV, their knowledge on HIV transmission, homosexuality and previous HIV testing are still limited. More researches on younger MSW should focus this group to better effective strategies on HIV for MSM in HCMC.

One surprising finding in this study was that 4 of the 5 MSW who knew that they were HIV infected continued to engage in unprotected sex with both female and male partners. With UAI with male clients in the past month would put these clients at extremely risk behavior of HIV transmission. A questions raised here is if these male clients having sex with these MSW could have unprotected sex with partners, both male and female, the impact is terrible. That’s why more work needs to be done with HIV infected MSW to decrease the chance of transmitting HIV to the community.

**Cultural beliefs about gender and sexual risk behavior**

The thesis findings showed that more than 20% of MSW had unprotected intercourse sex with their partners during the past month. Of which, about a half (42.5%) of MSW reported unprotected sex with any partners in both anal and oral sex. Specially, 36% of MSW had anal sex with all partners (i.e. male and female partners). In addition, in-depth interviews demonstrated MSW rarely or never used a condom with their intimate partners. Clearly, MSM become a linkage to their partners which may be wives, friends, and sexual partners. That infers women cannot protect themselves because of their male partners, heterosexual, MSM and both MSW. Even knowing infected with STI, MSW disliked to use preventive measures with their partners. There are some possible reasons for this. First,
MSW did not tell their partners at first since they could know that they possibly infected with STI because some STI’s symptoms could not be detected right away. The incubation period of STI varied such as genital warts (2-3 months), genital herpes (after 4-7 days), gonorrhea (2 weeks) and public lice (after 1-3 week) [62]. Second, hegemonic masculinity in their mind might have prevented them from telling partners about their partners. They did not want to let their partners know about their bad health with STI.

In terms of MSW’s clients, they ignore the sexual safety and HIV/STI infection to their partners and dare not to identify their status as MSM. If infecting with HIV/STI from having sex with MSW, they tried not to let their partners know since they are afraid that their partners could suspect hidden relations with other people. Internalized stigma causes themselves from disclosing STI status to their partners. As a result, risky behaviors among MSM and MSW exacerbate their health. Therefore, educational sessions at communes or wards as well as constructive and objective articles on mass media to involve the community a better outlook and sympathy to MSM and MSW.

Hegemonic masculinity might explain why MSW accept unsafe sex acts by their clients. They seem ignore risky behavior themselves and even to their sex partners regarding a condom refusal and protective ways against HIV/STI transmission. The findings from both questionnaires and in-depth interviews showed not all clients accepted using condoms. Some clients disliked using a condom in oral sex or at having sex. They failed to ask for health-seeking behaviors. Even worse, 36% of MSW reported UAI with all partners and 22% with male partners in past month. Here, hegemonic masculinity; to some extent, has its impact on MSW, unintentionally placing not only themselves but also their partners at risk. It showed a power and dominant position of masculinities to subordinate femininities. MSW in in-depth interviews showed their problems about refusal of condom use among their partners. In these situations, not all MSW negotiated successfully with clients. However, the problem does not come from only clients, but also within the MSW themselves. Four MSW knew they got HIV, but continued having UAI with partners. The question raised here is what would happen to clients of these MSW when they had unprotected with their close and intimate partners. As a result, an interlacing network between MSW and partners is likely to be a bridge of HIV/STI among the community. That’s why messages and intervention not only focus on MSW but to their partners as well. Therefore, peer educators, researchers and counselors should have more understanding on “manliness” as well as experience of being men of MSW to perceive and improve their health [63].
This paper also revealed special venues where MSW gather. It seemed there were social hierarchies to meet the demand of meetings and sex acts. Data from in-depth interviews showed that there were special venues for MSW, i.e. venues for the old-the young, the rich-the poor, the luxurious-the cheap, etc. About half of the respondents reported an awareness of such places. Findings proved not only that MSW had multiple partners, various types of sex but a diversity of settings where MSW could meet as well. MSW can visit the places that suit their needs and social position. For example, luxurious bars or disco were catered for the rich and street and park or cheap coffee shops were for the poor. Even a brothel was divided into two spaces for the young and the old MSW. Therefore, future researches and intervention should focus on these networks to give safe messages of HIV prevention such as providing free condom and material and encourage MSW and partners to go for a HIV test.

In Vietnam, legal impediment, cultural and social norms remained obstacles to MSM-related intervention and mainstream perception. Shame and discrimination make them invisible to access to HIV services. These findings highlight potential challenges and suggest an inquiry for future HIV prevention research in efforts to halt the epidemic in Vietnam.

**Suggestions for reducing sexual risks among MSW**

1. HIV prevention
   - Promoting edutainment activities which integrate MSW life into dramas and educational program at the drop-in center and the entertainment locations
   - Strengthening peer education to connect more MSW and provide them with safe sex messages and HIV prevention, focusing negotiation on condom use and encouraging MSW and their partners accessing to VCT services and receiving HIV test results
   - Developing tailored messages and HIV prevention materials for MSW
   - Update hot spots and networks of MSM-friendly VCT and STI clinics to MSW and partners
   - Enhancing consistent condom use among most-at-risk populations up to 60%

2. Access to HIV treatment care and support
   - Vocational support at MSM drop-in center with cooperation from other relating agencies
   - Taking advantages of available referral services to HIV/STI services at hospital, clinics and on mobile vehicles at regular time
- Providing free condom and lubricant at sex work settings such as bars, discos, sauna parlors and hotels where MSW gather and seek for sex partners.
- Ensuring 50% of MSM to have accessible VCT and STI services

3. Enabling supportive environment on prevention and care services
   - Formulating legal and psychological settings for MSW and their related people
   - Enhancing advocacy programs among policy-makers and in the communities such as schools, health institutions on anti-stigma and anti-discrimination to MSW and MSM
   - Cooperating with stakeholders such as local governmental agencies and polices to decriminalize MSW

4. Strategic information
   - Promoting social and ethnographic researches about MSW
   - Mapping MSW in other districts in HCMC
   - Monitoring and evaluation researches and interventions toward MSW
   - Mobilizing data on MSM into sentinel surveillance at HCM
6. CONCLUSION

Having multiple sexual partners and unprotected sex acts are causal factors for MSW in HCMC to be vulnerable to HIV/AIDS transmission. Sex with both male and female partners leads to the bisexual bridge from MSW to the general population. Although most of the participants reported an access to HIV prevention materials and HIV testing, but there is a variation between young MSW and older MSW. Understandings of gender theories, masculinities and social health inequalities are regarded as other ways to review on HIV prevention toward MSW, a subgroup of MSM in HCM. MSW is still one of the most-at-risk groups to address in HIV/STI intervention in Vietnam. Knowledge on social conditions would be effective way to implement work to these vulnerable groups.

It can be denied that studies of male sex work in Vietnam are still relatively modest in scope. The thesis, to some extent, suggests some implications which could develop tentative sexual health programs for MSW in particular and MSM in general in specific Vietnam context. More behavioral and ethnographic studies on MSW in Vietnam and tailored interventions as well should be formulated and implemented to address this vulnerable group. Particularly, studies and intervention to access more MSW and their partners; creating a network with owners of MSW settings such as bar, disco, hotels, sauna parlors and local government with an aim of enabling consensus and cooperation to deal with MSW. In addition, gender programs should be integrated in HIV/AIDS activities and strategies. A great concern and consensus should be interacted between related associations, stakeholders and competent government agencies to ensure a supportive legal framework in a mutual cooperation to reduce HIV/STI among MSW.

It is said that more commitment and consensus from both Vietnamese government and partnership from local and international NGO, program on HIV prevention for MSM get some certain results. Stigma and discrimination to MSM and homosexuality is improved but imbalanced in other regions in Vietnam. Nowadays, MSM interventions have just covered in 6 major provinces/cities where a large of MSM gather. These programs show a success of peer educators to access more high-risk populations to address to safe sex and HIV prevention message. However, very few researches on male sex workers are done combined with gender-tailored programs for these populations. Moreover, data on HIV/AIDS in sentinel surveillance which are not included into HIV program in Vietnam hinder comprehensively successful policies to tackle HIV epidemic in Vietnam. Hopefully, there are more social researches as well as intervention on homosexuality with gender-related issues are accompanied to better HIV programs.
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