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Self-perceived HIV risk and the use of risk reduction strategies among men who engage in transactional sex with other men in Ho Chi Minh City, Vietnam

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Abstract

An emerging HIV epidemic can be seen among men who have sex with men (MSM) in Vietnam, with prevalence as high as 18%. Transactional sex represents a risk factor for HIV transmission/acquisition among MSM globally, particularly in urban contexts, but remains largely underinvestigated in Ho Chi Minh City (HCMC), Vietnam. In 2010, 23 MSM who reported exchanging sex for money in the last month completed a brief survey and semistructured qualitative interview at The Life Centre, a non-governmental organization in HCMC, to assess sociodemographics, individual- and structural-level HIV risk factors and explore acceptable future prevention interventions. Participants' mean age was 24 years. Equal proportions of respondents self-identified as heterosexual/straight, homosexual/gay, and bisexual. Participants had a mean of 158 male clients in the past year, with a median of 60 male clients in the past year (interquartile range [IQR]=70) and reported inconsistent condom use and inaccurate perceptions of HIV risk. Nearly half of the sample reported engaging in unprotected anal sex with a male partner in the past 12 months and one-third with a male client. Major themes that emerged for HIV prevention interventions with male sex workers were those that: (1) focused on individual factors (drug and alcohol use, barriers to condom use, knowledge of asymptomatic STIs, enhancement of behavioral risk-reduction skills, and addressing concomitant mental health issues); (2) incorporated interpersonal and relational contexts (led by peer educators, built interpersonal skills, attended to partner type and intimacy dynamics); and (3) considered the exogenous environments in which individual choices/relationships operate (stigma of being MSM in Vietnam, availability of alternative economic opportunities, and varied sexual venues). HIV prevention efforts are needed that address the specific needs of MSM who engage in transactional sex in HCMC. Universally, MSM endorsed HIV prevention interventions, suggesting a need and desire for efforts in this context.

Keywords

HIV; Vietnam; prevention; male sex workers; transactional sex

Introduction

In 2008, the population of men who have sex with men (MSM) was estimated to be 40,000 (Nguyen, Nguyen, Le, & Detels, 2008). Surveillance data from Ho Chi Minh City's (HCMC) Department of Health showed 16.4% of MSM were HIV infected in 2009, an increase of 10% from 2006 (Family Health International, 2006; USAID, 2010). However, since MSM are not included in routine HIV sentinel surveillance in Vietnam, there is a paucity of data for HIV prevalence rates among MSM.

Data suggest that between 22% and 40% of MSM engage in transactional sex (Colby, 2003; Nguyen et al., 2008). Among 91 young MSM in HCMC and Hanoi, approximately two thirds were involved in transactional sex (Ngo et al., 2009). Nguyen et al. (2008) reported a HIV prevalence of 33% among MSW, and the probability of MSM acquiring or transmitting HIV was higher for MSWs compared to MSM who did not do sex work.

To inform specialized and culturally relevant prevention interventions, it is necessary to formatively investigate HIV-related risk factors that may contribute to this population's high vulnerability to HIV. The present study aimed to examine individual and structural risk factors among MSW in HCMC with an eye toward intervention development.

Methods

The study was conducted by the Harvard Medical School AIDS Initiative in Vietnam in collaboration with The Life Centre, a Vietnamese NGO working with MSM.

Participants and procedures

In 2010, semistructured interviews were conducted with 23 MSW in HCMC. Recruitment was conducted by peer health outreach workers from the Life Centre as part of ongoing outreach work. Of the 25 approached for recruitment, all were eligible and 23 agreed to participate. Participants (n=23) were biologically male, 18 years of age or older, identified as Vietnamese, and reported transactional sex (for money or goods) in the last month.

Interviews were conducted by one male and two female Life Centre employees. The interviewers were trained in qualitative interviewing techniques and were native Vietnamese speakers. To reduce response bias, interviewers were not affiliated with peer health education (PHE) efforts. Interviews were recorded and transcribed verbatim and translated into English for analysis. Participants received a 100,000 Vietnamese Dong (VND) incentive and provided written informed consent. Data were de-identified to preserve confidentiality. Study procedures were approved through Harvard Medical School AIDS Initiative in Vietnam and the HCMC Provincial AIDS Committee.

Study assessments

Participants completed a brief quantitative assessment related to basic demographic information and sexual risk. The semistructured interview guide addressed sexual identity, sexual history with men during sex work, sexual risk, and HIV/STI knowledge. The guide was based on existing literature on sexual risk behaviors of male sex workers in South-east Asia (Blanc, 2005; Clatts, Giang, Goldsamt, & Yi, 2007; Colby, 2003, 2004; Colby, Minh,

& Toan, 2008; Khuat, 2005; Ngo et al., 2009; Ngo, Ross, & Ratliff, 2008; Nguyen et al., 2008; Vu, Girault, Do, Colby, & Tran, 2008).

Data analysis

The quantitative assessment data were analyzed using SAS (v 9.2.1) statistical software to obtain descriptive statistics and summarize the study sample. Univariate analysis examined the distribution of variables, including frequencies and proportions, as well as measures of central tendency and dispersion, such as the mean (standard deviation; SD) and median (interquartile range; IQR) where data were skewed. Qualitative data were analyzed using the descriptive qualitative content analysis method. Initial themes were identified to develop a codebook (Silverman, 2010). Transcripts were coded by a trained staff member using NVivo software (v.8). The coded data were summarized and organized to fit the emergent themes relevant to individual and structural factors influencing sexual risk.

Results

Sociodemographic characteristics and sexual risk behavior

Twenty-three MSWs were included in the study (see Table 1). Participants' mean age was 24 (SD=3.9) years. Equal proportions ($n=7$) identified as heterosexual/straight, homosexual/gay, and bisexual and 8.6% ($n=1$) as other. The mean monthly income from sex work was approximately 5.6 million VND (21,000 VND is equal to \$1 USD) (US Department of Treasury, 2012) (SD=6,055,276). Table 2 describes the sexual behavior and characteristics of sex work reported by participants in the sample. Respondents had a mean of 156 (SD=406) transactional (clients) and non-transactional male sexual partners combined in the past 12 months. Overall, 47.8% ($n=11$) reported anal sex without a condom with all male sex partners in the same period.

STI and HIV awareness

All men sampled understood that HIV could be transmitted through sexual intercourse and injection drug equipment. Six participants stated that HIV was more transmittable through anal sex compared to other forms of sexual contact. Two participants said that oral sex could not transmit HIV. Few ($n=2$) participants described awareness that STIs could be spread without a person having any easily identifiable or visible symptoms of disease. Participants accessed information about HIV/STIs through a number of sources, including PHEs ($n=17$), close friends ($n=7$), and other MSWs ($n=7$).

HIV/STI status and testing

Of the 18 men (78%) that reported being tested, eight had received risk reduction counseling during testing and seven accessed free testing services. Health workers at STI/HIV testing facilities were generally described as friendly and non-judgmental. Barriers to testing included worry about being infected with HIV, HIV-related stigma, and worry about the effect that being HIV-positive would have on interpersonal relationships, especially with female spouses/partners. As a 19-year-old, straight-identified MSW said:

I do not want to [be tested]. Imagine how I will be when I find out that I have the disease. I think I will smash my head to death on the spot! I have never had an HIV test because I have no symptoms even when I have done this job for some years. If I have a test now, what can I do if I get the disease?

Additionally, some participants worried that someone might see them being tested and think that they had HIV or find out about their sex work activities.

Risk reduction strategies

Participants reported various strategies to reduce the risk of acquiring HIV/STIs with clients. Visual assessments of STI infection were an important tool for evaluating STI transmission risk. For instance, appearing excessively “skinny,” and having a “smelly body” were associated with infection. Other risk reduction strategies discussed included (1) a self-imposed restriction on the number of clients within a certain time; (2) abstaining from anal intercourse; (3) engaging in manual sex as an alternative to oral or anal sex with clients suspicious of have an STI; and (4) rinsing with mouthwash after oral sex.

Condom use

All participants knew about condoms and generally, respondents saw consistent condom use as a critical piece of maintaining sexual health. Participants obtained condoms from various sources, including, PHEs ($n=14$), peer support groups ($n=5$); friends ($n=5$), and other MSWs ($n=3$). Brand and price were important signifiers of condom quality. Ranging in price from 1000 up to 20,000 VND each, condoms were generally described as easy to use ($n=5$) and affordable ($n=9$).

Although 13 men knew where to obtain condoms, eight respondents worried that being seen with condoms was a potential indication of promiscuity. Five men described episodes of unprotected anal sex because a condom was not available. A 26-year-old, heterosexual/straight-identified participant said, “I told them to use [a condom]. They said they did not buy [any] so they had no condoms with them and they did not have any health problems. I was reluctant, and finally I agreed.”

Fourteen men cited a decrease in sexual sensation as a barrier to condom use. As a 28-year-old, heterosexual/straight-identified man articulated, “In general, sex without condoms has much more pleasure. Using condoms it is not so exciting ... It is one-hundred percent without condoms and thirty percent with condoms.”

Several ($n=7$) men in the sample reported relatively consistent condom use during anal sex with clients. Participants said that they most often used condoms with male clients whom they determined to be “risky.” As a 26-year-old, heterosexual/straight-identified participant said, “He looked smart, educated, clean, and how he behaved. Not bad ... I mean they may not be debauched – not have high risk behaviors.” Similarly, a client’s level of familiarity also impacted condom use. Often, relationships with familiar clients involved a level of trust. Some respondents believed that unprotected sex with familiar clients was less risky or that condoms would potentially interfere with the mutual trust between them.

According to many ($n=14$), clients generally discouraged condom use. A 28-year-old, heterosexual/straight-identified MSW stated, “Its normal. I often bargain with them before going. I only accept if they agree to use condoms.” To increase the likelihood of using a condom with a client, four participants said that they would directly discuss condom use before sex. Similarly, others said that they opened condoms and lubricant in advance or slipped a condom on without the client knowing.

Condom use with clients was reportedly less consistent with non-transactional female partners. As a 25-year-old, homosexual/gay-identified respondent said, “Once we are partners, we should not use condom, because we need special pleasant feelings between us ... Once the condom is discarded, the excitement increases.”

Discussion

In this formative study with MSM who engage in transactional sex in HCMC, men reported high numbers of sexual partners, inconsistent condom use, and inaccurate perceptions of risk for HIV/STIs. Consistent with prior research which found that MSM in HCMC can be easily reached through peer outreach workers (Colby, 2003), PHEs were the primary sources of information and condoms for men in this sample. PHEs were identified as trusted members of the MSW community and having shared similar experiences, they may be ideally suited to deliver HIV prevention intervention activities.

MSW sampled reported employing risk reduction strategies during transactional sex, including engaging in oral or manual sex instead of anal sex, selecting male clients they thought would be lower risk, and reducing their overall number of partners by having repeat transactional sex clients. Future intervention efforts should encourage existing HIV risk reduction practices among MSW. However, respondents commonly reported utilizing subjective visual appraisals of clients, including a “cleanliness” evaluation based on physical attributes to evaluate risk for HIV/STI infection and implement risk reduction strategies. Specifically, only two participants described being aware that STIs could be transmitted asymptotically. These findings are consistent with a study of 219 MSM in HCMC that found less than half of MSM knew that someone who looked well could transmit HIV and only one third knew that they could get an STI from someone without symptoms (Colby, 2003). A reliance on outward STI symptomatology may lead to inaccurate or incomplete risk appraisals for MSW. Future intervention efforts would benefit from incorporating education about the transmission of asymptomatic STIs and not relying solely on visual cues to practice existing HIV risk reduction strategies.

Multiple barriers to condom use were identified by MSW in this study, including access barriers (e.g., obtaining condoms) and usage barriers (e.g., decreased sexual sensation). Making condoms easily accessible, particularly distributing free condoms and lubricant within the sexual networks of MSW and in locations they frequent, was seen as important for HIV prevention efforts. Providing MSW with behavioral skills specific to transactional sex also represented an intervention target. For example, skills related to negotiating condom use when additional payment is offered for unprotected sex or with regular clients where there may be increased intimacy and temptation to compromise sexual safety was seen as important.

HIV testing was emphasized as a need that should be incorporated into future interventions. We found that behavioral interventions would benefit from addressing perceived and actual barriers to testing, including fear and embarrassment of being tested, unwanted disclosure of sex work, and concern about confidentiality or being “seen” by others in their social network, a particularly important concern given the close social connectedness between families and community networks in the Vietnamese context (Kaplan & Huynh, 2008).

This study has several limitations. Since men were recruited in regular outreach activities through a community-based organization, the sample may represent those who are already more engaged in existing HIV prevention services. Even so, all except two men wanted more information about HIV and sexual health. In addition, HIV testing was not conducted in this study, and participants were never directly asked about their sero-status.

Findings from this formative study are responsive to recent calls for additional research to more accurately and comprehensively assess the HIV epidemic among MSM in Vietnam (Vietnam Ministry of Health, 2009). Results suggest that HIV prevention interventions with MSM who engage in sex work would benefit from: (1) focusing on individual behavior change (addressing barriers to condom use, knowledge of asymptomatic STIs, enhancing

current risk reduction practices, concomitant mental health issues); (2) incorporating interpersonal contexts (simultaneously engaging MSWs and their peers, targeting interpersonal skills, attending to partner type and intimacy dynamics for regular sexual partners); and (3) attending to their exogenous environments (stigma of being MSM in Vietnam, stigma of HIV/STI testing, availability of alternative economic opportunities).

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Table 1Self-reported sociodemographic characteristics of study participants ($n=23$)

	<i>n</i>	%
Mean age (SD)	24 (3.9)	
Mean income (SD)	6,870,000 (7,719,834) VND*	
Mean income from sex work (SD)	5,600,000 (6,055,275) VND	
	<i>n</i>	%
Gender		
Male	22	95.70
Other gender identity	1	4.30
Sexual orientation identity		
Heterosexual/straight	7	30.40
Homosexual/gay	7	30.40
Bisexual	7	30.40
Other sexual orientation identity	2	8.60
Education		
Middle school (grades 6–8)	7	30.40
Secondary (grades 9–12)	14	60.90
Undergraduate/four-year college	2	8.70
Marital status		
Unmarried	21	91.30
Legally married	2	8.70
Employment		
Full-time (30+h per week)	21	91.30
Part-time (<30 h per week)	2	8.70
Sex work disclosure		
Homosexual/gay friends	7	30.40
Heterosexual/straight friends	4	17.40
Family members	4	17.40
Female partner or spouse	2	8.70
Male partner or spouse	6	26.10
Healthcare providers	10	43.50
Coworker	8	34.80
Have not disclosed to anyone	3	13.00
Have participated in prior HIV prevention program	14	60.90

* 21,000 VND is equal to \$1 USD (US Department of Treasury, 2012). SD, standard deviation.

Table 2Self-reported sexual risk behaviors in the last 12 months (*n*=23)

	<i>n</i>	% (95% CL)	Mean (SD)	Median (IQR)
No. male partner(s)	–	–	156.5 (406.3)	60.0 (70.0)
No. male sex work partner(s)	–	–	158.5 (405.6)	60.0 (70.0)
Unprotected receptive and/or insertive anal sex with male partner(s)	11	47.8 (30.6, 73.2)	–	–
No. unprotected male anal sex partner(s)	–	–	47.9 (118.5)	6.0 (22.0)
No. unprotected male anal sex work partner(s)	–	–	55.1 (131.2)	5.0 (3.0)
Unprotected anal sex with male sex work partner(s)	9	39.1 (38.5, 80.3)	–	–
No. unprotected male anal sex work partner(s)	–	–	47.6 (132.2)	3.0 (4.0)
Female sex partner(s)	11	47.8 (31.8, 72.6)	–	–
No. of female partners	–	–	5.8 (8.3)	3.0 (5.0)
Unprotected insertive vaginal or anal sex with female partner(s)	7	63.6 (7.9, 64.8)	–	–
No. unprotected female vaginal and/or anal sex partner(s)	–	–	4.0 (3.9)	2.0 (7.0)

95% CL, 95% confidence limit; SD, standard deviation; IQR, interquartile range.