Factors Supporting Young Ethnic Minority Males' Engaging in Commercial Sex and Accessing Health Care in Chiang Mai, Thailand

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ABSTRACT

A qualitative method was deployed to explain the factors supporting young males from ethnic minority groups engaging in commercial sex services and barriers in accessing the Thai health care system in Chiang Mai Province. The information was elicited from four different groups of key informants who were selected by purposive method; 15 young ethnic minority sex workers, 5 public health officers, 2 nongovernment office workers, and 3 gay bar owners. Question guidelines were developed and used to gathering information. Confidential in-depth interviews lasting 45 minutes were conducted in a private room at workplaces. The participants were approached until reaching data saturation. The NviVo Program was used for content thematic analysis to elicit the key findings. Most participants were from Shan, Myanmar. Economic constraints, younger age, low education, limited Thai communication skills and peer motivation constituted the factors supporting young ethnic minority males engaging in commercial sex services. Low education and limited Thai communication skills, rights to free access to the Thai health care system, time and privacy, illegal immigration and financial problems comprised the barriers in accessing the Thai health care system. Government and nongovernment agencies relevant to this issue in Thailand and Myanmar should collaborate to solve the problem of young males engaging in commercial sex services. Health agencies in the area should promote effective educational programs.

Keywords: Factors supporting, male sex workers, ethnic minority, access to health care services

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Introduction

A male sex worker (MSW) is one profession that has been in existence for a long time[1]. MSWs are fewer than female sex workers. MSWs can be categorized in three groups[2]: a) men who provide sexual services for only men (MSW), b) men who provide sexual services for only women and c) men who provide sexual services for both men and women. MSWs have become one of the risk populations for sexually transmitted infections (STIs) such as HIV/AIDS due to the pattern of sexual intercourse particularly anal sexual intercourse.

MSWs in Thailand have been reported to be the main population for HIV/AIDS and other STIs[2] especially those who are working in the cities with tourist attractions such as Bangkok, Phuket and Chiang Mai. Some MSWs in Thailand are ethnic minorities especially those in cities located in the areas. Chiang Mai Province is located in northern Thailand and bordered by Myanmar. Chiang Mai is one of the most favorite cities for Myanmar migrant workers. They are now working in different sectors depending on the daily wage and individual skill. Many young males and females prefer to work in the sex industry. However, MSW is a new sex industry in Thailand and most work in big cities with tourist attractions.

Many health problems have been observed and reported among MSWs. HIV transmission is predominantly reported among MSWs[3]. In 2016, the World Health Organization (WHO) reported that HIV/AIDS was a major cause of human health problems over the world with some countries reporting over 20.0% prevalence in the adult population[4]. Thailand has been recognized as one of the countries having successfully controlled HIV/AIDS over the past years[4]. However, recently, MSWs have been observed and reported as a new, major and vulnerable population for HIV and other STIs in Thailand[3]. In 2012, the survey results from a study on HIV/AIDS and STIs and behaviors, so called, Integrated Biological and Behavioral Surveillance (IBBS) conducted in three provinces, i.e., Bangkok, Chiang Mai and Phuket showed that the prevalence rates of HIV among MSWs and men who have sex with men (MSM) were 24.0%, 23.0% and 14.0%, respectively[5]. This prevalence was higher than that of the general population in the same year. STIs and HIV/AIDS prevalence among MSWs was higher than that of female sex workers[6] and venue-based sex workers[7]. MSWs had problems accessing health service programs and rarely accepted treatment and counseling about STIs and HIV/AIDS[8]. Many MSWs work in Chiang Mai particularly in spas, karaokes and go-go bars etc[9]. Most belong to ethnic groups and have worked in other areas before deciding to engage as MSW, consume alcohol, and abuse drug substances[10-11].

The number of MSWs in Chiang Mai increases annually particularly among young ethnic minority populations. A large proportion is not permitted to work legally. No clearly documented reasons or factors have influenced MSWs and barriers accessing health care services in this population continue. Therefore, the aim of this study was to explain the factors supporting MSW engaging in commercial sex services and barriers in accessing the Thai health care system in Chiang Mai Province, Thailand.

Methods

Study design

The qualitative method was used to elicit information from four different key informants using in-depth interviews among male ethnic minority MSW, public health staff who worked in the field of MSW health, Nongovernment Organizations (NGO) who worked in the field of MSW health, and three private gay bar owners.

Study setting

The study setting was Chiang Mai. Data were collected from October to December, 2016.

Study population

The ethnic minority MSW working in Chiang Mai comprised the study population.

Study sample

The purposive sampling method was used to recruit 15 male ethnic minority MSWs, 2 public health staff members working in the MSM project, 2 NGO staff working in the field as the organization staff without knowing their HIV status and three private gay bar owners in Chiang Mai.

Only those belonging to ethnic minority populations, working in the male sex industry in Chiang Mai for at least one year and had the ability to communicate in Thai were invited for interviews. Code numbers instead of names were used to represent the interviewees.

Research instruments and data gathering procedures

A 14-item questionnaire developed from the literature review and verified by three experts was used to collect data. The questions consisted of the reasons and motivations for engaging in male sex work, relationships among family members, risk and experience of HIV transmission in their job, rights to access health care and experience in accessing health care. The questionnaire was pilot tested using two MSM sex workers with similar characteristics to the study sample. This improved the questionnaire contents and ensured that the researcher could receive all relevant information from the participants. Two pilot tests were conducted before interviewing the participants.

A 12-item questionnaire was developed by the research team and standardized by

three external experts in the field before using to collect data among the other group of participants (public health officers, NGOs, and gay bar owners). The questions comprised three major issues: current challenges of working among male sex workers in Chiang Mai, roles of organizations in preventing STIs including HIV/AIDS among male sex workers and supporting and improving health care services for them.

All participants were selected using the purposive method. MSM workers were selected using the help of the bar managers. Only those who were MSM sex workers, belonged to an ethnic minority, and fluent in Thai met the criteria. After that they were contacted and appointments were made by phone call one week before interview. Participants were provided all essential research information before completing the consent form and nobody refused to participate. A private and confidential room was prepared and used to interview in the study setting, and each lasted 45 minutes. All interviews were conducted by the researcher. The interviews were tape-recorded after obtaining permission from the participants. Most participants were contacted more than twice before providing detailed and saturated information. A triangular technique was used to verify the accuracy of the information. Many participants were contacted for interview when collecting data before the research team made a conclusion that the information had been saturated.

Data analysis

Data was analyzed using a qualitative method. All recorded information was played and transcribed. The NviVo Program was used to form the pattern and structure of the key findings as content thematic analysis. After, all obtained structures were analyzed by the research team comprising those having different scientific backgrounds; medical anthropology and sociology, epidemiology, and medical technology. The data was analyzed after obtaining from the interview in every loop. Whenever conflicting information was found, a triangular technique and confirmation by interviewees were used. The data were extracted to derive saturated information until no more new ideas or information were found, before stopping the interview process.

Ethical consideration

All research procedures were approved by the Human Research Consideration Committee, Mae Fah Luang University, approval No.REH-59132.

Results

In all, 25 participants provided information; 15 MSMs, 5 public health staff, 2 NGOs, and 3 gay bar owners.

In all, 15 MSWs were recruited in the study. Most selected MSWs were Shan (9 Shan,

4 Myanmar, and 2 Karen) in Myanmar age range 18 to 30 years (mean = 20.2, SD = 4.35), living with others who were not relatives, while minors stayed with their girlfriends. Regarding education, most graduated from a primary school in the Myanmar educational system. Some had been ordained when they lived in Myanmar and a few could speak Thai because they lived near the border. Having a poor family was the reason to work in Chiang Mai. They sent money back to their families occasionally. Nearly one half needed to send money to their families and were persuaded by friends and overall, felt satisfied working as MSWs. On average, 5,000-10,000 THB was their monthly income. Commercial sex work brought in money and did not require hard work. More than one half of the participants reported they had no other choices to work in Chiang Mai. Working in Thailand required fluency in Thai and certification or qualifications. However, to be an MSW required none.

Five health officers were recruited to provide relevant information. Two were working in hospitals; another 3 officers were working in Chiang Mai Provincial Public Health Office and the Office of Disease Prevention and Control No. 1 in Chiang Mai. Four had a background in public health and the other was a nurse in training. All health officers had positive attitudes toward working to improve MSW health in Chiang Mai. They had much information on STI control and prevention among MSWs particularly in Chiang Mai and met together occasionally to share information. More than 10 million THB was spent on projects with MSWs with the support of the Ministry of Public Health, Thailand. One officer had worked with this group of people for more than 15 years, while 3 years work experience was the shortest.

Two young middle-aged men (29 and 43 years old) working in the NGO sector participated in the study and provided relevant information. One had a background in public health training. They had 7 and 21 years work experience among MSWs in Chiang Mai, respectively. These two selected NGO staff had frequently joined meetings with government officers particularly health professionals from different institutes both at local and national levels. They were working on three public health intervention projects focusing on improving access to STI testing, improving access to antiretroviral drugs (ARV), and sexual behavioral change projects in gay bar settings. The projects required multiple visits to MSWs to implement, monitor, and evaluate the interventions.

Three gay bar owners were willing to provide information and granted the researchers access to their bar. All had positive attitudes toward regular testing and monitoring of STIs

among their employees. In their business they had 7 to 23 MSWs. The number of employees fluctuated depending on the season such as having a large number of employees during New Year's and Songkran Festival. They had no formal registration form for their employees. Overall, the incomes of the businesses were from 40 to 50% of service charges and selling alcohol beverages. Sixty percent of clients were foreigners from western countries and looked for sex with MSMs. They performed many erotic shows nightly. On average, each MSW had 2 to 3 clients nightly. The bar was not responsible for any health problem of the employees. Because the business was not under the Thailand social security system, they did not contribute social security.

Factors supporting MSWs among young ethnic minorities

Five factors supported engaging in the MSW industry among young ethnic minorities as described below.

Economic constraints

All participants who were MSWs reported they grew up in a poor family in Myanmar. Family economic constraints were a major force that influenced them to work as an MSM.

One man disclosed, "I grew up in a very poor family and everyone needed to work, but I had limited opportunities in Myanmar". He added, "I have no good life and no better future in Myanmar."

Another boy told, "I just wanted to earn money to send back to my family and working here (gay bar) is a good way to get money". He added, "I earn a lot more working in Thailand compared with when I was working in Myanmar. I earn more in a gay bar than my friends who work in other sectors"

Age

Crossing the official border from Myanmar to Thailand requires that an individual must be at least 18 years old. However, all the participants were less than 18 years old when they first entered Thailand to work. Due to economic constraints and age restrictions, they decided to work as MSMs to earn money.

One man spoke, "I wish to make some money here so that someday I can go back to Myanmar. As a 15-year-old, I know that my entry into Thailand was illegal, but there was no better choice as I and my friends need to make money"

Low education

All MSW-participants had low education and no professional working skills. Professional and legal work in Thailand requires high education levels and professional skills. Most lowly educated people were forced to take up unskilled jobs in unskilled sectors including gay bars.

One participant explained, “I finished primary school in Myanmar, but I could not find a good job. I wanted to continue my studies but my family could not support me. That’s why I decided to come to Thailand”

Another revealed, “If I could choose, I would not work in a gay bar, but I had no choice”

Limited communication in Thai

A basic requirement for working in Thailand is fluency in Thai. All MSW-participants had low levels of Thai proficiency. However, the gay bar worker was not required to speak Thai.

A gay bar owner claimed, “Every boy can work in my bar. We do not need any specific skills because many MSWs who are working in Thailand could eventually use Thai. Then, they can help the new employees who come later”. One man said, “Yes, limitation in use of Thai is the reason why I am here. If I could speak Thai fluently, I would work in other fields”.

Peer motivation

All participants mentioned that they were motivated by their peers to come to Thailand and work as MSWs. for some, the easy nature of the work and high wages were other motivating factors. One said, “before I came here, my friend told me that I will earn a lot of money every night. This motivated me to join him here”.

A bar owner declared, “I do little to nothing to recruit new employees because they usually come with their friends who are already working with us”

Barriers accessing the health care system

Five factors were presented as barriers accessing the health care system as described below

Low education and limitation in communicating in Thai

Most participants had low education levels and limited use of Thai. Most health information in Thailand is released in Thai leading to little improvement in personal knowledge and skills to protect against STIs including HIV/AIDS in their work. The major source of essential health information was their peers. They always shared experiences with their peers such as how to care for themselves, how to negotiate with customers, and how to have safe sex. From the interview, most information to protect against STIs was incorrect. For instance, a) using more than one piece of condom is more effective in HIV protection, b) oral sex is safe for STIs, c) having climax and ejaculating outside after anal sexual intercourse is safe for STIs. Therefore, having low education levels and limited Thai proficiency increased the risk of STIs among MSWs.

Rights to freely access the Thai health care system

All MSWs were not Thais, so they did not have a Thai identification card (ID), usually needed to access all public services in Thailand. Whenever they needed to see a doctor even in a government hospital, they will be charged fully for all expenses. Many chose to buy medicines from drug stores to care for themselves instead.

One man stated, "I used to buy the drugs I needed from the drug store near by my apartment. Most of my friends do the same when we get sick. When I go to a hospital I have to pay full fees. They told me, I have no right to get free services".

Time and privacy

Problems accessing health care from a hospital includes the whole process and services take time. They had to stop work for the whole day. In terms of obtaining an HIV test at a hospital, the disadvantages they identified were lack of privacy and the long time it takes to receive the results. As a result, participants decided to use private clinics instead. Moreover, most participants had never been tested for HIV and other STIs. Time and privacy were reasons for not accessing the health care system. Some other reasons included barriers to access the health care system particularly for HIV and STIs testing such as a) little to no concern about the importance of testing, b) not knowing where the clinic was located and c) not knowing what would happen if they could not afford the HIV test. A participant said that it was more practical not to get an HIV test and not to know one's status because one would not be able to afford antiviral therapy (ART) anyway.

An NGO staff alleged, "the problem is they clearly do not understand the advantages of regular testing for HIV and STIs. At this stage they are not concerned about the problem; they only know how to get money"

A public health officer supported this by saying, "we have regularly visited and invited them to join the STIs and HIV surveillance program. However, only a few like the screening. Some told me that they are afraid to be in jail and be sent back to Myanmar".

Illegal living status in Thailand

Most participants had problems of legally living and working in Thailand due to a lack of work permits. As a result, they were usually insecure wherever they worked, be it in a bar or construction site. Therefore, their solution was to interact with people as little as possible. They lived in places that were far away, less crowded and avoided the police.

One man said, "If my place is crowded with people, the police will find out easily".

Therefore, they limited themselves to just their workplace and place of accommodation. Some people may have had a tribal identity card and were assigned to stay in specific areas, especially the Shan young men who were lower than 18 years, who had been confined more than others because they were commercial sex workers and did not have work permits. This was a barrier to daily life activities.

Financial problem

Because accessing health care incurs both direct and indirect expenses, many participants preferred not to visit a medical doctor in a hospital. Incomes of MSWs depended on the number of clients each night. They would rather fulfill their role as economic providers for their families than spend on their health.

One man expressed, “I usually send earned money to my family. I have no intention to use it to visit a medical doctor. It is very expensive to me”.

One gay bar owner claimed, “We do not have any health insurance for the employees. I know they are here illegally but I cannot find a way to support them”.

Discussion

The study found that young male from an ethnic minority population became MSWs workers due to economic constraints, young age, low education, limitation in Thai communication and peer motivation.

Several studies[12-13] have reported that becoming an MSW was mainly due to economic constraints, young age and individual sexual orientation. This coincided with our study showing that the major factors in support of engaging in the male commercial sex among the young ethnic minority were economic constraints and young age. Moreover, the study of Stefan, et al.[12] reported that most MSWs did not identify themselves as male sex workers. This was inconsistent with our study indicating that all MSWs in Chiang Mai identified themselves as MSWs and some became sex workers after marrying a female and were still living together as a family.

They grew up in a poor family and became MSWs in Thailand. Afterwards, they still needed money to support their family. The study of Heide[14] also reported that the major reason for engaging in commercial sex among migrant street-based MSWs in Germany was economic constraint.

We found that peer motivation was one of the most significant factors encouraging young males from a Myanmar ethnic minority to work as MSWs in Chiang Mai. However, their peers were in turn motivated by income. This was similar to a study in South Africa reporting that peer motivation was a supporting factor for young men becoming MSWs[15].

Kuosmanen, et al.[16] reported that low education levels and limited professional skills were major supporting factors for young men to become MSWs in Sweden. This supports our study in that most of the young MSWs from an ethnic minority in Chiang Mai were indirectly influenced by low educational level and lack of professional skills including ability in Thai communication.

Regarding the level of access to care, Apidechkul, et al.[17] reported that ethnic minorities particularly those who were living in northern Thailand had a low level of access to the health care system compared with the general Thai population. It reflected that minority populations in northern Thailand were facing the same problem of access to health care. One more study also reported that migrant populations in Thailand are faced with increased HIV transmission and have limited access to antiretroviral therapy[18]. Murray, et al.[19] reported that civil conflict in Myanmar had displaced thousands of people from the minority Shan ethnic group in northern Thailand, and finally, they had problems accessing to ARV.

Sineenart, et al.[20] reported that age, educational levels, and income were associated with medical care seeking behaviors among MSM. The study of Anthony and David[21] also demonstrated that cultural and social contexts were significant factors supporting the success of implementing health care services for MSWs. However, Katie, et al.[22] reported that MSWs themselves had the specific characteristic of low level access to health care services. One study in Mexico[23] reported that MSWs had less access to care compared with other groups.

Thailand has a great health care service system for those who hold Thai identification cards (ID-Card)[24]. This card is used to freely access all public services including medical care. However, this system does not cover non-Thais, particularly those who are living illegally in the country.

Conclusion

Working as a MSW in Chiang Mai is due to many factors including previous economic status, education level, age, limited job opportunities in Thailand due to inability to use Thai, and motivation from peers. MSWs have a high risk for STIs and HIV in their work and living conditions due to illegal status, low ability to communicate in Thai, and low power in negotiating with their clients. Financial problems, illegal status, limitations in Thai communication and having no Thai ID card were barriers to accessing the Thai health care system.

Thailand and Myanmar should develop a strategic plan to improve the economic and educational status of the people living

in border areas. This will ensure the reduction of MSWs in northern Thailand. However, all health agencies should find methods to improve health information access and safe sex skills among these groups. Research to develop systems to improve health care seeking behaviors among MSWs should be encouraged.

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ปัจจัยสนับสนุนการเข้าสู่ชายขายบริการทางเพศในกลุ่มชายวัยรุ่นชนกลุ่มน้อยทางชาติพันธุ์และการเข้าถึงบริการสุขภาพในจังหวัดเชียงใหม่

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บทคัดย่อ

การศึกษาเชิงคุณภาพนี้มีวัตถุประสงค์เพื่ออธิบายปัจจัยที่สนับสนุนการเข้าสู่ธุรกิจชายขายบริการทางเพศในกลุ่มวัยรุ่นชนกลุ่มน้อยทางชาติพันธุ์และปัจจัยที่เป็นอุปสรรคต่อการเข้าถึงบริการสุขภาพในจังหวัดเชียงใหม่ กลุ่มตัวอย่างคัดเลือกแบบเจาะจง จำนวน 4 กลุ่ม (25 คน) ในพื้นที่ คือ กลุ่มชายขายบริการทางเพศ จำนวน 15 คน เจ้าหน้าที่สาธารณสุข จำนวน 5 คน เจ้าหน้าที่หน่วยงานไม่แสวงหาผลประโยชน์ จำนวน 2 คน และอีก 3 คนเป็นเจ้าของบาร์ แบบคำถามนำได้รับการพัฒนาและทดสอบคุณภาพก่อนนำไปใช้ในการเก็บข้อมูล การสัมภาษณ์ดำเนินการในห้องที่มิดชิดโดยใช้เวลาสัมภาษณ์ประมาณ 45 นาทีต่อคน และดำเนินจนได้ข้อมูลที่ตกผลึก ใช้โปรแกรม NviVo ในการวิเคราะห์ข้อมูล ผลการดำเนินงานพบว่า ส่วนใหญ่กลุ่มตัวอย่างมาจากรัฐฉาน ประเทศพม่า ความขัดสนทางเศรษฐกิจ อายุ ระดับการศึกษา ความสามารถในการสื่อสารภาษาไทยและการชักชวนจากเพื่อนเป็นปัจจัยผลักดันให้กลุ่มเยาวชนชนชาติพันธุ์เข้าสู่ธุรกิจบริการทางเพศ ส่วนปัจจัยระดับการศึกษาน้อยและข้อจำกัดการใช้ภาษาไทย สิทธิในการรักษาพยาบาล ระยะเวลาและความเป็นส่วนตัว การอาศัยอย่างผิดกฎหมายในประเทศไทยและปัญหาทางด้านเศรษฐกิจเป็นปัจจัยอุปสรรคในการเข้าถึงบริการทางการแพทย์หน่วยงานราชการและไม่ใช่ราชการจากทั้งสองประเทศควรมีความร่วมมือกันเพื่อแก้ไขปัญหานี้และควรมีการพัฒนาโครงการส่งเสริมสุขภาพที่มีประสิทธิภาพ

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