Men Who Have Sex with Men in Cambodia:

HIV/AIDS Vulnerability, Stigma, and Discrimination

by Kha Sovannara and Chris Ward

January 2004

Cover photo: Kha Sovannara (standing center) and study participants at a dissemination meeting in Sihanoukville. All photos courtesy of POLICY/Cambodia.

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Kha Sovannara
Chris Ward
Phnom Penh, January 2004

Executive Summary

Sex between men takes place in most societies, including Cambodia, where there is limited data on male-to-male sex as a route of HIV transmission. Cambodia's National Centre for HIV/AIDS, Dermatology and Sexually Transmitted Diseases (NCHADS) does not collect epidemiological and behavioral data on the role of sex between men in the HIV epidemic in Cambodia. NGOs working in Cambodia have, however, collected some data on HIV prevalence among MSM and some behavioral data. In June 2000, Family Health International (FHI) assessed the prevalence of HIV, syphilis, and other sexually transmitted risk infections (STIs) and risk behaviors among MSM in Phnom Penh, and found HIV and syphilis prevalence of 14.4 and 5.5 percent, respectively. Risk factors for HIV were found to include anal sex with multiple partners, unprotected vaginal sex with commercial female partners in the past month, and infection with syphilis and other STIs.

Comparing consistent condom use by sex workers, FHI found that direct (i.e., brothel-based) female sex workers reported the highest rate of consistent condom use (78.1%), followed by male sex workers with female clients (69%), with male sex workers with male clients reporting the lowest rate of consistent condom use (47%).

Many of the men in Cambodia who have sex with men also have sex with women. To ignore the evidence of high HIV prevalence in MSM and the consequent risk to their female sex partners, and thus to the general population, points to a serious risk of undermining the gains that Cambodia has made in its response to the epidemic to date. The FHI research concluded that:

> In Phnom Penh, Cambodia, MSM should be considered a group at high risk of HIV infection because of a significant proportion who reported unprotected anal intercourse and multiple sexual partners. A large proportion of MSM were also found to have penetrative sex with both males and females. This indicates that MSM could be serving as a "bridge group" of HIV transmission to the general population.

This report by POLICY is indebted to the FHI report cited above, as well as to recent reports by the Khmer HIV/AIDS NGO Alliance and CARE Cambodia, which together represent the major resources currently available on the role of sex between men in the HIV epidemic in Cambodia.

There is little research in Cambodia on sex between men and its relationship to identity. In this report by POLICY, the term "men who have sex with men" (MSM) refers to biological males who have sex with other biological males. It does not indicate that those males do not have sex with females and does not imply that those males necessarily have a sense of identity or community based on the fact that they have sex with other men. The report also uses the distinction often made in Cambodia between "MSM short hair" and "MSM long hair," with the understanding that the former are men who present and identify as men with normative masculine gender characteristics, and the latter are men who present with more feminine characteristics and whose identity may sometimes correspond to the category of "transgender" used in some other cultures. The reason for this report's use of the distinction between "MSM short hair" and "MSM long hair" is that focus group participants frequently used the distinction, which to some extent also informs the structure of programs targeting MSM and HIV/AIDS in Cambodia. However, the distinction should not be considered an immutable or, obviously, exhaustive categorization system.

Sex between men continues to be a misunderstood and underaddressed risk environment for HIV transmission in Cambodia. As in many other countries, men who have sex with men (MSM) in Cambodia are stigmatized and socially marginalized, and the meaningful involvement of MSM in policy formulation and program design and delivery generally is overlooked.

To date, the POLICY Project/Cambodia has undertaken little work with this vulnerable population. The aim of this report is to provide the POLICY Project and its funding body, USAID, with relevant information to assist in developing future activities targeted to MSM. For

this reason, the scope of the research undertaken for this report was relatively limited. It consisted of

1. A literature review
2. Key informant interviews focusing on the programmatic environment
3. Focus group discussions to gain some indication of the target population's perceptions of unmet needs regarding HIV and sexual health
4. Limited mapping of current MSM sexual and social sites and networks

Over a 30-day period in July and August 2003, researcher Kha Sovannara collected qualitative data through key informant interviews and focus group discussions. Key informant interviews were conducted with staff of NGOs in Phnom Penh, Siem Reap, Battambang, and Sihanoukville, with two focus group discussions conducted in each of Phnom Penh, Siem Reap, Battambang, Sihanoukville, and Poipet.

Key informant interviews were used to gather information from NGOs regarding past, current, and proposed activities that target MSM and HIV vulnerability. Focus group discussions were used to gather information from MSM regarding sexual and social networks and meeting places, access to information and services dealing with HIV/AIDS and sexual health, advocacy activities, perceptions of existing services and unmet needs regarding HIV/AIDS and sexual health, whether MSM had experienced harassment from police because of their sexual behavior or identity, and the impact, if any, of their sexual behavior or identity on their relationships with family and community.

The stigma and discrimination faced by MSM in Cambodia pose obstacles to effective sexual health promotion. As research conducted for this report demonstrates, stigma and discrimination cause MSM to "hide their face," making them more difficult to be reached by health promotion campaigns.

In Cambodia, the reasons and motivations for sex between men are several. Although they may prefer sex with another man to sex with a woman, some homosexual Cambodian men stop engaging in sex with other men after they marry. Some young unmarried Cambodian men have sex with other men simply out of the desire to have sex and because cultural norms concerning gender make it easier to find a male rather than a female sexual partner. Some men have sex with other men as a way of earning money.

A senior Cambodian health official said:

Talking about homosexual in Cambodia, it is very straightforward. Most of our people do not believe that the same gender can have sex. In fact homosexuality is available in hidden condition in the last three years. And homosexual have started to show their face increasingly in the society. Some have form a group to ask for legal status.

The report also aims to promote increased attention to the issues of MSM and HIV vulnerability in Cambodia and collaboration between agencies addressing such issues.

Key Findings

MSM in Cambodia demonstrate a low level of knowledge about the risks of HIV transmission through sex between men. Many MSM, particularly MSM long hair, who are more easily identified as MSM, face difficulties in accessing HIV and sexual health services and can be subject to discriminatory treatment when they do access such services. MSM short hair who access such services are likely to conceal the fact that they have sex with other men and, in these cases, do not receive the necessary range of clinical services.

The available epidemiological and behavioral data indicate that MSM should be considered as a vulnerable group for HIV infection and that MSM could be serving as a "bridge group" of HIV transmission to the general population. Male-to-male sexual behavior represents an important link in the spread of HIV and sexually transmitted infection (STIs) in Cambodia that is currently unaddressed by national policy and program frameworks.

Information from key informant interviews suggests that implementation of the Frontiers Prevention Program (FPP) by KHANA and the organizations it funds will significantly increase the level of activity by nongovernmental organizations (NGOs) targeting MSM. In addition to HIV prevention initiatives, the FPP will provide the opportunity to develop advocacy activities by and for MSM. Information from focus group discussions suggests that all organizations—whether

government, nongovernmental, or other—should provide sensitivity training to staff working with this highly stigmatized population.

Cambodia currently demonstrates an over-reliance on "peer" outreach as a method of sexual health promotion and HIV prevention for MSM; other health promotion methods, including the use of both print and electronic mass media, should also be considered. The nation needs both more information, education, and communication (IEC) resources that specifically address the HIV and sexual health information needs of MSM, and the inclusion of MSM-specific messages in HIV prevention and health promotion activities targeting the general population.

The experiences of stigma and discrimination as reported by MSM point to the need to promote greater respect for the human rights of the MSM population for two reasons. First, greater respect for human rights will enhance the effectiveness of HIV and sexual health promotion campaigns targeting MSM. Second, the human rights of MSM are worthy of protection in their own right. MSM need access to technical assistance and material resources to undertake human rights—promoting activities both on their own behalf and in conjunction with human rights and HIV/AIDS organizations.

Recommendations

1. Regularly conduct further research on male-to-male sexual activity, HIV vulnerability, and HIV transmission in order to provide relevant and current evidence on which to base health promotion interventions with this vulnerable population. Donors should fund regular behavioral and epidemiological surveys through appropriately qualified organizations.

2. Review national policies and programs to ensure that Cambodia adequately addresses the issues of MSM, HIV vulnerability, and human rights.

3. Promote the active involvement of MSM in the development, delivery, and evaluation of policies and programs addressing sex between men, HIV vulnerability, and human rights.

4. Develop an MSM sensitivity training curriculum by and in collaboration with MSM as a resource for organizations involved in the response to HIV/AIDS in Cambodia. Such a curriculum can help build the advocacy capacity of MSM, enhance the capacity of institutions and organizations to work effectively on the issue of MSM and HIV/AIDS, and reduce the stigma and discrimination to which MSM in Cambodia are subjected.

5. Deliver sensitivity training to police and service providers on the issues of MSM, HIV vulnerability, and the law as it relates to male-to-male sexual activity in order to reduce human rights violations against MSM, and prevent some police officers from undermining the effectiveness of HIV prevention methods, such as the use of condoms by MSM.

6. Donors should require that organizations targeting MSM and HIV vulnerability conduct sensitivity training for staff to enhance their capacity to work effectively with this highly stigmatized and often hidden population.

7. Encourage organizations to ensure that their MSM target populations understand that the only circumstances in which organizations may record the names of MSM are when individual MSM volunteer as peer workers, and thus are asked their names so that organizations can develop and maintain a list of volunteers.

8. Adopt new approaches to IEC for MSM on HIV and sexual health, including the use of both print and electronic mass media and the delivery of MSM-specific HIV prevention messages in prevention initiatives targeting the general population.

9. Enlist the participation of MSM in the development and dissemination to the target audience of IEC materials that specifically address male-to-male sexual behavior, HIV risk and transmission, and sexual health.

10. Make condoms and lubricant widely available free of charge to MSM, with a particular focus on MSM long hair, who face significant stigma and discrimination and consequent economic hardship, owing to their greater visibility.

11. Undertake research modeled on the 2003 report by CARE Cambodia, which demonstrated that in-depth interviews (in this case, in two border provinces) provide an effective means of gaining an

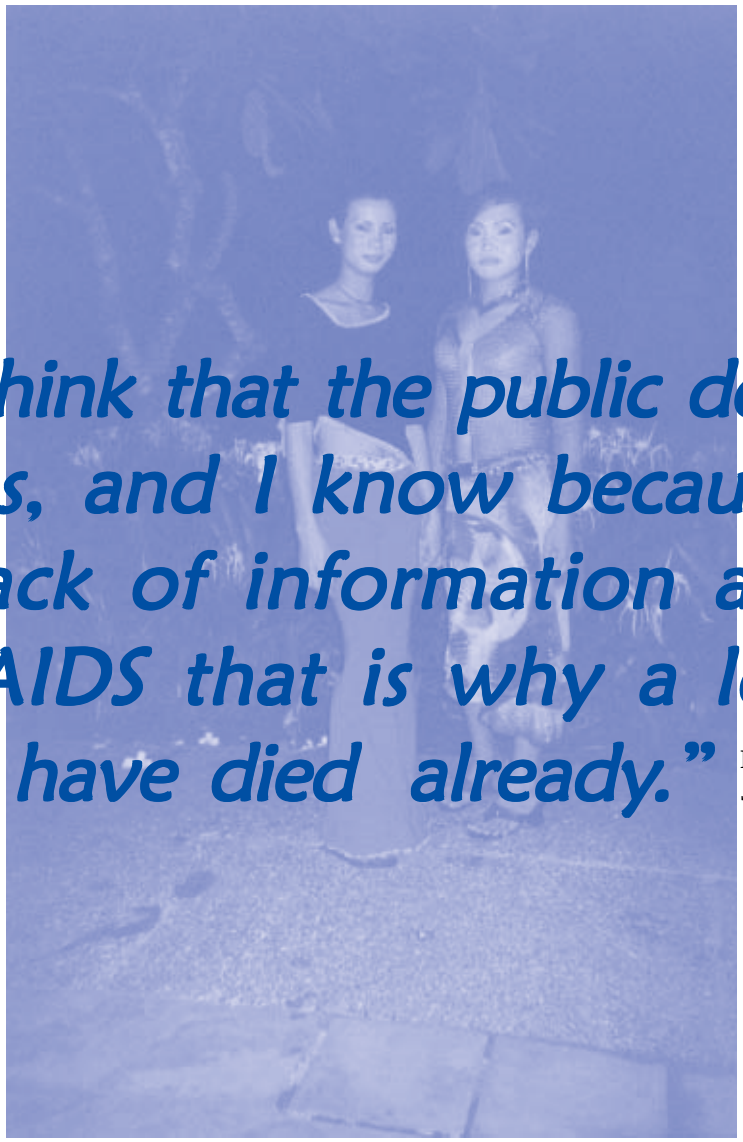
understanding of the knowledge, attitudes, and beliefs of MSM regarding HIV transmission and risk. Such in-depth research should be carried out with MSM populations in other locations to increase our understanding of the dynamics of sex between men in Cambodia's HIV epidemic and to provide evidence on which to base HIV prevention and health promotion initiatives. Ensure that the research findings are widely disseminated in English and Khmer, to promote their use in the design and implementation of HIV prevention and sexual health promotion initiatives targeting MSM.

12. Establish a national advocacy network of MSM. NGO MSM projects provide a starting point for building a national network. The stigma and discrimination faced by MSM in Cambodia undermines the effectiveness of the response to HIV/AIDS and violates the human rights of MSM. With funding from donors and technical assistance from organizations working with MSM, and with the involvement of organizations working in human rights and HIV/AIDS, a network could develop, for example, advocacy activities, a human rights training curriculum, and HIV and sexual health social marketing campaigns aimed at promoting the health of and respect for the human rights of MSM in Cambodia.

13. Develop and deliver clinical sexual health services that are sensitive to the needs of MSM. The research conducted for this report indicates that MSM long hair, who are more easily identifiable as MSM, experience stigma and discrimination at health care facilities. The research also indicates that MSM short hair may conceal from health care workers the fact that they have sex with other men, making it unlikely that they will receive appropriate clinical services, such as anal examinations and diagnosis of anal STIs.

Abbreviations

AIDS	Acquired immune deficiency syndrome
BCC	Behavior change communication
CARE	CARE Cambodia
CDA	Community Development Action
CWC	Cambodian Women's Clinic
DFID	Department for International Development, United Kingdom
FHI	Family Health International
FPP	Frontiers Prevention Project
HIV	Human immunodeficiency virus
IEC	Information, education, and communication
KDFO	Khmer Development of Freedom Organization
KHANA	Khmer HIV/AIDS NGO Alliance
KWCD	Khmer Women's Cooperation for Development
MEC	Médicin de L'Espoir Cambodge
MHC	Men's Health Cambodia
MHC Siem Reap	Men's Health Cambodia, Siem Reap Branch
MSM	Men who have sex with men
NCHADS	National Centre for HIV/AIDS, Dermatology and Sexually Transmitted Diseases
NGO	Nongovernmental organization
STI	Sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
USG	Urban Sector Group
VCT	Voluntary counseling and testing



"...I think that the public do not like us, and I know because of the lack of information about HIV/AIDS that is why a lot of MSM have died already."

MSM long hair, Poipet, July 30, 2003

Two "srey sros" or "pretty girls," MSM who identify as women, from Siem Reap.

Chapter 1: Introduction and Methodology

Introduction

Sex between men continues to be a misunderstood and underaddressed risk environment for HIV transmission in Cambodia. As in many other countries, men who have sex with men in Cambodia are stigmatized and socially marginalized, and the meaningful involvement of MSM in policy formulation and program design and delivery generally is overlooked.

To date, the POLICY Project has undertaken little work with this vulnerable population. Therefore, the aim of this report is to provide the POLICY Project and its funding body, USAID, with relevant information to assist in developing future activities targeted to MSM. For this reason, the scope of the research undertaken for this report was relatively limited. It consisted of

1. A literature review
2. Key informant interviews focusing on the programmatic environment
3. Focus group discussions to gain some indication of the target population's perceptions of unmet needs regarding HIV and sexual health
4. Limited mapping of current MSM sexual and social sites and networks

The report also aims to promote increased attention to the issues of MSM and HIV vulnerability in Cambodia as well as collaboration between agencies addressing these issues.

HIV and Behavioral Surveillance Data

Sex between men takes place in most societies, including Cambodia, where there is limited data on male-to-male sex as a route of HIV transmission. UNAIDS estimates that at least 5 to 10 percent of all HIV cases worldwide are attributable to sexual transmission between men, with sex between men accounting for up to 70 percent of HIV cases in some countries.[1] Cambodia's National Centre for HIV/AIDS, Dermatology and Sexually Transmitted Diseases (NCHADS) does not collect epidemiological and behavioral data on the role of sex between men in the HIV epidemic in Cambodia.

NGOs working in Cambodia have, however, collected some data on HIV prevalence among MSM and some behavioral data. In June 2000, Family Health International (FHI) assessed the prevalence of HIV, syphilis, and other STIs and risk behaviors among MSM in Phnom Penh[2] and found HIV and syphilis prevalence of 14.4 and 5.5 percent, respectively. Out of the total sample of 206 men interviewed, 81 percent reported anal sex with male partners in the six months before the interview, and 82.8 percent reported involvement with male partners who paid them to have sex. Risk factors for HIV were found to include anal sex with multiple partners, unprotected vaginal sex with commercial female partners in the past month, and infection with syphilis and other STIs.

The FHI study found that, while similar proportions of MSM reported a male or female regular partner, condom use at last sex was significantly higher with male rather than with female regular partners.[3] However, condom use by MSM with nonregular male partners was less common than condom use with nonregular female partners. For the month before the FHI study, 13.3 percent of MSM reported unprotected sex with at least one male and one female partner.[4] MSM reported a lower rate of consistent condom use with female commercial sexual partners than did three groups of high-risk men in Cambodia (police, military, and moto drivers) as well as lower than general population men in urban areas.

Comparing consistent condom use by sex workers, FHI found that direct (i.e., brothel-based) female sex workers (78.1 percent) reported the highest rate of consistent condom use, followed by male sex workers with female clients (69 percent), with male sex workers with male clients reporting the lowest rate of consistent condom use (47 percent).[5]

A majority of study participants (71.2 percent) reported that they knew where to get a confidential HIV test, but only 24.6 percent had ever been tested for HIV, and only 19.5 percent had been tested *and* had returned to learn their test results.[6]

A key finding of the FHI study was that MSM should be considered as a vulnerable group because of their high-risk behavior.[7]

A qualitative appraisal of male-to-male sexual behavior in Phnom Penh, Siem Reap, and Battambang commissioned in 2002 by the Khmer HIV/AIDS NGO Alliance (KHANA) found that, out of a sample of 370 MSM, 67 percent had engaged in anal intercourse in the previous month and that the rate of regular use of condoms for anal sex was noticeably low.[8] For example, in Siem Reap, where 92 percent of the sample engaged in anal sex, an average of 12 percent never used condoms, and 72 percent were inconsistent condom users.

A 2003 report by CARE Cambodia on male-to-male sexual risk behaviors and knowledge about HIV in two communities on the Thai border[9] used qualitative research methods and case studies to collect information on factors that contribute to the HIV vulnerability of MSM in these communities. The identified factors included the widespread belief that male-to-male anal sex does not transmit HIV, a lack of knowledge regarding the availability of voluntary counseling and testing (VCT) facilities, low levels of HIV testing (and of obtaining results when an HIV test was performed), and ignorance of the existence of water-based lubricant. Other misconceptions about HIV transmission included the notion that HIV is present in 20 percent of all condoms, that sharing a cigarette can transmit HIV, that there is no risk of HIV transmission during unprotected sex with a person who is considered to be clean and/or handsome or whose anus is loose, and that cleaning immediately after sex or taking oral contraceptives can prevent HIV transmission.

Of the 25 interviewees in the CARE study, 16 had never submitted to an HIV test. Only five of the nine who had been tested knew the results of the test.[10] Seeking an HIV test was not linked to the beginning of a monogamous relationship or engaging in risky sex but rather to the onset of symptoms perceived to be associated with HIV infection.[11]

This report by POLICY is indebted to the reports prepared by FHI, KHANA, and CARE as noted above, which together represent the major resources currently available on the role of sex between men in the HIV epidemic in Cambodia. The reports indicate a high HIV prevalence rate in MSM as well as a low level of knowledge of how HIV can be transmitted through male-to-male sex. The number of participants for all studies totaled just 601, but the findings suggest that the true scale of the HIV epidemic among MSM in Cambodia may be much larger than is currently acknowledged and that, as a result of stigma and discrimination, it is hidden in the same way that sex between men is hidden.

Many of the men in Cambodia who have sex with men also have sex with women. To ignore the evidence of high HIV prevalence in MSM and the consequent risk to their female sex partners, and thus to the general population, points to a serious risk of undermining the gains that Cambodia has made in its response to the epidemic to date. A recent article in the *British Medical Journal* commented on the dangers of ignoring HIV risk and prevalence in communities that are marginalized or "politically untouchable:"

> We must collect the information we need to track HIV infection and risky behaviour in the populations that may be exposed and use that information to make sensible choices about which prevention efforts are most likely to reduce new infections in a particular country at a particular stage of the epidemic.[12]

The FHI research referred to above concluded that:

> In Phnom Penh, Cambodia, MSM should be considered a group at high risk of HIV infection because of a significant proportion who reported unprotected anal intercourse and multiple sexual partners. A large proportion of MSM were also found to have penetrative sex with both males and females. This indicates that MSM could be serving as a "bridge group" of HIV transmission to the general population.
>
> It can be concluded that male-to-male sexual behaviour, which is often of a hidden nature, does represent a link in the spread of HIV and STIs in Cambodia.[13]

Terminology

There is little research in Cambodia on sex between men and its relationship to identity. The FHI 2002 report stated that it made no effort to categorize research participants into subgroups because not enough was known about the extent to which categories such as "self-identified gay," "transvestite," "sex worker," and so forth were appropriate.[14] However, the report presented information on self-reported sexual identity/labeling,[15] as reproduced in Table 1.

Table 1. FHI 2002 Data on Self-Reported Sexual Identity/Labeling (N=205)

Identity/Labeling	Percent
Man	30.3
Gay	0.1
Homosexual	22.8
Bisexual	27.4
Woman	19.4

In this report by POLICY, the term "men who have sex with men" refers to biological males who have sex with other biological males. It does not indicate that those males do not also have sex with females and does not imply that those males necessarily have a sense of identity or community based on the fact that they have sex with other men. The report notes that "katoy" may be used as a derogatory term to refer to any man who is known or believed to have sex with other men[16] or to a person of one biological sex who is thought to desire to be the other biological sex.[17] The use of this term was frequently commented on by focus group participants and is discussed in more detail in Chapter 3.

The report also uses the distinction often made in Cambodia between "MSM short hair" and "MSM long hair," with the understanding that the former are men who present and identify as men with normative masculine gender characteristics, and the latter are men who present with more feminine gender characteristics and whose identity may sometimes correspond to the category of "transgender" used in some other cultures. The reason for the report's use of the distinction between "MSM short hair" and "MSM long hair" is that focus group participants frequently used the distinction, which to some extent also informs the structure of programs targeting MSM in Cambodia. However, the distinction should not be considered an immutable or, obviously, exhaustive categorization system. The information from the FHI study provides some indication of the complexity of the meanings that may be associated with sex between men in Cambodia while suggesting that, in many cases, men may not attribute any meaning to sex with other men beyond the sexual act itself.

Methodology

Over a 30-day period in July and August 2003, researcher Kha Sovannara collected qualitative data through key informant interviews and focus group discussions. Key informant interviews were conducted with staff of NGOs in Phnom Penh, Siem Reap, Battambang, and Sihanoukville, with focus group discussions conducted in Phnom Penh, Siem Reap, Battambang, Sihanoukville, and Poipet.

Key informant interviews were used to gather information from NGOs regarding past, current, and proposed activities that target MSM and HIV vulnerability. The interviews also sought information on funding sources for such activities, the NGOs' human resources, the number of people reached by NGO activities, and any advocacy work with or on behalf of target populations.

Focus group discussions were used to gather information from MSM regarding sexual and social networks and meeting places, access to information and services dealing with HIV/AIDS and sexual health, advocacy activities, perceptions of existing services and unmet needs regarding HIV/AIDS and sexual health, whether MSM had experienced harassment from police because of their sexual behavior or identity, and the impact, if any, of their sexual behavior or identity on their relationships with family and community.

Focus group discussions were generally held at sites where MSM meet, such as parks and other public places. Participants for focus group discussions were recruited through the network of contacts that the researcher had developed as an openly gay Cambodian man and through his experience in conducting research on MSM and HIV/AIDS in Cambodia. The researcher recruited MSM who

were personally known to him; in some cases, these people recruited additional participants from their own MSM networks. Participants were invited to the focus group discussions either by telephone or word of mouth through those participants who could be contacted by telephone. During focus group discussions, the researcher asked participants to sit together and told them that everyone was invited to answer any or all of the questions asked. Participants were told that all of the information they provided was considered important. They were invited to comment on the accuracy of the information provided by other participants.

Names were not collected from focus group participants. The researcher reported that the age of participants ranged between 17 and 25 years, with the exception of several participants. In Phnom Penh, two participants were between the ages of 40 and 50 years. In one town outside Phnom Penh, two participants were 55 and 60 years old and, in another town, one participant was 57 years old.

Limitations of the Research

Apart from the recruitment methods described above, the researcher used no other means to engage participants; accordingly, the sample cannot be assumed to be representative of all MSM in Cambodia. Given that many of the focus group discussions were conducted in outdoor settings, the weather played a role in the success of efforts to ensure that people recruited for the discussions actually participated; when it rained, the number of participants was lower. The total number of focus group participants (75) also limits the extent to which generalized conclusions can be drawn from the information gathered. While conducting the interviews, the researcher simultaneously recorded responses in Khmer for later translation into English for the purpose of producing this report. Thus, it is possible that some of the information gathered is not accurately interpreted in this report or that nuances of meaning have been lost in the process of translation.

The researcher did not ask key informants to produce documents or other evidence of the information they provided; thus, there was no independent verification of the information provided.

As a result of the possible need to save face, information provided in a group setting may not be as accurate as information provided in a one-to-one interview, a consideration that may have influenced the accuracy of information collected in the focus group discussions.

Some of the questions used by the researcher to elicit information during focus group discussions could be described as "leading questions," that is, questions that are overly suggestive of a particular response. To the extent that this aspect of the report represents a methodological weakness, it is attributable to the brief given to the researcher by POLICY and not to the researcher himself. Chapter 2 provides a full list of questions used to prompt discussions in the focus groups.

MSM in Cambodian Culture

The issue of sexual practice and its relationship to identity in Asian cultures is a complex one. As discussed above in relation to the FHI report, many men do not consider their sexual encounters with other men in terms of sexual identity or orientation. A man who has sex with another man may or may not eroticize the fact that he is engaging in sex with another man. Some men deliberately seek out male sex partners who act in accordance with accepted feminine modes of behavior because they want the sexual act to be similar to the experience of engaging in sex with a woman.[18]

In Cambodia, there is a significant level of denial that sex between men takes place.[19] Some Khmer Buddhist texts have made statements that sex between men is unnatural and explicable only in terms of poverty, which forces men to sell sex[20] (although this explanation obviously does not account for the behavior of Cambodian men who purchase sex from other men). At the same time, some Khmer texts accept that sex between men is natural and not necessarily contrary to Buddhist precepts. One author has stated that sex between men in Cambodia is not a product of foreign influences on Khmer culture but rather has taken place from the early days of Khmer history and springs from the minds and hearts of Khmer men. [21]

The popular media, such as magazines and newspapers, provides numerous examples of stigmatizing attitudes toward MSM. One magazine aimed at young Cambodians includes a "problem page" in which readers can offer advice to other readers. A young woman asked for advice when she found out that her boyfriend was having sex with men. In reply, another female reader chastised the

This accomodation was built on a vacant plot of land by two MSM who had been thrown out of their family homes.

man, saying that his behavior was bad for society, for his future, for his family.[22] In another edition of the same magazine, an MSM reader wrote that he told his mother he was in love with another man. At first, she would not accept that her son could be a man engaging in sex with another man, but, in the end (after much explaining by her son), she said, "If both of you fall in love so much like this, you can do it. . .but do not show it too much. . . to the public."[23]

A traditional Khmer song includes the words "how much shame, to have a katoy child." A newspaper article in the style of a "tragic" human interest story reported the birth of triplets, of whom the second died and the two survivors were said to be katoy.[24]

The stigma and discrimination faced by MSM in Cambodia pose obstacles to effective sexual health promotion. As research conducted for this report demonstrates, stigma and discrimination cause MSM to "hide their face," making them more difficult to be reached by health promotion campaigns.

In Cambodia, the reasons and motivations for sex between men are several. Although they may prefer sex with another man to sex with a woman, some homosexual Cambodian men stop engaging in sex with other men after they marry.[25] Some young unmarried Cambodian men have sex with other men simply out of the desire to have sex and because cultural norms concerning gender make it easier to find a male rather than female sex partner. Some men have sex with other men as a way of earning money.

Talking about homosexual in Cambodia, it is very straightforward. Most of our people do not believe that the same gender can have sex. In fact homosexuality is available in hidden condition in the last three years. And homosexual have started to show their face increasingly in the society. Some have form a group to ask for legal status.[26]

Chapter 2: Key Informant Interviews

This chapter summarizes the information collected by the researcher through key informant interviews with the staff of NGOs engaged in activities targeting MSM and HIV vulnerability in Cambodia. Table 2 lists the questions that guided the key informant interviews. The researcher also asked key informants for information about any reports or other documentation that they were aware of regarding MSM and HIV in Cambodia. A list of references appears at the end of this report.

Findings from Key Informant Interviews

Local NGOs working with MSM in Cambodia are mainly funded from one or both of two main sources: Family Health International and the Khmer HIV/AIDS NGO Alliance (KHANA). CARE Cambodia also carries out some MSM-related work .

Family Health International

Funded by USAID, Family Health International provides funding and technical support to Men's Health Cambodia and the Urban Sector Group, two Cambodian NGOs working in Phnom Penh.

FHI was one of the first organizations to address the vulnerability of MSM to HIV/STI infection in Cambodia. Beginning in 2000, FHI conducted an HIV/STI prevalence and behavioral survey of MSM in Phnom Penh, referred to in Chapter 1. Based on the survey findings, which indicated a high degree of vulnerability and risky sexual behavior among MSM, FHI partnered with Marie Stopes International and its local partner, Cambodian Women's Clinics (CWC), to pilot a drop-in center for urban men, including MSM, in Phnom Penh. Following an 18-month pilot, FHI, in partnership with former members of the drop-in center, identified as a priority the creation of a local NGO charged with conducting outreach and peer education with MSM in Phnom Penh. In response, former CWC staff who had worked with FHI on the MSM HIV/STI survey in 2000 established Men's Health Cambodia.

Men's Health Cambodia

The mission of Men's Health Cambodia (MHC) is to address the HIV/STI vulnerability of MSM in Phnom Penh. MHC is located in central Phnom Penh and operates a small office in Siem Reap that is funded by KHANA (see below).

Table 2. Questions to Guide Key Informant Interviews

- The nature of the work they do—Health promotion? Peer support? Community development? Advocacy? Details of these?
- How long they have been operating?
- What activities have they undertaken in the past, what activities do they currently undertake, and what do they plan or hope to do in the future?
- How much funding do they receive, and from whom?
- The size of the organization—Number of staff and other resources?
- The populations they reach—Who are they? What methods do they use to reach them? How many do they reach?
- Do they represent the interests and needs of MSM to people involved in relevant policy or program activities, e.g., Ministry of Health, provincial AIDS committees, health centers, and so forth?

MHC focuses on the following strategies:

1. Reducing high-risk behavior and improving health-seeking behavior among MSM.
2. Strengthening care and support referral networks, including STI care, VCT, and HIV/AIDS care and support.
3. Strengthening the capacity of MHC to manage its program and set up an office and drop-in center.
4. Promoting the notion that MSM in Phnom Penh can live with dignity while enabling a favorable environment that will help reduce MSM marginalization and support positive behavior change.

Activities associated with these strategies include peer and outreach education and condom and lubricant distribution accompanied by a brochure about the correct use of lubricants. FHI is planning to conduct a qualitative assessment of risk behaviors and the situation among MSM in Phnom Penh to develop the existing interventions further. More recently, FHI has built the capacity of a local NGO, Médicin de L'Espoir Cambodge (MEC), to provide STI treatment to MSM. FHI provides specialized training to MEC health care providers with respect to the diagnosis and treatment of anal STIs and has forged institutional linkages between MHC and MEC for STI referrals, counseling, and VCT.

MHC holds meetings for MSM at its offices each month. During the meetings, MHC provides information and education about HIV/AIDS, STIs, and safe sex practices as well as training in peer outreach skills for HIV and sexual health promotion. People requiring sexual health clinical services are referred to MEC; if a client is under age 18, he is referred to Mith Samlanh-Friends. Clients who want to undergo an HIV test are referred to the Ponluer Chivit I and II HIV testing centers. MHC has developed a relationship with these clinics, which provide pre- and post-test counseling specifically for MSM. The clinics are also available to men who have sex with women.

MHC uses "key contacts" from its target communities in each of the main locations where MSM gather to meet each other in Phnom Penh. The contacts help MHC identify MSM who may need MHC services. The key contacts approach men whom they see at locations frequented by MSM and engage them in conversation to establish whether they are MSM and potential new clients. The contacts also use the "snowball approach"—identifying new clients through word of mouth from existing clients.

MHC works with MSM short hair but is willing to work with MSM long hair, who are treated as "part of the family" if they come to the MHC premises seeking information or assistance.

MHC says that it has not yet undertaken any advocacy work, although it has talked to "authorities" about its current efforts. In the future, MHC wants to provide additional services for its clients, for example, English classes. It also wants to provide outreach services in more locations in Phnom Penh. MHC says that, to date, it has made contact with 500 MSM in Phnom Penh, most of whom are MSM short hair sex workers.

The paid staff of MHC include the executive director, one administrator, one counselor, and four field workers—all complemented by four volunteer field workers. There are also two supervisors of the field work staff and volunteers, with each supervisor overseeing staff and volunteers at two locations each night. Field work staff work from 4:00 p.m. to 11:00 p.m. Wednesday through Sunday and, together with the volunteer field workers, provide HIV and sexual health outreach services at locations around Phnom Penh where MSM meet. They provide information and education about HIV/AIDS and condom use and distribute free condoms. They also distribute lubricant, which sells at a cost of 200 riels for a small bottle. MHC told the researcher that it also arranges home visits to MSM living with HIV/AIDS to provide support and assistance.

Urban Sector Group

Since 1999, FHI has provided funding to the Urban Sector Group (USG), located in central Phnom Penh. USG uses the funds to work with MSM, sex workers, and other vulnerable populations. In its MSM work, USG works mainly with MSM long hair by relying on three key contacts at two locations in Phnom Penh. Key contacts receive a payment each month, and FHI has trained them in HIV health promotion for MSM. USG uses premises at each of the two locations to run meetings for MSM on HIV and sexual health, with materials provided by FHI.

If clients wish to be tested for HIV, USG refers them to Pharmaciens Sans Frontières. USG also provides free condoms but not lubricant. USG manages a "savings box"

so that it can provide limited funds to MSM in need of financial assistance. It has not undertaken any advocacy work on behalf of MSM long hair but, in an effort to promote greater public acceptance of MSM long hair, encourages MSM long hair to participate in workshops and meetings with other groups.

Like MHC, USG uses key contacts and the snowball approach to reach new clients. It reports that, to date, it has reached 300 MSM long hair clients.

KHANA

KHANA's MSM work, and its funding of MSM work by other NGOs, is based on the Frontiers Prevention Project (FPP) clusters model, developed and funded by the International HIV/AIDS Alliance.[27] KHANA also receives funding from USAID. The FPP aims to reduce HIV infections in relatively low-prevalence countries put at risk by the growing HIV pandemic. FPP is undergoing implementation in Ecuador, India (Delhi and Andhra Pradesh), and Cambodia. The project strives to reduce HIV incidence by reducing risk behavior and STI prevalence among key populations, which are defined as members of groups central to HIV/AIDS epidemic dynamics. Populations include sex workers, MSM, people living with HIV/AIDS, and, in Andrha Pradesh, injecting drug users. The central hypothesis of the FPP intervention design is that the empowerment of important populations in a low-prevalence environment will, as part of a comprehensive package of services and interventions, not only reduce HIV transmission among pivotal populations but also slow the spread of HIV more widely in the population as a whole. The FPP identifies eight intervention "clusters" or areas of activity, as listed in Table 3.

Table 3. Frontiers Prevention Project Clusters

1. **Strengthening the capacity of NGOs and others to work with key populations**—for example, workshops for NGO staff and key populations on a variety of technical issues.
2. **Implementing peer outreach activities**—for example, training members of key populations as peer outreach workers to provide other members of those populations with information about HIV/AIDS, relevant services, and the distribution of condoms, lubricant, and IEC materials.
3. **Mobilizing key populations for advocacy**—for example, training members of key populations in advocacy and leadership skills to implement local advocacy efforts; supporting national advocacy efforts to promote the rights of key population members and their involvement in programming.
4. **Implementing key population mutual support and cultural and solidarity-building activities**—for example, mobilizing key populations and building peer support and social capital through social activities and the creation of safe spaces.
5. **Implementing key population risk-reduction skills-building activities**—for example, intensive group discussions and skills building for key populations on safe sex techniques, dealing with violent clients, condom use negotiation.
6. **Developing and disseminating IEC for key populations**—for example, IEC development for and by key populations.
7. **Strengthening clinical capacity and quality of services**—for example, collaborating with government to strengthen VCT or STI services.
8. **Implementing anti-stigma and HIV prevention with general public**—for example, working with gatekeepers such as police and brothel owners and implementing anti-stigma campaigns during high-profile events such as World AIDS Day.

As well as funding NGOs to carry out work targeting MSM, KHANA undertakes some MSM-related work itself, particularly strengthening NGOs' and others' capacity to work with key populations (cluster 1) and strengthening clinical capacity and the quality of services (cluster 7). The particular relevance of cluster 7 for MSM is that, to be accessible, clinics need to provide male-only spaces for the delivery of HIV and sexual health services to MSM. In addition, clinics need to develop the capacity to provide services that cater to the HIV and sexual health needs of MSM.


NGO and donor representatives at a dissemination meeting.

KHANA provides funds and technical support to NGOs in Phnom Penh, Battambang, Sihanoukville, and Siem Reap to carry out activities under the remaining six clusters. KHANA has provided training on HIV/AIDS and STIs to staff and peer workers from partner organizations that operate MSM projects. KHANA has conducted two assessments relating to the activities of MSM. The first was carried out in Phnom Penh, Battambang, and Siem Reap in October 2002.[28] The second was the Participatory Site Assessments that were carried out in Battambang, Sihanoukville, and Pailin as the first stage of the FPP and conducted in conjunction with local NGOs.

Each of the NGOs funded under the FPP will receive funding as of September 2003, not all of which must be spent on activities targeting MSM. The following section describes the NGOs that KHANA funds under the FPP and their activities.

Men's Health Cambodia (Siem Reap)

Since May 2003, MHC Siem Reap has been receiving a small amount of funding from KHANA for an initial pilot project targeting MSM. MHC Siem Reap relies on peer outreach workers and one volunteer. It provides free condoms to MSM at meetings it organizes. Condoms are also available free at other times from the MHC office. MHC staff record the names of MSM who volunteer for peer outreach work. Staff advised that they do not record the names of MSM contacted during outreach work or the names of MSM who attend other events organized by MHC Siem Reap, except when the MSM volunteers are to be listed on the peer outreach volunteer list. During meetings, MHC Siem Reap provides information and education about HIV and STIs.

Through group discussions and meetings, MHC Siem Reap staff have reached 216 MSM in two districts, Siem Reap and Pouk. In addition, MHC Siem Reap reaches 200 MSM each month through outreach activities, although there may be some overlap between the groups reached in meetings and outreach activities. MHC Siem Reap aims to reach 700 MSM over a one-year period. Peers teach their friends about HIV, and the volunteer helps MHC locate MSM that they have not previously reached. They also use the snowball technique to identify MSM not already reached.

Funding under the FPP was scheduled to commence in August or September 2003. MHC Siem Reap plans to use the additional funding to expand the geographic reach of its work. MHC Siem Reap employs a coordinator, a male worker whose sole focus is MSM, and a female worker who will work with female sex workers and other populations under the FPP initiative.

Khmer Women's Cooperation for Development

Khmer Women's Cooperation for Development (KWCD) is located in Sihanoukville and is funded by KHANA to work with MSM and other target populations, such as sex workers. KWCD will receive FPP funding for

activities with these populations. Its MSM work targets both MSM short hair and long hair. KWCD has invited local authorities, including police, to attend meetings to educate them about MSM. KWCD provides MSM with education and information about sexual health, HIV, and safe sex practices. KWCD also provides free condoms when it can, but, due to limited supplies, also sells condoms.

KWCD conducted a Participatory Site Assessment as the first stage of the FPP, with the results of the research (unpublished) presented to local authorities. KWCD has also assisted MSM in organizing small-scale advocacy activities to increase public awareness of MSM issues. KWCD would like to assist with two large-scale MSM advocacy activities each year.

KWCD planned to start peer outreach work in August 2003 and proposes to support MSM HIV prevention work and advocacy with the general public, local authorities, and the police. KWCD has already identified 71 MSM through its informal research and hopes eventually to reach 700 MSM in the Sihanoukville area. It relies on key contacts and the snowball approach to increase the number of MSM contacted.

Community Development Action

Community Development Action (CDA) works in Battambang and is implementing the FPP, including production of IEC by and for MSM; building peer support and social capital; undertaking peer outreach, advocacy, and focus group discussions; and ensuring the inclusion of MSM in workshops related to sexual health. CDA aims to reach 1,050 MSM through its activities during the first year of implementing the FPP.

Khmer Development of Freedom Organization

The Khmer Development of Freedom Organization (KDFO) is funded by USAID through KHANA to work with MSM in three areas of Phnom Penh. KDFO runs weekly group discussions to teach MSM (both short hair and long hair) about sexual health and provides referrals for STI treatment and HIV testing. It has worked with sexual health clinics to establish MSM-friendly services. Seven clinics in Boung Tompon and three clinics in Veal Vong now provide sexual health services at a reduced price to MSM. KDFO has had less success in Chba Ampov II, where only one of the seven clinics approached by the organization has agreed to reduce its prices for MSM.

KDFO distributes free condoms as well as information about where condoms can be purchased. It has established two safe spaces or meeting rooms in its target areas where MSM can meet to get information about HIV and sexual health as well as socialize. KDFO also collects money for MSM in need of emergency financial assistance.

Although KDFO is not part of the FPP in Cambodia, it nevertheless participates in FPP workshops that focus on MSM issues. KHANA strongly encourages KDFO to implement many of the FPP activities, as these represent "good practice."

CARE Cambodia

Since 1997, CARE Cambodia has implemented a package of prevention, care, and support interventions among mobile and other vulnerable populations. The prevention program includes peer education, mass media, condom social marketing, and STI and VCT components. Prevention activities reach diverse populations, including females in the sex industry and their clients and mobile men such as men in the uniformed services, transport workers, and seafarers, along with their wives. CARE has found that other vulnerable populations such as MSM are difficult to reach because of the stigma associated with male-to-male sex in Cambodian society. It was this difficulty that prompted the research cited in the introductory chapter of this report.

Poipet and Koh Kong

At present, no NGOs target MSM in Poipet. CARE Cambodia has conducted research on MSM in Poipet and Koh Kong provinces. As of October 2003, CARE had started planning for project work addressing the issues of MSM and HIV vulnerability with target populations in the two provinces and expects to begin implementing project activities within the next few months.

Discussion

At present, nine NGOs in Cambodia are involved in project work targeting MSM; for MHC Phnom Penh,

MSM is the NGO's sole target population. Projects are operating in Phnom Penh, Battambang, Siem Reap, and Sihanoukville, with further project activities planned for Poipet and Koh Kong. While it is encouraging that health promotion activities targeting this vulnerable population are underway, it is important to stress that each project relies on peer outreach and, in some cases, meetings at NGO premises, as the only means of delivering HIV and sexual health promotion messages to MSM.

Reliance on certain strategies, such as peer outreach and meetings, limits the number of individuals in the target population who can be reached. Moreover, a high degree of stigma is attached to sex between men; consequently, much sex between men remains hidden, posing difficulties for health promotion methods that rely on personal contact with members of the target population. Even without the challenge of stigma, however, there are inevitable limits on the "reach" of peer outreach as a health promotion technique because of its reliance on workers making one-to-one contact with members of the target population. Chapter 4 discusses this issue further, but it should be noted that while HIV and sexual health promotion work is targeting MSM in a number of locations in Cambodia, the overall reach of the work is not of the scale needed to effectively address the issue of MSM and HIV vulnerability in Cambodia.

Chapter 3: Focus Group Discussions

The researcher conducted a total of 10 focus group discussions with MSM short hair and MSM long hair. Two focus group discussions were conducted in each of the following locations: Phnom Penh, Poipet, Sihanoukville, Siem Reap, and Battambang, with a total of 75 MSM taking part in the discussions. Table 4 provides information about each focus group discussion.

At the start of each focus group discussion, participants were asked whether they had previously met each other; introductions were made between any participants who did not know one another. Participants each received $1 to cover the cost of attending the focus group. The only exception was for the focus group discussions held in Sihanoukville, where the local NGO advised that it had already paid participants' travel expenses. At the end of each focus group discussion, the researcher asked the participants to join in activities such as singing songs and telling jokes, as he wanted participants to leave with some pleasant memories of their participation in the focus group discussion. All participants were thanked for their contributions to the discussions.

Table 5 on the following page lists the questions that guided discussions with focus group participants.

Information from Focus Group Discussions

This section summarizes the key findings that emerged from the focus group discussions and then presents more detailed information from the discussions.

Key Findings from Focus Group Discussions

- Stigma and discrimination limit the capacity of MSM to maintain social networks or require such networks to operate clandestinely.
- MSM long hair are more likely to experience discrimination because of their greater visibility, the consequences of which can include poverty through unemployment and police harassment such as sexual assault.
- There is a perceived lack of information regarding HIV prevention for MSM as well as confusion as to

Table 4. Focus Group Discussions

Date	Location	Number of Participants	Identity	
July 25, 2003	Phnom Penh	10	MSM short hair	
August 4, 2003	Phnom Penh	4	MSM long hair	
July 29, 2003	Battambang	7	MSM short hair	
July 31, 2003	Battambang	10	MSM long hair	
July 30, 2003	Poipet	14	MSM short hair	
July 30, 2003	Poipet	4	MSM long hair	
August 5, 2003	Sihanoukville	7	MSM (6 long hair, 1 short hair)	
August 6, 2003	Sihanoukville	6	MSM short hair	
August 7, 2003	Siem Reap	6	MSM long hair	
August 8, 2003	Siem Reap	7	MSM short hair	
Total Participants		75	45 MSM short hair	30 MSM long hair

Table 5. Questions to Guide Focus Group Discussions

- How do the MSM identify themselves—MSM? Gay—short hair/long hair? Katoy? Transgender? Straight? Sex worker? Other?[29]
- What networks, or ways of meeting and staying in contact with each other, do they have?
- What access do they have to sexual health and HIV/AIDS information:
  - IEC/behavior change communication (BCC) materials?
  - HIV/sexual health clinical services?
  - Support groups or other forms of peer support?
- Are there any examples of how they have engaged in advocacy, for example, representing the interests or needs of their community to people involved in relevant policy or program activities?
- What do they know about the history of MSM in Khmer culture and society?
- What do they see as their unmet needs in terms of sexual health and HIV/AIDS? More education projects? Better clinical services? Better access to condoms? Other?
- Have they been subject to police harassment or assault because of their sexuality or sexual behavior? Was there anything they could do, or any assistance they could get, in dealing with mistreatment by police? Are there any police practices that discourage them from carrying condoms?
- How does their sexuality, or their MSM sexual activity, affect their relationships with their families and their relationships with people in their local community?

whether HIV prevention information targeting heterosexual sex is applicable to sex between men.

- There is a limit to the extent to which peer outreach alone can deliver HIV prevention and sexual health promotion messages to all the people who need to be reached by such messages.
- Other modes of delivering information such as radio and television should be used, and messages targeting the general population should include information specific to sex between men.
- Few focus group participants had been involved in advocacy activities on behalf of MSM, and most suggested that NGOs need to take the lead in initiating advocacy activities, which participants would be willing to "join."
- There was a low level of knowledge about the history of MSM in Khmer society or culture.
- Participants had mixed experiences in gaining access to appropriate clinical services. Some MSM reported that they received discriminatory treatment, such as being subjected to derogatory remarks or being made the target of jokes, while other MSM reported that they did not experience difficulties or unsatisfactory service when accessing sexual health clinics.
- MSM long hair more often reported experiencing discrimination and unsatisfactory service, which appeared to be related to the fact that they were easier to identify as MSM. MSM short hair were likely to conceal from clinic staff the fact that they had sex with men.
- Some focus group participants expressed dissatisfaction with the MSM-targeted services provided by organizations. Such dissatisfaction was related to the perceived homophobia of some staff and the belief that staff record the names of MSM seeking or being reached by services.
- In nine of the 10 focus group discussions, participants reported being subject to police harassment, including verbal abuse, extortion, and sexual assault.
- In most cases, being known to be MSM had negative consequences for focus group participants' relations with their families and local communities. Consequences included violence, ostracism and rejection, and dismissal from employment.

More detailed information regarding responses to the questions used by the researcher to guide focus group discussions appears below.

How Do MSM Identify [Each Other]?[30]

In eight out of the 10 focus group discussions, participants said that it was easy to recognize MSM long hair, and in nine of the 10 focus group discussions, participants said

it is not easy to recognize MSM short hair. One participant commented that "some of the boys keep long hair but they are straight. So I do not know."

Networks, Meeting, and Maintaining Contact

In many cases, focus group participants spoke of the difficulties of meeting and maintaining contact with other MSM because of stigma, discrimination, and the fear of being recognized as MSM.

I meet and talk to other gays short hair through phone. The reason why we want to communicate each other by this way because we do not want other people to know that we are MSM, or we do not want people to know that we talk about the boy. (MSM short hair, Phnom Penh)

. . . [M]ost of the MSM short hair they have the male student sexual partner, they do not want to go to the pick up areas because they do not want the public to recognize that they are MSM. (MSM short hair, Phnom Penh)

If there is no stigma or discrimination we are not worry about letting people know that we are MSM. The police cannot recognize us because we are short hair. I think most of MSM are not open. We know other MSM through friends by their introducing. (MSM short hair, Phnom Penh)

Normally there are a lot of MSM in Battambang, but most of them do not stay in contact with each other. This is because most of them do not want the public to recognize them as MSM. (MSM short hair, Battambang)

MSM long hair they are more open, they like to stay in contact each other by phone, or go to their friend's house. (MSM short hair, Battambang)

MSM long hair always help each other. Many of them meet each other at the rich MSM long hair's house or at a place where there is a dance music. (MSM long hair, Battambang)

There is no specific places for us to pick up a boy. We meet handsome boys by chance. (MSM short hair, Poipet)

We meet each other at night club, or at beach, most of us do not have a mobile phone, so it is not easy to contact. (MSM long hair, Sihanoukville)

Participants also commented more generally on the stigma and discrimination faced by MSM.

It is hard for MSM to get a job, . . .to make friends, to get along with other student at the school. (MSM short hair, Sihanoukville)

MSM at a dissemination meeting. Two MSM hide their faces behind papers.

MSM short hair and long hair recognized and commented on the greater discrimination that MSM long hair face as a result of their greater visibility. The consequences of being more easily identifiable as MSM include poverty through unemployment and ostracism by their local communities.

I think it is hard for being katoy. The MSM short hair do not have any problem with money because most of them can get [a] job easily. (MSM long hair, Battambang)

We still talk to each other by telephone or go to their house, and some time we manage a gay party, we never invited MSM long hair, we do not hate them, but if people see they will call us katoy also. (MSM short hair, Siem Reap)

. . . I think that the public do not like us, and I know because of the lack of information about HIV/AIDS that is why a lot of MSM have died already. (MSM long hair, Poipet)

Access to HIV and Sexual Health Information

In nine of the 10 focus group discussions, participants commented on the lack of HIV and sexual health information and education resources specifically for MSM. The exception was a focus group of MSM long hair in Siem Reap, in which participants made comments such as:

I think that MSM know how to use condom, most of them use condom, because they are afraid of the disease such as HIV/AIDS.

We used to receive IEC material. It can apply for both man and woman. That is very good.

Other focus group participants expressed confusion as to whether HIV/AIDS and sexual health education messages targeting heterosexual sex also apply to sex between men. For example:

We learn about sexual health, but sexual health with female only. I never heard about sexual health related to MSM through the media or radio. I heard before about the risk of anal sex, but they do not tell whether anal sex with woman or with both man and woman. (MSM short hair, Phnom Penh)

There is no IEC specific for MSM here, MSM still do not know exactly if they can get HIV from their sexual partners, and most of them do allow their partner insert without a condom. (MSM long hair, Poipet)

Comments from focus group participants suggest that different approaches to HIV prevention education for MSM are needed. In five focus group discussions, participants said that electronic media—radio and television—should be used to convey HIV prevention information targeting MSM in the way that the same media convey HIV prevention information concerning sex between men and women. These media are accessible to MSM whether they are short hair or long hair and whether or not they wish to disclose their MSM activity. A limitation of IEC activities conducted at NGOs is that some MSM will not attend for fear of being exposed as MSM. Other suggestions called for a gay magazine available at an affordable price, and combining information about MSM and HIV prevention with information targeting sex between men and women.

Advocacy

The only focus group in which participants had been involved in advocacy concerning MSM issues was the group of MSM long hair in Sihanoukville:

We used to join the advocacy at the Department of Information about MSM. And at Holiday Hotel, and at Phka Mhlis hotel (about MSM right and present the result of KWCD informal research). We help KWCD to do the research and we present it to the authority and police and to the health center and other.

In other focus group discussions, participants were in favor of advocacy for MSM, but many stated that they could not "join in" advocacy activities unless an NGO took the lead:

We never join the advocacy activities or program because there is nobody do it yet. So how can we join, we just not want the knowledge about HIV/AIDS but advocacy for rights or better consider from the public. (MSM short hair, Phnom Penh)

Five years ago the police went to [a] pagoda and catch all the MSM long hair, and ask for money, they said MSM against the law and the religion. So there is no reason for us to be brave to do an advocacy without the support from NGOs. (MSM long hair)

The two focus groups where participants did not express willingness to join in advocacy activities were in Poipet:

No, we do not have any advocacy, or join any advocacy. I do not think MSM in Cambodia will have a chance like MSM in Thailand. In Thailand are more open. (MSM short hair, Poipet)

We do not join any advocacy or talk to anybody about MSM. We talk to MSM same as us. (MSM long hair, Poipet)

History of MSM in Khmer Society and Culture

The question about the history of MSM in Khmer society and culture elicited little information from focus group participants. Some comments follow:

I heard about the history of MSM, such as there were many discrimination from the public and the neighbor, and some MSM, their boss stop them from work because they find out that he is MSM. (MSM long hair, Sihanoukville)

I heard from my father that one of his father's grandfather is MSM. So I think MSM are exist a long time ago not just now. (MSM short hair, Battambang)

My teacher said that MSM exist in Cambodia because of tourism. Many people from western bring this culture. (MSM short hair, Battambang)

I don't know about the history of MSM in Cambodia. But I think it's nature. I born, I grow up, I fall in love with a boy. (MSM short hair, Poipet)

Unmet Needs Regarding Sexual Health and HIV/AIDS

In eight of the 10 focus group discussions, participants said that public clinics should provide MSM-targeted sexual health services and similarly suggested that MSM long hair should receive free condoms and lubricant. The comments may reflect a shared awareness of the greater discrimination and consequent economic hardship that MSM long hair face by being more easily identified as MSM. In one focus group, MSM long hair said that they had experienced problems with clinic staff:

Some clinic they pretend that they do not mind about MSM but actually they laugh at us in the back.

This observation stands in contrast to comments from the focus group discussion with MSM short hair in the same location:

MSM short hair like us do not have any problem to go to the clinic.

However, while MSM short hair were more likely to report that they could attend clinics without facing stigma and discrimination, their experience is consistent with being able to conceal the fact that they are MSM and indicates that they might not disclose information about their sexual activities with other men. The stigma and discrimination associated with sex between men in Cambodia are an obvious reason for MSM to conceal such information from clinic staff, but a consequence of such concealment is that the men will not receive the range of sexual health services, such as anal examinations, that are necessary for maintaining sexual health.

The stigma associated with sex between men in Cambodia can also create challenges for organizations working or seeking to work with the target population. In particular, stigma might make it difficult to establish relationships of trust. For example, in some cases, focus group participants believed that NGO outreach workers recorded the names of MSM they contacted during their outreach activities. The relevant NGO has stated that it records names only with the consent of MSM who offer to participate in volunteer outreach work and only for the purpose of maintaining a list of volunteers. It may be that NGOs need to clarify this practice with their target communities. Misperceptions can potentially undermine the effectiveness of NGOs' MSM-related activities.

We are not involved with NGOs because we afraid that they will announce our name in the TV or something. (MSM long hair)

I think it is not good for the NGOs to go and try to find out who is MSM and write their name. (MSM short hair)

Three focus group discussions suggested that some NGO staff took jobs working with MSM in order to earn a wage but were nonetheless homophobic. It is hardly surprising that earning a wage would be a motive for any person undertaking paid work, but the comments from the three groups are worth noting because they stress the fact that MSM are a highly stigmatized population subject to discrimination by their families, their local communities, employers, police, and others. MSM expressed the feeling that society in general disapproves of and rejects them:

I think that the public do not like us...(MSM long hair, Poipet)

Katoy is a word that the public hate...(MSM long hair, Siem Reap)

Special measures such as sensitivity training for staff and an emphasis on the employment of peer workers—

that is, workers who are themselves MSM—may enhance the effectiveness of NGOs' HIV and sexual health promotion work.

Police Harassment or Assault

Participants in nine of the 10 focus group discussions talked about police harassment, including sexual assault and demands for free sex from MSM sex workers. The only focus group discussion in which police harassment did not emerge as a problem was a discussion with MSM short hair, one of whom said:

We do not have any problem with police because we are short haired and strong. So it is not so easy for them to recognize us. (MSM short hair)

The following are additional comments made during focus group discussions regarding interactions with police:

MSM long hair have some problem with the police...But there is no problem with MSM short hair because the police do not easily recognize them. (MSM short hair)

A long time ago at [a] pagoda, a police caught all the MSM long hair and asked for money, they said MSM [are] against the law and against the culture and religion. (MSM short hair)

The police also like to look at us and laugh, they do not respect us even a little bit. Not all of the police but some of them. (MSM long hair)

When we back home late at night time the police ask us, you boy or girl, and the police check us to find out if we have a penis or a vagina. The police do not like us, and they check us and ask us for money. (MSM long hair)

Some police man are MSM, and they always want katoy to [perform oral sex on them]. These police know that MSM afraid [of] the police, so they do anything they want. (MSM long hair)

There are many kinds of stigma and discrimination, such as the police laugh at us, the police scold us, check our body. (MSM short hair)

We have some problems with police, the police always check to find some money and take it, some they check to see if we have a vagina. And some police scold us. (MSM long hair)

All of us are sex workers, we hang out at the park at the night time...We do have some problems with police such as they come straight to us and asked, "What are you doing here, why you stay here till late at night? What for?" Or sometimes the police said that we use drug, so they want to check. Yes, sometimes if they see a condom, they throw it away. They said, "Do not use condom because you are katoy, and I think all the katoy will die all soon." And they laugh. (MSM long hair)

Before at [an outdoor meeting place] there were many male sex workers there, when the police go to see, and the boy stay late in the evening, the police will ask them [for] money, or some police will [have sex with] the male sex workers without condom. (MSM long hair)

Relations with Family and Community

Overwhelmingly, participants' visibility as MSM had negative consequences for their relations with their families and local community. Consequences included violence, ostracism and rejection, and loss of employment.

Being a katoy, some parent[s] hit their children because they know that their children are katoy. Some parent hit their katoy child because they want their son to change their nature behavior. I mean change from homosexual to heterosexual. (MSM short hair, Phnom Penh)

If the family or community know that we are MSM many of them are not accept. Some family they hit their MSM members or they ask MSM to go away...That is why too many MSM short hair...hide themselves, and not identify as MSM. (MSM short hair, Battambang)

Some family they hit their MSM son. Some neighbor they scold us...I think it is really hard for being MSM. I want to [be] born as other people, so nobody will hate me but now I cannot change...It is natural. (MSM long hair, Battambang)

It is hard for MSM to get a job. To get along with people in their community. To make friends or get along with the student at school. (MSM short hair, Sihanoukville)

However, participants commented that families sometimes accepted their MSM children:

Some MSM their mother do not mind, so they still let their child stay in their house. Some parent they do not like their child after they know that their child are MSM. So their child have to go to stay outside, some of them stay at their friend's house. (MSM long hair, Siem Reap)

One of my grandfather is katoy. My father is katoy and I am katoy. My mother she is ok. She not angry with us. I hope she understand that is nature. I heard from my mother that the father of my grandfather is also katoy. (MSM long hair, Phnom Penh)

CASE STUDY: A short story about an MSM who had to leave his family

During the course of the dissemination meetings with focus group participants, the researcher by chance found himself sharing a taxi from Battambang to Siem Reap with a 17-year-old MSM. The 17-year-old told the researcher the following story:

"I cannot stop loving boys, but I love my mom. My parents forced me to leave home when they found out that I am MSM. They said they do not have a son like me, they are shamed by the people in the village in Siem Reap where I was born. I left home almost five months ago. I went to stay in Pailin where my grandparents live. I stay with them. Now I miss my family so much, especially my mom. I hope they will accept me. And I hope I can stay with them. I do not know what to do, I am just 17 years old. Now I am taking a taxi to Siem Reap, I do not know whether they will accept me or not. My grandparents, they know about all these things, and they said that if my family do not accept me, I can come back and stay with them at any time. I do not have much money with me now, but if they do not accept me I do not know what to do. Maybe I can find some work to do, and maybe I can earn some money for going back to Pailin. Mom and Dad want me to get married to a girl, after they found out I had experiences with boys. They do not understand that if I married a girl, it would be the same as if my father married a man, or my mother married a woman, someone they do not have feelings for. I do not hate girls, but I just cannot have sexual feelings for girls. My mom sends me money through other people. It was my father that forced me to leave home."

Terminology

The range of terms used in Khmer to describe sexual relationships gives some indication of the variety and complexity of meanings attributed to these relationships in Cambodian society. A study by Population Services International in 2002[31] lists over 60 terms used by men to refer to women and over 60 terms used by women to refer to men, indicative of different types of relationships—some of them sexual and some involving commercial and/or emotional components. As noted, the number of participants in the present study is relatively small and precludes any attempt to develop a definitive lexicon of MSM-related terms. Opposite are listed the terms, and comments on terminology, offered by participants in the current study. They are included in this report because they may add to our understanding of the way in which language is used by and in relation to the target population, as well as the meanings attributed to sex between men.

Terms Used or Discussed by Focus Group Participants

bros sart—generally for a straight handsome boy
bros penh tom hung—straight
bok lahong—anal sex
apsara—masturbation
srey sros (meaning "pretty girl")—transgender/katoy long-hair
chrearng (meaning "to sing")—oral sex performed on a man
reng (meaning "to move your waist around")—anal sex (receptive)
rung (meaning "hard")—MSM who behave like a boy
ton (meaning "soft")—MSM who behave like a girl
bros luk khluon (meaning "taxi boy")—a male sex worker who openly solicits clients in public

indirect male sex worker—a male who will not openly solicit sex from paying clients but will ask for money either before or (usually) after sex. The researcher reported that, in Phnom Penh, indirect male sex workers are most likely to go to public parks or restaurants and will usually strike up a conversation that only gradually leads to the subject of sex. Indirect male sex workers are more common than taxi boys because the stigma of being seen to be working openly as a male sex worker mitigates against openness.

katoy—term most often discussed by focus group participants:

- "It doesn't matter I am short hair, long hair, or whatever as long as you have sex with [a] man they will call you katoy. We don't like this word, it is a taboo word for us. We prefer them to call us gay ('kee')."
- "We hate this word, we don't want them to call us katoy, we want them to [call us] anything they want to call but not katoy."
- "We do not like the people to call us katoy. Katoy is a word that the public hate."
- "We have different word for MSM, some place they say like this, some place they say like that, so it is difficult to tell you. Just remember that the public call us katoy (it does not matter you are long haired or short haired). And also remember that the MSM do not like the public to call us katoy; some of them they call themselves as srey sros [pretty girl] or whatever, [depending on] what they like."
- "People will call us katoy. No matter that we are short haired or long haired, if they know that you sleep with boy, they will call you as katoy even we call ourselves as brossaart (handsome man) or whatever."
- "Even gay people have some words to use for themselves, but the people still call them only katoy, and we think that the word katoy is a word that all of gay people do not want the public to call."

kee—gay

kin ice tem*—oral sex performed on a male

koy yai yai*—big penis

tham daiy*—you can do it (anal penetration)

* The researcher reported that these are Thai terms.

Chapter 4: Conclusions and Recommendations

Conclusions

MSM in Cambodia demonstrate a low level of knowledge about the risks of HIV transmission through sex between men. Many MSM, particularly MSM long hair, who are more easily identified as MSM, face difficulties in accessing HIV and sexual health services and can be subject to discriminatory treatment when they do access such services. MSM short hair who access needed services may conceal the fact that they have sex with other men, suggesting that they will not receive the necessary range of clinical services.

The available epidemiological and behavioral data indicate that MSM should be considered as a vulnerable group for HIV infection and that MSM could be serving as a "bridge group" of HIV transmission to the general population. Male-to-male sexual behavior represents an important link in the spread of HIV and STIs in Cambodia that currently remains unaddressed by national policy and program frameworks.

Research by CARE has highlighted the particular unmet needs for HIV and sexual health information and services for MSM in communities in Koh Kong and Poipet and has demonstrated the value of using highly focused qualitative data collection methods, including case studies, to gain new and valuable insights into the sexual practices and HIV-related risk behaviors of MSM.

Information from key informant interviews suggests that implementation of the FPP by KHANA and the organizations it funds will significantly increase the level of activity by NGOs targeting MSM. In addition to HIV prevention initiatives, the FPP will provide the opportunity to develop advocacy activities by and for MSM. Information from focus group discussions suggests that all organizations should provide sensitivity training to staff working with this highly stigmatized population.

At present, NGOs rely too heavily on "peer" outreach as a method of sexual health promotion and HIV prevention for MSM. It is essential to consider other health promotion methods, including the use of both print and electronic mass media. There is a need for more IEC resources that specifically address the HIV and sexual health information needs of MSM, and for the inclusion of MSM-specific messages in HIV prevention and health promotion activities and resources targeting the general population.

For two reasons, the experiences of stigma and discrimination as reported by MSM point to the need to promote greater respect for the human rights of this population. First, a climate of respect will enhance the effectiveness of HIV and sexual health promotion campaigns targeting MSM. Second, the human rights of MSM are worthy of protection in their own right. MSM need access to technical assistance and material resources to undertake health promotion activities, both on their own behalf and in conjunction with human rights and HIV/AIDS organizations.

Given the available epidemiological and behavioral data, it is significant that no government institutions or programs actively target or involve MSM in either policy or program development or in epidemiological or behavioral monitoring concerning HIV transmission and vulnerability. An understanding of the dynamics represented by MSM in Cambodia's HIV epidemic is vital to but limited by the national response to HIV/AIDS.

These conclusions give rise to the following recommendations:

Recommendations

1. Regularly undertake further research on male-to-male sexual activity, HIV vulnerability, and HIV transmission in order to provide relevant and current evidence on which to base health promotion interventions targeted to this vulnerable population. Donors should fund regular behavioral and epidemiological surveys through appropriately qualified organizations.

2. Review national policies and programs to ensure that Cambodia adequately addresses the issues of MSM, HIV vulnerability, and human rights.

3. Promote the active involvement of MSM in the development, delivery, and evaluation of policies and programs addressing sex between men, HIV vulnerability, and human rights in Cambodia.

4. Engage MSM in developing a sensitivity training curriculum as a resource for organizations involved in the response to HIV/AIDS in Cambodia. The curriculum itself and the experience of developing it can help build the advocacy capacity of MSM, enhance the capacity of institutions and organizations to work effectively on the issue of MSM and HIV/AIDS, and reduce the stigma and discrimination to which MSM in Cambodia are subjected.

5. Require police and service providers to undergo sensitivity training on MSM, HIV vulnerability, and the law as it relates to male-to-male sexual activity in order to reduce human rights violations against MSM and to reduce the role of some police in undermining the effectiveness of HIV prevention methods, such as the use of condoms by MSM.

6. Donors should require that organizations targeting MSM and HIV vulnerability conduct sensitivity training for staff to enhance their capacity to work effectively with this highly stigmatized and often hidden population.

7. Encourage NGOs to ensure that their MSM target populations understand that the only circumstances in which organizations record the names of MSM are when individual MSM volunteer as peer workers and consent to their names being recorded so that the organization can maintain a list of volunteers.

8. Adopt new approaches to IEC for MSM on HIV and sexual health, including the use of both print and electronic mass media and MSM-specific HIV prevention messages in prevention initiatives targeting the general population.

9. Involve MSM in developing IEC materials for MSM that specifically address male-to-male sexual behavior, HIV risk and transmission, and sexual health for dissemination to the target population.

10. Make condoms and lubricant widely available free of charge to MSM, with a particular focus on MSM long hair, who face significant stigma and discrimination and consequent economic hardship as a result of their greater visibility.

11. The 2003 report by CARE Cambodia demonstrated that in-depth interviews represent an effective means of gaining an understanding of the knowledge, attitudes, and beliefs of MSM in two border provinces regarding HIV transmission and risk. Undertake further in-depth research of this type with MSM populations in other locations to increase our understanding of the dynamics of MSM in Cambodia's HIV epidemic and to provide evidence on which to base HIV prevention and health promotion initiatives. Ensure that the research findings are widely disseminated in English and Khmer, to promote their use in the design and implementation of HIV prevention and sexual health promotion initiatives targeting MSM.

12. Establish a national advocacy network of MSM. NGO MSM projects provide a starting point for building a national network. The stigma and discrimination faced by MSM in Cambodia undermine the effectiveness of the response to HIV/AIDS and violate the human rights of MSM. With funding from donors and with technical assistance from organizations working directly with MSM and other organizations addressing issues of human rights and HIV/AIDS, a network could develop advocacy activities, a human rights training curriculum, and HIV and sexual health social marketing campaigns, for example, with the aim of promoting the health of and respect for the human rights of MSM in Cambodia.

13. Ensure that sexual health services provide clinical services sensitive to the needs of MSM. The research for this report indicates that MSM long hair, who are more easily identifiable as MSM, experience stigma and discrimination at health services. The research also indicates that MSM short hair may conceal from health care workers the fact that they have sex with other men, making it unlikely that they will receive appropriate clinical services, such as anal examinations and diagnosis of anal STIs.

Appendix: Report on Dissemination Meetings with Focus Group Participants

The following information is included in the report as it was a condition of USAID funding that "The consultant will present the findings of the work to the NGO/donor community, and will also present the findings to study participants who will have a chance to see that their contributions are contextualized and accurate."

In most cases, more MSM attended the dissemination meetings than the focus group discussions, and, in a number of cases, local officials attended as well. The researcher interpreted the attendance pattern as an indication of both significant interest in MSM issues by MSM and others, and the potential for effective advocacy activities involving MSM and others, such as health care service providers, police, and local authorities.

Sihanoukville, August 25, 2003

A number of MSM joined the dissemination meeting in addition to the 14 MSM (both short hair and long hair) who had participated in the focus group discussions, although the exact number was not recorded. Also in attendance were the Chief of the District, a police officer, a staff member from the local health center, and the director and other staff of KWDC.

Dissemination meeting in Phnom Penh.

The Police Chief of District Number 3 asked that all MSM tell him if the police or anybody makes trouble for them, as he wished to help reduce stigma and discrimination against MSM.

The Director of KWDC stated that funding under the Frontiers Prevention Program would begin in September 2003. So far, KWDC has made contact with 70 MSM, but it is experiencing difficulty in increasing contacts with the target population because most MSM are short hair and hide their face. KWDC wants to increase its work with MSM short hair to help reduce stigma and discrimination.

Battambang, August 26, 2003

The meeting was used to disseminate information to focus group participants from both Battambang and Poipet. In Battambang, 17 MSM attended the focus group discussions, seven MSM short hair on July 29 and 10 MSM long hair on July 31. In Poipet, 14 MSM short hair attended one focus group discussion, and four MSM short hair attended a second focus group discussion, both held on July 30. For the dissemination meeting in Battambang, 29 MSM—both long hair and short hair—attended, including 10 from Poipet. Other participants included a local policeman, a staff member from the Somrong Knong Health Center, the acting commune leader for Kompong Sombou commune, the assistant leader of Kompong Sombou village, and some elderly people from the village. The researcher reported that the MSM expressed surprise at the number of MSM.

Siem Reap, August 27, 2003

Despite only 13 focus group participants in Siem Reap, 17 MSM—both short hair and long hair—attended the dissemination meeting held there. Also in attendance were the village leader and the group leader. The researcher reported that the village leader expressed surprise at the number of MSM present and said that he was pleased to have the chance to know about the findings presented by the researcher. He said he would talk to his village staff about the need to accept MSM.

Phnom Penh, August 28, 2003

Although only 14 MSM participated in focus group discussions in Phnom Penh (both short hair and long hair), 31 MSM attended the dissemination meeting. Of the MSM who attended the latter meeting, there were four MSM long hair and 27 MSM short hair. Most of the MSM short hair attendees were married and have sex with both men and women. The researcher reported that the additional 17 people attended because they heard about the meeting through their friends and wanted an opportunity to hear information about MSM and HIV issues, as well as the chance to ask the researcher about issues that concerned them. Some of the questions they asked were:

- There are a lot of MSM and they face a lot of stigma and discrimination. Do you think that in the future there will be clinics or health services specifically for MSM?
- MSM short hair do not like to make friends with MSM long hair. Do you have any ideas about how MSM short hair and long hair can get to know each other better and accept each other?
- Can you get HIV from kissing on the mouth?
- Can you get HIV from performing oral sex on a man without using a condom?
- I love girls, but I sleep with boys for other reasons. Will I become a gay man in the future?
- I have heard that there are NGOs that work with MSM. Do they try to stop them from becoming MSM, or do they work to support MSM?
- Do you think that in the future Cambodian society will accept MSM the same as they accept other people?
- What will happen if I tell people I am MSM?
- Do you think society can stop people from becoming MSM?
- Can anal sex with a male or a female give you HIV?
- Why don't they make IEC specifically for MSM?
- Do MSM NGOs work for themselves, or do they work for MSM?
- How many MSM are there in Cambodia?
- Given that most MSM are short hair, hide their face, and are married, what are the ways to work with MSM?
- Is it important just to collect MSM [at meetings] to talk about HIV? How about television or radio?
- Please tell us about the differences between katoys and MSM.

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[28] See footnote 8.

[29] This question was used by the researcher to elicit information on how MSM are able to recognize other MSM, rather than how focus group participants self-identify, or how their male-to-male sexual activity influenced their sense of identity.

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