INSTITUTE FOR STUDIES OF SOCIETY, ECONOMY AND ENVIRONMENT

RESEARCH REPORT

STIGMA AND DISCRIMINATION OF HEALTHCARE WORKERS IN PROVIDING HEALTHCARE SERVICES FOR MEN WHO HAVE SEX WITH MEN

(A case study of Family Health International referal network's healthcare centers in Hanoi and Ho Chi Minh)

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ABBREVIATIONS

HCC	Healthcare centres
FHI:	Family Health International
HCM:	Ho Chi Minh City
HCWs:	Healthcare workers
HN:	Hanoi
*i*SEE:	Institute of Sociology, Economics and Environment Studies
MSM:	Men who have sex with men
STIs:	Sexually Transmitted Illnesses
VCT:	Voluntary Counselling and Testing

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I. INTRODUCTION

1.1. Background

Men who have sex with men (MSM) in Vietnam have become an HIV high-risk group besides drug addicts and prostitutes. IBBS statistics 2009 revealed that HIV contraction ratio in MSM in Hanoi and Ho Chi Minh was much higher than in 2006. Particularly, the percentage of HIV-infected prostitute MSM in Hanoi rose by 5% (from 9% to 14%) and non-prostitute MSM rose by approximately 10% (from 11% to 20%); HIV infection rate in HCM increased by 6% and 8% respectively. The trend for Sexually Transmitted Illnesses (STIs) in HCM has been upward from 17% for both groups to 21% and 22% while this trend is downward in HN.

Online survey conducted by iSEE in 2009 on 3,231 MSM, members of five most popular forums for MSM showed that less than 46% of the participants gave the correct answers to 5 questions developed by UNGASS to gauge youngster's knowledge on HIV transmission routes.

Investigations and surveys across countries in the world show that the prevalence of HIV positive and STIs is highest among MSM[1]. Studies by Vu Ngoc Bao, Phillippe Girault[2] and Institute of Social Development Studies (ISDS)[3] found that misunderstandings and misinformation about MSM and transgender population have worsened discrimination toward these groups, which puts them at higher risk of HIV and STIs contraction. Fear of discrimination discourages MSM from seeking information and services in HIV prevention and treatment at healthcare services when they are infected.

Besides, the coverage of intervention programs for MSM in Vietnam is confined to just 10 provinces and cities (Hanoi, HaiPhong, Danang, KhanhHoa, Ho Chi Minh City, Can Tho, An Giang, Thai Nguyen, Hai Duong and Thanh Hoa) out of 63 provinces and cities nationwide. This intervention program focuses on such activities as propaganda to MSM on HIV, STIs, condom delivery, transfer to Voluntary Consulting and Testing (VCT). However, there remain numerous challenges for HIV intervention to have greater access to MSM who have high qualifications, income and social status[4].

Due to stigma and discrimination, a large number of MSM reluctant to get counselling and healthcare service from HCC, so they are not accessed by intervention programs. Because MSM is often associated with HIV and used to describe the behavior in which men are involved in homosexual behavior. This way of addressing ignores their

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[1] WHO (2009). Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender populations. Report of a technical consultation 15-17 September, Geneva, Switzland.

[2] Vũ Ngọc Bảo, Philippe Girault. 2005. Facing the Facts: Men Who have Sex with Men and HIV/AIDS in Viet Nam. Publisher The Gioi: Hà Nội. Series Gender, Sexuality and Sexual Health, Vol. 5, Consultation on Investment In Health Promotion.

[3] Institute for Social Development Studies. 2004 (unpublished). MEN WHO HAVE SEX WITH MEN in Hà Nội: Social Profile and Issues of Sexual Health. Report of the study under the request of Health Policy Project.

[4] Some key points for MSM and HIV/AIDS program in Vietnam. Presented by Dr. Vu Ngoc Bao, Program Manager, FHI Vietnam at Evaluation workshop on HIV/AIDS program and MSM in Hanoi on 30th Octorber 2008.

gender and sex identities, many homosexual people dislike being referred as MSM and ignore messages on HIV for MSM[5].

In order to improve access to HIV/STIs intervention programs for MSM in Vietnam, iSEE with an independent research group have carried out a qualitative study on 'Stigma and Discrimination of Healthcare Workers in providing Healthcare services to Men Who Have Sex With Men" in HCC in FHI referal network in Ha noi and Ho Chi Minh Cities.

1.2. Objectives

The study is conducted in Ha Noi and Ho Chi Minh City with an aim to find out the discrimination by HCWs toward MSM in healthcare services. The findings of the study will be used in the design of intervention programs in order to alleviate the stigma and discrimination of HCWs toward MSM.

Specific objectives:

- To find out the manifestations of stigma and discrimination by HCWs toward MSM
- To find out factors which affect the stigma and discrimination by HCWs toward MSM
- To recommend the ways to reduce the stigma and discrimination by HCWs toward MSM

II. RESEARCH METHODOLOGY

2.1. Definition of Stigma and Men Who Have Sex with Men

2.1.1. Stigma

The study employs the definition of stigma by UNAIDS (2011)[6]. Stigma is a dynamic process of 'devaluation' that significantly 'discredits' an individual or a group in the eyes of others. Within particular cultures or settings, certain attributes are seized upon and defined by others as deviating, discreditable and unworthy. Stigma can lead to discrimination when it is manifested by actions and any acts of distinction, exclusion and restrictions of individuals.

As such, stigma is a continuous process which is manifested in different forms, ranging from attitude, judgement, and assessment to behaviors/actions. According to Link and Phelan (2001), stigma consists of four interrelated components, including labelling, stereotyping, distinction, and discrimination.

Labelling is a process in which people in society adhere particular attributes to an individual or a group of individuals. These attributes can be appearance, behaviors or actions, ability/disability compared with others in the society.

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5 Dialogue between *i*SEE staff and lesbian, gay, biasexual, and transgender (LGBT) people participating LGBT forum in Vietnam.

6 UNAIDS Termiology Guideline 2011

Stereotyping is the process to give the negative connotations to these attributes of stigmatized people. The labelling and stereotyping are to distinguish between 'we' and 'them', e.g. between heterosexual and homosexual groups. These distinctions are associated with certain social meanings which other differences in human qualities do not have. The labelling, stereotyping and distinction can devaluate individuals or group of individuals who are stigmatized, resulting in feelings of inequality and reduced opportunities for them. This study employs Link and Phelan's[7] concepts of components of discrimination to analyse forms of stigmatizing by HCWs toward MSM

It should be noted that, because of different beliefs and values, one stigma in a society or community at a time can be accepted at another time or in another society or community.

Social stigma has a great negative impact on the life of an individual who are stigmatized. It can cause stress for the stigmatized individual or self stigmatization, inequity in access to social, economic, politic resources and restrict their opportunities and options in pursuing a better life.

2.1.2. Men Who Have Sex With Men

According to Vu Ngoc Bao and Philippe Girault[8], the term MSM was introduced in Vietnam in the 1990s with the HIV epidemic. This is translated into Vietnamese as 'nam quan he tinh duc voi nam'. In recent research studies, ISDS[9] and FHI in Vietnam[10] have interpreted the term as 'men who have sex with men'. Framework for Actions by UNAIDS on universal access to MSM and transgender population[11] defines these two groups as

MSM is men who have sex with other men, regardless whether they have sex with women or have related personal or social identities as 'homogeneous' or 'heterogeneous'.

In this study, the term MSM is used to describe any men who have sex with men regardless of contexts, interests, sexual tendency, or personal identity. In Vietnam, men having sex with men is not new but is covered and hardly mentioned because this is a sensitive issue given social norm and value on gender and sex. Due to stigma on homosexuality, MSM have become a personal identity and individuals who have homosexuality are being regarded as the stigmatized group, regardless who they are.

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7 Link.B & Phelan. J (2011). Conceptualizing Stigma. Annual Review Sociology. 2001. 27:363–85.

8 Vũ Ngọc Bảo, Philippe Girault. 2005. Facing the Facts: Men Who have Sex with Men and HIV/AIDS in Viet Nam. Publisher The Gioi: Hà Nội. Series Gender, Sexuality and Sexual Health, Vol. 5, Consultation on Investment In Health Promotion.

9 ISDS (2010) "Understanding and Reducing Stigma related to Men Who Have Sex with Men and HIV". Tool Kit for Action. Hanoi.

10 FHI in Vietnam. 2008. 'Exchange with MSM: Their opinions about changing behaviours to prevent HIV"

11 UNAIDS. 2009. "UNAIDS' Action Framework on universal approach to Men who have sex with men and transgender people"

2.2. Research Design

2.2.1. Research sample, survey location and subjects

Subjects of the study include

(1) HCWs belonging to referal network by FHI
(2) MSM having criteria a) having or not used some healthcare services for MSM b) being or not members of MSM clubs

Information, opinions on stigma as well as barriers to MSM healthcare service access from both providers and users of service allows the research group to compare and contrast in order to pinpoint the forms of discrimination by HCWs in a thorough and objective manner.

Due to time and finance constraints, data collection was conducted within one month, in November 2010 and focused on the discrimination of HCWs in just Ha noi and Ho Chi Minh. In each location, six centres in the network of FHI transfer were chosen which cover various forms of services including VCT, STI clinics in public and private hospitals, community aid centres. In each centre, some HCWs with different expertise were invited to participate voluntarily in-depth interview. (See table 1)

Table 1. Population sample by research location

Subjects	Ha Noi	Ho Chi Minh City	Total
Manager	2	1	3
Practician	3	5	8
Consellor	2	4	6
Nurse/Tester/administrator	3	3	6
MSM (PVS)	5	8	13
MSM (TLN)	8 people/1 TLN	8 people/1 TLN	16
Total	**15 PVS + 1 TLN**	**21 PVS + 1 TLN**	**52 people**

Through iSEE network with MSM in clubs, 8 MSM were invited to have group discussion and 5 MSM were invited to in-depth interviews in Ha Noi. Some individuals who are not members of any club or MSM network are also invited to voluntarily participate in the study and introduce other MSM to participate (using 'rolling snow ball' method). As a result, there were 8 MSM involved in group discussion in HCM and 8 in in-depth interviews (See table 1).

2.2.2. Data collection tools and methods

2.2.2.1. Data collection tools

Tools for data collection are as following (see Appendix 1)

As for HCWs:

- Guidance for in-depth interview with managers at healthcare service providers.
- Guidance for in-depth interview with doctors.
- Guidance for in-depth interview with counsellors, testers, and administration workers

As for MSM

- Guidance for in-depth interview with MSM
- Guidance for group discussion with MSM

2.2.2.2. Data Collection Methods

Methods for collecting data include

- *Document analysis:* Analysing reports, books, brochures related to stigma and discrimination of MSM
- In-depth interview: This is the main method to collect data from HCWs and the opinion, personal experiences of MSM
- *Group Discussion:* Group Discussion is used to gather information on opinion and thinkings of MSM through experience sharing and information Exchange on stigma and discrimination in HCCs.

2.2.2.3. Data Analysis

In addition to the analysis of training and coaching document, the study will analyze mainly data from indepth-interview and group discussion. Information is recorded by Digital Recorder and then transcripted. Qualitative analysis software NVIVO 7.0 is used to manage and code data.

Code system is arranged thematically according to the components of stigma in Link and Phelan's framework of Stigma. Other codes of data on barriers to MSM's healthcare Access are arranged according to broader themes on barriers from MSM and HCCs. Data codes are in the analysis and finding report ensuring the criteria to repeat in in-depth interviews and group discussion. Because of small population simple, some exploratory information which is found in the study but is not repeated in in-depth interviews and group discussions will be presented in smaller information box beside main findings.

2.3. Research Ethics

Prior to the in-depth interviews and group discussion, the participants are informed and explained about the aim, significance of the research, their rights and responsibilities in research so they can decide themselves whether to continue in the research or not by signing in the agreement form. In-depth interviews and group discussion take place in comfortable and private venues so that participants can share their view and experiences about stigma at HCC.

2.4. Research constraints

The study is conducted in some HCCs in FHI referal network and having their staff attending the training program on MSM of FHI or FHI's partners so the results reflect only the stigma of HCWs with expertise in certain services.

Analysis in the report focuses mainly on the information from active MSM members of forums or propaganda from their peer sor younger MSM. Interviews with some MSM as office workers reveal that they often use private hospitals, especially high quality services. Therefore, the study does not reflect their view as well as their experience on HCWs' stigma. Besides, the research group has not accessed to MSM prostitutes.

III. MAJOR FINDINGS

3.1. Forms and manifestations of stigma and discrimination of HCWs in providing healthcare services for MSM

As it is said earlier, Link and Phelan classify four manifestations of stigma, i.e. labelling, stereotyping, exclusion and discrimination. However, our study examines these four manifestations simultaneously through the knowledge of HCWs on MSM, their attitude toward and their skills in counselling and healthcare services.

3.1.1. Healthcare workers' knowledge about MSM

The way HCW defines MSM affects how they identify MSM. According to some HCWs, it is hard to recognize an MSM in the first encounter. They often do not identify them as MSM until they have talked with or treated them or MSM themselves confess. They believe that MSM are not simply men with femininity, or having sex with other men, but probably prostitutes. The identification of sexual tendency in MSM prostitutes is socially based. To these HCWs, MSM prostitutes account for a high proportion of MSM community. Therefore, it is not easy to know if a person is MSM by their appearance. This definition of MSM is popular among HCWs in public HCCs. These HCWs often classified MSM into different types:

"It is easy to recognize ones as MSM if they have noticeable tendency in appearance and voice; they do not try to hide it, even bring their partner to show off. (Female tester, public HCC, HN)

"There are some people who have innate homosexuality, but there are few of them"(Female Nurse, Public HCC, HCM)

"Real MSM who are more or less accepted by their family and society often do not have sense of inferiority. Yet this type is not popular, accounting just 30%; the rest 70% are male prostitutes." (Female, manager, public HCC, HN)

While these are a balanced and comprehensive views on MSM community, HCWs in public HCCs still have some biased judgements as following:

"….effaminate voice, movements…face is not manly….especially their looks are indecent.' (Male, 28 years old, counsellor, public HCC, HCM)

"MSM have high sexual desire. They live in an aggregate manner, gathering in a private places to have fun and then sex. I think they have high sexual demand." (Male, 25 years old, counsellor, public HCC, HCM).

For other HCW groups more often in non-public HCCs, MSM are men who have effeminate appearance and/or have sex with men so they can be easily recognized through observation.

"…feel that this guy is gay through his voice and movements" (Female, Doctor, Non-public HCC, HN).

" those who are willowy.."(Female, 23 years old, testing nurse, non-public HCC, HN)

"…have a male look but is effeminate ..." (Female, administrative nurse, *non-public HCC, HN)*

"This MSM type does not have a musculous and well-formed body but slender or thinny one (Female, 21 years old, counsellor, non-public HCC, HN)

The difference between these two HCW groups in defining MSM can be associated with the fact that non-public HCCs have closer links with MSM clubs and referal network and MSM peers. MSM as club member or introduced by peers have often already shown up so HCWs can recognize them more easily through appearance.

There is also a difference between HCWs working in public HCCs (hospitals, district's community aid centres, etc) and non-public HCCs in the knowledge and information about MSM. Basically, HCWs working in non-public providers under study, which are centres in FHI referal network, are often better informed about MSM. They say that they have atended many training courses on knowledge and skills in counselling, check-up, or specialised knowledge about MSM. Meanwhile, HCWs in public sector say that they have little chance to attend these courses, and lack knowledge about the counselling, check-up skills, and especially about MSM.

It is a fact that HCWs in public sector participate less in training courses, especially on MSM but this is not because they have fewer opportunities, but because these centres perform more functions and have wider range of customers. Whereas in many non-public HCCs, voluntary HIV testing, counselling, and check-up for MSM are their main functions, these are just peripheral activities in public HCCs. Therefore the different views between HCWs in public and non-public centres result from different information intake on MSM as well as experience in encountering and working with MSM groups. These differences need to be counted when adopting MSM service providing solutions in the future.

Most HCWs acknowledge the change in their understandings from being uninformed about MSM, reluctant or afraid to being informed and having different view about MSM.

"In the past, I had no idea about MSM, thinking that homosexuality is quite queer but I have got used to this and feel that it is nothing abnormal. I was afraid in the first encounter with MSM but this feeling disappeared in the next meetings. The fear is not because MSM is not an illness or so, but just because when thinking someone belonging to the third gender, not male or female, it is a little scary." (Female, 21, administrative nurse, non-public HCC, HN)

" I have better understanding about MSM group after the training course. But I was amazed by the proportion of this group in Ha noi population. I have got new knowledge in order to have right look at MSM. I have no stigma with them. I feel that they are totally normal people, belonging to a third gender. I haven't had any idea about them before." (Female, 51, doctor, non-public HCC, HN)

'Prior to the training, I also had stigma with them. Something blurry, but I think that kind of people is unacceptable." (Female, 22, counsellor, non-public healthcare center, HCM)

One obvious effect of the training courses for HCWs is that they change the way the label MSM from 'patient' to 'customer'. Through the study we realize that this labelling is an indicator of how trained an HCW is. The use of the term 'customer' is popular and frequent among HCWs in non-public centres while the term 'patient' is still preferred by HCWs in public centres. This term coining determines the way HCWs see their client. While

HCWs addressing a patient/client by 'customer' implies the relationship between service provider and user (demand- supply in a particular service); 'patient' means the relationship between benefitor and beneficiary (social welfare fufilment). However, either these terms does not imply any stigma of HCW toward their client, MSM.

HCWs say that public has not accepted MSM yet and. However, they do not stigmatize MSM because their frequent encounter and working with them give them 'the heart' to 'sympathize' (words by HCW) this group. But becoming MSM (not just inborn, but imitateor prostitutes) is unacceptable and the society is harsh upon them.

> *"The public is easier now but some still make insulting remark like 'that guy is abnormal' which upsets them. I think they are innocent people"* (Male, 28, counsellor, public healthcare centre, HCM).

> *"I notice that people in the street often call someone with an devaluating name such as 'pede' or 'that homosexual guy'*.(Female, 22, counsellor, non-public healthcare centre, HCM)

From MSM perspective, a large number of HCWs have not fully informed about MSM and their sexual tendency and sexual behavior.

> *"…In some cases, doctor questioned and inquired MSM, then they express their contempt. They ask what the hell men have that anus infected… "My god, men have sex with men! It is disgusting! Why men have sex in anal route with men? Isn't it pede?* (PVS SMS, 44, Peer, HN)

> *"He has got his anus injured and that doctor shouted that "anus is just for shit, not for sex""* (TLM, MSM, HN)

3.1.2. HCWs' attitude toward providing services to MSM

Most HCC in FHI referal network provide free VCT. In many cases, MSM is referred to as high-risk group which need special check-up, counselling and treatment.

> *MSM is highly sensitive, having sense of inferiority so if we are not tactful in our words or behavior, they are ready to react, often overly. For example, counsellors and MSM communicate freely with each other in a private room but if they are not in the room, it is difficult to talk openly* (Female, 51, counsellor, non-public HCC, HCM)

Many HCWs do not support MSM's sexual tendency, but they tend to accept that rather than regarding it as unethic.

"I am still in support of heterogenous sex. Though I do not favor homogenous sex, I respect their private life because I think that they are simply suffering from external impact." (Female, 21, counsellor, non-public centres, HN).

Some other say that homosexual tendeny has become trendy and being MSM is a fashion and a way to become famous.

> *"Nowadays, youngsters are chasing fashion. In my opinion, they themselves have no particular tendency, but if something becomes a fashion, they will follow it and become famous and they like it. (*Female, 21, counsellor, non-public centres, HN).

HCWs think that seeking healthcare service is the last resort to MSM when they feel that they have high risk or their illness is exacerbated. HCWs believe that this group is very sensitive so they need to have peculiar access to each individual.

> *"I know that MSM are psychologically different from normal people; they fear stigma*

from others so I need to be empathetic and give counsul and check-up in a special way" (Female, 22, counsellor, HCM)

In many cases, when MSM come to HCC, they do not hesítate to tell that they are gays or from MSM clubs. So HCW gives counsul or check-up in order to find out their illness history and tendency for right treatment or counselling.

*"We treat everyone equally whether we like or not. Even the way we greet also leave an impression that they are discriminated or not. Most people who come here say that they like this place because the staff is nice and funny. They enjoy being in a place like this and they sometimes come back. There is almost no discrimination here because we know that they are highly sensitive." (*Female, 51, non-public healthcare centre, HCM).

HCW's treatment with MSM

When I returned him the result which is negative, he was so relieved, kinda wanting to hug me. He stood up like wanting to hug me, but I felt so…scary. He was so intimate that I am afraid…So I told him to calm down. He was that overjoyed. At that moment, I did not think he was male or female, just he was overjoyed. Honestly when you return the result, there is some boy jumping up and you have some feeling that he was about to hug you. So I stopped him by sitting down…'cause I feel it was too intimate and can mean something more….'cause counselling is to be more friendly, not something further.

(Female, 22, counselor & tester, non-public HCC, HN).

Questioned about the attitude of HCWs in providing healthcare service for MSM, most MSM participants reported their satisfaction about the attitude and skills of practicians of HCCs in FHI referal network.

"at XXX, there is a doctor A, he is a kind and sympathetic man, not ever referring to us with any devaluating name. He is thus very reliable and popular so many MSM come to him…
'…at that time there was no clinic in XXX club; MSM chose 4 clinics on STIs, B's clinic is the most crowded because he has good understanding about MSM, he's very skillful and friendly. So he gradually attracted more customers and other clinics were 'dying.'(TLN, MSM, HN)

Obviously, besides skills and knowledge, understanding about MSM and a friendly and open attitude of HCW is a key to access to MSM in the counselling, check-up and treatment.

However, there are still reports of the stigma and discrimination of HCWs toward MSM when providing services.

"…the doctor spoke right to my face that that hole (anus) is for shit not for sex or anything like that. Why do you do so? Honestly, I was ambarrassed before him. There were just he and I, but I still felt ashame, speechless. Then I went out straightforward without even lifting my face…and never came back." (PVS MSM, 30, HN)

Addressing customers with a devaluating name like 'may' (you) implies HCWs' discrimination and disrespect toward MSM. Moreover, not fully informed about MSM's sexual tendency and behavior, HCWs can insult MSM when providing healthcare service. So even if that clinic is well equipped with modern machines and has skilled practicians, stigma and discrimination can discourage MSM from using services there. MSM will communicate that message with each other and will boycott that clinic. Then the investment by the government, domestic or international organizations will be fruitless, no matter what.

Result of group discussion in HCM reveals an interesting explanation to the stigma and discrimination of HCWs.

> *"…the attitude of HCWs depends on their salary, if the pay is high, they are nice and vice versa. In Saigon (HCM), where clinics are more well-off, HCWs are sweet and pleasant, but in a poorer provincial clinic, HCWs dislike us so much. I don't mean to overgeneralize, but I think that is one reason."* (TLN MSM, HCM)

As such, the stigma and discrimination of HCWs toward MSM result from the fee for using service, not MSM themselves. Apparently, clinics in HCM are much more commercialized than HN, a reason why a MSM peer expresses their frustration when he introduces his customer to a clinic in HN.

> *"For example, in that XXX, the sign says the service time from 2.30 -4.30 pm but sometimes when we arrived at 3p.m they say it is too late and come back next time. When I asked them why, they answered that 'interviewing someone may take up 5 or 10 minutes, but another can last 1 and a half hour. So after the interview, it is too late to give a test." 'This is unacceptable; he is my customer. Like me, you are working within office time, so you need to work until the close time. I have managed to invite him over here but your working manner is unreasonably. If I had been told earlier, it would be ok.'', I reacted. But they bluntly replied that 'If so, please go somewhere else. 'cause it is free here/".*
> *"You are wrong. If it is free, I would not come without the commitment and agreement between projects. The address is indicated so we come. Besides, your clinic is also benefited from the project.",I replied. 'Free, voluntary, and anonymous'- how much they understand what these words mean. They could not say any more but they seem not comfortable.*
>
> (In-depth Interview, MSM, 40 years old, Peer, HN)

In other words, data show obvious differences between HCW's attitude in hospital-based clinics and outside clinics.

3.1.3. HCWs' skills and MSM service providing and counselling practice

For HCCs in FHI network, the process of counselling, check-up is strictly followed. HCWs are fully informed about this procedure in their position. In many places, the procedure and suggestions for communicating with clients are sticked up around the working area for reference. This can be considered as a success in the standardization of counselling, check-up and service procedure in HCCs in FHI referal network.

This procedure is flexibly employed for individual client, based on information collected from the client. For example, when dealing with familiar MSM club members,

HCWs will opt out some preliminary steps to go straight into the main stage. At this stage, spotting out MSM types is useful in increasing the effect of the encounter and avoiding unnecessary unpleasant feelings from the client.

> *'At first, I found it difficult to access to him. He was a learning man and had learnt much about MSM because he had studied abroad. He saw that I was younger than him so he did not reveal much in the first place. Yet, after sometime counselling, he confided more and appeared to believe me. He talked easily about sex but not about his sex partner, he even refused to say at first."* (Female, 22, counsellor, non-public HCC, HCM)

However, not all HCWs display friendly and helpful attitude toward their clients:

> "*… They are not afraid but they show the stigma through their eyes, their behavior and their criticism. Besides, they are not open, refusing to talk much or teasing them. That is the sign of stigma and discrimination.*" (Female, 51 years old, counsellor, non-public HCC, HCM)

The study also reveals a marked difference in healthcare practice in public and non-public HCCs. One reason for this is the number of customers varies according to these places. In public HCCs, like in Dermatology Hospital in HCM, there is an average of 200-300 visits a day, too much for HCWs to spend more time on each customer. Meanwhile, in non-public HCC, there are just fewer than a hundred of visits per day. So MSM tend to choose the latter type because their counselling or check-up take very long time.

Data from in-depth interviews and group discussions report this difference in practice skills of HCWs between public HCCs and non-public HCCs.

"In some big central hospitals, HCWs' attitude is unpleasant. For instance, some female counselors asked me such stupid questions as 'Do you feel uncomfortable and unpleasant when working with this gender (MSM)?' even though they know that I work and study together. They are not unskilled workers. Other people also say so. Despite being trained to counsel, stigma is deep-rooted in their blood." (TLN, MSM, HN)

HCWs and MSM agree that male HCWs are better choice for MSM because MSM say they feel very reluctant to trip off the clothes for chec-up even before male HCWs, not counting female HCWs. In many cases, MSM asked outrightly to change to male HCWs

> *"He comes and says that: "Honestly, I do not like you as my counsellor!' I asked why, he thought for a while and replied: "You know it already!"* (Female, 22 counsellor, non-public HCC, HN)

> *"I think it is reasonable for MSM to prefer male HCWs because of their sexual tendency. When they talk to a man they feel that it is their own world. They see women as a strange world to them and sometimes they do not trust the counsellor in the first encounter 'cause they think that women cannot understand their world, their private life and can laugh at them. They think that male counselors are easier to talk with."*
>
> (Female, 22 counsellor, non-public HCC, HN)

Exploring the history of the problem is also important in spotting out the risk for customer. HCWs aim to empower customers by explaining the transmission routes, the infection, high risks so that they can have safety measures. Learning about sexual tendency is to find the risk in order to have safety measures.

3.2. Barriers to MSM's healthcare service access

3.2.1. Media about MSM

Recently, media is considered as an important channel to provide information about MSM. Nevertheless, these programs focus more on the rights of MSM than on the information and knowledge about the risk of contracting STIs if their current sexual tendency is to continue. MSM therefore is not equipped with the right information for self protection and prevention. Seeking help from HCCs is the last resort to cure the illnesses rather than to prevent them.

> *"Our city has not done enough to meet the need of MSM. Our advertising should be on a wider scale, in the broader community, in order to access them. "*
>
> (Female, 51, counsellor, non-public HCC, HN)

MSM participate more actively in forums, clubs and peer groups. The study reveals that one barrier that prevents MSM from using healthcare services is the lack of information about the HCCs. This is a startling fact because though there are numerous efforts to educate and propaganda to raise the knowledge of MSM, these efforts are not fruitful. This is illustrated by two following statements representing group discussion in Ha noi and Ho Chi Minh.

> *"To tell the truth, I have long been MSM but I haven't no idea about HCCs for MSM, even in Vietnam. I just know about HCCs for community in general. And I go there to use the check-up and testing services like any other, nothing special…. I think that we are biopsychologically and pathologically normal people like others, we are complete entities.* (Focus group discussion, MSM, HCM)
>
> *"To my knowledge, many MSM have not known about STI yet. If they have any illness, they buy medicines at the chemists' to cure themselves because they are embarrassed. For example, if they've got clap (gonorrhea), there will certainly be pus in the penis, and they will be asked to undress for the doctor to check, which will frighten them because they are already stigmatized.. So they just go to the pharmacist's, telling them the symtoms and get the medicines. I don't know what they do when the illness gets worse. I see that few MSM is informed about STIs, especially those who are new comers. If they contract STIs, they have no idea what to do. It is ridiculous that even the propaganda workers have little understanding about syphilis, gonorrhea, HF- too dangerous. In many programs, it is all said about HIV and AIDs but nothing about STIs.* (Focus group discussion, MSM, HN)

3.2.2. Barriers from HCCs

3.2.2.1 Service Time

Time for the check-up, counselling is a barrier to ensuring a good quality health care service for MSM, especially in public HCCs. Over crowded clinics in these centres prevent HCWs to follow strictly the standard procedure for check-up and counselling. If HCWs had more time for their customer, they could have better understanding of MSM's problem history or even listen to their feelings.

"Doctors work very hard in here. Sometimes they try to provide service for all the patients in the morning, because they sympathize with the patients from far away. In a crowded day, we are blown off." (Female, treatment nurse, public HCC, HCM)

3.2.2.2 The availability of accompanied services

Healthcare providers for MSM need to have accompanied services. Most of the centre currently only offers voluntary HIV testing, and then transfer to other centres in case more complicated actions are required. Moreover, insufficient facilities for check-up or treatment also discourage MSM from these centres.

In addition, most HCCs are limited to HIV conselling and testing services for MSM, while just a few public HCCs provide STIs services. This is among the reasons why MSM are reluctant to access to the services. To make it worse, the risks of stigma and discrimination at public HCCs also prevent MSM from using their services.

3.2.2.3 Healthcare cost and quality

The FHI referal network's HCC under the study are financed by intervention and relief programs by FHI and other domestic as well as international organizations, so the services are free.

Data from in-depth interviews with HCW and MSM indicate that being 'free'is an attraction to MSM to the centres. However, data collected from different MSM groups under study reveal that the free services attract just MSM who are students or are economically disadvantaged. Besides, being 'free' means low quality services and drugs, which lengthens the treatment period for a common illness.

Therefore, these FHI network's HCCs have not been accessed by a large number of MSM who have money and do not want to use low quality services. Private clinics are their better choices.

3.2.3. HCWs' Demographics, knowledge and attitude

3.2.3.1 HCWs' demographics

HCWs of any gender or age could be a barrier for MSM access to HCCs. Fundamentally, MSM prefer aged and male HCWs.

> *"I myself prefer male counsellor because I think that it is easier to work with a person of the same sex. Like if we seek gynecology counselling in hospitals, we will certainly like HCWs of the same gender. Take myself for example, if I had gonorrhea, which means I have to expose my genital organ, I would feel more relaxed if the doctor were my sex because it is just a man's problem and the male doctor would understand me more, though a female doctor can be more psychologically better."*

> *"Counsellor can be male or female, but if the customer is a man, that should be male too, because the counsellor of the same sex can have similar experience, thinkings or emotions which a female counsellor does not have, so he can give better counselling"*
>
> (TLN MSM, Thành phố Hồ Chí Minh)

3.2.3.2 HCWs' knowledge and attitude

HCWs' inadequate understanding and knowledge about MSM is an enduring obstacle for accessing MSM. Until HCWs know well about psychological and biopsychological characteristics of MSM, they cannot provide reliable counselling and cannot engender trust among MSM.

THe lack of knowledge about MSM also leads to conflicting reactions between HCWs and MSM to the same event. For instance, HCWs would like use such slang words as 'bong kin, bong lo' to be friendly and accesible while learned and high-status MSM disprefer them because these words are thought to associate with stigma.

> *"Sometimes we say something inappropriate which can hurt them because they are very sensitive. So I think we need to learn their slangs so that we can get to know their needs as well as their behaviors better.* (Male, 28, counsellor, public HCC, HCM)

3.2.4. MSM doubled Stigma

Doubled stigma is the coining term for self-stigma by MSM and stigma from other people. Most of MSM participants say that they are stigmatized by other people and the society when they confess to be an MSM. Stigma and discrimination are reported as primary reasons which prevent MSM from using VCT and STI services.

Even the stigma and discrimination are worsen when MSM do not admit that they are having homogenous sex and refuse to take STIs tests. A large number of MSM avoid VCT and STI centres for fear that their sexual tendency is recognized by the public.

"…we are trapped in the thoughts that people who seek to have STIs or AIDs testing are related to promiscuous sex. Most MSM think ' Oh, I do not have promiscuous sex; I just have oral sex, not anal sex so it is not necessary to have a test."People often seek to have a test only when they already have some symtoms or fear about their latest sexual behavior."

(TLN MSM, HCM)

Even when MSM have access to these centres, the fear of stigma and discrimination prevents them from using the services, as following remarks.

> *"Before I entered XXX, I had talked to people at a street stall and knew that they supposed anyone customer to XXX was either a prostitute or 'old goat' who had contracted STIs. Therefore, though the service is quality, not many dare to use it."*

(TLN MSM, Thành phố Hồ Chí Minh)

IV. CONCLUSION AND RECOMMENDATIONS

CONCLUSION

The findings of the study reveal the existence of HCWs' stigma and discrimination toward MSM in providing services at FHI referal network's HCCs in Hanoi and Ho Chi Minh City. Nevertheless, their forms and manifestations are complex, from different perspectives. Specifically,

HCWs' Stigma and discrimination through their identification and knowledge of MSM.

For some HCWs, it is not easy to recognize an MSM by the first impression. Not until they have talked with, asked information, checked up or been told by MSM do they know that he is an MSM. According to them, MSM is not just a man who has feminity or homosexual tendency but also is a prostitute. An MSM prostitute is seen as not having any inherent tendency, but his sexual tendency is socially identified. This way of identifying MSM community makes it hard for HCWs to recognize an MSM in the first encounter.

There are marked differences in the knowledge and understandings about MSM among HCWs at public and non-public HCCs. Thanks to the close connection with MSM clubs, FHI referal network and peers, non-public HCWs can easily identify an MSM through his appearance.

Besides, HCWs in the non-public HCCs under study, which are in FHI referal network, are equipped with better information and knowledge about MSM. They often have many more opportunities to attend training courses about knowledge and skills for counselling, check-up and specialised knowledge about MSM than their counterparts in public HCCs.

In a large part of non-public healthcare centers, voluntary HIV testing accompanied by counselling, checking up for MSM is their main functions, but in hospitals or community aid centres, these activities are just peripheral. The differences between HCWs in public and non-public HCC result from the gap in their knowledge and information about MSM as well as their experience working with these groups. These differences need to be counted in coming up with solutions to service providing for MSM in the future.

HCWs think that public has not supported MSM yet. They claim that they are less discriminative and more sympathetic because they have more contact and opportunities to work with MSM. However, in the public's eyes, it is unacceptable to become MSM (who have either innate tendency, follow fashion, or be prostitutes). The public is still harsh upon MSM.

HCWs' Stigma and discrimination through their attidue in providing services for MSM

A large proportion of HCWs do not approve with MSM sexual tendency, yet they tend to accept it rather than associate it with ethic values. Interviewed about HCWs' attitude in providing services for MSM, most MSM participants say that they are satisfied with the attitude and skills of HCWs in the centres in FHI referal network. Apparently, besides HCWs' profesional knowledge and skills, their understandings about MSM, friendliness and openness are key to successful access to MSM in the counselling, check-up and treatment.

However, there are still complaints about the stigma and discrimination of HCWs toward MSM when providing them healthcare service. Addressing a customer/patient by 'may' implies discrimination and disrespect toward him. Besides, being not fully informed about sexual tendency and sexual behaviors of MSM, HCWs insult MSM when they use services at their centres. Even if the centre is well-equipped with modern facilities, qualified doctors, the stigma and discrimination at the centre will prevent MSM from using the services there, through other MSM's experience and hearsay. The investment of the government, domestic as well as international organization will be useless and ineffective.

In addition, stigma and discrimination also root in the cost of health services. Evidently, the commercialization of HCC in HCM is much higher than in HN.

HCWs' Stigma and discrimination through their practical skills in providing service for MSM

In HCCs in FHI referal network, the procedure for counselling and check-up is strictly followed. HCWs are fully informed about stages in the procedure according to their work. In many cases, the procedure or hints for communicating with customers are sticked on the wall or around the workplace for reference. This is considered as a success in standardizing the procedure of check-up, counselling and providing services for customers in FHI referal network's HCCs.

This procedure is flexibly applied according to different subjects, based on harnessed information about customers. For example, for familiar MSM club members, HCW can omit the preliminary steps and go straight into the point. In the central steps (counselling and check-up), classifying MSM is an effective way to enhance communication with the customers, avoiding unnecessary doubts.

Public and non-public HCCs also exhibit significant differences in providing healthcare services. This is partly due to differences in the number of customers to them. In public HCCs like HCM Hospital of Dermatology, the average number of visits can be up to 200-300 per day, which makes it impossible for doctors or counselors to have longer talk with customers. Meanwhile, in non-public HCCs, there are just less than a hundred visits a day, which attract more MSM to come because for MSM counselling and check-up take quite a long time.

During the process of check-up and counselling, a large proportion of HCWs and MSM agree that male counsellor or doctor is the best choice to work with MSM. MSM say that they are embarrassed to expose their body to a female doctor.

The study also investigates into the barriers to MSM service access, apart from forms and degrees of stigma and discrimination of HCWs. Barriers are from media about MSM, from HCCs (service time, availability of accompanied services, cost and quality of health check-up and treatment), demographics, knowledge and attitude of HCWs toward MSM and MSM doubled stigma.

RECOMMENDATIONS

Based on the study findings, in order to reduce stigma and discrimination of HCWs toward MSM in providing healthcare services and to increase MSM access to services at HCCs in FHI referal network, project and program managers, and sponsors should take into account following recommendations.

Recommendations for program improvement

1. Provide detailed information about available services through different channels so that MSM have better choice (including healthcare staff, service types, and cost)
2. Train HCWs about the complexity and variety of MSM and their peculiar needs. Current programs focus merely on skills and counselling and check-up procedure, not psychological and biopsychological characteristics of MSM. Better understandings of MSM bio-psychology can help HCWs address and behave with MSM more appropriately, avoiding unnecessary troubles.
3. Selecting doctors and counselors should take into account their age and gender. For example, male and middle-aged doctors and male counselors should be given more priority. Especially, it is essential to provide HCWs general information and knowledge, and specific knowledge about MSM.
4. Raising effectiveness of media for MSM through more appropriate channels such as social networks, MSM forums, posters at MSM venues, leaflets to MSM clubs and groups to introduce them about the HCCs.
5. Diversifying services for MSM by providing STIs check-up and treatment services besides voluntary and free HIV counselling and testing services.
6. Holding talks between HCWs and MSM in order to identify MSM needs and the quality of the HCCs.

Recommendations for long-term programs

1. Empower MSM community in order to reduce self-stigma, and increase knowledge and rights to friendly healthcare service access.
2. Change the public's opinion and knowledge about gender diversity and sex.
3. Conduct other research studies on HCWs' stigma and discrimination toward MSM in non-FHI referal network's centres.
4. This study focuses on FHI referal network's HCCs in Ha Noi and Ho Chi Minh City and MSM using services there. However, the study reveals that many other MSM who have high qualifications, income and social status who seek services at private clinics. So in order to have a better insight into this situation, more research studies on MSM using services at private clinics are required.

APPENDIX

Appendix 1: List of HCC in the study

Ha noi	Ho Chi Minh City
Daytime Healthcare Centre-48 Yen Phu	Hospital of Dermatology II
Nguyen Quy Duc Youth House	Community Counselling and Aid Centre- District 5
Hanoi Hospital of Dermatology	Community Counselling and Aid Centre- District 8
Hoang Mai Clinic	Ánh Dương HCC
Hai Dang Club Clinic	Hoang Minh Giam Peer Bus
	ATS Voluntary Testing and Counselling Centres

Appendix 2: List of MSM groups under study

Hanoi	Ho Chi Minh City
Hai Dang club	Green Apple group
Daytime Healthcare Centre-48 Yen Phu	MforM group
Hanoi Hospital of Dermatology	Free MSM Group
Self-effort Group	

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