REVIEWING FEMALE SEX WORKERS' ACCESS TO AND QUALITY OF HIV, SEXUAL AND REPRODUCTIVE & OTHER HEALTH SERVICES IN VIETNAM

RESULTS OF A COMMUNITY-LED STUDY

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ABSTRACT

This report presents findings from a mixed-methods study that explored barriers to health care among female sex workers (FSW) in Ho Chi Minh City and Hanoi, Vietnam. It discovered multiple barriers to health care, including inconvenient locations of health services, inconvenient opening hours, long waiting times, internalized stigma, lack of health insurance, and difficulties registering at health services due to bureaucratic procedures. Reports of stigma and discrimination by health care providers were relatively rare, but this was partly explained by the hesitation among FSW to disclose that they were engaged in sex work. Overall, the study found that there was a lack of involvement of FSW in the planning and design of interventions aimed at improving their life. Partly as a result of this, interventions are focused mostly on health, whereas other pertinent problems in the life of FSW are not (sufficiently) addressed. A more holistic approach that incorporates priorities of FSW, including reducing exposure to violence and police harassment and improving child care and opportunities for vocational and educational development will likely improve health outcomes at the same time. In addition, new ways of providing services to FSW operating online need to be designed, as current efforts are based mainly on street- and venue-based FSW.

ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
APNSW	Asia-Pacific Network of Sex Workers
ART	Antiretroviral Treatment (against HIV)
CBO	Community-based Organization
CCM	Country Coordinating Mechanism for the Global Fund
FSW	Female Sex Worker(s)
HCMC	Ho Chi Minh City
HIV	Human Immunodeficiency Virus
ILO	International Labour Organization
KPRA	Key Population Rapid Assessment
MoLISA	Ministry of Labour, Invalids and Social Action
NGO	Non-governmental organization
PEP	Post-Exposure Prophylaxis (after possible exposure to HIV)
PEPFAR	The President's Emergency Plan for AIDS Relief
PrEP	Pre-Exposure Prophylaxis (to prevent against HIV)
SCDI	Center for Supporting Community Development Initiatives
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
VAAC	Vietnam Administration for HIV/AIDS Control
VUSTA	Vietnam Union of Science and Technology Associations
WHO	World Health Organization

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CHAPTER 1

INTRODUCTION

1.1 Background

According to 2016 data from the International Labour Organization (ILO), there were 101,272 sex workers in Viet Nam and most of them were female (72,000) (1). A recent study estimated that there were over 10,000 FSW in Ho Chi Minh City alone, but the study admitted it could not count FSW who operated online, hence, the real number was likely to be much higher (2). Sex work is becoming increasingly diverse; whereas previously it is believed that sex workers were mainly women, in recent decades Vietnam has seen the emergence of male and transgender sex work (3-5). The work locations of sex workers in Vietnam are varied and include public areas, bars, hotels and hostels, as well as entertainment establishments. With increased access to internet services in recent decades, people engaged in sex work increasingly use the internet and mobile phones to find clients, including via social media platforms such as Facebook, Zalo, Viber, etc (1).

As is the case in other countries in the region, people engaged in sex work are disproportionally affected by the human immunodeficiency virus (HIV) epidemic, as well as by sexually transmitted infections (STI) (6, 7). For this reason, the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) have identified sex workers as a key population for focused HIV service provision. These organizations suggest that the HIV epidemic can only be contained if key populations, including sex workers, are engaged and reached with comprehensive, diversified, high-quality and non-judgmental HIV, STI and sexual and reproductive health services (8-10). As of 2018, an estimated 3.6% of Vietnamese FSW were living with HIV; in Ho Chi Minh the prevalence was 10% (11).

1.2 Study rationale

From a human rights perspective, sex workers are a vulnerable group because they are at high risk of experiencing sexual abuse, violence, exploitation, discrimination and poor health. Related to the latter, this refers mainly to exposure to HIV, STI and unwanted pregnancy due to limited access to health protection and social and healthcare services. Sex workers are often also disproportionally affected by addiction to alcohol or other substances. Therefore, programs to address sex workers' needs have to include comprehensive HIV and STI services, sexual and reproductive health services (SRH) and harm reduction interventions. In other countries, studies have found that important barriers to accessing such services exist for sex workers (12-15). These barriers include stigma directed towards sex workers by health care providers, long distances and high transportation costs to reach the services, inconvenient opening hours of the services, long waiting hours, unfriendly attitudes by medical personnel, and high costs (actual or perceived) of the services. It has been proven that projects aimed to help FSW attain better health lack a focus on services that many sex workers deem important, and which they often consider to be of higher priority than HIV/STI/SRH, such as reducing gender-based violence by clients, reducing violence and harassment by police and improving child- and other care and social support services (16-21).

The APNSW KPRA Project aims to strengthen evidence-based advocacy and, related to this, the capacity of sex workers to monitor the quality of HIV/STI/SRH services, so that they can effectively demand for improvements of these services for their community. The project is envisioned to strengthen community capacity to improve access to quality HIV prevention, testing, treatment, care and support services among key populations. One focus of this work includes female sex workers, building evidence and engaging in strategic advocacy for the purposes of improving quality of HIV prevention and care services for sex workers in Bangladesh, Cambodia, Indonesia, Myanmar and Vietnam.

This report presents the results of a mixed-methods assessment study in Vietnam, which will form a baseline for further program implementation.

1.3 Study objectives

The main objectives of the study were:

- To better understand policies, laws, legislation and other barriers that affect access to HIV and health services including HIV prevention and testing, treatment and other services for sex workers.
- To better understand the needs of sex workers for HIV and health services and the quality of current HIV and health services for sex workers.

CHAPTER 2

METHODOLOGY

2.1 Study location and design

Four broad methods were used for this study:

1. A desk review of national level legal policy and current HIV and SRHR programming efforts for female sex workers.
2. A community survey with 316 female sex workers in Vietnam on their experiences accessing HIV testing and counselling services, STI services and SRH services, as well as their views on the quality of services received (including experiences of stigma and discrimination).
3. A health care facility assessment on quality of HIV, STI and SRH services.
4. Semi-structured qualitative key informant interviews on the situation of service providers, as well as to elucidate barriers and opportunities to improve access to health services for female sex workers.

A community-based survey of 316 sex workers was conducted in Ho Chi Minh City and Hanoi on the quality of HIV testing and counselling services, STI services and SRH services. HCMC and Hanoi were selected as study sites for this research due to the concentration of FSW population and the availability of HIV, STI, SRH services in these two cities.

The quantitative component used a non-probability sampling that relied on collecting data from persons who were conveniently available to participate in the two sites with a peer-based method of recruitment relying on networks of local CBOs (CCM) and snow ball techniques.

2.2 Sampling

A ***sample size*** of 316 was decided for the survey, of which 186 from HCMC and 130 from Hanoi, under the estimated size of SW population in HCMC as 8000 and in Hanoi as 7000.

Key Informant Interviewees were selected, including stakeholders such as National AIDS Program managers, members of the Country Coordinating Mechanism for the Global Fund, UN agencies, and others involved in the HIV response based on a rapid review of policies and programming affecting sex workers. Key informants are listed in the table below:

	Ho Chi Minh City	Ha Noi
Governmental stakeholders	2 leaders of Ho Chi Minh Department of Social Vices Prevention and Combat (Cục PC TNXH) 1 leader of Ho Chi Minh AIDS center (PAC)	1 leader of VAAC 1 specialist of Department for SW preventions - MOLISA
iNGO, NGO	1 UNFPA program manager	2 PEPFAR grantees (1 vice director of VUSTA's project, 1 director of Institute for Social Development Studies)
CCM	1 CCM community member	1 CCM community member

2.3 Eligibility criteria

The ***inclusion criteria*** for participation in the sex worker survey were being over 18 years old, self-identifying as a female sex worker, and to have, over the past 12-months, used at least one of the following services: HIV services, SRH services, or STI services.

2.4 Data collection tools and process

The co-ordinatoor from the Center for Supporting Community Development Initiatives (SCDI) worked closely with collaborators in Hanoi and HCMC throughout the data collection period to facilitate participant recruitment and arrange and supervise interviews. In each site, five collaborators were hired as enumerators for the survey, who took the responsibility to conduct all the face-to-face interviews with FSW and ensured the questionnaires were completed. All these collaborators, alongside with SCDI staff and CCM members who were involved in the project, were trained on using the research tools and were given interview tips prior to the field-work. During the field-study, completed questionnaire forms were checked by the SCDI coordinator and field supervisor before they were sent off for data-entry.

2.5 Ethical considerations

All participants were given a full introduction about the study and were made aware of their rights to participate or refuse to participate prior to their interview. For each participant, consent was gained twice, one time from the SCDI coordinator who did the screening interview, and one time from the enumerator.

2.6 Limitations of the study

The study had a few limitations. First, the interviewers that were hired to conduct the study were well trained beforehand, but in the future it might be better to recruit current or former FSW as interviewers in order to reduce the distance between interviewer and interviewee. It also is good international practice to engage key populations in research on key populations (22). This study found that FSW were sometimes ‘not motivated’ to access or engage with health services, but there was a lack of follow-up questions about

this; a stronger engagement of FSW in the design and implementation of the study could probably have prevented this.

Since participants in the survey were recruited via existing organizations, there was a selection bias towards street-based and venue-based FSW. FSW operating via mobile and social media networks were not included in the study since current intervention models are not reaching these women.

Finally, the quantitative and qualitative parts of the study were conducted by different people; in the future, more interlinkages between the two components should be considered so that findings and observations can be utilized between them.

CHAPTER 3

OVERVIEW OF THE HIV/STI/SRH RESPONSE FOR FSW IN VIETNAM

3.1 Legal and policy environment of sex work in Vietnam

In Viet Nam, selling and buying sex, running businesses on sex work, referrals of sex workers to clients, and any other forms of commercial sexual transactions are strictly forbidden under the Ordinance No. 10/2003 on Prostitution Prevention and Combat. The Ministerial Council (currently known as the Government) issued Directive No. 14/CT (1986) detailing the rehabilitation or labor force for professional sex worker with the Ministry of Labor, Invalids and Social Affairs (MoLISA) as the standing management agency for prostitution prevent and control.

After a decade of punitive laws against sex workers and evidence of high HIV prevalence among sex worker with estimated rates of over 15% in big cities such as Hanoi, Hai Phong, Ho Chi Minh City, and Can Tho (23), the government's approach in June 2012 turned in a more positive direction. The restrictions around sex work began to ease and sex workers found that they could access health and other social services without fear of arrest. The National Assembly Law on Handling Administrative Violations and Resolutions No. 24/2012/QH13 regulated that, "Sex workers are no longer subject to be taken to medical centers in communities, wards, or townships as before. They are subject to be financially fined with the amount of 100 to 300 thousand dongs."

The National Assembly also proposed that localities pay attention to creating favorable conditions and supporting sex workers by promoting the implementation of national

programs on vocational training, preferential credit loans, job creation, and creating conditions such that sex workers find means for a stable income and can integrate into the community. The Five-year Programs of Action for Prostitution Prevention and Combat introduced measures such as communication, education, awareness raising, behavior change, and changing life styles of individuals, families, and communities. It has focused on family and community support in health care, prevention of HIV transmission, and opportunities for sex workers to change their lives and integrate into the community.

The Constitution of Viet Nam (2013) has a strong non-discrimination clause on the right to health care and access to services. The Law on Gender Equality, 2006, stipulates that equal treatment and access to services for men and women including measures for safe sex and for preventing and protecting against HIV/AIDS and other sexually transmitted infectious diseases (24). The government is also paying special attention to ensuring the right to information and access HIV testing services as a priority for key populations. Nonetheless, there are legal barriers to ensuring sex workers access to health services.

First, there are no measures regulating sex workers' right to health care and medical services. The authorities have discussed the issue but since there is no legal precedent—the Ordinance on Prostitution Prevention and Control only provides treatment for those sex workers who give up sex work and the Law on HIV/AIDS Prevention and Control (2006) only gives the right to treatment for those living with HIV. In 2015 the Ministry of Health, the Ministry of Labor, Invalids and Social Affairs, and the United Nations Population Fund (UNFPA) held a workshop to review existing legislation and develop an Inter-Ministerial Circular on provision of sexual and reproductive health services for people working in recreational facilities, but this initiative failed to materialize. The government lacks any legal basis to develop guidelines for establishing specialized and accessible services for sex workers.

Second, there are no legal measures for addressing stigma and discrimination against sex workers especially those who are HIV positive. The Law on HIV/AIDS Prevention and Control introduces measures to combat stigma and discrimination against people living with HV but doesn't specifically mention and include any provisions for key populations living with HIV. The Action Plans on Prostitution Prevention and Control try to encourage sex workers to no longer engage in sex work, and encourages community reintegration. However, the government has tried to implement programs on prevention and control of HIV among sex workers with specific activities such as social services, strengthening family and community support, condom distribution, vocational training, and community reintegration. The Program on Prostitution Prevention and Control between the period 2016-2020 aims to support activities that end gender-based violence, ensure access to counseling services and information, and focus on improvement of skills. The focus is not on ensuring the rights of sex workers but concentrating on social solutions to reduce harms caused by sex work and sex workers to the social life of communities.

Three model pilots supporting services for sex workers have been put into place and include:

- **Model 1** - Providing support services for sex workers in communities and in social work centers and piloted in 5 localities;
- **Model 2** - Proving support to ensure rights of sex workers in business establishments and piloted in 15 localities; and
- **Model 3** - Strengthening capacity of sex workers through peer groups/self-help groups and clubs to access harm reduction interventions and prevention of gender-based violence and piloted in 7 localities.

The information from these pilots is still coming in, but so far 690 sex workers and 3,446 high-risk people have benefited from these services. But evidence suggests that sex workers are hesitant to approach services for fear of having to give up their sex work or being identified as sex worker and as a result detained by authorities. The Viet Nam Administration of HIV/AIDS Control (VAAC) is introducing a model of HIV testing in the community that will target high-risk groups including sex workers. VAAC will ensure that sex workers have access to basic health services, periodic testing for other infectious diseases such as hepatitis B and C and other STI, and access to condoms. These programmatic interventions are currently supported through the Global Fund grants, which will be transitioning out of Viet Nam in the near future.

Third, target groups who have access to health services under the current laws are limited and those sex workers who are working in restaurants, bars, massage establishments, and other entertainment venues do not have access (25). According to results from the 2009 Integrated Biological and Behavioral Survey (IBBS), the distribution of condom varies by location with more than 60% of female sex workers in Ho Chi Minh City, Lao Cai, and Dong Nai reporting that they did not receive any support especially those working in bars and restaurants.

Fourth, funding for sex workers' programming is limited and funds are difficult to track. The government does allocate funds in the central budget for implementation of the Action Program on Prostitution Prevention and Control through the MoLISA. But the budget is small when it reaches community level interventions and local governments cannot allocate funds from their budgets. The HIV programming budget also does not delineate clearly interventions that go towards supporting sex workers.

Fifth, Viet Nam is taking great efforts to implement universal coverage of health insurance for all persons including the informal workers, those who are not covered by compulsory health insurance, and those currently not entitled to social benefits such as sex workers. Before 2019, The government was encouraging people to buy health insurance by household, making it difficult for sex workers to purchase insurance because many of them are not living with their families or do not possess their identity cards. The insurance scheme also specified where care can be accessed based on where the health insurance was registered. Given that sex workers tend to be highly mobile and the process of transferring to other locations for services was very complicated, many sex workers decided to opt out from purchasing health insurance. Fortunately, decree 146/2018 / ND-CP (effective from 01.01.2019) has removed the requirement to obtain health insurance via the household. Unfortunately, this amendment was not communicated broadly and effectively to the policy enforcement agencies at local level, making it difficult for sex workers to purchase insurance because many of them are not living with their families or do not possess their identity cards.

The stigma and discrimination against sex workers remains because the government continues to treat sex work as a social evil to be eliminated from society. Shifting perspective from sex workers as 'bad' people to protecting their rights will create more confidence in accessing health services. The laws need to reflect the rights-based approach of the Constitution and ensure that sex workers are equal citizens with equal rights.

3.2 FSW within the Vietnamese HIV/STI/RSH response

In recent years, changes in the mind-sets of local authorities (police, policy makers, MOH, MOLISA, VAAC etc.) have made it easier for NGOs to implement interventions with FSW. After years of advocating on the need for engagement with key populations for provision of HIV services and harm reduction interventions, governmental bodies such as Department of Social Vices Prevention and Combat, part of the Ministry of Labour,

Invalids and Social Action (MOLISA) have become much more open-minded with SW related work and started providing their support. However, according to governmental program leaders interviewed in this study, in the near future, FSW are not considered as an important target population in the national HIV program. Rather, FSW will be serviced as part of the harm-reduction program—i.e. FSW who are involved in heroin or other substance abuse.

According to key informants and documents reviewed, whereas CBOs and NGOs are still active in terms of outreach, clinical HIV and SRH services specifically targeting female sex workers are now mostly non-existent in Vietnam. Several key informants mentioned that there used to be international NGOs that supported the provision of STI testing and treatment for female sex workers in hotspots such as Do Son, Hai Phong City, however, these have now been closed. This happened due to funding cuts as well as the lower priority given to HIV by authorities in the country in recent years.

> "For the FSW target group, we set up clubs, the club presidents are FSW themselves, or those who used to be FSW, so that they understand, they know the women, they have access to other women. We could never do that by ourselves."
>
> **KII, VAAC Leader**

Most interventions for FSW by both governmental and NGO programs rely on outreach work of the FSW CBOs or peer-groups. There is a policy to encourage the proactive participation of FSW; they are encouraged set up support groups and build capacity of these groups. Such small CBOs can help strengthen the sense of community among FSW and FSW them to work for their own specific needs in groups.

Budgeting for interventions is based on project design (NGOs, iNGO) or by annual allocation (government) which is not key-population-specific. For example, in the national HIV program, budget for activities are allocated for two target groups: the general population and key populations, of which FSW are one. Comparing to other key populations FSW are not a prioritized group. Interventions are focused more on MSM, transgender women, and on PWID and their sexual partners, as it is among these populations where most HIV infections have been reported in recent years. As the key informant in the box on the right suggests, in a way the FSW HIV program in Vietnam has become a victim of their own success: by bringing down HIV infection rates among FSW, these projects are now being deprioritized and defunded, similar to the situation in other countries.

> "Currently, we focus our priority on MSM the most, second come transgender women, the third priority goes to partners of [PWID] with HIV, fourth is [PWID] themselves, the last group is female sex workers. FSW is not much of a high-prioritized group. That is not really a bad thing, it is somehow a good sign, because FSW are now no longer a population with a high rate of HIV infection."
>
> **KII with program manager of GF project**

Since the Vietnamese Administration for HIV/AIDS Control (VAAC) still considers FSW as a key population for HIV, they are provided access to free, government-provided services such as HIV testing and counselling, information, education and communication events, condoms and lubricants, pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), and methadone programs and provision of syringes/needles for those dependent

on heroin or other substances. The VAAC manages most of the national program on HIV/AIDS prevention; however, it has declared that FSW is currently not a priority population for their interventions. According to one of the VAAC program managers, there is no health specific intervention for FSW that is provided or managed by the government (although there are CBO/NGO managed interventions for FSW). VAAC also does not manage or operate any clinic that provides health services specifically for FSW or other key populations. Rather, VAAC aims to work as facilitator and to provide guidance to such activities, implemented by different projects.

The largest nationwide HIV/AIDS prevention effort is currently the project funded under the Global Fund, which covers the 15 Vietnamese cities and provinces with higher-than-average HIV prevalence. Within these projects, FSW are one of the key populations targeted, however, FSW are not a top priority of this program. Key informants suggest that FSW who know or are involved with CBOs have better access to available HIV and health services due to the information provided and connections made by CBOs leaders and staff.

3.3 Services for FSW by government-led programs

- *HIV testing and referral for ART treatment:* Testing kits and other supplies for HIV testing among FSW, referral for verification test if found positive, are provided via government health services. This includes the provision of free condoms and lubricants for FSW.
- *Harm reduction services:* Needles and syringes exchange programs and methadone substitution therapy are provided if FSW are dependent on heroin or other illegal substances.
- *Legal support:* Governmental HIV/AIDS agencies work in collaboration with Lawyers Association to offer legal support for FSW if needed.
- *Livelihood support:* Governmental HIV/AIDS agencies work in collaboration with the Women's Union, Job Centres and several other organizations to provide vocational training and job referrals for women who have left sex work, including the provision of small loans.
- *GBV prevention:* Trainings are being provided and referrals for GBV prevention and supports for GBV victims are provided by MOLISA and VAAC

> There are five types of service for FSW: healthcare services, legal support, emergency support, first-aid, and vocational training for women at social support centers. Most of the policies are aiming at harm reduction support, HIV/AIDS prevention and reduction of GBV"

KII, MOLISA specialist

> We have many programs, such as legal support, job referrals, or giving out loans for these groups, we work in collaboration with the Lawyers Association and City Job Center. We would categorize them following their needs and then introduce them to suitable resources."

KII, leader of the Department of Social Vices Prevention and Combat

> We should work in collaboration with MOLISA to roll out intervention activities for FSW. VAAC provides materials for HIV testing, refers clients to clinics or hospitals to do confirmation tests and treatments if needed. VAAC can give guidance and facilitates the collaboration among partners. Our local units will be in charge of reaching out to FSW groups, providing condoms and lubricants, if the FSW are also [PWID], we will provide free syringles and needles as well"

KII, VAAC

3.4 Services for FSW supported or implemented by NGO and INGO programs

1. *HIV services:* provision of training and education on HIV/AIDS and STI transmission and prevention, provision of free condoms and lubricant, supporting access to STI and HIV testing and treatments for FSW at various project sites. The biggest donor is the Global Fund, which covers 15 cities/provinces with higher HIV prevalence, PEP/PrEP, access to ARV treatment. FSW is one of several target groups. Within the Global Fund project, priority is given to street-based FSW. The programs promote cross-referrals between HIV and STI services.
2. *Harm reduction:* Provision of clean syringes/needles for FSW who are using substances. There are also methadone replacement therapy programs in place; these activities are also supported by the Global Fund.
3. *Safe working environment and GBV protection for FSW:* UNFPA rolled out a model for peer support among FSW, which also includes information, education and communication on sexual and reproductive health (including prevention of STI/HIV) and protection from GBV.
4. *Support formation of CBOs for FSW by UNFPA, VUSTA, ISDS, and others:* capacity building (trainings on proposal writing, fund raising, management, etc.)
5. *Health insurance awareness:* CBOs of FSWs and some PEPFAR programs have rolled out activities to educate FSW on their rights to use publicly funded government health services including their right to insurance services to reduce healthcare costs.

> Due to limited budget, we have not focused on [SRH healthcare for FSW] recently. Now we focus more on topics such as a safe working environment and prevention of GBV and [on promoting] gender equality."

KII, UNFPA program manager

> In the past, we had healthcare services mainstreamed into our projects. For example, the project we had with UNFPA that was carried out [...] focused mainly on harm reduction interventions, healthcare, condom promotion, and communication with FSW in entertainment establishments in Do Son, Hai Phong. VAAC worked closely with health centers at the district level. The clinics participated in this project as part of the model, as implementing partners."

KII, VAAC specialist

> We had many capacity building activities for [FSW], we supported them to set up their own groups. For example, we helped them to recruit new members, set up their office, provide work space. Then we supported them in carrying out their activities, such as communication events, reaching out to clients, training on HIV, stigma and discrimination, report writing skills, proposal writing, information seeking skills, peer education and so on."

KII, Global Fund grantee

3.5 Services/activities implemented by CBOs

1. *Community-based HIV rapid test and referral* for confirmation tests and ARV treatment, if needed.
2. *Mapping of 'friendly' clinics, hospitals, health centers* that provide SRH – STI services.
3. *Case management approach:* In order to avoid loss to follow up, if needed, CBO staff accompany FSW to health services, and provide them with support with administrative procedures.
4. *Networking:* Helping FSW make connections with job centers, general healthcare providers, police officers, local authorities, etc. By doing this, the FSW are able to seek support from these connections in time of need.
5. *Livelihood support:* Provision of materials to start-up small businesses, provision of small loans, establishment of micro-credit groups.
6. *Support on GBV prevention:* Communication and training for FSW on self-defence skills and how to cope with being abused by clients or owners of establishments where they work. Identification of perpetrators of GBV so that other FSW can avoid them.

> We were supported with documents that we can use as references when we contact to hospitals or OPC. We can do rapid [HIV] tests within our group, but if the result is reactive, for women who are not from this city and aslo do not have IDs, we can introduce them to the clinics using our group name."

KII, CBO leader

CHAPTER 4

RESULTS OF THE QUANTITATIVE SURVEY

In this chapter, the results of the quantitative survey are presented, and where appropriate, these are linked to the findings from the qualitative key informant interviews discussed in the previous chapter.

4.1 Socio-demographic characteristics & history of working in the sex industry

The final sample of the survey consisted of 316 FSW participants; 186 were from Ho Chi Minh City (HCMC) and 130 were from Hanoi. The women ranged in age from 18 to 69 years; the mean age of participants was 38. The table below provides the basic descriptive statistics of the survey sample.

The average education level of participants varied. About a quarter did not complete primary education: 10.4% (n=33) had no schooling at all and 14.2% (n=45) had some schooling but had only basic literacy skills. About a third of the sample, 33.54% (n=106), finished primary education. A bit under a third (30.7%, n=97) finished secondary education. Only a few (10.4%, n=33) finished college and two participants (0.6%) had a professional degree.

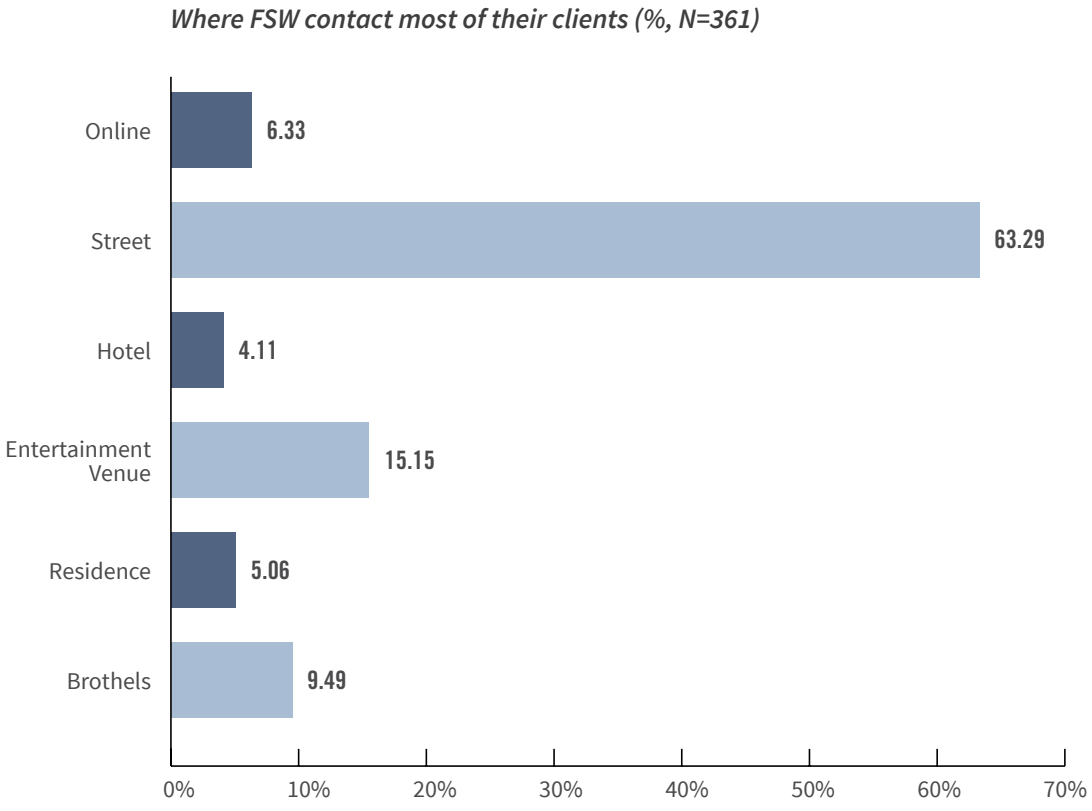
Almost half of the sample (45.9%, n=145) reported being divorced or separated at the time of the survey; a fifth (19.3%, n=61) was in a marriage and 9.81% (n=31) reported being widowed. The rest of the participants (25%, n=79) had never been married.

The majority (73.7%, n=233) reported living in a private home, either self-owned or rented. About one in eight (12.3%, n=39) lived in a family home, while 5.7% (n=18) lived in a shared home. A small number (7.3%, n=23) reported living at their work place and two participants were living on the streets. Almost a third of the participants (29.3%) were away from their residence address for more than one month per time within the last 12 months, indicative of the high level of mobility of Vietnamese sex workers.

The majority of the sample (60.4%, n=191) did not have any type of health insurance. A bit over a third (37.7%, n=119) had voluntary national health insurance coverage. Four participants had compulsory national health insurance from their workplace, and one woman reported to have private health insurance coverage.

The women in the survey reported that they had been working in the sex industry for an average of more than six years, ranging from one to 51 years. About two thirds (63.3%, n=200) worked on the streets; 15.5% (n=49) worked at entertainment venues to meet clients, whereas slightly less than one in 10 worked in brothels (9.5%, n=30). A small percentage of the sample reported to use other channels to reach to their clients, such as online platforms (6.3%, n=20), hotels (4.1%, n=13), or meeting clients at their own residence (5.1%, n=16). (Figure 1)

Figure 1: Locations where FSW operate



Within the past three months, the women had sexual intercourse with on average 71 different men (minimum 1, maximum 750). Within the past one month, the women had sexual intercourse on average 37 times.

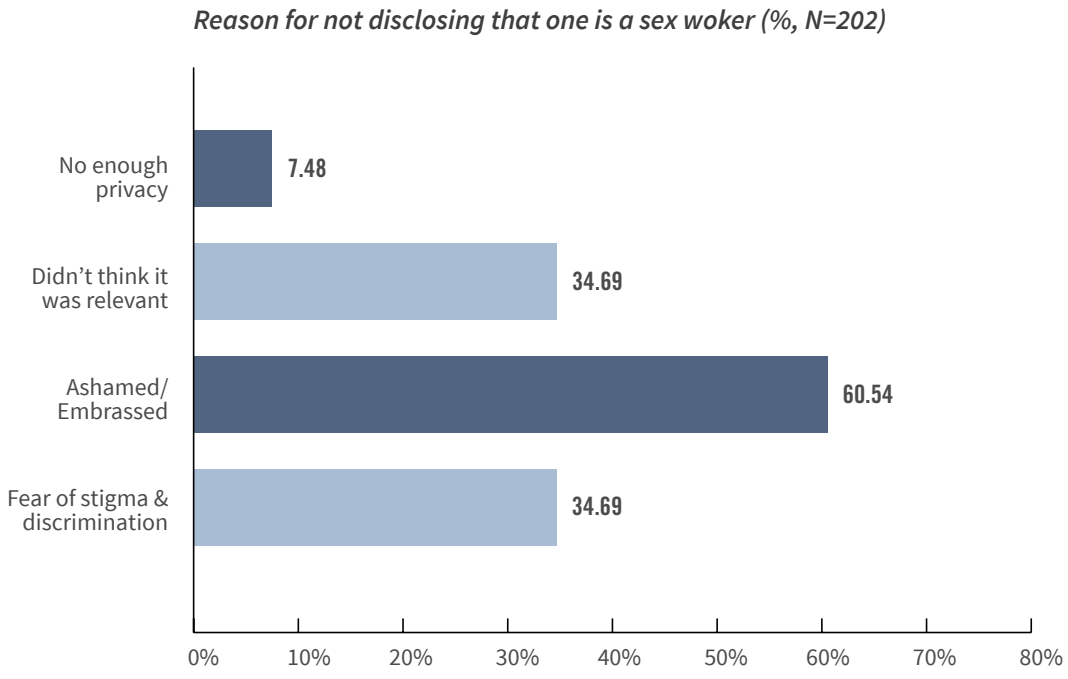
They women had on average one regular, non-paying sexual partner (the number of non-paying partners ranged from zero to 12). Non-paying partners could either be a husband, boyfriend, or another partner whom they trusted and/or liked.

4.2 Experiences in accessing general healthcare services

Reported instances of stigma and discrimination while accessing health care services were low. Almost all (92.3%) of the sex workers in the survey reported that they felt they were treated 'normally' by health care providers. A small number (7.03%, n=22) of the sample who used healthcare services within the last 12 months reported being discriminated against or stigmatized by healthcare providers; three respondents reported that they were refused services after they revealed their occupation, whereas another three were refused from healthcare services even though they did not reveal their occupation.

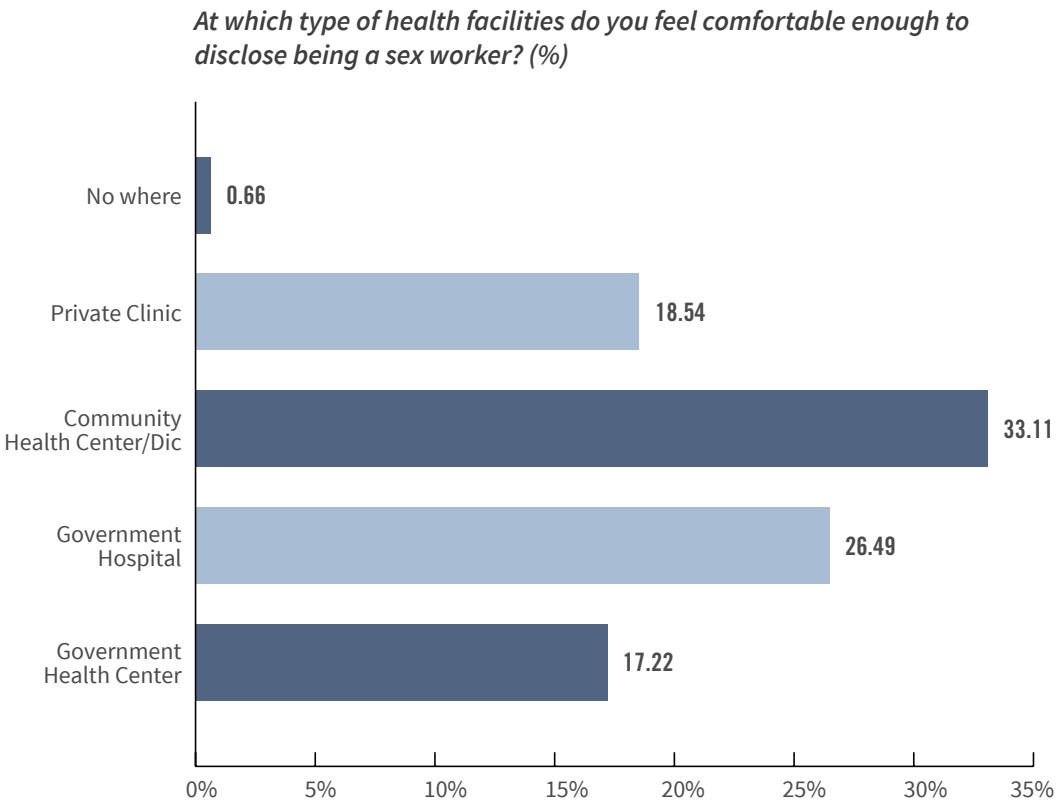
This does not necessarily mean that health care providers all have accepting or tolerant attitudes towards sex work: a majority of FSW did not disclose the fact that they were working as sex workers. About two-thirds (202 out of 308) of the surveyed FSW said they felt never or not always confident to disclose their occupation as a sex worker. Indeed, when asked why they choose not to disclose being a sex worker to healthcare providers (participants could give more than one answer), the majority (60.5%) reported that it was because they felt ashamed or embarrassed. A third (34.7%) did not disclose due to fear of stigma and discrimination, and another third (34.7%) thought that disclosing their occupation was not relevant to their visit. A smaller number (7.5%) thought that the clinics did not provide enough privacy for them to comfortably talk about being a sex worker (Figure 2).

Figure 2: Reasons for not disclosing that one is a sex worker



In general, the women felt most comfortable to disclose their occupation at the community health centers (DiC) (33.1%). A bit over a quarter (26.5%) felt comfortable to disclose that they were a sex worker at Government hospitals; 18.54% felt comfortable to disclose at private clinics, and 17.2% at government health centers. (Figure 3)

Figure 3: Comfort in opening up about doing sex work by facility type



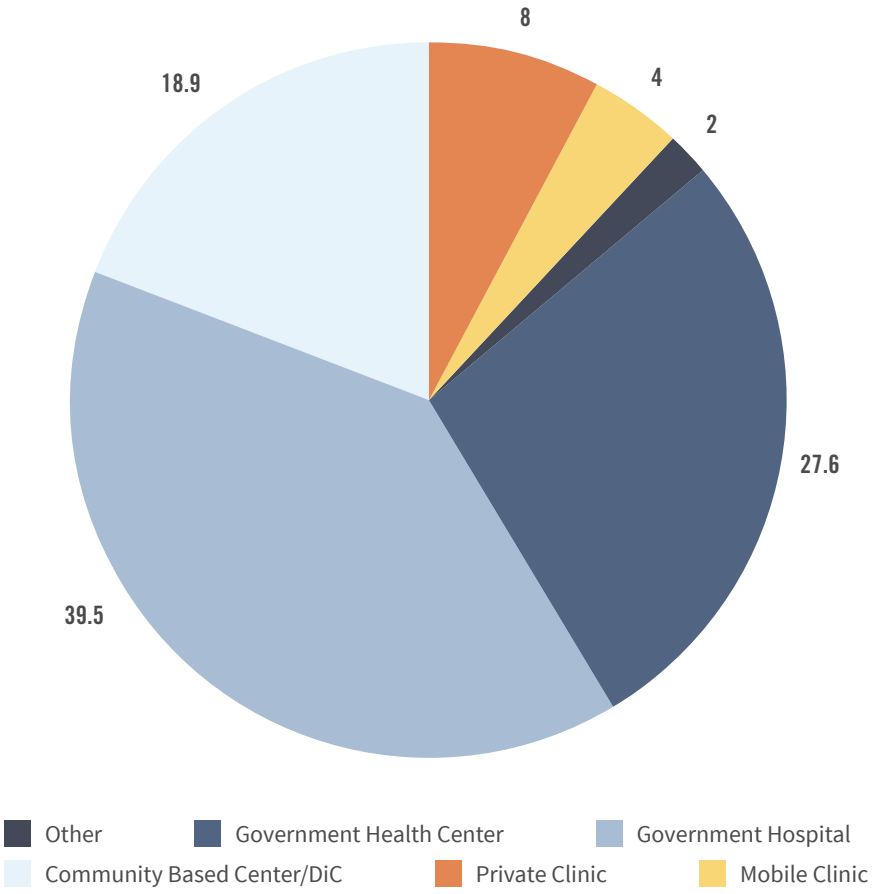
4.3 Access to HIV services

Almost all of the sample (95.9%, n=301) had been tested for HIV. Among those who had been tested, 12 women (4.2%) reported being HIV positive. 11 out of these 12 HIV positive women (91.7%) reported that they already had been medically evaluated, and were receiving treatment and care related to their HIV infection. Only one woman did not have any evaluation and care because she did not know where to go to and did not feel sick. Among those who had tested for HIV, 5% (n=15) reported being tested without their consent. With the 13 women who had not gone for the test, 84.6% said they believed they were not at risk, 7.7% did not go because no one advised them to go and another 7.7% did not want to know their HIV status.

Among those who had tested for HIV, 39.5% (n=119) reported their most recent test was done at a government hospital, 27.6% (n=83) was done at a government health center, 18.9% (n=57) was done at a community-based health center/drop-in center (DiC). A smaller number was tested at a private clinic (8%, n=24) or at a mobile clinic (4%, n=12) (see Figure 4).

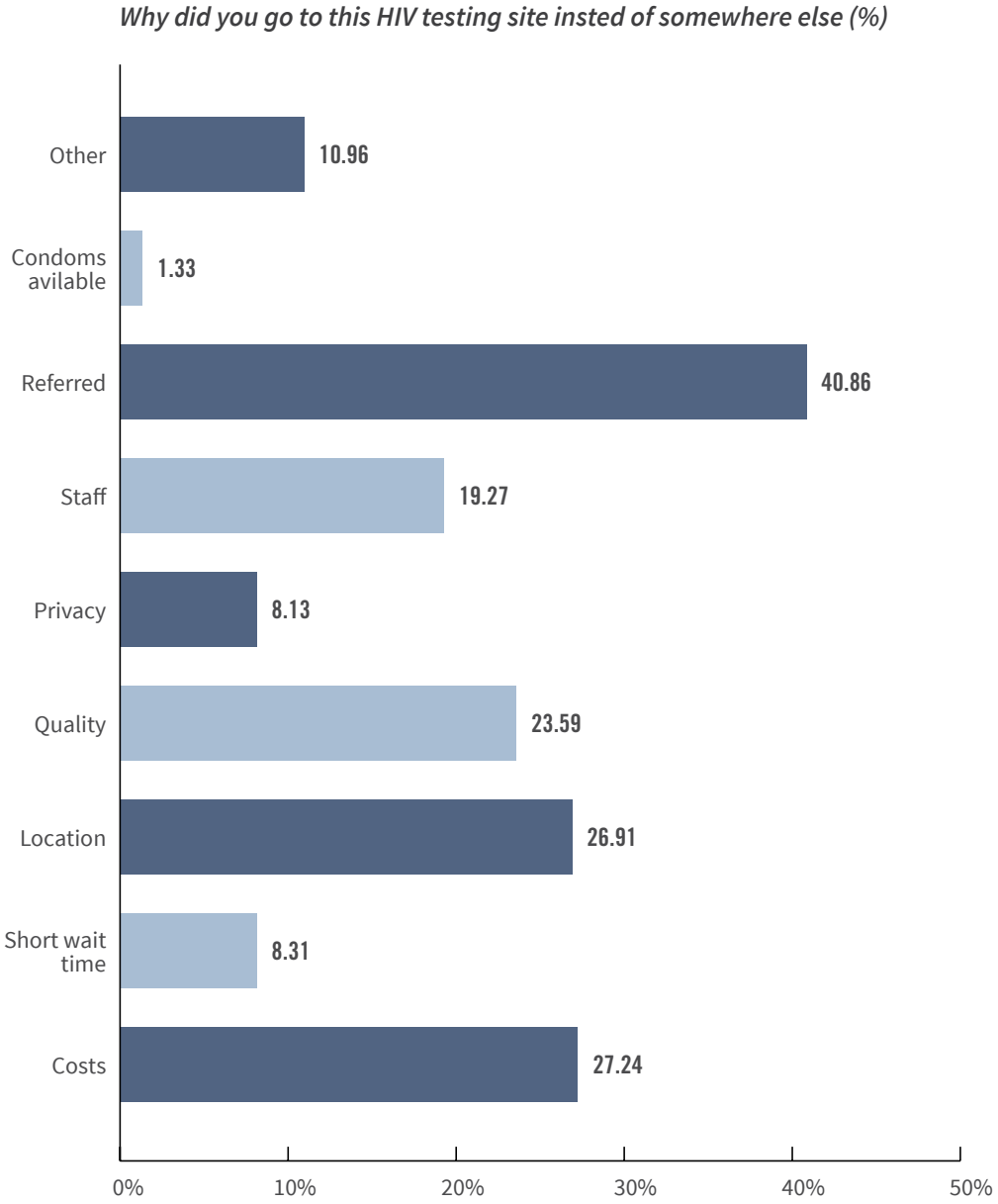
Figure 4: HIV testing sites

Where did you do your most recent HIV test ?



The most common reason for these women to go to clinics for HIV testing was because they were referred or introduced by staff of community-based organizations (CBO) or other projects that they participated in (40.9%). A bit over a quarter (27%) reported that they went to such clinics because the cost was not too high. Around a quarter (26.9%) mentioned the location as the main reason why they chose that particular testing site. Nearly a quarter (23.6%) said they chose that site because they believed in the service quality there. Around one in five (19.3%) said they chose their clinic because of the friendly and skillful staff. A smaller number (8.3%) mentioned that the clinic had short waiting times; a similar number (8.3%) mentioned the privacy provided at the clinic (see Figure 5 below):

Figure 5: Reasons for picking a particular site for HIV testing



According to the participants, the clinics they went for HIV testing offered a range of other services alongside the test itself. A large majority of participants (85.7%, n=257) received education about HIV transmission and prevention; a similar number (87%, n=261) was provided counseling about the HIV test and results. Over two-thirds (70.1%) reported that they received advice on testing for other STI; nearly two-thirds (63.2%, n=189) were referred to other sexual and reproductive health services, and almost half (47.8%, n=143) reported that they were provided condoms (See Table 2 on the next page).

The participants were also asked to comment on any negative experiences they may have had when accessing HIV testing sites. About one in 11 (9%) reported facing difficulty in traveling to the clinics for the HIV tests (1.3% said this was very difficult and 7.7% somewhat difficult). Nearly a fifth (17.7%) of those who went for an HIV test (n=53) reported feeling uncomfortable sometimes during their visit to the clinics because of the service providers, while two participants reported always feeling uncomfortable due to the behavior of the service providers at the HIV testing places.

Over a third (37.7%, n=113) did not feel comfortable to open up about their occupation as a sex worker to the staff at the testing facility. For those who did not tell the staff about being a sex worker, the most common reason was because they felt ashamed and embarrassed to tell (62.8%, n=71). Nearly half (44.3%, n=50) thought that it was not necessary or relevant to talk about their sex work. A large number of FSW (40.7%, n=46) did not tell the staff that they were a sex worker because they feared they would face stigma and discrimination if they did so. A smaller number (7.1%, n=8) thought that the clinics did not provide enough privacy for them to disclose.

	n	%
Services provided		
Explanation of HIV transmission & prevention		85.67
Counseling regarding HIV testing and results		87
Suggestion to test for other STIs		70.1
Referral to SRHS		63.21
Condoms		47.83
How difficult would you say it was for you to travel to get there from your home?		
Very difficult		1.33
Somewhat difficult		7.67
Not very difficult	79	26.33
Somewhat easy	117	39
Very easy	67	22.33
Not applicable (Mobile Clinic)	10	3.33
During any time of your visit, did the service provider make you feel uncomfortable?		
All the time	2	0.67
Never	227	75.67
Sometimes	53	17.67
Not sure	18	6
Feel comfortable in telling the staff at the testing facility that you were a sex worker?		
Yes	187	62.33
No	113	37.67
Why did you not tell them?		
Fear stigma & discrimination	46	40.71
Ashamed / Embarrassed	71	62.83
Didn't think it was relevant	50	44.25
Not enough privacy	8	7.08
Would you recommend the services to other sex workers?		
Yes	173	57.67
Some reservations	73	24.33
No	50	16.67

Despite these experiences, overall, only 3 participants reported not feeling satisfied about their HIV testing experiences. Nearly two-thirds (57.7%, n=173) said that they would definitely recommend the clinic to other sex workers. Another quarter (24.3%, n=73) said they would recommend the clinic, but with some reservations (see Table on the previous page).

When asked about condom availability, in general the women said that they could easily buy condoms from a nearby pharmacy (27.5%), or at work such as in the hotel or motel, or at the entertainment facility where they meet clients (15.8%). One in six (16.8%) mentioned that they received free condoms from peer educators (12.7%) or CBOs (4.1%).

4.4 Access to STI services

A large majority (90.8%, n=287) of the sample reported to have accessed an STI clinic at least once within the past 12 months. Among the 29 women who did not visit an STI clinic in the past year, most (89.7%) said they did not think it was necessary and 13.8% did not go because of financial difficulty. Fear of health provider attitudes, worries about confidentiality and privacy, and lack of information were also reasons for some women not to go for STI check-ups.

For those who went for STI services in the past 12 months, the main reason for their last visit was that they had a suspicion of having an STI (54.6%); the second-most common reason was for a routine screening check-ups (39.1%). A small number (1.1%) went to receive STI counseling and for follow-up check-up after having been treated for STI (0.7%).

Most of the women chose to get health services for an STI at a government hospital (81.2%) or a private clinic (76.2%). Over half (56.7%) also went for STI services at government health centers, and nearly half (48.2%) came to community based health centers/DiC (Figure 6).

The participants were asked what their criteria were for selecting an STI clinic. The women found it most important that the clinic was in a convenient location (36.9%), and that the quality of the service was high (28.6%). Over a quarter (28.2%) did not mention any criteria, and said they went to the clinic simply because they had been referred there. About a fifth of the sample (20.2%) mentioned the cost of the service was important for them to decide where to go. A smaller number of participants said that the clinic they chose provided free services (10.5%), did not require long waiting times (9.8%), had high quality facilities (8.3%), and ensured privacy for patients (7.3%) (Figure 7).

Figure 6: Types of STI clinics visited by participants

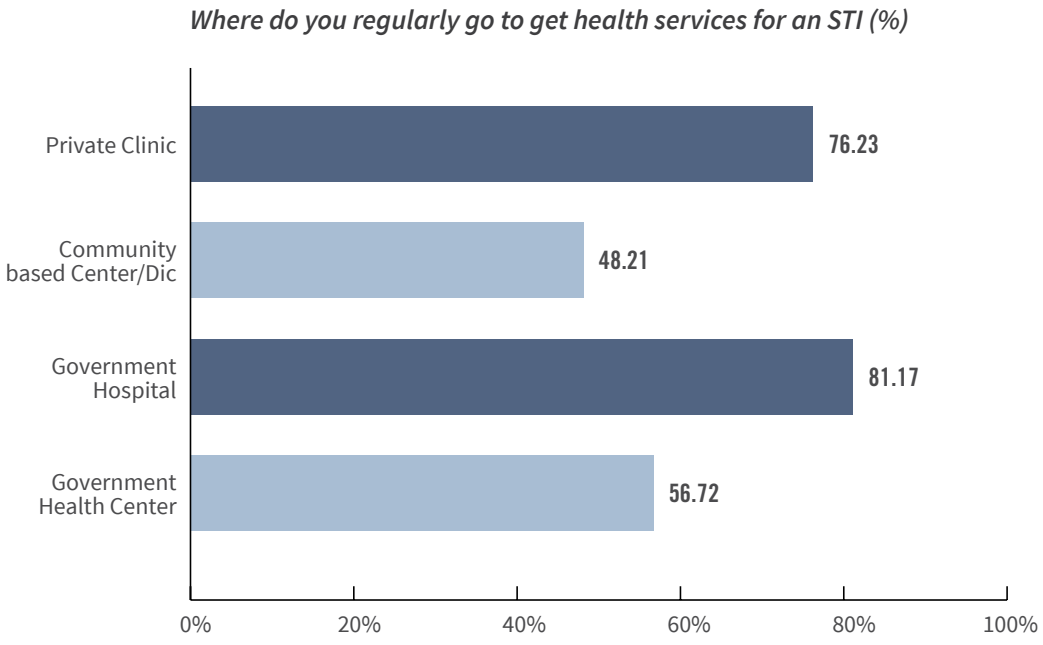
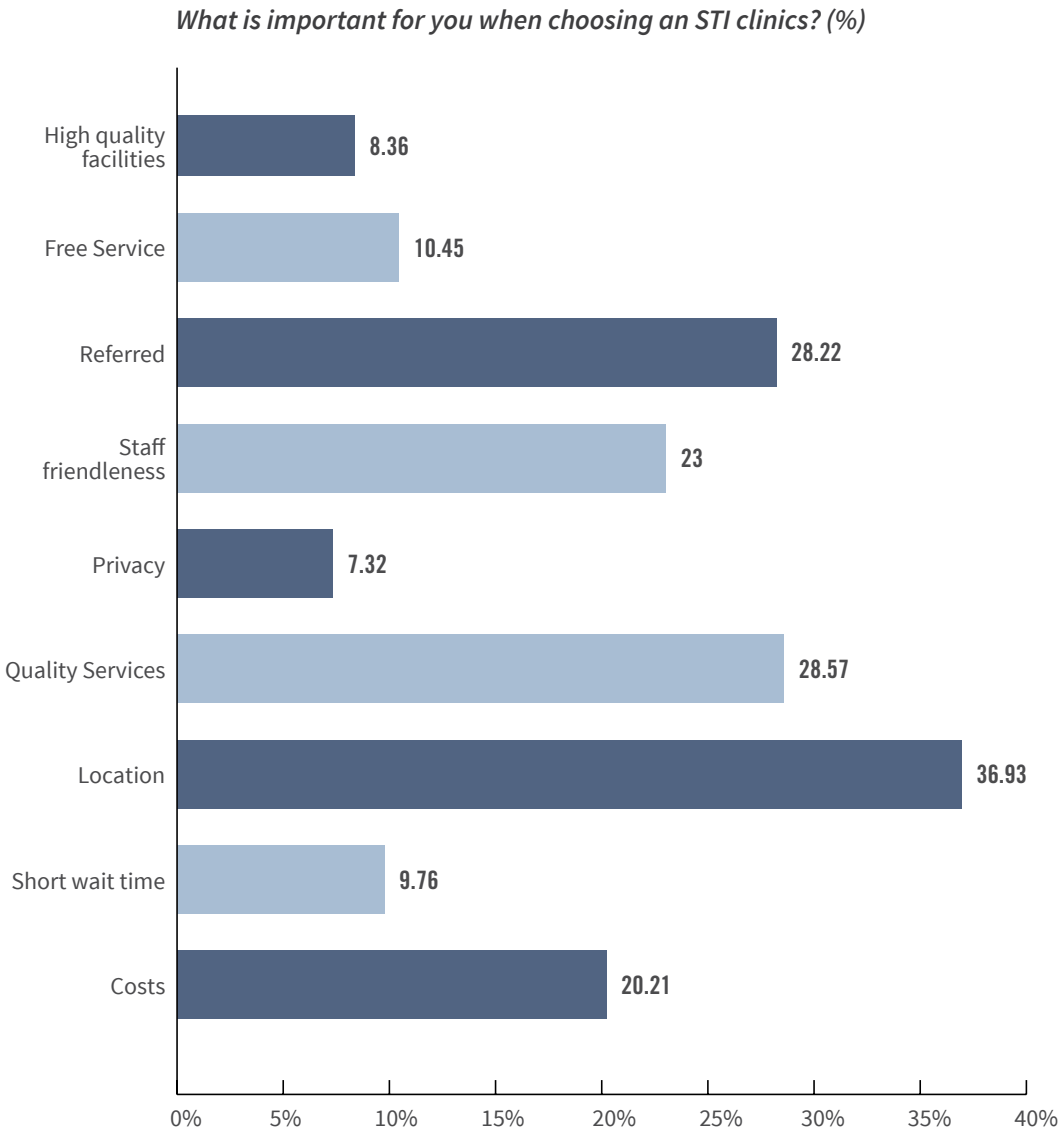


Figure 7: Criteria for choosing an STI clinic



Similar to the HIV services discussed in the previous section, services provided at STI clinics go beyond mere STI testing. About three quarters (76.2%) of the research participants reported that the clinics had private space to discuss overall healthcare needs. In fact, 81.6% reported the clinics provided good confidentiality for clients. Nearly two-thirds (60.1%) reported that the STI clinics also provided HIV services, and 59.8% reported the clinics also offered sexual and reproductive health (SRH) services.

The majority (63.3%, n=131) of participants who went for STI services were asked to return for a check-up. The reasons for not to return for a check-up were feeling embarrassed (57.9%), fear of discrimination (38.6%), fear of being refused service (15%), or not thinking that a re-check was necessary (27.9%). A smaller number said they feared a lack of privacy (5.7%) (See Table 2).

One out of ten participants found it difficult to get to the STI clinic for check-up and treatments. In general, the women either did not have any impression or felt satisfied with the services they got at the clinics; only 7 participants (2.5%) reported dissatisfaction with the STI services they received. About the same number of participants (2.8%) reported dissatisfaction with the attitude of the healthcare providers at the clinics they went to. About one in eight (12.2%) said that the time for each visit to the clinics was somewhat long, and 6.3% thought that it was too long (Table 3).

Table 2: Overview of services received & scheduled return visit

	n	%
Service provider provided/offerred:		
Private space to discuss healthcare needs	218	76.22
Confidentiality	233	81.75
HIV services	172	60.14
SRHR services	171	59.79
Why did you not return for a check up?		
Feared Discrimination	54	38.57
Feared Services Refused	21	15
Embarrassed / Ashamed	81	57.86
Didn't think was relevant	39	27.86
No privacy to disclose	8	5.71

Table 3: Difficulty in reaching and satisfaction with STI services

	n	%
How difficult would you say is the travel for you to get there from your home?		
Very difficult	2	0.7
Somewhat difficult	27	9.44
Not very difficult	46	16.08
Somewhat easy	149	52.1
Very easy	62	21.68
How satisfied are you with the overall services that you received?		
Very satisfied	79	27.62
Somewhat satisfied	138	48.25
Okay, not satisfied or dissatisfied	62	21.68
A little satisfied	4	1.4
Not satisfied	3	1.05
Did you feel satisfied with the attitude of the healthcare service providers?		
Very satisfied	73	25.52
Satisfied	178	62.24
A little satisfied	27	9.44
Not satisfied	7	2.45
Disliked it	1	0.35
Did you find that the time obtaining services on your last visit was reasonable?		
Too Long	18	6.29
Somewhat long	35	12.24
Reasonable	229	80.07
Short wait time	4	1.4

In terms of disclosure, about half (51.1%, n=146) of the women did tell the STI healthcare provider that they were a sex worker. For those who did not tell, the reasons given were that they felt ashamed/embarrassed (57.9%), they thought that such information was irrelevant to the visit (27.9%), and they feared being discriminated against by the healthcare provider (38.6%). A smaller number feared being refused from the service (15%), or they thought there was no privacy at that clinic (5.7%). Despite this, a large

majority (71.4%, n=202) of the participants said they would recommend to other sex workers to use the services at the clinic that they had been to (Table 4):

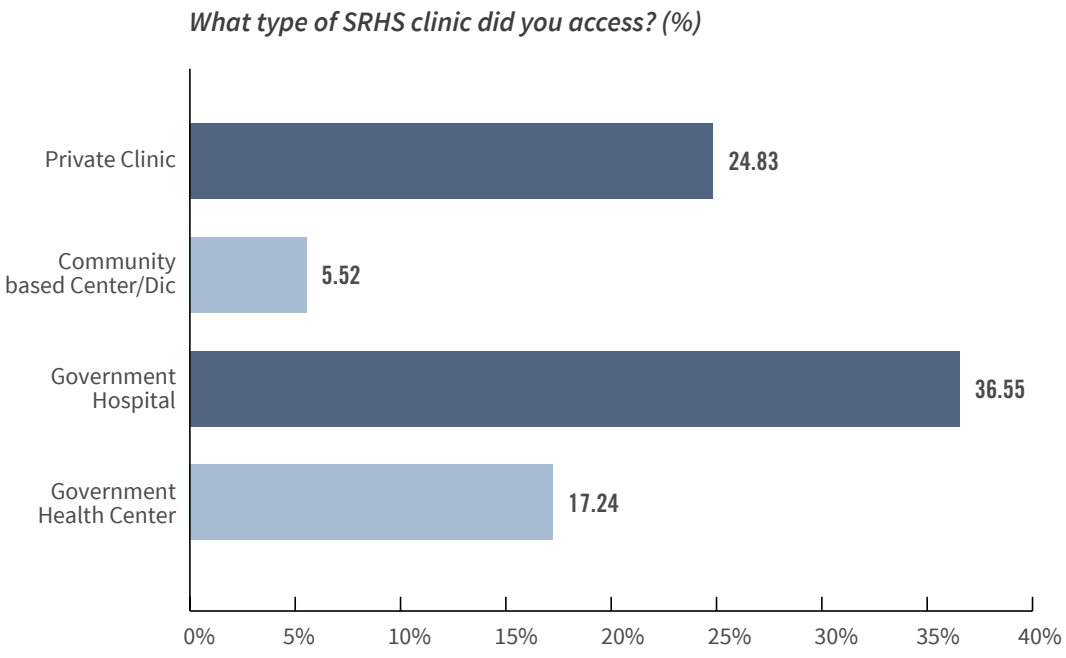
Table 4: Disclosure of status as sex worker at STI clinics and reasons for non-disclosure

	n	%
At your last visit, did you feel comfortable in telling the healthcare service provider that you were a sex worker?		
Yes	146	51.05
No	140	48.95
Why did you not tell your healthcare service provider that you were a sex worker?		
Feared Discrimination	54	38.57
Feared Services Refused	21	15
Embarrassed / Ashamed	81	57.86
Didn't think was relevant	39	27.86
No privacy to disclose	8	5.71
Would you recommend these services to other sex workers?		
Yes	202	71.38
No	75	26.5

4.5 Access to sexual and reproductive health services

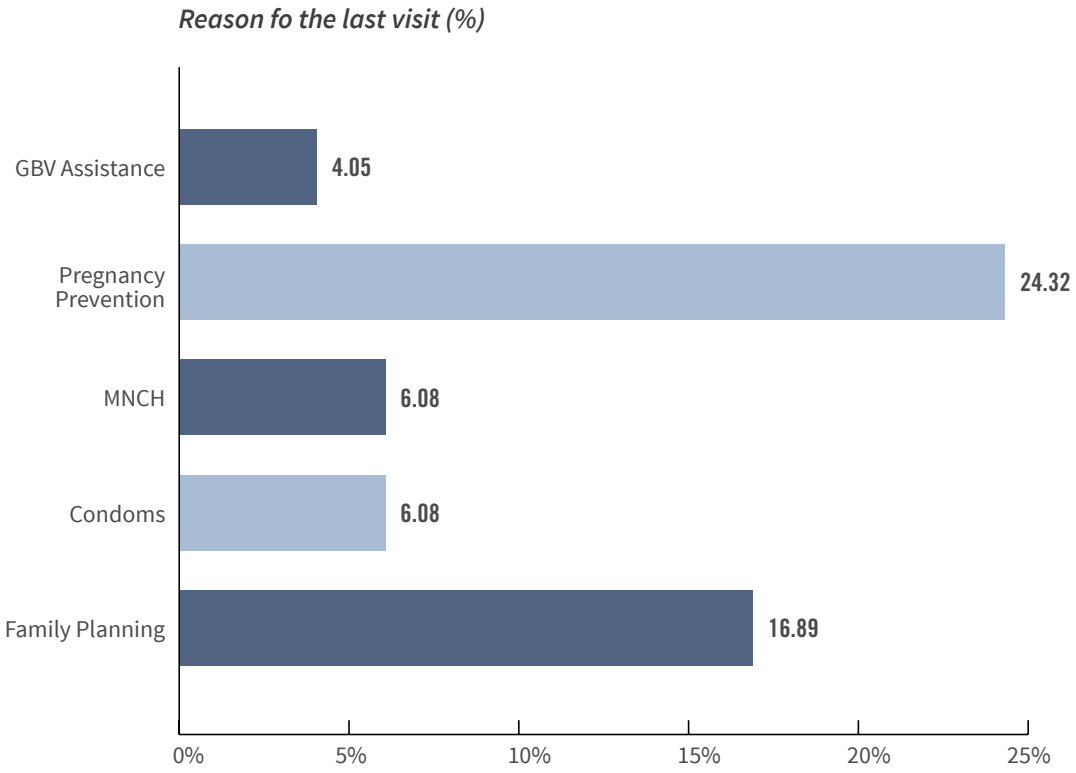
Out of all participants in the survey, nearly half (46.5%, n=146) reported using at least one sexual and reproductive healthcare service within the last 12 months. Four out of five (80.6%, n=168) of the women had ever been pregnant in their life. Out of these women, nearly a quarter (22.5%, n=27) had an unwanted pregnancy in the last 12 months. Government hospitals are the most common destination for the women in the survey when seeking SRH services (36.6%); about a quarter (24.8%) went to private clinics and 17.2% went to a government healthcare center. A small minority (5.5%) relied on community-based health centers/DiC for their SRH needs (Figure 8).

Figure 8: SRH clinics accessed by the participants, by type



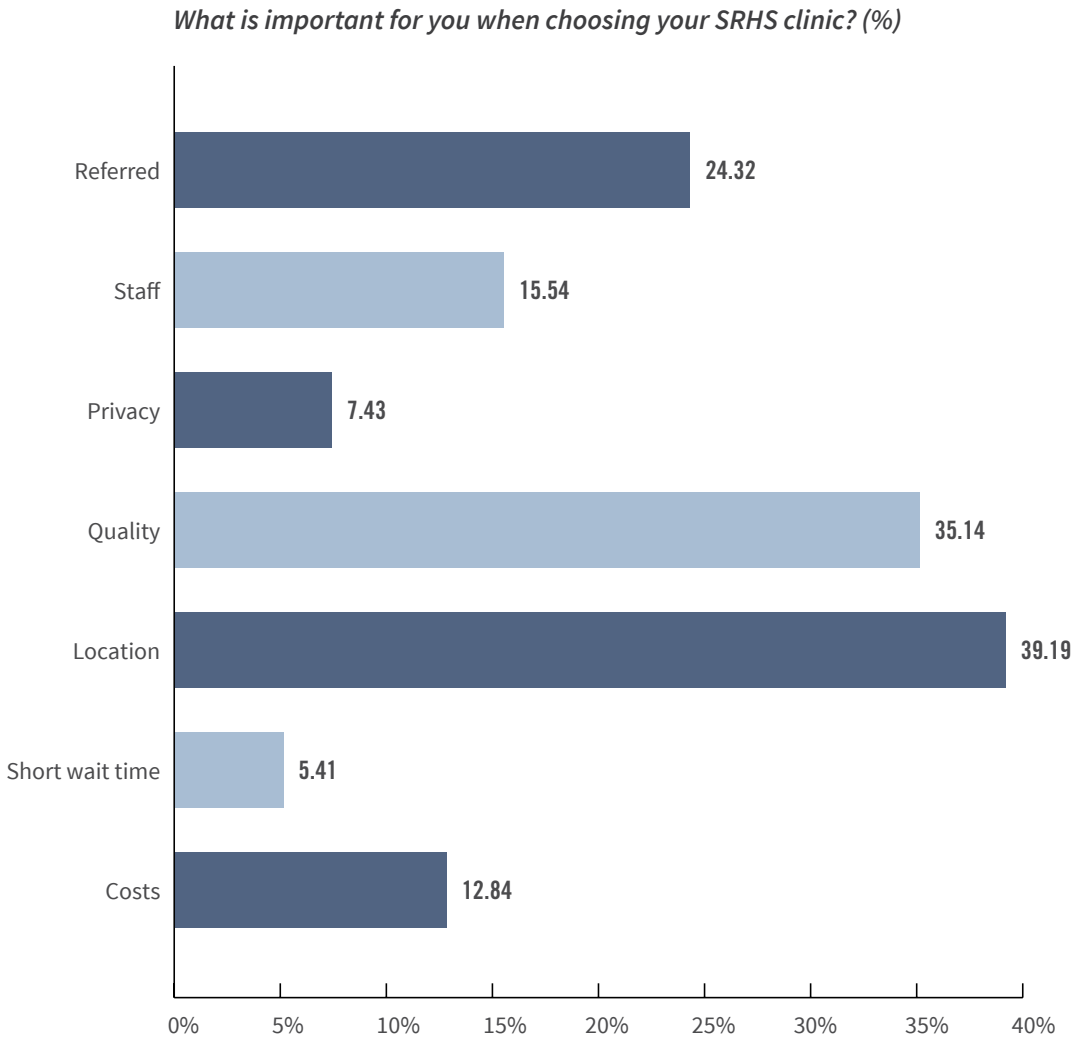
When asked why they visited an SRH clinic the last time they went there, a quarter of the participants (24.3%) said they went for pregnancy prevention and about one in six (16.9%) went for family planning purposes. Smaller numbers of women went for maternal and newborn care (6.1%), to obtain condoms (6.1%),or for GBV assistance services (4.1%) (Figure 9):

Figure 9: Reasons for visiting a sexual and reproductive health clinic



Similar to the questions asked about general health services, HIV services and STI services, the women were also asked what their most important considerations were in deciding to which SRH clinic they went. Being in a convenient location was the most common reason for the women to decide which clinic to go (39.2%). The other criteria based on which they chose their SRH clinic were service quality (35.1%), being referred to it (24.3%), friendly staff at the clinic (15.5%), reasonable costs (12.8%), high degree of privacy and confidentiality (7.4%) and short waiting times (5.4%) (Figure 10):

Figure 10: Criteria for choosing which SRH clinic to go to



According to the participants, most of the SRH clinics offered services with privacy (80.7%, n=109) and protected their patients' confidentiality (86.6%, n=116). The participants also reported that besides SRH services, the healthcare providers there also offered them HIV services (60.74%, n=82), and STI services (53.3%, n=72) (Table 5):

Table 5: Privacy, confidentiality and other services received at SRH clinics

	n	%
Service Provider provided / offered		
Privacy	109	80.74
Confidentiality	116	86.57
HIV services	82	60.74
STI services	72	53.33

More than ten percent of the participants who used SRHS reported facing difficulty in getting to the clinics from their home (9.6% reported this to be difficult and 0.7% reported it to be very difficult). About one in 11 (8.9%) said that the time to obtain services on their last visit to SRHS clinic was long, and 5.9% said that it was too long.

In general, the women felt satisfied with the SRH services they received; 44.4% reported feeling satisfied, 31.9% reported feeling very satisfied, and 18.5% felt the services were merely 'acceptable'. About 5% participants did not feel satisfied with the SRH services

they received in the last 12 months. About 7% participants said they were not happy with the attitude of healthcare providers at the clinics they went to get SRH services.

This looks relatively good—but again, the sex workers did not feel comfortable disclosing their status as being engaged in sex work. Only 52.6% of the women who used SRH services said that they felt comfortable to tell the healthcare providers that they were a sex worker (Table 6).

Table 6: Difficulty reaching SRH services, overall satisfaction and disclosure

	n	%
How difficult would you say it was for you to travel to get there from your home?		
Very difficult	1	0.74
Somewhat difficult	13	9.63
Not very difficult	18	13.33
Somewhat easy	61	45.19
Very easy	42	31.11
Did you find that the time obtaining services on your last visit was reasonable?		
Too Long	8	5.93
Somewhat long	12	8.89
Reasonable	111	82.22
Short wait time	3	2.22
How satisfied were you with the overall services that you received?		
Very satisfied	43	31.85
Somewhat satisfied	60	44.44
Okay, not satisfied or dissatisfied	25	18.52
A little satisfied	5	3.7
Not satisfied	2	1.48
Did you feel satisfied by the attitude in which healthcare service providers		
Very satisfied	39	28.89
Somewhat satisfied	65	48.15
Okay, not satisfied or dissatisfied	22	16.3
A little satisfied	7	5.19
Not satisfied	2	1.48
At your last visit, did you feel comfortable in telling the healthcare service provider that you were a sex worker?		
Yes	71	52.59
No	64	47.41

4.6 Barriers while seeking healthcare services at different service sites

According to key informants, the following key barriers exist for sex workers who seek health care in different service sites in Vietnam; many of their answers are confirmed by the information from the survey.

Opening hours of clinics & long waiting times.

This is a barrier especially for public hospitals. Most hospitals only open during office hours (from 7AM until 5PM). Besides these inconvenient hours of operation, there are

long waiting times: each visit to the hospital would take around two to four hours. This causes difficulty for FSW to find time off from work, especially those who are working at entertainment establishments. Some hospitals offer check-up services only during morning hours and ask clients to come back to get their test results in the afternoon or even the next day; these are the hours that FSW usually need to rest and sleep, especially those who have to work during the night time.

Fear of stigma and discrimination.

Stigma related to sex work is strong in Vietnamese society. The survey findings above confirm that many if not most FSW avoid revealing their occupation to healthcare providers in fear of being treated badly. Some healthcare providers may not be sensitive when asking questions to FSW. Questions about risky sexual behaviours, numbers of sexual partners, etc may make FSW feel uncomfortable, especially when they are asked in an aggressive or judgmental manner. Most hospitals have private rooms for check-ups and consultation with doctors; however, the reception areas where patients sit and wait to be called upon are often public and crowded. For many FSW, these areas are intimidating spaces; they feel unsafe about being identified as a sex worker.

> "...its difficult for women in this industry to go [for STI, SRH services] because it could cost them their jobs, it's hard for them to go out of their workplace to go to a hospital, and they have to be back quickly."
>
> **KII, CBO leader**

Difficulties with identification documents and administrative procedures.

Many FSW do not have a national ID card, or they have lost it; sometimes their ID is being held by sex work establishment owners. As a result, they cannot register for check-ups or treatments at some public clinics/hospitals or healthcare programs. For example, harm-reduction programs (such as the methadone program) require FSW to show either their ID or (temporary) residency registration in order to get services. Since many FSW come from other provinces and live in the city without registration or ID, it becomes impossible for them to get services. In addition, many FSW face difficulties in filling out administrative forms and communicating with police officers and authorities due to a lack of self-confidence and, for many, limited or no literacy skills.

Timing of intervention activities.

HIV or health service events organized by NGOs, as well as trainings or healthcare services are mostly held during daytime, within office hours, and may last several days. FSW find it difficult to stop working for several days to join such activities, or sometimes it is impossible for them to get up early in the morning to participate in trainings, or go to hospital after a long working night.

Cost of healthcare services.

Many FSW do not have a stable income, yet they have to financially support their family and children. Whereas most FSW believe that they would be provided with high quality and friendly services at private clinics, they cannot afford these. Meanwhile, at the public hospitals they are

> "I think, medically, [doctors] would know how they get it [STI], often there is no need to ask how they got it. When they said they got it from their husband, the doctor asks the husband to do the tests and treatments too. They can't just admit the truth [about their job], if saying so, [doctors] would look at them differently."
>
> **KII, CBO leader**

afraid that their occupation would be revealed and that they would be discriminated against by healthcare providers and other clients.

Lack of knowledge about, coverage, and use of health insurance.

As became clear from the quantitative survey, a large majority of FSW do not have any health insurance coverage. Even those who have national health insurance feel resistance to go to public hospitals for check-ups and treatment because they want to avoid long hours of queuing and waiting and they fear the lack of privacy while seeing the doctors.

Government-led programs find it difficult to reach out to FSW to provide their service.

VAAC and MOLISA carried out several programs to provide free condoms and lubricants for FSW and free syringes and needles for those who also engaged in substance abuse. They could only reach FSW via outreach workers from CBOs. Without the connection with CBOs, government-led interventions would become impossible, especially if FSW refused to join or communicate with government program officers.

The mobility of FSW makes it harder for service providers.

Intervention programs find it difficult to keep track of their FSW clients due to their mobility. They are also reported to have a low level of commitment to participate in health projects. The mobility of FSW is also a challenge in terms of project data management and providing follow-up interventions.

> For social workers like us, sometimes we really feel difficult to work with them, because they also have their inferiority complex, they feel ashamed about their jobs so that they want to come [for the test] and go very quickly, even when the HIV test came out, it is very difficult to track them down, to contact them to put them into treatment programs"
>
> **KII with PAC officer**

Operating capacity.

Among the projects that require collaboration between NGOs and CBOs of FSW, program officers reported that because of CBO's limited capacity, they face difficulties in ensuring compliance with the donor's reporting deadlines and other requirements.

Social workers' attitude toward sex work.

When providing services, some program officers and social workers do not fully understand and are not sensitive while working with FSW.

Government HIV agencies and organizations do not have enough information and insights about the dynamics of sex work markets in the country, and do not fully understand the diverse risky behaviours and specific needs of different groups of FSW, especially those who operate online.

4.7 Engagement of FSW in CBO/NGO planning

Networks of CBOs and NGOs have been putting efforts in facilitating the dialogues between FSW and the program designers and policy makers, yet no significant influence and change was made. VAAC provided trainings for their provincial officers in mapping out and reaching out to FSW to provide support yet still they find there is a gap, a distance that is difficult to erase between their social workers and the FSW clients.

From the survey it became clear that during the past 12 months, 136 participants in the

survey reported participating in at least one group, organization or network that defends the rights of female sex workers. Among these women, 33.8% (n=46) were currently members of such group, organization or network.

> Whenever a new program rolls out to the area, other members and I are invited to give our comments and ideas, suggestions, but we are not always the ones to decide."
>
> **IDI, CBO leader**

Although some FSW participated, FSW generally have played almost no role in designing the interventions aimed at them, or in the decision-making about projects aiming to reach them. Rather, they are invited to give feedback during consultations on the program intervention designs, or providing ideas and voice out their needs. However, the ideas raised by FSW are not always adopted by these projects and and rarely turned into actual activities. For example, Global Fund projects always involve FSW in every phase of their activities to listen to their ideas and feedback to adjust the design and agenda of the program. However, due to limited budget and donors' requirements, not all needs/ideas suggested by the FSW were deemed feasible. Suggestions such as organizing more trainings, activities around team building, networking activities and CBO office maintenance costs were rejected.

The national HIV/AIDS program managers admitted that their failure to involve FSW in the design phase of their programs was a limitation. They suggested that this limitation was caused by the working hours of governmental officials, which hinder FWS participation in their consultation workshops. Also, FSW find themselves hesitant to work with the authorities, due to fears of maltreatment, fears of not being taken seriously and stigma. Understanding such dynamics, the FSW CBOs themselves started get together and collecting their members' ideas, recommendations and needs to form a collective voice to work with NGOs and National Programs and advocate for changes. For example, every year-end meeting, the FSW groups would conduct a survey among their members to ask about their visions of the group activities for the next years, the needs, the priorities. The survey results would then become the inputs for their work plan proposals to send to donors to seek funding.

> Yes, we did [involve FSW in activities], for example, when we designed and budgeted activities for the GF project, at each phase we had to work with the [FSW] groups to see if those activities were suitable, would they be fine to participate in, and what would be the challenges. We also let them know about the budgeting, but it was only sharing so that they knew. It's difficult for them to involve in budgeting, to say how much money they need. Because even from our side, we also could not decide on that. "
>
> **KII, Global Fund Grantee**

CHAPTER 5

DISCUSSION

The study found that it has generally become easier for CBOs/NGOs to work with/for FSW in Vietnam during the past decade. Attitudes of government officials have changed, and good collaboration between government agencies and CBOs/NGOs working with/for sex workers is now in place. This is partly because government officials realize that government health services are not able to reach FSW without the help of CBOs/NGOs; their outreach workers are essential to facilitate access of FSW to general health care, SRH, STI and HIV services.

At the same time, the priority accorded to FSW as part of the overall HIV response has been on the decline. Other key populations (men who have sex with men, transgender women, people who inject drugs and their sexual partners) are considered of higher priority, based on epidemiological dynamics. Ironically, it seems that NGOs and CBOs working on HIV prevention among FSW have done such a good job that they are now facing cuts in their funding.

Overall, health services available to Vietnamese FSW are comprehensive. Whereas sex worker-specific health facilities and services have been largely phased out due to reduced funding, linkages to and with government and private sector health services have replaced these. Condoms and lubricants are freely available, although many FSW prefer to buy them at pharmacies. HIV and STI testing and treatment services are available at low or no cost; for FSW who use substances, methadone therapy and needle/syringe exchange programs are available. In some places PrEP and PEP are also available as additional preventative options.

As a result, the FSW engaged in the quantitative survey had high exposure to HIV, STI and SRH interventions: 96% had been tested for HIV and 91% had accessed STI services in the past 12 months. These high numbers may be partly caused by selection bias of the survey, since most FSW were recruited via health-focused NGOs and CBOs. Only 6% of the sample found clients online; it is believed that in reality, more and more (especially younger) FSW are operating online, and these women may have had a smaller chance to be recruited into the survey. It is expected that uptake of HIV, STI and SRH services among FSW operating online is probably much lower.

However, several obstacles to FSW accessing health services were described. First, the opening hours of HIV, STI, SRH and general health services were considered inconvenient for FSW; there are no services available after 5 P.M. Even activities organized by CBOs and NGOs often occur in daytime, during office hours, which makes it impossible for many FSW to attend—or, if they attend, they may not be fully rested.

Waiting times at health services are usually long, especially in government clinics and health centres; one key informant said that FSW who leave their work premises for too long risk losing their jobs. About 10% of the women in the survey said that they faced difficulty reaching/attending HIV or STI services due to transportation costs/time and 20% mentioned long waiting times. These figures are relatively low; they may again be partly be explained by selection bias in the sample. In other words, FSW who operate online and further away from urban centres may not have been included in the survey, and hence the challenges they face in accessing health care are not reflected.

Another important obstacle was that nearly two-thirds of FSW had no health insurance; this is an important issue that CBOs/NGOs should work on. Especially the problems FSW face when registering for health care services, in terms of not having an ID or house registration card, are issues that can be resolved using a 'case management approach', where dedicated support workers help FSW overcome bureaucratic hurdles and other obstacles that are in the way of accessing the services they need.

Key informants did mention the mobility of FSW as a challenge. Nearly a third of the women in the sample said they had been away from their main residence for at least a month during the past year. This shows the need for stronger networking among health care services across the country, and a strong(er) referral system.

Key informants also mentioned the low capacity of CBOs and FSW informal groups to implement and manage activities for FSW. Involvement of FSW in the prioritization of interventions, in agenda setting, in budgeting and in design of interventions was considered to be insufficient. The low educational level of FSW (over a quarter completed no or only partial primary education) requires creative solutions for them to be able to play their role; reporting and other administrative deadlines and rules by donor organizations (particularly the GF) can be intimidating and can act as a disempowering force.

Instances of stigma and discrimination reported by the women in the survey were surprisingly low: only about 7% of respondents reported stigmatizing or discriminatory attitudes by health care providers when accessing SRH or general health services, and for HIV and STI services these figures were even lower. However, these figures are deceptive, and are probably low because most FSW tended not to disclose their status as sex workers. According to the survey, the percentages of FSW accessing health services who decided not to disclose their sex worker status were 65.5% for general health services, 49.9% for SRH services, 47.4% for STI services and 37% for HIV services. Non-disclosure was driven by shame about one's profession, as well as fear to be stigmatized by health care providers, or at least a preference to not have to deal with questions, remarks or strange looks. Key informants mentioned social workers in

government institutions as a particular group that often holds negative views about sex work. Some FSW said they thought their profession is not of relevance to the health care provider, hence they did not disclose it—and in some instances that may be the right and rational thing to do. At the same time, it shows that there is still room for improvement to make HIV, STI, SRH and general health care services more sex worker-friendly.

Since part of the hesitation of disclosing sex worker status was found to be linked to shame about being engaged in sex work, the issue of internalized stigma among FSW themselves should be addressed. Internalized stigma this means that negative attitudes about sex work (in relation to gender and 'good/bad' women) in Vietnamese society may be internalized and affect health-seeking behaviour among FSW. A recent qualitative analysis among a small group of Vietnamese FSW uncovered negative/unhelpful core beliefs (including those related to disclosure, self-stigma and shame) but also identified important coping mechanisms to deal with these. The study concludes that such core beliefs are important in understanding self-stigma, paving the way for CBOs/NGOs to address self-stigma among sex workers (26).

Whereas health services may be relatively comprehensive, other services of interest and importance to FSW seem to be less available. It was mentioned that some organizations are involved in 'legal support' (although it is not likely that many FSW make use of such services, and they are unlikely to have achieved much success). "Support to improve livelihoods" is also mentioned by key informants, but it is likely that such interventions were part of approaches that have a punitive, reformative character, and are implemented by the same agencies that have a history of harassing FSW as part of the 'social evils' campaigns. Key informants also said there were referrals for services dealing with gender-based violence (GBV), but no further information was provided; it looks like these services are, like 'legal support', focused on taking action within the legal system and provision of shelter and short-term support, rather than on empowering women to prevent GBV or promote group-level responses to GBV. There seems a lot of room for improvement in these areas; a side-effect of such efforts may very well be improved health outcomes.

Indeed, some key informants mentioned that FSW generally show low motivation to be involved or engaged in HIV, STI or SRH programs offered by government entities, and even by CBOs/NGOs. No further data was collected on why this might be the case. If the situation in other countries is anything to go by, this may be related to the fact that many programs for FSW are only focusing on health. Implicitly these programs view FSW as actual or potential disease vectors, so they are overly focused on reducing risk behaviours and on 'containing contagion' of the general population. As such, these programs do not deal with problems that are important to FSW themselves, such as reducing violence by clients, reducing police harassment and provision of social or financial support. Donor organizations often consider such programs to be beyond their scope or focus of operation, even though it has been proven that health outcomes can directly improve by addressing non-health issues (16-18, 20, 27).

CHAPTER 6

RECOMMENDATIONS

6.1 Overall recommendations

- Improve the involvement and engagement of FSW in agenda-setting, prioritization of interventions, and intervention design, ensuring that their ideas and concerns are properly addressed. 'On paper' this happens already, but in reality, budget & donor concerns usually prevail. Meaningful participation by FSW should be in a format / using a methodology that is effective also for those who are illiterate or semi-literate. If necessary, it should happen outside official office hours, and at a location/site where FSW feel safe and comfortable (i.e. not necessarily inside a government office).

- Overall, it should be studied how the motivation of FSW to engage in / make use of interventions can be further improved. It is likely that the health concerns that are addressed by ongoing interventions are not necessarily top priorities for FSW. If the situation in other countries is anything to go by, it might be the case that health-related interventions will become more effective in achieving their goals if they also take on board the most pressing priority problems of FSW themselves (for example, reducing violence by clients; reducing harassment by police; improving care, support and child protection services to children of FSW; livelihood after quitting sex work, for example by providing opportunities for education or vocational training; strengthening social/psychological support groups, et cetera)

- The sex industry in Vietnam is changing rapidly. Much of sex work is beginning to

happen online, via social media platforms, or via mobile phone private networks. Current health interventions cannot currently reach FSW operating in these environments. A mapping study should be conducted to assess the importance of phone- and online-based sex work, and look at how online information and education campaigns, online outreach and online HIV testing promotion strategies can be implemented in Vietnam. Again, such interventions can only work if the concerns and priorities of FSW have been fully incorporated.

6.2 Additional recommendations for policy makers

- In order to improve the enabling environment for HIV, STI and SRH interventions for FSW, collaboration among different governmental bodies should be improved, especially health authorities, social welfare authorities and law enforcement authorities (both at the national and the municipal level).

- Since a large percentage of FSW felt unable or uncomfortable to share information about their involvement in sex work, at the local level, it is important to build the capacity of governmental social workers and other officers involved in providing services to FSW. Government staff should be sensitized to the specific situation and needs of FSW, and they should be taught ways to address openly or lingering stigmatizing and discriminatory attitudes they may harbour. The basic principle should be that the government should provide services without passing judgment on clients; it is their role to be professional service providers, not to uphold societal norms or values.

6.3 Additional recommendations for health care providers

- Consider relocating HIV, STI and SRH clinics to more convenient locations, i.e. closer to where FSW operate.

- Study if there are ways to reduce the waiting times for each visit, for example by opening satellite clinics from government hospitals or by opening more community-based health centers at residential areas, or by introducing mobile clinics that can visit areas where FSW operate.

- Reduce or abolish the extra cost for health services provided outside office hours (overtime)

- Raise the awareness and sensibilities of health care providers in working with FSW patients by training them with knowledge and skills to understand the particular issues and needs of FSW. (see above)

- Advocate for quality of health service facilities, in particular making support staff at clinics (guards, receptionists, nurses) friendlier and to provide more private space for medical personnel to talk to patients with confidentiality.

6.4 Recommendations for CBOs/NGOs and the private sector

- Engage non-clinical organizations to focus on sex worker rights and reducing the impact of GBV and violence by police; this is likely to be more effective than expanding the remit of public health projects to include a rights component.

- Raise awareness among FSW on health insurance and how it can be used to reduce the cost of using health care services.

- Pilot a ‘case management approach’ where outreach workers accompany FSW

(especially those who are very young / vulnerable of illiterate/less literate) to deal with government officials, for example when registering for health services, obtaining a house registration document or national ID card.

- Train CBO/NGO staff on techniques to solicit inputs from FSW, including those who are non- or semi-literate, so that they can support FSW to channel their inputs and concerns to policy makers during the design of interventions or funding proposals. CBOs/NGOs must be careful not to fall in a 'nanny trap' where they speak on behalf of FSW; they should work to empower FSW to speak for themselves.

- CBOs/NGOs should prioritize and play a major role in mapping research on new forms of sex work via mobile phones and the internet (see above) and in the process to work with FSW to design effective and appropriate interventions to reach FSW working online/via mobile phone networks.

REFERENCES

1. International Labour Organization. Viet Nam's Sex Industry: A Labour Rights Perspective - A Qualitative Study - Summary Report. Hanoi, Vietnam: International Labour Organization 2016.
2. Le G, Khuu N, Nguyen PD, Luong HTY, Pham QD, Tran HP, et al. Population Size Estimation of Venue-Based Female Sex Workers in Ho Chi Minh City, Vietnam: Capture-Recapture Exercise. JMIR public health and surveillance. 2019;5(1):e10906.
3. Clatts MC, Goldsamt LA, Yu G, Colby D. Sexually transmissible infection and HIV prevention and treatment for young male sex workers in Vietnam: findings from the SHEATH intervention. Sexual health. 2016;13(6):575-81.
4. Goldsamt L, Clatts M, Giang L, Le B, Colby D. Sexual health promotion intervention for male sex workers in Vietnam in-creases knowledge of STI/HIV transmission risk. J AIDS Clin Res. 2017;4.
5. Bao A, Colby DJ, Trang T, Le BQ, Dinh TD, Nguyen QH, et al. Correlates of HIV testing among transgender women in Ho Chi Minh, Vietnam. AIDS and Behavior. 2016;20(3):371-8.
6. Shannon K, Strathdee SA, Goldenberg SM, Duff P, Mwangi P, Rusakova M, et al. Global epidemiology of HIV among female sex workers: influence of structural determinants. The Lancet. 2015;385:55–71.
7. Baral S, Beyrer C, Muessig K, Poteat T, Wirtz AL, Decker MR, et al. Burden of HIV among female sex workers in low-income and middle-income countries: a systematic review and meta-analysis. The Lancet infectious diseases. 2012;12(7):538-49.
8. Francis C, Mills S. HIV cascade framework for key populations: FHI 360, Linkages, PEPFAR and USAID; 2015 October 2015.
9. World Health Organization. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations–2016 update. 2016.
10. World Health Organization. Policy brief: Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. World Health Organization; 2017.
11. (UNAIDS) UNJPoHA. Vietnam Country Snapshot 2019. Geneva: United Nations Joint Programme on HIV/AIDS; 2019.
12. Scambler G, Paoli F. Health work, female sex workers and HIV/AIDS: Global and local dimensions of stigma and deviance as barriers to effective interventions. Social science & medicine. 2008;66(8):1848-62.
13. Ghimire L, Van Teijlingen E. Barriers to utilisation of sexual health services by female sex workers in Nepal. Global Journal of Health Science. 2009;1(1):12-22.
14. Beattie TS, Bhattacharjee P, Suresh M, Isac S, Ramesh B, Moses S. Personal, interpersonal and structural challenges to accessing HIV testing, treatment and care services among female sex workers, men who have sex with men and transgenders in Karnataka state, South India. J Epidemiol Community Health. 2012;66(Suppl 2):ii42-ii8.
15. Chakrapani V, Newman PA, Shunmugam M, Kurian AK, Dubrow R. Barriers to free antiretroviral treatment access for female sex workers in Chennai, India. AIDS patient care and STDs. 2009;23(11):973-80.
16. Dayton R, Alvarez B, Morales GJ, Rojas Almonte J, Faccini M, Gomes B, et al. Assessing an inclusive model to increase access to comprehensive gender-based violence response services and improve HIV outcomes in Puerto Plata, Dominican Republic. Culture, health & sexuality. 2019:1-17.
17. Leddy AM, Weiss E, Yam E, Pulerwitz J. Gender-based violence and engagement in biomedical HIV prevention, care and treatment: a scoping review. BMC public health. 2019;19(1):897.

18. Jana S, Singh S. Beyond medical model of STD intervention–lessons from Sonagachi. Indian journal of public health. 1994;39:125–31.
19. Jana S, Basu I, Rotheram-Borus MJ, Newman PA. The Sonagachi Project: a sustainable community intervention program. AIDS Education and Prevention. 2004;16:405–14.
20. Jana S, Bandyopadhyay N, Saha A, Dutta MK. Creating an enabling environment: lessons learnt from the Sonagachi Project, India. Research for Sex Work Newsletter. 1999;2:22–4.
21. Ghose T, Swendeman D, George S, Chowdhury D. Mobilizing collective identity to reduce HIV risk among sex workers in Sonagachi, India: the boundaries, consciousness, negotiation framework. Social science & medicine. 2008;67:311–20.
22. Van der Meulen E. Action research with sex workers: Dismantling barriers and building bridges. Action Research. 2011;9(4):370-84.
23. NIHE. Results from the HIV/STI Integrated Biological and Behavioral Surveillance (IBBS) in Viet Nam, Round II 2009 Hanoi: NIHE; 2011.
24. Law on Gender Equality, 17 (2006).
25. Binh LN, Phuong TT. Orientation for improvement of social support policy for sex workers. 2018.
26. Huber J, Ferris France N, Nguyen VA, Nguyen HH, Thi Hai Oanh K, Byrne E. Exploring beliefs and experiences underlying self-stigma among sex workers in Hanoi, Vietnam. Culture, health & sexuality. 2019;21(12):1425-38.
27. Newman PA. Reflections on Sonagachi: an empowerment-based hiv-preventive intervention for female sex workers in West Bengal, India. Women's Studies Quarterly. 2003:168–79.