CHAPTER II

LITERATURE REVIEW

The researcher has studied and reviewed the concepts and theories from textbooks, research papers and related documents as a basis for the research approach. The following content has been consulted.

- Sex workers and HIV/AIDS Situation in Asia, Thailand and Cambodia
- Theory and concepts Related to the Research
- Related research

2.1 Sex Workers and HIV/AIDS Situation in Asia, Thailand and Cambodia

2.1.1 ASIA

The sex industry in Asia is changing rapidly. (WHO, 2001) The culture of Asian men has also encouraged the growth of sex industry. In some countries, most men will pay for sex at some point in their lives and many will do so on a regular basis. The proportion of men who buy sex is very high. It also varies between Asian countries for instance Japan, Thailand, Philippines, Cambodia and Pakistan (Louise, 2000) and in some areas of Thailand, Nepal, India and China prostitution is socially acceptable (WHO, 2001).

Table 1: The estimated number of sex workers from selected countries in Asia

Country	Estimated number of sex workers	Total population in year 2002 –source: WHO 2004	The proportion of sex workers and total population*
Bangladesh	36,000	143 809 000	1: 3996
Cambodia	30,000-50,000	13 810 000	1:460-1: 276
India	2 million	1 049 549 000	1: 525
Myanmar	30,000-50,000	48 852 000	1:1628-1:977
Nepal	> 250,000	24 609 000	1:98
Thailand	1.3 million	62 193 000	1:478
Viet Nam	200,000- 300, 000	80 278 000	1:401-1:267

Sources: MoPH-Thailand, 1996; UNICEF, 2002; WHO, 1998; WHO 2001

* Calculated by the researcher

The rising levels of HIV among sex workers can provide an early warning of increasing probability that the epidemic will expand into the general population (UNAIDS, 2004.). The estimates of HIV prevalence rates from sentinel surveillance of DCSWs from many countries are normally higher than the general population as the table below indicates.

Table 2: The estimates of HIV prevalence rates from sentinel surveillance from many countries

Observed and estimated HIV prevalence in selected populations		
Country	**Sex workers HIV prevalence rate (year)**	**Adult population (15-49) HIV estimated prevalence rates (end 2001)**
Bangladesh	20% (2002)	< 0.2%
Cambodia	18.5% (2002)	2.7%
India	5.8% (1998)	0.8%
Myanmar	26.0% (2000)	1.0%
Nepal	17% (2002)	0.4%
Thailand	2.6% (2002)	1.7%
Viet Nam	11.5% (2001)	0.3%

Source: UNAIDS, 2002 & 2004

2.1.2 Thailand

Thailand was the first country in Asia to document an HIV epidemic and HIV in Thailand has rapidly spread throughout the country. Most HIV transmission occurred through heterosexual and commercial sex. UNAIDS (2004) reported the estimated number of adults and children living with HIV/AIDS at the end of 2003 was 570,000 (with a total population of 62 million) which was highest in South East Asia neighboring countries such as Cambodia, Lao PDR, Myanmar and Vietnam had an estimated number of people living with HIV as 170 000, 1 700, 220 000 and 330 000 respectively.

In Thailand, the official position on sex workers is that "a sex worker does not exist because it is illegal," therefore, the setting of "massage parlours, restaurants, motels and tea houses may well offer sexual as well as other services, but they do not count as brothels.". This explains the situation of the sex trade in Thailand. Thailand provides a good example of the way in which the sex industry has become institutionalized and more sophisticated. Many of the women involved in the sex trade

migrate to find lucrative sex work and many others are trafficked. They come from rural areas of Thailand and from neighbouring countries such as Myanmar, Lao PDR, Cambodia, Vietnam and from the south of China. Most of these women work in shadowy brothels and venues at the very cheapest end of the sex market. They have little negotiating power and very little awareness of health issues (WHO, 2001).

Sex work has been illegal in Thailand since 1960 and is often disguised as other forms of entertainment. Estimates of the number of women in the business and their place of origin are imprecise and wide ranging. In recent years, the Ministry of Public Health of Thailand has estimated the number of sex workers to be about 1.3 million (MoPH, 1996). In 1991, the Thail government implemented a nationwide campaign to promote condom use during commercial sex. Condom use increased substantially in the early 1990s, and male patronage of CSW declined. Condom use when visiting sex workers has become the norm (Kilmarx et al, 1998). In 1996, the government was forced to prevent and suppress the prostitute; therefore, a result of this has been for the sex industry to change itself away from direct prostitution and turn towards indirect prostitution. Brothels disappeared and then reappeared as karaoke bars, massage parlours and restaurants (WHO, 2001). The HIV epidemic detected in sex workers was 2.6% in 2002 and has been slowly decreasing (UNAIDS, 2004).

Thailand has international borders with many countries. Some parts of Thailand share a physical border with Cambodia where there are many border check points for cross-border trade, tourism, business including illicit businesses (gambling, drug and sex trade). There has been an increasing population movement between the two countries in recent years. Among the increased trading activity and cross-border sexual movement is an expansion in commercial sex establishments along the border and in cross-border sexual activity (Pramulratana et al, 1995). Thailand has a serious epidemic of HIV and it has now emerged in neighbouring countries such as Cambodia and Myanmar. Therefore, border locations have emerged as areas of critical concern in the fight against AIDS (Chantavanich et al, 2000).

2.1.3 Cambodia

There are many factors contributing to the rapid spread of HIV in Cambodia, but the major factors are poverty (around 36% of the Cambodian population live below the poverty line), and low literacy rates, especially among girls. Only 30% of girls aged between 15-49 years have attended school, which means there are few opportunities for them to look for professional, skilled jobs. The risks for young women of starting to work in entertainment places or brothels if their virginity is destroyed by their boyfriends, by sexual violence, or they are sold by their parents or relatives are increasing. Sexual trafficking, exploitation, violence, high illiteracy rates, drug use and sexual tourism are all also contributing to the rapid spread of HIV in Cambodia (WHO, 2001). A major problem in contemporary Cambodian society is the trafficking of young women from Vietnam to Cambodia, and from rural Cambodia to Cambodia's urban centres. Those trafficked women are often kept in closed brothels where they have no access to HIV education programs directed to sex workers. Vietnamese women trafficked to Cambodia are doubly disadvantaged because they not only have a high degree of illiteracy in their own language, but may also be totally illiterate in Khmer (Fordham, 2003).

In Cambodia, there are many different categories of sex workers but they have been defined to two groups: "direct commercial sex worker" (DCSW) and "indirect commercial sex worker" (IDCSW). "Direct sex workers" refer to those who sell sex full time in a brothel, and "indirect sex workers" refer to those who have a formal job like beer promoter girls, or one who works in the entertainment business such as night clubs, bars, karaoke lounges, massage parlours, garment workers or street workers/orange sellers. DCSWs are considered a core group because they usually have many more sexual partners than IDCSWs. Thus DCSW is an important group for the HIV Behavioural Sentinel Survey (NCHADS, 2003). The majority of sex users in Cambodia are civil servants and young men between eighteen and twenty -five years old. It varies from moto-taxi drivers to senior government officials. In addition, there are many foreigners who also use the services of sex workers according to a study in the biggest sex trade area in Phnom Penh called Toul Kork where Cambodian,

Vietnamese, Chinese, Thai or other nationalities were sex workers' clients (Dunn et al, 1995).

Phal (no data) has stated that practical attitudes reflect the stigmatized role of the sex worker in society. Sex workers are highly discriminated against in Cambodia and these attitudes place them in a vulnerable position. Dunn et al (1995) studied the demographics of the DCSWs in Toul Kork area and found that the age of the DCSWs ranged from 14 to 33 years, with an average age of 20. Vietnamese DCSWs were slightly younger that the Khmer DCSW with an average of 20 and 21 respectively. He found three of them were 14 years old and that 47.4% (172) of DCSWs involved in the study had never been to school

In 1998, the government decided that in addition to sex workers having HIV/AIDS/STD information and knowledge, skills in condom use and negotiating condom use, sex workers needed to use condoms with every sexual contact. Therefore the 100% condom use program (100% CUP) was introduced. Condoms are available throughout the country and within each brothel. In order to gain cooperation with sex workers, and provide the STD case management services in health centres, the 100% CUP was implemented in provinces along the Cambodian-Thai border where a high prevalence of HIV infection among direct or brothel based sex workers existed (WHO, 2001).

Piet (2003) reported that the Malteser organization had a monthly mobile STD clinic and weekly stationary STD clinic (for the general population) in Osmach commune, Oddar Meanchey Province and distributed condoms to brothels there. HIV/AIDS education to risk groups including military and police was also provided. In 2002 the mobile clinic served 550 DCSWs of which 57% were diagnosed with an STD with gonorrhea being the most frequent diagnosis. Malteser (2003) reported its survey of the HIV prevalence in pregnant women in Osmach commune as 4%.

Osmach Health Centre has been in operation since January 2003 with a total of 5 staff (Medical assistant, Midwife, ant three workers for Expanded Program of

Immunization, administrative person and midwife assistant). The services are under the supervision of PAO and PHD.

2.2 Theories and Concepts Related to the Research

2.2.1 Definitions of Sex workers

"Sex worker" has been defined by UNAIDS (2002) as "female, male and transgender adults and young people who receive money or goods in exchange for sexual services, either regularly or occasionally, and who may or may not consciously define those activities as income-generating". The term "sex worker" has gained popularity over "prostitute" because those involved feel that it is less stigmatizing and say that the reference to work better describes their experience.

Hsieh & Chen (2004) defined the term of "sex worker" by the place of work as either a "direct" sex worker or an "indirect" sex worker. The DCSW works in brothels while the indirect sex workers are based in commercial establishments such as bars, cafes, and massage parlours where sex can be bought on request and conducted elsewhere.

2.2.2 Identification of safe sex practices

The safe sex category reflects activities that involve no exchange of bodily fluids and sexual acts are completely safe. Behaviors in the unsafe category generally involve semen or blood coming into direct contact with mucous membranes in the rectum, vagina or mouth. Activities in the possibly safe category either involve contact with low risk fluids, such as saliva and urine, or will not transmit the virus unless the latex barrier breaks. Activities in the possibly unsafe category are less likely to transmit viruses.

Safe means massage, hugging, body rubbing, dry kissing, masturbation, hand-to genital touching (hand job) or mutual masturbation and erotic books and movies (Hatcher et al, 1994).

"Safer sex" is promoted by introducing protective measures such as consistent condom use and the modification of risky sexual practices and by reinforcing behavioural change towards adopting these practices (UNAIDS 2002).

2.2.3 Effectiveness of condoms

Rubber latex condoms, when used properly have been shown to be an extremely reliable method of preventing the spread of HIV and STDs (Rosenberg and Waugh, 1997). Used correctly each time people have sex, it is over 95% effective against the transmission of HIV. Carefully monitored studies have demonstrated conclusively that:

- Consistent and correct condom use prevents STD/HIV infections.
- Latex condoms, which have been appropriately tested, are effective barriers to spermatozoa and pathogens. (The male latex condom. UNAIDS, 2002)

When used consistently and correctly, condoms effectively prevent transmission of HIV during sexual activity. Condoms can protect the mouth, vagina or rectum from HIV-infected semen. They can protect the penis from HIV-infected vaginal fluids and blood in the mouth, vagina, or rectum. They reduce the risk of spreading other sexually transmitted diseases (Hatcher et al, 1994).

2.2.4. The PRECEDE model

The PRECEDE (Predisposing factors, Enabling factors and Reinforcing factors) model originated in the1970s by Lawrence W. Green and Marshall Krueter, and was developed to enhance the quality of health education intervention. This model is the attention given to identifying the multiple factors that affect health practices as a basis for focusing on the subset of factors. This model looks at health behaviour as complex and multidimensional, influenced by a variety of factors and the important role of environmental factors as determinants of health and health behaviours. The individual lifestyle contributes significantly to public health and well-being. These are then analysed to establish both environmental and behavioural risk factors because health and health behaviours have multiple causations that must be evaluated in order to assure appropriate intervention.

In the present study, the PRECEDE model has been used widely in a variety of settings such as school health education, patient education, and sexual health areas and assessing individuals' behaviour as follows:

- **Predisposing Factors** are personal factors that influence motivation to change, such as knowledge, belief, attitudes, values and demographics such as socioeconomic status, age, gender, family size. These factors are the antecedents that provide the rational or motivation for the behaviour.

- **Reinforcing factors** are those elements that appear subsequent to the behaviour and that provide continuing reward or incentive for the behaviour to become persistent. Such factors are social support like family, teacher, employer or Peers influence

- **Enabling factors** are antecedents that enable (allow) motivation to be realized; they can have an affect. Enablers can be any characteristics of the environment that facilitate action and any skill or resource required to attain a specific behaviour such as accessibility and availability to the health service, skills, laws (local, state, federal) (Glanz, Lewis and Rimer, 1997).

Source: Green, W. L. and Krueter, M. Health promotion planning: An environment and environment approach, 1991

2.3 Related research

2.3.1 Predisposing factors

- **Demographic characteristics of DCSWs**

Age of DCSWs: WHO (2001b) mentioned that throughout the world, young sex workers are favoured but in Asia, the demand for clients wanting young sex workers is greater than other areas. The premium age for sex workers in many Asian societies is between the ages of 12 and 16. Age has been mentioned in the Trafficking in Child in Asia Report by Tumlin (2000) where young sex workers have a higher chance of having sex without using condoms and therefore an increased risk of contracting STDs and becoming HIV positive because they are not in a position to

insist that clients wear condoms. Young sex workers are less likely to prevent tricks used by clients.

Nationality: Based on the Cambodian national registration of brothel-based sex workers by the outreach program team, there are 757 brothels with 3872 brothel-based sex workers throughout the country and around 70% of the sex workers are Cambodian and 30% are Vietnamese (WHO, 2001). The nationality of sex workers has to be taken into consideration with unsafe sex practices as it has been mentioned in a study of 500 female sex workers in northern Thailand (Kilmark et al 1998) that sex workers who are in a minority group or migrate from neighboring countries are increasingly involved in commercial sex and face difficulties because of the language barrier. Most of these migrant sex workers are living in the illegal status which means they are less able to protect themselves, and have an even greater chance to participate in unsafe sex practices which puts them at a higher risk of HIV infection.

Education: People, who are illiterate, always have less access to information and may misunderstand some events. They cannot read, so they can only obtain information from television, radio and other verbal sources. Unfortunately, Cambodia faces big challenges with broadcasting information throughout the entire country. It is hard to get the message on television or radio in the rural areas. It was mentioned in the study of Hof and Oei (1999), who studied HIV/AIDS knowledge and attitude of female sex workers in Cambodia, that because sex workers are unable to read or write, and because the skilfulness of the literate sex workers is low, these sex workers have an insufficiency to understand health education or information to prevent STD and HIV/AIDS. Much research about sex workers has found that in general, sex workers have low education and high illiteracy rates which lead to less chance in obtaining a better job (or there were no better paying jobs available). This brings sex workers into the sex work industry (Kanchanachitra, 1998; Dunn et al, 1995; Endang and Sedyaningsih-Mamahit, 1999).

Income: There are many studies that have found that poverty is one factor that forces sex workers into the sex trade (Metzenrath, 1998). Rao et al (2003) showed the compensating differential for condom use among Calcutta prostitutes i.e. there is a relationship between condom use and the price of sex. Sex workers who always use condoms face large losses of money - about 60%-79% of the average price of each act.

This may lead to unsafe sex practices if sex workers definitely need the money. This can be explained by the study of Wojicocki and Malala (2001) who mentioned in the study on condom use of 50 female sex workers in Johannesburg that if sex workers definitely need money for any reason, they will accept to sell sex without condom use and either be paid more or they will not refuse the client and have sex with no condom. The result was similar to a study with sex workers in Singapore (Wong et al 1999), who found that the rate of STDs among sex workers was significantly associated with a decrease in the number of clients (less income).

- **Steady partners and sweethearts:**

Many researchers found that sex workers use condoms to distinguish between paying and non-paying partners. Surveys of sex workers in Asia generally find that, although many use condoms with their clients, which is different to having sex with their steady partners that fewer than 40% of sex workers report that they use condoms in their last sex act (Editorials, 2004). Cusick (1998) mentioned in Glaslow, UK that sex workers did not perceive condom use as appropriate for private sexual relationships. Condoms were seen as normal, routine components of the commercial trade. The sex workers reported not using condoms on only a minority of commercial sex encounters but the majority of private encounters.

- **Duration in the profession**

One risk factor for STD and HIV/AIDS infection among sex workers is the duration in this profession, which has been shown, in the study of Hoek, et al (2001) who studied 966 female sex workers in China. They found that the STD prevalence was higher among the group of women who in general had recently started sex work. This is different to the study of Ohshige, et al (2001) who studied commercial sex workers in Cambodia. They mentioned that the duration in the profession showed a statistically significant association with HIV infection, with the reason being that long-term sexual activity raised the risk of HIV infection due to increased exposure to HIV.

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- **Past history of Sexually Transmitted Disease (STD)**

Having an STD is a marker of unprotected sexual intercourse. The STD and HIV/AIDS prevention can be done by consistently using condoms during sex. The prevention depends on the different perception of levels of risk in different individuals (Hatcher et al, 1994). Condom use was more frequent in sex workers who had experienced and had previously been treated for an STD, which was mentioned in the study of Flisher et al (1994) in New York.

- **Knowledge and attitude regarding STD and HIV/AIDS**

Knowledge is described in the Oxford Dictionary (2004) as "facts, information and skills acquired by a person through experience or education, the theoretical or practical understanding of a subject". As AIDS was first recognized in 1981, therefore, the knowledge about HIV/AIDS had increased more and more through many various kinds of research. Many studies regarding HIV/AIDS knowledge among sex workers has been found to be very low particularly in those countries which have a high prevalence of HIV infection. At the same time, there has been much research about sex workers and HIV/AIDS. A lack of knowledge and misconception about AIDS can lead to the high possibility of HIV infection (Endang and Sedyaningsih-Mamahit, 1999; Chantavanich et al, 2000a; Aklibu et al, 2001)

"Attitude is a key concept in social psychology. Attitudes are positive or negative views of an "attitude object": a person, behaviour, or event. "Implicit" attitudes, which are essentially attitudes that people are not consciously aware of, but that can be reveals through sophisticated experiments using people's response times to stimuli" (Wikipedia, 200-) . Attitudes toward people living with HIV/AIDS (PWHAs) are a critical issue in many countries as families, friends and communities come to terms with the "unexpected event" in their lives. In many places, PWHAs and their families are very isolated, discriminated against and abused (Chantavanich et al, 2000a). Sex workers who neither perceived vulnerability nor seriousness of AIDS, which may affect their health and income which have significant effects on condom use (Pramulratana et al 1995; Sohn and Jin, 1999).

2.3.2 Reinforcing factors

- **Clients characteristics**

Clients as buyers, who step in brothels, have many perspectives of sexual buying. Hsieh and Chen (2004) have identified that brothels are more often visited by truck drivers, factory workers, and other low-income men who choose to buy sex in brothels. Further information of Cambodian males that there are changes in social norms regarding male behavior are growing up around party celebrations (including wedding parties, religious parties, national and international holidays, birthday parties etc.) At these parties young men meet their friends and then, as a group, go on either directly to a brothel or to entertainment places to have fun or sex before returning home (WHO, 2001).

Wojcicki and Malala (2001) mentioned in their study in Johannesburg that clients can be one factor to influence unsafe sex practices for sex workers because sometimes clients are willing to pay more to have sex without condom use therefore sex workers will accept it if they need the money. Sex workers do not want to refuse those clients, who want to have sex with no condom, when they have few clients. Another reason that clients have to be taken into the consideration according to the study in Cambodia of Akilibu et al (2001), and Lowe (2002) was sometimes sex workers have occasionally not used condoms because of the violence from a client that forces sex workers not to use a condom during sex.

- **Brothel owner/manager or pimps**

There are some strategies to encourage brothel owners to take part in condom use among sex workers such as the 100% condom use promotion program which is supported by both WHO and UNAIDS. It was initiated in Thailand and has now been applied to many countries in Asia (Loff, Overs & Longo, 20003). It is also applied in Cambodia where the brothel owner/manager has to encourage the CSWs to use condoms for all sexual encounters. However there are many reasons that brothel owners managers would not support consistent condom use because if the brothel is not attracting many clients, the owner/manager/pimps may force sex workers to have sex without a condom. Sometimes when sex workers have foreigner clients, many owners

say the foreigners are healthy so there is no need to use a condom, and they may get paid higher if they do not use a condom. The owners will not insist on condom use if police or powerful clients are drunk or can create any violence (Lowe, 2002).

- **Peers**

Peers are people who are alike in several respects: age, gender, interests, language, use of time, aspirations, and perhaps HIV status. Peers can be friends, colleagues, and neighbours. Since commercial brothel based sex workers often live under difficult circumstances, there are many factors that force them into having unsafe sex practices. They need someone to discuss or consult with when needed. Peers can also influence practices. Peers can teach how to use condoms or take herbs/medicine to control diseases, stop vaginal discharge or to wash the vagina (Endang and Sedyaningsih-Mamahit, 1999).

2.3.3 Enabling factors

- **Availability of condoms**

In 1998, the Ministry of Health of Cambodia endorsed the 100% CUP as a central element in the Cambodian National HIV/AIDS Strategy. The most important aspect of the establishment of 100% CUP is its involvement of a wide range of people and institutions. The idea is to instruct or require all sex workers to use condoms in all sexual encounters. If their clients refuse to use condoms, sex workers are urged to withhold services and refund their clients' money. All sex establishments must be involved in the project, so that clients cannot purchase sex in other places without using condoms (Lowe, 2002). In some practices, the clients carry condoms for themselves, or if sex workers cannot find a condom, they may have sex without a condom Pramulratana et al (1995).

The common practice in Cambodia is that brothel owners pay for condoms and make sure that condoms are always available. Either owners pay for condoms or they charge sex workers or make clients pay. Social condom marketing is one program which was established in Cambodia in 1998 in order to make sure that condoms were consistently available through out the country. Population Services International

(PSI) is a non-government organization who sells and distributes condoms at low prices to the pharmacies or groceries for further selling to those who need (WHO, 2001). At the health centre level, condoms are provided for family planning only.

- **Availability of health services (STD clinic and IEC materials)**

Availability means a measure of the service being there if we need it or not, and is part of the measurements used for potential access. The availability will be seen as whether it is easy to reach from both the physical and financial point of view (WHO, 2002).

Nowadays, health services for sex workers regarding HIV/AIDS care and prevention programmes emphasize condom use promotion, STD prevention, case finding and treatment. Many papers mention how to maximize the usefulness and appropriate of health services for sex workers because there are many obstacles to reach these services (Wolffers, 1999).

Bloem (1999) described that the majority of Sex workers in Dhaka city, Bangladesh are an unprivileged group who have less access to public services. It is obvious that many sex workers try to avoid physicians and official health care services. Many of them turn to a pharmacy in case they have symptoms of STDs. Brussa described in 1999 that sex workers in Europe do not have access to the health care system, health promotion measures and no access to information on STD/HIV/AIDS prevention and treatment. Since they are have an illegal status and insecure situation, sex workers distrust all kinds of authorities, including health care services, which mean that they do not make use of these services. Gorter et al (1999) mentioned that female sex workers in Nicaragua are too ashamed to visit a clinic, which their pimps' prevent them from visiting or they did not have time. Though, under those conditions, causing them less access to the information, education and materials of STD/HIV/AIDS and putting safe sex into practice is not a priority.

- **Negotiation skills of CSWs**

Negotiation means the discussion aimed in reaching an agreement (Oxford Dictionary, 2004). Tep and Ek (2000) who studied Vietnamese sex workers in Cambodia have mentioned that most negotiations regarding condom use will be successful if those clients have an awareness of HIV/AIDS. In the situation of sex workers in Singapore, Wong et al (1992) found that negotiation was performed with the majority of clients who did not want to use condoms spontaneously with a success rate of only about half of them. According to Wong et al (2003) it was found that the success rate in persuading clients to use condoms (negotiation skills) had a significant association with consistent condom use among sex workers.

Based on the theoretical concepts and review of this literature research, it can be concluded that the determinants, which have an influence on condom use for sex workers, come from personal, interpersonal and environment conditions. This is because some factors have more people to influence safe sex practices which is not only the role of DCSWs. Therefore, it is necessary that the main factors affecting safe sex practices of DCSWs be determined. It will also enable the PHD, PAO and the health center to be more effective in promoting STD and HIV/AIDS prevention to sex workers, raising awareness of HIV/AIDS infection to clients, collaborating with brothel owners/managers/pimps and providing sufficient health services (STD clinic and health education) to sex workers as well.