

PUBLIC HEALTH

The HIV related risks among men having sex with men in rural Yunnan, China: a qualitative study

W C W Wong, J Zhang, S C Wu, T S K Kong, D C Y Ling

Sex Transm Infect 2006;**82**:127–130. doi: 10.1136/sti.2005.016790

See end of article for authors' affiliations

Correspondence to:
Dr William C W Wong,
Department of Community
and Family Medicine,
Chinese University of Hong
Kong, Room 408, School
of Public Health, Prince of
Wales Hospital, Shatin
Hong Kong, Hong Kong;
cwwong@cuhk.edu.hk

Accepted for publication
17 August 2005

Objectives: To explore the characteristics and issues specific to HIV related risk behaviours among men who have sex with men (MSM) in rural China.

Method: Qualitative study using semistructured in-depth interviews in Dali prefecture, Yunnan. 24 informants recruited through a local MSM network, snowballing and by word of mouth. The main outcome measures were themes identified as increased exposures and risks to HIV.

Results: Risk behaviour, social stigma, one child policy and concepts of traditional Chinese medicine (TCM) had significant roles in the spread of HIV in rural China. Many MSM lead a life with double identities in China and condom use was found to be variable with attempts to "rationalise" the risky behaviour being its major determining factor. Health seeking behaviours of genitourinary problems were infrequent and illogical, which were further held back by the existing healthcare system and lack of sensitivity expressed by the health professionals.

Conclusions: Clear education messages to the general public while raising awareness among health professionals of the health risks and needs in MSM are essential in the prevention of the current HIV epidemic.

China is currently undergoing a serious HIV epidemic with the United Nations estimated up to 1.5 million people infected with this virus in 2001 and the number of infected people could reach 10 million by 2010.¹ Yunnan is one of the provinces worst hit by this infection.² So far, the national HIV/AIDS sentinel surveillance has been restricted to five high risk groups including injecting drug users, female sex workers, truck drivers, pregnant women, and patients with sexually transmitted diseases¹; thus, the great majority of the HIV prevention programmes (official or by non-governmental organisations) are targeted at the aforementioned groups. Although not illegal, homosexual behaviour is condemned morally and socially in mainland China. In this paper, the term MSM (men who have sex with men) is used instead of homosexual or bisexual, as a distinction between issue of sexual identity and issue of sexual behaviour should be made.³ The few studies that were conducted in mainland China have put the homosexual population at 2–4% of the male population and MSM at 10–15%.^{4–5} The prevalence of HIV was found to be 1.3–5.45% among MSM.^{6–7} However, nearly all of these studies were cross sectional surveys conducted in major cities and among Han Chinese. Little is known or has been done about HIV risks and risk behaviour among Chinese MSM in rural areas.

Dali prefecture is a Bai autonomous region in the Yunnan province of southwest China and has a population of 680 000 people. Its municipality, Xiaguan and the nearby old town Dali, is a popular tourist destination, and forms a major drug trafficking route. These two small cities are surrounded by farming villages and small towns. Bai people have been integrated with Han Chinese for many centuries and in many ways, and they are famous for being pragmatic at preserving the traditional Chinese values. Therefore, not only do they share many common characteristics of the mainstream Chinese culture in opposing same sex sexual behaviour, but rather express them in a more exaggerated way. The lifestyle and networking among MSM is unique in that the local MSM farmers would meet their potential sexual partners outside public toilets or at the teahouse on a market day according to the Chinese lunar calendar. Unlike in an urban

setting, networking by means of the internet is not common. The aim of this study is to explore the characteristics and issues specific to HIV related risk behaviours among MSM in rural China. It is hypothesised that such behaviours are common among these MSM and there are a number of misconceptions contributing to the spread of HIV that are specific to this cultural and social setting.

METHODS

Qualitative methods were used because little was known about the attitudes and sexual behaviour of MSM in rural China. For practical reasons, a pragmatic approach was adopted in recruitment of subjects through a local MSM network, snowballing, and by word of mouth. Inclusion criteria include (1) men admitted having MSM behaviour; (2) adults over 18 years of age; and (3) those living in Dali prefecture. The research team travelled there on two visits between February and November 2004, and the interviews took place at local bars, restaurants, hotel rooms, or hangout places after spending considerable time familiarising themselves with potential informants to gain their trust.

The interview was based on a prepared semistructured questionnaire, which has been pilot tested and modified throughout the study period to address the emerging themes. It was mainly conducted in Mandarin except on one occasion when a translator was required for a Bai speaker. The interview schedule included their demographic data, sexuality, social networking, sexual health, and medical needs. The interviews lasted between 40 minutes and 90 minutes, were audiotaped, and transcribed verbatim. Each interviewer also wrote field notes. Verbal consent was obtained before the interview and the study was approved by the survey and behavioural ethics committee of the Chinese University of Hong Kong.

Data were analysed principally by the researchers using Burnard's model of qualitative study analysis,⁸ which was adapted from Glaser and Strauss's "grounded theory"

Abbreviations: MSM, men who have sex with men; STI, sexually transmitted infections; TCM, traditional Chinese medicine

Six main themes identified from the interviews

- 1 Networking and meeting/sex places
- 2 HIV/STI risks
- 3 Knowledge, attitudes, and experiences of HIV/STI
- 4 Protective measures against HIV/STI
- 5 Genitourinary health seeking behaviours and health needs
- 6 Psychological burden

approach and from various works on content analysis.^{9–12} The researchers would start with broad headings, then identify more detailed codes before deciding on higher order headings. Some of the themes were based on descriptive codes derived directly from responses to interview questions while others were more interpretive, based on data from a number of questions. The constant comparative approach was used with an independent researcher who was not involved in the data collection analysing all interviews. The results of the analyses was compared and discussed among the researchers until the final version of codes were agreed. The headings and codes from this analysis were combined into a list of six themes (box). Quotes were translated into English and back translated by an independent person.

RESULTS AND INTERPRETATION

A total of 24 interviews were conducted and their characteristics are shown in table 1. Four of the six key themes to emerge from the data are presented below.

HIV risks

Risk exposure including multiple partners, commercial sex, and alcohol and drug use were identified.^{13 14} Multiple sexual partners were common among our informants with up to 20 partners estimated in the previous year while another informant perceived 5–6 partners in the previous year as “very few.”

Many informants had dual identity as “husbands and fathers” as well as “MSM”; 54% of our informants were married with children (table 1). Since homosexuality was unacceptable in rural China, none of our married informants had disclosed their sexuality to their wives. One informant said he had to pretend and have sex with female sex workers to hide his sexuality from colleagues. Three informants said they had been asked for money after sexual intercourse, for which they would usually pay up as they were worried about blackmail. Some informants admittedly chose a job that would give them greater freedom or mobility, or lived away from home to avoid confrontation with family members. At the same time, the one child policy in China had put tremendous pressure for these men to get married and reproduce:

- “I need to reproduce and men have to marry women...I am the only son at home and would not otherwise marry.” (15)
- “Can open up (to my parents) because my brother has had a son.” (2)

Many informants reported frustrations and distress as a result of their sexuality. Alcohol and, less frequently drugs, were mentioned as a means of escape from pressure to get married or after arguing with a boyfriend. A young informant said he had used “ecstasy,” alcohol, cigarettes, and even engaged in fights to “give vent to my agony. It is beyond my control.”(15) Sometimes, it helped an MSM to get close to the potential partner and open up a conversation, or to “numb” his own feeling.

Table 1 Characteristics of participants

Characteristics	No of informants (n = 24) (%)
Age	
8–20	3 (12.5)
21–30	11 (45.8)
31–40	9 (37.5)
>40	1
Place of residence	
Xiaguan	11 (45.8)
Dali Old Town	4 (16.7)
Zhoucheng	2
Others	8 (33.3)
Ethnicity	
Han	8 (33.3)
Bai	10 (41.7)
Yi	3 (12.5)
Others	3 (12.5)
Education level	
Primary	2
Secondary	16 (66.7)
University	4 (16.7)
Work	
Student	1
Self employed	10 (41.7)
Employed	11 (45.8)
Unemployed/farming	2
Marital status	
Married	13 (54.2)
Single	5 (20.8)
Single with stable girlfriend or/and boyfriend	5 (20.8)
Divorced	1
Children	
One	11 (45.8)
Two	2

Base number less than 10 percentages not calculated.

- “If I meet someone I don’t like, but I feel that I need to fulfil my sexual need. This is not what I call love, right? He would invite you (me) for a drink and we could get together once drunk.” (“Did you use of condoms?”) “No, I didn’t” (15)

Knowledge, attitudes, and experiences of HIV

They acknowledged that their HIV related information was mostly obtained from popular health magazines, television programmes, books, or friends. Fear and exaggerations of HIV symptoms such as having a rash all over the body or non-stop bleeding were mentioned. Eight informants said they would choose to commit suicide and one said he would run away if they were diagnosed to have HIV. Shame, pressure from people who are ignorant of HIV, and potential medical costs are cited as the reasons for their choice of action.

- “I won’t dare to go for (HIV) test, what if they are positive? It would cost a lot of money to treat.”(13)

The concept of traditional Chinese medicine (TCM) was also applied to explain HIV. One informant used condoms as he thought it would protect him from the “poison” of the faeces (a concept of TCM) getting into his body through the broken skin rather than HIV prevention. When asked if he was worried about HIV, another informant had replied,

- “Yunnan is at high altitudes and has dry weather. Thus, we often get “heat” in our body... (so it can result in) sore throat or dysuria. Therefore, I am more vulnerable to HIV, right?”(12)

Nine informants perceived their HIV risk as being the same or lower than other men of the same age (three thought it was higher):

- “I know about HIV—I often saw those propaganda on TV. First of all, people like us who are healthy would not mix with drug addicts or promiscuous people.” (14)

In addition, three MSM strongly believe they could screen out “unhealthy” people or conversely, some could not believe they could be so unlucky. One informant said HIV was not something in his mind before having sex with another man. When stripped, they would look for ulcers and, if in doubt, they would find an excuse to leave. Only one informant said he had met a HIV positive MSM in the nearby town. As a result, people felt that “HIV was far fetched.” (13)

- “Unlike others who would get to bed with anyone and would do anything, I chose people carefully. I would only have a relationship with him if I think everything was alright.” (6)
- “Having sex occasionally would not result in HIV.” (14)
- “No one from my MSM community was known to have HIV.” (8)

Protective measures against HIV

Protective measures such as washing the body, flushing the rectum with water, or cleaning the penis with antiseptics before and/or after sexual intercourse were adopted. Two men admitted taking regular antibiotics to prevent sexually transmitted infections (STI). Condom use was very variable in the studied sample, ranging from no condom use in an informant known to have multiple partners who had admitted many one night stands because using condoms would lose the thrill or trust, or increase the distance between partners, to 100% condom use in two MSM (they were partners). Most fell somewhere in between the two extremes and the main reasons for its inconsistent use included condoms not being available or when partners were perceived as “clean.”

- “Condoms are certainly not used when both of us felt good and in need (of sex).” (7)
- “It depends if the other person has it or not.” (16)
- “I don’t carry condoms because my wife and I don’t use them and if she sees one, she will suspect something happening.” (7)
- “If I like someone and he looks clean after stripped, then I won’t use condoms.” (16)

Condom use also depends on the sexual act—for example, not used in masturbation or oral sex. It may depend on the number of sexual acts in one evening—for example, “not after the second intercourse.” (6) On the whole, no married men were able to initiate condom use with their wives and casual sex with women other than a sex worker was perceived as low risk.

Genitourinary health seeking behaviours and health needs

Most informants did not have a habit of regular health checks on their genitourinary system and had never been tested for STIs. Some would only seek medical help if they became symptomatic but even when they did, they would travel to another town to see a doctor and/or conceal some of the history from the doctor.

- “I will definitely make up some lies...I could only say I had messed up with an entertainment girl.” (17)
- “I will say I don’t feel well for the last 2 days after being away for a business trip.” (7)

Usually, the doctors would not ask either.

- “The doctor would ask if I was messing up with an entertainment girl. He would not discuss whether it was boys or girls... he would not imagine that, I should say.” (14)
- “He won’t ask and I will not tell him (the sexuality) neither. I never think about what to tell him. Just let him see and ask him if I have anything.” (13)

Lack of confidentiality and privacy were cited as the major barriers to utilising medical care. One informant described his terrified experience of having genital swabs conducted with no curtains drawn, the door wide open, and some student nurses (male and female) observing. Cost of medical care and the standard of care were also major concerns.

- “I suspected having some STI. I stayed in the hospital for 1 week: 700 yuan (\$1 = 8.2 yuan) per day and over 7000 yuan altogether. I was told different things a few days later so I went to a big hospital to repeat the tests. Eventually, nothing was found. I was so angry...and worried to death.” (12)

On the other hand, a couple of worried informants reported having monthly ultrasound scan to check for STI or 6 monthly HIV/STI screening. Another frequently cited misunderstanding among our informants was the false reassurance created by the mandatory health checks for state factory or entertainment workers conducted at the local Centres of Communicable Disease Control. They believed they would be healthy and free from HIV/ STI if not told otherwise.

DISCUSSION

Condom use is variable with attempts to “rationalise” the risky behaviour. Many factors can influence an individual’s decision whether or not to engage in a risky sexual practice which is usually culturally specific.^{15 16} For example, some of our informants believed that risks had varied as a function of partner characteristics, sexual practices, and personal hygiene or HIV preventive measures. Many MSM perceive these methods to be effective and use these factors to “rationalise” behaviour to a comfortable level of risk. Recent literature indicates that MSM make “rational” choice for risky sex—for example, choosing a “suitable” sex partner (for example, look young, few sex partners) to engage in unprotected sex is “safer” than using condoms with an “older” or “promiscuous” sex partner, or engaging in unprotected anal intercourse with someone once they are “in love” is more worthy than having protected sex with a casual partner.^{16 17} Given the multiple bridging effects between MSM and their male and female sexual partners, it is this low perceived susceptibility of risks that will contribute to more infection of HIV once the virus finds its way to the community.

Most rural MSM in China lead a life with dual identities because they are reluctant to “come out.” As a result, the official agencies fail to recognise the extent of MSM activities and to prioritise MSM as a high risk group in the current HIV prevention programmes, which can send a misleading message to the community. Like MSM around the world, in other Chinese societies, or in other mainland Chinese cities, the process of stigmatisation operates at multiple levels.¹⁸⁻²¹ Stigmatisation is reflected in life chances such as job choices, types, and quality of social and family support, likelihood of being a target of blackmailing, health, and quality of life may result in poor psychological and physical health. Apart from feelings of imbalance and lack of personality cohesion caused by these internal tensions of double identities,²² they are also suffering from other social pressures. For example, single MSM face another problem: the pressure from their family to get married and bear children.²³⁻²⁵ This is particularly important for those who are the only child in a family because they are the only hope to continue the family line.

There are considerable myths in relation to HIV transmission, clinical presentation, and treatment. These misconceptions and misunderstandings inevitably lead to infrequent and sometimes illogical health seeking behaviour, which is further held back by the existing healthcare system and lack of sensitivity expressed by the healthcare professionals. MSM are reluctant to present themselves to sexual health services owing to stigma and structural and psychological barriers associated with their sexuality. This, in turn, results in low level of disclosure and inaccurate history when presented to the medical service. Beliefs about how to acquire HIV and links to the fear of isolation and discrimination if MSM contract HIV is a repeated theme in our study. These beliefs strongly undermine a health seeking behaviour among MSM and the efforts of many HIV prevention programmes. Therefore, measures to convince medical professionals to take the MSM's health concerns seriously and treat them with empathy have not been enough.

This study, however, has a number of limitations. Firstly, the study concentrates on MSM in only one prefecture and half of the informants were of Bai ethnic origin. However, this prefecture has an ideal mix of rural and semi-rural areas. It was also selected for a practical reason as there are very few non-governmental organisations providing MSM support and counselling in China and nearly all of them are based in major cities. Secondly, the study adopted a convenience sampling method through a local MSM network and has the sample size of 24 men representing a relatively small proportion of MSM in rural Yunnan. Moreover, the findings rely on self reporting with potential memory bias and whether they told us the whole truth.

Perhaps it is timely to reopen the debate as to whether to accept the existence of MSM and their choice of partners. Such a debate would, at least, contribute to a more coherent policy across different government departments to balance the basic rights of these men and ease their pressure to marry. At the same time, it is paramount to provide clear education messages to the general public on the health risks and costs in relation to MSM and the importance of self protection. Until then, stigma associated with HIV and MSM can only be confronted using health education while raising professional and public awareness that will allow sexually active MSM to access affordable and regular HIV testing and medical treatment when needed. The concepts of TCM strongly influence the understanding of HIV and its acceptability in the social and cultural setting may have some parts to play in achieving this goal.

ACKNOWLEDGEMENTS

The authors thank the Barry and Martin Trust for their support and Mr S Stevenson for proofreading.

CONTRIBUTORS

The estimated contribution of each author is: WCWW 45%; JZ 20%; SCW 15%; TSKK10%; DCYL 10%.

Authors' affiliations

W C W Wong, S C Wu, Department of Community and Family Medicine, Chinese University of Hong Kong, Room 408, School of Public Health, Prince of Wales Hospital, Shatin, Hong Kong
J Zhang, People's Number Two Hospital, Dali Old Town, Yunnan, China
 PRC

T S K Kong, Faculty of Social Sciences and Humanities, University of Macau, Macau

D C Ling, Department of Economics, California State University, Fullerton 800 N, State College Blvd, Fullerton, CA 92834, USA

Competing interests: WCW received a travel grant from Barry and Martin Trust, UK, for this study. Barry and Martin Trust is a charity working on HIV prevention and control in China.

Key messages

- Dual identities of MSM as a result of social stigma and pressure from "one child policy" strongly affects the life chances and "coming out" of MSM in rural China
- High risk behaviour such as multiple sexual partners, commercial sex, and drugs and alcohol consumption have significant roles in the MSM relationship in rural China
- The low perceived susceptibility of risks and inadequate/inappropriate health seeking behaviour among MSM will contribute to more infection of HIV among MSM

REFERENCE

- 1 **UNAIDS**. *The UN theme group on HIV/AIDS in China. HIV/AIDS: China's titanic peril, 2001*, Update of the AIDS situation and needs assessment report. Geneva, Switzerland: UNAIDS, 2002.
- 2 **Zhang KL**, Ma SJ. Epidemiology of HIV in China. *BMJ* 2002;**324**:803-4.
- 3 **Clatts MC**. Disembodied acts: on the perverse use of sexual categories in the study of high-risk behaviour. In: H ten Brummeluis, G Herdt, eds. *Culture and sexual risk: anthropological perspectives on AIDS*. Luxembourg: Gordon and Breach, 1995.
- 4 **Zhang BC**, Li XF, Hu TZ, et al. "Friend communication" program—an effective AIDS intervention program for MSM. [Chinese] *Chinese J Health Educ* 2001;**17**:206-10.
- 5 **Zhang BC**, Li XF, Shi TX, et al. A preliminary assessment about the population of male homosexual/bisexual and the prevalence of HIV/AIDS in China. [Chinese] *Chin J STD/AIDS Prev Cont*, 2002;**8**:197-9.
- 6 *South China Morning Post*, First official survey puts gay male community at 5-10m, 2 December, 2004:A4.
- 7 **Choi KH**, Liu H, Guo YQ, et al. Emerging HIV-1 epidemic in China in men who have sex with men. *Lancet* 2003;**361**:2125-6.
- 8 **Burnard P**. A method of analysing interview transcripts in qualitative research. *Nurse Educ Today* 1991;**11**:461-4.
- 9 **Babbie E**. *The practice of social research*, 3rd ed. Belmont, CA: Wadsworth, 1979.
- 10 **Berg BL**. *Qualitative research methods for the social sciences*. New York: Allyn and Bacon, 1989.
- 11 **Fox DJ**. *Fundamentals of research in nursing*, 4th ed. Norwalk, NJ: Appleton-Century-Crofts, 1982.
- 12 **Glaser BG**, Strauss AL. *The discovery of grounded theory*. New York: Aldine, 1967.
- 13 **Gold RS**, Skinner MJ, Grant PJ, et al. Situational factors and thought processes associated with unprotected intercourse in gay men. *Psychol Health* 1991;**5**:259-78.
- 14 **Stall R**, McKusick L, Wiley J, et al. Alcohol and drug use during sexual activity and compliance with safe sex guidelines for AIDS: The AIDS behavioral research project. *Health Educ Q* 1986;**13**:259-371.
- 15 **Parker R**. Sexuality, culture and power in HIV/AIDS research. *Annu Rev Anthropol* 2001;**30**:163-79.
- 16 **Jones R**. Identity, community and social practice among men who have sex with men in China. In: Tam M, Ku HB, Kong T, eds. *Rethinking and recasting citizenship: social exclusion and marginality in Chinese societies*. Hong Kong: Centre for Social Policy Studies, The Hong Kong Polytechnic University, 2005.
- 17 **Adams BD**, Sears A, Schellenberg EG. Accounting for unsafe sex: interviews with men who have sex with men. *J Sex Res* 2000;**37**:24-36.
- 18 **Plummer K**, ed. *Modern homosexualities: fragments of lesbian and gay experience*. London: Routledge, 1992.
- 19 **Kong TSK**. Queer at your own risk: marginality, community and the body politics of Hong Kong gay men. *Sexualities* 2004;**7**:5-30.
- 20 **Gil VE**. The cut sleeves revisited: a contemporary account for male homosexuality. In: Blum SD, Jensen LM, eds. *China off center: mapping the margins of the Middle Kingdom*. Honolulu: University of Hawaii Press, 2002.
- 21 **Chou WS**. Homosexuality and cultural politics of Tongzhi in Chinese societies. In: Sullivan G, Jackson P, eds. *Gay and lesbian Asia: culture, identities, community*. New York: Harrington Park Press, 2001.
- 22 **Nemoto T**, Operario D, Soma T, et al. HIV risk and prevention among Asian/Pacific Islander men who have sex with men: Listen to our stories. *AIDS Educ Prev* 2003;**15**:7-20.
- 23 **Ruan FF**, YM Tsai. Male homosexuality in contemporary mainland China. In: Wayne RD, Donaldson S, eds. *Asian homosexuality*. London: Garland Publishing, Inc, 1992.
- 24 **Bullough VL**, Ruan FF. Same-sex love in contemporary China. In: Hendriks A, Tielman R, van der Veen E, eds. *The third pink book: a global view of lesbian and gay liberation and oppression*. New York: Prometheus Books, 1993.
- 25 **Li YH**. *The homosexual subculture*. [Chinese] Beijing: China Today Publishing House, 1998.