

**AN ANTHROPOLOGICAL STUDY ON CERVICAL CANCER
SCREENING AMONG FEMALE SEX WORKERS
IN HO CHI MINH CITY, VIETNAM**

LE THI NGOC PHUC

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OF THE REQUIREMENTS FOR THE DEGREE OF
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Thesis
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.....
Ms. Le Thi Ngoc Phuc
Candidate

.....
Assoc. Prof. Pimpawun Boonmongkon,
Ph.D. (Medical Anthropology)
Major advisor

.....
Assoc. Prof. Siriwan Grisurapong,
Ph.D. (Population and Development)
Co-advisor

.....
Asst. Prof. Penchan Sherer,
Ph.D. (Health and Social Welfare)
Co-advisor

.....
Prof. Patcharee Lertrit,
M.D., Ph.D. (Biochemistry)
Dean
Faculty of Graduate Studies
Mahidol University

.....
Assoc. Prof. Luechai Sringernyuang,
Ph.D. (Medical Anthropology)
Program Director
Master of Arts Program in
Health Social Science
Faculty of Social Sciences and Humanities
Mahidol University

Thesis
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was submitted to the Faculty of Graduate Studies, Mahidol University
for the degree of Master of Arts (Health Social Science)

on
April 16, 2015

.....
Ms. Le Thi Ngoc Phuc
Candidate

.....
Lect. Darunee Phukao,
Ph.D. (Addiction Studies)
Chair

.....
Asst. Prof. Niphattra Haritavorn,
Ph.D. (Anthropology)
Member

.....
Assoc. Prof. Pimpawun Boonmongkon,
Ph.D. (Medical Anthropology)
Member

.....
Asst. Prof. Penchan Sherer,
Ph.D. (Health and Social Welfare)
Member

.....
Assoc. Prof. Siriwan Grisurapong,
Ph.D. (Population and Development)
Member

.....
Prof. Patcharee Lertrit,
M.D., Ph.D. (Biochemistry)
Dean
Faculty of Graduate Studies
Mahidol University

.....
Assoc. Prof. Wariya Chinwanno,
Ph.D. (American Studies)
Dean
Faculty of Social Sciences and Humanities
Mahidol University

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LE THI NGOC PHUC 5638610 SHHS / M

M.A. (HEALTH SOCIAL SCIENCE)

THESIS ADVISORY COMMITTEE: PIMPAWUN BOONMONGKOL, Ph.D., PENCHAN SHERER, Ph.D., SIRIWAN GRISURAPONG, Ph.D.

ABSTRACT

The research aims to understand the attendance in cervical cancer screening among Vietnamese female sex workers in Ho Chi Minh City, and to explore how the socio-cultural factors influence their attendance. Qualitative research was designed with in-depth interview, observation, key informant and secondary data. Fifteen female sex workers aged 18-44 years were recruited by a non-government group. In addition, two health professionals and three community leaders were recruited as key informants in this study. To analyze data, theoretical concepts of discourse by Michel Foucault, felt-stigma by Goffman, beliefs by Kleinman and perceived quality of health service were used.

The study found that the various institutionalized discourses on sex work and sex workers such as “a source of transmitted diseases”, “risk group definition of cervical cancer” influenced not only individualized discourses but also attendance in cervical cancer screening of female sex workers. These discourses created fear for cancer and stigma of female sex workers. Although most female sex workers considered that they were at risk for cervical cancer, they still postponed doing cervical cancer screening. The reasons for non-attendance were most often economic burden, beliefs about cervical cancer and screening, perceived quality of health services and felt-stigma. Some female sex workers had fatalistic attitudes which were associated with the idea of God. Others believed that cervical cancer was a specific genital infection which resulted from white blood discharge, poor hygiene, having unsafe sex with multiple sexual partners. In addition, fear of cancer, fear of being blamed as “promiscuous woman” and embarrassment were mentioned as barriers to cervical cancer screening. In terms of perceived quality of health services, interpersonal relationships, adequate information and convenience affected their non-attendance in gynecological examination as well as cervical cancer screening.

The findings suggest that health promotion and education about the importance of cervical cancer screening are necessary for female sex workers by health professionals and peer-educators. In addition, to reduce the associated felt-stigma, messages to the public community may emphasize that all sexually active women may be at risk for human papillomavirus infection and cervical cancer. Furthermore, interaction between health providers and clients should be improved in healthcare settings.

KEY WORDS: CERVICAL CANCER SCREENING / DISCOURSE / FEMALE SEX WORKERS / BELIEFS / FELT-STIGMA

124 pages

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Treatment
CIN	Cervical Intraepithelial Neoplasia
FSWs	Female sex workers
HCMC	Ho Chi Minh City
HIV	The Human Immunodeficiency Virus
HPV	Human Papillomavirus
IEC	Information-Education-Communication
MOLISA	Ministry of Labor, Invalid and Social Affair
NCADPPC	National Committee for AIDS, Drugs, and Prostitution Prevention and Control
NGOs	Non-governmental Organizations
STDs	Sexually Transmitted Diseases
VIA	Visual Inspection with Acetic Acid
WHO	World Health Organization

CHAPTER I

INTRODUCTION

1.1 Background and justification

1.1.1 Background

According to a report by the World Health Organization (WHO, 2012), cervical cancer is the fourth most common cancer in women, and the seventh overall. While breast cancer, colorectal and lung cancers contributed more than 43% to all cancers (excluding non-melanoma skin cancer), cervical cancer made up nearly 8% of all cancers (Ferlay et al., 2013). The incidence and mortality of cervical cancer in developing countries was higher than in developed countries (Sankaranarayanan, 2002; Zeferino, & Derchain, 2006). It was estimated that the incidence was 444,000 cases and 230,000 deaths. This rate was higher than stomach, corpus uteri and ovary cancers (Ferlay et al., 2013). Cervical cancer can impede reproduction, incur high medical costs, or lead to deaths although this disease can be successfully treated when it is diagnosed in time (Bruni, Alemany, Diaz, Xavier Bosch, & de Sanjosé, 2013). In recent decades, most countries have attempted to promote cervical cancer screening in the population with the aim of reducing mortality. However, the proportion of women who have regular gynecological examinations, including cervical cancer screening is quite low (Anorlu, 2008; Dunn & Tan, 2010). Some women refuse to have a screening, and others who have screening do not follow up due to many reasons such as lack of knowledge, lack of facilities, cultural beliefs, lack of time and money and poor physician-patient relationship (Abdullahi, Copping, Kessel, Luck & Bonell, 2009; Agurto, Bishop, Sanchez, Betancourt, & Robles, 2004; Anorlu, 2008; Markovic, Kesic, Topic & Matejic, 2005). A large number of women have cultural beliefs related to cervical cancer. They believe that cervical cancer is associated with gynecological symptoms including discharge, itching, and abdominal pain (Boonmongkon, Nichter & Pylypa, 2001). Others believe that cervical cancer comes

from god as a form of punishment and people can do nothing about it (Abdullahi, Copping, Kessel, Luck & Bonell, 2009). Others believe that cervical cancer is associated with poor hygiene (Lee, Tripp-Reimer, Miller, Sadler & Lee, 2007). From these beliefs, they often delay going to the hospital for screening and get treatment early or they end up relying on self-medication (Boonmongkon, Nichter & Pylypa, 2001; Bush, 2000; Denberg, Wong & Beattie, 2000; Evans & Lambert, 1997; Lee, Tripp-Reimer, Miller, Sadler & Lee, 2007). Moreover, they also have other beliefs about cervical cancer screening. They believe that screening is most important when there is a family history of cancer; otherwise, it may be irrelevant (Denberg, Wong & Beattie, 2000; Lee, Tripp-Reimer, Miller, Sadler & Lee, 2007). A few women actively participate in gynecological exams but they do not know or distinguish whether a Pap-smear is included in the gynecological exams or not (Boonmongkon, Nichter & Pylypa, 2001). In other cases, women sometimes still refuse to have regular medical screening due to embarrassment, pain or fear for cancer (Rezaie-Chamani, Charandabi & Kamalifard, 2012).

Aside from cultural beliefs, medical discourses also affect the way people understand and response related to their health, diseases and illnesses (Bush, 2000). According to Foucault, discourse is power through language production from professionals. Discourse is considered to be a social construction because it is produced and maintained by those who have the power and means of communication (Victor & Letseka, 2013). Moreover, Foucault also argued that discourse not only transmits and produces power, but it also undermines and exposes it (Foucault, 1978). Discourses also give the individuals degrees of social, cultural, and even possibly political power because certain types of discourse specify types of individuals with unquestioned credibility to speak the truth. For example, it is believed that when doctors talk about physical or mental disease, this gives them an authority to suggest appropriate patterns of behaviors or courses of action (Whisnant, 2012).

A study by Bush (2000) pointed out the importance of cervical screening discourses in framing the way in which women see their bodies and themselves in the United Kingdom. He also emphasized that the nature of medical discourses embedded in invitation letter for a cervical cancer screening shaped the feelings of normalcy and sense of obligation associated with having smear tests. In this study, discourse on Pap-

smear test is forceful, compulsory like demands or orders rather than invitations. Health care providers created a discourse on non-attendance and attendance. In Bush's study, "attendance" meant "normal" and "non-attendance" meant "abnormal". Women with non-attendance were blamed for threatening the success of the cervical cancer screening due to their deviant behavior from medical construction of having a Pap-smear. Consequently, some women resisted program by non-attendance. Or even, they did not ask any benefit of the screening program (Bush, 2000).

Another factor is the patient's perception on quality of health service which also affects health care practices (Chakrapani, Newman, Shunmugam, Kurian & Dubrow, 2009; Ghimire, Smith & Van Teijlingen, 2011). Quality refers to the increase of desired outcomes and be consisted with current professional knowledge. The perspective of practitioners, patients and community are addressed in quality assessment. Under the patients' perspective, the process of care and the physician-patient interaction have impacts on patient adherence, satisfaction and outcomes of care (Steinwachs & Hughes, 2008). According to Ghimire, Smith and Van Teijlingen (2011), the major barriers in seeking sexual health services among FSWs in Nepal are a lack of confidentiality, discrimination, healthcare providers' negative attitudes, poor physician-patient relationships. These barriers affect their utilization of sexual health services.

Therefore, there are socio-cultural factors including beliefs, medical discourses and perceived quality of health service which significantly influence women's decision on going for cervical cancer screening which challenge social scientists to explore.

1.1.2 Justification

1.1.2.1 Cervical cancer and cervical cancer screening in the world and the developing countries

Cervical cancer is one of the most common cancers for women in the world, and is ranked the fourth. Based on statistic from the World Health Organization (WHO, 2012), there were an estimated 528,000 new cases and 266,000 deaths from cervical cancer in the world. It accounted for 7.5% of all female cancer deaths. Especially, more than 87% of deaths occur in the developing countries. For

example, the highest mortality was in Eastern Africa at aged-standardized rates exceeding 27.6 per 100,000 populations. It was compared with rates ranging from less than two per 100,000 in Western Asia, Western Europe and Australia.

The burden of this disease affects not only individual but also the community and society. Women with cervical cancer often have a hysterectomy to save their life, thus they cannot reproduce. In serious cases, the disease can cause death (Bruni, Alemany, Diaz, Xavier Bosch & de Sanjosé, 2013). This shows the necessity for early detection and treatment of cervical cancer in its early stages.

Nowadays, there are many kinds of screening for early detection in the world such as cytology screening (also known as Pap-smear), visual inspection with acetic acid (VIA), and HPV DNA. Each type has its own strengths and weaknesses. In many countries, cervical cancer prevention programs have been implemented and lead to positive results. The morbidity and mortality have been reduced. However, there are different results between developed countries and developing countries. Most developed countries have controlled cervical cancer more successfully than developing countries. The failure to get similar success in developing countries is related to limited human and financial resources, poorly developed healthcare services, women are disempowered, war and civil strife, widespread poverty and the nature of screening tests (Denny, Quinn & Sankaranarayanan, 2006).

1.1.2.2 Cervical cancer and cervical cancer screening in Vietnam

Cervical cancer in Vietnam is ranked the fourth cause of cancer among women and the second most common female cancer in women aged 15 to 44 years (Bruni et al., 2014). According to the Ministry of Health in Vietnam, most recent studies showed that the proportion of women with cervical cancer is increasing. It has been estimated that 5,146 new cervical cancer cases are diagnosed in Vietnam every year. Besides, there is substantial variation in the country (Kim, Kobus, Diaz, O'Shea, Van Minh & Goldie, 2008; UNFPA, 2007; Van, 2005). In 2010, Vietnam had 5,664 cases, where the incidence was 13.6/100,000 women. In the period 2001-2004, the incidence in Hanoi was only 9.5/100,000 population while in the period 2004-2008, the incidence increased to 10.1/100,000 population. Although, in recent years

Vietnam has investigated programs and policies on reducing cancer rates in general and cervical cancer in particular, this rate is still high. In 2012, there were 5,155 deaths from cervical cancer in Vietnam and the incidence rate was estimated 11.0/100,000 population (WHO, 2012). Experts estimate that the incidence and deaths will increase by 25% for ten years without screening, prophylaxis and treatment (<http://hpvinfo.vn>). If patients are screened in early detection, the treatment will get good results and improve the quality of life. They will continue working and contribute to the economic development.

While cervical cancer screening programs have been effectively implemented with the aim of reducing cervical cancer incidence in developed countries, cervical cancer prevention in Vietnam has largely relied on opportunistic screening with low levels of coverage (Kim et al., 2008). Early detection of cervical cancer through screening is recommended by the National Target Cancer Control Program in 2008. The Vietnamese government has proposed up to 2020 with the aims of reducing cervical cancer mortality rate and decreasing the proportion of advanced stage cancer from 80% to 50%. Cervical cancer screening is recommended beginning at age 21 or three years after first sexual contact. Sexual contact consists of intercourse, or oral sexual contact involving the genital area. According to BC Cancer Agency (2007), a Pap-smear is recommended every year until there are three consecutive negative results, and then continues every two years for all sexually active women until the age of 69. Women over 69 may stop having regular Pap-smear if all their previous smears have been normal.

Currently, the screening program for early detection of cervical cancer has been implemented in many provinces and cities in the country. Moreover, in recent years, Vietnam has implemented a vaccination program for cervical cancer prevention program in parallel with Pap-smears or VIA (Dinh et al., 2007; Domingo et al., 2008; PATH, 2007). However, few women can access the vaccine due to high cost. The control program for cervical cancer has mainly focused on the Pap-smear test. However, the effectiveness of screening activities is limited (Domingo et al., 2008; Hoang et al., 2013). The fact that some cases of cervical cancer has increased markedly, particularly majority of cases are detected at the last stages (Van, 2005), proves this.

1.1.2.3 Cervical cancer and cervical cancer screening in Ho Chi Minh City (HCMC)

As studies elsewhere, Human Papillomavirus (HPV) is seen as a key cause of cervical cancer. 99% cases of cervical cancer associated with high-risk HPV types (Parkin, 2011; Walboomers, Jacobs, Manos, Bosch, Kummer, Shah, Snijders, Peto, Meijer & Munoz, 1999). In HCMC, rate of high-risk HPV types related to cervical cancer is higher than in Ha Noi (Lan, Dieu & Ha, 2013). Especially, the morbidity prevalence of cervical cancer among women in southern Viet Nam was 26/100,000 compared to 6.1/100,000 for women in northern Viet Nam (UNFPA, 2007; Van To, T., 2005). And HCMC is one of areas in Southern Vietnam. The number of women who are diagnosed with cervical cancer is 5,000 and with 2,500 deaths from cervical cancer annually (Ferlay, et al., 2010). However, in reality, most patients go to hospitals when they are at the last stage of cervical cancer (Van To, T., 2005). A statistic from five centers for treatment of cervical cancer showed that 53.98% patients were only examined at the last stages of cervical cancer. Based on data from (Bruni et al., 2014), there is a limit of statistics on cervical cancer screening in the populations as well as the high risk groups so that they set up appropriate preventive or intervention programs.

In recent years, the HCMC authority has constantly improved the control technique for detecting cervical cancer. In parallel, the health education programs are widespread in districts. In addition, the city has implemented many mobile programs that provide free-testing to poor women in isolated areas. However, these programs are not systematic and many different subjects have still not been approached. This implies that the cervical cancer screening rate is still quite low.

The reasons related to this rate are lack of knowledge, lack of facilities, women's perception of cervical cancer screening, cultural beliefs of health and disease, social position of women, poor physician-client relationships and medical discourse on cervical screening (Abdullahi, Copping, Kessel, Luck & Bonell, 2009; Blomberg, Ternestedt, Törnberg & Tishelman, 2008). Although these reasons have been studied extensively, limited published research on cervical screening has focused on female sex workers (FSWs).

1.1.2.4 Why FSWs were studied

In Vietnam, sex work is illegal and the government has attempted to control this activity through several decrees (Rekart, 2002). Although there is no official breakdown by sex, experts in the field estimate that about 3,500 women work in the sex industry in HCMC. Sex workers work from many different venues such as small restaurants, clubs, hair salons and other entertainment venues (Rekart, 2002). Working in the sex industry is considered as a social evil like drugs, theft, and robbery (Rekart, 2002; Rushing, 2006; Thanh, 2011). They are often the people who are disregarded. This subject has been paid much attention since the human *immunodeficiency virus (HIV)* was discovered in Vietnam and sex workers are considered as one of the two main key affected populations along with injecting drug users who cause HIV infection.

It is said that most sex workers have negative health outcomes due to stigmatization as a key barrier to access health services (Lazarus, Deering, Nabess, Gibson, Tyndall & Shannon, 2012). Sex workers often face discrimination and rejection. Especially, within context of the illegal sex work, concealing their involvement in sex work not only increases their vulnerability to stress, depression or other diseases but also places them at risk of abuse from those who are more powerful, including the authorities (Benoit, Jansson, Millar & Phillips, 2005). As mentioned above, FSWs are at high risk group for sexually transmitted diseases (STDs) and HIV. In the past, Vietnamese FSWs were treated STDs compulsorily at rehabilitation centers when they were sent by police and city authority. Nowadays, rehabilitation centers were closed due to new policy on management sex workers with human rights. Thus, seeking treatment related to STDs is conducted at Preventive Health Centers, Faculty of Community Support and Consultation and hospitals. However, their accessibility to health services is still limited due to both structural and individual factors such as social stigma, medical costs, fear of social discrimination and healthcare providers' negative attitudes. Several previous studies reported that healthcare provider's negative attitudes impacted on seeking healthcare among Vietnamese with STDs symptoms, particularly for FSWs. Based on results from a study on health-seeking behavior for STDs and HIV test among Vietnamese FSWs, the results showed that FSWs went to private pharmacies to seek treatment. Their

inaccessibility to health services and HIV test was due to high medical costs, healthcare providers' judgmental attitudes, and lack of information on testing services (Ngo, et al., 2007).

Moreover, medical professionals and society often considered sex workers to be one of risk groups for STDs and HIV (Kietpeerakool, Phianmongkhol, Jitvatcharanun, Siriratwatakul & Srisomboon, 2009; Trani et al., 2006). Nevertheless, little is known about health problems beyond STDs and HIV. In recent years, many studies attempted to show that there is co-relationship between higher transmission of HPV and cervical cancer rates among FSWs (Kietpeerakool et al., 2008). Besides, other studies reported that the prevalence of abnormal smears and high risk HPV types in sex workers is higher than general population (Arioz, Altindis, Tokyol, Kalayci, Saylan & Yilmazer, 2009; Kietpeerakool, Phianmongkhol, Jitvatcharanun, Siriratwatakul & Srisomboon, 2009; Mak, Van Renterghem & Cuvelier, 2004; T. NÚÑEZ, Delgado, GirÓN & Pino, 2004).

However, many programs and intervention from government and non-governmental organizations (NGOs) focused on HIV, but they pay less attention to promote policy and program implantation related to cervical cancer prevention. Based on a report of National Committee for AIDs, Drugs, and Prostitution prevention and control (NCADPPC, 2012), the Vietnamese government has set up many programs or policies related to HIV and sex workers such as: National Strategy on HIV/AIDS Prevention and Control, Program of Action on Sex Work 2010-2015, National Comprehensive Condom Program for 2011-2020, Needle and Syringe Program, National Methadone Maintenance Therapy program. Besides, international non-government organizations, projects and foundations such as Population Service International (PSI), Program for Appropriate Technology in Health (PATH), AIDS Health Care Foundation (AHF) and others have provided technical assistance and funding for the national HIV response in Vietnam (UNAIDS, 2012). In contrast, cervical cancer prevention is mentioned on National Target Cancer Control Program or cervical cancer projects are supported by PATH for general population (PATH, 2007b). In fact, they are at an increased risk for cervical cancer due to the sexual transmission pattern HPV in comparison with general population, multiple sexual partners, STDs and socioeconomic status (Kietpeerakool et al., 2009; T.

NÚÑEZ, Delgado, GirÓN & Pino, 2004). Therefore, it is necessary to face the issues regarding cervical cancer prevention beyond STDs prevention among women in the context of sex work.

1.1.2.5 Why study discourse on sex work

Discourse can be understood as language which we use in everyday life. According to Michel Foucault, discourse is used to shape, regulate and control individual's thoughts and action (Danaher, Schirato & Webb, 2000). Through language, we produce discourse to explain the world in certain time and space.

“Discourses can be understood as language in action: they are the windows, if you like, which allows us to make sense of, and “see” things” (Danaher, Schirato & Webb, 2000:31)

Discourse refers to a type of language associated with an institution, and includes the ideas and statements which express an institution's values. Discourse implies the operation of institutions that build up stable relationship between people and objects or different people (Danaher, Schirato, & Webb, 2000). According to Foucault, discourse operates in four basic ways: (1) discourse creates the world; (2) discourse generates knowledge and “truth”; (3) discourse says something about the people who speak it; and (4) discourse is power through knowledge production from professional. The four basic ways in which discourse operates will be explained in detail in the literature review.

In the research, examining discourse on sex workers from society will give a better understanding of cervical cancer screening among FSWs. Discourse on sex worker from social institution or medical institution will construct female sex worker's subjectivity and body. How does society look at FSWs and label them through language or discourse? These labels also influence their subjectivities. And how does it influence the female sex worker's feelings and practice in health care? In other words, discourses from social institution or medical institution on sex workers and cervical cancer have profound impacts on what sex workers see cervical cancer and themselves. As a result, this affects to their surveillance and control of their bodies, and then influence on their cervical cancer screening attendance. Moral discourses such as sex workers are promiscuous, immoral which are thought to be

deviant behaviors and epidemiological definition of risk group and public health message also effects on sex workers (Bush, 2000).

Moreover, many previous studies in Vietnam focused on women's knowledge, attitude, and practices regarding to HPV vaccine (Dinh et al., 2007; Poulos, Yang, Levin, Minh, Giang & Nguyen, 2011); other studies mentioned on HPV infection prevalence (Hernandez & Vu Nguyen, 2008; Hoang et al., 2013). However, an anthropological study towards practice related to cervical cancer has not been deployed. Some reasons that affected low cervical cancer screening rate among women in various groups including women in sex work context have not been investigated deeply. In particular, little is known about the frequency and pattern of health care utilization and perception of quality of care by FSWs. There is very little research that analyzes socio – cultural factors, which include social stigma of female sex worker, and cultural beliefs about cervical cancer and cervical cancer screening which are shaped by medico-moral discourse on sex workers/prostitutes. This research argues that these above mentioned issues are important and urgently need to be explored in order to promote understanding about this issue and provide recommendation on policy, program and implementation to enhance FSWs' attendance on cervical cancer screening service.

Therefore, the objectives of this research are to understand FSWs' attendance in cervical cancer screening services and to find out socio-cultural factors related to their attendance on cervical cancer screening service. In detail, this research would like to explore the medico-moral discourse on sex workers/prostitutes, especially FSWs who have cervical cancer screening and how these discourses influence FSWs' believes about cervical cancer and have impacts on their attendance to cervical cancer screening. In other words, this study would like to provide an in-depth understanding of attendance in cervical cancer screening among FSWs by paying attention to (1) medical and social discourse on sex work, sex workers, FSWs who have cervical cancer, (2) the role of cultural beliefs about cervical cancer, (3) and perceived quality of health service in cervical cancer screening.

1.2 Research questions

1.2.1 What are institutional and individual discourses on sex work, sex workers and sex workers who have cervical cancer in Vietnamese society?

1.2.2 What are felt stigmas of FSWs as a result of institutionalized and individual discourses?

1.2.3 What are cultural beliefs about cervical cancer among Vietnamese FSWs?

1.2.4 What are the Vietnamese FSWs' perceived of quality of service in terms of information adequacy, privacy, gender of doctor, technical competence, convenience and interpersonal relationships?

1.2.5 What are Vietnamese FSWs' attendance of cervical cancer screening in term of frequency and purpose of screening?

1.2.6 How do socio-cultural factors in terms of discourses on sex workers and cervical cancer, cultural beliefs related to cervical cancer, perceived qualities of health service impact on Vietnamese FSWs' attendance in cervical cancer screening?

1.3 Research objectives

1.3.1 General objective

I would like to understand the attendance of cervical cancer screening in terms of frequency and purpose of screening among Vietnam FSWs and how socio-cultural factors influence their attendance.

1.3.2 Specific objectives

1.3.2.1 To explore institutional and individual discourses on sex work, sex workers and sex workers who have cervical cancer in Vietnam.

1.3.2.2 To explore felt stigma of FSWs as a result of institutionalized and individual discourses.

1.3.2.3 To explore cultural beliefs related to cervical cancer among Vietnamese FSWs.

1.3.2.4 To explore Vietnamese FSWs' perceived of quality of service in terms of information adequacy, privacy, gender of doctor, technical competence, convenience and interpersonal relationships.

1.3.2.5 To explore the Vietnamese FSWs' attendance on cervical cancer screening in terms of frequency and purpose of screening.

1.3.2.6 To understand how socio-cultural factors in terms of discourses on sex workers and cervical cancer, cultural beliefs related to cervical cancer, perceived qualities of health service impact on Vietnamese FSWs' attendance in cervical cancer screening.

CHAPTER II

LITERATURE REVIEW

2.1 Theoretical concepts

2.1.1 Concept of discourse

There are different definitions of “discourse”. Every definition reveals the complex nature of discourse and reflects a theoretical underpinning (Cheek, 2004). Discourse is defined as a set of sentences in the written and spoken language, which reflects systems of thoughts as well as power structure in the society. There are two kinds of discourse that run our social lives. One is authoritative/institutionalized discourses which are embodied in social values, social norms, ideologies, family planning campaigns, HIV/AIDS prevention programs. The other is individualized/personalized discourses on personal desire, personal judgments and personal critical thinking.

According to Foucault, discourse refers ways of thinking and speaking about aspects of reality. He also argued that discourse generates the world of our everyday life by shaping our perceptions of the world, pulling together chains of associations that produce a meaningful understanding, and then organizing the way we response towards objects in the world and towards other people. Besides, discourse also constitutes all forms of knowledge and “truth”. Through language, knowledge is complex communicated; all knowledge is organized through the structures, interconnections, and associations that are built into language. Moreover, discourse communicates knowledge not only about the intended meaning of the language, but also about the person speaking the discourse. By analyzing the discourse a speaker uses, one can often tell things about the speaker’s gender, sexuality, ethnicity, class position, and even more specifically the speaker’s implied relationship to other people around him. Medical discourse, for example, gives doctors the authority to speak, thus putting them in a more powerful position than their patient (Whisnant, 2012). Among

the four basic ways, Foucault emphasized that discourse is a complex reality that allows us approaching it at different levels with different methods and indicates concept of power with assumption of language and discourse (Best & Kellner, 1991). He developed intimate connection between power and knowledge and alternative modes of knowledge and discourse.

The relationship between power and knowledge or language under the concept of discourse has been emphasized by Foucault. Discourses both enable and constrain the production of knowledge. In this way, discourses determine who can speak, when, and with what authority. In reality, not all discourses produce equal authority. Some discourses achieve dominance over others (Cheek, 2004). Besides, discourse can be both instruments and effects of power. In Foucault's analysis, power takes responsibility for creating our social world or certain knowledge. Furthermore, power also rules out what it is possible to be known in a certain situation. Therefore, power is not only exclusively oppressive but it is also a productive concept. According to the common view, power is seen as a tool for the social construction of reality, thus discourse is considered as an instrument of power and ideological control (Cheek, 2004; Victor & Letseka, 2013).

2.1.2 Concept of felt-stigma

Stigma is socially constructed. This can affect the life experiences of marginalized people such as street children, sex workers, and people with HIV. Stigma represents a construction of deviation from the expectation. According to Goffman's perspective, stigma is a powerful discrediting and tainting social label (Alonzo & Reynolds, 1995) that radically changes the way individuals view themselves and are viewed as persons. Goffman (1963, as cited in Gaudine, Gien, Thuan & Dung, 2010) also described stigma as people's attitudes towards someone who is discredited by physical or personality deformity or association with a group.

According to Gilmore and Somerville (1994), there are four characteristics or components of stigmatizing response. First, it is a problem that can trigger a stigmatizing reaction. In the context of STDs, such a problem might involve fear of being exposed to, say, an STDs or being labeled as having one, being harassed, tormented or embarrassed especially when infected, or being accused or threatened or

even assaulted. Second, the person or group to be stigmatized has to be identified. This means that they have characteristics which can be used to stigmatize them. Usually, this involves some traits which, itself, can be stigmatized or through which stigma can be assigned to them. For example, sex workers, street youth, drug users, gay men or even the urban poor are the convenient targets for stigmatization with an STD. Third, the stigma must be recognized in the particular persons who are stigmatized. They are labeled with the stigma, and the stigma and the negative characteristics associated with it are perceived as belonging to them. For example, the person who is stigmatized may be considered to be irresponsible, predatory, insensitive, or criminal. Fourth, there is a reaction or response to the stigmatized person which resolves the problem that initiated or elicited the stigmatization.

Stigma is divided into two kinds: felt stigma (also known as perceived internal stigma) and enacted stigma (also known as external stigma) (Scambler, 1998). Felt stigma refers to how individuals perceive others' attitudes and behavior to them. Others' perceived negative reactions can reduce individual's self-esteem or feelings of guilt or shame. On the other hand, enacted stigma refers to behaviors or perceptions by others toward the individual who is perceived as different (Scambler, 1998).

The impact of stigmatization on the stigmatized person has been well documented (Gaudine, Gien, Thuan & Dung, 2010; Gilmore & Somerville, 1994; Riley & Baah-Odoom, 2010). Stigmatization can cause harm to stigmatized people, it is seen as a barrier to accessing health services, especially access to treatment that can cure or suppress infection. Moreover, Kleinman indicated that the stigmatization process usually begins with the community's response to the person. He argued that in a healthcare setting, many people feel shame not due to the cultural meaning of illness but rather in response to the reactions of family and especially healthcare providers (Duffy, 2005).

2.1.3 Concept of quality of health service

Health care quality is a broad concept. It is difficult to clearly define. Institution of Medicine (1990, as cited in McQuestion, 2006) defined as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge". This

definition is widely used in studies on health care quality because it emphasizes both individual and population levels of analysis, and also associates with health care service. According to this definition, both treatment and prevention are incorporated. “Desired” health outcomes are those sought by the recipients of the services, while “current professional knowledge” refers to ever-changing technical standards of care (McQuestion, 2006).

To assess and measure quality, many indicators and dimensions of quality of care are given. Donabedian conceptualized three qualities of care dimensions: structure, process and outcome (Campbell, Roland & Buetow, 2000; Ndhlovu, 1995). Structure is the attributes of settings where care is delivered. Process refers to whether good medical practices are followed or not. Outcome is the impact of the care on health status. The context where care is delivered affects processes and outcomes. For instance, if the facility is unpleasant, people will not come. Outcomes indicate the combined effects of structure and process. Donabedian also emphasizes that to monitor outcomes is to monitor performances, which are conditional on structure and process. For example, low coverage rates in immunization program imply poor performance which might be because of without electricity, poor attitudes, other factors (McQuestion, 2006).

Based on Donabedian’s framework, Judith Bruce also gives a definition and measurement of quality of care in family planning services. However, she focused on the process dimension of quality of care. Her framework is divided into three levels: the policy, service delivery and client provider interaction levels (Bruce, 1990; Ndhlovu, 1995). At the policy level, legal system and policies become enabling or limiting factors to quality services delivery. To service delivery or clinic level, the quality level is a function of the infrastructure that exists such as building, toilets, sitting facilities, equipment, skills or what Donabedian referred as the structure. At the final level, quality measures the services received by the client. The six elements that were identified as part of the process of service delivery are: choice of methods, information given to clients, technical competence, interpersonal relationship, continuity and follow up, appropriate constellation of services (Bruce, 1990). In this framework, choice of methods refers both to the number of contraceptive methods offered on a reliable basis and their intrinsic variability. Information given to all

clients means that information delivered during service contact that enables clients to choose and employ contraception with satisfaction and technical competence. In this sense, technical competence involves the competence of the clinic techniques and the observance of protocols. In term of interpersonal relationships, it refers to the personal dimensions of service namely the affective content of the client-provider transaction. It is an important element because for many clients, being treated badly is worse than receiving no care at all. Besides, Bruce also noted that program needs to set up a mechanism to manage continuity of well-informed users because a program's willingness to establish continuity or follow-up mechanism is one measure of its longer term commitment to individual welfare. Finally, the appropriate constellation of services refers to situating family planning services so that they are convenient and acceptable to clients, responding to their natural health concepts and meeting pressing pre-existing health needs rather than an inflexible medical discrimination of where a need begins and where it ends. The outcomes of care which are recognized by Bruce are knowledge, behavior, and satisfaction. It is expected that a quality program would impact these three outcomes.

2.1.4 Concept of human body and beliefs

According to Helman (1990), the human body is not only a physical organism but also the focus of a set of beliefs about its social and psychological significance, its structure and functions. He categorized body image into three groups: (1) beliefs about shape, size, clothing and the surface of the body; (2) beliefs about the body's inner structure; and (3) beliefs about how it functions. These groups are socially and culturally constructed and can have important effects on the individual's health. It influences the way people consider and respond to health, disease and medical treatment. Each person has two bodies: an individual body-self (both physical and psychological) which is formed at birth, and also the social body that it needs in order to live within a particular society. People perceive and interpret their own physical and psychological experiences through the social body (Helman, 1990).

In his works on the normalization of bodies in prisons, schools and hospitals, Michel Foucault repeatedly mentioned the understanding of the human body as both an object of power and the site at which power is disseminated and resisted.

However, Foucault also gave another rethinking about the body. He considered that the body is a “surface of inscription” which is marked by dominant cultural norms, but holds the possibility of inscribing itself on social practices through resistance. He emphasizes how particular forms of power can manipulate the “political economy of the body” to produce bodies which suffer systemic subordination; instead of emphasizing how bodies resist and subvert power. Political economy of the body refers to the body as a subject of political power or power relationship. According to Law (2000), a pathologized sex worker subject (prostitutes) can be found in a series of institutional discourses that seek to identify, name and regulate the sexual practices of these bodies. She maintains that prostitute bodies are irreducible and the objects of a disciplinary power.

2.2 Overview about cervical cancer and cervical cancer screening

Cervical cancer is cancer that forms in tissues of the cervix (the organ connecting the uterus and vagina). It often grows slowly without symptoms. It begins as a form of pre-cancer, called dysplasia. Precancerous state can be detected by a test and it can be treated successfully. This is the reason why it is important for women to have regular health screening. There are many causes related to cervical cancer. HPV infection is seen as the key causal agent in most cervical cancer. There is an estimated more than 118 different HPV types are divided into two groups. HPV types 16,18,31,33,35,39,45,51,52,56,58, and 59 are considered as high-risk types; on the other hand, types 6, 11, 42, 43 and 44 are considered of low or no oncogenic risk (Bosch, Lorincz, Munoz, Meijer & Shah, 2000; Franco, Duarte-Franco & Ferenczy, 2001; Smith et al., 2007). Among these types, HPV types 16 and 18 are two high-risk types and account for more than 70% cervical cancer cases (Franco, Duarte-Franco & Ferenczy, 2001; Smith et al., 2007). However, the relationship between HPV and cervical cancer is not strong. Most people in the general population can get HPV; however only a small proportion of women with high-risk type HPV infection will develop a clinically evident lesion. Among these cases, the proportion of women getting cervical cancer is small. Therefore, HPV is a necessary but not a sufficient cause of cervical cancer. Based on epidemiological studies conducted during the past

more 30 years, the authors have indicated various co-factors relating to the development of cervical cancer such as age of first sexual intercourse, number of multiple sexual partners, parity, early age of first delivery, smoking, and STDs (Franco, Duarte-Franco & Ferenczy, 2001; Juneja, Sehgal, Mitra & Pandey, 2003; T. NÚÑEZ et al., 2004).

There is variety of screening methods for cervical cancer precursors. It includes cytology screening (Pap-smear test), VIA and HPV DNA. Since cervical cytology (pap-smear) was introduced over 50 years ago, it has been used to identify precancerous lesions for treatment or follow-up. Using cytology screening has reduced from 70 % to 80 % incidence of cervical cancer in developed countries since the 1960s (Kitchener, Castle & Cox, 2006). Even in industrialized countries, the success of this approach may be different. For example, in the United States, where the number of cervical cancer cases has decreased significantly; however, in poor countries it remains high. In developing countries, Pap-smear screening cannot be successful due to limited resources such as a lack of supplies, equipment, medical personnel, quality control and infrastructure (Kitchener, Castle & Cox, 2006). An estimated 75 % of women in industrialized countries have been screened in the previous five years. In contrast, a survey in India found that only 2.6 % of women had been screened (Sankaranarayanan et al., 2008). In Kenya, only 1 % of people have participated in any kind of refinement, although there have been many efforts to improve screening programs. The main reason for the low cervical screening rate is lack of information and understanding about the importance of cervical screening in both women and health workers (Denny, Quinn & Sankaranarayanan, 2006).

Together with Pap-smear, VIA can replace cytology or techniques can be used in conjunction with a Pap-smear or HPV DNA testing. VIA involves a technique of washing a cervix with acetic acid from 3% to 5% (vinegar) for one minute and then the color of the cervix is observed with the naked eye. If a defined white area is seen near the mucosal area conversion, the test results are good. Currently, VIA is a technique that can be applied in many countries because the result from VIA can be gotten faster than Pap-smears results and thus prevent cervical cancer. VIA can replace HPV DNA testing as a primary screening tool and VIA is useful when selecting treatment after a positive HPV DNA test. However, like Pap-smears, VIA assessment

results are more subjective than HPV DNA. Results may vary when seen by other doctors or in different days. In addition, the evidence of the effectiveness of VIA is relatively new. Some medical experts find that it is difficult to trust and accept VIA. Testing can detect oncogenic HPV DNA in the cervix or vagina. This test is not subjective as visual inspection by cytology or VIA. A review of studies concluded that HPV DNA testing is most valuable in the detection of precancerous lesions in women over 30 years old. However, evidence of HPV DNA testing is relatively new. The medical facilities in many parts of the world lack the resources and may not be willing to accept them because of inappropriate and large costs compared to the base material conditions and their financial capability. Therefore, the Pap-smear is the preferred screening method in many countries.

Moreover, there are many different guidelines for cervical cancer screening. For instance, guidelines from the National Workshop on screening for cancer of the cervix that was ratified by the Cervical Cancer Prevention Network in 1998 showed that Pap-smear screening should be begun at age 18 or at initiation of sexual activity and be continued every year. After two negative consecutive results, the Pap-smear test is done once every three years until the age of 69. If mild dysplasia (cytological equivalent of cervical intraepithelial neoplasia (CIN)) grade 1, or low-grade squamous intraepithelial lesion (SIL) is found, the smear is repeated every six months for two years (Miller et al., 1991). The guidelines from the American Cancer Society in 2012 made the following recommendations: all women should begin cervical cancer screening at 21 years old; however, women between the ages of 21 and 29 only should have a Pap-smear test every three years; they should not be tested for HPV unless it is needed after an abnormal Pap test result; women over 69 may stop having regular Pap-smear if all their previous smears have been normal; and women with high risk for cervical cancer need to be tested more often (Saslow et al., 2012).

2.3 Related literature review

2.3.1 Discourse on sex work and sex workers

According to Law's research on sex work in Southeast Asia (2000), a case study in the Philippines mentioned sex workers as victims from tourist development policies. The policy was set up for foreign tourist arrivals and this attracted women to come and find works in the sex industry. The country's political economy produced a sexual identity discourse and constructed their live. Although the Catholic Church thought the medico-moral discourses condemned the "three P's" of premarital sex, promiscuity, and prostitution, women not only considered themselves as "prostitutes" or "sex workers" but also considered sex work as their choice that allows women to create their representation of identities (Law, 1997).

Likewise, a qualitative research on negotiating safer sex practices by FSWs infected with STDs/HIV in Haiphong city, Vietnam conducted by Vu Thi Du (2009) reported on discourses on sex work and FSWs in Vietnamese context. First, sex work is seen as a social evil. The close cooperation between Ministries to deal with sex work and drug in terms of social security, education, oriented occupation and healthy of society has been developed in many programs on controlling and prevention AIDS epidemic, the evils of sex work and drugs. She showed that the female sex worker is considered to be a slut and to be a person who commits sinful acts. Cultural norms produce discourse of the virginity pledge. Virginity is considered as a sign of faithfulness on a girl, and is a female moral standard among four female virtues. Thus, a girl who has lost her virginity is considered as bad, depraved and immoral. As a result, she will not have a "good" husband and future. This ideology surrounding virginity leads to FSWs being disregarded in society because they have lost their virginity. However, these women considered sex work as a real job to make money for daily needs. They think that they are good workers because they are well prepared for their job, and have professional skills to please clients and negotiate for safe sex (Du, 2009).

Sex workers are also labeled as a "high risk group" associated with HIV/AIDS or STDs by public health or medical experts (Law, 2000). It is claimed that they transmit diseases to their male clients as well as the general population. That

implies that the prostitute is an agent that threatens the whole population, and nation (also known as “social evils”); thus, the government tries to eliminate or control them. Beyond HIV/AIDS or STDs, FSWs are also considered as a risk group related to cervical cancer. A study on cervical smear and HPV typing in sex workers (2004), Mak, Van Renterghem and Cuvelier showed that the prevalence of abnormal smears and high risk HPV in sex workers is higher than in control groups. The authors suggested sex workers should be screened when they work as sex worker regardless of their age (Mak, Van Renterghem & Cuvelier, 2004). Likewise, T. NÚÑEZ, Delgado, GirÓN & Pino (2004) revealed co-factors in pre-invasive and invasive lesions of the cervix among FSWs. FSWs are associated with cervical cancer because they have first sexual intercourse at the early age, number of multiple sexual partners, and smoking.

2.3.2 Beliefs about cervical cancer affect health care practice

Cultural beliefs are the ideas and thoughts common to individuals. Cultural beliefs differ from scientific knowledge and get tagged with connotations of truth (Nakkeeran, 2010). In other words, cultural beliefs are not empirically discovered and universally explained. Cultural beliefs become identical and commonly known through the socialization process by which culture is unified, maintained and communicated (Greif, 1994).

Each culture has its own system of health beliefs to explain what causes the disease, how it can be cured or treated, and who should be involved in this process. In Western industrial society, the disease is considered as a result of natural scientific phenomena. In other words, disease is dysfunction of organs in the body, therefore, it is necessary to use sophisticated technology to diagnose and treat disease (Helman, 1990). People with disease are tested or treated in the hospitals. On the other hand, other societies believe that illness is a result from supernatural phenomena or imbalance between yin and yang principle; thus they have different response to healthcare seeking (Helman, 1990; Lisa, Farrah & Raymond, 2009; Prior, 2009).

A review of the literature on women’s bodies illustrate the linkage between women’s perception about body and health care practices, in particular cervical cancer screening. Some studies revealed that the conceptualization of the body as private greatly influences the ways in which they seek and receive health care

because the cervix is seen as the most private body part of a women. Women often link this to feelings of embarrassment and hesitation. For example, based on results from Prior's research (2009), the spiritual Christian belief about the sacredness of the body also explained why some women rejected surgical cancer treatment. Women believed that their body was a creation of god and they should not interfere with it whatever happens. Donnelly (2004) in research on "Vietnamese women living in Canada: Contextual factors affecting Vietnamese women's breast cancer and cervical cancer screening practice" showed that many women believe that nobody should touch the women's body except her husband. Thus, their decision on cervical screening was influenced by their husband. This becomes a barrier for them to participate in health care. Besides, this belief also affects their choice of who can treat them, male or female physicians.

Many studies on perception of cancer showed that most people expressed fearful and fatalistic attitudes toward cancer. Prior (2009) pointed out that the meaning of cancer is a social and cultural construction. It may be derived from their personal and community perception, tradition, mythical beliefs. These traditional beliefs or perceptions about spiritual force influenced the attitude and the belief that cancer was "a killer disease". Consequently, many women were ambivalent about medical advice for treatment because they considered treatment to be futile. They postponed check-up, diagnosis or treatment until side-effects became a problem. It was shown that Australian Aboriginal women considered cancer as a "dirty disease", especially cervical cancer. In this sense, women who understood cervical cancer as a STD embodied the same social stigma as other STDs such as gonorrhea and syphilis. Another contributor in the construct of cancer as a social disease was the acronym CIN meaning Cervical Intraepithelial Neoplasia – the biomedical classification of cervical cell dysplasia. Some women heard the term CIN as sin, implying immoral behavior. Therefore, when a woman heard that her Pap-smear test identified CIN as abnormal cells, she first assumed this meant cancer and then got concerned that others, in particular her husband or male partner, would assume this was evidence that she had been unfaithful. Moreover, the women's beliefs in the spirit world would be transformed into fear of "bad spirits" that caused sickness or other harm. They

believed that cancer was a manifestation of payback inflicted by “bad spirits” as punishment of a misdemeanor (Prior, 2009)

Another research on knowledge, awareness and attitudes of FSWs toward HPV infection, cervical cancer, and cervical smears in Thailand (2009) showed that the feelings of fearful in abnormal results, the pain of procedure and embarrassment affected FSWs’ cervical cancer screening. The FSWs with a negative attitude had cervical cancer screening less than those with positive attitude (Kietpeerakool, Phianmongkhol, Jitvatcharanun, Siriratwatakul and Srisomboon, 2009).

Likewise, Donnelly (2004) also showed that cervical cancer was predetermined by a higher power. They had no control over their life. It was up to God. Due to that belief, a woman might not seek treatment, believed that a cure was up to God. Another a qualitative study on “Worse than HIV” or “Not as serious as other diseases?” the conceptualization of cervical cancer among newly screened women in Zambia (2012) showed that women believed that cervical cancer was associated with HIV/AIDS. When a woman went for cervical cancer screening test, it was assumed that she was HIV positive because in this community, cancer was associated with HIV/AIDS, thus she might fail to come for screening for fear of being found with cervical cancer (White et al., 2012).

Furthermore, cervical cancer was believed to be associated with gynecological symptoms including discharge, itching, abdominal pain, and *mot luuk* (uterus) problems. Thai women considered Pap-smear as a general evaluative exam to check for problems, they were also afraid that their symptoms may represent cancer. Therefore, when they had vaginal discharge associated with feelings of fear cancer, they wanted to go for Pap-smear test (Boonmongkon, Nichter, & Pylypa, 2001).

Another qualitative research on Korean American women’s beliefs about breast and cervical cancer associated symbolic meaning also gave same results (Lee et al., 2007); however, there are some differences compared to the ones mentioned above. Korean American women’s symbolic meanings with regard to their breasts and cervix were almost all related to their interpersonal relationships with their family members, either children or husbands. Among older Korean American women, negative past experiences in their lives, such as having abortions or having husbands with promiscuous lifestyles, contributed to negative perceptions about the cervix and

cervical cancer. Their beliefs about breast, cervix and cervical cancer influenced their perceived risk for breast or cervical cancer. They believed that as long as they stay healthy, eat a healthy diet, do not have a family history of cancer, do not think or worry about it, and have not had multiple sexual partners or abortions. Overall, the beliefs about cervical cancer and cancer screening as well as symbolic meanings regarding cervix, are associated with the cultural and interpersonal context. This affects their screening behavior.

2.3.3 Discourses on sex worker affect health care practice

As Choudhury (2010) pointed out labeling FSWs as “being at risk woman”, which related to drinking alcohol, smoking, having sex with multiple partners and transmitting disease affected FSWs’ perception about their body in risk environment, and then they protected themselves rather than focusing on the risk encountered while working. They tried to take control their bodies and developed strategies to reduce their risk within their lived realities of a sex worker.

However, a study on the relationship between sex and cervical cancer in New Zealand explored that sexuality discourses prevented women from being screened (Braun & Gavey, 1999). Discourses on good or bad girls, notion of promiscuity were used. This research pointed out that STDs and cervical cancer were associated with dichotomy between sexually “bad” and “good” girls: The good girls were sexually responsible, did not get STDs, had a sexual partner; on the other hand, the bad girls were sexually irresponsible, had many sexual partner, and got STDs. These discourses not only effectively separated two women’s positions on sexuality, good or bad, but also punished women for their sexuality. Therefore, these discourses expressed attitudes to cervical cancer and its prevention as well as they could cause women to feel blamed if they carried on cervical cancer. Women believed that a promiscuous woman would get cervical cancer because cervical cancer was associated with promiscuity. In contrast, those who did not regard themselves as promiscuous believed that they were not at risk and so did not concern them with cervical cancer as potential problem.

2.3.4 Stigma attached to being sex workers and health care practice

Chakrapani, Newman, Shunmugan, Kurian and Dubrow (2009) described barriers to free antiretroviral treatment (ART) access for FSWs in Chennai, India. In individual level, most FSWs had fear of being exposed as HIV-positive and FSWs to their family members because they did not want to disclose that they engaged in sex work. For FSWs got HIV-positive, disclose might also suggest that they became infected through sex work, thus they had to face several problems such as rejection by family members, domestic violence from the husband, and eviction from the home by the husband and in-laws. As a result, many FSWs did not access ART. They also pointed out that the way society looked down upon them as “immoral” or “bad in character” prevented them from seeking health care because they scared being isolated. The authors concluded that fear of adverse consequence was a main barrier which prevented FSWs from accessing proper health care, including free ART. In addition, health care system barriers also influenced their attending ART centers. FSWs had negative experiences with healthcare providers. Some FSWs pointed out the staff’s unfriendly attitudes in the government hospitals such as viewing FSWs as “promiscuous” and using insensitive language. This was a reason why FSWs did not attend ART centers. Furthermore, they also perceived biased treatment of FSWs who were not referred by NGOs. People who come to ART centers accompanied by NGOs had priority over than others who were not referred by NGOs (Chakrapani, Newman, Shunmugam, Kurian & Dubrow, 2009). Based on this information, it can be argued that if FSWs find it difficult to access ART, they would find it equally difficult to access cervical cancer screening.

2.3.5 Perceived quality of health care service affects health care practice

A research on barriers to utilization of sexual health services by FSWs in Nepal by Ghimire, Smith, and Van Teijlingen (2011) showed that the major barriers in seeking sexual health services among FSWs were a lack of confidentiality, discrimination and healthcare providers’ negative attitudes, poor communication between service providers and clients, and fear of exposure to the public. Most FSWs in this research reported that asking personal questions, especially about their job and

sexual history by health service providers in private clinics as well as doctors in the government hospital made them de-motivated in seeking care. They also reported the doctor's and other health service provider's indifference as a reason for the non-attendance to governmental health services. They did not feel comfortable during examination and felt a lack of proper care by health service providers. Sexual harassment by service providers was also a barrier to access to health service among FSWs in Nepal.

Also the research on barriers to free ART treatment access for FSWs in Chennai, India by Chakrapani, Newman, Shunmugam, Kurian and Dubrow (2009) showed the lack of comprehensive and adequate counseling service at government centers as a barrier to attend ART program. FSWs reported that their rights to privacy during counseling were not protected in some government hospitals. They also believed that getting adequate information about ART and its benefits during post-test HIV counseling kept them motivated to go to an ART center for their check-up and treatment.

2.4 Explanation of conceptual framework

2.4.1 Discourse

In this framework, discourse will be explored in two types. One type is institutional discourses which include discourses on sex work, sex worker and sex workers who have cervical cancer screening, which are produced by social and medical institution such as promiscuity, sexually immoral, sinful act, social evil, source of HIV/STIs, abnormal smears, high risk HPV. These institutional discourses may influence the general population's attitude toward FSWs as well as the way FSWs make sense of themselves and their cervical cancer screening practices. Another type is individual discourses in which FSWs use to explain their job and themselves such as: sex work is a choice/work, their felt-needs on money for their family and daily lives, and being a good mother, wife, daughter and sexual partner. Both institutional and individual discourses will influence their felt stigma of being a sex worker and also shape their cultural beliefs about their body and cervical cancer, and perceived

quality of health service. Then, these feelings, cultural beliefs and perceived quality of health service have impacts on cervical cancer screening among FSWs.

2.4.2 Felt-stigma

In this framework, felt or internalized stigma will be investigated. Felt-stigma is sex worker's feelings of embarrassment, fear of being rejected, or being a person with bad character. These negative feelings are experienced through medico-moral discourses at the institutional and individual level, for example languages, terms, words being used at work places and health services by clients, brothel owners, community members and health staff. Then, these feelings have impacts on their decision-making on cervical cancer screening practices in terms of frequency and purpose of screening.

2.4.3 Cultural beliefs

Cultural beliefs are individual's ideas, thoughts and perceptions. It differs from scientific knowledge. It is not empirically discovered and universally explained. In this framework, it is used to explore the way FSWs think about their reproductive organs and cervical cancer, and this has an impact on their cervical cancer screening practice. Cultural beliefs about reproductive organs will be examined at three aspects: physical, psychological and social aspects. Physical aspect refers to the belief on inner structure and functions of the reproductive organ. Psychological aspect refers to the way Vietnamese FSWs consider their reproductive organ subjectively such as being dirty, not clean, polluted body or purified, cleaned body. Social aspect mentions the belief on pathologized body which requires being disciplined and surveillance (disciplined body). Cultural beliefs on cervical cancer such as etiology and symptoms also affect Vietnamese FSWs' cervical cancer screening practices.

2.4.4 Perceived quality of health service

Quality of service which is assessed by FSWs' perspective is also explored. In this case, quality refers to information adequacy, privacy, gender of doctor, technical competence, convenience and interpersonal relationships. These elements will influence cervical cancer screening practice among Vietnamese FSWs.

2.4.5 Attendance of cervical cancer screening

In this research, the understanding of cervical cancer screening attendance among Vietnamese FSWs will be demonstrated in terms of frequency and purpose of screening.

2.5 Conceptual framework

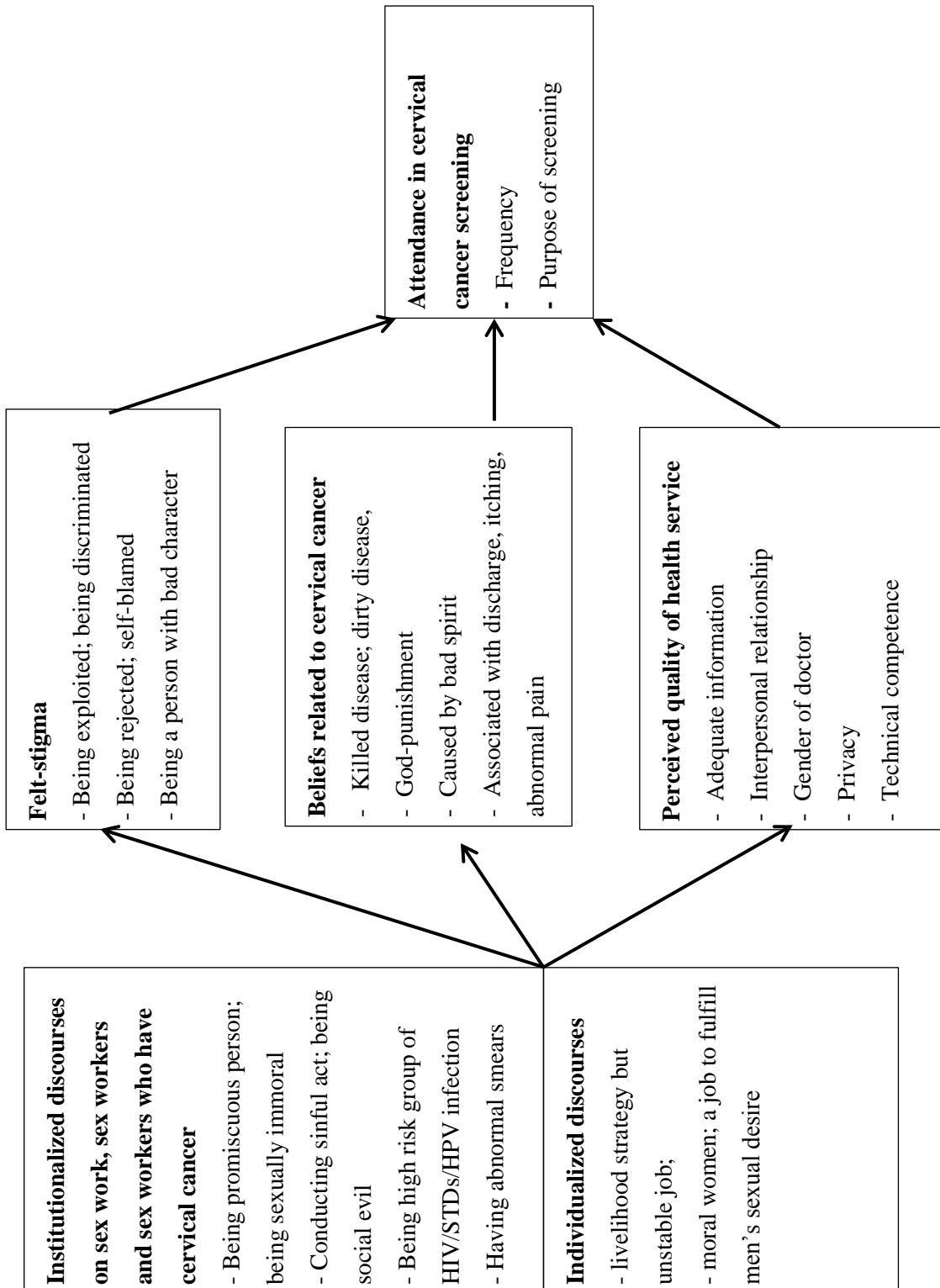


Figure 2.1 Conceptual framework

CHAPTER III

RESEARCH METHODOLOGY

3.1 Research design

The study aimed to understand cervical cancer screening practices among FSWs in HCMC, Vietnam. The socio-cultural factors influencing FSWs' decision on undergoing cervical cancer screening were explored. Therefore, the study was designed with qualitative approach.

Berg (2001) defined that qualitative approach was a method to emphasize the importance of context. This approach will help to gain comprehensive understanding of people and how they structure and give meaning to their daily lives. Therefore, a qualitative research design was carried out in four months to explore how institutionalized and individualized discourses on sex work and sex workers influenced the felt stigma of being a sex worker; shaped the cultural beliefs related to cervical cancer and screening practice among FSWs in HCMC; and impacted on their perceived of quality of health services.

I attempted to analyze based on theoretical concept of discourse which views discourse as a reflection of cultural and social reality and tried to find holistic explanations about cultural conceptions and constructions of meaning and behavior. Discourse analysis not only analyzes the content of texts in term of syntax, semantic and so on. Rather, discourse analysis involves the way in which texts themselves have been constructed in social and historical context. In discourse analysis, primary data and secondary data were used at the same time to gain objectives of this research. I interviewed FSWs and key informants; made observation at the health center; and summarized secondary data including policies and perspectives on sex work.

3.2 Site selection

I selected HCMC as a site of this research with the following reasons:

(1) The sex worker rate in HCMC is higher than other provinces (MOLISA, 2015) because HCMC is center of economy, culture and tourism. Therefore, HCMC has attracted thousands of foreign and domestic tourists. The economic development, especially in tourism requires a larger number of workers to seek jobs in this industry, and sex work is also seen as an occupation.

(2) The cervical cancer rate in Southern areas is higher than Northern areas (UNFPA, 2007; Van To, T., 2005). Although until now there is no accurate statistic of cervical cancer rate in HCMC, it was estimated that this rate was six times higher than in Ha Noi (Tuoitrenews, 2013).

(3) In the past years, HCMC authority has kept on promoting preventive programs about health for FSWs; however stigmatization still exists as a barrier or influencing-factor to their perception of health, disease and health care participation.

However, HCMC is too big for me to do research. I started to contact with government or non-government organizations to select suitable site. After I contacted with NGOs through my friends, I selected district 4 as a detail site in this research. The reasons for site selection included

(1) There is a large number of FSWs working in district 4. District 4 is one of urban districts in HCMC and is shaped like a triangle isle. District 4 is located in the Southeast gate of HCMC; bordering district 1, 2, 7 and 8; and has waterways and roads overlooking the sea. Therefore, district 4 became the focal point of sea transport which has created the commercial development of port service, shipping, transport and international and domestic transaction. In the past, district 4 was a semi-rural area. The economic life of the inhabitants was quite poor. Although district 4 and district 1 stand one river apart, the life is different. In district 4, most inhabitants were laborers, craftsmen, small traders, porters at Saigon dock warehouse. They lived in the shabby houses, poor sanitation. District 4 is known as a place of criminal, prostitution, drugs, theft, and robbery. At the present, this district has been changing. Roads have been widened, houses have been renovated, and slum areas have been demolished to build new apartments. From a poor and unsafe district, district 4 has become a potential residential area. Like district 1, many hostels, mini hotels, restaurant and beer pubs have been built. Thus, many people move here to find jobs, including sex work. However, this change also negatively affects social aspects. Although there have been

many efforts in the prevention of social evils including prostitution, these evils are still complicated. Activities associated with sex work become sophisticated and widespread.

(2) The Union Toward Future Group is located in district 4. This group is responsible for connecting and supporting FSWs in district 4 and some other districts. The activities of this group include providing free condoms, consulting HIV/AIDS or STDs for FSWs, introducing free health services related to HIV/AIDS or STDs for FSWs, supporting FSWs who want to integrate into community after detoxification or rehabilitation. Therefore, this group is a bridge between community and sex workers. Through this group, I was introduced to meet and interview FSWs. In addition, I had general understanding of FSWs and their life, especially issues of health.

3.3 Entering into research field

Entering the research field, I started with The Union Toward Future Group through my friends. One day of the beginning of July, I had made a call to set up an appointment before I met the leader of this organization. Her name is Mi. However, Mi did not reply. Then, I left a message. After an hour, I got Mi's message. Mi told me to be the person who chose place for appointment. But I let Mi set up because I needed to respect my participant's privacy and comfort. From then, my timetable was suitable with Mi's one. Sometimes, I felt disappointed because I had been waiting Mi's call or message for long hours. I eventually met Mi at 8.45 p.m. near Mi's house after a waiting hour. That was a coffee shop on the street in district 4.

I introduced myself as a student from Mahidol University and currently doing a thesis with title "An Anthropological study on cervical cancer screening among FSWs in HCMC, Vietnam". The objectives of this research were to find out socio-cultural factors including institutionalized and individual discourses on sex work and cervical cancer; beliefs about cervical cancer and screening; and perceived quality of service which significantly influence FSWs' decision on going for cervical cancer screening. After then, Mi gave me some information. Mi advised me not to call FSWs "prostitutes" because FSWs feel that they are discriminated. I should call them "sister" or "their nicknames". Mi promised to introduce me to her clients. She often calls

FSWs “clients”. She said that her group has many FSWs working at many different districts. In reality, they always move from one place to another place. Therefore, Mi would introduce me with FSWs at the first time. Later, I and my participants had appointment through Mi’s introduction. I also asked Mi for what kind of the gift should be given to FSWs. She advised me to send the remuneration for each person at least 100,000 VND (approximately 5 USD) for an hour-interview. This small amount of money was more practical for FSWs than souvenirs.

Two days later, I conducted three pilot interviews at Mi’s office. I would like to test the guideline and the way I ask participants. Three participants gave me some useful information which helped to edit the interview-guideline. However, I recognized that they had not been comfortable when they talked at Mi’s office. Although Mi arranged a quiet place for them, they were not comfortable. When they were talking, some people passed them. Mi selected this place for them because three participants were afraid to meet stranger without Mi. Therefore, her office became a place for interview. In addition, I followed four FSWs who got support small amount money for gynecological examination, including cervical cancer from Mi. I met and chat with them. After their examination, I asked them to attend in this research. A focus group discussion was conducted as a research pilot. Information was used to edit some points in the interview guideline before official interviews.

After that day, I met Mi again and suggested to be taken to the working place of FSWs. I would like to observe and draw a site map before I officially conducted. We went to some places such as: parks, beer-pubs, and female sex worker’s house. I was introduced to participants by Mi. Most participants agreed to attend my research. We set up appointments. Before I had met them, I called them first. After one week, I had three participants. Two participants are working on the street. One is working at the peer-pubs. I had made friends with them before I started to interview.

And then, Mi was so busy that she could not take me to other places. She introduced me to other person. She is Chi, the vice leader of peer educator group. From Chi’s introduction, I approached participants and used snowballing techniques to get more participants.

Most participants worked in the evening so I met them in the morning. In reality, it was difficult for me to meet participants at their working place without support from the peer-educator. Therefore, most interviews were carried out between 10 a.m. and 3 p.m. because most participants get up so late in the morning. Others do house chores and take care of their children until they go for work.

Additionally, I had observation at one big hospital and one health center. I selected these places from participants' information. Most participants said that they often go there for gynecological examination when they suffer heavy symptoms. At the big hospital, there was not cervical cancer screening. However, at the health center in district 4, they can do cervical cancer screening. Sometimes, I worked as a volunteer of peer-educator. I took FSWs to health center for gynecological examination because FSW did not have a bike. Besides, there was a good chance for me to make friend with them before inviting them in my research. While they were waiting in front of the doctor's room, I chatted with them. I asked them to attend my research. I introduced with them about my research and the benefits of participants. During data collection, rapport was always developed.

3.4 Participants recruitment process and selection criteria

Data collection was collected in four months, and that was quite limited for doing a qualitative research. Hence, the first month was for creating networks of participants and trust building with participants. Participants were recruited through the Union Toward Future Group and snowballing techniques. To FSWs, I selected those who are at 18-45 aged because they are at high risk group with cervical cancer in Vietnam. In addition, FSWs working at the different venues were also selected. Working at the different venues helped me to fully understand because each groups had own explanations. FSWs who under 18 years old or over 45 years old; those who refused to participate in this research or those who work below three years were exclusion criteria. Since the objectives of the research were to explore discourses on sex workers, the key informants including community leaders and health professionals were also recruited. This was to explore the way they think about FSWs and the

relationship between FSWs and cervical cancer, which affect cervical cancer screening practice among FSWs.

I conducted a pilot after I had contacted with the leader of the peer-educators. To gain objectives of this research, I recognized that it was necessary for me to meet various kinds of FSWs. Before I had selected participants, I made plan with different criteria because I would like to find out and understand comprehensively about cervical cancer screening practice among FSWs. I divided participants into different groups.

To criteria for venue, I suggested Mi and Chi taking me to many different venues. However, Mi and Chi were so busy that they could not take me to all venues. After one month, I had only 5 participants. Two of them are working at the peer-pub and coffee-shop; others are working on the street. Later, I tried to contact and used snowballing techniques to find more participants. Finally, I had 15 FSWs. Half of participants are working on the street or at the park. Others are working at the beer-pubs, coffee-shops, barber shop and karaoke. Especially, I met two participants who had worked abroad, but now they are working independently.

To criteria for cervical cancer screening, I also divided into two groups. One group was those who had done cervical cancer screening. The other was those who have not ever done cervical cancer screening. The difference between two groups helped me to find out socio-cultural factors affecting their decision on cervical cancer screening practice.

To health professionals, I had difficulty in approaching these subjects because I have not got acquainted with any health professionals. Later, I was introduced to two health professionals by my friends. Both of them were female doctors. Although I found a male doctor, he refused to attend my research due to his business. He could not manage to meet me. Therefore, I did not choose him as a participant.

To leader community, I met three leader communities. One is female; others are male. Especially, I invited Mi as a key informant because Mi has worked with FSWs. Mi can deeply understand about their clients. I also met a male peer-educator. He has the same Mi's job. He has worked with FSWs and HIV people for 10 years. He is also HIV person. His information was useful for me to understand and

analyze under male's perspective. It was lucky for me when I was introduced to a project manager by a peer-educator. I got useful information related to programs for FSWs in HCMC, especially health programs.

After I had had the criteria for selecting participants, I found Mi and Chi to ask for help. I was easy to meet and talk with participants. Almost participants were friendly to share their lives and information related to the aims of the research with me.

3.5 Research methods

To answer research questions fully, I used multiple qualitative methods including in-depth interview, participant-observation; key informant interviews; body mapping and secondary data. Total twenty participants were involved in this research. There were fifteen in-depth interviews, five key informants and two observations. I had also conducted three in-depth interviews and one focus group discussion as a pilot before I collected data.

3.5.1 In-depth interviews

The period of data collection lasted for four months. To achieve the objectives of research, in-depth interview with high degrees of flexibility was used. Through this method, discourses on sex work and sex worker, cultural beliefs about cervical cancer among FSWs, their felt stigma as well as their health care participation were explored. The interview guideline with the high degrees of flexibility was used. This flexibility gave me an opportunity to add some questions for rich data. Additionally, the important issues were not missed and gave the participants a chance to talk about what was important to them. The interview guideline included main topics with open-ended questions; the participants could unrestrictedly answer what they were asked.

I carried out an informal interview for an hour with jotting and the permission of audio voice recorder. I had not conducted interview as soon as I entered into field work. I recognized that it was necessary to build rapport before the interview. Furthermore, I spent time discovering social context, and the life of FSWs. I

introduced the objectives of the research, the process of using data and ethical consideration before the interview. The permission of audio voice recorder was also asked. It made the participants more comfortable and avoided hesitantly saying. All interviews were carried out between 10 a.m. and 3 p.m. because most participants went back so late. Additionally, it was dangerous for me to interview at their working place without support from the peer-educators. There were not any photos taken during the interview due to the inconvenience and privacy. The nicknames of participants were used instead of their real names. I got their permission through verbal language.

3.5.2 Participant-Observation

I carried out observation at two places. One was the Preventive Health Center, another one was Dermatological hospital. I went to health centers and played role as a patient. I used an observation guideline including setting, privacy, convenience, doctor-patient interaction and the process of cervical cancer screening. I made observation quality of health services which FSWs in this research got during cervical cancer. The data from observations such as privacy, convenience and doctor-patient interaction helped me to made clear FSWs' answer about perceived quality of health service. However, I had difficulty in getting permission from the hospital to observe the process of cervical cancer screening. Therefore, data about the process of cervical cancer screening were draw from the interview of participants. I could not take photos in the doctor's room due to privacy. I only got permission to take photos outside such as posters and news boards. Taking notes were done during observation.

3.5.3 Key- informant interviews

To build interview guidelines and get rich data, I selected someone as key informants. In this research, discourse on sex work and the relationship between sex work and cervical cancer needed to be explored under many various perspectives. Therefore, I conducted three key informants' interviews. Two interviews were for the leader of peer-groups. One was for female and another one was for male. One interview was for project manager, who gave information related to programs on sex work, especially health programs.

3.5.4 Body mapping

I also used body mapping to describe how participants perceived reproductive organs and cervical cancer. The drawings were made by participants to supplement with in-depth interview. Using body mapping promoted participants to attend into this research creatively through a more reflexive process (Solomon, 2002).

3.5.5 Secondary data analysis

Secondary data from magazines, newspaper, government of reports and laws related to discourses on sex workers, cervical cancer and cervical cancer screening were searched, collected and analyzed to answer the institutionalized discourses.

3.5.6 Field note writing

Almost field notes were written into Vietnamese after the interview and observation. I described participants, contexts, and activities in every field notes. While I was writing, I always gave relevant questions to expand themes and checked data what I collected. The information related to using methods, research tools, the advantage and disadvantage in collecting data, and my thought were written carefully. Later, these field notes were translated into English for analysis and thesis writing.

3.6 Research instruments

The research instruments included:

- 1) Interview guideline
- 2) Observation guideline
- 3) Notebook and pen for taking note
- 4) Audio voice recorder for recording
- 5) Field notes
- 6) A camera
- 7) A computer

The guidelines for interview and observation were developed from the conceptual framework. Most of them were translated into Vietnamese. During

interview and observation, the guidelines were modified to achieve comprehensive understanding. The audio voice recorder was also used to record data and store information. It was useful to check against the field note. Furthermore, it was more convenient than jumping into a taking-note during interview.

I took some photos about the Union Toward Future Group and posters related to cervical cancer and cervical cancer screening at the hospital after getting approval from group and health professionals. These photos were attached to the findings as an illustration.

The field notes were written by the research at the end of each interviews and observations.

3.7 Data processing and analysis

The research period lasted from July 2014 to March 2015. Data collection period was carried out from beginning of July to November 2014. The process of data analysis and thesis writing were done from January to March 2015.

I started to contact with the peer group as soon as I went back Vietnam. After one week, I conducted a pilot with some FSWs. After the research pilot, I made plan

The process of data collection and analysis was conducted at the same time because data analysis in qualitative research is an ongoing process, which starts from the beginning of fieldwork to the end of data collection. Research tools and guidelines had been prepared before I collected data. Interviews were carried out and field notes were taken. The interview lasted for about an hour with open-ended questions. An audio voice recorder was used to record data and store information. These audio voice recordings were transcribed, translated into English and checked against the field notes. I had reread all field notes several times before I started coding data. This helped me to understand the meaning behind the words.

The collected data were open-coded for all cases and all information related to research questions. Themes and subthemes were identified through process of open coding. Moreover, the focus of the research was discourse analysis, so coding case by case was more appropriate. This process was done manually and NVivo

version 7.0 software. Theoretical concepts of discourse by Foucault, stigma by Goffman, beliefs by Kleinman were used during analysis.

3.8 Validity of the data

3.8.1 Researcher's identity and trust building

Validity of data depends on the way researcher and participants communicate. If the space between researcher and participants is distant, information cannot be fully shared. Therefore, trust building was an important element in the research and I found ways to build trust with the informants before the interviews were conducted.

In the research, I always expressed sympathy to all participants during the interview. People say that my participants are marginalized group. Thus, I always said gently with participants. I listened to their story carefully. This was important to build trust. During the interview, sometimes the participants asked me to share my story and I was ready to reply them after interview. It made our conversation more comfortable.

3.8.2 Reflexivity

Personal bias can influence the research. To avoid a bias, I engaged in "reflexivity". Before I entered into field work, I had broken down prejudices and experiences. During the interview, I never interrupted when my participants were talking. Sometimes, I was asked by the participants. However, I shared my experience or knowledge with the participants at the end of the interview. I recognized that during the interview, my explanations about cervical cancer or consideration of sex work made the participants be influenced by what I told.

3.8.3 Triangulation

Triangulation is the combination of two or more data types, methods or theories so that diverse standpoints cast light upon a topic. It is considered as appropriate strategy of founding credibility of qualitative approach. There are four forms of triangulation: data triangulation (retrieve data from different sources to form

one body of data), investigator triangulation (refers to using multiple observers in term of gathering and interpreting data), theoretical triangulation (involves using more than one theoretical perspective in interpreting data) and methodological triangulation (involves using more than one research method or data collection technique). These types of triangulation can be used at the same time in a study; it depends on the purpose of study. Triangulation helps the researchers overcome the weakness or intrinsic biases and the problems that come from single method; single theory studies (Yeasmin & Rahman, 2012).

In this research, I used triangulation that included interviews and participant observation. Using this method of triangulation helped me have an in-depth understanding of cervical cancer screening practice among FSWs. Especially; the interpretation on perceived of quality of health service should be made by interview and observation. In addition, I could check information throughout the combination of interview and observation. Theoretical triangulation was also used. By combining the explanatory model of disease and post-structuralism on discourse, I clearly explained the attendance of cervical cancer screening among FSWs.

3.9 Ethical consideration

3.9.1 Privacy

I let almost participants choose the place that gave privacy and comfort during interview. Ten of fifteen interviews were carried out at the coffee-shop in district 3. The room looked like a karaoke room. It was soundproofed. During the interview, only the participant and I were together. Nobody was inside to interrupt us. Other interviews were conducted in the park where the participants were waiting for their clients. I also carried out two interviews at the participants' house.

All data about participants and what they had answered were privately kept and were only used for this research. I have not shared any data with other people. All data will be destroyed after I have finished using the data for thesis and paper writing.

3.9.2 Confidentiality

Elliot (2005) considered that the protection of the privacy to those who participate in the research is a key ethical principle for the researcher. Therefore, all information about participants such as their name, where they live and work were kept confidential. Their names were replaced with pseudonyms which FSWs allowed me to use in this study. I kept all data from field notes in a locked cabinet for safety and privacy. The process of collection, transcribing, diary analysis and translation were done.

3.9.3 Informed consent

The participants were introduced to the objectives of the research and my role in this study. I always asked for permission from my participants to record the interview after I had explained the reason why I used audio voice recorder. I also explained that all participants could refuse to answer my questions or withdraw from this study any time if they felt uncomfortable. Before the beginning of all interviews and observation, I always asked participants read and sign into the informed consent paper. However, it was difficult for the participants to sign into the paper although they agreed to participate in the research. They would not like to show their identity. Therefore, instead of signature, verbal consent was accepted between me and the participants.

3.9.4 Benefit and reciprocity

After each interview, I gave 100,000 VND (approximately 5 USD) to my participants as a thank you for their willingness to share their stories in the study. In addition, FSWs also had a chance to not only share about their thoughts and feelings but also information related to cervical cancer screening. Because most participants did not know the place for cervical cancer screening, I shared these addresses with them. At the end of interview, I also answered all participants' questions.

CHAPTER IV

RESEARCH FINDINGS

4.1 General context of HCMC

HCMC, formerly named Saigon, is the most populous city and is also the center of economy-culture-education in Vietnam. On the basis of the natural area, HCMC is the second largest urban of Vietnam besides Ha Noi. Currently, HCMC and Ha Noi are great urban centers of Vietnam. This area was originally known as Prey Nokor, an important Khmer sea port prior to annexation by the Vietnamese in the 17th century. In 1698, Nguyen Huu Canh, a Vietnamese noble, established Gia Dinh Province, marking the form of the city. Saigon was established and quickly grew to be one of the most important urban in Vietnam since French colony. In the past, Saigon was known as “The Pearl of Far East” and the capital of French colony of Indochina. The Vietnamese National Assembly decided to rename Saigon “HCMC” on July 2, 1976.

Located in the transitional zone between the South East and South West, HCMC today consists of 19 inner districts and 5 suburban districts. The total area is 2,095.06 km². According to the official census in 2009, the population of HCMC was 7,162,864 people accounted for 8.34% of Vietnam’s population. By 2013, the city’s population rose to 7,818,200 people, excluding unregistered residents. Being an important role in the Vietnamese economy, HCMC accounted for 21.3% of total gross domestic product (GDP) and 29.38% of the total revenue in the national budget. Due to favorable natural condition, HCMC became an important transport hub of Vietnam and Southeast Asia including road, rail, waterways and air.

In the past, Vietnamese government implemented the closed-door policy. Until 1986, Vietnam Congress reformed a new economic-political-social changes policy, it was called “Doi moi” (literally means “renovation” program). This reform marked the end of the lag in production and inflation. “Doi moi” has been very successful in transforming Vietnam from a centrally planned economy to socialist-

oriented market economy (Axel & Katja, 2008; Khuat, Le & Nguyen, 2009). HCMC became a key economic zone in southern. Together with the other socialist countries, Vietnam integrated World Trade Organization in 2006. Vietnamese government has actively established new relationships with other countries in the field of foreign trade and investment (Tuan & Giang, 2013). There is some evidence that HCMC is considered as a center of economy-culture-education (Tuan & Giang, 2013; Khuat, Le & Nguyen, 2009).

However, HCMC is facing with the problems in a large urban and quickly growing population (Teriman, Yigitcanlar & Mayere, 2009). In the inner of city, the roads become overloaded with a lot of traffic jams. Public transport system is inefficient. Environment is polluted by transportation, constructions and manufacturing industries. Also, with a large population and a large amount of non-resident, HCMC has generated a great demand for health and wellness. The social evils such as sex work, drugs, and environmental pollution cause a major influence on population health city. Infectious diseases in developing countries such as malaria, dengue fever, cholera, typhoid or disease of the industrialized countries such as heart disease, hypertension, cancer, mental and occupational diseases have appeared in HCMC.



Figure 4.1 Map of HCMC

In the past twenty years, there is less attention to the increase of sex work in this globalizing country (Megan, 2011). Although Vietnamese government implemented policy to regulate sex work during the past many centuries, sex work still exists and becomes more complicated. From 1975 to 1980, sex work in HCMC decreased markedly with 80% in total over 100,000 FSWs which were counted until April 1975. However, sex work gradually increased from 1980 to 1990. This was a negative consequence resulting from the development of economy during Doi Moi period. According to Professor Bui Thi Kim Quy has recognized that sex work has increased in Vietnam immediately after Doi Moi policy. In 2001, HCMC had about 15,000 FSWs; and mostly they were migrants from rural areas (MOLISA, 2009). According to Department of Social Evils, there were approximately 200,000 Vietnamese women entering into sex work (CATW, 2005). Age for sex work was under 25 years old. The majority of FSWs have changed their working places within

past 10 years due to looking for new clients, avoiding police raids and stigma (MOLISA, 2009).

Together with the reforms related to economy, Vietnamese authority also launched a mission of anti-social evils at the Fifth Party Congress in 1991. The city's authority insisted that "social evils such as sex work, drugs, robbery, superstition, and the pavement life are pushed back in order to clean up the society." (Lam, 2009) According to the Ministry of Labor, Invalids and Social Affairs, sex work and crime related to sex work are complicated and volatile in each city. The number of sex workers tended to increase; brothels and dens of sex work still exist; especially disguised sex work in the business services. The risk of HIV/AIDS and other sexually transmitted diseases are growing due to unsafe sex, especially with the emergence of male sex work and men sex with men. In addition, sex work is synonymous with drugs and crime, so the prevention of sex work is the responsibility of the whole society. HCMC is one of the cities where sex work is complicated and has a rather high number of sex workers in comparison with other provinces in Vietnam. The increase of sex work is leading to many social consequences such as sex work and unsafe sex are at the risk of HIV and other infectious diseases. The authority in HCMC also set up "target program for three reduction" including reducing crime, drugs and sex work in 2000. This is one of twelve key programs in HCMC. With common perspective, sex work is a serious social evil. It causes negative consequences such as moral corruption and HIV/AIDS transmission which affect the order of society. Therefore, sex work is prohibited in any forms (VNA, 2003).

Under the previous regulations, sex workers being arrested would be sent to the Labor-Education centers or mandatory medical establishments. However, a new policy entitled "Law on Handing of Administrative Violation" has been implemented on 1st July 2013. Sex workers only pay a fine for administrative sanctions and return to the local communities for integration. The reason for this is to promote sex workers' voluntary to give up their work. In fact, there are very few sex workers integrating into community after being arrested. Therefore, sex work is still a serious social evil in HCMC as well as the whole Vietnam.

4.2 Sex work in HCMC

Sex work is defined as the practice of engaging in sexual relations in exchange for payment or some other benefits. There are many different perspectives on sex work in the world. Some countries recognized sex work as a job like Netherland. Others have not recognized sex work as a job yet, including Vietnam.

4.2.1 History of sex work in HCMC

In Vietnam, sex work has emerged for a long time and constantly evolving. Until now, there are no accurate data about the number of sex work. According to the Vietnamese government, there are estimated 30,000 sex workers. In the feudal period, sex work was not prevalent in Vietnam due to strict hierarchy, moral standards and customs.

Along with the establishment of military stations at different areas, sex work in Southeast Asia developed rapidly during the French colonial period and the Vietnam War. By the time the French colonial, policies of colonization as well as conspiracy to degenerate were set up by French colony which made sex work become popular (Kay Hoang, 2010). Issues related to sex work were published in newspaper in 1929. In the 1930s, sex work became a serious problem in Vietnamese society. The rate of syphilis increased dramatically (Guenel, 1997). In 1933, a big hospital in Saigon (a different name of HCMC) reported that there were more than 20,000 people who were treated syphilis. At that time, there were two types of FSWs. One type had a license and paid taxes to the colonial government. Another was “*gái lậu*” who evaded taxes. Most FSWs in Vietnam did not have licenses and found clients by themselves, because sex work was seen as immoral acts. Therefore, both FSWs and clients disclosed. During this time, the Communist Party of Vietnam built the policies “against polygamy, opposed the maintenance and taking advantage of sex workers to collect tax of French government” (The Community Party of Vietnamese, 1999). Therefore, the slogans such as “anti-prostitutes or advocate women’s participation in the struggle for national liberation, building a civilized society and equality” were spout in the newspapers and leaflets. This is considered as the most practical way to eliminate FSWs in the society, improve women’s status and respect for their dignity. Overall, sex work in Vietnam developed with French colony to serve colonists

whereas Vietnamese got used to living mostly in the countryside before the French colonialism. The development of urban centers, the headquarters of the administrative apparatus, commercial and financial state of the colony not only promoted the upheaval in the economic structure of the country but also made the increase of sex work (Kay Hoang, 2010).

In Southern Vietnam, most brothels were shut down and pimps were fined during 1959 to 1962. Thus, the organized prostitutes seemed to be extinguished. And by the end of 1960, there were about brothels existed in Saigon. During the Vietnam War, the policies of the United State Department of Defense attempted to control sex work wherever possible. However until 1960s, the management of the American societal became more flexible, the prostitutes re-emerged. In the period 1960-1975, millions of American expeditionary troops flooded into Vietnam during the Vietnam War. Since then, the providing goods and services including pimps, prostitutes, dancing girls or call girls to Americans developed (Kay Hoang, 2010; Tournier, 2008). The economic gap led to the overturning of traditional moral values. To please the expeditionary army, The United State – Ngo Dinh Diem allowed opening a series of bars, saunas, nightclubs, and especially brothels. There were estimated around 100,000 women engaged in sex industry (Kay Hoang, 2010).

Especially Vietnam entered a period of innovation, integration market economy, the interference of the cultures since 1986; sex work has become a complex phenomenon. Based on report on anti-sex work in 2013, there were estimated 30,000 sex workers in Vietnam, mostly women. However, some NGOs estimated that there were up to 300,000 in the country, including those who engaged in sex work part-time or seasonally. Among this figure, only 9,000 FSWs have documentary management. Many of the FSWs are quite young and under 18 years old.

4.2.2 Ways into sex work

Most female sex workers conceded that they entered into sex work due to economic burden. However, based on statistics in 2012 after a survey in Ha Noi, Hai Phong and HCMC, Ministry of Labor, Invalids and Social Affairs (MOLISA) reported that the majority of FSWs have average family background (42,4% poor family; 52.2% average family and 2.4% rich family). In line with economic burden, 27,6%

FSWs entered into sex work by friends' enticement. 63,9% FSWs were dragged by the other FSWs. Only 6% were tricked or forced. 51% FSWs have an addiction to heroin. Thus, they work as FSWs to earn money for feeding their drug addiction (MOLISA, 2012).

This is similar with our research. Most FSWs reported that they have difficulties in raising their family or children due to miserable family, a broken marriage or unstable job in their hometown. For example, Linh, a sex worker who has worked in the beer pub more than 15 years, narrated her story that she is the eldest in her family. After her father had died, her family had big difficulty because she had many siblings. Her mother could not raise them without her help. And then, she recognized that she had to take responsibility to help her mother for earning money to raise other younger sisters and brothers. She said that "*I could not stand deprivation when I looked at my younger brothers and sisters*". Therefore, she decided to work as a FSW through her friend's introduction. This case implies that Linh entered into sex work as a daughter of the family so that she could earn much money for her family while some other FSWs in this study worked as sex workers to earn money for their own family. For instance, Van, who has worked at the beer pub during past 8 years, is a single mother with two children. She must make money to take care of her children after her broken marriage. Van came from a miserable family. However, in the past, she had worked as a sex work before she married with a security guard. She entered into sex work due to her own life and friend's enticements instead of supporting her original family. And then she got married and stopped working. However she started working again after her broken marriage so that she could earn money for her children. She said that she tried to do some works, but it was not enough for her to cover daily things. Therefore, she chose sex work because it was too easy to get money without any requirements. In Van's story, it is easy to recognize that she entered not only due to being enticed by her friends but also due to family responsibility. This may reflect that friends or peers considerably influence on decision to enter into sex work.

Based on report of MOLISA in 2012, the researchers indicated that some FSWs had been burden with a debt before they entered into sex work. They choose sex work as the most way to earn much money and pay off their debt. Among the

participants, the researcher met Mai, who had a debt and used heroin. Thus, she worked as a female sex worker to settle her debt.

“Frankly, I had a debt and used heroin so I chose this job. I wanted to earn money to pay off and meet my heroin. And then, I detoxified and no longer used it. Until now, I have had a debt because my life is too difficult to pay off. Therefore, I cannot give up this job.” (Mai, working on the street)

Overall, the researcher found the similarities ways into sex work compared with a report of MOLISA in 2012. The researcher recognized that reasons for entering into sex work are the combination of individual reasons and reasons relating to family and friends.

4.2.3 Types of sex workers

There are various types of sex workers. According to Kay Hoang (2010), she reported that there are three types of sex workers in HCMC such as low-end sector; mid-range sector and high-range sector (Kay Hoang, 2010). The women in the low-end sector cater mainly to Vietnamese clients. Among types of FSWs, they are the lowest paid, they often have a short and quick interaction with their clients, and they involve in the forms of oppressive emotional labor (Xiao, 2009). For FSWs in the mid-range sector, they often cater to white men in the backpacker’s districts. In contrast, FSWs in the high-range sector are those who cater to overseas Vietnamese men and are the highest paid.

The form of sex work activities are varied and complex, especially the development of informational technology and globalization. According to the Department of Social Evils Prevention, the development of new industrial zones in the suburban has transferred agricultural lands to catering business such as coffee, soft drinks, massages and motels. However, in fact, this is illegal business. Based on the working place or the activities, FSWs are divided into many types. Streetwalkers are known as those who catch clients on the street. Depending on the circumstances, they can have sex in public places such as parks, lawns, bushes, benches in the shop coffee or in a private room. They often earn little money and face more exploitation and vulnerability. Another type is those who working at the beer pubs, barber shops, saunas, massage parlors, and coffee shops. They negotiate with clients as working.

They sometimes engage in sex at the workplace or other venues such as hotels and motels. They can be classified into medium sector where they earn money from low to moderate salaries. Especially, sex work changed to complex trend since the development of informational technology. “Call girls” are increasing. The management of sex work in the form of call girls has been industrialized throughout modern media such as mobile phones, internet, websites or forum. These independent escorts often advertise their service online. They earn much money and keep their profits as they are self-employed.



Figure 4.2 Female sex work is catching a client on the street.

Source: Tienphong newspaper

4.3 Social characteristics of informants

The FSWs in this study are 20-44 years old. Most of them were divorced. Only three of 15 FSWs are single. Two – third of FSWs had children, and majority of children lived with them. There are only three cases that children are living with grandparent or other relatives. The time spent in sex work ranged from 3 to 25 years. They have worked at many different places such as: street, beer pubs, barber shop,

karaoke, coffee shop and brothel. According to Kay Hoang (2010), the classification of types of sex workers, they are all in low-end sector because their clients mostly are Vietnamese men and they get low price.

Also, most of them come from rural areas largely due to poor conditions and unstable job. Two – third of participants used to inject heroin, while one – third (30%) got HIV disease. Some participants have been sent to the Labor-Education centers. Half of the participants entered into sex work due to economic situation. Other participants were enticed into sex work by friends or the other FSWs. Only a participant was raped when she was young. She was rejected by her family, so she decided to work as a female sex worker. Besides, almost FSWs suffered prolonged white blood. HIV, STDs and cancer were kinds of diseases FSWs concerned. They thought that HIV and cancer lead to death sooner or later. For sexually transmitted diseases, they cannot control due to their job. They said that although they try to have safer sex, they are still transmitted by their clients due to low negotiation power for using condom with boyfriends or acquainted clients. These social characteristics of FSWs in this study are the same result in a study on “Sex work and Mobility from a gender perspective” in three cities in Vietnam (MOLISA, 2012).

In this part, the researcher divided all participants into two groups to describe the context of participants in detail. This helps the researcher gain comprehensive understanding of each participant’s situation and individual behavior. One is those who work on the street. Another is those who work at the shop, including barber shops, coffee shops, brothels, karaoke shops and beer-pubs. There are six FSWs working on the street, including Binh, Hong, Mai, Thanh, Uyen and Xinh. Among this group, Uyen is seen to be the youngest FSWs at 20 years old and has worked on the street for three years. She is also a migrant from Cai Be province, one of Southern provinces. Uyen entered into sex work after she was raped by your friend’s uncle. Her family rejected her after they had heard this news. They rejected her because her father-in-law would like to introduce her with Taiwanese men for marriage. However, she lost her virginity. After she had been got out of home, she was so sad and followed her friend. She started using heroin. Therefore, she needed money to raise herself. Binh, Hong and Mai have the same situation. They do not live with their husband due to divorce or widow. They have worked in near 10 years. They are non-residents, they

come from another province. Both of them have children. Binh's son is living with her parents in her hometown. Hong and Mai's children are living with them in lodging room. They entered into sex work due to poor situation, unstable job and debt. They saw their neighbors to become richer after moving into HCMC. Therefore, they decided to move into HCMC to find another job. For Xinh, she is the eldest in this group. Her family settled in United State of America. She has worked as a female sex worker when she was 28 years old. When she was young, her family had difficult situation because her father was rehabilitated. She helped her mother to support her family. She tried to work many jobs, but it was not enough. She was introduced by her friends and she started working this job to earn much money. She was sent to Labor-Education school two times for working as a female sex worker. She married and had two children. After she had come back from Labor-Education school, her family advised her not to quit this job. And then they would take her to America in order to live with them. However, she could not leave this job due to her bad karma. And she had to stay in Vietnam to take care of her children. Her younger sister took care of her children when she was in the Labor-Education school at the second time. However, she felt stigma and being rejected due to attitudes and behaviors of her younger sister and her son. Her daughter is studying in America with her parents. Consequently, she left home and continued working. Now she rent room and lived alone. In this group, most participants have not ever done cervical cancer screening. Only Binh and Mai did cervical cancer screening during last year (2014). They reported that they had suffered white blood discharge and itching in the past. Especially, Xinh got syphilis when she was young. However she was treated successfully in the Labor-Education school.

Another group consists of Linh, Loan, Ngoan, Nguyet, Quyen, Thoa, Thuy, Tuyet and Van. The reasons for sex work are to make money for raising their family, drug addiction or paying a debt. In this group, Ngoan and Tuyet used heroin and were sent to rehabilitation center. Both of them had worked in the karaoke to make money for drug addiction. Now, Ngoan works independently while Tuyet is working in another karaoke shop. Especially, in this group, Loan had worked abroad in many years. She is growing old, thus she cannot worked abroad. Thus, she returned Vietnam and has worked independently. As short description above, Linh entered into sex work due to the responsibility of daughter in her family. Linh moved many

workplaces to look for new clients. In the past, she worked in the beer pub on the pavement, but now she works independently because she has many regular clients and she does not want to be managed by boss. In addition, in this group, case of Thoa is different from other people who work as sex worker to earn money for supporting family, drug addiction or paying a debt. Thoa worked because she wanted to enjoy her life. She did not want to be depended on her family. Her family is not as poor as other FSWs' families. However she would like to earn money by herself and enjoy it when she goes outside with her friends. Therefore, she accepted as soon as her friend made suggestion to work as a female sex worker. However, at the first time, she just worked as a waitress at the beer pub through her friend's introduction. After working for a long time, she saw her colleagues going outside with clients and getting much money. Thus, she started following her colleagues. After working, she will go outside with clients if suggested (Table 4.1).

Because most participants work in low-end and medium-end sectors which include street, barber shops, karaoke shops, beer pubs, coffee shops, massage and brothels, their income is not stable. Some participants who work at entertainment areas said that average monthly their income is about 400 – 500 USD. They do not have fixed salary, they only get bonus from clients for drinking beer, massage or arousing client's sexual desire. It is around 5-10 USD/table. However, sometimes, they do not get any tips from their clients. They also accept because they cannot ask their clients to give it. Thus, they must go outside with clients after finish drinking. They often have one or two clients after working. As usual, they get 25 USD for going outside with a client. However, they give 7-10 USD to pimps because pimps introduce clients to them and allow them to go outside. This implies that sometimes they do not have enough money to cover daily things because some days they cannot find any clients and any tips. For FSWs working on the street, they also have unstable income. The price for going outside depends on their appearance and age. Thus, the old FSWs said that they find more difficulties in catching clients than the younger FSWs. Some days, they cannot find any clients. Therefore, they must save money to spend for next days. Especially, some FSWs in this study said that they have debts. It means that they have more difficulties than those who do not have debts.

Daily lives of participants

Most participants said that their job started in this evening, around 4 p.m. It lasts until midnight. They often go home with tiredness. To FSWs who do not have family or children, they can go outside overnight with clients. However, those who have children living with them, they give sex service for the client in their working place and seldom go outside with the client for sex because they fear of being disclosed. Their children may have disrespect for them or feel ashamed of their job. In the morning, they often stay at home, do house chores or take care of their children. Therefore, they seldom communicate with their neighbors. Unless participants meet their neighbors, they do not actively communicate with their neighbors. They said that they often refuse programs of the Women Union because they need to relax after working hard. Also, they do not meet strangers because they fear of being arrested. This explains the importance of peer-educators' role. Most participants asserted that I would have more difficulties in meeting them without peer-educators' introduction.

At present, the development of technology contributes into complicated phenomena of sex work. Participants, especially those who work independently, said that they do not catch clients on the street anymore because they have network and several acquainted clients during their job. Thus, they only go outside when they get their client's phone. Sometimes, they still work in the morning if requested. Also, some old FSWs said that at present, it is more difficult to find a client than in the past due to competition. A large number of sex workers are increasing; many beer-pubs, karaoke, barber shop and other entertainment areas have been increasing. Consequently, they face competition and they lost income. Participants said that although they perceived risks and disadvantages when they had chosen sex work, sometimes they felt very tired. They must face many things such as violence, economic burden and health risks. This implies that their live is very complicated. They constantly struggle to survive.

Table 4.1 Social characteristics of informants

No	Case	Age	Married status	Hometown	Years of sex work	Working place	Income (per month)
1	Binh	31	Widow	Nha Trang	10 years	Street	300-350 USD
2	Hong	34	Divorce	Tra Vinh	11 years	Street	N/A
3	Linh	41	Divorce	Long An	More than 15 years	Beer pub, freelancer	400-500 USD
4	Loan	35	Divorce	Binh Duong	10 years	Bar, freelance	About 600 USD
5	Mai	34	Divorce	Vinh Long	8 years	Street	N/A
6	Ngoan	33	Divorce	Long An	12 years	Karaoke, freelance	About 400 USD
7	Nguyet	44	Divorce	Khanh Hoa	More than 20 years	Baber shop, freelance	N/A
8	Quyten	30	Married	HCMC	More than 10 years	Freelance	N/A
9	Thanh	28	Single	Can Tho	More than 10 years	Street	About 300 USD
10	Thoa	27	Single	Khanh Hoa	5 years	Beer pub	About 400 USD
11	Thuy	39	Widow	Quang Tri	Near 10 years	Coffee shop	N/A

Table 4.1 Social characteristics of informants (cont.)

No	Case	Age	Married status	Hometown	Years of sex work	Working place	Income (per month)
12	Tuyet	29	Divorce	Nha Trang	13 years	Brothel, karaoke	N/A
13	Uyen	20	Single	Cai Be	3 years	Street	N/A
14	Van	33	Divorce	HCMC	More than 10 years	Beer-pub	400-500 USD
15	Xinh	43	Divorce	HCMC	Near 15 years	Street	200-300 USD

4.4 Discourses on sex work, sex workers

Sex work has not been recognized by the Vietnamese society. Although there are many positive changes, FSWs still face deep-rooted prejudices. There are discourses and languages around FSWs. Sex worker is considered to be social evil against the moral and traditional customs and habits of the nation which lead to serious consequences for FSWs and the social security. In daily life, most people call them “*gái mại dâm*” (“*gái*” means girl, “*mại dâm*” means selling sex. “*gái mại dâm*” refers a girl who selling sex to other people; “*đĩ*” (it means a woman who have sex with multiple sexual partners, except her husband) and “*buôn hoa bán phấn*” (it means that a woman use her beauty and seduction to earn money). All these words refer a woman who loses traditional values, who does sinful acts, who makes other people’s families unhappy, who have adulterous liaison. Many people believe that sex work is available for those who do not have educational levels and skillful jobs. Especially, sex worker is considered to be a source of transmitted diseases due to their habits of unsafe sex. They are easy to get any diseases and transmit to their clients during intercourse.

4.4.1 Institutional discourses

4.4.1.1 Sex work as social evils and the sources of diseases

In Vietnam, sex work was officially mentioned since HIV/AIDS epidemic occurred. Sex work is seen as illegal status and social evils. It not only damages habits and traditional customs but also influence on the socio-cultural aspects and causes AIDS epidemic. Therefore, Vietnamese government has attempted to eliminate sex work. This was set out in the legislation as sex work prevention ordinance No 10/2003/PL-UBTVQH11 and resolution 05/CP dated 29/01/1993.

“Prostitution and drugs are social evils against the moral and traditional customs and habits of the nation, which bring negative influences on the health, offspring, material and spiritual life of the people and social security, which cause serious consequences for subsequent generations. All forms of these social evils should be prevented and violating person should be severely punished”

Before 2012, there were Labor-Education centers in Vietnam. When FSWs were arrested, they would be sent to these centers so that they were

educated, trained and amended their ways for a better future. Taking FSWs to the Labor-Education centers strengthen authority's perspective on sex work. Sex work is a social evil which need eliminating to ensure the order of society. Although these centers were closed two years ago, the anti-FSWs campaigns have been still conducted.

From authoritative discourse on sex work, FSWs are also constructed. For instance, FSWs are seen as the sources of STDs or HIV/AIDS epidemic under medical perspectives. Tuyet, a key informant as well as a female doctor has 13 experiment years with obstetrics and gynecology, said that

“It has not been recognized as a job in Vietnamese society because there is nothing to be mentioned in the law. When they are not recognized, they often work surreptitiously. Some FSWs have unsafe sex, thus it is easy to be transmitted. Or others are transmitted by their clients. In general, they encounter pitiful situation.”

Another female doctor, who worked as an educator in many years ago, agreed with Tuyet's opinion. She suggested that the authorities should set up many programs to promote disease prevention for FSWs instead of controlling or managing them. As the following quote:

“Generally, for social aspect, Vietnamese society has not considered sex work as a job. Or even there is not a law recognizing sex work. Working into sex industry means that FSWs are breaking the law. Sex work is very difficult to control and eliminate. Thus, unless the authorities are more likely to control or eliminate them, they should give adequacy information related to how to protect themselves and the community.”

4.4.1.2 Sex work as bad karma

In religious regulations, although sex work has not been described and put into regulations, some issues related to obscenity have been mentioned. In the moral foundation of Buddhists, “do not commit adultery” reflects the spirit of mutual respect in the relationship emotionally couples, especially married life. In other words, human beings should have normal attitude and behavior, should not commit adultery. This refers that men and women had better not have illegitimate sexual expression because it can make emotional breakdown, notorious for themselves

and their family. To protect happiness, ensure social order and safety and reduce social evils, it is essential not to commit adultery.

With the right view, the Buddha said that human beings are living in the world of passion. It means that people live with full of desire, fallen in love and sexual desire. However, the theory of causality and Buddhism karma also asserts that man is the owner of his karma. In Hinduism and Buddhism, karma is defined as “person’s a bad or good action which is believed to decide the nature of the person’s next life”. In reality, Buddhist belief in karma influences Vietnamese culture and lifestyle. Therefore, being sex worker is ethical consequence of previous transgression. As a key informant as well as a Buddhist monk said that being a female sex worker means they must have got transgression in their previous incarnation. Now FSWs must get stigma, discrimination from other people as a bad karma. They may suffer this situation until their karma end. However, key informant did not confirm exactly what their transgression was in previous incarnation.

4.4.1.3 Sex worker as a promiscuous woman

Sexuality in Vietnam is considered as a sensitive topic or a taboo (Khuat et.al, 2009). Although the development of economy and technology affect the perspective on sexuality, Vietnamese sexuality culture is still influenced by Confucian ideas which emphasize the cultivation of virtuous conduct. Confucian models set up social norms to guide a person’s behavior in the daily life (Go et al., 2002; Khuát et al., 2009). Based on Confucian ideas, women are expected to possess “tứ đức” (was literally called “The four Virtues”) and “tam tòng” literally called “the three obedient”. Women will be blamed as promiscuous women due to her extra-marital or premarital. They lose traditional cultural values which constructed feminine virtue (Go et al., 2002). A key informant, who work as a peer-educator, said that

“People often call prostitute “gái bán hoa”, “buôn hoa bán phần” (girls selling flowers or her beauty – euphemism for using her body and seductive to earn money). These words are derived from the ancient period. It means that the prejudices appeared in the past, not in today. The old people had a deep-rooted prejudice on sex work and female sex worker.”
(Hai, a male peer-educator has worked with FSWs for over 10 years)

In his opinion, based on cultural construction about feminine, he also described how FSWs' dignity was.

“From social prejudices, people considered FSWs to be immoral women because they made other people's family breakdown. Overall, the virtuous woman is a faithful woman with her husband, taking care of their family, treat husband and children with kindness. For FSWs, people often see them as concubines for many men. This means that those who do not have a proper husband sell their body to make money. Thus, they are working illegally because this society has not recognized their work.” (Hai, a male peer-educator has worked with FSWs for over 10 years)

4.4.2 Individual discourses

Most FSWs also described about their job. In their story, individual discourses are belonging to institutionalized discourses. This means that institutionalized discourses constructed female sex worker's identity. However, they also gave some explanations and arguments. Their discourses surround themes such as sex work is a job to get money easily; sex work is an unstable job; sex worker is not immoral woman; and sex work is a job to meet men's sexual desire.

4.4.2.1 Sex work is a livelihood strategy but unstable job

Each FSWs has own reason for entering into sex work. Some FSWs chose it due to economic burden. They could not find a stable job in their home. Or even they had a job, but it was not enough for them to cover daily things. In this study, a common situation of FSWs is miserable family, a lot of siblings, or broken marriage. They need money to spend expenditure for daily life. They chose sex work as a job because they could earn much money than other jobs. They also have flexible time. FSWs said that sex work is easy to get much money without requirements. Most FSWs believed that any jobs also require educational level, professional skills, working hard or money. They believed that those who have high education, they seldom choose sex work as a job. To get a stable job with reasonable salary, FSWs need to have a professional skill. Or even, they will give a job agency an amount of money. But, in fact, they do not have enough money to do that. In this study, some FSWs also said that before they worked as sex workers, they had done another job

such as waitresses, vendors or female workers at the factory. Although those works did not require them to have high educational levels or professional skills; salary was not enough for them to survive. Thus, they chose sex work as an alternative job which they could earn much more money. When asked “why did not you choose another job?”, most answers are due to money. For instance, Binh compared her sex work with a previous work. Before she had worked as a female sex worker, she was a waitress. She got fixed salary but the expenditure was not enough. On the other hand, sex work makes her much more money than waitress. Someday, she can catch many clients, about 700,000 – 800,000 VND per day (35-40 USD), her income is about 6,000,000 – 7,000,000 VND per month (300 – 350 USD). But the salary for waitress was 3,000,000 VND per month (150 USD). It means that she got 100,000 VND per day (5 USD) on average. It was not enough for her to cover daily demands. Other FSWs also said that unless they lived alone, fixed salary would not be enough for them. They said that they not only live for themselves but also for their family or their children.

As Hong said, *“If I just work and raise myself, salary may be enough for me. But I have family and support my mother; fixed salary is never enough for all of us.”*

Together with money, flexible time is mentioned when participants explained the reasons why they chose sex work as a livelihood. FSWs, especially FSWs are working on the street, said that they can have days-off when they feel tired. They will not be scared to be scolded by their boss. In addition, they have much free time due to the characteristic of their job. They often have free time in the morning. Some FSWs who live with their children or their family, said that they spend free time to take care of their family and children. They can cook, clean house, wash clothes, or take their children to school.

Therefore, it is easy to recognize that sex work is effective livelihood due to high income, flexible time and no requirements relating to educational levels, professional skill or starting capital.

Although sex work helps FSWs easily earn much more money, most participants said that sex work is not stable job. In this study, all participants used “*lóc*” to refer days when they cannot find any clients. It implies their income depends on clients and it is unstable. Some days they can earn much money, but

sometimes they cannot earn money. Moreover, unstable job also means that they often change their workplaces due to police raids and looking for new clients. Their mobility makes them more vulnerable in accessing health service or programs. Consequently, most FSWs considered sex work as a temporary job. They attempt to make money as much as they can. And then, they save money to change another job which helps them to survive without debt. Many FSWs in this study planned a hopeful future. They would like to work and save money for a small shop.

Based on FSWs' stories, it is clear that FSWs still face many difficulties in their job. This implies that they also need much attention to reduce vulnerability.

4.4.2.2. Sex worker is moral woman

As the researcher mentioned, most FSWs entered into sex work with many different reasons and routes. At one level, FSWs said that they do not lose traditional customs value. Although they work as a female sex worker, they work this because of their family or children. In Vietnamese tradition, women are expected to be a good mother, wife or daughter. Women have to take care of their family; sacrifice for family, husband and family. Although FSWs did not consider themselves as a good mother, wife or daughter; they often insisted that they are not immoral women. They earn money for their family and children. Some FSWs said that at one aspect, they are dutiful daughters. They also spend time to take care of their family and children.

Quyen, a female sex worker independently working, said that sometimes she mocked herself. She thought that sex work is available for poor women at the rural or remote areas while she comes from HCMC. She had 10th grade. However she did not believe that she had been a female sex worker. For her, she must work to earn much money for her mother, husband and child.

“About 10 years ago, I entered into this job. And then, I stopped for a long time but now I must return because of difficult situation. My mother needs money to treat breast cancer at the last stage.”

Also, FSWs who have children talked about their children during the interview. For them, their children are motivation for them to quit their job. They often thought of their children. They were afraid to make their children ashamed.

Therefore, they tried to conceal as they could. They do not want their children to know their job so that they can maintain image of being a good mother. Thuy, a female sex worker working at the coffee shop, had a son at 17 years old. She worried that she could not teach him and his wife if they knew about her job.

“I am fear to be arrested and fined because my son will know what job his mother does. And then, he will be ashamed of my job. Moreover, it is very difficult for me to teach my child, especially he is a boy. After he marries, I cannot teach his wife. Maybe he says that “Ur, you were a prostitute in the past. You do not have right to teach my wife.””

In addition, most people and medical professionals believe that sex worker is a source of transmitted diseases. Although FSWs know about this, they considered that they were a good sexual partner. They always convince their clients to use condoms during intercourse. They were afraid to transmit to their clients and family of clients. They also thought using condoms protects not only their clients but also themselves. Some old FSWs said that there was a marked change of using condoms. At the present, the rate of using condoms is higher than in the past.

Xinh, the old female sex worker working on the street, said that *“I see that young FSWs use more condoms than we did. I suffered syphilis in the past and I thought that I was transmitted by clients due to having sex without condoms.”*

Binh, Mai, Thanh, Thuy and Van also said that some clients did not like to use condoms during intercourse. Their clients believed that condoms made them unpleased. Sometimes, their clients agreed to use condoms before having sex. However, they suddenly threw it away during intercourse. Fewer FSWs still continued because they did not know the way to reflect with their clients. Or even fewer FSWs accepted due to client's tips. However a large number of FSWs, especially those who worked for a long time, attempted to persuade their clients. They often said that

“Dear, nowadays there are many diseases. I do not know whether you have disease or not, or vice versa. I want better for both. You go outside with me; you should cover so that you cannot transmit to your wife and children.”

In some cases, their clients did not agree with them. They refused to have sex and asked their clients to give them money. They thought that it was very dangerous for them and their clients to continue. It is necessary to protect their health because they must take care of their family. Or even they threaten their clients that they will shout loudly. FSWs thought that they do not have anything to lose. People still see them as a social evil and need to be eliminated. However, for their clients, they will be ashamed because they have sex with a female sex worker. Not only FSWs but also clients try to conceal their family.

4.4.2.3 Sex work is to fulfill men's sexual desire

Intercourse is natural essence of human beings. Thus, many FSWs consider sex work as a job to meet men's sexual desire. They believed that they play role as a supplier to satisfy men sexual desire. Some FSWs and key informants said that unless all clients are eliminated, sex work will exist. This implies that clients should be seen as feature in controlling phenomena of sex work and related issues.

As Binh said that *"We are not faults in this business. This is an exchange of money and sex. We need money; they need sex. Therefore, we feel that it is unfair when we are controlled by authorities, but clients are not controlled."*

4.5 Discourses on sex workers who have cervical cancer and cervical cancer screening

In this part, discourses on sex workers who have cervical cancer and cervical cancer screening are examined under institutional and individual perspectives.

4.5.1 Discourses from medical professionals: HPV-related discourse, cervical cancer screening is for those who have conscious awareness and stable income

As mentioned above, sex worker is seen as a source of transmitted diseases by medical professionals due to their habits of sexual intercourse. They often have unsafe sex with multiple sexual partners. Thus, they contribute to the spread of diseases in community. However, in terms of cervical cancer or another disease, medical professionals said that sex workers are a part of general women. Any woman

can get cervical cancer if they get HPV-related to cervical cancer, especially types of 16 and 18. Besides, unsafe sex with multiple sexual partners is seen as a reason to get HPV easily. Therefore, even if sex workers who have cervical cancer, medical professionals still see them as general woman. They thought that almost women have human rights to access health services, so do sex workers. Medical professionals do not classify them into different group to have different way to behave and examine.

As a key-informant as well as a female doctor said that *“We do not have discrimination with FSWs because all women can get cervical cancer if they get HPV types 16, 18.”*

However, some key-informants completely agreed that FSWs often go for diagnosis and treatment at the later stage than general women. The reasons for this are economic burden and awareness of risk in cervical cancer. A medical professional in this study said that those who have a good awareness of health risk seldom choose sex work as an occupation. But, FSWs still choose sex work as their work. It implies that their awareness of risk is not high because they accept risk willingly. Therefore, only few FSWs who do regular gynecological examination or cervical cancer screening have conscious awareness of their risk in cervical cancer. The second reason for attendance is that they do not face economic burden.

“I think that FSWs’ decision on going for gynecological examination or cervical cancer depends on their conscious awareness of their risk when they are FSWs. Besides, entertainment-based sex workers often practice many times than street-based sex workers because they have stable income and earn much money.”(A key-informant as well as a female doctor)

4.5.2 Discourses from sex workers: “cervical cancer is prolonged infection and highly sexually active diseases”; “cervical cancer screening is for rich sex workers”

Unlike medical discourses, FSWs described those who have cervical cancer with different ways. FSWs also agreed with medical perspective that every woman can get cervical cancer and they are at the risk of this group due to their sexual intercourse with multiple partners. But they did not mention HPV as a key cause of cervical cancer. FSWs had comparison among sex workers to describe those who have

cervical cancer. Some FSWs often said that sex workers who work on the street are riskier than other sex workers. They explained that frequency of sexual intercourse among street-based sex workers is higher than those who work at the beer pubs; and sometimes they have sex at the dirty places and do not have water to wash after intercourse. Therefore, their vagina easily gets inflammation or infection. As a result, they get cervical cancer from prolonged infection. Clearly, in this explanation, participants described that sex workers who have cervical cancer are those who get prolonged inflammation or infection due to their high frequency of sexual intercourse. In addition, they also said that sex workers who have cervical cancer are dirty and they must stop working. They believed that menorrhagia is one of symptoms related to cervical cancer. When sex workers get menorrhagia, bleeding so much makes their body dirty. They cannot have sex with clients because clients do not like their symptoms.

In addition, they said that all sex workers should do cervical cancer screening if they have money. For them, economic factor plays an important role in their attendance to cervical cancer. Thus, sex workers doing cervical cancer screening have money. Besides, they believed that cervical cancer can help them to detect cancer. Therefore, sex workers who do cervical cancer screening are normal, a being part of woman. They should know their health status to know how to protect. They said that people should not blame them as promiscuous women when they go to hospital for a Pap-smear.

Van said that *“I think that sex workers working in the shop or beer pub can choose clients. Their clients have money, so they get much money than street-based sex workers. Therefore, they may attend gynecological examination or cervical cancer screening.”*

4.6 Felt-stigma: “being exploited, discriminated, rejected, self-blamed”

From institutionalized discourses on sex work and sex workers, many FSWs reported that sometimes they felt so sad, especially when they just entered into sex work. They wondered that why other people did not sympathize with their situation. Although there is a positive change of stigma now, sometimes they still face

stigma. Some FSWs said that they felt unsecured by having fear of being arrested by police. Many police behave them badly. Many police not only say harshly and authoritatively but also abuse FSWs. For example, a female sex worker in this study said that *“We were forced to keep nude body so that police took photos as considerable evidence to sentence us. These behaviors made us deeply ashamed. We felt that people may try to eliminate us in the society.”*

Or in healthcare setting, FSWs in this study also said that they did not dare to ask information from health staffs because health staffs said curtly to them. Sometimes, they catch inquisitive eyes of other patients. Maybe other patients are blaming FSWs as immoral women or promiscuous women when they see FSWs' appearance. FSWs said that they often face these attitudes. At the first time, they felt hesitated. But later, they thought it was not important. They tried to behave normally because they needed to be examined by doctors.

In addition, many FSWs choose remote place to live and seldom interact with their neighbors. They do not want other people to know their job because they are afraid to catch inquisitive eyes from their neighbors. Thanh said that sometimes she cried and self-blamed due to all the backbiting and gossip in her neighborhood.

Quyen said that *“sometimes I reproach myself. I think that sex work is for poor women or rural women with bad condition. However, for me, I live in HCMC and have little knowledge, but I chose sex work which many people often accuse. Thus I feel that I am useless.”*

Especially in the context of family, FSWs in this study often felt that they were neglected or rejected by their family. So majority of FSWs try to conceal their job. They said that if their family knows their job, they will face eviction from their home. Some FSWs who have worked for a long time said that they were reviled and beaten badly by their parents. Their parents did not allow them to do sex work, so they felt ashamed when they returned home. Consequently, they moved to another place to earn money and support their own life. For FSWs who have not been disclosed by family, they often try to conceal. If they are asked what their jobs are, they answer that they are workers, waitresses or vendors.

4.7 Beliefs about cervical cancer

4.7.1 Terms of cervical cancer

All participants in this study called cervical cancer “*ung thư cổ tử cung*”. “*Ung thư*” is called cancer; “*cổ tử cung*” is called “cervix”; “*ung thư cổ tử cung*” literally means the cancer of cervix. Almost participants used medical term of cervical cancer; there is no other term that from local culture. The reason for this is that they are overwhelmed knowledge that they received by peer-educator. FSWs do not care about this disease, so they do not have traditional culture model of explanation. They often said that their time is for earning money and taking a rest.

As a result, they thought that cancer develops from primary infection of cervix. This means that bacteria attack their cervix and cause infection. And then, prolonged infectious cervix created cancer cells. Later, cancer cells may invade other organs such as uterus and ovary cyst.

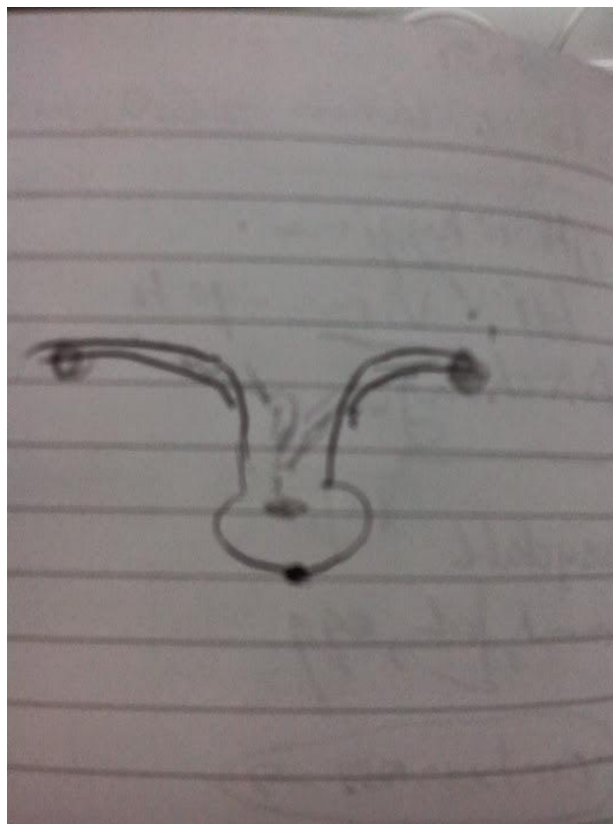


Figure 4.3 The development of cervical cancer by a FSW

However, under medical discourse, a key informant said that cervical cancer is abnormal growth of cells in the cervix. In other words, cervical cancer is a malignant tumor in tissues of the cervix. In fact, at the early stage, there is no symptoms related to cervical cancer. Therefore, it is difficult to detect cancer without doing cervical cancer screening. However, in the later stage, there are some symptoms such as abnormal vagina bleeding, pelvic pain or pain during intercourse. Thus, medical professionals often advise women to go to the hospital for cervical cancer screening as soon as possible. A key informant also said that it had better do cervical cancer screening if women had sex.

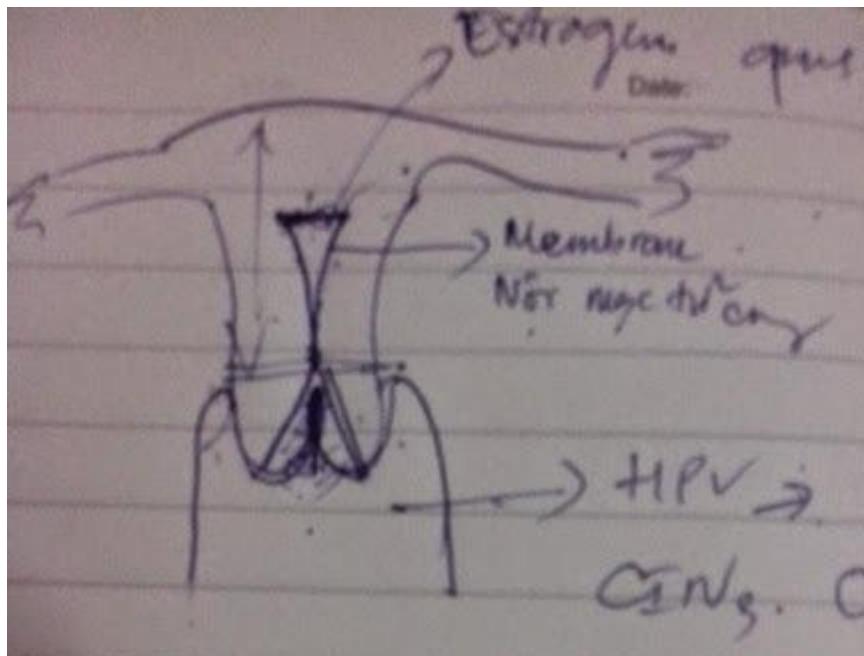


Figure 4.4 A key informant explained about cervical cancer

4.7.2 Notion of cervical cancer from FSWs' perspective

4.7.2.1 Cervical cancer as an incurable disease

Some FSWs in this study believed that cervical cancer is dangerous. Any cancer leads to death sooner or later. Screening only helps them to detect if they get cervical cancer or not. Although they try to treat, it is very difficult to recover. At the first stages, they believed that uterus and ovary will be cut. They cannot get pregnant. At the last stage, they will die.

Thoa, a single FSW, said that *“When a person has cancer, it means that it is difficult to cure. If you get cervical cancer, uterus or ovary will be cut. For other FSWs, they got married and had a child. But for me, I am so young and it is unlucky for me if I get cervical cancer. I cannot get pregnant anymore.”*

4.7.2.2 Cervical cancer as the predestination of “*Ông Trời*” (God will)

In Vietnamese culture, although there are many religions, Vietnamese people always believe in “*Ông Trời*” which literally means that the Jade Emperor or God. “*Ông Trời*” is considered to be a person with tremendous power to create all species, judge objectively and hold the fate of each person. These beliefs were rooted in the subconscious and thoughts of Vietnamese and express through their everyday language.

Therefore, FSWs in this study believed that cervical cancer was the predestination of God. Everything will be controlled by God, including diseases. They thought that they could not change because that was their destiny. When God puts her in any position, it seems that she is predestined to get diseases. Although she tries to solve it, she is less likely to change her destiny.

Xinh is one of FSWs working for a long time. She entered into sex work due to miserable family and being rejected after returning from Labor-Education school. Although she considered germs or bacteria as causes of cervical cancer, she did not call exactly what the name of virus was. Additionally, she believed one woman got cervical cancer by the God. Everything was controlled by the God. They could not change because this was their destiny. She has been a female sex worker for more 15 years but she has not had cervical cancer yet. She only suffered purulent discharge and white blood because she had sex without condoms and maybe she was transmitted by clients. While some women have a proper husband, they maybe suffer female disease including fibroma, cyst and cervical cancer. However she believed that even though she tried to treat, she might not recover. She believed that women’s recovery ultimately depends on God.

Or Hong said that *“everyone has own fate. The die is predestined. Anyone does not suffer diseases. We survive, it’s certain that diseases are always beside us.”*

4.7.2.3 Cervical cancer as disease of being highly sexually active and unsafe sex practices

Most FSWs thought that every woman can get cervical cancer due to multiple sexual partner and unsafe sex. Some FSWs believed that not all of women know exactly how to use condoms in correct way. As a result, they get sexually transmitted diseases easily such as syphilis, gonorrhea or condyloma acuminata. They explained that if they do not treat these sexually transmitted diseases, they may get cervical cancer because the development of these diseases can create cancer cells and invade cervix or uterus.

As Hong said that *“Some clients don’t like using condom because it makes them displeased. But, we don’t know if clients get diseases or not. If we agree to have sex without condom, perhaps we easily get sexually transmitted diseases. Later it leads to cancer. Thus, I think that unsafe sex is also a reason for cervical cancer.”*

Few FSWs also believed that cervical cancer happened with women over 30 years old due to long history of sexual intercourse since they were in younger age. This implies that they may have multiple sexual partners than other people. In addition, sometimes FSWs have unsafe sex such as putting strange and sharp things into vagina, not using condoms during intercourse. They also said that sometimes, they did not use condoms during intercourse due to client’s pressure or money. As a result, it makes their vagina easy to be infected. They believed that if the primary infection is not treated in time, it will lead to cancer. Besides, an over 30 year-old-woman has weak resistance left. Quyen and Van saw a lot of women who suffered cervical cancer in their villages. These women were older than they were.

As Quyen said “FSWs are very young. Perhaps, they have early sex. It makes their cervix wounded. And then it is easy to get disease. Also, I think, cervical cancer often happens to women over 30 years old. As usual, the old people are riskier than the younger people are. I think they have weak

resistance left. Their antibody is weak. So they are easier to suffer disease. I saw some women with cervical cancer living in my village are often old.”

In this study, there is difference between street-based group and other groups. Most participants assessed that street-based group is riskier than other groups. The reasons for this are working place, limited choice of clients, unsafe sex, and lack of water to wash after intercourse.

Thoa has worked at the beer-pub for 5 years. She compared between street-based group and beer-pubs. She believed that *“the street-based group is riskier than beer-pubs.”* She said that those who go to the pubs have much money. For street-based group, they can go with any clients. Or even they engage in sex in polluted areas such as unoccupied house or in the bush. They do not have many chances to choose clients. For beer-pubs, she can choose clients. She often gets invitation from clients. For street-based group, some clients sometimes pass across FSWs and ask them to follow him. As FSWs solicit one client, they can follow with any price. Also, she heard from her clients that *“many clients fear the street-based group because some FSWs are not neat. Their appearance is not good-looking. Moreover, clients fear of being caught by an acquainted person in the street.”*

In addition, some FSWs working on the street completely agreed with Thoa’s view. They shared that *“clients only want to have sex with them or arouse sexually desire to ejaculate.”* Therefore, they often quickly engage in sex in anywhere. After intercourse, they only use tissue to clean up their vagina and then they continue soliciting another client. On the other hand, few FSWs insisted that any types of FSWs are susceptible to get cervical cancer due to multiple sexual partners. Ngoan had worked in the karaoke shop when she was young. Nowadays, she is working independently. She said,

“I think any FSWs can get. Or even they are high level because most of us have sex with multiple sexual partners. We cannot say that you work on the street; you are riskier than other groups. I don’t agree with this opinion. As long as you have sex, you are risk of this disease, I think.”

4.7.2.4 Cervical cancer as prolonged abnormal symptoms related to reproductive organs

All FSWs believed that prolonged abnormal symptoms related to vagina or cervix were causes of cervical cancer. Most FSWs said that when white blood changed from odorless to yellow and bad smell, their vagina might be infected. White blood creates a good environment for bacteria to develop. As a result, vagina is susceptible. As usual, discharge and itching happen at the same time. When FSWs feel uncomfortable, they attempt to scratch their vagina by their hand. They put their finger inside their vagina to take white blood out. Again, their vagina and cervix are extremely susceptible to disease.

“Sometimes, when white blood discharge so much, my underwear is wet. It makes me uncomfortable. I tried to take it out. I put my finger into vagina to take dirty things. Especially, the more I scratch vagina and touch cervix, the more terribly vagina and cervix itch. Until I cannot suffer, I visit a doctor for treatment. During working, sometimes I see other girls using their vagina as a bottle-opener. They open bottle of beer by their vagina. I was so curious and asked them to teach me. I tried to practice however I never succeeded. Another important thing was my vagina blooded and scratched. And then I imagined that maybe vagina of young FSWs bleed many times. If they continue opening bottles of beer, they get cervical cancer easily.” (Tuyet, 33 years old, has worked for 13 years at the karaoke and brothel)

Together with white blood discharge, a menorrhagia is also seen as a cause of cervical cancer. Some FSWs said that when a woman suffers menorrhagia, dirty blood exist inside their body. Bacteria or germs have a good environment to develop. It is bacteria or germs that affect their vagina, cervix and uterus. Binh, Nguyet and Xinh gave the same opinions. For instance, Binh had a cervical cancer screening in 2014. She absolutely agreed with a nurse who examined for her at Preventive Health Center. Although Binh did not ask the nurse more information related to the relationship between menorrhagia and cervical cancer, Binh also agreed and said

“I don’t know exactly about symptoms of cervical cancer because it happens inside our body. I cannot see it because I am not a doctor, so I cannot explain these symptoms. Actually, maybe it is the same what the doctors said. It is menorrhagia. You imagine, we get menstruation during 3 or 5 days, we feel uncomfortable because of blood. For menorrhagia, it means that you get menstruation more days than usual. If you don’t wash cleanly, don’t have good hygiene, maybe you get disease because blood is good environment for bacteria to develop.”

In addition, other FSWs such as Linh, Tuyet and Xinh thought infected urinary tract as a cause of cervical cancer. When they suffered this symptom, they believed dirty things inside their body did not discharge. For a long time, it makes them more difficult to urinary. Urinary tract will be infected and spread to vagina. At that time, their vagina becomes drier; they also feel hurt during urination. The reason of this symptom is poor hygiene. Some FSWs often get used to using tissue to clean vagina after intercourse, especially FSWs are working on the street. This symptom often recurs. As a result, cancer will happen because dirty things are not taken out.

All FSWs thought that poor hygiene causes prolonged abnormal symptoms related to vagina or cervix. Poor hygiene means that washing vagina without special hygienic water or soap; putting fingers into vagina to take dirty things out.

Binh said *“for street-based FSWs like me, sometimes we have sex in the abandoned house or at the corner of street. There is no water to wash, we only use tissue to clean and throw it. Most FSWs are itched or discharged. And then they scratch. Not all of us use hygienic water. Generally, unclean hygiene means that you don’t wash your vagina cleanly after urination or intercourse.”*

Or Thoa described poor hygiene from her clients. Her hands and her clients’ ones are very dirty. Or even, sometimes the way to use condom is very dirty because clients do not wash their hands cleanly. Some clients go with her after working hard. They have not washed their hands yet. And then their penis covered with condom and put inside her vagina, it is easy to be infected.

4.7.2.5 Cervical cancer as a hereditary disease

Half of FSWs in this study believed that history of family's disease was a cause of cervical cancer. A member of family suffered cancer and died of it. When a FSW lived with those who had cancer, perhaps she was also susceptible to cancer.

Van said that *"I heard that most cancer is heredity. Maybe a member of the family gets cancer, and then she gets cancer."*

4.7.3 How to prevent cervical cancer

To prevent cervical cancer, most FSWs considered doing cervical cancer screening, treating white blood discharge, keeping good hygiene, having safer sex and limit to work as solution to prevent cervical cancer.

4.7.3.1 Doing cervical cancer screening

Almost FSWs thought that doing cervical cancer screening is the best way to prevent cervical cancer. They believed that when they visit to the hospital, doctors help them to detect abnormal cells. Later, they will be treated under doctor's diagnose.

Binh said that *"I think the best way is screening. We should go to the hospital to test. The doctors help me to know about our state of health. I think unless we are detected as soon as possible, we cannot manage money to prevent. If you are at the last step, you cannot control although you have much money."*

4.7.3.2 Treating white blood discharge

Together with having cervical cancer screening, most FSWs thought that they should treat white blood discharge. Almost FSWs suffer white blood discharge when they work this job. They believed that white blood comes from poor hygiene, sex with multiple sexual partners, or hot inside their body. A FSW said that *"perhaps, our inside body is hot ... Sometimes I feel hot inside my body or before menstruation, I get white blood. I don't often get it. ... I heard from another people. They said that white blood discharge when our body is hot. I agree with them because I felt hot when I suffered white blood. And when you don't wash cleanly, maybe it occurs. You don't wash cleanly; your vagina is easy to be infected; and then white blood discharges."* (Hong)

Participants also shared traditional practices of treating white blood. The old FSWs said that they used hot water with salty or betel leaf to steam their vagina. They believed that it is the best way to ooze pus and antiseptic from white blood. Other FSWs mixed using medicine and practicing traditional remedy. They went to pharmacy store and bought some medicine. Especially, unless their symptoms get worse, they will not come to meet doctor.

4.7.3.3 Keeping good hygiene

Good hygiene is considered to be a way to prevent cervical cancer and white blood discharge. In FSWs' opinion, good hygiene is washing vagina carefully. Some FSWs felt their vagina become cleaner after washing with hygienic water. In contrast, other FSWs felt their vagina become drier and they felt painful during intercourse due to without lubricant substance. They visited to doctors and were suggested not to use hygienic water so much. These FSWs wash vagina with water. Sometimes, they put their vagina in steep with hot water and permanganate.

Also, most FSWs often use finger to penetrate into vagina. They thought that they can take out dirty things such as white blood, menstrual blood. Consequently, they had problem with infection due to dirty fingers with bacillus. They were advised not to do like this by doctors or peer educators. Later, they try to follow that advice.

4.7.3.4 Having safer sex

Moreover, FSWs thought that they were at the risk group of cervical cancer. In their view, having safer sex with multiple sexual partners can lead to cervical cancer. Therefore, they believed that they should have safer sex with condoms and limit to work. When they reduce frequency of sexual intercourse, they will not be susceptible to get sexually transmitted diseases and cervical cancer.

Hong said that *"I think that limited work is the best way to protect myself. I told you before. Now I choose the clients. If they agree to use condom and give me good tip, I will follow them."*

In terms of using condoms, Quyen said that some FSWs get allergy to condoms. It is dangerous for them to engage in sex. Therefore, she thought that FSWs should know how to use condoms correctly to prevent from being tagged during intercourse.

4.8 Beliefs about cervical cancer screening: “screening is detection”, “screening is the same gynecological examination”

There are many kinds of cervical cancer screening which were reviewed in the literature part. However, in this study, I selected Pap-smear as a kind of screening because Pap-smear is used much than other methods in Vietnam. Most participants did not know the name of Pap-smear. During interview, they described the process of Pap-smear to call its name. Under medical perspective, cervical cancer screening is literally called “*tầm soát ung thư cổ tử cung*” (“*tầm soát*” is defined as a person is checked at high risk of cancer)

For those who have not done cervical cancer screening, some people thought that screening helps them to know whether they get cervical cancer or not. All FSWs should do cervical cancer screening to protect their health and treat cervical cancer in time. They believed that screening is the best way to save their life and money.

Quyen said that *“Actually, I don’t know about cervical cancer screening. I think it helps us to detect pre-cancer. If we test, we will know if we get cervical cancer or not.”*

From this view, FSWs in this study thought that screening is only detection. In a bad condition, they are diagnosed with cervical cancer and it cannot be cured. It means that screening is useless. Also, getting cervical cancer makes them more depressed. Thus, it had better not going for cervical cancer screening.

“Actually, I don’t believe in screening because ... if I do it, then doctor say that I get cervical cancer and it cannot be cured. Clearly, diagnosing cancer in time through screening is impossible, screening is useless. It also makes me much worried.” (Hong)

For those who have done cervical cancer screening, they thought that cervical cancer screening is the same as gynecological examination. Screening helps them to know their white blood which brings cancer cells or not. They described the process as following

“At the beginning, the doctor inserted speculum inside to open my vagina. And then they use wood stick to spread cells on the cervix, I think. I

felt that the doctor practiced the same process of gynecological examination. They test my white blood to find cancer cell.” (Binh)

From this view, most FSWs who have cervical cancer screening said that they should undergo cervical cancer screening to know about their disease and protect their health. They should be healthy so that they can earn money and support their children. However, they do not intend to follow up because screening is the same process of gynecological examination. Now, they have not get symptoms, so it is unnecessary to do screening. Or even, they do not have regular gynecological examination unless their symptoms get worse.

“I don’t know that I will not follow up or not. I am waiting results. If I get bad result, actually I don’t know how I solve. If I get good result, I think that I don’t need to screen more because it is the same process of gynecological examination. You also know, most FSWs like me do not have regular gynecological examination if their symptoms do not get better.” (Binh)

4.9 Perceived quality of health care service

According to Ghimire, Smith, and Van Teijlingen (2011), quality of health care service will influence decisions on seeking care. Most FSWs in this study seldom go for regular cervical cancer screening. Therefore, I used data related to perceived quality of health service in gynecological examination from observations and interviews because there are common reasons of attendance and non-attendance to gynecological examination and cervical cancer screening. I focused on two groups to gain comprehensive understanding of cervical cancer screening practice. One group has FSWs undergoing cervical cancer screening. Another group includes FSWs who have not ever done cervical cancer screening. The issues of quality of health service consist of the physician-client relationship, gender of doctor, information adequacy, technical competency and privacy.

4.9.1 The physician-client relationship

A majority of FSWs reported that doctors seldom ask them private questions related to their work. Doctors often ask the reason why FSWs go to the hospital, what symptoms they suffer, how many children they have, daily practices of washing vagina and menstrual cycle. FSWs thought that these questions are normal and they do not feel stigma. They only express unsatisfied attitude with health staffs or doctor. From institutionalized discourses on sex work as an illegal status, a source of the diseases and a promiscuous woman, FSWs often carry social stigma and they also felt stigma by themselves. Some participants said that when they went to the hospital, they were afraid to be blamed as immoral women by people surrounding them. Sometimes they caught inquisitive eyes and impolite words by other patients and health staffs. This made them feel sad. They were also afraid to be scolded by doctors. Thus they did not dare to ask the doctors more information related to their symptoms.

Thuy, a female sex worker working at the coffee-shop, said that *“When we go there, we are scared to be considered. We worry that most people will keep inquisitive eyes and consider us as a call girl or a prostitute. They think that maybe we get STDs or HIV, so we must go there for a check.”*

Another participant told her story when she went to the hospital. Binh said, *“Doctors did not have enough time to talk with me. I saw a lot of patients waiting in front of the doctor’s room. Maybe I made the doctor angry and scold me. The doctor said shortly. They gave me a prescription and asked me to follow it. If I hadn’t got better, I would have visited again. They often talk without subject, sometime they wound my pride. Instead of giving more explanations and talking gently, they just gave and requested to visit if I didn’t get better. I wish that the doctor could give me more explanations and talking softly. This makes me be at ease.”*

Binh also recognized that most doctors say by snatches. If they like, they talk softly with subject. If they don’t like, they talk tersely with squeaky voice, it means that they browbeat her. They wear mask while they am talking, so she cannot hear clearly. When she asked again, they changed their voice. Since then, she has not wanted to ask more.

In this study, FSWs compared between doctor's attitude and other health staffs' attitudes. They often make more complaints with health staffs than doctors. Doctors often treat them equally as other people. They seldom speak authoritatively or impolitely with FSWs. For health staffs and nurse, they expressed bad attitude with FSWs. This made FSWs feel so sad and self-pity. As Van's story, she changed her voice when she talked about nurse's attitude. For doctors, she thought that they had a high quality, so they treat her equally. She was not stigmatized by doctors. However, for nurses, she sometimes feels extremely angry due to nurse's attitudes and behaviors. She said that nurses talked loudly as if she heard but not do. In her opinion, the way they talked was hard to please everybody. New sick people go there to check, she spent much time to go there, so they should respect her.

She said that *"They are very odd, they impolitely talk, and they always scream everybody."* One day, she quarreled with them. She was angry and said *"why you learn much, you go to school much time than me, but you badly talk. If you talk like this, I think you should be at the market. You don't learn from your school how to communicate with people. I think you are not a nurse; you are rude as a seller at the market. I go here to have a check-up; it's too crowded for me and everybody to hear your voice. You should repeat again. Why do you scream them? If you don't know how to talk to everybody, I will teach you. I learn lower than you but I can teach you about this."* She thought that she should not quarrel with them. If she had done like this, she would have been condemned. People say that she was obscure, not proper.

4.9.2 Gender of doctor

Together with interaction of physician-client, gender of doctors is sometimes mentioned as barriers by few FSWs. Some FSWs do not hesitate to expose their body and ask doctor during examination. They thought that they get sick and need to be treated. They considered that *"I do not feel shy or hesitated because male doctors like my clients. Showing the body in front of strangers is very normal. If they are hesitated, how will they earn money by exposing their body? Another thing is that we are patients, we are getting sick. Thus we need to ask doctors more information to protect our health. I never feel shy or hesitated due to this."* (Linh, who has not done cervical cancer screening)

On the other hands, other FSWs are afraid to expose their body, especially male doctor. Despite that they cannot choose doctors, they like female doctors much than male doctors.

Binh had just cervical cancer screening during last year and said that: *“Of course, if female doctor examines, I am not shy because she is female like me. But male doctor is different. They are different gender with mine, so I am shy a little. However, I accept this because I cannot choose another doctor. This is public health center, not private center. Hence, I cannot order female or male doctor.”*

Quyen also thought that she felt safer when she talked with female doctors because they could understand her situation and symptoms.

Van has not done cervical cancer screening yet, but she felt embarrassment when she was examined by male doctor. She just felt uncomfortable a little bit. Later, she was normal. She though that vagina is private body. For clients, she does not feel shy because they do not know her disease. However, for doctor, when they exposed her vagina and looked it at; she did not like. She believed that *“anyhow it is my private body.”* However, she still accepted this issue because she got sick. *“How can I choose? Actually, I cannot. It depends on the day when I visit to the hospital. In the same examination room, today female doctor may be there, but tomorrow it changes”*. Despite that she felt shy a little bit; she liked male doctor better than female doctor because male doctor was very skillful and careful.

4.9.3 Adequate information

In this study, some FSWs thought that they got enough information from doctors. Doctors often gave them some advices. In contrast, other FSWs said that sometimes doctors did not talk so much. They just give FSWs prescription and ask FSWs to follow their guide. In fact, doctors do not have much time to talk with all patients. The process of examination lasts about five minutes for one patient. Therefore, they rarely say many things.

“I only want to finish soon, I do not like waiting for a long time” and *“I do not know questions which I should ask doctors”* are used by two-third of FSWs. In daily life, FSWs in this study said that they often got up so late. It was about 10

o'clock. They stay at home until they work. They were tired of waiting for doctors. Thus, they would like to finish examination soon to go back.

I made observation at the health center and big hospital. At the health center, I only saw some posters related to cervical cancer and HIV. Especially, there were more posters about HIV than cervical cancer and screening. During observation, I took a note of questions which doctors often asked patient.

“Q: What is your name?

Q: How old are you?

Q: Why do you go here today?

Q: How long have you suffered this symptom?

Q: How many children do you have?

Q: Which contraceptive method do you choose?

Q: When did you get menstruation?

Q: Have you engaged in sex during past two days?

Q: Do you hang your knickers in the sun?

Q: Do you often wash your vagina after intercourse?

Q: What kinds of hygienic water do you choose?

Q: How do you wash your vagina?

Q: Do you know how to put medicine inside your vagina?”

Also, two key informants said that they have few chances to interact with their clients. Tuyet said that, “*We must obtain regulations of hospital. We do not have much time to talk with patients. Each patient just has some minutes. We still consult or suggest them to do cervical cancer screening in some cases. However, they have right to do or not to do.*”

4.9.4 Privacy and convenience

I observed doctor room when I voluntarily took two FSWs to health center. It is the Preventive Health Center in district 4. It is a three-floor building. The first floor is clinic and ultrasound. It is a place that FSWs get gynecological exam. In front of the clinic, there are row-seats. Although the door was closed, outside-people could still hear the conversation between the doctor and the client. In fact, there is only one room. The room consists of one long-table for the patient lies on the examination

and one desk for doctor to consult and write prescription. Another place is Da Lieu hospital. I had opportunity to follow a FSW into the doctor room. I just stayed with nurse and introduced myself as a researcher as well as a volunteer of peer-educator group while FSW was being examined by the doctor. Again, I heard the conversation between doctor and client.

After FSW had finished examination, I interviewed her at another place. She said that *"I must accepted because the examine room is quite small while many patients come there. They wait and hear. I think nobody want to hear my conservation. In big hospitals, you also see like here. You must wait outside examine room. There are 3-4 patients come to test at the same time. It is normal. However shy you feel, you will not get anything at all. Thus I don't feel shy. I just think I get disease and I should visit the doctor. It is everything I thought."* (Binh, who did cervical cancer screening at the Preventive Health Center)

However, when I interviewed other FSWs who have not ever done cervical cancer screening, they said that they felt uncomfortable while other patients stayed with them in the examination room. They did not know if people concerned on their conservation or not. But they were afraid a little bit. One FSW said that *"Sometimes, I gave doctor inaccurate information. I do not want doctor and other people know about me. Once time, I said that I was a poor woman; I worked as a street vendor. I also said that I did not have sex in recent days. However, actually the doctor knew that it was right or wrong. For other people, they did not know about my frequency of sexual intercourse. It was such a sensitive topic that most people did not like to talk more."* (Ngoan)

In terms of privacy, most FSWs felt inconvenient due to complex administrative documents and waiting for a long time. Thuy, whom I followed to Da Lieu hospital to testing white blood discharge, said that *"The first thing is to take me much time to go there and wait for a long time. I went with you from 1 p.m. to 3.30 p.m. The second thing is complex administrative documentary. For example, a moment ago, I spent much time to move around to ask where the examination room was."*

4.9.5 Technical competence

In terms of technical competence, FSWs agreed that some doctors were very skillful, especially the old doctors. Doctors penetrated speculum into vagina very softly. Actually, FSWs felt painful a bit when speculum was used to open their vagina. To reduce pain, doctors often asked FSWs some questions. When FSWs concentrated to answer doctor's questions, they would be less painful. In some cases, doctor encouraged FSWs not to fear. They tried to do carefully.

However, FSWs also compared young doctor's competency with old doctor's competency. They thought that young doctors were not skillful and enough experience. Thus, sometime they put speculum very strong. It made FSWs fear and painful.

4.10 The pattern of cervical cancer screening among FSWs

Although FSWs in this study considered that they were at the risk group of these diseases, they often postponed going to the hospital for test or treatment, including cervical cancer screening. A majority of FSWs did not go for regular gynecological examination and cervical cancer screening. Among FSWs, one-third of FSWs did gynecological examination at least one time during past two years. FSWs often mentioned economic factor, lack of time, administrative documents and the physician-client relationship as reasons for non-attendance for gynecological examination. They often had self-medication when they suffered symptoms related to vagina, cervix or urinary tract. Unless they got worse, they would postpone going for a check at the hospital. For HIV test, almost FSWs in this study had been tested at least once time during the past two years. This implies that HIV is the most concern of FSWs.

Only four of fifteen participants had ever had experiences one to two times cervical cancer screening in the last two years. Only one person had done a Pap-smear twice times during the past two years. She had the first cervical cancer screening two years ago. At that time, she went for regular gynecological examination and was suggested doing cervical cancer screening by doctor. For the second, she did again during last year. Three participants just did a Pap-smear during last year (2014). They

were also suggested to do cervical cancer screening when they went to the health center for treating white blood. Three participants said that they were hesitated to do Pap-smear when suggested because they thought that it took them much money and time. However, when doctors gave accurate information about price, they accepted to do. They thought that it was good for them to know their health status. In addition, it was convenient; they did not spend much time waiting (Table 4.2).

Table 4.2 Cervical cancer screening practice during past two years

No	Case	Have information about cervical cancer	Cervical cancer screening practice during past two years
1	Binh	Not yet	Yes
2	Hong	Yes	Yes
3	Linh	Yes	Not yet
4	Loan	Yes	Not yet
5	Mai	Yes	Not yet
6	Ngoan	Not yet	Not yet
7	Nguyet	Yes	Yes
8	Quyên	Yes	Not yet
9	Thanh	Not yet	Not yet
10	Thoa	Yes	Yes
11	Thuy	Not yet	Not yet
12	Tuyet	Not yet	Not yet
13	Uyen	Not yet	Not yet
14	Van	Yes	Not yet
15	Xinh	Yes	Not yet

Cervical cancer screening of FSWs who get HIV infection and drug users

In this study, there are three FSWs who get HIV infection. Nowadays, they are being treated. They explained that they have not done cervical cancer screening because their biggest concern is HIV infection. At the present, they are infected with HIV. They thought that they would die sooner or later. The second reason is

affordability. They said that they earn less money than other people because their appearance is not good. They are very thin. They lost their attraction, so it is difficult for them to find clients. To two drug users in this study, although they no longer used heroin, they still get methadone for treatment. They said that they felt fear when they went to hospital. Although they got treatment at health center, they believed that they were still discriminated due to their deviant behaviors. Sometimes, they postponed getting medicine due to their felt-stigma. As usual, they often go health center in every district to get medicine. However, there is no cervical cancer screening service at these health centers and they must move to other place. They will be discriminated in new healthcare setting by other patients and healthcare providers. Now, if they are detected with cervical cancer, they also suffer multiple stigmas. People look down on them; and this makes them more depressed. Consequently, they may refuse HIV treatment and cervical cancer screening.

4.11 The socio-cultural factors affecting cervical cancer screening

In this study, I also found out the socio-cultural factors affecting non-attendance to cervical cancer screening among FSWs. The socio-cultural factors include economic factor, cultural factor related to beliefs about cervical cancer, and social factor surrounding felt-stigma, perceived quality of health care service.

4.11.1 Economic factor

When asked the reasons for non-attendance to cervical cancer screening, almost participants answered that they had economic burden. It was not enough for them to cover daily things. Although money was easy to earn; their income was unstable. Someday, they had many clients. Sometimes, they could not find any clients. They had many things to do and worry. It is essential to save money for their family, children and themselves. Therefore, they thought that it is not necessary to screen.

As Van said, *“I have many things to do. I have two children. If I go for a check, I will not have enough money for other things such as: foods and tuition fees. Working as a female sex worker is difficulty to make money, because today you can have three or four clients, but tomorrow you do not have any clients. I work at the*

beer pub; some money I earn is tips from clients. I drink beer so much. After working at beer pub, I only have sex with one client.”

Or Mai working on the street also reported that money is the most important to her now. Unless she got worse, she would not go to the hospital for a test or treatment. She often has self-medication.

“Because now I am busy earning. I do not have time to care about it. Frankly, screening is available for those who have good condition. For me, making money is the most important now. After earning money, I feel tired and only want to take a rest. I do not want to go anywhere. Unless I suffer heavy symptoms, I buy medicine myself.”

In reality, many FSWs reported that there were few team mobile programs for gynecological examination, excluding cervical cancer screening. As a result, a large number of FSWs want to screen with free of charge like gynecological examination. This helps them reduce economic burden. For instance, Thuy said that she saw team mobile programs for poor women, including FSWs like her in two or three years ago. However, in recent years, she has not seen again. She told that once time, a team mobile program dropped in front of her working place to examine for all poor women. She also tested, but there was not cervical cancer screening. It only included syphilis and gonorrhea. Although doctor did not examine in detail, that program helped to reduce amount of money for test. She likes this model because she can know about her health problem.

Clearly, doing cervical cancer depends on the affordability of Vietnamese FSWs. Although price of a Pap-smear test is 4 USD, FSWs thought that it was still high for them to access. Based on their income, average they can earn 10-15 USD for a day. They explained that if they did a cervical cancer screening, they only had 4-11 USD. It is not enough for them to cover and raise their family or children. However, economic factor is not a main barrier to do a cervical cancer screening. Some participants have a good knowledge about times for a cervical cancer screening. They said that cervical cancer screening is done once a year. They can spend 4 USD for a test. However, they may spend much than 4 USD for other costs such as travel cost, registration fee, and medicine.

4.11.2 Cultural factor

Although economic burden was mentioned as a main barrier to cervical cancer screening among the participants, this study also reported beliefs related cervical cancer which affected their decision on screening. In this study, there are two groups. One group is those who have not ever done cervical cancer screening. Another group is those who had cervical cancer screening at least one time during past two years. There is a different explanation between two groups. While FSWs who have not ever done cervical cancer screening believed that highly sexually active and unsafe sex; prolonged abnormal symptoms related to reproductive organs and the predestination of God are causes of cervical cancer. Based on these causes, they thought that they could self-medicate by buying medicine from pharmacy, practicing traditional methods or keeping vagina in good hygiene. At one level, beliefs of “*Ông Trời*” in Vietnamese culture influence partly to their attendance in cervical cancer screening. They asserted that cervical cancer is predestination of God. They cannot control. Therefore, they believe that even if they go for cervical cancer screening, getting this disease or successful treatment depends on God. Moreover, many FSWs said that because they are FSWs, they often have sex with multiple sexual partners. However, they believed that their job is also the predestination of God. Maybe they did some transgressions in previous incarnation, so they were punished to become as a FSW by God. For example, Xinh narrated her story that she entered into sex work not only due to her family but also due to her destiny. She explained that “*clearly, sex work is my destiny. God forced me to do this job.*” She said that although she did not know and remember about her transgression in her previous incarnation, she was punished by God. She tried to do many jobs to earn money after she had returned from Labour-Education centers. But she could not earn enough money to raise herself. And then, she worked as a female sex worker again. In terms of cervical cancer, she also mentioned the predestination of God. She insisted that she has worked as a female sex worker for a long time, but she has not got cervical cancer yet. However, she saw some younger FSWs who have cervical cancer. Therefore, she believed that cervical cancer comes from the God. Everyone cannot control.

On the other hand, those who have cervical cancer screening believed that health plays an important role in their life. They need to know about their health statue

so that they can protect and prevent from diseases, including cervical cancer. For instance, Nguyet has had two cervical cancer screenings during past two years. Before she did the first cervical cancer screening, she had the same other FSWs' views about cervical cancer. Cervical cancer is an incurable diseases, it leads to death. It takes her much money to treat. Cervical cancer does not have any symptoms. Therefore, she had misunderstanding about it. As a result, she thought that she could control cervical cancer by keeping good hygiene, treating white blood discharge and having safer sex. However, when she visited to the hospital for regular gynecological examination, she was asked to screen by doctor. Doctor gave her some information related to cervical cancer. She thought that she was a female sex worker, she needed to screen so that she could protect her health. As a result, she did cervical cancer screening. She continued following after one year.

4.11.3 Social factors

4.11.3.1 Felt-stigma from discourse on sex worker

In FSWs' story, although they always told that they adapted discrimination, they were still hesitated to visit to the health center. They felt embarrassment. People believed that only bad girl goes for gynecological examination or cervical cancer screening due to her promiscuity. People guess that maybe she has multiple sexual partners or she is a prostitute. Therefore, she gets this disease and come here to treat. If she has a proper husband, she will not get female diseases. As a result, FSWs often postponed undergoing a cervical cancer screening. Thoa had the same opinion about fear for embarrassment like other FSWs. She said,

“You know, I am sure that if we go for a treatment, we will face stigma because you get female diseases such as cervical cancer, syphilis, or gonorrhea. However, it had better ignore them because we need to be treated. Frankly, maybe they will blame you as a bad girl. Your sexuality is promiscuity. If she has a proper husband, why does she suffer? Or maybe, her husband goes outside with prostitutes, and then he transmits for her. Actually, they never talk in front of me. However, I always feel that they are looking at me and talking about me.”

4.11.3.2 Perceived quality of health care service

In this study, most participants said that interpersonal relationship and complex administrative process are two influencing-factors in their decision. As mentioned above, many FSWs complained about health staff's attitude. They said that health staffs often say curtly. Therefore, they felt uncomfortable; and they did not ask more information from health staffs. For doctors, they also said that they did not have enough time to ask doctors. Consequently, they did not have adequate information related to diseases. Many FSWs said that they get information related to sexually transmitted diseases and cervical cancer from peer- educator instead of health staffs or doctors. However, it was not enough. Therefore, they often have misunderstanding of diseases, including cervical cancer.

Moreover, majority of FSWs do not like to wait for a long time. As a result, they are afraid to go to the hospitals, especially big hospitals. They said that it took them much time to go for check-up because patients were very crowded.

4.11.3.3 Medical discourses on cervical cancer affect pattern of cervical cancer screening

Under medical discourses, although cervical cancer is treated successfully if it is detected soon, in the later stage reproductive organs will be cut. Or even cervical cancer can lead to death. People often spend much time and money to treat in last stage. From these discourses, many FSWs said that they felt fear of cervical cancer. They imagined that their reproductive organs would be cut, so they could not get pregnant. It will take them much money to diagnose and treat while they are very poor. Sometimes for many FSWs, what they earn is not enough even to eat and live. Therefore, they cannot afford if medical costs are high. They often said that they will felt more depressed if they are detected with cervical cancer or any kinds of cancer.

As Binh's story, she has worked on the street for ten years. She moved to HCMC and worked as a female sex worker because she wanted to find a new job. She had an unstable job in her hometown and it was not enough to raise her family. She rarely went for a gynecological examination due to lack of time and money. Unless she suffered heavy symptoms, she did not go there for check or

treatment. I met her first time at the Preventive Health Center in district 4. She went to the health center to treat her prolonged itching. She tried to buy medicine by herself but it was not better. She was diagnosed with an infectious vagina. At that time, she did cervical cancer screening because she got a support from one peer-educator. She told that she wanted to do cervical cancer screening because she worked as a female sex worker. She would like to know whether she get disease or not? She believed that however rich she was, she could not keep her life without good health. Therefore, she did a cervical cancer. However, she told that she had not done a cervical cancer screening before due to fear of cancer. She absolutely agreed that lack of time and money are barriers to undergo a cervical cancer screening. However, for her, fear of cancer plays an important role. She scared that cancer made her depressed if she was detected. She has not got enough information related to cervical cancer and screening. Thus, she believed that cervical cancer is a dangerous. It had better not to know so that she never worries about disease.

CHAPTER V

CONCLUSION, DISCUSSION AND RECOMMENDATION

5.1 Conclusion

By using discourse analysis, stigma and beliefs model as theoretical frameworks, this qualitative research's main method was in-depth interviews. Fifteen Vietnamese FSWs working at the different venues in HCMC, two health professionals and three community leaders participated in this study. This study revealed discourses on sex work, sex workers and sex workers who have cervical cancer; and several socio-cultural factors that influenced their decision to do cervical cancer screening. Those included economic factor, beliefs related to cervical cancer and screening, fear of cancer and embarrassment.

In this study, I found out institutionalized and individualized discourses on sex work, sex workers and cervical cancer. I recognized that although HCMC is constantly developing in all aspects, phenomena of sex work still exist. Local authorities attempt to control and eliminate them because sex work has not been recognized yet. At one level, FSWs are also considered to be a social evil, source of transmitted diseases and promiscuous women by institutions. It is clear that these discourses create stigma and discrimination; so FSWs are more vulnerable. Together with institutionalized discourses, FSWs also produce their own discourses on their job. Majority of individualized discourses are belonging to institutionalized discourses. FSWs often described themselves as a source of transmitted diseases when they try to convince their client to use condoms during intercourse. But, FSWs also asserted that their clients should be a part of target for controlling the diseases. Many FSWs thought that sex work is a job to fulfill men's sexual desire. Therefore their clients are also factors that contribute into the transmission of the diseases. Besides, FSWs did not consider themselves as immoral women. At one aspect, they explained that they entered into sex work due to their family, their children or their own life. They and their family are so poor, so they need to work to earn money. They insisted that their

job is an exchange of money and sex. Rather, they still work by their labor-power. Therefore, they would like to be recognized by the society. They believed that they are in illegal status and face stigma and discrimination because the society has not recognized sex work as an occupation.

In terms of cervical cancer screening practice, most FSWs acknowledged that cervical cancer screening is important to do, yet the rate of attendance is still limited. Almost FSWs described difficult economy as an obstacle to attendance for cervical cancer screening. As previously shown, Vietnamese FSWs' most important concerns are paying a debt, supporting their family and looking after their children. They try to work to earn money. Due to difficult economy, FSWs in this study often choose self-medication instead of going to the hospital for diagnosis and treatment. FSWs often mix traditional remedy and Western medicine when they suffer symptoms related to genital inflammation. When they suffer heavier symptoms, they often seek to health care service with free of charge through introduction of peer-educators. Therefore, poverty leads to health-related issue and is an obstacle for Vietnamese FSWs to undergo in cervical cancer screening. However, this study also explored other socio-cultural factors such as discourses on sex work and cervical cancer which affected cervical cancer screening practice of Vietnamese FSWs. Especially, medical and social discourses on sex worker and cervical cancer influence on cervical cancer screening among FSWs. Medical discourses considered FSWs as a risk group of cervical cancer due to their sexual behavior. FSWs are more susceptible to get HPV than other groups. In line with medical discourses, social discourses also described sex work as social evils, deviant social norms. These discourses make FSWs fear, embarrassment or felt-stigma. Consequently, it contributes to low rate of cervical cancer screening practice among Vietnamese FSWs.

Unlike medical and social discourses, FSWs explained the reasons of non-attendance for cervical cancer screenings included beliefs on cervical cancer and cause-related to cervical cancer within the context of sex work. There are similarities between previous studies and this study. Prolonged abnormal symptoms related to reproductive system, poor hygiene and the predestination of the God are seen as causes of cervical cancer. Several FSWs had fatalistic attitudes which were associated with the idea of "the predestination of the God". They cannot control although they try

to do. Others believed that cervical cancer were specific genital infection which arisen from white blood, poor hygiene and multiple sexual partners. From these beliefs, FSWs thought that the best way to prevent cervical is treating white blood, or practicing good hygiene, having safer sex with condoms and limiting work. Some FSWs thought that as FSWs suffer white blood, they often have self-medication by buying medicine at the pharmacy or practicing the traditional remedy. Others believed that vagina is very easy to be inflamed or scratched and lead to cervical cancer. Good hygiene practices are important for them to protect their vagina and prevent cervical cancer. As a result, they often delay going to the hospital for check-ups, including cervical cancer screening.

In line with beliefs about causes of cervical cancer, fear of cancer is also mentioned. Most FSWs believed that any kinds of cancer, including cervical cancer are incurable diseases. They will be more depressed and cannot pay health cost when they are diagnosed with cervical cancer. Therefore, they do not dare to go for a screening. Embarrassment is also a barrier to cervical cancer screening because most FSWs scare of being blamed as a bad women as going for screening at the health center. In addition, the relationship between physician-clients is limited in the healthcare setting. FSWs fear to ask questions, while the health professionals do not have enough time to talk more. Lack of time leads to lack of information on cervical cancer and cervical cancer screening. Doctors and health providers have little opportunities to consult clients. As a result, FSWs do not have enough information and they do not concern about cervical cancer so much.

5.2 Discussion

In this part, I would like to discuss some important theoretical points which were used to interpret data. Theoretical concepts on discourse by Michel Foucault and felt-stigma by Goffman will be discussed to make clear about cervical cancer screening attendance among Vietnamese FSWs. Moreover, I discuss the physician-client interaction as a feature to improve quality of health service.

As mentioned above, cervical cancer should be detected and treated at the early stage under medical perspectives. Medical discourses produced by health

practitioners and Information-Education-Communication (IEC) materials described FSWs as the risk group for STDs, HIV and cervical cancer. According to Michel Foucault, individual's thoughts and action are shaped, regulated and controlled by discourse (Danaher, Schirato & Webb, 2000). Language production from professionals holds power to formulate behavior (Victor & Letseka, 2013). Findings from this study showed that medical discourses on sex work and cervical cancer affect FSWs' decision on undergoing cervical cancer screening. By exploring the way in which FSWs narrated their stories on their cervical cancer screening practices, I recognized that the nature of discourse on sex work and cervical cancer framed perceptions of screening practices among FSWs. For example, although FSWs in this study hardly go for cervical cancer screening, they also thought that they are at the risk group of cervical cancer due to their having sex with multiple sexual partners, unsafe sex, and poor hygiene.

In addition, despite that HPV was not mentioned in FSWs' explanation of causes of cervical cancer, discourses on the effects of cervical cancer affected their cervical cancer screening practice. Some FSWs felt fear for cancer, so they did not do cervical cancer screening. They thought that at the last stage, their uterus or ovary will be cut. They cannot get pregnant. Or even they will die sooner or later. These thoughts will make them more depressed. Consequently, they postpone going for cervical cancer screening. However, some other FSWs did cervical cancer screening because they also fear of cervical cancer. This fear was reflected in the way in which many FSWs felt that they are riskier than general women due to their sex work. For instance, in Nguyet's story, she has had regular cervical cancer screening during past two years. She has worked for a long time and she thought that she is at the risk to cervical cancer. Thus, it was necessary for her to do cervical cancer screening. She needed to know her statue of health and prevent it from diseases. This result is similar with Bush's study. Bush reported that discourse on cervical cancer screening in call and recall program in United Kingdom regulated women's participation. For instance, discourse on development of cervical cancer created fear in women. These fear also affected women's practices in United Kingdom. Some women would like to do cervical test more times. Other women continued having cervical cancer test despite of

disliking them so much (Bush, 2000). This is similar with a study on Thai women's fear for cervical cancer (Boonmongkon, Nichter, & Pylypa, 2001).

At one level, I found the similarities between Foucault's work on surveillance and how medical power is embodied over women's bodies in cervical cancer screening. Foucault's conceptualization of "docile bodies" correctly reflected the way in which FSWs feared for cancer, keeping good hygiene as a method for preventing cervical cancer. Medical professionals also produce languages or terms of keeping female genital in good hygiene. Doctors often advise patients to wash their vagina carefully. They teach patients how to wash and take care of vagina when it is infected. As observed and taken note in the Preventive Health Center, a doctor said that "You should hang your underwear under the sun because bacteria in wet environment cause inflammation and itching. It had better hang your underwear and your husband's one under the sun. Another thing is washing after intercourse." These advices shaped women's behavior. Almost FSWs in this study mentioned keeping good hygiene. They believed that good hygiene helps them to protect their vagina and prevent cervical cancer screening. Some FSWs practice washing with hygienic water; other FSWs wash with water. Sometimes they get discharge and itching, they mix traditional remedy and Western medicine. It is clear that medical discourses play role in controlling and making FSWs surveillance.

However, in other level, I also argue that FSWs actively resisted cervical cancer screening due to their felt-stigma from negative attitudes in health care setting and beliefs. FSWs gave beliefs on cervical cancer associated with genital inflammation or white blood discharge. They believed that keeping good hygiene and treating white blood are better than doing cervical cancer screening within the context of difficult economy. Consequently, Foucault's conceptualization of "docile bodies" did not absolutely reflect the way in which discourses were used under FSWs' perspective. Clearly, most participants perceived reproductive organs and cervical cancer like biomedicine aspect. Participants considered cervical cancer as physical disorder in their body such as infected cervix for a long time. This infection may lead to cell cancer. Then, cell cancers invade and develop to other organs. Consequently, their reproductive organs will be cut at the last stage. Based on this finding, participants have good perceived about risk body. They located risks within their

body. This is similar with Shonali's study. Shonali (2010) highlighted how FSWs in Mexico had defined their health and risk body when they worked at the entertainment areas. Perceived body risk helped them identify obstacles and motivations for treatment. According to Law (2000), she argued that sex worker's body is irreducible and the object of a discipline power. Embodied risks showed additional challenges about the necessity of medical surveillance; and the absence of medical discourses to enable people to explain and reflect to their embodied risks. Thus, physician and clients have to understand how the other perceives cancer, its prevention and its treatment. This mutual understanding may create a good foundation for physicians and clients to cooperate in healthcare setting.

Although participants perceived their bodies at risk due to their job, they still postpone doing cervical cancer screening. The reasons for this included felt-stigma and beliefs about cervical cancer. In this study, I found that stigma was drawn from cultural, economic and moral factor. The moral aspect of stigma is relevant to the fact that sex work has been reprimanded in Vietnam and elsewhere due to their deviant behaviors. Besides, people believed that sex work inevitably led to STDs or HIV/AIDS. Therefore, sex workers face multiple stigmas because they are considered to be social evils. FSWs were afraid to be blamed as prostitutes when they visited to the hospitals for treatment. People believed that one woman went for a test associated with having extramarital sex. Women with STDs are considered as sex workers, while they tried to conceal their identity. Aside from institutionalized discourse which influenced their decisions, sex work is seen as an unrecognized job (ICRW, 2004). Medio-moral discourse such as sex worker are promiscuous, immoral which are thought to be deviant behaviors and epidemiological definition of risk group and public health message also effects on sex workers' felt-stigma. As mentioned above, many previous studies on the influence of healthcare provider's attitudes to accessibility to health services for STDs among FSWs. These studies reported that negative healthcare provider's attitudes such as "say shortly", "have an unwilling attitude", "gossip behind patients" created felt-stigma and became an obstacle for FSWs when they seek health care behavior. This prevents health services utilization of FSWs because they are illegal status. Most participants reported that they kept themselves almost isolated from people living around them, even doctors. They were

scared of exposure to public and discrimination although people never say anything in front of them. However behind them, people may blame or disregard them. These findings are similar to previous researches about sex workers and utilization of health services (Ghimire, Smith & Van Teijlingen, 2011; Ngo MD MPH Mphil, Ratliff, McCurdy, Ross, Markham & Pham; 2007). Ngo et.al (2011) stated that stigma-related to STDs, discrimination and judgmental attitudes of health staff influenced FSWs' low utilization of STDs in Vietnam. Although many FSWs and key informants agreed that level of stigmatization and discrimination changed due to the development of economy-culture-politics in HCMC, sex work is still unrecognized job and stigma occurs in my study. Discourses surrounding the relationship between sex workers and STDs or HIV/AIDS created illegal status. FSWs felt stigma when they were blamed for STDs, HIV/AIDS, and promiscuous women. Consequently, illegal status becomes a barrier for Vietnamese FSWs to access health care services. I argue that to promote health education or health program for FSWs, it is essential to eliminate prejudice on the link between sex work and STDs and HIV/AIDS.

According to Kleinman, the physician-client relationship has been seen as an important component in health care service. Therefore the way Vietnamese FSWs do cervical cancer screening is influenced by the way they look at physician-client relationship. For Vietnamese FSWs, health providers possess great authority because they have a high social status. Therefore, the physician-client relationship is hierarchical and the doctors hold enormous power. Vietnamese people often say "*lương y như từ mẫu*", it literally means "*doctors like gentle mothers*". This implies that the care of a physician like a mother's care. Xinh said that "*Doctors should be a gentle mother. To young doctors, they need to be friendly and respect to patients. It is important to make patients feel comfortable to come and talk to doctors.*" However, in fact, some FSWs are quite uncomfortable to ask doctors, especially when doctors are busy.

This study reported that the relationship between health professional and FSWs was limited. Although the doctors do not ask private things, they give a little information. It is not enough for clients, especially FSWs. This is seen as a direct cause of the inaccessibility to the cervical cancer preventive screening program. Most participants are always afraid to ask more because they fear for being scolded.

Therefore, sympathy and good interaction are necessary to improve the physician-client relationship. Although there is the positive change of discrimination, most participants face this problem. They are still vulnerable. They are less likely to access to health service due to their illegal status. This is similar to previous researches which considered as an obstacle to health care utilization. The previous studies reported that FSWs have negative experiences with healthcare providers. Some FSWs pointed out the staff's unfriendly attitude in the government hospitals such as viewing FSWs as "promiscuous" and using insensitive language (Ghimire, Smith and Van Teijlingen, 2011; ICRW, 2004; Ngo MD MPH Mphil, Ratliff, McCurdy, Ross, Markham & Pham; 2007). Others reported that doctors in the government hospital make them demotivated in seeking care (Braun & Gavey, 1999; Chakrapani, Newman, Shunmugam, Kurian & Dubrow, 2009; Ghimire, Smith and Van Teijlingen, 2011; Lazarus, Deering, Nabess, Gibson, Tyndall & Shannon, 2012). In addition, gender of doctor also plays an important role in good interaction. Some FSWs who had cervical cancer screening or gynecological examination during past two years revealed that having female doctors examine the test was critical because it helped to reduce their uneasiness. Although some FSWs like male doctors because they are very skillful, FSWs still would like to be examined by female doctors. They thought that they easily talked and found sympathy from female doctors. Most FSWs in this study have also felt-stigma. They said that they feel sad when most people keep inquisitive eyes with them or talk about them. In healthcare setting, they sometimes catch inquisitive eyes and impolite words. Therefore, unless they could not manage it, they did not come to meet doctors. Therefore, how doctors and health providers interact with clients affects the rate of regular Pap-smear or gynecological examination among Vietnamese FSWs.

Together with felt-stigma, beliefs about cervical cancer also contribute non-attendance to cervical cancer screening. This study explored beliefs about cervical cancer from Vietnamese FSWs in HCMC. Clearly, it is necessary to understand barriers to cervical screening in addition financial factor, especially in the context of Vietnam where a Pap-smear price is not high compared with other screening. It costs 4 USD per test. However, to FSWs, this costs influence their expenditure in daily live due to their unstable job. Or even FSWs said that they often have self-medication much than going to hospitals for diagnosis and treatment when they suffer symptoms

related to STDs. This is similar with cervical cancer. They believed that cervical cancer prevention should be done by treating white blood discharge, keeping good hygiene and having safer sex. These practices are easy for them to do everyday and save money and time.

The findings are similar with those previous studies in countries (Boonmongkon, Nichter, & Pylypa, 2001; Lee, Tripp-Reimer, Miller, Sadler, & Lee, 2007). For example, Korean American women believed that cancer is caused by God, promiscuous lifestyle, poor hygiene, multiple abortions, and family history of cancer. Almost Korean American women did not consider themselves to be risk for cervical cancer. Therefore, they believed that staying health, eating a healthy diet, not having a family history of cancer, not worrying about cancer, not having multiple sexual partners or abortions are the way to prevent cervical cancer. Another similar variability in the perceived causes of cervical cancer has also been found among women in Northeast Thailand. They also believed that a bad uterus caused discharge. When a woman has much discharge, she will be susceptible to get cancer (Boonmongkon, Nichter, & Pylypa, 2001).

However, in this study, especially within context of sex work, most participants recognized that they were risk for cervical cancer. When participants described about causes of cervical cancer, sometimes they used knowledge the same biomedicine perspective. However, they also postpone doing cervical cancer screening because of their beliefs about cervical cancer. Within their context, treating white blood discharge, keeping good hygiene and having safer sex are ways most participants chose. Especially, FSWs have a strong faith in God and they believed that cancer cannot be cured. This is different with housewife's perception in HCMC. Housewives acknowledged that cancer is curable. They postpone doing screening because they thought that screening was not necessary and they had embarrassment (Hiep, Nguyet & Ha, 2010).

5.3 Limitations of the research

Although the researcher has identified socio-cultural factors influencing cervical cancer screening practices among Vietnamese FSWs in HCMC, its result

cannot be generalized to the general FSWs. Firstly, because participants of the study are working at the low or medium sectors such as: coffee shop, barber shop, beer pub and street, insights gained from this research applied to Vietnamese FSWs of this group. FSWs work in high sector might have different obstacles in accessing health care services as well as different explanation on cervical cancer. Secondly, the results of this qualitative research do not demonstrate the extent at which Vietnamese FSWs participate in cervical cancer screening.

5.4 Recommendation

5.4.1 General recommendations

With the understanding of socio-cultural factors that affected Vietnamese FSWs' attendance in cervical cancer screening. I would like to suggest promotional strategies which might increase FSWs' participation in this program.

Most FSWs stated that they seek help from peer-educators. This highlights the important role of peer-educators in promotion of cervical cancer screening. It is important to recognize that most participants talked about peer-educator's advice when they suffer heavier symptoms. However, in practice, knowledge and information on cervical cancer which peer-educators received is limited. It is not enough to provide to FSWs. The findings suggest that health education about the importance of cervical cancer screening for FSWs should be done by both health professionals and the peer-educators. When FSWs have adequate information and understand the importance of screening, they will be more likely to participate in screening in the future. In addition, health education about cervical cancer and cervical cancer screening for FSWs should be improved not only to increase knowledge but also to rebuild their beliefs and existing knowledge in a creative way. This might be more effective than only providing medical information to change FSWs' cervical cancer screening behaviors.

Moreover, to reduce the associated felt-stigma, there should be many programs that were implemented at the individual and social level, especially in healthcare setting. At the individual level, FSWs should be empowered so that they are more likely to access to information and services in the society. At the social level, sex

work as a work should be issue for advocacy. By giving visibility to sex worker as a type of work, the society is able to understand their necessity and choice for sex work through a different light. At the community out-reach, Pap smear examination service should be conducted to save time, money and other expenses for FSWs. It is necessary to have the team-mobile programs for cervical cancer screening like gynecological examination. Or in the free gynecological examination should cover a Pap smear for FSWs. Media messages play an important role in giving information to FSWs on cervical cancer screening. In addition, cervical cancer has been associated with HPV infection, multiple sexual partners, and history of STDs and early age of first intercourse so Vietnamese FSWs often are blamed for “promiscuous women” or “a risk group”. This will prevent them from doing cervical cancer screening because of “fear of being disclose”. Rather the impact of low socioeconomic status in shaping healthcare should be critically examined. To recognize unequal power relationships between physician and clients is important for health care provider. It is true that unequal power will lead to resistance and ineffectiveness in healthcare. For instance, going unnoticed by the public is one kind of Vietnamese FSWs’ resistance.

Especially, in the health setting, the physician-client interaction should be improved. At the theoretical level, the researcher propounds that health care professionals should recognize that Vietnamese FSWs’ health care behavior is influenced by many factors including income, beliefs and socially constructed position. Therefore, at the practical level, the doctors spend much time talking and expressing empathy with clients. Also, the trained programs related to change of behavior, attitudes and the way to provide health information during cervical cancer screening should be launched for health staffs and nurses. Moreover, to increase accessibility to cervical cancer screening, health care policy makers should increase funding to support services to FSWs.

5.4.2 Recommendation for future research

Based on findings and limits of this study, I would like to make some recommendations for future researches.

(1) A population-based survey to assess the current state of Vietnamese FSWs' cervical cancer screening attendance and to explore the relationship between identified factors and Vietnamese FSWs' cervical cancer screening attendance;

(2) The development and implementation of a health promotional program should incorporate the findings of this research into its promotional strategies.

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APPENDICES

APPENDIX A

INTERVIEW GUIDELINE

1. Institutionalized discourses on sex work, sex workers and sex workers who have cervical cancer screening

- What do Vietnamese people (for example: medical professionals, religious leader, media and government) think and explain about sex work, sex workers and FSWs? What term do they use to call sex work, sex workers? What are these terms mean?

- In your opinion, what are main characters as a female sex worker?

- How do you describe FSWs who go for cervical cancer screening? Why? What reason? What kinds of FSWs do screening? And for what purpose?

- Is it common that FSWs to be at risk for cervical cancer? Why? What should they do to prevent it?

- In your opinion, should FSWs be concerned with cervical cancer screening? Why?

(The researcher should pay attention to observe the context, meaning, and discursive practices in which the discourse on sex work is produced by these institutions and people)

2. Individualized discourses on sex work, sex workers and sex workers who have cervical cancer screening

- How would you describe your sex work comparing to other women's jobs?

- How would you describe yourself as a sex worker? Why you do it? Are you comfortable, and happy to do this job? Why and why not?

- How do you describe yourself who go or do not go for cervical cancer screening? Why? What reason? What kinds of FSWs do screening? And for what purpose?
- In your opinion, should you concern about cervical cancer screening? Why and why not?

3. Cultural beliefs about women's reproductive organ and cervical cancer

- What do you think and feel about your body especially uterus and vagina in term of its shape, structure, size, functions?
- In your opinion, what kind of care and practices are required to prevent or protect your reproductive organ and its functions from cervical cancer?
- What is cervical cancer? What causes cervical? Are you at risk for cervical cancer, why or why not? What should you do to prevent it?

4. Felt stigma

- Do you feel discriminated? Could you please tell me what kinds of discrimination you have felt?
- How do you feel from interaction you have with people in the society around you (for example: working place, hospitals, community, shopping, market, family)

5. Perceived quality of services

- What do you think about quality of service in term of information adequacy, privacy, gender of doctor, technique competence and convenience when you go to the hospital?

6. Cervical cancer screening practices

- Have you ever heard of cervical cancer screening/Pap-smear?
- Do you have cervical cancer screening during the last two years? How many times? Do you follow with doctor's appointment or by yourself? If you follow the appointment, are you late for your Pap-smear appointment? If you do not following the date of Pap-smear appointment, how many days do you miss?
 - When was your first Pap-smear exam? Why did you do it? After the first Pap-smear exam, do you continue to do it regularly or not? Please describe.
 - If you don't do pap-smear, why or why not? If you do pap-smear regularly, why? If you don't do Pap-smear irregularly, why?
 - Do you think that the way society look at you will affect your decision on cervical cancer screening practices? Why or why not?

APPENDIX B

PARTICIPANT-OBSERVATION GUIDELINE

Setting: in the hospital or clinic where female sex workers go for cervical cancer screening

Time: _____

Purpose: 1) To observe quality of care female sex workers receive during the cervical cancer screening.

2) To answer are their needs met by hospital or clinic?

3) To answer how the female sex workers perceive quality of service they get

Procedure for observation at the cervical cancer screening room

1. Stay at the front counter and waiting for staff to identify which clients are FSWs who come to do the cervical cancer screening on the observation day.

2. Approaching the female sex worker client, introducing the study's objectives, and ask for informed consent to participate in the study.

3. Follow them throughout the process of the cervical cancer screening for participant observation and use the observation checklist

Observation checklist

1. Patient flow observation

a. Front counter interactions: Does the female sex worker ask for a Pap-smear?

b. Is she clear about why she is being examined?

() Yes () No

c. Waiting time at the OPD/registration area _____

d. Prepare time in the dressing room _____

e. How long does female sex worker wait for Pap-smear in the exam room in an exposed position?

- f. Who conducts the procedure? Nurse_____ student
nurse_____ doctor
- g. Who else is in attendance?
- h. Is the female comfortable with who is in attendance?

2. Privacy issues:

- a. Observe ways in which privacy is maintained and breached
 - When female sex worker is being asked about problems at front counter?
 - When being examined during Pap-smear
 - When talking to doctor/nurse in registration area
 - When being examined by doctor in examination room
 - How many people are there in the examination room? Is the patient comfortable with who is in attendance?
- b. Make notes on room positioning – () Yes, () No
Can people overhear, see into room, are door or curtain completely closed, is patient's lower body covered with cloth
 - Note female sex worker's response to being examined – shyness, etc.
 - Is female sex worker blindfolded? If so, was she asked if she wanted to be blindfolded?
- c. Did female sex worker use time in examination room as an opportunity to ask doctor or nurse sensitive questions or to talk about sensitive issues? If so, what issues?

3. Convenience issues:

- How far is female sex worker's place to this hospital/clinic?
- How long do female sex workers wait to register for check-up?
- How long do female sex workers wait to call into doctor's room?

- How long does female sex worker wait for cervical cancer screening?
- Is there time for female sex workers to ask sensitive questions about their problem?
- How is the internal exam explained? (at counter, in cervical cancer screening room, in doctor's examination room)
- How long will it take for results of the cervical cancer screening to be mailed to the female sex worker? Female sex worker surprised at how long

4. Interpersonal relationships issues:

- How is the female sex worker greeted and spoken to by nursing staff/doctor? (warmly or not? Politely or impolitely? Friendly or not?) Observe if discrimination exist (physically, verbally and psychologically)
- What kind of questions does nursing staff/doctor ask female sex worker? (duration of symptoms, severity, prior treatment, history of sex and others). Do the nurses always follow up with these questions to all female sex workers? Which questions does nurse often ask female sex workers? Observe if discrimination exist (physically, verbally and psychologically)
- What questions does female sex worker ask the nurse/doctor? And where (at counter, in cervical cancer screening room (if referred), in doctor's examination rooms (if referred) ...)

5. Information given

- How many information boards are there in the hospital/clinic?
- What kind of information is posted on the board? (Information related to cervical cancer or not?)

- Is female sex worker given enough information when she asks question to health staff?
- Is female sex worker given enough information about procedure of Pap-smear examination?
- What is female sex worker told about the letter she will be mailed: results of her investigation? (only be informed negative or positive exam, and others)

6. Technical competence:

- Observe how the procedure is (time for dressing, the way doctor conduct, how long it happens)
- After the researcher observe all procedure during follow up with patient's flow, ask the female sex worker with all these exit interview guideline

7. Exit interview after Pap-smear

- What did the female sex worker expect from the doctor or nurse during this visit to the hospital/clinic? Are their expectations being met?
- What questions would female sex workers have liked to have asked the nurse or doctor but did not? Why?
- What are information being needed but are not received?
- What are bad practices/treatment being experienced during the Pap smear screening services?
- What has the quality of service she experienced?
- What was good about the service? (waiting time, doctor's/nurse's competence, courtesy, information given, treatment-medications, referral, and others)
- What was bad about the service? (waiting time, doctor's/nurse's competence, courtesy, information given, treatment-medications, referral, and others)

BIOGRAPHY

NAME	Le Thi Ngoc Phuc
DATE OF BIRTH	9 January 1989
PLACE OF BIRTH	Ho Chi Minh City
INSTITUTIONS ATTENDED	University of Social Sciences and Humanities – Vietnam National University in Ho Chi Minh City, 2007-2011 Bachelor of Art (Anthropology) Mahidol University, 2013-2015 Master of Art (Health Social Science)
SCHOLARSHIP RECEIVED	Graduate studies scholarship for ASEAN countries, Mahidol University Hongwiwatana Fund Fellowships, Center for Health Policy Studies, Faculty of Social Sciences and Humanities, Mahidol University
HOME ADDRESS	766B/79 Lac Long Quan Street, Ward 9, Tan Binh District, Ho Chi Minh City Tel: (+84) 908 968 925 Email: ngocphuc@hotmail.com
EMPLOYMENT ADDRESS	University of Social Sciences and Humanities, 10-12 Dinh Tien Hoang Street, Ben Nghe Ward, District 1, Ho Chi Minh City