NARRATIVES FROM OVER THE RAINBOW: HEALTH DISPARITIES, SEXUAL HEALTH CARE, AND BEING GAY, BISEXUAL AND 'MSM' (MEN WHO HAVE SEX WITH MEN) IN CAMBODIA

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ABSTRACT

Health issues of non-heterosexual men are not similar across the world. Health issues come with varying consequences to the lives of individuals when studying violations to the right to health. Health disparities exist in societies regardless of their attitudes towards LGBT individuals. This study's added value to the existing abundance of academic knowledge is its attention on sexual identity and subjectivities and its profound impact in the fulfillment of the fundamental right to health. The majority of previous studies on gay, bisexual and other men who have sex with men (MSM) identities in Cambodia are focused largely on individualistic risky sexual behaviour. The global HIV epidemic raised the awareness of LGBT communities but has led to the labelling of non-heterosexual men as "at-risk" or "socially deviant" populations.

Therefore, the research question put forward by this research is: "How does the GB-MSM sexual identity impact (or affect) the access to sexual health care of GB-MSM in Cambodia?" This study takes into consideration indigenous Khmer terminologies that describe sexuality and gender, such as the boros sralang boros, sak lay and pros saat. This study employs queer theory and queer methodology in its analysis premised on the notion that privilege heterosexuality discriminates those outside this stem of power. This study pays close attention to the multiplicity and fluidity of the subject and subjectivities which are sculpted not only by sexuality and gender, but also race, ethnicity, postcoloniality and class. This research "queer(y)" presents the narratives of Khmer GB-MSM individuals and medicalized notions of sexual identity (and behaviour) impacting the navigation of sexual health access. Utilizing the stories of the participants, this paper challenges the labelling, regulating and controlling of sexuality under categories of "deviance", "risk" and "illness". Biomedicine constructed a causal link between homosexuality and HIV/AIDS developing standards wherein queer bodies are seen as diseased and heterosexual bodies as the standard of normality and health.

The findings from this study have evinced that sexuality plays a pivotal role in the access to sexual health services due to fear of exposing one's sexuality, distrust in the healthcare system because of previous experiences of mistreatment, and acceptance within social circles including the family. However, other factors to access have surfaced such as cost of sexual health care services (like HIV/AIDS testing and treatment), outreach strategies of health service providers and existence of peer-based models. In order to achieve global health justice we have to place prime focus on the dismantling of the hierarchizations and categorization of non-normative sexual identities.

KEY WORDS: HIV AIDS / SEXUAL HEALTH / MSM / QUEER THEORY / CAMBODIA

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LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
CCHR	Cambodian Center for Human Rights
CSE	Comprehensive Sexuality Education
GB-MSM	Gay, Bisexual and Men Who have Sex with Men
HIV	Human Immunodeficiency Virus
LGBT	Lesbian, Gay, Bisexual and Transgender
MHC	Men's Health Cambodia
NGO	Nongovernment Organization
STI/STD	Sexually Transmitted Infections and/or Diseases
RHAC	Reproductive Health Association of Cambodia
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

CHAPTER I
INTRODUCTION

Background of the study

> "It does not take a vivid imagination to recognize that the health and well-being of a gay man living in the redneck depths of Alabama are likely to be different from that of his counterpart in Copenhagen or Gothenburg (Wilton, 2002), *or consequently even in a city like Phnom Penh, Cambodia. (Italics phrase added by the author)*

Health issues of non-heterosexual men are not similar across the world. Health issues come with varying consequences to the lives of individuals when studying violations to the right to health. Primarily, this study tackles ~~on~~ sexual identity and any impact that this may have on access to health services. As a sphere of life, sexual identities include sexual freedom, flexibility, and diversity that are only applicable to the privileged parts of the world. Local and global inequalities brought about by existing societal and historical structures have a profound impact on the fulfillment of the right to health for gender and sexual identities and relations (Rahman and Jackson, 2010).

The right to health ensures accessible, quality, affordable and inclusive health care. As in previous studies, political-economic conditions, structural violence, cross-cultural and regional variations in the social construction and expression of sexuality shape the vulnerabilities in the health of lesbian, gay, bisexual and transgender (LGBT) populations (Padilla, Vásquez del Aguila, and Parker, 2007). Various social and cultural contexts will produce variation in narratives and this study looked into the narratives coming from the Kingdom of Cambodia.

The Cambodians struggled for their autonomy against their French colonizers. King Sihanouk proclaimed independence in 1953. In 1970, a pro-American government was established in the Kingdom which sparked anger and dissent from a Chinese-backed Khmer Rouge (Williams, 2010). Similar to other former colonies of Western countries, this period meant that homosexuality was largely forced into hiding or persecuted.

In more contemporary Cambodia, both the former King Sihanouk and the present King Sihamoni have expressed support for the LGBT community and this has uplifted public perception. Cambodia is at the stage of recovery from the Khmer Rouge years. The economic revival of Cambodia has been dependent on its tourism industry that has benefited the LGBT community.

Compared to other countries in the region, The Royal Government of the Kingdom of Cambodia (RGC) is said to be a country that has a “neutral and tolerant, stance on LGBT issues”, claimed by civil society organizations and human rights activists, with “even a favourable stance on same-sex marriage in 2015” (Williams, 2010; Destination Justice and Rainbow Community Kampuchea, 2015). However, despite this growing recognition, many individual rights remain invisible and concrete legislation that protects against violence has not yet taken root. The favorable stance by Cambodia’s monarchy on same-sex marriage did little to address the significant degree of stigma, discrimination and exclusion of persons with different sexual orientation, who express themselves not consistent with their sex assigned at birth and in a socially and culturally unacceptable manner, in certain settings due to social perceptions, cultural practice and religious beliefs (Salas and Srorn, 2013).

Despite generally positive and tolerant attitudes towards LGBT people in Cambodia health disparities still, exist on a much larger scale. Cambodia has a poor health care system contributed by the low-quality services delivered from most of the national hospitals which face problems such as limited public financial resources, shortages of drugs and medical materials, and inadequate regulation of the quality of care (Uy, Akashi, Taki and Ito, 2007). A maternal health-related study by Hong and Them (2015) did point out that there have been significant improvements in the health and health care status of the Cambodian population, however, predisposing factors such as socio-economic status still determine the country’s population health status.

More specifically, Cambodia's weak economic structure and insufficient resources present a formidable obstacle for financing anti-HIV/AIDS programs and the treatment of AIDS (Yasar, 2010). Gaps in the quality and delivery of health and other population-specific differences in the access to healthcare constitute health disparities (Riley, 2012), which can exist in all societies regardless of their attitudes towards LGBT individuals. The need for HIV/AIDS health support was realized after the first recorded case of infection in the early 1990s. It was initially concentrated within the sex industry of the country, specifically female sex workers (Vun, Fujita, Rathavy, et.al., 2014).

This study's added value to the existing abundance of academic knowledge is its attention on sexual identity and subjectivities and its profound impact in the fulfillment of the fundamental right to health. The majority of previous studies on gay, bisexual and other men who have sex with men (MSM) identities in Cambodia were focused largely on individualistic risky sexual behavior. Studies such as that of Catalla, Sovanara and van Mourik (2003) and Hoefinger and Srun (2017), were driven by the global HIV epidemic which raised the awareness of LGBT communities but has also labeled them as "at-risk" or "socially deviant" populations. There is insufficient data that elucidate the influence of sexual identity (more specifically, a GB-MSM or LGBT identity) on the access to sexual health care leading to health disparities, is a gap in the existing and available literature.

Research problem, question, and objectives

This study seeks to primarily provide narratives into the lived experiences of GB-MSM individuals and the influence of this identity on access to sexual health care. This is under the premise that without access to sexual health care, health disparities will occur for gay, bisexual and other men who have sex with men (GB-MSM) which is a violation to the right to health:

Therefore, the research question put forward by this research is: "How does the GB-MSM sexual identity impact (or affect) the access to sexual health care of GB-MSM in Cambodia?"

The study shall revolve around the respondents' lived experiences in the access and provision of sexual health services as it is connected to the GB-MSM identity. This study specifically aims to discuss the following points in order to achieve a clear understanding of the topic:

1) To describe the experiences of GB-MSM in accessing sexual health services in Cambodia.

2) To document the narratives of GB-MSM as regards the delivery of sexual health services in Cambodia.

3) To analyze through narrative inquiry on how GB-MSM sexual identity contributes to disparities in the access to and delivery of sexual health services in Cambodia.

4) To argue how lack of access to health care and health disparity is a violation of basic human rights.

The scope of this study is self-identified GB-MSM (including those that identify using sexual and gender identities derived from the local Khmer language) from Cambodia who has accessed sexual health care service in the past year. Specifically, these are individuals who have actually experienced accessing sexual health care. The study maintains that in order to obtain diverse narratives coming from across Cambodia, the respondents may come from any city or province as long as they match the inclusion and exclusion criteria provided in the methodology section of this study.

CHAPTER II
LITERATURE REVIEW

2.1 Defining “gay”, “bisexual”, and “other men who have sex with men” (gb-msm)

Establishing the sexual identity definitions that will be used in this study is fundamentally crucial for this study. This is indispensable in studies that measure and assess health disparities that are caused by sexuality and gender traits (Ridolfo, Miller and Maitland, 2012). In both scientific/medical research and HIV/AIDS programming, homosexual men (commonly termed as ‘gay’) and bisexual men have been lumped into one category of “men who have sex with men”. This ubiquitous grouping of men who engage in sexual activity with other men has totally ignored that ‘gay’ denotes an amalgamation of sociocultural identities, behaviors that are important in health promotion work, influences of sexual and relational identification, and other components of sexuality (Young and Meyer, 2005; Moe, Reicherzer and Dapuy, 2011). In recent studies, it has been noted that to properly understand the issues and for the development of programs best suited for the community it is imperative to recognize local identities and communities (Caceres, Aggleton and Galeac, 2008).

While we find conceptual definitions in academic and organizational papers, of “gay”, “bisexual” and “MSM”, as having men having emotional and sexual relations with other men (or self-identifying as such) (UNAIDS, 2010), these terminologies and identities, along with the activism that accompanies the liberation of LGBT persons, are known to be “western patterns” employed by activists to promote, visibility, legitimacy and equality, and to resist heteronormativity and homophobia. Studies have contrasting views on the notion that western hegemonic notions of sexual identities are finding tolerance in Asian societies, but have likewise destroyed indigenous sexual cultures and diversities (Laurent, 2005 & Kole, 2007).

For the benefit of this study, there is a strong need to identify local and indigenous identities that may not necessarily be synonymous or direct translations of the more western terminologies of "gay" and "bisexual" and the more medical and programmatic terminology of "men who have sex with men". As Kole (2007) points out, there is a need "to preserve sexual diversity, gender plurality, sexual rights and freedoms in diverse societies as the spirit of a rights-based approach". Kole argues that indigenous queer sexualities may emerge in Eastern societies without the political rhetoric of the west. Whilst Kole's study was within the context of India and South Asia it will not be far-fetched when juxtaposed with the Cambodian context.

Reports have claimed that western categorizations of sexual orientation and gender identity would not be applicable due to the flexible way Cambodians perceive sexuality and due to the lack of vocabulary available in the Khmer language that describes sexual preferences and behavior (Cambodian Center for Human Rights, 2010; UNDP and USAID, 2014). Studies have attempted to provide definitions of sexuality and gender in Khmer, although not exhaustive. Some reference dating back to the 13th century have defined diverse sexual behaviors and gender identities but these documents have likely been destroyed during the Khmer Rouge era (UNDP and USAID, 2014).

In Khmer language, gender is commonly described as "*srei*" and "*pros*" meaning "human being of the female sex" and "human being of the male sex", respectively. The Cambodian society also recognized two distinct personality types, the "*charek srei*" and "*charek pros*" which means having feminine and masculine character, respectively (Tan, 2008). Gender and sex are not clearly differentiated in Cambodian text as identity is based on masculine or feminine traits rather than on sexual desire (UNDP and USAID, 2014).

Khmer sexual identities such as the *sak klay* (short haired MSM) or *pros saat* (handsome boy) and the *srei sros* (*srey sros*) have been identified (Catalla, et.al., 2003; Earth, 2006). In a study of male-to-male sexual behaviour in Cambodia, Catalla, Sovanara and Van Mourik (2003), various other sub-groups, self-identities and sexual partner preferences were further identified such as the *sak veng* (long hair), *boroh pith brakat* (real man), *srey roth bambang kay* (the girl who hides herself), *chun cheat pheak tech* (minority group), and *pros luk kluan* (male selling his body). Other terms

like the *sim-pi*, which in English translation means “two SIM cards” indicating that they were attracted to, and had sex with, people of both sexes (Salas and Srorn, 2013) and the *pet ti bai*, which in translation means the third sex (UNDP and USAID, 2014) have also been identified.

The *kteuy* (similar to the *srei sros)*, is a person raised as a male who have transgender identity or characteristics (Jackson and Sullivan, 1999), which has also been widely used in Cambodia’s neighboring country of Thailand. Although the *kteuy/kathoey* is readily visible in traditional Thai society, the term remains marked and problematized as it is often used in a derogatory manner similar to the usage of “queer” and “fag” (Storer, 1999), or as a direct translation to the term “hermaphrodite” (Sinnott, 2004).

The adoption of HIV/AIDS programming in Cambodia following the dramatic rise of the epidemic has brought to Cambodia the ‘MSM’ identity. The term was intended to describe behavior only in the context of identifying populations most at risk of HIV/AIDS transmission. Outside the public health and HIV/AIDS discourse, the term is largely unknown (Earth, 2006). The literal Khmer translation of the ‘MSM’ is *pros slan pros (*or *boros sralang boros*), meaning ‘men who love men’, indicating both affection and behavior.

The terminologies presented in this section may appear in this study’s data gathering process. It is imperative to point out that other similar terminologies may come up since this list is not exhaustive in nature; however, this study maintains that all terminologies and classifications which the respondent deems to best describe his identity will be considered. It may also provide added terminology to the existing available literature.

2.2 Being lgbt in cambodia: lgbt rights, hiv and aids, and sexual health

The notion of diversity enriches the LGBT community; however, diversity in the text is dependent on the existence of the social setting in which diversity is acknowledged. Homosexuality is non-existent in some societies, while in others, non-normative sexuality and gender prescribe social roles (Meem, Gibson, and Alexander,

2010). Codes of conduct in Cambodia regulate and disciple gender regimes with rewards for virtuous behavior. Kent (2010) describes two specific codes of conduct composed by Buddhist Monks, "*Chbap Broh"* for men and the "*Chbap Srey*" for women.

In terms of LGBT persons in Cambodia, there is actually no specific law that criminalizes on the basis of one's sexual orientation and gender identity. However, prevailing social stigma results in abusive treatment by society, including by state actors (ASEAN SOGIE Caucus, 2017). In certain cases the Village and Commune Safety Policy (VCSP) of the Ministry of Interior signed in 2010, is used to justify arrests and harassment of gay men and transgender person in public places as they are assumed to be selling sex, involved in trafficking and other deviant acts (Salas and Srorn, 2013).

Discrimination on the basis of sexual orientation, gender identity and expression (SOGIE) is recorded in the four reports (CCHR 2010; 2012; 2015 and 2017) of the Cambodian Center for Human Rights (CCHR). As evidenced in these reports discrimination and the violation of human rights crosscut various sectors and contexts in Cambodian society. The prevalence and effects of SOGIE-related bullying in Cambodian schools (CCHR, 2015) and the lack of legal measures that provide Cambodia's '*rainbow families*' with marriage equality, adoption and legal gender recognition rights (CCHR, 2017) are highlighted.

In terms of existing statutes, the 1993 Constitution of the Kingdom of Cambodia has explicitly stated in Article 31 therein that:

> "*The Kingdom of Cambodia recognizes and respects human rights as stipulated in the United Nations Charter, the Universal Declaration of Human Rights and all treaties, conventions, and covenants related to human rights."*

In the same paragraph, the article mentions some of the provisions and limitations of these rights:

> "*Khmer Citizens are equal before the law, enjoying the same rights, liberties and duties regardless of race, color, sex, language, beliefs, religions, political tendencies, birth origin, social status, wealth of other situations. The exercise of personal rights and liberties by any individual shall not adversely affect the rights and freedom of others. The exercise of such rights and liberties shall be in accordance with the law.*"

The state's constitution guarantees equal rights for Khmer Citizens regardless of any social identifications, including sex. However, as studies have proven social perceptions and written law differ both in implementation and interpretation. At the state level, being LGBT in Cambodia will not merit any criminal sanctions, however, state actors are reluctant to tackle sexual orientation discrimination, which often leads to material inequality, power disparity between heterosexuals and homosexuals, and the notion that these individuals pose a risk to public order (Lek, 2014). Cambodia's HIV/AIDS Law provides a human rights-based legal framework for prevention, treatment, care, and support efforts. It similarly provides provisions that prohibit discrimination against people known or suspected of having HIV/AIDS and their families (UNDP, 2013). There is no law, however, that protects persons from discrimination on the basis of sexual orientation or gender identity.

The access to information related to sexuality and health begins as early as fifth grade with the development of Comprehensive Sexuality Education (CSE) Programs by the Ministry of Education, Youth and Sports (MoEYS). The curriculum currently includes topics such as puberty, gender-based violence, and values which varies depending on the grade level. Comprehensive Sexuality education sees sexuality as a fundamental aspect and a rights-based approach is essential to fully understand its dimensions, however, although the implementation of CSE programs in Cambodia include HIV/AIDS, sexual health and gender issues, it does not explicitly mention LGBT identities (Shahbaz, 2018).

Health indicators (such as life expectancy, fertility rate, child mortality, and maternal mortality) have improved since the start of the new millennium and this includes noteworthy progress in reducing HIV prevalence and achieving universal

antiretroviral treatment (ART) access (Vu, Fujita, Rathavy, et.al., 2014). One study has estimated that the MSM population of Cambodia is approximately thirty-one thousand (31,000) between the ages of 15 and 49 in 2014 with an HIV prevalence of 2.3% among the MSM community (Yi, Chhim, Chhoun, et.al., 2016).

Interestingly, it was noted that the introduction of the 2008 Law on the Suppression of Human Trafficking caused a shift from the initially high prevalence of HIV among female sex workers (in brothel-based work) to other key populations, such as MSM (Vu, Fujita, Rathavy, et.al., 2014). It is evident and clear that the work on HIV with MSM populations has increased the understanding of Cambodian society about different sexual orientations and gender identities albeit under the categorization of HIV 'risk groups' based on sexual acts (UNDP and USAID, 2014). On the HIV/AIDS front, the Positive MSM Network advocates for those members who face unequal access to healthcare due to healthcare providers' lack of understanding of their specific needs (Cambodia Center for Human Rights, 2012). Beyond the typical health and HIV/AIDS framework, other civil society organizations now play a very crucial role in promoting social justice and human rights for LGBT persons in Cambodia, such Rainbow Community Kampuchea (RoCK) (Lek, 2014). It is this emergent LGBT network in Cambodia that undertakes positive initiatives to fight for the rights of LGBT persons that would benefit when strengthened through increased resources, membership, and capacity-building (Cambodian Center for Human Rights, 2012).

The literature available has evidenced that despite positive messages that were espoused by members of the Royal Government of Cambodia in recent years, positive social perceptions and public acceptance is far from reality. There is also a grave difference between the letter of the law and its implementation. Certain fundamental laws (such as the 1993 Constitution of Cambodia) and other laws (such as the HIV/AIDS Law) have protection mechanism that addresses discrimination for some identities (if you are a GB-MSM who is HIV positive, for example). One of the gaps of previous literature is looking into the influence of the GB-MSM identity on the access to sexual health care that consequently leads to health disparities and this is the objective of this research.

2.3 The human right to health: specific sexual health needs of gb-msm populations

The right to health is an inclusive right that contains freedoms and entitlements such as freedom from non-consensual medical treatment and equal and timely access to essential medicines and basic health services (OHCHR and WHO, 2008). The right to health ensures that the underlying preconditions for health are fulfilled. Among the guiding principles for the right to health, is the access to health care services necessary for these preconditions which holds the most weight in this paper. The element of 'accessibility' affirms that health facilities, goods, and services have to be accessible on the basis of *non-discrimination,* within the jurisdiction of the State party. These facilities, goods, and services must be *physically and financially* accessible including the right to accessibly seek, receive and impart health-related *information,* without impairing the right to have personal health data treated confidentially. Non-discrimination, physical accessibility, economic accessibility or affordability, and information accessibility are the four overlapping dimensions of accessibility. (OHCHR, 2000; OHCHR and WHO, 2008)

The availability, accessibility, quality, and equality in access for vulnerable groups in society safeguard the right to health (Toebes, 2001). There are also specific health needs, such as mental health of GB-MSM, that need to be included in sexual health programming (Yi, Tuot, Chhoun, et.al., 2016) or the specific histories and needs of older GB-MSM adults (Emlet, 2016) and even the more obvious differential occurrence of health disparities between sexual minority men and women (Operario, Gamarel, Grin, et.al., 2015). Many health concerns experienced by GB-MSM populations are avoidable and should be addressed by health care providers (D'Souza, Wiley, Li, et.al., 2008; Garofalo and Katz, 2001). The homogenizing of an abstruse MSM group and gender blind strategies have resulted in the exclusion of the specific health needs of non-normative groups. (Earth, 2006 & UNDP and USAID, 2014).

A human-rights based approach can address the root cause of sexual health determinants in countries where sexual health is a question of "life and death" (Glasier, et.al., 2006 & Campbell, 2013). The recognition of the specific health needs of members of the LGBT Community is imperative to the goal of ensuring that the

human right to health is achieved (Ruben, Shipherd, Topor, et.al., 2017 & Pereira, 2016). A violation on the right to health in the form of institutional homophobia has subsequent consequences to health service access (Wilton, 2002 & Raja and Stokes, 1998).

The operational definition provided by the World Health Organization (WHO) in 2006, will be adapted into this study defining "sexual health" as "a state of physical, emotional, mental and social well-being in relation to sexuality that requires a positive approach to human sexuality and an understanding of the complex factors that shape human sexual behaviour". Non-heteronormative genders and sexualities have been a part of the social fabric of Cambodia's society, albeit, subject to discrimination. The denial of rights, homophobia, and discrimination increases vulnerability, reduces access to services, and drives the discourse of homosexuality underground (Altman, Aggleton, et.al., 2012 & Campbell, 2013).

The need for structural and policy change efforts to improve the health of gay, bisexual and other men who have sex with men begins with addressing the damaging effects of a hostile social and political environment (Wolitski and Fenton, 2011), ensuring a more holistic approach in improving health and well-being both in the provision of sexual health services and in the referral system (Mercer, Prah, Field, et.al., 2016), and promoting data collection that identifies the unique health needs of LGBT populations, such as increased minority stress and other serious health disparities which may heighten the risks to HIV and AIDS and generally hinder physical health (Lick, Durso, and Johnson, 2013), to effectively reduce health disparities in diverse policy systems (Wilton, 2002 & Cahill, Baker, Deutsch, et.al., 2016).

Exclusion and inequality from mainstream culture perpetuate the exclusionary practices that desirably seek to police gender and adult sexuality. This is necessary when we look beyond the civil rights paradigm and look into institutional systems and who they exclude, (Meem, Gibson and Alexander, 2010) when greater inclusion of the LGBT community may have positive impacts on the health of sexual minorities (Baptiste-Roberts, Oranuba, et.al., 2017)., especially when the patient is looking for an "LGBT-friendly" healthcare that fosters the patient's trust in the medical system (Hudak and Bates, 2018).

This has led other scholarly articles to recommend discrimination reduction strategies which provide a social and human rights climate that enable GB-MSM to access health care without fear of discrimination (Ross, Nyoni, Larsson, et.al., 2015) and ensuring that health professionals are trained and qualified to effectively step into the issues surrounding sexuality (Albuquerque, Quirino, Figueiredo, et.al., 2016). There is also the invaluable role of Persons Living with HIV and AIDS (PLHA) workers, who experience structural violence, in the development of HIV services in Cambodia that we should look into (Bureau-Point and Phan, 2015).

Health disparity or inequity: concept, components, and causes

There is variance in the definitions provided by authors on what is health disparity. It has been loosely defined as any structural, systematic, plausibly avoidable health differences, adversely affecting socially disadvantaged groups through the unequal distribution of resources for health. (Wilson, 2009 & Braveman, P., Kumanyika, S., Fielding J., et.al., 2011). Inequality and inequity are interchangeably used with the latter constituting a passage of moral judgment that social group differences in health care, based on population characteristics is wrong (Arcaya, 2015 & Rose, 2018).

The National LGBT Health Education Center (2016) have suggested that the long history of anti-LGBT bias in health care, along with the expectation of poor treatment and lack of informed health care providers, have affected the health-seeking behavior and access to care of LGBT individuals, hence it is necessary for health care providers to be informed about LGBT health. High rates of HIV and other STI, substance abuse and smoking, unhealthy weight control, depression and anxiety, violence, and victimization are some of the selected health disparities among LGBT populations in the United States of America, which may differ from actual health disparities affecting LGBT populations in Cambodia or Asia.

However, this provides us with an excellent idea for some possible commonalities. A full understanding of health disparities necessarily requires consideration of distal causes that generate the continual reemergence of health

disparities (Freese and Luftey, 2011; Phelan, Link, and Tehranifar, 2010). Several studies have attempted to provide some fundamental factors to health disparities. Socio-economic status, including its components (education, income, occupation) and indirect pathway, such as social environment affects the access to a broad range of flexible, multi-purpose resources for health benefits (Adler and Newman, 2002 & Wilson, 2009). In accessing reproductive and other health services, Schuler, Bates, and Islam (2002) point out the concept of "consumer awareness" that had brought a level of consciousness among people on the variety of health care alternatives, such as clinics and NGO services, that are a good value for their money.

There is a gap in health disparity research due the scarcity of literature that puts specific attention to men who have homosexual identities and behaviors as it tends to homogenize LGBT-identifying populations (such as Bogart, Revenson, Whitfield, and France, 2014). There is on the other hand, an overabundance of literature that links health disparities with social-economic status (such as Adler and Newman, 2002). Although studies have identified other socio-political determinants, such as availability of resources, quality of education and job training, and the existence of health policies, (namely, Grochowski, 2010 & Pacquiao, 2017) there are dismal references to more concrete links between sexual identity, sexual behavior, and health inequity. Bartley (2017) and Operario, et.al. (2015), correctly pointed out two things, "power structures" breed health inequity and disparities persist beyond socioeconomic factors. Another observable gap of current literature is the lack of health disparity research in non-Western countries and (more specifically) on health disparity of non-normative sexual identities in non-Western countries.

Conceptual Framework of this Study

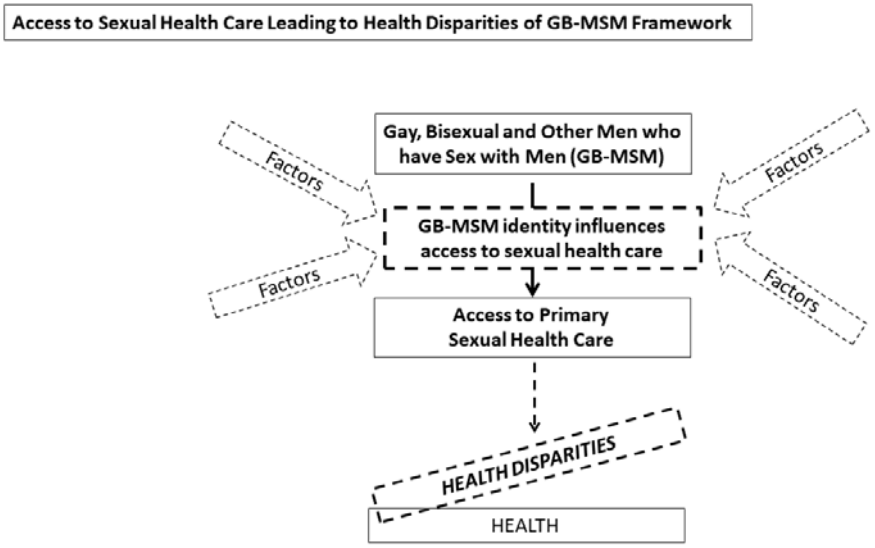


Figure 2.1 Access to Sexual Health Care Leading to Health Disparities of GB-MSM Framework

In this study, the GB-MSM identity, within a larger societal and historical context, is central to this conceptual framework as the research question seeks to determine whether the identity influences the access to sexual health care. The right to health is compromised when health disparities exist among the GB-MSM population. The conceptual framework uses a structural approach that sees a society with an ordered existence which shapes and constrains the lives of its individual inhabitants (Rahman and Jackson, 2010), in this case, GB-MSM individuals.

2.4 Queer theory introduced

Queer theory today can be attributed to the early works of Eve Sedgewick (1985) and Judith Butler (1990). The pioneering work of these scholars continues to inspire the queer theoretical paradigm in contemporary literature. The notion that privilege heterosexuality is fundamental in society discriminates those outside this stem of power. The queer theory addresses the categorizing and privileging of heterosexuality as ‘natural’ and homosexuality as its deviant and abhorrent “other”. (Cohen, 1997, Browne & Nash, 2010, & Filax, Sumara, Davis and Shogan, 2011).

Queer research pays close attention to the multiplicity and fluidity of the subject and subjectivities which are sculpted not only by sexuality and gender but also by race, ethnicity, post-coloniality, and class, including categories of able-bodiness and age along with the context of place, culture and time. Scholars have noted that while the sexual subject is deemed as the central focus of queer research, there is always the possibility to extend its focus to the 'stratifying of homosexualities' and illuminating the interconnections between the class and sexuality of queer lives. (Gorman-Murray, et.al, 2010, Taylor, 2010 and Filax, et.al., 2011).

Queer theory, as a liberatory politic, radically questions social and cultural norms and destabilizes the disciplinary regulation of sexuality and gender by liberating sex, desire and sexuality that organizes all human behaviour including religion, education, family and kinship, politics, work and so on (Smyth, 1992, Cossman, 2004 & Filax, Sumara, Davis, Shogan, 2011). While queer theory is liberatory in nature, Namaste (1994) argues that it is also interested in exploring the borders of sexual identities, communities, and politics recognizing the existing paradox that although the adoption of homosexual identity allowed for the guarantee of civil rights, some people are "visible" about their sexuality while others remain silent – the notion of the "closet".

In studying sexual identities, we see that proliferating identities interlock and produce hyphenated identities. To sexuality, race, and gender we add class, physicality, religion, age, colonial, post-colonial and culture categories. This problematization challenges and destabilizes how heteronormativity organizes and structures everyday life like education, law, religion, psychiatry, family, and any other area of human activity being seen as normal and normalizing mechanisms in human relations (Filax, Sumara, Davis, Shogan, 2011). This study identifies the crucial role of the GB-MSM sexual identity which in turn plays a role in health care access leading to health disparities. Lived experiences of GB-MSM individuals will evince the manifestation of the privileging to heterosexual identity in sexual identity formation, social interactions, engagement with power structures, and perceptions of the 'normal majority'. The GB-MSM identity belongs to the 'deviant' category, hence, inherently discriminated in everyday life including access to healthcare. This study recognizes the intersectional identities of these GB-MSM individuals to fully understand sexual

identity as having a strong influence on access to health care services. As access to sexual health care is a human right, this study aspires to queer the human rights discourse around sexual health access, care, and delivery. There is also a dearth of literature that utilizes queer theory to illustrate queer subjectivities in non-Western culture (as queer theory is a Western construct itself), hence this endeavor.

CHAPTER III
RESEARCH METHODOLOGY

3.1 Research design and methods

As this study seeks to answer the question of how the GB-MSM identity is a fundamental cause of influencing access to sexual health care leading to health disparities, a qualitative research method is most suitable as it focuses on the in-depth understanding of the research subject by means of on-site fieldwork, observation, and interview (Vromen, 2018). This study employed a narrative inquiry research design looking into in-depth first-hand accounts and stories from the research participants. A narrative inquiry, according to Creswell (2013), tells an individual's story in chronological order, set within a personal, social, and historical context, including the important themes in those lived experiences. This research method would benefit this study primarily because the lived experiences of the GB-MSM respondents will determine the influence of their sexual identity as a fundamental cause to the access to primary sexual health care leading to health disparities. Narrative inquiry is deemed the most appropriate for this study as the humanizing of the GB-MSM individuals is integral to producing unique accounts of sexual identity and access to sexual healthcare.

Utilizing a blend of purposive, convenience and snowball sampling techniques, the data for analysis is collected through key informant interview and one-on-one interviews with an estimated five (5) respondents until reaching desired data saturation. The mixture of sampling techniques that this study manipulated will ultimately be determined during the course of data gathering. The selection of possible respondents is done with the assistance of civil society organizations, non-government organizations and individual activists/advocates who are working closely with GB-MSM populations. Then with the selection of these individuals from the GB-MSM populations, a possible referral system (snowballing technique) can be adopted as the

respondents recommend other persons who may fit the inclusion criteria, as stated below.

The respondents are self-identifying Cambodian/Khmer gay, bisexual or other men who have sex with men (MSM) who reside in any of the provinces of Cambodia and have accessed any sexual health service for the past year. The respondents have to be self-identifying to ensure that the study does not encroach of the respondent's personal identity and rights. As long as the respondents identify themselves as part of GB-MSM population or within the umbrella of local or indigenous Cambodian/Khmer sexual identities of men who engage in romantic or sexual relations with other men, they fit the inclusion criteria of this study. This is a crucial inclusion criterion as the sexual identity of the respondents will influence the succeeding narratives.

As part of the inclusion and exclusion criteria, the respondents should be between the ages of 18 years old and 49 years old similar to a factsheet by UNAIDS (2017), where HIV prevalence among adult men is disaggregated between the ages of 15 years old and 49 years old. This study increases the age inclusion criteria to 18 years old for ethical reasons. HIV and AIDS being a common sexual health issue among GB-MSM populations, this age range provides a clear age group that commonly access sexual health services due to risky sexual behavior that leads to sexually transmitted infections or diseases, among other things.

All other demographic variables such as employment, level of education, and place of residence will not be included in the inclusion and exclusion criteria. To provide a health service provider lens to the study, the researcher will also be conducting eight (8) Key Informant Interviews (KII) with health service providers and technical experts who work in sexual health-specific clinics or non-government organizations providing primary sexual health care. The inclusion criteria for the KII respondents shall solely be their experience (in years, at least more than 5 years) working in a sexual health-specific clinic of non-government organizations providing primary sexual health care services, that are frequented by GB-MSM individuals.

The interviews will be non-schedule-structured or semi-structured interviews, also known as, focused interviews. With its focus on the subjects' (respondents') experiences regarding the situations under study (Frankfort-Nachmias

& Nachmias, 1996), a semi-structured interview complements a narrative inquiry research design as it allows for a flow of more narratives and an added opportunity to ask more questions. The interviews will be conducted primarily in English but when necessary Khmer language will be used only for more technical terminology and those that cannot be directly translated to English. An interpreter will be used when there is a need to provide a precise translation of certain words. A copy of the interview questions have been attached as "Appendix A".

The data gathering was done between April to June of 2019 in Phnom Penh, Cambodia. The participants were either permant residents of Phnom Penh or temporarily residing in Phnom Penh for various reasons (employment and education as two of the common reasons) but were born and raised from various parts of Cambodia. The KIIs were done with United Nations agencies (particularly UNAIDS) and non-government organizations and associations. This was a limitation as KIIs with government hospital and health centers would require an ethical board approval obtained from the "*National Ethics Committee for Health Research*", which the author did not have. However, the data provided by KIIs from non-government institutions contributed to providing an essential contextual backdrop of sexual health service access in Cambodia both for sexual health services of government and non-government agencies. The KIIs from non-government institutions yielded substantial findings which contributed to the succeeding chapters of this paper.

A narrative analysis strategy will be used upon collection of the data which will then be discussed thoroughly in the results. Bryman (2004) stresses on narrative analysis as an approach that emphasizes the stories that people employ to account for events. The approach according to him elicits and analyses data which are the temporal sequence of the storyteller's (the people) life. The narrative analysis approach will enable the researcher to formulate and describe, while identifying trend and themes, in the stories presented by respondents taking into account the context of each case and different experiences of each respondent. If there is a need for a translator in the analysis portion of the study, a Khmer speaking person was tasked to assist the researcher in doing so. There are different forms of narrative analysis – some focus on 'content' of stories; others on 'meaning' (maybe both). This study focused on the content of the stories provided by the participants/respondents. As Polkinghorne

(1995) and Etherington (2004, p.81) explain, narrative analysis treats stories as knowledge constructions in their own right that values messiness, differences, depth and texture of experienced life which constitutes 'the social reality of the narrator'.

Finally, to strengthen this section on the methodology, triangulation of the data essentially allows for cross verification of the data secured from the participants. This study triangulates its data by first looking into UNAIDS fact sheets (such as the UNAIDS, 2017 factsheet) and available population-specific sexual health data from non-government organizations, obtained through empirical and designed research methodologies, to determine the right age groups, geographical location, services accessed and other similar contextual data. These provide secondary literature and pre-existing statistical and empirical data which are paralleled with the data obtained during fieldwork. Secondly, the duality of narratives obtained from sexual health service providers (the KII, in this study) and the GB-MSM populations (the participants, in this study) are co-dependent as they show two interlinked processes and experiences from the medical side and the patient side. These will be further elaborated and shown in the fourth chapter of this paper. This method will bring a single harmonious process to the 'data gathering' and 'analysis' portion of this study.

3.2 The narrative in-queer(y) methodology

In the introductory chapter of their book Schilt, Meadon and Compton (2018) encourage scholars of sociology (and sexuality) to veer away from the narrowing and stigmatizing focus on sexual deviance and into a pluralistic view of sexual differences applying the queer idea that sexual power permeates all aspects of the social world. In order to "queer" methodology Gorman-Murray, Johnston and Waitt (2010), encourages researchers to rethink how narratives are appraised by giving prime concentration on the sexual subject and subjectivities. This methodology allows a query into the complexity of human subjectivity through sexualized and gendered constructions (Detamore, 2010). This theory responds to the normalization of heteronormativities and practices that biased on monolithic ideas of social norms and taxonomies.

To queer methodology is to go beyond just acknowledging diversity, it requires navigating fluidity and dynamism in multi-disciplinary (which are often rigid) fields of thought. This refusal of of orthodox methods is what Ken Plummer (2011) calls a “queer standpoint”. This stance decenters identity and shuns all normalizing strategies. This study’s narrative method ought to be “queered” as it challenges sexual identity categories while soliciting the deconstructionist insights of queer theory.

Utilizing the stories of the participants, challenging how sexuality is labeled, regulated and controlled, under categories of “deviant”, “risky” and “unhealthy”, we may discover the power structures enabling this and its effects on social interactions (Hoppe, 2018). Sociologists, sexologists and psychologists alike have delved into methodological applications of queer theory that discusses sexual control, body politics and the performative nature of identity (in the works of Warner, 2004, Hoppe, 2018, and Ruvalcaba, 2016). In this research “*queer(y)*” we move toward presenting the narratives of Khmer GB-MSM individuals and medicalized notions of sexual identity (and behavior) impacting the navigation of sexual health access.

3.3 Importance of research and ethical considerations

The findings of this study situated in Cambodia can be replicated in other countries in South East Asia. This study hopes to delve into a discussion on the right to health in relation to the sexual identities of certain individuals. Specifically, how sexual identity plays a role in the manner certain populations are afforded their human rights. The importance will determine further programming of sexual health services for sexual and gender minorities. It is important to note that a major limitation in this study is in the fact that the results in the succeeding sections will reflect the experience of only five (5) respondents and should not be taken as the general perception of GB-MSM individuals in Cambodia.

Throughout the course of this study the anonymity of the data, which can be delicate and sensitive, will be given top priority. This can include, but not limited to, the respondent’s sexual orientation, gender identity, sexual activity, sexual

behavior, and HIV status. In order to keep the privacy and identity of the respondents confidential, the researcher will not be using their real, birth or legal names.

A participant's information sheet and consent form will also be provided and signed prior to the conduct of any interview with the respondents. If at any point, the respondent chooses to withdraw from participating in the study due to discomfort, risk or difficulty, he will be fully allowed to do so. All information gathered will be kept confidential. Finally, the thesis was implemented after being provided with approval from the Institutional Review Board (IRB) of Mahidol University, Thailand (See Appendix B)

CHAPTER IV
RESULTS AND DISCUSSION

4.1 Introduction

The Ministry of Health of the Royal Government of Cambodia's mission is to ensure sector-wide, equitable, and quality healthcare for all people of Cambodia especially the poor and areas of greatest need. Henceforth, health policies assert that all people of Cambodia, regardless of gender, age, residency, or financial ability, should have access to good healthcare and information (Ministry of Health Royal Government of Cambodia, 2006). Provided that policies are in place that would ensure universal access to sexual (and reproductive) health services for different key populations in all of Cambodia, there still remain other factors that hinder access to sexual health services. This study hopes to describe the experiences of Khmer GB-MSM individuals in accessing sexual health services through narrative analysis and through the descriptive methodologies.

As this study utilizes humanistic values, such as human rights and the reduction/removal of human sufferings, this analysis will focus on human experience and its daily lived nature acknowledging political and social roles. One methodology of humanism is life story strategies. This intersects with the theoretical framework of this study, queer theory, as it seeks out political and ethical backgrounds into sexual identity, its representations, and complexities (Plummer, 2011).

This study's participants included the following GB-MSM participants. The participants all fit the inclusion criterion that was set by this study. Their full information will be found in their individual sections that narrate their lived experiences. The key informant interviewees of this study provided vital information on the context of sexual health provision, LGBT rights and HIV/AIDS statistics of the Kingdom of Cambodia.

The participants of this study include the following persons and their age. These are not the real names of the participants rather 'codes' derived from sections of the legal names of the participants put together:

Table 4.1 Table of Participant Names and Age

Mony	18 years old
Sos	34 years old
Keo	39 years old
Kong	27 years old
Dee	24 years old

The key informant interviewees of this study include the following persons and the organizations or agencies which they belong to. Permission was obtained to use the name and organization/agency of the key informant interviewees in this study:

Table 4.2 Table of Key Informant Interviewees Name and Organization/Agency

Kem Vichet	Men's Health Cambodia (MHC)
Gavin Tsai	KHANA Organization
Rachana Chhoeurng	Micro Rainbow International Foundation
Prach Sinath	Reproductive Health Association of Cambodia (RHAC)
Yun Phrearun	Chhouk Sar Clinic / Chhouk Sar Association
Srorn Srun	CAM ASEAN Youth's Future
Polin Ung	UNAIDS Cambodia

The key informant interviews conducted by this study provided in-depth and expert facts on the context present in Cambodia with regard to GB-MSM populations, their access to sexual health services and the fulfillment of their rights to health.

The organizations or agencies included in this study along with their short descriptions are as follows: **Men's Health Cambodia (MHC)**, a non-governmental

and non-profit organization working on MSM, Transgender and drug users issues in Cambodia. **KHANA,** a linking organization of the International HIV/AIDS Alliance and the largest national NGO providing HIV prevention, care, and support services at the community level in Cambodia, as well as integrated sexual and reproductive health, family planning, maternal-child health, TB and livelihood programming.

Micro Rainbow International Foundation addresses the situation of poverty of LGBTI people in Cambodia. It envisions to contribute to a world where lesbian, gay, bisexual, trans and intersex (LGBTI) people can achieve their full potential in life and have equal access to employment, training, education, financial services, healthcare, housing, places of faith, and public places and services. **Reproductive Health Association of Cambodia (RHAC)** is an indigenous Cambodian non-governmental organization (NGO), which was established in 1996 with a strong determination to bring quality health services to the community, especially for the poor and vulnerable sections of the population.

Chhouk Sar Clinic / Chhouk Sar Association provides quality treatment and care services to people living with HIV/AIDS, including STI/Family Planning, HPV and Voluntary Counselling, Care and Treatment (VCCT) services to the most at-risk population living in Phnom Penh. **CAM ASEAN Youth's Future** works to combat discrimination against the diversity of minority people include LGBT, young girls living with HIV/AIDs, sex workers, drug users, disable girls, widows/single mothers, elderly, indigenous and other ethnic peoples in Cambodia.

Finally, **the Joint United Nations Programme on HIV and AIDS** (**UNAIDS) Cambodia** is the country office of UNAIDS, which is leading the global effort to end AIDS as a public health threat by 2030 as part of the Sustainable Development Goals.

The succeeding parts of this paper will present the stories and narratives of GB-MSM individuals from Cambodia in accessing sexual health care services. However, this study finds it beneficial to initiate the discussion by providing perspectives from health services providers. The next section will discuss what health services providers, like NGO-ran clinics and health centers, and national sexual and reproductive health organizations believe are the primary reasons why GB-MSM individuals do not access sexual health service.

PART 1: The contextual backdrop of the health structure of cambodia

4.2 Laws, policies, sexual health and hiv care in cambodia

UNAIDS provides the strategic direction, advocacy, coordination and technical support needed to catalyze and connect leadership from governments, the private sector, and communities to deliver life-saving HIV services. UNAIDS generates strategic information and analysis that increases the understanding of the state of the AIDS epidemic and progress made at the local, national, regional and global levels (taken from UNAIDS 2016-2021 Strategy). Therefore, the mandate of UNAIDS Cambodia is to lead on the efforts of the United Nations to eliminate HIV and AIDS in Cambodia.

Mr. Polin Ung is the community mobilization and networking adviser of UNAIDS Cambodia. Mr. Ung provided details into policy and strategy advocacies of UNAIDS to provide accessible HIV testing, prevention, treatment, and care. He noted that current national policies provide protections only to key populations as defined by the "*Law on the Prevention and Control of HIV/AIDS*", these include, MSM, transgender, people who use drugs (PWUD), people who inject drugs (PWID), female entertainment workers (FEW) and sex workers. The HIV/AIDS Law enacted by the National Assembly of Cambodia on June 14, 2002, specifically states in Article 2 that,

> "*Section 2: Prohibit all kinds of discrimination against those persons suspected or known to be infected with or affected by HIV/AIDS;…*
>
> *x x x*
>
> *Section 6: Mainstream HIV/AIDS prevention and control programs, and make it a priority in the national development plan."*

The protection against discrimination stated in the national policy provides protection only on the basis of health or HIV status (perceived and actual) and not on the basis of a person's perceived or actual sexual orientation and gender identity, including being LGBT. Favorably in Cambodia, there is also currently no law that

criminalizes or persecutes citizens on the basis of their sexual orientation, gender identity and HIV status (compared to neighboring ASEAN countries like Myanmar, Malaysia, and Singapore).

> As Mr. Ung stated *"there is still a lack of an overall policy around sexual and reproductive health and rights for LGBT overall… In practice, there is a lot of discrimination and harassment for LGBT individuals. UNAIDS and other UN agencies, together with LGBT communities, are working together to advocate non-discrimination laws, ensuring legal documents that reflect their gender identity, non-discrimination in school and healthcare settings and even same-sex marriage."* [sic]

It was noted in the conversation with Mr. Ung that the Royal Government of Cambodia's Ministry of Education has started to include contents related to sexual orientation, gender identity and expression in the primary and secondary education curriculum. This would contribute to "reducing stigma and discrimination".

Srun Srorn, the founder of the Cam ASEAN Youth's Future, provided three angles that may have contributed to the weak engagement with GB-MSM populations and the LGBT community as a whole. Mr. Srorn attributes the lack of engagement on these three levels: "systems", "NGO level/movement level", and "community level". According to him, at the systematic level, the RGC has not taken an initiative to develop a national plan to support LGBT populations and this is conspicuous as the "government don't (doesn't) care or talk about it (LGBT)". The young LGBT movement being fragile and fragmented is the second reason at the NGO level. Although there was a Gay Pride Celebration in Phnom Penh in 2003, it was only in 2009 when a largely endorsed and formal civil society organization called Rainbow Community Kampuchea (RoCK) was formed by Khmer individuals themselves (Lek, 2014; UNDP and USAID, 2014).

The third level that Srorn describes relates to the fragmented LGBT movement, at the "community level", economic disparities divide the community between "rich" and "poor" LGBTs, which often clash resulting in disunity. These, according to Mr. Srorn, contribute to the rise of interrelated issues that cause barriers

to GB-MSM populations (arguably a subset of a larger LGBT population) from accessing sexual health care services.

Moving into sexual health care in the country, this visual provides a guide to the process of sexual health care provision in Cambodia. Gavin Tsai, the technical advisor of KHANA Cambodia, explains the "*HIV Care Cascade*". It should be noted that the following HIV Care Cascade may not necessarily be similar to the provision of other sexual (and reproductive) healthcare services (like Hepatitis A and B testing and treatment, hormone therapy for transgender individuals, and cervical cancer screening). It should also be noted that this is not often a linear process and there may be slight (or considerable) deviation in the procedure. However, to provide a benchmark for succeeding discussions, let us operationalize this process as shown below:

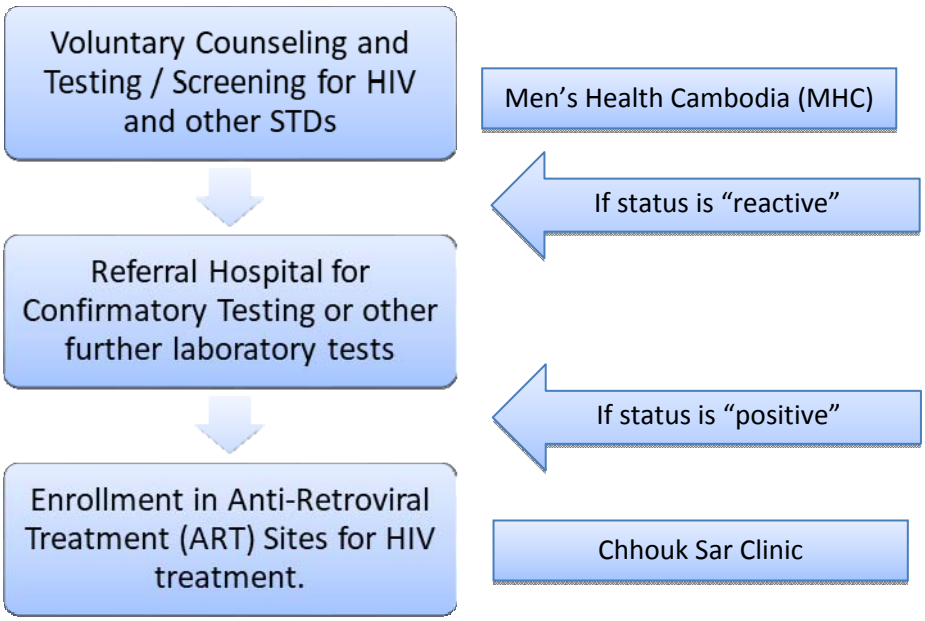


Figure 4.1 HIV and AIDS Care Cascade in Cambodia (Developed through compounded information gathered from KIIs in Cambodia)

The HIV and AIDS care cascade above shows a coherent process which a client (who is GB-MSM) would typically undergo. Moreover, this process normally applies to HIV/AIDS (and closely similar to Syphilis), while other sexually transmitted infections and diseases (STIs/STDs) may follow a similar process with

slight variation. In the HIV and AIDS care cascade, it begins with the voluntary counseling and testing (VCT) of the client. The testing may come in the form of the clinical testing in government-run or NGO-run clinics, such as Men's Health Cambodia, or through the outreach initiatives of some NGOs.

In both the clinical and outreach settings, the client has the potential to receive a "reactive" or "non-reactive result". This result indicates the presence of "HIV antibodies" in the client's blood. The client along with the blood sample is then sent for confirmatory testing at a referral hospital for a second test. The result of which is usually "positive" indicating that the client is living with HIV. The final step is enrollment at a treatment clinic or facility, commonly known as antiretroviral treatment (ART) sites. These ART sites are clinics, such as Chhouk Sar Clinic, that regularly dispense medication for the client.

4.3 Outreach initiatives and peer-based interventions for b-msm populations

MHC, located in Khan Daun Penh, Phnom Penh, is a sexual health clinic that specifically caters to MSM and transgender populations. During a focused group discussion (FGD) with seven (7) staff members of MHC, they revealed that MHC had reached out to almost 10,000 MSM in nine provinces of Cambodia. MHC's clinic offers HIV/AIDS voluntary counseling and testing (VCT) services, STI/STD testing, doctor check-ups, free condoms and lubricants, and information on matters related to sexual health. Kem Vichet, Program Manager of MHC, also revealed that their programs focus on HIV and STI prevention. Note that the FGD was not planned in the original methodology. Mr. Vichet served as a translator and allowed for the staff of MHC to introduce the program and engagement with GB-MSM populations. It was noted that most of their clients identify as "*Srei Sros*" or "*Boros roum Phed chea mouy Boros*". Specifically, it is their "*MStyle Programme*", a multi-channel HIV prevention and sexual health program, which has allowed GB-MSM populations to access sexual health services outside of clinical settings: outreach, events, hotline, website, and Facebook groups. MHC has been known to rely on "virtual outreach" to increase the uptake of HIV/STI/STD testing and maximize platforms for promotion of HIV

prevention information. It is common for MHC staff, health care providers and outreach workers to use online Facebook pages to disseminate information to GB-MSM individuals.

Interestingly, MHC applies a Peer-Driven Intervention model (*PDI Plus*), which is a process of new case detection, HIV prevention education, proper condom and lubricant use, and STI testing services information through field workers that also identify themselves as MSM (more information on this in succeeding section).

Included in this outreach model is MHC's pilot HIV self-testing (HIVST) service. The pilot self-testing allows MSM (and other populations) to administer an HIV rapid diagnostics test (RDT) and interpret the results in private. One study has investigated the acceptability and perceived barriers of HIVST among key populations, including MSM. It was noted that the MSM respondents of that study found HIVST to be confidential and convenient and preferred it to test at a health facility or through NGO outreach workers. However, lack of knowledge on its proper use, cost of HIVST kits, lack of counseling before and after testing were also seen as barriers (Pal, Ngin, Tuot, et.al., 2016). MHC also sees HIVST has having contributed to the uptake of HIV testing among MSM populations that are not easily contacted by outreach workers. Of the statistics provided by MHC since the beginning of their HIVST program, 152 MSM have accessed self-testing methods and approximately 18 have turned out reactive to HIV.

The FGD also revealed that young (adolescent) MSM who are below the age of 15 years old have to bring a parent when seeking testing for HIV or STI/STD at the MHC clinic. This is mandated by law as testing cannot be done to a minor without parental consent. According to MHC staff, this has posed as a barrier to young MSM who are sexually active and engaged in unprotected penetrative sex and those that engage in drug use. This is especially concerning when the UNAIDS Country Factsheet in 2017 reveals an estimate of 3,300 children living with HIV between 0 to 14 years of age. Parental consent is also required for the testing of other sexually transmitted infections (STIs).

HIVST only applies to testing for HIV antibodies. As the FGD reveals, despite several initiatives such as virtual outreach, PDI Plus, and HIVST, many MSM face barriers in accessing sexual health services. Although MHC's sexual health

services are not limited to HIV counseling, testing, education, prevention, and outreach, it is evident that most of the sexual health services accessed by MSM populations are those concerned with HIV and AIDS. Vichet also clarifies that MHS is a testing facility and not a treatment facility (this will be expounded in the succeeding sections).

Another online resource platform managed by Cam ASEAN Youth's Future is called "*Be Your Truth"* which provides sexual and reproductive health and rights information including the location and address of testing centers or clinics in Phnom Penh, Cambodia and in other provinces. Another strategy that is being used is the social media communication strategy by the Reproductive Health Association of Cambodia (RHAC). RHAC penetrates social media sites like Facebook & Instagram that are typically accessible to general and specific populations. According to Prach Sinat, communication officer of RHAC's HIV project, they operate within Facebook groups, such as one named "*69 club*", where the engagement of *Boros Sralang Boros* (Men who love Men) is high. RHAC uses these platforms to promote HIV awareness, how to prevent sexually transmitted diseases/infections, and where to get tested.

4.4 Financial capabilities: cost of sexual health care services

Another identified external factor in access to sexual health services is the affordability of services. Affordability may be an issue as many GB-MSM seek services that are well within their financial capability. The current HIV prevention package of many NGO-ran clinics, such as Men's Health Cambodia Clinic and the Chhouk Sar Association Clinic, are free of charge. However, other sexual health services like testing for Hepatitis A & B, sexually transmitted infections/diseases like Gonorrhea, Chlamydia, and Syphilis, and other lab tests come with a small fee. Doctor check-ups may also come with a fee depending on the clinic, especially with private and public health service facilities. Generally, condoms and lubricants are free in NGO-ran health centers and are easily accessible in convenient stores but with a price.

Treatment for HIV is also free in Chhouk Sar Clinic which operates under the new national HIV guidelines. According to Yun Phearun, program manager of the Chhouk Sar Clinic, the dream is to establish a system where they, "*test today, enroll today, treatment*

today". This system will allow easy and speedy access to HIV treatment for key populations, including GB-MSM, by providing same-day enrolment to treatment when they get tested and receive a "reactive" status. Chhouk Sar Clinic provides services to reduce new HIV infection and AIDS-related deaths. They also provide support against stigma and discrimination. Chhouk Sar Clinic is one of the few HIV treatment centers (otherwise known as ART sites) in Phnom Penh. In the data provided by Chhouk Sar, between the period of January to December 2018, about 366 MSM who are living with HIV had received anti-retroviral treatment (ARV) from the clinic. This data provided might be limited to just one clinic, however, this is to show that treatment for HIV is, in fact, available and accessed by GB-MSM populations. The availability of treatment may be attributed to financial donor funding provided for HIV/AIDS treatment in Cambodia. The data also shows other key populations that received ARV from the Chhouk Sar Clinic.

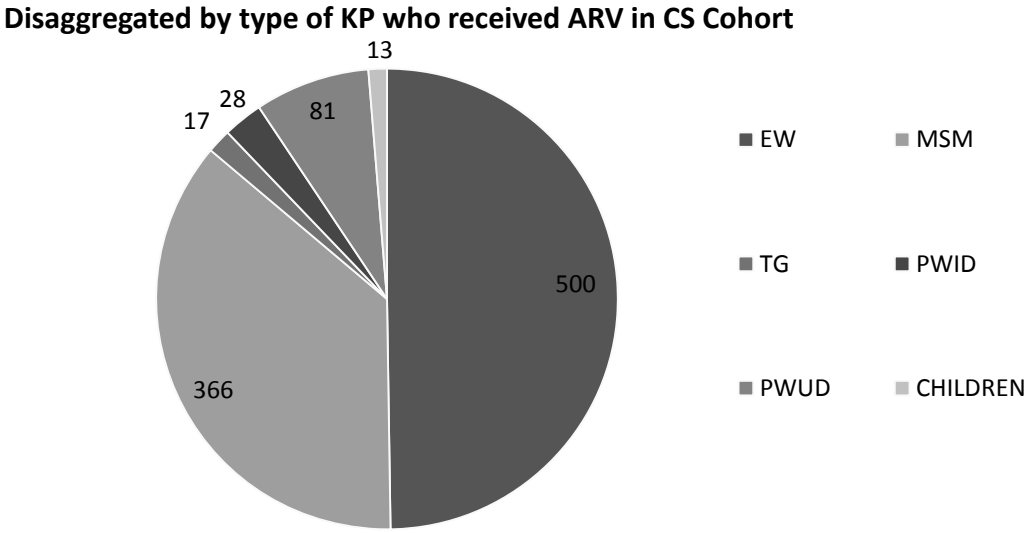


Figure 4.2 Graph showing the number of "PLHIV who are active on ARV in CS Cohort, Start up-Dec 2018".
This is taken from the "*CS Progress update Jan-Dec 2018*" provided by Yun Phearun, Chhouk Sar Clinic

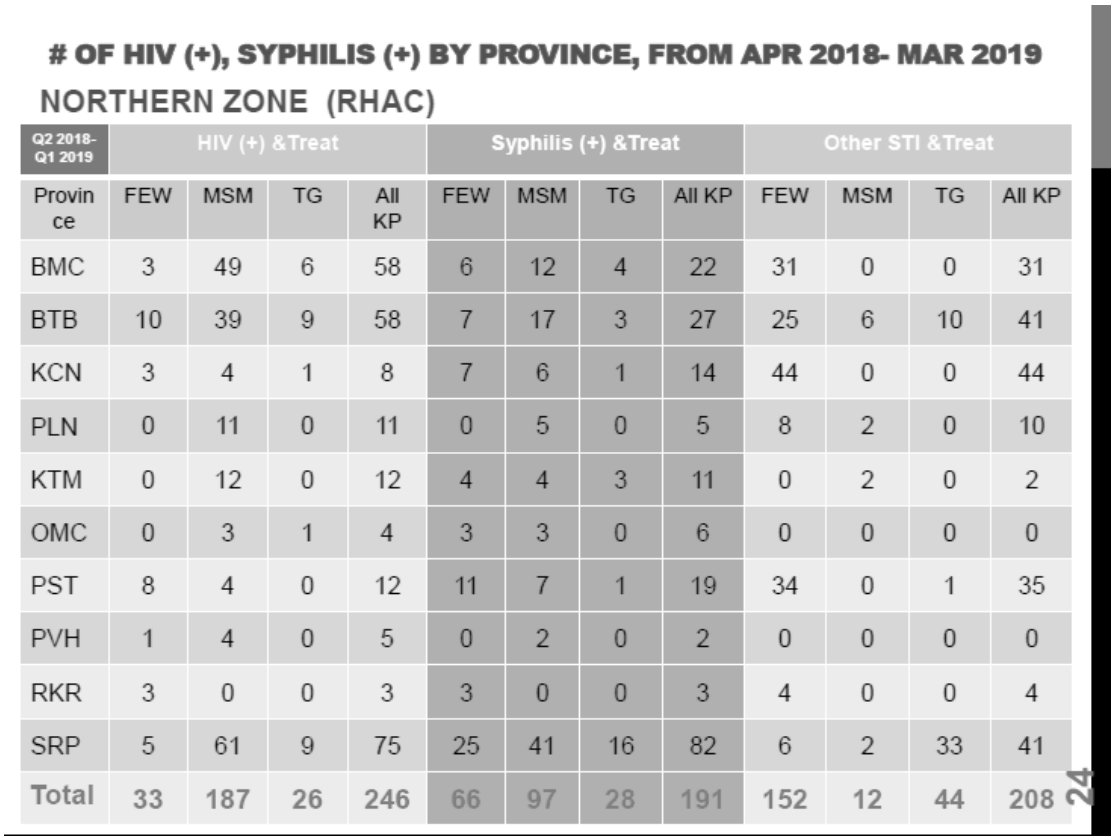
Another factor associated with affordability is that many GB-MSM individuals do not own a "poor I.D. card". Rachana Chhoeurng is the founder of Micro Rainbow International Foundation in Cambodia which works on economic empowerment and poverty reduction of marginalized communities. Rachana explains

that the poor I.D. card allows Khmer individuals to access free public health services usually from the government. It was noted that based on conversations with GB-MSM individuals the application and issuance of a poor I.D. Card from the local authority is generally not easy as the process takes a long time especially when the government official issuing the poor I.D. card discriminates LGBT persons.

According to Prach Sinath, the poor I.D. card is useful if they (GB-MSM) community members have it. She estimates that a low "5% of key populations have a poor I.D. card". This relatively low number of the person who has a poor I.D. card is alarming as this government-issued document ensures free health care services for indigent Khmer people. In addition to this, Ms. Sinath noted that young GB-MSM individuals who "live with family and don't have money" are not able to access sexual health services. Coupled with the fact that they have not disclosed their sexual identity to their parents or immediate guardian and the need for parent's consent for a minor to receive testing puts young GB-MSM below the age of 18 years old in an arduous situation. Williams (2010) noted that many poor Khmers cannot afford medical care and die early which spelled disaster during the 1990s when the first HIV infections reached Cambodia. Generally, poor I.D. cards are used for government or public health care services; another issue has to do with the available funding for sexual and reproductive health services. As several informant interviewees have noted, donor funding for sexual health care services, such as operational costs, staff salaries, testing equipment, and kits, treatment medication, among other things, have decreased over the past few years. Srorn noted that funding is available for HIV prevention programs (although decreasing) and there is very low funding for testing and treatment of other sexually transmitted infections and diseases. The Ministry of Health (MOH) of the RGC provides funding for these specific sexual health services on STI testing and treatment, however, non-government organizations, such as MHC, Chhouk Sar, RHAC have to offer their services for a minimal fee. However, even this minimal fee is proven to be too much for some GB-MSM individuals as the uptake rates of testing remain stagnant. RHAC has similarly admitted that certain services now charge a fee due to the rapidly decreasing donor support for HIV testing and treatment.

Evidence of the upsurge of HIV testing and treatment and the continued diminishing number of testing for other STIs is visible in the data provided by RHAC

in the 10 provinces where it operates (including Siem Reap, Battambang, Krong Pailin, and Pursat). The number shows that for the period of April to March 2019 only 12 MSM received examination and treatment for other sexually transmitted/reproductive tract infections (STI/RTI), excluding Syphilis (as a separate number of 42 MSM receiving Syphilis finger prick test was shown). This is an immense contrast with the 187 MSM who were tested for HIV through the finger, in the same period (See Figure 1 below).



 # OF HIV (+), SYPHILIS (+) BY PROVINCE, FROM APR 2018- MAR 2019

NORTHERN ZONE (RHAC)

Q2 2018-Q1 2019	HIV (+) &Treat				Syphilis (+) &Treat				Other STI &Treat			
Province	FEW	MSM	TG	All KP	FEW	MSM	TG	All KP	FEW	MSM	TG	All KP
BMC	3	49	6	58	6	12	4	22	31	0	0	31
BTB	10	39	9	58	7	17	3	27	25	6	10	41
KCN	3	4	1	8	7	6	1	14	44	0	0	44
PLN	0	11	0	11	0	5	0	5	8	2	0	10
KTM	0	12	0	12	4	4	3	11	0	2	0	2
OMC	0	3	1	4	3	3	0	6	0	0	0	0
PST	8	4	0	12	11	7	1	19	34	0	1	35
PVH	1	4	0	5	0	2	0	2	0	0	0	0
RKR	3	0	0	3	3	0	0	3	4	0	0	4
SRP	5	61	9	75	25	41	16	82	6	2	33	41
Total	33	187	26	246	66	97	28	191	152	12	44	208

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Figure 4.3 Number of HIV (+), Syphilis (+) by Province, from April 2018 – Mar 2018 in the Northern Zone coverage of RHAC.

Taken from the "*Achievement of HIV Prevention Project in Northern Zone*" Report provided by Prach Sinath, RHAC Cambodia.

4.5 Confidentiality, disclosure, and reliance

It is beneficial to note that during the key informant interviews one thing surfaced: GB-MSM individuals possess other identities that subject them to specific vulnerabilities. Intersectionality plays an integral role in the succeeding analysis of the results. GB-MSM individuals additionally identify as a youth, the person who inject/use drugs (PWID/PWUD), sex workers, persons living with HIV (PLHIV), among other identities. Each of these identities has its own distinct added vulnerability. Mr. Vichet of MHC noted that "MSM have different situations. MSM selling sex also faces stigma", This was to highlight that there has been a case of harassment by police authorities to MSM and Transgender sex workers in public parks at night.

Ms. Sinath of RHAC noted that "some MSM are young key populations and don't know any information on SRHR". Due to this lack of information on SRHR, there is a reliance on informal channels of information such as peers (friends and classmates), which often result in receiving erroneous information. One effective method being exercised by Chhouk Sar Clinic is a *"Partner Notification Test and Treat"* model, as all partners (romantic and sexual) of GB-MSM individuals are an equivalently high risk of acquiring HIV. This model encourages newly tested MSMs to contact and persuade their partners to get tested as well. Going beyond the lack of information, we have discovered that lack of access goes beyond the availability of channels of communication and the availability of resources.

Another strong factor that contributes to the low uptake of sexual health service access is the fear of disclosure, the lack of confidence to health service providers due to previous bad experiences, and lack of confidentiality of health service providers. Confidentiality arose multiple times as a major factor in the interviews with several key informants. Mr. Tsai of KHANA provided an explanation to the desire of GB-MSM to remain "hidden" – "Being gay entails being attached to sexual behaviors". This attachment to sexual behaviors causes GB-MSM individuals to be labeled as immoral, promiscuous, predatory, and illegal (the biomedicalization of homosexuality as explained in the theoretical framework). He further expounds the reality that "a person struggling with sexual identity won't be able to take care of sexual health".

Sexual identity has surfaced here as a game-changer when paralleled with sexual health, consequently in the access to sexual health care services. Confidentiality comes into play when designing effective outreach and intervention programs. As Mr. Vichet of MHC explains, “the office (referring to the clinic of Men’s Health Cambodia) looks like it focuses on MSM (referring to the perception of people towards the services offered at the clinic).” This has prompted MHC to design an outreach program where GB-MSM individuals can make an appointment by phone so that an outreach worker can visit their private homes. Hidden from the public eye, testing at homes removed unwanted attention to GB-MSM individuals, who choose to undisclose their sexual identity to the general public.

Several organizations and clinics that offer sexual healthcare services apply a peer-based model (such as MHC’s peer-driven intervention model). This is intended to build trust between outreach worker or healthcare provider and the GB-MSM identifying client. Although peer-based models exist in Cambodia, Mr. Tsai of KHANA noted that the “Peer support model is lacking. Peer-based model is the foundation of HIV work”. Peerage would ideally instill confidence between the health service provider or outreach worker and the GB-MSM identifying client. Mr. Tsai clarifies that the peer-based model “doesn’t mean lack of the clinical setting”. Part of the standard operating procedure of any peer-based model is to first introduce the concept of confidentiality to the client. This is believed to be an effective way to increase the modes of accessing sexual healthcare services.

Chhouk Sar Clinic also utilizes a peer-based model as they pride themselves as being “better than public (healthcare) services”. Mr. Phearun explains that Chhouk Sar Clinic, “has high potential to work with key populations and they have low waiting time.” Apart from that, Chhouk Sar’s peer-based model is not driven by GB-MSM individuals but by persons living with HIV (PLHIV). Chhouk Sar Clinic being both a testing and treatment center have a large number of GB-MSM (and non-GB-MSM) clients who ultimately (after HIV testing – regardless if self-tested or clinically tested) turn out to be PLHIV, as well. The peer-based model here allows the client and healthcare provider to build trust and confidence with the PLHIV (and GB-MSM) client on the grounds of shared experiences. This leads to medication adherence and an increased uptake to treatment enrollment.

The peer-based model has bridged the gap between the distrust of the GB-MSM community to sexual healthcare providers due to lack of confidentiality and outreach initiatives of organizations to ensure the access to sexual health services for GB-MSM populations.

In this section, we have established the following context-specific facts about access to sexual health care services in Cambodia. The next section of this paper will provide the narratives of young GB-MSM from Cambodia.

PART 2: Narrative from over the rainbow: humanizing gb-msm sexual health care access

This study analyzes the narratives of five (5) Khmer self-identifying GB – MSM persons. This section will utilize narrative analysis through a descriptive and story-telling method. It is divided into two sections, the first being a narration of the self-discovery of the participants. This will outline the “coming out” stories of the participants, including the struggles that they have experienced as a person who identify themselves as GB-MSM.

The second section will provide the sexual health access experience of the participants. It will highlight their perceptions of the sexual health service; the process undertaken to receive the sexual health service and the factors that prevent access to sexual health services. The participants have also provided information on the legal, political and cultural context of Cambodia which facilitates or hinders access to sexual health services.

Both sections of narratives from the participants exert a queer methodology by elucidating the statements of the participants beyond typical notions of sexuality and gender. This means that while the experiences of sexual health care access, premised by this study, advises or is advised by sexual identity, we also take into account other intersectional subjectivities such as family relations, employment / educational status, economic factors, genealogies, mobility, among other things. In order to also queer the narratives in this area-specific study, that talks about sexual identities in Asia, we treat the experiences as unique to the country or region devoid of

global values. This is the “decolonial queer praxis” that considers gender and sexuality being inherently an existing part of Asian (or Cambodian/Khmer) culture (Lee, 2019).

4.6 Stories of self-discovery: identity, acceptance and personal growth

This section will provide a nuanced chronicle of the participant’s life events that parallels with the results in the preceding section on choices of disclosure and self-identification. This study has taken into account the usage of terminology to describe and categorize the sexual identity and behavior of Khmer GB-MSM individuals.

Mony, 18 years old, noted the ‘generational gap’ in the use of certain terminologies. He narrates that,

> “I identify as gay and currently we, new generation, use English words like gay, lesbian or bi, and old people would call me as “*sak lay*”, so meaning male who have sex with male. So those terms are used by middle-aged people and for us new generation we use the English term.” (*sic*)

He recounts his initial realization of his sexual identity at a later age. The realization of his sexual identity came about when feeling towards a person of the same sex began to occur. This, to Mony, was the affirmation of being “gay”:

> “I identify as gay… you can say that I am a late bloomer because I started to realize and started to have sexual attraction when I was in 10th grade. So it was like late in high school and before that, I didn’t really have any sexual attraction. I didn’t really know like what’s going on in my body. I started to hang out with more friends and more people at 10th grade. I started to have close friends. I had a friend who was a guy and the more time I spent with him, I started to feel like (we were) more than friends. So you start to realize that you are actually not straight. It took me like a few months to realize that I am actually gay.” (*sic*)

Another participant, **Sos**, 34 years old, likened his sexual identity and gender expression with sexual behavior. It is common for gay men to adopt the gender performative expression of drag. Greaf (2015) argues that drag queen takes gender characteristics from both the heterosexual and LGBTI communities in order to create their persona, self-identity, and their stage performances. Sos intersects gender expression and sexual behavior as he changes appearance when sexual urges occur,

> "… But in the night time I always dress as a woman (drag queen) to explore sexual partner in the community… When I feel to have sex with the men, I feel to change the (my) appearance, like dress to be like a woman." (*sic*)

Sos further noted that he identifies as "MSM" or "*boros sralang boros*, however, he has also been called as *"kateuy*" which, to him is a derogatory term. Notably, there is no Khmer indigenous terminology which directly means "drag queen", in translation, which may be the reason why he is called as a "*kateuy"*¸typically used for transgender women or effeminate homosexual men,

> "When I was born, I don't know I am MSM but when I have (turned) 13 years old, I feel like I want to sex (with) the man. I want to concentrate on men. Then, when I turn 14, 15, 16, I want to love men. When I feel love, I feel sex also. For me, kateuy is bad word… very stigma. Feels not good when someone calls me "*kateuy*". (*sic*)

Dee, 24 years old, also uses English terminologies to describe his sexual identity. He recognizes the fluidity of his sexual identity and admits that this could shift,

> "Well, to me I think, I don't really want to specify myself as any specific sexual orientation because I think it changes over the years. I would say I am like pansexual but I am comfortable of being gay. For one's life, like I said, it could vary from one to another. Like right now, I have more interest

> over the same sex (gay) but maybe in the future I would like marry a girl, I don't know, or maybe something else." (*sic*)

While Dee, accepts the "gay" sexual identity, he also introduces pansexual. The term "pansexual" has been defined by Eisner (2013; p.114) as any person who "experiences desire towards people of more than one gender without identifying as bisexual" such as straight-identifying MSM.

While, **Keo,** 39 years old, shares his coming out experience and the feelings of loneliness because of not having peers that know about his sexual identification:

> "I come out as I am gay almost 10 year. Since 2009. Before I come out, I got the feeling that I feel lonely. I need a friend. I'm still hidden myself to other people. I don't want someone to know me that I am gay. That make me feel that cannot do anything. And I also decided to come out to my family that I want to be who I am." (*sic*)

He attributed his knowledge of his sexual identity to sexual orientation, gender identity and expression (SOGIE) lessons which an NGO facilitated. These non-formal educational discussions provided by civil society organizations (see Lek, 2014) are considered avenues for GB-MSM individuals to learn about sexual identity.

> "I study SOGIE. That make me so proud to be a gay and then I also saw something about information about gay in my Facebook page because people should know who we are. Why we still hide our identity? Why we don't proud and show up what we are?" (*sic*)

Keo has previously worked as a teacher and he has noted that he struggles to fit certain stereotypes enforced on him by his colleagues. As a gay man there is pressure to conform to these stereotypes in order to be accepted in social circles as he narrates his experience,

> "Some teacher and director accept me but some of them not yet because they want me to be a straight. They want me to be (like) another teacher but actually I cannot do it. You know that straight men, like other teachers, some of them also invite me to party. (They ask me) to have beer together but for me I don't like beer because they think that a straight man have to drink a beer. But for me, I don't like beer. When I go to work, I'm not comfortable. I want to do what I can. To be a good teacher does not mean that you have to follow other opinion." (*sic*)

Interestingly, one participant, **Kong**, 27 years old, identifies himself as gay but also as "*katoey*", typically used for transgender women and as a derogatory term. He narrates details of his story being born gay,

> "I can't choose myself to be gay. Nothing can change my identity and sexual orientation. I know that I am gay since I was 10 years old because (I) don't feel that I am boy or girl… definitely, I know that I am ktoey." (*sic*)

This study does not enforce labels on its participants hence Kong's identity of being *"ktoey"* was very much welcomed as it provided a sense of availability of non-Western terminology to define sexual relations and identities.

Acceptance in social circles, including family, school, and employment, was the next sequence of narratives provided by the participants. The participants have varying experiences of acceptance within the family. Some had such positive experiences with family members, like Mony who shared that,

> "… there's actually no official come out to my family. It's just like me being me and them being them… If I want to talk about sexuality or I have STD or AIDS, or if I am dating a guy, it's an easy free flow conversation with my parents… So I didn't really have to like 'Hey, mom I'm gay". I'm gonna be like "I'm not gonna marry a woman or anything like that"." (*sic*)

He noted that although his mother was unprejudiced, his father would remark against any display of effeminacy, however, this later changed when he "opened up",

> "… then my dad at first was not really into this kind of stuff. He was like when I was being a little feminine at home, 'what are you doing?". But later on the more time, I spend with him, the more I open. Everything just goes with the flow." (*sic*)

Similar to Mony, Keo was initially unsure if his family did accept his sexual identity, he retells that,

> "… now my family accept me fully. They don't reject me like before. When I just come out to them, they are all silent. Accept or not accept, they don't say". (*sic*)

However, not everyone shared the same experiences of acceptance with Mony and Keo. For instance, Sos noted that he was not accepted by his family, particularly his father, who tried to throw him away (disown him) and not allow him into the house. Strong family values strongly affected Kong's relationship with his family, he noted that

> "It is very hard for my family because I am (the) only a son … my parents are Chinese and Vietnams blood." (*sic*)

The difficulty of coming out was evident in Dee's narrative wherein, he chooses to identify as gay, rather than pansexual, as it was easier to explain to his family. He narrates that,

> "… I just told them I'm gay because it's more easier because telling them I'm pansexual would be not very clear for them. So, first I told my friends. They were very supportive because they really understand about diversity of

> sexual orientations. When I came to my mom, the first thing I told her that I use to have a boyfriend. I didn't say that I am gay or something. She brought to me an example about being gay and being tricked into a bad situation like being rob or stolen, or being cheated by gay people." (*sic*)

The experiences of acceptance within their formative years in education until college and the struggles of seeking employment provided a more nuanced perspective into the social perceptions of being LGBT (or in this case, GB-MSM) in Cambodia.

Keo, who worked as a computer science teacher, describes his experience of being a teacher for seven years and how gender options in application forms matter,

> "Some of my student know but like 70% of them don't know that I am gay. One day my identity will show up to them and I will try to make them accept me… sometimes when I apply for new job, I still keep (hidden) my identity as MSM. In our form they not ask us to show if gay or bi, only male or female. If they add information about gay, I will complete it." (*sic*)

Interestingly, as most people would usually hide their sexual identity during the employment process, Keo would willingly admit to being "gay", if an option in the application form is available. He further provides a reason why some persons would opt to keep their sexual identities hidden,

> "Today, LGBT people knowledge and education are limit(ed) because they still think that when someone knows that they are gay, they will lose job, lose friend, lose family, lose honour." (*sic*)

Workplace bullying on the basis of sexual identity has even prompted Kong to reconsider his career choice. As he recounted that during his first job,

> "… many people they insulted me and bully me in all time. I resigned from my working place and moved to be an LGBT activist in my community… I

> want to show that gay is also human and they can do good job as other people." (*sic*)

Kong now works for a non-government organization (NGO) which, according to him, has alleviated his past traumatic experiences.

> "It is hard for my life to (be) open as gay because base on my experiences, I have lost many chance and many job when people known that I am gay. I lost my big job in the TV company when my manager know that I am gay. Thus, after they found that I am gay they terminate my contract one month after." (*sic*)

Kong also remembers his experience in school where he was targeted by his male classmates,

> "Many people they don't like me even my teacher. Especially many boy always fear me fight me and sometime they touch my body. They made me hurt almost every day. I decided to change to private school." (*sic*)

For Dee, who works as an electrical engineer, he has encountered offensive jeering and inappropriate questions from his supervisors and colleagues at work. During one instance, a colleague of his verbally questioned his sexuality and uttered a crude suggestion. This proved to be a displeasing experience for Dee. He narrates that,

> "… some of my colleagues have conservative ideas about gays. I'm not happy about that, but I don't take it as a big deal because I don't want to fight anyone… They are not okay with me being gay. They would go as far as asking if there is an electric shock to make people stop being gay. I was like, "How could you say something like that?"" (*sic*)

Mony, who is taking up a bachelor's degree in tourism and hospitality management and also working as an English teacher, provided his initial thoughts about sexuality during his early high school years and how this was tested during his college days.

> "When I was in high school, I was kind of paranoid. You know like when you just discover that you're this (gay) and you don't really know what's gonna happen. What's going on? Is this going to change your life or anything? So, I was kind of panicking... School is the worse place ever for my sexuality. In college, I had a teacher, a human resource teacher, and in one of the lesson we were talking about hiring staff and he was like 'one of the three people you shouldn't hire is LGBT people and people with disability. I was so mad that I had to file a complaint to the head of study. So a lot of my teachers are really awful." (*sic*)

Mony reiterates that there is inaction among teachers when they are faced with bullying complaints related to sexual identity. He also explains that there are cases when the teacher propagates the culture of bullying through the harsh language that they use in class. Furthermore, Mony provides us with an interesting insight into the contrasting level of acceptance of LGBT persons in rural/provincial areas in Cambodia with that of urban cities and districts.

> "Well, I used to work in a music school that was funded by a church. It was kind of sensitive, I guess. I was in that environment where I was a translator for a violin class. I also teach and learn violin there… When I move here to the city, I got into better environment. So my first job was a waiter at a café. So yeah, like now I am an english teacher. I openly talk to my students that, "I'm gay!" I tell my students that sexuality is a thing and it's not fake or like that." (*sic*)

The level of same-sex relationships and certain sexual identities are differently perceived, as well, by the general population. Mony explains this clear distinction,

> "Phnom Penh, the city, and Siem Reap is like LGBT friendly, but beside these two province, it's just like horrible... For some reason, Cambodian people have like more stigma against MSM than like girls with girls. So like, in my province there is a lesbian couple who is like legally married because one of them changed their I.D. to male. Then, there is like other lesbian relationship in my province but if there is like a gay relationship, they are more against it. So, for me as a gay person, I would say like the city is more friendly and more convenient for me." (*sic*)

Another factor that would influence social perceptions towards LGBT persons, is the availability of community-led events that promote the human rights of the community. Keo provides a distinct example of the annual gay pride march in Phnom Penh, Cambodia,

> "Every year in May, it's some kind of gay pride in Cambodia. We have gay pride support and it encourage them to be so proud. And stakeholders and NGO, create discussion about LGBT. So, I think now LGBT in Cambodia, almost open and almost find everywhere. They still need advocacy to make LGBT society stay together like same-sex marriage. Right now, they (Royal Government of Cambodia) just support same-sex marriage. But we need time and we need a law. Prime minister and some of official department here support but we need some time to process, to study, to learn more how we could create the law." (*sic*)

Since recently, discussions on marriage equality and anti-discrimination laws have periodically occurred in Cambodia which may be attributed to the vibrant and visible LGBT movement in the country. The civil society space in Cambodia,

which gives rise to human rights activism, has allowed for engagements on the levels of policy development and community mobilization.

4.7 Access to sexual health care services: what is lacking in cambodia?

In the previous section, the respondents have provided their personal stories of acceptance and the formation of their sexual identities. This study hopes to provide a clear link between their sexual identities and access to sexual health care services in Cambodia. At the foundation of this study is queer theory, which positions heterosexuality as the dominant identity and ascribes oppression on the existence of binaries that inform what is normative and what is deviant.

Now we look into the individual narratives of the participants in accessing sexual health care in Cambodia. This will reveal some of the identity barriers, referring to barriers involving the participant's sexual identity, and external barriers, referring to barriers caused by other variables beyond sexual identity.

The participants described the fear of stigma and discrimination on the basis of their sexual identities as one of the factors that affect access to sexual health care. In one narrative, **Sos** shares his previous experience with sexual health care,

> "… I don't want to get tested if I don't have symptoms… I don't know what is sexual health before. When I got the feeling not good and feeling hurt, at the 'anal', I find a doctor to make a consultation or treatment. When I meet the doctor, I didn't know how to describe the symptoms because I look like a man and I have the symptoms at the 'anal'." (*sic*)

He further narrates that as the health check-up and consultation began the doctor's choice of questions and the delivery of the inquiries influenced the participant's physical ease and increased the feeling of shame. He continues his narrative by explaining the process and the line of questioning used by the doctor,

> "I feel scared when the doctor ask what is your problem?
> And I tried to tell the he feeling hurt at the anal,
> And the doctor ask him why you feel hurt this area? What did you do?
> I tell the doctor that I got "sex by anal",
> and the doctor ask me, "*Why? You are a man why you go to sex with a man*".
> I try to describe that I love man. I tried to describe my own feelings from my heart to the doctor,
> the doctor ask me, "*Why you have sex with the same sex? Why you not go to have sex with the woman?*"
> After, the examinations the doctor provide the medication. The doctor suggest I must stop to have sex with man. He said, "I should be a real man and have sex with woman. You must change the (your) status.'" (*sic*)

Sos describes the experience as "depressing" and that the doctor failed to provide "encouragement or motivation". Additionally, Sos indicated that the doctor worked in a "public hospital" or a government hospital. When asked why he didn't access an NGO-ran clinic and if he thought the experience would be different, had he done so, he shares that he would have wanted to go to *Marie Stopes Clinic* in Chbar Ampov District in Cambodia but it was too far from his home. Services provided at NGO-ran clinics is perceived by the respondent as being "more friendly" than a government hospital, however, distance from the place of residence hinders access to these "friendlier" sexual health services.

Another identified factor that affects access to sexual health care is the creation of "sub-groups" within the social circles of GB-MSM populations. These usually are prominent not only in digital spaces, such as social media platforms, but also among peers.

Keo provides some insights into his experience belonging to GB-MSM groups in Cambodia. He describes the populations as "high-risk" because of their activities, preferences, and niches. For instance, he describes "condom behavior" (or the lack of) as something that causes high-risk sexual encounters,

> "Among key population, MSM and gay is high risk for HIV. In their behavior, they still sex with men and men. They think condom is not comfortable. They think condom is not safety. MSM and gay do more "fun" almost everyday." (*sic*)

Condoms are regarded as a reliable prevention tool against sexually transmitted diseases, however, "condom behavior" is usually low among GB-MSM communities in highly sexualized settings. He describes "*fun*" as sexual encounters between GB-MSM persons usually facilitated by dating applications. Social media and the digital world have provided a veil of safety and anonymity for GB-MSM individuals who typically do not disclose their sexual identity.

> "… so they still have fun, have sex and have private communication. I mean they have privacy hidden, like their identity right now because of social media, Facebook, Line, Instagram…
> The behavior of MSM and gay right now related to HIV is that most MSM and gay use the app to contact each other like at social media and now they create the group and do live video. MSM group created using Facebook to contact other people.
> I have a lot of Facebook group. For me, I just join them but I never post. They show videos and sexy body. That is the main problem that link to HIV. They don't like to use condom." (*sic*)

Keo has provided a crucial link between HIV prevalence and the use of applications, however, this also provides us with a context where GB-MSM persons interact and build community on a regular basis. The users of these dating applications usually frequent the "scene", engage in sex work, and find multiple sexual partners for pleasure. This supposed "community" are usually not engaged in sexual health promotion and sexually transmitted disease prevention, but rather, perform and proliferate behaviors that are deemed "high risk". Keo elucidates further that dating applications are not only health risks but also security risks,

> "Also, Grindr, Blued, Jack'd, Scruff, these dating applications are very dangerous. (They are) popular for contact and for fun, also dangerous for meet up. Sex worker use Grindr for money. Dating application are not safe." (*sic*)

Confidentiality vis-à-vis affordability of the sexual health care services has been evinced as influencing each other. This is mostly visible in the narratives of Mony and Keo,

> **Mony**: "… they charge consulting also. Just because you go to like talk to diagnose, they charge for that. So, that was like a good amount of money. You have to pay for medicine also. In Cambodia, we don't have like health care from the government. So, everything you have to pay from your own pocket so that was a lot of money…
> … I go to that clinic because it was the cheap one and friendly one. I like that they don't ask too much questions like, "Did you have sex with a guy?" They didn't actually like specifically ask and like go really hard on my sexual orientation. That's kind of like friendliness and professionalism is something I would go back to." (*sic*)
> **Keo**: "Gay people most of them need free service. Some MSM, work in club, sex worker, or massage, how can we afford for private service. Public service is free. Most of sex worker prefer the public because free, but when they go, they think the doctor will know they are gay …
> … Public service different from NGO services also. Some service provider on HIV testing don't like the gay men because they think gay men is not good people. Our society still discrimination on us. Some NGO provide training to provide good service for PLHIV people." (*sic*)

GB-MSM individuals have to often negotiate the choice of accessing services that are affordable (as advised by whether the individual belongs to a certain social class) and the confidentiality measures undertaken by the sexual health service (privacy of information and use of inclusive/friendly language).

Kong's experience of accessing sexual health services yield another major factor to accessing sexual health services in Cambodia. Whilst, the experience of other participants may be displeasing, a peer-based model of service delivery has eased the access of Kong to HIV and STI testing.

> "I don't get any casual sex and I have regular partner and I always used condoms while I have sex with my boy friend. I always concern about my health too thus I always do HIV test every 3 months and SIT check-up in every months…
> I met a doctor for my HIV test in last 3 months, I visited because I don't trust my boyfriend because I am sure that I has only him but I don't know he has only me or not.
> I always went to RHAC Clinic and clinic staff they treated me very well… I have known RHAC clinic because some of my friends they working as MSM and TG counsellor in RHAC Clinic…" (*sic*)

The major factor to sexual health care access that was established in this study as an external factor is the quality of services. Mony provided comprehension into a process he underwent to determine the diagnosis of his sickness, seek the right specialist and receive the proper medication. This whole process, when factored in, would provide this study with a glimpse into the quality and delivery of sexual health care services in Cambodia,

> "The last time I got tested was like seven months ago. I got tested for HIV. I gotten like a weird disease spot so I panicked. I thought it would suddenly disappear but it didn't. So, I went to see the doctor and the care was nice… Then, the doctor suggest me to go to another place that specialized in men… So, I went to the (next) doctor, he did a test on me and he recommended me to another hospital. I don't know why but Cambodian hospitals specialize in small stuff, so you don't really get one thing in one place… So to cure my sickness back then, I went to three hospitals to actually get it done." (*sic*)

His experience included visiting three clinics which he deemed as an inconvenience but was necessary for his treatment. It was also identified during the interviews with the participants that the quality of sexual health services in Cambodia is low especially among public hospitals. One participant, Sos, would only seek sexual health care when he has symptoms but would not access it for regular screening and testing. This is largely due to the perceived low acceptability and quality of services.

The quality of sexual health services is determined according to the services available in the clinic (such as HIV/STD counseling and testing, condoms and lubricants, and other laboratory tests), swiftness of service delivery, friendliness of the reception staff, expertise and specialization of the doctor in-duty, among other things. While the lack of information on sexual and reproductive health and the appropriate clinic to visit has hindered the access to services for **Dee.** He mentions that,

> "Normally, hospitals take so much time. It won't take long. It's faster in a private clinic. If I need information, I would probably check internet but if I get STD I might go to clinic. I don't know any clinic actually that work on sexual health. The last thing I would do is go to state hospital." (*sic*)

This lack of information has developed reliance among GB-MSM populations to seek guidance and direction from alternative sources, such as MSM groups (mentioned earlier). These information and communication channels may not be necessarily reliable but they are the most accessible and frequented platforms that GB-MSM individuals use. There seems to be distrust in clinical settings due to the factors stated above. The lack of information has consequently slowed the process of accessing sexual health service and has subjected GB-MSM persons to health care services that are not suitable for their diagnosis.

CHAPTER V
ANALYSIS OF RESULTS

The previous chapter has identified, through KII interviews and participant narratives, the factors that affect the access to sexual health services. The researcher will present a table that would provide a visual guide to the findings of this study. This table is influenced by the discussion provided above. The key informant interviews have provided this study with “community factors” and “systems factors” that affect the access to sexual health care of GB-MSM in Cambodia. Sexual identity is evidently at the core of each of these factors as it determines the impact, target group, and priority of government policies and NGO support. It also determines whether outreach strategies and models of interaction are effective.

The participant’s narratives have yielded “identity factors” and “external factors” that impact or affect the access to sexual health care of GB-MSM in Cambodia. Through their narratives, this study was able to pinpoint specific lived experience wherein sexual identity played a pivotal role in ensuring sexual health care access. Some of the identity factors included the fear of discrimination and stigma and the effectiveness of peer-based models. The external factors meant that these were not influenced mainly by the participants’ sexual identities but by the current political, cultural and economic context of the country.

Table 5.1 Identity, Community, External and Systems Factors to GB-MSM Sexual Health Care Access in Cambodia

	COMMUNITY FACTORS	**SYSTEMS FACTORS**
KEY INFORMANT INTERVIEWS	Outreach Strategies (i.e. Virtual Outreach)	Lack of protection mechanism
	Peer-Based Models (i.e. PDIPlus & HIVST)	Cost of Sexual Health Care Services (in relation to the issuance of poor I.D. card)
	Confidentiality & Disclosure	The decrease in Donor Funding for NGOs
	IDENTITY FACTORS	**EXTERNAL FACTORS**
GB-MSM PARTICIPANTS	Fear of Stigma & Discrimination	Distance from Sexual Health Service
	Creation of "Sub-groups" and Peer-Based Models	Type of Sexual Health Service
	Confidentiality vis-à-vis Affordability	Quality & Delivery of Services

5.1 What have we learned?: factors to sexual health care access for gb-msm individuals

The results of the previous section have revealed four (4) categories of factors derived from the narratives of the participants. These categories of factors are influenced by and influences the access to sexual health care of GB-MSM individuals in Cambodia, at least in the perspective of the five (5) participants interviewed. We revisit "Figure 1" presented in the second chapter of this study and bridge that with the findings after interviews were conducted. The conceptual framework of this study strives to identify the factors that influence access to sexual health care. It is important to note that these factors should not be summed up merely as being all hindering

factors, as some of these may be considered as facilitating factors to sexual health care access. Needless to say, whether they are facilitating or hindering factors, this study remains adamant to link these factors with sexual identity as being the core value of sexual health programming and sexuality and gender studies.

To demonstrate the previous point, two examples from the participants will provide a viewpoint of sexual identity being a facilitating and hindering factor to sexual health care access. First, the peer-based models and outreach strategies identity are facilitating factors because sexual health programming in Cambodia is exhibited to be designed to support and hearten GB-MSM individuals to access sexual health care through outreach programs that are tailored-fit to their needs and preferences. Peerage strategies and digital outreaches as new innovative and community-specific methods to facilitate sexual health care access go beyond the conventional, clinical and medical procedure. Second, affordability and quality of sexual health care is a hindering factor as this proves highly impactful in sexual health attitudes on testing and adherence to treatment. Understandably, affordability and quality of sexual health care are advised not only by personal economic materiality but also by more structural and financial realities, such as availability of donor funding and distance from the nearest sexual health clinic. It is clear that when testing and treatment comes with a price, this becomes a high-value investment that not many persons are willing to undertake. Considering the weak health economic structure of Cambodia, which remains underdeveloped and unaffordable low-quality services become more problematic, especially for the development of programs for global epidemics like HIV and AIDS.

However, going beyond just structural circumstances of the sexual health care landscape of Cambodia, this studies queer(ed) theory veers away from surface-level analysis and aspires to challenge sexual identity genealogies and paradigms of health human rights by providing a nuanced analysis and argument into a differentiable access to sexual health care of non-heteronormative sexual identities, specifically GB-MSM individuals.

In a nutshell, the identity, community, external and systems factors to GB-MSM sexual health care access in Cambodia are those that originate from two things: social perceptions towards the ‘deviant homosexual’ and the ‘AIDS carriers’ and several intersectional elements that make up health inequity (or disparity) for GB-

MSM populations. Admittedly, this study referenced HIV/AIDS rather considerably, as opposed to other equally worth mentioning sexual health care services, in text. Although sexual health is operationally a fragment of several interlinked, amalgamated concepts this study wishes to illuminate, including sexual identity and health human rights. In the research question and objectives of this study sexual identity is seen to be a central value to the concepts of health and human rights, especially when we functionally study oppression on the basis of sexuality and gender.

If we are to trace back the unsettling histories of HIV in Cambodia we would be able to see evidence that this global epidemic is a product of cross-border interactions and processes, including displacement, migration, and conflict. Chis Beyer (2017; p.69) unveils a history of HIV in post-Khmer Rouge Cambodia between 1988 and 1990 wherein he presents three varied possibilities of how the virus entered the country through different channels: the western Thai-Cambodia border, the southern coast where Gulf of Siam meets Khmer soil, and more centrally in the heart of Phnom Penh with the influx of foreign aid. This was all in the age where cheap brothels and female sex workers were not policed strictly by the Khmer government (similarly pointed out by Vun, et.al., 2014). This history provides us with crucial insight and that is the ever-changing sexual and gender norms, advised by policy developments and foreign influences, in Southeast Asia, where Cambodia is nestled comfortably in the middle, at least geographically (the human rights record of Kingdom of Cambodia provides a different picture). This includes the evolving “sexual networks, which Beyer (2017; p. 233) later referenced in the same book. According to him, these networks shape perceptions of “risk”.

Risk is central to the advancement of public health discourse of not only HIV but also of sexual health, more generally. Central to sexual health is gender and sexuality which is shaped by and shapes prevailing social norms. The community factors and identity factors on “confidentiality and disclosure” and the inherent “fear of stigma and discrimination" are by-products of increased legal regulations and a wave of conservatism, on a global (and sub-regional) scale, where homosexuality was increasingly seen as a social problem, the antithesis of morals, and the ‘inversion’ of the respectable heterosexual (Rahman & Jackson, 2010).

Raimondo (2009) provides another outlook of the “AIDS carrier” dilemma and the proliferation of sexual categories used to define epidemiologic imagery based on “risk categories”. The rise of HIV/AIDS in Cambodia has resulted in the policing of non-normative sexual behaviors and identities, such as condomless anal sex between ‘masculine’ men seen as transgressive practices in the current prevention discourse (Gasch, 2018). Similar to the commonly used African-American terminology, “Men on the Down Low”, which describe the behaviour of men who have sex with men as well as women and who do not identify themselves as gay or bisexual, GB-MSM individuals in Cambodia are subject to a specific distinction on the basis of their sexual identity and behavior. This was visible in the narratives of participants being labeled as “*boros sralang boros”* or “*srei sros*”.

The early work of Cindy Patton in 1990 attributed the framing and interpretation of HIV/AIDS discourse as a disease attached to identities dubbed as the “queer paradigm”. This is a shift from the category of “homosexual” to ”MSM” transforming infected persons into “risk categories” and subsequently unleashed a virulent conservative campaign against sexual practices (Raimondo, 2009 & Ruvalcaba, 2016). In Cambodia, even without using English terminologies such as gay, bisexual, or even the more epidemiological term “MSM”, the Khmer general public knows that “*boros sralang boros*”, ‘*katheuy*”, “*sim pi*”, “*sak lay*” or a pleathora of other available terms, are “risk categories” of HIV/AIDS or identities that are devoid of all normalcy of sexual and gender identity.

The need to create “sub-groups” is also not an alien phenomenon in Cambodia as initially thought. “Men on the Down Low” in urban communities in America formed secretive groups whose purpose is providing opportunities to have clandestine sexual encounters with one another (Meem, Gibson and Alexander, 2010). The formation of sub-groups facilitated a notion of “community” and “unity” within similar-identifying individuals. The “down low” phenomenon in the United States bridged the intersections of queer sexualities and people of color forming the perfect concoction of oppression on the basis of sexuality and race. This study evinced other intersectional oppressions related to socio-economic status and gender expression evident in these few excerpts:

> **Keo:** "… They want me to be (like) another teacher but actually I cannot do it. You know that straight men, like other teachers, some of them also invite me to party. (They ask me) to have beer together but for me I don't like beer because they think that a straight man have to drink a beer. But for me, I don't like beer. When I go to work, I'm not comfortable..." (*sic*)
>
> **Kong:** "… It is hard for my life to (be) open as gay because base on my experiences, I have lost many chance and many job when people known that I am gay. I lost my big job in the TV company when my manager know that I am gay…" (*sic*)
>
> **Dee**: "I would say I am like pansexual but I am comfortable of being gay… My colleagues, they are not okay with me being gay. They would go as far as asking if there is an electric shock to make people stop being gay. I was like, "How could you say something like that?" (*sic*)

We can, therefore, conclude that being GB-MSM in Cambodia (similar to many other countries) means being attached to "high-risk" sexual behavior categories and subjected to heteronormative standards. Learning from the findings of this study, intersectionality became a central concept in understanding the barriers to sexual health care access. It allows us to emphasize social identities of race, class, gender, sexuality and power and the manifestations of privilege, opportunities, and subordination (Romero, 2018 p.82). Contemporary academics have established links between social, political, economic, and psychological dimensions with the systems of inequality and power relations that particularly disadvantage sexual minority identities. Dominant group perspectives in sexuality scholarship and HIV/AIDS activism curtail the narratives of non-normative sexual status (Weber, 1998 & Taylor, 2011). The narratives of the GB-MSM participants of this study, show what Berger (2004) coined as "intersectional stigma", a concept of intersectionality and stigma tied together. Berger notes that intersectional stigma affects identity, resources, participation, and placement of political voices.

While outreach strategies and peer-based models facilitate access, system factors like the non-existence of protection mechanisms and the cost of sexual care services remain as antecedents to sexual health care access. It can be further noted that

at any point in the "HIV care cascade" (provided above) barriers to access can take share and emerge because of these factors. This is most evident in the narratives of several of the participants such as those by Mony and Sos. A snippet of their account shows how "intersectional stigma" comes into play during sexual healthcare service delivery:

> **Sos:** "When I meet the doctor, I didn't know how to describe the symptoms because I look like a man and I have the symptoms at the "anal"… The doctor suggest I must stop to have sex with man. He said, "I should be a real man and have sex with woman. You must change the (your) status." (*sic*)
> **Mony**: "In Cambodia, we don't have like health care from the government. So, everything you have to pay from your own pocket so that was a lot of money… I go to that clinic because it was the cheap one and friendly one. I like that they don't ask too much questions like, "Did you have sex with a guy?" (*sic*)

These narratives show interlinks between sexuality, gender identity, class, and health status. The concept of "consumer awareness" put forward by Schuler, Bates, and Islam (2002) is coupled with preferential attitudes towards "friendly" (or rather LGBT-friendly) health service providers. Instrumentally, this study also addresses the negligence of queer theory and of HIV/activism: the failure to unpack intersecting material dimensions, such as class, and the reliance towards the voices of privileged, white, middle-class gay men (Taylor, 2011).

Varying subjectivities placed side-by-side may constitute "multiple jeopardies" (derived from several studies like Deborah King, 1988). Multiple jeopardies are the levels of oppressive barriers faced by individuals contributed by several factors culminating together to cause further and greater oppression. Although King's study has aspects of black feminist ideology at the center of her philosophical arguments, this study goes beyond racial and gender identities and challenges post-colonial perceptions and medical terminology genealogies.

It also allowed for the spotlighting of indigenous Khmer and non-conventional sexual (and gender) identities and expressions, although, there is still

much improvement needed here. Finally, the findings also showed us a gap in our own perception of a homogenous GB-MSM category, as our findings suggest that GB-MSM individuals may also belong to other HIV/AIDS "key populations" such as sex workers and persons who use drugs. This study does not seek to discredit the epidemiological usage of "risk categories" rather it provides a conceptual argument that would answer the fundamental query initially laid out. It is important to note that sexual health (as a branch of a larger public health discourse) uses "risk categories" to identify populations in need of medical and psycho-social interventions. Fundamentally, oppression, in any form, violates the human rights of any individual regardless of sexual identity and behavior, henceforth, the succeeding section presents a discussion on the application of queer theory to sexual health and rights paradigm.

5.2 Queer theory in the sexual health and human rights paradigm

There is a conscious effort in the conduct of this study to provide a paradigm where human rights intersect with queer theory. Human rights work must reject binary hierarchical categorization of gender and sexuality as it must take necessary measures to ensure the respect and liberation of sexualities (Miller, 1999 and Gross, 2012). The human rights discourse in non-Western countries involving non-normative sexual identities should critically consider these post-colonial perspectives in order to formulate an effective agenda on sexuality rights using political opportunity structures (Miller, 1999, Kollman and Waites, 2009 & Swiebel, 2009). However, this should not be a template solution as certain political opportunity structures perpetuate the same binaries, hierarchization and risk category classifications which queer theory hopes to dissolve.

In discourses around global health, scholars of human rights have suggested a paradigm shift that centers on global health justice and pragmatic solidarity (Gostin and Dhai, 2014 & Farmer and Gastineau, 2009). The global burden of disease is shouldered by states that have little capacity to provide tenable solutions and the poor shoulder disproportionate levels of health disparity. Global health justice, according to Gostin and Dhai, exhibits a shared responsibility of the global south and north. Pragmatic solidarity, for Farmer and Gastineau, encourages the rapid

deployment of tools and resources to improve the health and well-being of those who suffer. This paradigm of global health justice should remember that “the distribution of AIDS is strikingly localized and non-random” (Farmer 2005). Farmer recognizes that HIV transmission and human rights abuses stem from structural violence affecting different populations. In his book, Farmer recognizes intersectionality as he proposes a new agenda for health and human rights, “if you are likely to be tortured or otherwise abused, you are also likely to be in the AIDS risk group composed of the poor and the defenseless” (Farmer, 2005; p.231). In his new proposed agenda, Farmer places the provision of services at the core while advocating for societal transformation in how health is prioritized by governments.

There is a difference between international health and global health as elaborated by Lock and Nguyen (2018). International health is built on early post-war biomedical efforts by states to improve health structures, counter diseases, improve sanitation and develop better health economic policies within states. This was during the early days of the League of Nations and the World Health Organization (Lock and Nguyen, 2018; p.293). Global health was conceptualized exactly as a response to global epidemics like HIV, which easily spread because of globalization, including migration, decolonization, and industrialization. This brought health concerns down to the state level while solutions were developed collaboratively among states to address the epidemic and ensure health security within their borders (the ‘pragmatic solidarity’ concept of Farmer and Gastineau, 2009) In discussing global health justice, authors do not encapsulate health human rights as merely a “global” issue and ignoring specific country contexts. Global health brought concerns notably about national security but also of the state’s commitment to protecting human rights. HIV and AIDS is a good example of an epidemic that has brought to life health human rights. For example, activists have lobbied to states to ensure that access to antiretroviral treatment as a fundamental human right and the denial of which is unacceptable (Lock and Nguyen, 2018).

If we are to “queer” this paradigm, we have to reject divisions between the affluent and the poor, the hetero- and the homo-, the normal and the deviant, as well as the safe and the risky. We believe that this may indeed be a new concept evidenced by the dearth of literature that queers health human rights. We see various authors

who challenge the biomedicalization of homosexuality but never with an effort to situate all components of queer identities in health human rights together.

To address this drawback, we have to fundamentally acknowledge sexualized and gendered subjectivities affecting health care by focusing our attention on the social binaries perpetuating oppression. Medical humanities would call this "critical healing", involving a rejection of exclusive territories of defined normalcy by contesting standards and mechanisms of injustice and discrimination (Garden, 2019). Garden points out that biomedical history has been known to define persons as disordered, diseased and deviant. These definitions that earlier sprung up from public health's effort to curve epidemic transmissions, has led to the identification of "risk groups" of sexually transmitted infections (STI) such as HIV/AIDS (Spurlin, 2019).

Queer theory looks at risk in lived contexts and queer men are seen to perform risky behaviors in the context of the HIV pandemic. This led to the hierarchization of identities against health statuses and the categorizing of persons as "ab/normal, us/them, visible symptoms/invisible illness, and risk/non-risk. Furthermore, it prompted social and public health policing of the sexual subject's sexuality and gender performativity, and the development by public health of a label for non-gay-identifying men, the "men who have sex men" (MSM) identity (Arguello, 2016; Young & Meyer, 2005).

Biomedicine has, in the early history of the pandemic, constructed a causal link between homosexuality and HIV/AIDS which has developed standards wherein queer bodies are seen as diseased and heterosexual bodies as the standard of normality and health (Spurlin, 2019). Beyond just the pathologization of homosexuality and the creation of standards, society's perceptions of deviance, heteronormative and Western biases, and the enforcement of gender norms may have led to a critical failure in sexual health human rights (Garden, 2019).

Therefore, the rejection of the biomedicalization of homosexuality and categorization of "risk groups" would achieve global sexual health justice reducing health disparities and improve current human rights strategies. This rejection does not mean the existence of the term should be altered (or totally erased) in medical and epidemiological literature rather consciously avoiding homogenizing gay, bisexual and MSM under risk labeling. Re-quoting and expanding the insights of Kole (2007), the

author points out that "… sexual diversity, gender plurality, sexual rights, and freedom must be preserved and upheld in diverse societies in their own way" (the same way that Khmer sexual identities should be celebrated) devoid of categorizations of "deviancy", "health risk", "criminality" and "the abnormal".

CHAPTER VI
CONCLUSION AND RECOMMENDATION

6.1 Queer and Beyond: GB-MSM Sexual Health Care

As we continue to modernize queer literature in Asia, queer studies have to take into consideration that ‘queering’ should be accompanied with the decolonizing of gender and sexuality – ‘decolonial queer praxis’ as it is termed (Lee, 2019). Queer existence in modernisation process must acknowledge its pre-colonial roots and celebrate its gendered/sexual heritage. This should strive to work without the same Western milieu which brought to Asia the us/them, norm/deviant, and risky/healthy binaries. Sexual health care must catch up and refashion its terminologies to keep up with the times. Beyond this “queer paradigm” lies an effective sexual health care system that operates for communities that need it the most in Cambodia and other parts of Asia.

Expanding a little bit more on the ‘decolonial queer praxis’ in relation to the ever-evolving human rights agenda (where sexual health rights are lodged within interconnected economic, social and cultural rights), we look into Roland Burke’s 2010 book. Burke argues a post-colonial human rights agenda which asserts individual freedom, religious liberty, and democratic governance (Burke, 2010, p.33) with this concept’s first emergence during the 1955 Asian-African Conference in Bandung, Indonesia. More importantly, Burke describes the Bandung Conference as being influential in the creation of a “third world identity”. This then turned into the political force of decolonization which reframed the United Nations human rights agenda, between the 1950s to the mid-1970s.

More importantly, when we place this alongside queer Asian studies, “queering has everything to do with decolonising” (Lee, 2019). The macropolitcs and micropolitics of ‘queer asia’ has everything to do with a critical contestation of sexual identity in relation to consumerism, cultural etiquette, national feelings, and patriotism in queer postcolonial societies. Hence, as Burke posits that the Bandung Conference

has changed the landscape of human rights agenda until today, the condemning of colonialism in all its manifestations is essential to the queering of human rights and the challenging of categorizations of sexuality and gender.

To “queer” in itself is to destabilize any normative references and transforming assemblages. The dismantling of oppressive structures in social activism must, therefore, acknowledge that the “universality of rights” does not mean the erasure of sexual identities. The multi-dimensional nature of anti-colonialism and its relationship to individual rights would assist in the argument that there is multiplicity within queer communities (Burke, 2010). To put “queer” and “Asia” together is to operationalize gender equality and sexual rights in non-normative literature. The emerging “third world” voice that shapes the current human rights discourse along with the revolutionary influence of decolonization should be central values to ongoing queer Asian studies.

AIDS was earlier called GRIDS (Gay-Related Immunodeficiency Syndrome). Later, when the virus was identified in different population groups that the nomenclature was changed to AIDS. With this, gays became identified as a ‘risk group’, amongst others. (Joseph, 2005). Though there has been a shift in the pathological definition of AIDS the stigma still remains especially in public health discourse in relation to the “risk society”. Paradoxically, straight men who have sex with men are lumped together with gay men in sexual health programming, but there is still the immutable “real” homosexual (Ward, 2015). In Jane Ward’s book “Not Gay”, the sincere ‘gayness’ is something that symbolizes romantic congenital engagements with the same sex and are homosexuals to their core; while “straight MSMs” exhibit an insincere and “meaningless” homosexuality. These ‘insincere homosexuals’ might reject the whole denomination of MSM that they were unwillingly homogenized into for epidemiology’s sake. “The identification of gays as a risk group made it even more difficult to work with them as they were an already stigmatized population. The stigma experienced by MSM populations are similarly visible in different contexts (as we have discussed the “Men on the Down Low” phenomenon earlier in African-American communities). However, what is common in any context is that the combination of prejudices against homosexuality and AIDS

drove gays underground, making it difficult for any intervention to reach them (Joseph, 2005).

The complexity of the "MSM" categorization is an aftereffect of the initial responses of biomedicine to the AIDS crisis over three decades ago. Therefore, we may even conclude that the "MSM" identity is a "queer identity" as it challenges conventional definitions of homosexuality. MSMs, as a homogenized sexual and behavioral non-heteronormative identity, challenges normativity of sexual behavior, the monogamy of relationships, and the singular, linear definition of homosexuality as a mere attraction. This then becomes a whole new discussion of what this paper hopes to achieve, which is the queering of human rights. In sexual health discourse, the "queer identity" is often a subject of concern as it provokes a sense of deviation from health standards.

This now leaves a corridor of opportunities to boost policy advocacies and social science scholarship as advocates can lobby to enact laws that provide protection against discrimination not only on the basis of sexual orientation and gender identity, but also on the basis of health status and sexual practices (as it is uncommon to speak about MSM behaviour and other non-normative sexual behaviours in sexual orientation and gender identity anti-discrimination laws). This can also encourage the sensitization of public health programming to reconsider its treatment towards MSM individuals and to ensure inclusive sexual health care in Cambodia.

Moving more specifically to sexual identity and sexual health in Cambodia, the plethora of MSM, sexual health and HIV/AIDS studies in Cambodia is admirable with studies available on MSM population size estimates (Yi, S., et.al. 2016a), factors associated with HIV testing of MSM (Yi, S., et.al. 2015a), the acceptability of HIV testing among MSM (Pal, K., et.al. 2016), prevention and care case study on MSM (Yi, S., et.al. 2016b), mental health among MSM (Yi, S., et.al. 2016b), factors associated with inconsistent condom use among MSM (Yi, S., et.al. 2015b) and achieving universal access to HIV health services (Vun, et.al. 2014). This study moves beyond epidemiology and towards human rights, providing an essential argument wherein the disruption of oppressive structures, including terminologies, is in effect a queer process and a new queer human rights paradigm. This study yielded narratives from GB-MSM individuals that allowed us to identify factors affecting their

access to sexual health care. Through queer theory, we have deduced that these factors exist because of the categorization of GB-MSM individuals as sexual anomalies and inverts of hetero-normative standards. This paper has integrated queer theory to a country known for a long history of divergent genders and sexualities. However, reflecting on the literature review on indigenous Khmer sexual identities there is a growing need for future studies in contextualizing applications of queer theory to non-Western settings, such as Cambodia. It is recommended for both academia and civil society to utilize non-stigmatizing terminologies, such as “key populations” or “sexual identities”, and for an overarching recognition of indigenous sexual identities which also challenge colonial and patriarchal gender ideals, and dichotomized stereotypes. When situated in the post-colonial Cambodian context, this is the “decolonial queer praxis” that is earlier mentioned, which represents the multiplicity of queerness and Asianness, while being prideful of the idigenity of sexual identity.

In order to achieve the desired universal accessibility of sexual health care as a human right, we have to place a prime focus on the dismantling of these hierarchizations. Ensuring the propagation of literature that discusses non-normative sexual identities in non-Western countries is also crucial to expand the discourse on health, human rights, and queer theory. This study premised on health disparities as a result of inaccessibility to sexual health care of a homogenized population; ultimately, the factors were identified, which included negative social perceptions provoked by the biomedicalization of homosexuality. This study failed to provide other fundamental and distal factors that generate the re-emergence of health disparities in Cambodia, which remains a gap in literature and theory.

It is therefore recommended to assiduously seek ways to study indigenous sexual identity, its intersections with power structures, spatial relations, and queer theoretical underpinnings all under a human-rights based approach. Health disparities should also be a subject of interest among researchers especially in countries with weak health infrastructures. This means going beyond sexual identity categories by considering age, physical and mental ability, social class, among other social and economic classifications. This is a challenge to medical and epidemiological researchers to reconsider terminologies and to humanize the experiences of sexual identities devoid of binaries and categorizations. There is resistance in changing and

restructuring the terminology, the same way that there is resistance, among the conservative right, to recognize the valiant efforts of the LGBT movement. Although this study rejects "risk" and "deviant" categories, it is imprisoned in what the labeling theory calls "subjective conception of the self" (this can be another study altogether).

As all arguments have been laid out, we revisit this study's objectives and determine whether these were achieved. This study has successfully provided a descriptive chronicle of the experiences of GB-MSM in accessing sexual health services in Cambodia. This study advocates for qualitative studies to use the power of storytelling in describing the lived experiences of participants. This practice has allowed for the thriving of "queer methodology" effective in detecting unique stories of queerness and Asianness. This study has also found answers to the question of sexual identity's impact on sexual health care access and even goes beyond to further argue that these factors are caused by categorizations and stratifications of sexual identity as "risk groups". Henceforth, this study did not only identify why the lack of access to sexual health care is a violation of human rights but it also provides a solution. This study then argues that a new queer human rights paradigm must not only challenge genealogies and taxonomies but also finds itself within the on-going political academic movement of queering Asian studies in post-colonial societies.

This study, therefore, advocates strongly for more queer Asian studies that challenges, through inquiry, colonial standards in modern Asian societies. It encourages for more studies in Cambodia (and beyond) that uses this queer human rights paradigm. At least for this one, it has to end here. As we started this journey with a quote of health differences, we end this study with a reminder of the dichotomies that privilege some and disenfranchise others,

> "In *Discipline and Punish: The Birth of the Prison*, Foucault demonstrates how grand narratives, or what he might call normalizing discourse, constitute difference solely in terms of degrees of difference from the norm that is the ideal. It is this sort of logic that engenders and legitimizes the representation of homosexuality as an aberration from heterosexuality (the norm/ideal)." (an ode to Foucault, who authored *The History of Sexuality*, taken from Sullivan, 2003).

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APPENDICES

APPENDIX A
INTERVIEW GUIDELINES

TITLE: NARRATIVES FROM OVER THE RAINBOW: HEALTH DISPARITIES, SEXUAL HEALTH CARE, and BEING GAY, BISEXUAL and “MSM” (MEN WHO HAVE SEX WITH MEN) IN CAMBODIA

INTERVIEW GUIDELINES

Discussion points for GB-MSM Respondents
SELF-DISCOVERY and BEING GB-MSM
Part 1: Introductions: Name (Optional), Age, Occupation and other details the respondent would like to share to us about themselves.
Q1: Can you tell me the stories about why you chose this identity and how did you know about it?
Q2: Can you tell me some of your experiences when you told people about your sexual identity/sexual orientation or when people assumed what their identity/sexual orientation was
1.1. Experiences in the family
1.2. Experiences in in the workplace?
1.3. Experiences in school
1.4. Experiences with friends
1.5. Experiences in daily life

Q3: Can you share any specific example where you have faced social stigma or discrimination because of your sexual identity/orientation?

ACCESS TO SEXUAL HEALTH CARE

Q4: Can you describe what you usually do when there is a need to get help because of sickness or other concerns about your health?

Q5: When was the last time you went to see the doctor? Can you tell me the experience? What was the reason for the visit (if respondent willing to say)?

Q6: Imagine that you were back in that clinic; can you share to me the story of your experience? How did it make you feel? What was the clinic like?

Some guide follow-up points/questions:

- The type of health service visited
- Whether they have used that health service before
- Which other health services they've used
- How many times in the last X years they've accessed health services
- The medical reasons for the different visits (if respondent willing to speak about them)
- Reasons when the respondent has been reluctant to seek advice on a health related concern
- How did you know about this hospital/clinic/facility?
- Why this particular hospital/clinic/facility was chosen
- Did you check other hospital/clinic/facility before going to that one?

Q7: Can you tell me some stories that you believe are highlights of your experience?

- Respondent invited to share an example of when he had a good/helpful/supportive visit to a hospital/clinic/facility and when he may have had a bad example (if he has one). Explore the reasons why.

Q7: So since you told me about the story of how you started to identity as _____, can you tell me the experience of this identity in the clinic? Did you tell anyone about your identity? How did they react?

Q8: Would you come back to that clinic again?

APPENDIX B
ETHICAL APPROVAL DOCUMENT

IPSR-Institutional Review Board (IPSR-IRB)

Established 1985

COA. No. 2019/02-056

Certificate of Ethical Approval

Title of Project: ***Narratives from Over the Rainbow: Health Disparities, Sexual Health Care, and Being Gay, Bisexual and Other Men Who Have Sex with Men (MSM) in Cambodia***

Duration of Project: ***4 months (April - July 2019)***

Principal Investigator (PI): ***Mr. Justin Francis Castro Bionat***

PI's Institutional Affiliation: ***Institute of Human Rights and Peace Studies, Mahidol University***

Approval includes:
1) Submission form
2) Research proposal
3) Interview guideline
4) Participant information sheet
5) Informed consent document

IPSR-Institutional Review Board (IPSR-IRB) met on 28th February 2019 and decided to issue the COA to the above project.

Signature

(Professor Emeritus Pramote Prasartkul)
Chairman, IPSR-IRB
Valid from April 7, 2019 to April 6, 2020

Remarks
1) Upon the completion of this project, the PI should inform the IPSR-IRB of such progress.
2) The PI is obliged to notify any modification of the research project to the IPSR-IRB.

IORG Number: IORG0002101; FWA Number: FWA00002882; IRB Number: IRB0001007

Office of the IPSR-IRB, Institute for Population and Social Research, Mahidol University, Phuttamonthon 4 Rd., Salaya, Phuttamonthon district, Nakhon Pathom 73170. Tel (662) 441-0201-4 ext. 223

BIOGRAPHY

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Conference Room, Ateneo Professional Schools, Rockwell center, Makati City

14th Singapore Graduate Forum on Southeast Asian Studies, 22-26 July 2019, Asia Research Institute, National University of Singapore, Singapore