Between HIV And “Male Sex Workers” Identity: Young Shan Men And The Presentation Of Enviable Life In Chiang Mai

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Abstract
Integrated in the global economy of HIV intervention, young and mobile Shan men in Chiang Mai who work as hosts, dancers and masseurs in gay establishments are now plugged into discrete health categories (i.e. men who have sex with men (MSM), male sex workers (MSW), “Burmese” migrants, “hidden population”, etc.). Current HIV intervention has employed information communication technology (ICT), which produces standardized HIV information dissemination, testing and treatment. This paper examines Shan men’s use of their mobile phones. Using Miller and Slater’s (2000) concept of dynamics of objectification, I analyze the creative use of mobile phones as realizing aspired and ascribed identities, characterized as presentation of enviable life in Chiang Mai. On Facebook, they engage in political discussion, conduct religious activities, and manage their social networks. I argue that the presentation of enviable identities reflects notions of masculinity and health, which determine Shan men’s access to, awareness of and management of health information. HIV testing is crucial in HIV prevention, but Shan men value their role as economic providers more than spending for personal health and undergoing an HIV test. They perform Buddhist rituals as supplication for a healthy body. The paper illustrates the failure of dissemination models and the importance in knowing the situated knowledge of Shan men’s sex work in order to provide effective HIV intervention.

Introduction
While HIV/AIDS has stabilized globally, there is currently a rise in HIV infections amongst men who have sex with men (MSM)1 in the Asia Pacific (UNAIDS, 2013). The MSM sector has the fastest growing HIV epidemic in the region, concentrated in main cities and affecting mostly young men (15-24 years old). Migrant MSM are considered to have extra greater risk to HIV infection because of their migrant condition such as limited education and financial resources and lack of access to healthcare services and HIV programs.

Voluntary HIV counseling and testing (HCT) has been viewed as a potential avenue for prevention efforts, as newly diagnosed HIV-positive individuals can be initiated into ARV therapy (ART), which will reduce the possibility of viral transmission. Current access and uptake of HCT amongst MSM in Thailand remain low at 26% (AIDSDATAHUB, 2013) because of the following: not being able to pay for the HIV test and HIV treatment; belief of not being at risk for infection, lack of knowledge of where to get tested; fear of the consequences of a positive test result; fear of not getting support from family/friends/partner; and lack of confidentiality of health care personnel (Blas et al., 2010;

1 This covers male sex workers (MSW) and gay-identified men.
Broekhuysen, 2012; Spratt et al., 2011). Traditional methods of intervention to increase uptake of HCT such as outreach work and walk-in clinics proved to be unsuccessful, with only 7% of MSM reached through these methods taking the HIV test (Anand et al., 2015).

In May 2013, USAID convened a meeting of 40 prominent HIV activists, scientists, entrepreneurs, and public health leaders from around the world to respond to the rising epidemic. Innovations in prevention approaches were encouraged, and one of the target interventions suggested was to increase access and uptake of HCT using information communication technology (ICT) features that are popular amongst MSM and TG such as the Internet and mobile phones.

There are currently ICT-based HIV interventions on MSM and TG, which are both mobile and PC-based. The interventions have focused on: motivating behavior change, sustaining behavior change, support and referral to healthcare, networking, data information/ collection, advocacy (AIDSTAR-Two, 2012; Natarajan and Parikh, 2013; Ybarra and Bull, 2007). Most of the interventions have focused on HIV prevention through awareness raising by increasing access to information (Natarajan and Parikh, 2013).

The ICT-based HIV interventions have been criticized on two main grounds: the unproblematized health development paradigms and the continued unproblematized understanding of male- to-male sexuality as a disease issue. With regard to the former, there is a growing concern on the ways in which the technology-led intervention programs are reproducing norms of information dissemination and standardization that have been characteristic of health development models. Many health development projects have adopted universalized notions of health care and quantity-based metrics that expel socio-cultural aspects of health (Natarajan and Parikh, 2013: 149). They are said to be loaded with unproblematized assumptions about development as being related to scientific expertise and technological advancement coming from the Global North (Escobar, 1995). ICT-led interventions on HIV are criticized for the standardization and efficiency of information flow between the NGO with domain knowledge, and the patient (Natarajan and Parikh, 2013: 143), which produces the same failures of health development models of information dissemination, and standardization. While there is an extensive research of the social aspects of HIV in public health, they are conspicuously absent in ICT4D and mobile health projects (Natarajan and Parikh, 2013). The term MSM (men who have sex with men) demonstrates this standardization of health intervention and the disregard for social and cultural factors in shaping sexual health practices. With a health objective of counting the sick, the deployment of the term is said to undermine self-determined sexual identities (Young and Meyer, 2005). “It has contributed to the medicalization and depoliticization of homosexuality” (Boellstorff, 2011: 305) and “deflects attention from social dimensions of sexuality that are critical in understanding sexual health” (Young and Meyer 2005: 1144).

Similarly, the focus of the interventions on the illness of gay men and MSM fails to view male sexuality beyond the discursive hegemonic development perspective on masculinity and sexuality. Sexuality in ICT4D is viewed in the framework of medical health, related to disease control and economic growth. Scholars have proposed other ways of viewing sexuality in development, such as Sen’s (2001) idea of the expansion of freedom of choice as a way to development; framing men’s
“loving bodies” in the context of social justice (Nussbaum, 1999) to give importance to other issues men face such as sexual oppression apart from HIV and AIDS; or through a rights based approach related to bodily freedom and autonomy (Gemmerli, 2009).

Responding to calls for interdisciplinary approach in ICT-based HIV interventions (Donner and Toyama, 2009), a greater understanding of socio-cultural factors in sexual health and a reconfiguration of concept of development beyond disease control I employ the anthropological concept dynamics of objectification in the research.

I will use the concept “dynamics of objectification” by anthropologists Miller and Slater (2000). Dynamics of objectification looks at the “realization” of one’s identities and cultural values while engaging with ICT. For instance, people are able to “realize” themselves through the use of the mobile phone since aspects of the mobile phone allow them to objectify themselves and “enact core values, practices and identities” (p. 7).

Dynamics of objectification can happen in two ways: expansive realization and expansive potential. In expansive realization, ICT is viewed as a means through which one can enact – often in highly idealized form – a version of oneself or culture that is regarded as old but can finally be realized. “Through ICT, one can become what one thinks one really is (even if one never was)” (p. 8). For instance, the mobile phone can be used to enact idealized Shan identities that are projected and promoted in discursive historical narratives. In expansive potential, ICT is viewed as a means through which one can expand connections and possibilities and where one can enact one’s aspired identity – “what one could be”.

Employing expansive realization and expansive potential, I will analyze how Shan MSW use the mobile phone to objectify themselves and present both idealized and aspired identities. I will analyze how the use of mobile phone allows them to produce and maintain “new spaces of sociality in cyber spaces and take on new identities” (p. 10), which is related to the presentation of an enviable life. I will examine how these identities reflect Shan notions of masculinity and health. By situating these notions of masculinity and health with the lived experiences of sex work, I will analyze how these notions shape Shan men’s access and management of health information.

**Background**

**HIV among men who have sex with men (MSM) in Chiang Mai**

Despite declining trends in new HIV infections throughout Asia and the Pacific, there is an emerging epidemic among men who have sex with men (MSM) and transgender (TG) populations in several locations (UNAIDS, 2013). The latest data reveals that in 2012, approximately 15% of the total population of MSM in Southeast Asia were infected with HIV (Amfar, 2014). By 2020, UN Commission on AIDS estimates that 50% of all new infections in Asia will be within the MSM population (Amfar, 2014).

Thailand mirrors this grim regional situation. While there has been a drop in overall HIV prevalence over the last two decades, HIV infections among the younger (between the ages 15-24) MSM and TG
have considerable access to the Internet via computers at schools, public spaces, such as social media (Facebook and Twitter), websites and web apps. Specification, and convenience, and control. The Internet also provides various platforms to conduct HIV intervention such as social media (Facebook and Twitter), websites and web apps. Specific to MSM and TG, they have considerable access to the Internet via computers at schools, public spaces, and Internet cafés.

As the second largest city in Thailand, Chiang Mai has become an important nexus for HIV transmission. HIV prevalence amongst MSM is highest in large tourist cities, with the latest data putting it to 20% in Bangkok, Chiang Mai, and Phuket (Avert, 2014). Located near the Thai-Burma border, Chiang Mai has one of the highest populations of migrants from Burma, majority of whom are Shan. They are predominantly skilled workers with contractual employment and minimum wage of 7,000 Thai Baht/month.

One of the challenges in HIV prevention is reaching MSW. Mobile MSW are predominantly poorly educated and lack basic understanding of safe sexual practices related to HIV and STIs (Walsh, 2011). The latest data put HIV prevalence among migrants from Burma at 1.16% (Avert, 2014). Their sexual practices have been identified as including paying for sex and having multiple non-regular sex partners. Their knowledge of HIV and AIDS is extremely low. Moreover, barriers prevent them from accessing HIV/AIDS information and health facilities: language difficulties, exploitative working conditions, and frequent migration. All these make them vulnerable to HIV infections (Avert, 2014). While the Thai government has made efforts to increase access to HIV medication for migrants, such as through the National AIDS Plan (2012–2016) and the insurance scheme (launched in 2014), hospitals have often denied insurance claims and care to migrant laborers (Reuters, 2015).

A recent study by Davis and et al (2013) on MSW in Chiang Mai has found out that majority of MSW are migrant Shan from Burma who have unstable employment (depending mostly on tips as main source of income), frequently experience sexual abuse, and commonly take recreational drugs.

ICT for HIV intervention

Most of the HIV interventions utilizing mobile phones are based on the use of SMS. They have focused on clinical care, such as disseminating factual information, connecting users with HCT and clinic schedules, and sending messages related to ARV medication adherence, self-monitoring, risk assessment, and data gathering (Horvath et al., 2012; Mbuagbaw et al., 2012; Sarath et al., 2012).

Several factors have been identified that make the Internet suitable for HIV intervention. It is able to reach many people rapidly at a relatively low cost (Carpenter et al., 2010; Halpern et al., 2008). It has been proven to reach hidden populations such as rural and minority MSM (Chai et al., 2010). More people are now using the Internet to obtain health information, conduct health transactions, and also Rind sex partners (Chai et al., 2010). The Internet allows individuals to access interventions privately and confidentially, and on their own time. The Internet offers anonymity, access, convenience, and control. The Internet also provides various platforms to conduct HIV intervention such as social media (Facebook and Twitter), websites and web apps. Specific to MSM and TG, they have considerable access to the Internet via computers at schools, public spaces, and Internet cafés.

(male-to-female) populations are experiencing alarming upward trends (Amfar, 2014; UNAIDS, 2013; VOA, 2014). From 2003–2013, HIV prevalence among MSM rose from 17% to 25% (Amfar, 2014). In 2012, 41% of new HIV infections were among MSM (Bangkok Post, 2014). The causes for this increase were the lack of exposure by younger men to Thai HIV campaigns of the 1990s; inconsistent approaches by the government to MSM and TG; limited HIV prevention campaigns to MSM and TG; lack of study of MSM and TG, including the socioeconomic factors that affect risks of HIV infection.

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and through their mobile phones. They are active users of Internet, and this has changed the ways they communicate, socialize, and seek information (Ybarra et al., 2007).

Various community-based and non-governmental organizations in Southeast Asia utilize ICT for their HIV work AMONG the MSM and TG communities. The ICT-led HIV work has been focused on campaigning, education, and outreach. A review of the work of these organizations reveal the following characteristics, summarized as:
1. Most of the ICT projects focus on HIV/AIDS education and prevention.
2. Most projects are campaigns that address HIV/AIDS and positive valuation of the self.
3. The campaigns are promoted via social media and mobile chat/social apps.
4. The ICT projects are complemented with non-ICT components, such as partnering with local health centers and government health agencies and relying on volunteers and peer counselors.
5. There is limited-to-no monitoring or evaluation of the projects, so their impact is unable to be measured or ascertained.

**Methodology**

The research was part of a 2013 HIV intervention project in Chiang Mai undertaken by Save the Children Thailand. It is an action-research, which is the use of research methodologies such as participatory exercises in extracting data from respondents. The main characteristic of action-research is “handing the stick” to the respondents, or allowing the respondents to decide for themselves how the research should develop and what the priorities should be. The principle behind this is that respondents know – more than the researcher – the problems and solutions related to their community/ies (Chambers, 1994). The data gathering was conducted between March – August 2013. Data analysis and writing extended to April 2015. The research was conducted while the intervention project of Save the Children was being implemented. The data gathering and analysis components of the research shaped the intervention, just as the intervention informed the research process.

The research employed the following methodologies:

- **Respondent driven sampling (RDS)** = RDS is a sampling methodology for hard-to-reach populations. It is incentive-based and starts with “seeds” (first set of informants) who invite their peers to participate in the research (called “waves,” or secondary sets of informants) until a web network of participants is created (Johnston et al., 2007). For this research, RDS was used to obtain respondents. The incentive to participate and recruit three participants was 500 Thai Baht. The research reached three waves.

- **Focus group discussion (FGD)** = Three FGDs (composed of five MSW per FGD) were conducted and covered the following topics: HIV testing, ICT usage, and cultural understandings of self and health.

- **Desktop research**

In this research, MSW refers to Shan men who receive money in exchange for sexual services. They were either working in host bars, go-go bars and gay massage places at the time of the research, had
previously worked in these establishments, or do not work in these establishments but operate informally with their friends. In the field of health planning, MSW is part of the broader men who have sex with men (MSM) category. MSM is a public health category used to define sexual behaviors of males, regardless of sexual orientation, gender identity, identification with a community, or motivation for engaging in sex. Hence, it covers a wide array of identities, including gay-identified and straight-identified men. It also covers a large variety of settings and contexts in which male to male sex takes place. The MSM category is not a homogenous group, as many Shan MSW do not consider themselves exclusively homosexual (Spratt and Escobar, 2011).

The research was considered highly sensitive. It practiced free prior and informed consent in conducting the survey interviews, FGDs, and participant observation. Data was kept confidential and only shared with the research team.

All interviewers/research assistants participated in training and sensitization workshops to ensure the practice of free prior and informed consent and ethics in doing HIV research.

**Findings and Analysis**

**General profile of respondents**
The informants were between 15-25 years of age, with median age of 20. Most of them have completed secondary education (equivalent to high school), were fully employed, and have lived in Chiang Mai for less than a year.

All informants reported initially coming to Thailand to look for work in construction. They were introduced to sex work through their friends and/or relatives. They said they were tempted to enter sex work because of the need for extra income. The sex work was classified into four types: massage, show bar, karaoke bar and freelance bar. Most of the informants were working at freelance bars. The average income per week was 3,000 Thai Baht. Most of the informants relied on tips for their income and only few (masseurs) were getting fixed salaries. Regarding sex work, informants from freelance bars reported having an average of three regular clients every month while informants from show bars and massage places reported having an average of 10 clients every month. According to informants’ assessments, the clients were all men within the age range of 35-60 years old and a mixture of Caucasian and Asian men. Informants reported that most customers prefer anal sex. Caucasian clients preferred performing the role of penetrator in anal sex, while most Asian clients preferred getting penetrated in anal sex.

Regarding their sexual experience, most were sexually active, having had one-to-three sexual partners (both with clients and romantic partners) in the last four weeks before the FGDs were conducted. Condom usage was low, and most respondents engaged in risky sexual practices. These practices were informed by their risk reduction strategies. Most MSW said that they regularly use condoms with their male customers, but they seldom use condoms with their female partners. MSW have received information about HIV from NGOs in Chiang Mai.

Regarding knowledge about HIV, most informants had adequate knowledge of HIV/AIDS, but
misconceptions are common. Many respondents associated the virus with characteristics of unhealthy appearance: thin, very pale skin, and weak. On the other hand, they associated being healthy with physical and spiritual wellbeing: having a strong body for physical work, offering merit to the monks, and demonstrating good values, such as providing for the family.

Most of the informants did not know what ARV drugs are. Gay-identified MSW were comparatively more knowledgeable about HIV/AIDS and HCT than straight-identified MSW. They knew about the importance of HIV testing and the benefits of early diagnosis and treatment. However, most gay-identified and straight-identified MSW did not know about ARV.

Most of the informants have never been tested for HIV. They provided several reasons as barriers to HIV testing: they did not have information about HIV testing: why it is important, where to get tested, and what will happen if they test positive. Unaffordability is likewise an issue. Some informants said that they could not afford the HIV test. One informant said that it is more practical not to get an HIV test and not to know one’s status because one would not be able to afford ARV anyway.

Usually, when we are sick we won’t go to the hospital because we can’t afford the medicines and the doctor’s fee. We just sleep over it. Sometimes we try herbal medicine or consult a monk and ask for his advice. You don’t need to know if you’re HIV-positive or not because [either way] you will die in the end.

Access to health clinics is also an issue. Some informants said they were shy to access health clinics and interact with Thai people. Most of the informants preferred going to a public hospital for treatment. They said hospital services are more professional and have better standards compared to health clinics. However, the informants preferred certain hospitals that they were already familiar with and which are frequented by migrants from Burma, such as Lamphun Hospital and Nakhon Ping Hospital. They said their friends went to these hospitals whenever they were sick, and that the doctors were their friends. While they preferred getting an HIV test at a hospital, the disadvantages they identified were lack of privacy and the long time it takes to get the results.

With regard to the general use of ICT, the FGDs revealed that all informants have basic Internet skills. There is low access to and use of the Internet via PC/laptop. The Internet is primarily accessed via the smartphone. They have limited use of other Internet platforms. They reported that they seldom access their email accounts, seldom use web browsers, have limited use of social media (concentrated only on Facebook), and do not know how to download video or document files. Most informants have access to smartphones, and a few possessed regular phones. The top three usages of their phones were: phone calls, text messaging, and social media.

Use of Facebook = All the respondents are heavy users of Facebook. They said they use Facebook everyday, liking, sharing, and commenting on the posts of their friends. They regularly update their status, expressing their feelings or what they are thinking. They also post photos of their activities. They share news articles about current events, as well as amusing photos and video clips. Some respondents reported also using Facebook to meet new friends.
YouTube = Most of the respondents use YouTube to listen to their favorite musical artists and watch news clips.

Line, Viber and WeChat = Most of the respondents use their phones to communicate with their family members and friends. They preferred Line, Viber, and WeChat apps in communicating with them. Some respondents reported also using Line to meet new friends.

Presentation of enviable life
The main theme that came out of their use of Internet on their phones was the presentation of enviable life. On Facebook, the informants post photos of their activities such as events at their workplace and excursions in the city. They also post photos of newly acquired material possessions such as a brand new mobile phone or tablet, shoes, clothes and motorbikes. They said that they post these because they like their friends to see that they are doing well in Chiang Mai and are having a good time. The informants also post and share news reports about Burma. The news reports are related to politics and current events. They also participate in discussions about political news, such as the recent religious conflict in Rachine (Arakan) State between Buddhist Rachines and Muslim Rohingyas. Similarly, the informants post and share information related to Buddhism, such as photos of themselves and friends giving merit in a Buddhist temple, photos of activities during the Shan New Year, and religious quotes.

This presentation of enviable life can be viewed as expansive potential. On Facebook, Shan men construct an aspired modern and cosmopolitan identity. This is apparent in the ways informants present themselves on Facebook. According to Kwang Mone, an informant who works at a go-go pub:

I have many friends who are back in Taunggyi. Most of them like my photos, especially when I show the new places I’ve been to and my new mobile phone. I think they are envious of me.

Here, I can study English. There are some schools for migrant Shan. I study for free. I can also practice English with my clients. When I go back to Taunggyi, I will speak English to my friends and they will respect me because I have attained education. Some of my friends also want to move of Thailand to improve their English and find a better life.

This modern and cosmopolitan identity is presented not only through the collection of new gadgets and the ability to speak English, but the ability of these men to participation in the digital world. Consider the response of Jarmleng, a masseur:

My family’s house in Shan state is outside Taunggyi. In my village, few young men know how to use a computer. Also, very few have mobile phones. And they’re phones are made from China. But I have a Samsung phone. It’s one of the most expensive. I can do many things on my phone: play Facebook, play games, listen to music or watch and read news. I have friends all over Thailand, even in the south. I also have a lot of friends all over Myanmar. It’s easy to
connect with them and we always keep in touch through Line or WeChat. Internet connection in Thailand is very fast, unlike in Myanmar, so I can do many things on my phone.

This presentation of enviable life can also be viewed as expansive realization, or the recuperation of discursiveidealized Shan male identity. These discursive traits are presented in Shan literature and dance and rehearsed in contemporary times through the Internet. On Facebook, informants perform these idealized characteristics when they call their parents or chat with their brothers and sisters via Line or WeChat. Consider the response of ZawLin, a bar host near The Night Bazaar:

I speak with my mother on the phone once a month. She doesn’t have a mobile phone but my sister who lives with her has. I always assure them that I’m fine in Chiang Mai and my relatives take care of me. I tell them that I’m a waiter. They don’t know I don’t have a regular job and that I work as a bar host. They will not understand this kind of job. As long as I can assure them that I can take care of myself here and that I can send money through, it is fine. I always tell my sister to take care of our parents. Even if I’m not in Shan state, I can still fulfill my duty as a good son because I can send money to my family and take care of them. My sister looks up to me and when we chat I always tell her to study very hard and to study English too because if she knows how to speak English well people will respect her.

**Notions of masculinity and health**

What do these idealized and aspired identities have to do with HIV/AIDS? The research reveals that these identities reflect socio-cultural factors such as notions of masculinity and health, which determine access and responses to health information.

In the FGD, we asked informants to draw and explain what they considered as the ideal characteristics of Shan men. The drawings revealed that informants viewed Shan men as being endowed with physical, mental, emotional and spiritual strengths. Shan men are seen as economic providers in their roles as father, uncle, brother or son. They are seen as financially helping their parents through old age. They are viewed as holding leadership roles in the family and in their community. They are characterized as being well educated and can speak English. They are also seen as being rational and just. They are viewed as being equipped with controlling their feelings and not letting emotions affect their decisions. Finally, they are seen as faithfully following the Buddhist scriptures.

These notions of masculinity are played out in the ways informants use their mobile phones and the Internet. As has been gleaned from the preceding texts, informants perform their masculine identities by fulfilling their duty as economic bearer in the family. The phone facilitates this fulfillment of duty. Putting greater value over this duty meant sacrificing expenses for their own personal health, as explained by the informant who said that most Shan men would rather sleep over their illness than consult a doctor and spend money for medicine.

MSW’s socio-economic condition contributes to this dilemma of having to prioritize expenses. Their social status as migrants (with limited Thai language skills) does not make them eligible for health care benefits in Thailand, which explains their limited access to health care facilities. Their economic
status as having irregular employment, on the other hand, prevents them from spending money on the treatment of illnesses. Refugees, and migrant workers are not covered by the Universal Healthcare scheme.” Thailand’s “30 baht scheme” (health care and treatment of any disease for 30 baht), is a promising government program; however, individuals lacking a Thai ID are not eligible to utilize these health services (Davis et al., 2013: 47).

Also in the FGDs, we asked the informants about their ideas of a healthy Shan man. The informants’ notions of a healthy person are related to Buddhism: having both a healthy body and a healthy mind, offering merit in a Buddhist temple, and joining other religious ceremonies. AiMoe, a masseur and gay-identified, reflects on the role of Buddhism in his life:

Before, I wasn’t very religious. When I moved to Thailand, I became a monk for one year. When I was a monk, many boys my age and younger would visit me and tell me about their life as a money boy. They told me about the problems they encounter at work and also about their health problems. They also told me about the kind of activities they do for their customers. When I left the monkhood, I work as a construction worker. After six months, I contacted the boys who used to visit me in the temple to look for work in the go-go bar. I first worked there as a cleaner, until I became go-go boy. Then I and other boys left the bar and worked as masseurs.

In my opinion, it’s fine to be a masseur as long as you practice safe sex such as wearing a condom. I’ve seen some posters about the importance of using condom. My boss in the massage place also tells us to use condom with customers. But sometimes the customer insists not to use the condom, and if he is your only customer, then there’s no choice but to follow him, because you need the money. Sometimes when the customer is young and handsome, I allow him to enter me without condom. Usually, a first sex with a new customer is always with a condom. But when the customer becomes your boyfriend and treats you everywhere including going to Phuket or Pattaya, then I don’t use condom with him. But I’m very religious and I always give merit in the temple especially on my birthday. I think this also helps me have a strong body and mind, and so I never got sick.

These notions of health being related to Buddhism are likewise played out in the ways informants use their mobile phones and the Internet. As described from the preceding texts, informants’ religiosity is presented on Facebook. They post of pictures of their activities in the Buddhist temples and share Buddhist scriptures. They also actively engage in discussions on the Rachine-Rohingya conflict, posting opinions and liking and commenting on posts that are pro Rachine people and Buddhism. This manifests the role of Buddhism in Shan men’s concept of health. Monks are seen as possessing great knowledge of the body and the mind, and informants often sought health advice from the monks. They also reported relying on herbal medicine, which is cheaper than pharmaceutical drugs, and are also peddled in Buddhist temples. The non-prioritization of spending on medical expenses for oneself is offset through activities related to Buddhism such as offering merit. These are thought to maintain and improve health.
Conclusion

This paper sought to explore how Shan male sex workers’ use of mobile phones can reflect aspects of their ascribed and aspired identities which, in turn, reflect socio-cultural factors such as notions of masculinity and health that shape their access and management of HIV information. The research has demonstrated how the use of mobile phones allows for the presentation of enviable life in Chiang Mai, which relates to notions of an idealized Shan male who is financially able to take care of his family. This presentation of an enviable life also relates to notions of good health when men fulfill their religious obligations and regularly give merit to the monks. It is against this context of cultural notions of masculinity and health that HIV information is disseminated. The situated knowledge of HIV determines how MSW manage the HIV information. What this research has demonstrated is that identities are circumscribed within socio cultural factors, which affect access and management of health and health information. Young Shan men engaged in sex work are aware of HIV/AIDS and HIV testing but because of irregular employment value fulfilling their role as economic providers for their families rather than spending on their health. Likewise, notions of health are strongly related to Buddhism, and these men employ strategies to counteract health risks such as non-use of condom through performance of Buddhist rituals. The research has underscored the problem in current standardized ICT-based HIV information dissemination which fails to account for these unique socio cultural factors affecting management of health and health information.

In order to have effectively HIV/AIDS prevention using ICT, development agencies need to address these socio cultural factors. For instance, development agencies can also explore the possibility of leaders (i.e. religious or community leaders) taking up a role in educating the target groups about HIV, AIDS, and HCT. Concepts of health can be utilized in increasing knowledge for HIV, AIDS, and HCT awareness. For instance, HCT can be introduced by relating it to respondents’ concepts of health and their values (i.e., knowing HIV status and getting early treatment if testing positive will enable them to continue performing their responsibilities as father/brother/partner; the value of a healthy body in pursuing a Buddhist path, hence the importance of HIV testing and ARV therapy in maintaining a healthy body). Moreover, development agencies can combine HIV, AIDS, and HCT topics with other topics of interest to the respondents, such as reproductive health and other health-related issues, human rights, politics, sports, and entertainment.
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