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Risk Behaviors Among Young Men Who Have Sex With Men in Bangkok: A Qualitative Study to Understand and Contextualize High HIV Incidence

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Abstract

The Bangkok Men Who Have Sex With Men (MSM) Cohort Study has shown high HIV incidence (8–12/100 person-years) among 18–21-year-old MSM. These data led to a further study using qualitative methods among young (18–24 years old) MSM in order to understand the factors driving the HIV epidemic among YMSM. We conducted eight focus group discussions and 10 key informant interviews among YMSM in Bangkok, Thailand. Sociodemographic and behavioral data were collected using a questionnaire. We audio-recorded, transcribed, and analyzed qualitative and questionnaire data using computer software. The categories relating to risk behavior were (1) the use of social networks for seeking sexual partners and the marketing promotions of MSM entertainment venues, (2) social influence by peers and older MSM, (3) easy access to high parties and group sex, (4) easy access to club drugs, (5) conceptions related to HIV risk, and (6) sexual preferences of YMSM. Increased HIV testing, same-sex education, and YMSM-specific HIV prevention efforts are urgently needed for YMSM in Bangkok.

Keywords

Young; men who have sex with men; HIV/AIDS; risk behavior; qualitative methods; Thailand

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Disclaimer

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Globally, HIV incidence and associated morbidity and mortality have been on the decline in heterosexual populations (UNAIDS, 2017). However, HIV epidemics among men who have sex with men (MSM) continue to expand, and despite being a small minority group (2%–3% of the general population; Peerapatanapokin, 2012), MSM now account for more than 50% of new HIV cases in the majority of higher- and middle-income countries, including Thailand and the United States (FHI 360, 2008; Beyrer et al., 2010; Centers for Disease Control and Prevention, 2013). The high HIV incidence among young (≤ 21 years old) MSM was documented in multiple locations, including Southeast Asia (Beyrer et al., 2012; Gouws, White, Stover, & Brown, 2006; Van Griensven et al., 2013). This development is especially alarming given that, globally, MSM accounted for 12% of new infections in 2015. Data reported by countries across the world show that HIV prevalence among gay men and other men who have sex with men often is substantially higher than it is among than the general population (UNAIDS, 2017).

The HIV prevalence in the general population in Thailand has declined to ~1% since peaking at slightly over 2% during the mid-1990s (UNAIDS, 2017). In contrast, the HIV prevalence among MSM recruited from entertainment venues and sampled in greater Bangkok has almost doubled, from 17.3% in 2003 to almost 30% in 2012 (Van Griensven et al., 2013) without any sign of abating. This increase in HIV prevalence largely was accounted for by high HIV incidence in young MSM (YMSM) ≤ 21 years of age. Data from clinic and cohort settings in Bangkok have confirmed a high ongoing HIV incidence among YMSM varying from 8.8 to 12.2 per 100 person-years (PY) during 2005–2012 (Ananworanich et al., 2013; Van Griensven et al., 2013), much higher than among their older counterparts.

There are several behavioral risk factors for HIV infection that may help explain the high incidence among YMSM globally. YMSM express significant variability in terms of risk behavior, including alcohol use, drug use, and sexual risk (Wong, Kipke, & Weiss, 2008). Other studies have implicated drug use, connectedness to the gay community, peers as agents of behavioral change, gay sex partnering apps, and Internet sex-seeking as correlates of sexual risk-taking among YMSM (Mustanski, Newcomb, Nicholas DuBois, Garcia, & Grov, 2011). Substance use and social environmental context have also been associated with high-risk sexual behavior among African American and Latino HIV-infected YMSM in New York City (VanDevanter et al., 2011). The studies about behavioral factors affecting elevated HIV incidence among the youngest group of MSM in Thailand were conducted but not sufficient. Some quantitative studies found that alcohol and drug use are important factors among MSM in Thailand and the United States (Chemnasiri et al., 2010). Moreover, YMSM who attend sex parties are more likely to have more sexual partners and to use drugs than those who do not (Solomon et al., 2010). Finally, social media is frequently mentioned by YMSM population as having both positive and negative roles influencing their behaviors (UNICEF, UNFPA, UNESCO, 2014). However, it is not known how these factors have changed over time and to what extent they contribute to the likelihood for HIV infection among YMSM today.

We conducted this study to understand and contextualize the HIV epidemic in YMSM in Bangkok, Thailand.

Methods

This qualitative study was conducted within the framework of the Bangkok MSM Cohort Study (BMCS), a longitudinal investigation of prevalence, incidence, and risk factors for HIV infection among 1,744 men. It is a cohort study with follow-up visits every 4 months conducted between April 2006 and July 2012. Participants were homosexual Thai men, at least 18 years old and residents of Bangkok (Van Griensven et al., 2013).

We conducted eight focus group discussions (FGDs) consisting of four to eight participants per group and 10 key informant interviews (KIIs) in two phases. Of all the FGD participants, 10 participants were selected to participate in KIIs. In phase one, five FGDs and five KIIs happened between June and August 2012. In phase two, the remaining three FGDs and five KIIs occurred between March and June 2013. FGDs and KIIs were used to explore factors contributing to the elevated risk for HIV infection among YMSM. Topics discussed included peer pressure, Internet use, use of methamphetamine and sexual enhancement drugs, sex parties, sex on drugs, and related issues (e.g., “Have you ever heard about Internet use for searching new sexual partners?” and “Do YMSM usually use condom while high on drugs?”). No personal identifiers were collected. Participants were asked to use a fictitious nickname to address each other throughout the focus group and key informant interview. FGDs and KIIs were audio-recorded, transcribed, and analyzed using qualitative software. Sociodemographic and behavioral data were collected using a paper-based self-administered short questionnaire, and data were key-entered into the database. No personal identifiers were used. Focus group discussions and key informant interview participants were reimbursed 500 baht for their time and cost of travel.

Study population

Participants were selected using a purposive sampling method. Inclusion criteria were Thai nationality, age 18–24 years, uninterrupted availability for two hours during the time of the FGD or KII, and a history of oral or anal sexual intercourse with another man in the preceding six months. Seventy-three participants were recruited from the BMCS and from individuals presenting for HIV testing services at the Silom Community Clinic. During the FGD, the moderator carefully observed the potential YMSM who reported more sexual risk experiences but could not fully describe them in the FGD. YMSM were selected from FGDs for participation in KIIs based on their involvement with HIV risk activities and settings (e.g., online and offline entertainment, video chat rooms, sex parties, dating services). Of 73 recruited participants, 21 were unavailable during scheduled FGD times, and five were unable to be reached prior to FGDs being conducted. In total, 47 young men participated in the FGDs, and 10 participants were selected from FGDs to share more in-depth experience in the KIIs. Eligible participants were asked to provide available dates and time. Study staff assigned them to a prescheduled focus group discussion upon their availability. The study staff did not stratify the groups by any particular characteristics to make sure a wide variety of YMSM of different backgrounds was represented in the group.

Ethical issues

As part of the consent procedure, participants were informed about the purposes of the focus group discussion and key informant interview, procedures, risks, and benefits, and their rights as a study participant. A study staff answered all questions asked. All participants were asked to sign the informed consent form prior to their participation in the study. Participants were given a copy of the informed consent form to keep.

The study protocol was approved by the Institutional Review Board at the United States Centers for Disease Control and Prevention and the Thai Ministry of Public Health Ethical Review Committee for Research in Human Subjects.

Setting

We conducted FGDs and KIIs in a private meeting room at the Silom Community Clinic in central Bangkok on weekdays and weekends, between 16:00 and 22:00 hours.

Data collection

A short self-administered questionnaire was administered before the FGD to assess key sociodemographic characteristics and sexual and drug-use risk behaviors. We developed a FGD guide and KII guide to streamline and facilitate discussion and to ensure that all predetermined topic areas were addressed.

A moderator, a note taker, and an interviewer were well trained and experienced in working with the YMSM and MSM community.

Data analysis

Professional typists transcribed audio files from FGDs and KIIs in Thai. The verbatim transcripts were coded and analyzed in the original language (Thai). The study staff analyzed the data by themes corresponding with research questions, and categories of findings were developed. Standard computer software for qualitative data analysis was used for coding Thai language scripts and categorization (Atlas.ti, Scientific Software Development, GmBH, Berlin, Germany, 2011). Content analysis was used to identify key categories, such as certain risk behaviors, risk situations, and other factors that may contribute to high HIV incidence among YMSM. The findings with verbatim quotes in Thai were translated to English during manuscript development.

Results

Participant characteristics

Among the 47 participants, the mean age was 22.5 years. Most participants were full-time employed (44.7%), graduated bachelor’s degree or higher (44.7%), and self-identified as gay (87.2%). All participants were sexually active, with the largest proportion engaging in both oral and anal sex (87.2%). Many participants reported that they had had receptive anal sex only (36.2%) and had been to clubs, bars, or saunas in just one area in Bangkok (36.2%; Table 1).

Among YMSM who participated in this study, 76.6% reported ever meeting a partner from the Internet, 29.8% having used club drugs, and 23.4% having had sex while high on drugs. A similar percentage (23.4%) had used Viagra or its generics. Participation in sex parties was reported by 27.7% of YMSM, high parties (events generally held in private settings where group sex was accompanied by methamphetamine and club drug use) by 12.8%, and having sex in exchange for money or goods by 17.0%. Overall, the average number of risk behaviors a participant experienced is 2.19 (Table 2).

Regarding anal sex experience in the past six months, 91.3% of YMSM reported having had anal sex with a steady partner, and among these 53.5% reported always using a condom; 74.5% YMSM reported having had anal sex with a casual partner, and among those 54.3% reported always using a condom (Table 3).

Factors influencing HIV risk behavior

We classified emerging categories in focus group discussions and key informant interviews related to factors influencing HIV risk behaviors among YMSM into six categories: (1) the use of social networks for seeking sexual partners and the marketing promotions of MSM entertainment venues, (2) social influence by peer and older MSM, (3) easy access to high parties and group sex, (4) easy access to club drugs, (5) conceptions related to HIV risk, and (6) sexual preferences of YMSM.

The use of social networks for seeking sexual partners and the marketing promotions of MSM entertainment venues

Social networking (e.g., mobile applications, Facebook) and MSM entertainment venues were perceived by most participants to encourage casual partner seeking. Participants described that several mobile applications were made for MSM to seek casual partners and were free to download. Participants explained how easy it is to browse photos and find the nearest partners with specific preferences and to identify a meeting spot through private chat rooms:

> Sexual partners from the Internet, especially Camfrog, are the type of people I actually have sexual intercourse with. For those partners from public places, I don’t take them back to my room or go to their places. Only hand jobs or oral sex are enough. (KII5)

> I paid $2.99 a month for a privilege to see more cute guys than ordinary members and more features added. I added a list of favorite guys to get notifications if they came close to my location. I didn’t have to travel far to have sex with them. (FGD 2)

Some participants discussed that MSM entertainment venues such as saunas and clubs presented a sexually challenging and stimulating environment for YMSM. Participants expressed that they knew about marketing promotions for YMSM (i.e., free entrance/locker rental in saunas or free first drink in the clubs for customers aged 18–20 years) or special events (e.g., bareback show, threesome show, shower show) through word of mouth, Web sites, Facebook, MSM magazines, and sauna posters.

> First of all, I call my friends asking where they are. They update the promotions that free alcohol and close at 4 a.m. I will follow my friends. Some people like to go to saunas so they go to saunas after the clubs close. Some MSM clubs also close at 9 a.m. (FGD 1)

> I usually go to the saunas during weekdays because they have nice promotions. On weekends, I go to the clubs because they open until dawn. After the clubs, I go home because I cover with sweat and smell of alcohol. (FGD 2)

Social influence by peer and older MSM

Participants expressed that peer pressure was the most influential factor accelerating risk behaviors, especially for those MSM who lived away from family. Most YMSM who participated in the discussions had relocated to Bangkok for further education and, therefore, did not live with family members or relatives. Instead, peer groups had become a main part of their social life. Participants stated that sexual orientation and sexual experiences with casual partners were revealed and often discussed among friends. Peer groups introduced them to MSM entertainment venues and social networks and supported their sexual identity disclosure. Living without family, participants have more freedom to express their sexuality, and they are more willing to disclose their sexual orientation among peers than among family members. In return, they gain connections and the ability to fit in with a new society.

We found evidence that peers from university and older MSM from clubs were a main factor increasing risk behavior in YMSM in this study. Participants reported that in order to recruit YMSM into private sex events, older MSM searched online for attractive members to participate in group sex. Free drugs and alcohol were offered for guests. Sex occurred among guests and sometimes with the hosts' steady partners, while some older men often watched these activities for pleasure. Emotionally, both same-aged peers and older MSM provided a sense of belonging, security, and acceptance, as well as feelings of value and excitement.

> My friends took me to saunas for the first time. I never go there by myself even I have all my freedom because I live alone. I don't have a lot of free time but if my friends ask me to, I will definitely find time for them. (FGD5)

Some participants mentioned that older MSM were one of the most powerful peer groups for YMSM due to Thai culture's respect for age and seniority. Older MSM were 30 years old or higher and had long-standing MSM connections and more money to influence YMSM who wanted to be protected and welcomed into MSM society. As mutual benefits between YMSM and older MSM, YMSM gained protection and financial support, while older MSM had the power to influence sexual risk by urging YMSM to have sexual intercourse with multiple sexual partners, consume alcohol, and use drugs.

> When I hang out with older MSM, I don't have to pay for anything because I'm a young one. (KII4)

> From my own experience, I went out with older MSM and he put a pill in my mouth followed by a glass of water. I didn't know what it was and I swallowed it. It

> turned out to be ecstasy, I was high and I knew it is not a good thing to do but couldn't say no. He always takes care of me and (financially) supports me. (FGD 4)

Easy access to high parties and group sex

"High parties" involve the consumption of recreational drugs to facilitate sexual activity. Participants reported that easy access to drugs was particularly true for high parties. Most high parties were several days long, and participants were solicited online, typically sponsored by older MSM who selected YMSM attendees based on profile photos or live video images.

Some participants had experienced group sex, or swinging parties. They stated that the structure was similar to high parties, except high parties involved drug use and lasted over a few nights. Group sex could occur indoors and outdoors. There were various venues for young men to seek sexual pleasure, regardless of security concerns such as getting robbed, sexually abused, or raped by multiple sexual partners. YMSM gathered for adventurous casual sex acts in public places such as public toilets, parks, theaters, and fitness centers. Outdoor sex was freely advertised through Web sites that provided the meeting time and location for such activities. Participants explained that members were recruited from Web sites, social networks, and on site in sauna dark rooms. Sometimes, group sex involved up to 30 members and took place in settings such as bareback parties (sex party without using condoms), sex-in-the-jungle parties (sex party in animal print clothing), and full moon parties (all-night beach party happening on the night of every full moon). Some participants reported using ice (crystal meth) to increase sexual pleasure; however, it also had an effect on erectile dysfunction. This led to the use of erectile dysfunction medication together with club drugs during many sexual events.

> In high party, the main objective of the host is to have sex. Using drugs is not the main thing. For the guests, the objective is to get free ice (crystal). The host uses Ice to exchange with sex. Nothing comes for free. (FGD3)

Easy access to club drugs

According to Thai law, illicit drug use is prohibited. Illicit drug dealers and drug users can be sentenced to lifetime incarceration. However, access to club drugs has never been difficult for YMSM who seek them. Participants described finding club drugs through peers at university, casual sexual partners, older MSM at high parties, and through a government law officer at the club.

Participants explained that the types of drugs varied and were used differently depending on the purpose of the event. Frequently, ice (crystal meth) and Viagra were used together during high parties. Ecstasy (tablet/liquid) and poppers (inhaled nitrates) were sometimes provided by party hosts. Participants reported that there were Internet posts for selling club drugs, but it was safer to buy from peer connections. Most participants reported having once used drugs for different purposes such as weight loss, hyperactivity, and sexual pleasure.

> I used ice when I wanted to have good sex with my boyfriends. It added so much pleasure and fun. Sometimes, I used it while I worked as a masseur… just to give pleasure when I had to have sex with clients. (KII1)

Conceptions related to HIV risk

Participants discussed three categories of conceptions that often led to higher-risk behaviors and became barriers to effective HIV prevention: (1) anal sex, (2) HIV transmission, and (3) HIV risk assessment.

Anal sex.—Common conceptions that potentially reduced condom use included beliefs that anal sex did not transmit HIV because it was "not really sex." One conception of participants was that the definition of sex was a physical activity in which a man inserted his penis into the vagina of a woman. HIV risk level of anal intercourse was perceived to be low:

"Everyone knows three ways of HIV transmission from health education class in school. But I don't get it how HIV can be transmitted through anus. It is totally different from vagina" (KII9).

HIV transmission.—YMSM participants believed that the likelihood of HIV transmission in one episode of sex was low. Not using condoms once in a while could not cause HIV transmission because no one was that "unlucky." However, MSM who had multiple sexual partners at the same time were perceived to be at a greater risk than those with one sexual partner at a time, regardless of the frequency of changes in partners: "Most people think they are not that unlucky. This time (sex without condom) may be fine (not HIV transmitted)" (FGD2).

Another participant conception about modes of HIV transmission was that HIV could not be transmitted unless ejaculation occurred. Participants believed that there was no need to use a condom as long as they could control ejaculation to be outside the anus: "It is risky if I ejaculate inside my partner's anus because HIV is in semen. The safe thing to do is I control ejaculation to be outside (of anus)" (KII10).

HIV risk assessment.—Participants believed that someone who looked "clean" or "young" (as young as high school age) could not be HIV-infected. Participants explained that young sexual partners represented naivety and innocence. They were desirable among older MSM and believed to be a "never been touched" type of sexual partner: "Because he is young, I think he is cleaner (HIV-free) than I am" (KII5).

Participants who had never personally known any HIV-infected persons believed that HIV infection could not happen among their circle of friends and that HIV commonly spread among other groups such as commercial sex workers and people who inject drugs: "AIDS is for people who don't know how to protect themselves, like hookers or MSM who sell sex at (name of location). We are upper-class educated MSM" (KII7).

HIV testing.—A belief among YMSM was that it is better not to know HIV status. It only brought stress into their lives. Participants also believed that people their age should not go to the clinic regularly. Participants reported seeking clinical services for symptomatic STI treatment only: “I never wanted to know my HIV status. I would not come here (clinic) if I didn’t have to get herpes treatment. When you don’t know about it, you don’t have to think about it” (KII 4).

Sexual preferences of YMSM

Condom use and sexual desire.—YMSM reported that they preferred not to use condoms, despite general knowledge of HIV risk. They did not like the feeling of having sex with a condom especially in an insertive anal role. Carelessness, laziness, overwhelming sexual desire, and curiosity were perceived to be causes of non-condom use:

> Mostly, craving for sex is more powerful than fear of HIV. They don’t care about anything else (condom use) at that moment, only focus on intercourse. The desire for sex is overwhelming. (FGD3)

> When I was having outdoor sex with many men, condoms were not enough and it would take time to go get more. I was lazy to waste my time on buying them. (FGD 7)

> It is hard to carry a condom in sauna when you’re in a small towel or underwear. Sometimes when I needed it, I already dropped it somewhere. I had to go downstairs to get a new one. (FGD 2)

Receptive anal role: A role of a giver.—Receptive anal role participants stated that they also performed oral sex with partners both before and after intercourse. They tried to please a partner by swallowing a sexual partner’s semen after ejaculation. It was a gesture to show appreciation for manhood and represented affection for a man. This commonly accepted view was believed to cause difficulty in rejecting unsafe sex or negotiating condom use: “To be receptive role, you cannot choose to use a condom, nor choose a sexual partner who will use a condom” (FGD3).

Discussion

Our study shows six categories in focus group discussions and key informant interviews related to HIV risk behaviors among YMSM: (1) the use of social networks for seeking sexual partners and the marketing promotions of MSM entertainment venues, (2) social influence by peers and older MSM, (3) easy access to high parties and group sex, (4) easy access to club drugs, (5) conceptions related to HIV risk, and (6) sexual preferences of YMSM.

Our analysis indicates that nearly 75% of participants in our sample have had sexual intercourse with partners found via the Internet and mobile applications. Our findings were consistent with previous studies that found the Internet to be an effective tool for reaching numerous sexual partners, while anonymity and same-sex behavior were maintained (Delaney, Kramer, Waller, Flanders, & Sullivan, 2014; Sowell & Philips, 2010). Men who

seek sexual partners through the Internet were more likely to have multiple partners than those who did not use the Internet as a sex-seeking tool (Bauermeister, Leslie-Santana, Johns, Pingel, & Eisenberg, 2011).

Based on descriptions of sexual activities given by participants, MSM gathered for adventurous casual sex acts indoors and outdoors. Most YMSM fantasized about having group sex experiences with their boyfriends and others. MSM couples may have sexual agreements with mutually agreed-upon conditions involving group sex between friends, swinging parties, and group sex in saunas (Gass, Hoff, Stephenson, & Sullivan, 2012).

We found that YMSM risk behaviors were associated with a combination of factors as also found in New York City (Solomon et al., 2010). Findings from other studies also showed similar characteristics of YMSM who engaged in risk behavior and YMSM who were binge drinkers. Both groups were more likely to live without their families, frequent gay bars, have greater numbers of friends who engage in risk behaviors, and be sensation seekers (Wong et al., 2008).

Conceptions about HIV risk behavior stemmed from discussions among peers. YMSM search for same-sex education from the Internet or learn how to react to situations by consulting with peers. The Internet contains inaccurate information that contributes to YMSM risk behavior. Sex education at school emphasizes heterosexual practices and neglects homosexual practices. Most of YMSM understood basic HIV risks such as sexual intercourse, mother-to-child transmission, and shared needles. However, YMSM underestimated how easily they could become infected with HIV from anal intercourse. Lack of MSM-specific HIV knowledge is worrisome, including a lack of knowledge about sexual sanitary practices such as anal douching for receptive anal role.

HIV prevention methods for YMSM

Given the high incidence of HIV among YMSM in Bangkok, prevention strategies aimed at this population are urgently needed. HIV and sex education that address the conceptions held by this group could help to increase condom use.

Data from this study reveal the significant influence of the Internet on risk behaviors for YMSM in Bangkok. Therefore, prevention efforts may benefit from appropriate and targeted use of the Internet. This is consistent with other research that suggests that online and social network–based strategies for YMSM may be useful (Holloway, Cederbaum, Ajayi, & Shoptaw, 2012). In Los Angeles, YMSM suggested the use of technology, including the Internet and mobile devices, for HIV prevention strategies (Holloway et al., 2012). Similarly, the Internet plays a significant role in HIV prevention messaging for YMSM 18–29 years of age in New York City (Kingdon et al., 2013). Participants in another study among YMSM in the United States also suggested use of technology including social networking and the Internet for HIV prevention programs. Men noted that, in the absence of formal sex education for YMSM, the Internet was a main source of sex education. They suggested that sex education including HIV prevention information relevant for YMSM at an early age would be beneficial (Flores, Blake, & Sowell, 2011). There is also evidence that Web-based HIV prevention strategies for MSM may be useful in Thailand, especially when MSM are

involved in the design of prevention materials (Kasatpibal et al., 2012). Although the Internet can accelerate certain risk behaviors, it may also be a tool for successful HIV prevention among YMSM. This study provides evidence, consistent with other findings, that strategies using the Internet and social networking may be effective in Bangkok.

In cooperation with the Thailand Ministry of Public Health, MSM entertainment venues openly support HIV prevention efforts and provide condoms and distribute information. Despite these attempts, venues such as saunas and clubs, which usually provide an irresistibly sexually stimulating environment for YMSM, remain a challenging setting for HIV prevention. For example, although condoms are provided onsite, it is not convenient to carry a condom into saunas. In order to provide convenience and promote condom use for MSM customers, a wristband with a small pocket for condoms could be helpful.

Continued high HIV incidence and risk behaviors among YMSM showed the need for innovation and increased efforts to prevent HIV infection in this population (Van Griensven et al., 2013). After three decades of HIV, it is obvious that condom use and abstinence alone are not enough to stop this epidemic. Additional effective ways to protect MSM from HIV infection are urgently needed (Sineath et al., 2013). One clinical trial and its open label extension study have shown evidence that pre-exposure prophylaxis (PrEP) reduces the risk for HIV infection among MSM (Baeten et al., 2012; Grant et al., 2014; Thigpen et al., 2012). However, acceptability and feasibility of PrEP use in YMSM should be further explored in order to find the most effective way for their sexual practices (Peinado et al., 2013). Prevention approaches that combine behavioral, biomedical, and structural interventions also should be considered and tailored for vulnerable and high-risk populations globally (Hankins & De Zalduondo, 2010).

Limitations

The topics discussed in this study are sensitive and personal. Some of the participants may have felt uneasy answering questions openly in front of other participants. This study showed a fair amount of risk behaviors and drug use, but it was possibly an understatement of actual risk. The small sample size might affect generalizability; nevertheless, we collected in-depth useful insights from a sufficient number of YMSM to reach data saturation. Participants from FGDs and KIIs may have been relatively well educated in terms of HIV risk as all participants were members of the Bangkok MSM Cohort Study and/or had been attending the Silom Community Clinic for VCT for 2–5 years. They may have had more knowledge about HIV/AIDS and fewer risk behaviors than MSM in the wider community.

Conclusion

Our qualitative data show that social networks and MSM entertainment promotions, peer groups and older MSM, high parties and group sex, drug use, conceptions related to HIV risk, and preferences of YMSM are influential factors of HIV risk behaviors among YMSM.

While most YMSM had basic HIV knowledge, several conceptions were common that likely reduced condom use and increased HIV risk, particularly in the presence of events with multiple sexual partners and drug use. Evidence from our study suggests that YMSM-

specific HIV prevention efforts are needed to reduce HIV and STI infection in this population.

YMSM Voluntary Counseling and Testing (YMSM VCT) and peer-group sex education related to same-sex practices are urgently needed for YMSM, with emphasis on consistent condom use, particularly in tandem with drug use and multiple partner situations.

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Table 1.

Sociodemographic characteristics of young men who have sex with men who participated in qualitative component of Bangkok MSM Cohort Study, Bangkok, Thailand, 2012–2013 (n = 47).

Variable	*N* (%)
Age (years)	
Mean	22.5
Min	18
Max	24
Educational background	
Secondary school	16 (34.0)
Vocational school	10 (21.3)
Bachelor's degree or higher	21 (44.7)
Working status	
Work only	21 (44.7)
Study only	14 (29.8)
Work and study	11 (23.4)
Not work and not study	1 (2.1)
Sexual identity	
Gay	41 (87.2)
Bisexual	6 (12.8)
Sexual practice	
Oral sex only	2 (4.3)
Anal sex only	4 (8.5)
Oral and anal sex	41 (87.2)
Sexual role	
Insertive	16 (34.0)
Receptive	17 (36.2)
Both insertive and receptive	14 (29.8)
Ever been to club/bar/sauna area	
1 area	17 (36.2)
2 areas	14 (29.8)
3 areas or more	5 (10.6)
Do not go out	11 (23.4)

Table 2.

Risk behaviors of young men who have sex with men who participated in qualitative component of Bangkok MSM Cohort Study, Bangkok, Thailand, 2012–2013 ($n = 47$).

Variable	*N* (%)
Ever met a partner from the Internet	36 (76.6)
Ever used club drugs *	14 (29.8)
Ever had sex while high on drugs	11 (23.4)
Ever used Viagra	11 (23.4)
Ever joined sex party	13 (27.7)
Ever joined high party **	6 (12.8)
Ever sold sex for money or goods	8 (17.0)
Average number of risk behaviors a participant experienced = 2.19	

* Club drugs are recreational drugs such as ecstasy, methamphetamine, ketamine, GHB, LSD, and Rohypnol.

** "High parties" involve the consumption of recreational drugs to facilitate sexual activity.

Table 3.

Anal intercourse and condom use in the past 6 months among young men who have sex with men who participated in qualitative component of Bangkok MSM Cohort Study, Bangkok, Thailand, 2012–2013 (n = 47).

Variable	*N* (%)
Anal intercourse with steady partners	43 (91.3)
Consistent condom use with steady partners	23 (53.5)
Anal intercourse with casual partners	35 (74.5)
Consistent condom use with casual partners	19 (54.3)