

Surveillance Report:

Sexual risk behaviors

and

HIV prevalence

Among Male Sex Worker

In 2014

The 2014 Surveillance Results of Associated Risk Behaviors and HIV Prevalence among MSW

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Introduction

The surveillances on associated risk behaviors and HIV prevalence among Male Sex Worker: MSW that are currently being implemented by the Bureau of Epidemiology (BOE), Ministry of Public Health had been extended from a study through collaboration between Thailand – U.S. CDC Collaboration (TUC), The Thai Red Cross AIDS Research Centre, and Rainbow Sky Association of Thailand. The surveillance was initiated in 2005 and Bangkok, Chiang Mai and Phuket were chosen to be pilot provinces. The 2015 surveillance reported that HIV prevalence among MSW was 18.9% in Bangkok, 11.4% in Chiang Mai and 14.4% in Phuket. Based on the results, the high HIV prevalence among MSW was considered to be a public health related issue. In 2007 the BOE had therefore classified MSW group as one of the key populations to be monitored in the surveillance system for associated risk behavior and HIV prevalence. The surveillance was aimed at monitoring epidemic trends of HIV prevalence and HIV associated risk behaviors.

However, the results from the above three provinces were not sufficient to response to questions at the national level. To response to the epidemic questions at the national level and the availability of resource, therefore; in 2010 the surveillance model and the tool were adjusted to cover more surveillance areas and to integrate into regular surveillance system. Four provinces, Udon Thani, Ratchaburi, Songkla and Chon Buri were chosen to test the adjusted model and tool. From the surveillance, the HIV prevalence among MSW was 6.0% in Udon Thani, 8.1% in Ratchaburi, 20.0% in Songkla and 20.6% in Chon Buri.

In 2012 and 2014, the surveillances were re-conducted in five provinces, which were Chiang Mai, Phuket, Ratchaburi, Chon Buri and Bangkok. The surveillance was aimed at obtaining quality data to inform the current HIV prevalence and HIV associated risk behaviors among MSW.

Objectives

- 1) To study HIV prevalence and HIV associated risk behaviors among MSW; and
- 2) To promote access to HIV testing service among MSW.

Surveillance Methodologies

For the 2014 surveillance of associated risk behaviors and HIV prevalence among MSW, serial cross-sectional survey was used among the same dynamic population in the five provinces including Bangkok, Phuket, Ratchaburi, Chonburi and Chiang Mai, which were conducted by the BOE.

The participants selected would be qualified with all of these following conditions which include 1) Aged 15 years old and over; 2) Be Thai national; 3) Ever had oral or anal sex with men in the past 6 months; and 4) Resided in the study sites for at least one month. The required sample size was calculated based on the formula and proportion to sites.

Through the surveillances, Venue Day Time sampling (VDTS) technique was used based on the venue list. The followings were data collection steps:

- 1) A survey and mapping of places where target group gathering were conducted;
- 2) Based on the mapping, the research team counted the numbers of target group from each place to record numbers of them coming to the study areas. Each counting must clearly specify period of time and day in a week that target group had gathered, especially the time and day that was most crowded with target group. For instance, for the 1st counting at Lumpini Park on Monday during 18.00-20.00., the numbers of target group recorded were

35 people while the 2nd count on Saturday during 22.00-24.00 had shown 50 people. Under these results, the 2nd count on Saturday during 22.00-24.00 was chosen to be the surveillance time due to the greatest numbers of target group was recorded. To ensure accuracy in counting, MSW volunteers were assigned to record the data;

- 3) The data obtained from the busiest time and day was entered into the venue list with period of time and day clearly specified. The venue was then sampled to determine the place for interviewing the target group. By sampling, the simple random technique was used with one venue being selected at each time until the required sample size had been reached. For instance, for the required sample size of 360 cases, if the first sampling from the first venue list identified as 50 people as the sample number, the surveillance would collect data from this 50 cases from the identified venue. After the sample of 50 cases had been reached of the first venue, the research team would identify another venue and another sample cases at the busiest time and follow the same procedures until 360 cases had been reached;
- 4) During data collection at the study areas, the research staff would start by informing the project details to the target groups, and also seek for their willingness to participate in the screening questionnaire process. It is important to note that only the target group who were qualified would be explained about the project details. The target group who gave their consent to participate in the project would be asked to provide additional details for the project; and
- 5) Palmtop Assisted Self –Interview (PASI) was used to facilitate the participants to give data on demographic and HIV associated risk behaviors. Then OraQuick^R Rapid HIV Testing was conducted in order to detect for HIV Antibody from oral fluid. The appointment date for receiving the testing result was then made on the same day of the test. The result would be informed to the participants at counseling center of provincial hospital in each study site, and by the staff who received counseling training. If the result was positive, the counselor would encourage the participants to access to health services at hospital where the participants are entitled for the universal health insurance.

Data had been analyzed in order to identify percentage of prevalence rate of HIV, Chlamydia trichomatis and Neisseria gonorrhoea, condom use rate, experience of HIV test and receiving testing result, access to prevention program, and level of HIV knowledge at each study site.

The Surveillance Results

The 2014 results of the five provinces where total number of samples were 714 MSW had revealed that the average age of the sample was 25.5 years old (Median 24 SD 6.4). Over ninety-five percent (96.3%) of them were Buddhists. About 30.8% graduated their secondary education level. Almost fifty percent (49.6%) were single and the majority (29.9%) of them was currently staying with their friends. Most of them (33.3%) had income of THB10,000 -20,000 per month. For the HIV prevalence among MSW, the highest rate of HIV infection (24.8%) was found in Phuket while the lowest rate (2%) was shown in Ratchaburi province (Table 1).

Table 1 HIV prevalence among MSW by province in 2014

Province	Number	HIV infected cases	Percentage
Bangkok	252	30	11.9
Chon Buri	113	20	17.7
Chiang Mai	150	10	6.7
Ratchaburi	50	1	2.0
Phuket	149	37	24.8

From the data, Phuket province was recorded as the province where condom use rate among MSW during the last anal sex with male customers was the highest at 97.8% while the lowest rate was at Ratchaburi province at 86% (Table 2).

Table 2 Percentage of condom use among MSW during last anal sex with male customers by province in 2014

Province	Number	Cases of condom used at last anal sex	Percentage
Bangkok	223	213	95.5
Chon Buri	103	96	93.2
Chiang Mai	126	121	96.0
Ratchaburi	50	43	86.0
Phuket	89	87	97.8

From the data, it was indicated that the highest rate (93%) of condom use among MSW at every anal sex in the past three months was reported in Chiang Mai province. On the other hand, Ratchaburi was the province with lowest rate (47.6%) of condom use (Table 3).

Table 3 Percentage of condom use among MSW at every anal sex in the past 3 months by province in 2014

Province	Number	Cases of condom used in the past three months	Percentage
Bangkok	202	177	87.6
Chon Buri	97	79	81.4
Chiang Mai	115	107	93.0
Ratchaburi	42	20	47.6
Phuket	82	74	90.2

From the data, the highest rate (55.8%) of MSW who had ever received HIV test and the testing results was reported in Chon Buri province while the lowest rate (24%) was reported in Ratchaburi (Table 4).

Table 4 Percentage of HIV test and receiving HIV testing results among MSW in the past 12 months by province in 2014

Province	Number	Ever tested and received HIV testing result	Percentage
Bangkok	252	132	52.4
Chon Buri	113	63	55.8
Chiang Mai	150	73	48.7
Ratchaburi	50	12	24.0
Phuket	149	78	52.3

For detecting *Chlamydia trichomatis* (CT) from urine testing among MSW, Chiang Mai province was reported the highest infection rate (20%) while Ratchaburi province was indicated the lowest rate of 8% (Table 5).

Table 5 Percentage of *Chlamydia trichomatis* infection among MSW by province in 2014

Province	Number	CT infected cases	Percentage
Bangkok	-	-	-
Chon Buri	113	22	19.5
Chiang Mai	150	30	20.0
Ratchaburi	50	4	8.0
Phuket	149	13	8.7

Remark: Urine testing for detecting CT was not conducted in Bangkok.

For detecting *Neisseria gonorrhoea* (NG) from urine testing among MSW, Chon Buri province was reported the highest infection rate (5.3%). Meanwhile, the lowest rate (0.7%) was found in Phuket province (Table 6).

Table 6 Percentage of *Neisseria gonorrhoea* infection among MSW by province in 2014

Province	Number	NG infected cases	Percentage
Bangkok	-	-	-
Chon Buri	113	6	5.3
Chiang Mai	150	6	4.0
Ratchaburi	50	1	2.0
Phuket	149	1	0.7

Remark: Urine testing for detecting NG was not conducted in Bangkok.

In regard to access to prevention program among MSW which is relevant to becoming aware of places where HIV test service can be provided and receiving free condom, 77.4% was reported as the highest rate among MSW in Bangkok while the lowest rate of 42% was found in Ratchaburi province (Table 7).

Table 7 Percentage of access to prevention program among MSW by province in 2014

Province	Number	Access to Prevention Program	Percentage
Bangkok	252	195	77.4
Chon Buri	113	76	67.3
Chiang Mai	150	87	58.0
Ratchaburi	50	21	42.0
Phuket	149	102	68.5

In relation to HIV knowledge among MSW based on Global AIDS Responses Progress Report (GARP) indicators, it was revealed that the majority of all five provinces provided the correct answer to question #1: 'Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?'. The highest rate of 84.6% was in Phuket province while the lowest rate of 46.8% was in Bangkok. For question #2: 'Can a person reduce the risk of getting HIV by using a condom every time they have sex?', Chiang Mai province ranked the highest score at 96% while the lowest score (72%) was reported in Ratchaburi. For question #3: 'Can a healthy-looking person have HIV?', the highest rate in providing the correct answers was from Chonburi province (86.7%) while the lowest rate (50.4%) was indicated in Bangkok. For question #4: 'Can a person get HIV from mosquito bites?', the province with the highest rate (84.9%) of correct answer was Bangkok while Ratchaburi province showed the lowest rate at 60%. For question #5: 'Can a person get HIV by sharing food with someone who is infected?', it showed that 90.5% was the highest percentage of MSW from Bangkok providing the correct answer to this question and 58% of MSW in Ratchaburi province was reported as the lowest rate. For providing correct answers to all five questions, Ratchaburi was reported as the province with the lowest percentage (4%) while the highest percentage (45.1%) was in Chon Buri (Table 8).

Table 8 Percentage of MSW who provided correct HIV knowledge by each question and province in 2014

Province	Percentage of MSW who provided correct answers					
	Q1	Q2	Q3	Q4	Q5	Q1-Q5
Bangkok	46.8	86.5	50.4	84.9	90.5	20.2
Chon Buri	66.4	94.7	86.7	82.3	89.4	45.1
Chiang Mai	62.7	96.0	72.0	60.7	76.7	28.7
Ratchaburi	76.0	72.0	68.0	60.0	58.0	4.0
Phuket	84.6	94.0	82.6	72.5	67.8	42.3

Remark

Q1: Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?

Q2: Can a person reduce the risk of getting HIV by using a condom every time they have sex?

Q3: Can a healthy-looking person have HIV?

Q4: Can a person get HIV from mosquito bites?

Q5: Can a person get HIV by sharing food with someone who is infected?

Conclusion and Discussion

From the surveillance on associated risk behaviors and HIV prevalence among MSW, which had been implemented in the pilot provinces including Bangkok, Chiang Mai and Phuket in 2007, 2009, 2010 and 2012; the high HIV prevalence was reported in these provinces. This was because they were the center of civilization, and many entertainment places had been established. In 2014, the highest rate of HIV infection was found in the following provinces: Phuket, Chon Buri and Bangkok, respectively. Over the years, high incidence of HIV had been continued due to the existing issues of poor access to services and prevention programs.

The report of BOE had shown the overall picture of the provincial level that MSW had reported a higher rate of condom use during last sex with customers compared to FSW. However, HIV incidence was still found higher among MSW compared to FSW.

MSW had shown a good level of knowledge and understanding on HIV prevention, which might contribute to a high rate of condom use among them. This was indicated that over 94% of MSW by province provided the correct answer to question #2: 'Can a person reduce the risk of getting HIV by using a condom every time they have sex?' However, a positive attitude on safe sex and HIV preventive knowledge should be simultaneously promoted among MSW. Due to strong and well integrated collaboration among health personnel from government and private sectors, the proactive approaches were expanded to reach more MSWs, especially to the venue based MSWs. In contrast, a challenge in reaching non-venue based MSW through proactive services still existed to this day.

With regard to access to reactive service by analyzing data on experiences of receiving HIV test and HIV testing result (through VCT; Voluntary counseling testing), low access among MSW had been revealed. From this result, it was evident that access to reactive service was still a problem.

However, through efforts of various agencies, promoting access to reactive services and the holistic prevention approaches among MSW had been more advanced compared to the beginning of the surveillance system. This was clearly shown from the continual level of attention among MSW towards health and health seeking behaviors, especially on the HIV test.

For knowledge on HIV infection among MSW, the majority had shown an understanding on 'using condom correctly could prevent HIV transmission'. However, the question that obtained the lowest score was 'Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?'. When calculating for number of samples who provided all correct answers, the results was less than expected in relation to HIV prevention. It was inferred that lacking of preventive knowledge could cause an increase of unsafe sex.

For the past 12 months, low rate of receiving HIV test and testing result among MSW had been reported, which could be affected from lacking of awareness. Thus, increasing awareness among MSW in health care through health examination is important.