Prevalence of HIV Testing and Associated Factors among Young Men Who Have Sex with Men (MSM) in Bangkok, Thailand

Possawat Vutthikraivit MD*,
Buncha Lertnimitr MD*, Piyawat Chalardsakul MD*,
Worarachanee Imjaijitt MA**, Phunlerd Piyaraj MD***

** Phramongkutklao College of Medicine, Bangkok, Thailand*
*** Office of Research and Development, Phramongkutklao College of Medicine and Phramongkutklao Hospital, Bangkok, Thailand*
**** Department of Parasitology, Phramongkutklao College of Medicine, Bangkok, Thailand*

Background: *Without the safety and effective vaccine for HIV, the HIV voluntary counseling testing (VCT) has been documented as a central component of comprehensive HIV prevention strategies targeting individual risk reduction by modified high risk behaviors. However, the coverage of HIV testing among men who have sex with men (MSM) is suboptimal. Moreover, the information regarding to factors associated with HIV testing among young Thai MSM are limited and not well understood.*
Objective: *This study aimed to evaluate the prevalence and factors associated with HIV testing among young MSM in Bangkok, Thailand.*
Material and Method: *A cross-sectional study was conducted in Bangkok. Descriptive statistics were presented with crude- and adjusted-odds ratios with 95% confidence interval and the logistic regression models were used to identify factors associated with prior HIV testing.*
Results: *Fifty-six participants were enrolled into study and 51.8% of men previously had an HIV test. After adjusting for potential confounders, logistic regression revealed that older age was positively associated with HIV testing (AOR = 14.4, 95% CI 1.88-111.22) while perceived at low risk for HIV infection was inversely association with HIV testing (AOR = 0.1, 95% CI 0.02-0.94).*
Conclusion: *Young MSM in Thailand are at risk for HIV infection and uptake of HIV testing is suboptimal. Understanding the motivators and barriers to HIV testing are essential to planning and improving the effective HIV prevention interventions-relevance to HIV-serostatus.*

Keywords: *VCT, HIV testing, Young MSM, Thailand*

J Med Assoc Thai 2014; 97 (Suppl. 2): S207-S214
Full text. e-Journal: *http://www.jmatonline.com*

As of 2011, it was estimated that about 34.0 million people were living with HIV and 2.5 million people became HIV infected. In Thailand, the discordant burden of HIV infection was observed as similar in other countries. Recent meta-analysis of men who have sex with men (MSM) in low- and middle-income countries indicated that MSM had 19.3 times greater chance for being HIV positive compared to the population as a whole[1].

While the prevalence and risk behaviors were decreasing among Thai population as a whole, MSM were continuing to engage in high-risk sexual behaviors. The studies among high risk sub-population, MSM continued to documented the high prevalent of HIV infections, 17.3% in 2003, 28.7% in 2005, 32.7% in 2007, 28.3% in 2009, and 21.3% in 2011[2]. In addition, younger age was significantly associated with HIV incidence among sample of MSM in Bangkok, Thailand[2]. Furthermore, the incidence among young MSM in Thailand has been increase from 4.1% in 2003 to 7.7% in 2009[2,3].

Under the explosive epidemic of HIV infection with absence of promising HIV vaccine, among MSM, voluntary counseling and testing (VCT) for HIV/AIDS has been a core component of HIV prevention and control strategies targeting behaviors modification of

Correspondence to:
Piyaraj P, Department of Parasitology, Phramongkutklao College of Medicine, 315 Rajavithi Road, Rajathewi, Payathai, Bangkok 10400, Thailand.
Phone & Fax: 0-2354-7761
E-mail: p_phunlerd@yahoo.com

individuals. Previous studies have found that awareness of HIV status decreased risky behaviors substantially among those HIV infected person. HIV testing is considered as a mainstream for an effective secondary HIV prevention strategy because it is an entry point to appropriate care and support services among those who are HIV-infected[4,5].

In 2013, the majority of MSM in the western countries reported the awareness of HIV status; 56.0% in US and 73.7% in Europe[6], while the lower prevalence were observed in China and Mongolia range from 18.0% to 48.9% of MSM known the HIV[7,8]. In Thailand, despite free access, data from sentinel surveillance in 2004-2005 demonstrated that the history of prior HIV testing was reported by 32.1%, 36.0%, and 24.9% of Thai men, women, and MSM, respectively[5].

Although several studies have examined factors associated with HIV testing, the correlates of seeking HIV testing are not well understood. In this study, we present baseline sociodemographic data and behavioral risk factors for HIV infection, and aims to identify associated factors of HIV testing among MSM in Bangkok. The findings from this work could provide basic information for the effective HIV prevention.

Material and Method

Study design and population

Descriptive cross sectional study was carried out among young MSM who attending to the conquer AIDS, life skills camp in Bangkok, 2009 hosted by the Rainbow Sky Association of Thailand (RSAT). This program is a camp for MSM network to learn more about HIV/AIDS which is held on a regularly each year by open to applicants across Thailand. Approximately 50-80 MSM attended this camp.

A study participants of 56 from 60 participants was obtained during the hypothesis testing method and based on the following assumptions: 95% confidence interval, an expected rate access to VCT of 24.9% from a previous study and a 5% margin of error[5]. The calculated minimum sample was inflated by 10% to account for anticipated subject non-response.

Instrument description/data collection

Thai-Informed consent was obtained from all study participants. Literate respondents indicated acceptance by signing the consent form. Approval for the study was obtained from the Ethics Committee of the Royal Thai Army Medical Department, Thailand. A standardized self-administered questionnaire containing both open- and closed-ended questions was used.

It was divided into three parts, the first section inquired about socio-demographic characteristics included age, educational level, marital status, and occupation. The second part inquired about awareness of the existence of VCT, what is involved, where one could have VCT and previous VCT. Lastly, the third part elicited information about the modes of transmission and misconceptions such as transmission by mosquitoes and through sharing of meals and methods of prevention and availability of cure.

Questions about sexual behaviors included condom use with all partner types, usual position when engaged anal intercourse, having sexual intercourse for gift-exchange, having history of sexually transmitted infection, substance use and substance use prior to sex. The response questions were dichotomized as "never" versus "at least sometimes". Perceived lifetime risk for HIV infection was measured on a 5-points scale with the following question: "Choose a number that best describes how likely it is that you will become HIV-infected in your sexual active lifetime". Men who responded (1) Very unlikely or (2) Unlikely were defined as perceiving themselves at low risk, and those men who responded (3) Somewhat likely, (4) Likely, or (5) Very likely were defined as perceiving themselves at moderate/high risk.

In addition, study participants were asked about their first sexual experience (age, type of partner, condom use) and life-time number of male sex partner(s). Consistent condom use was based on the item "How often do you use condom when you have sexual intercourse?". The response option "always" was considered consistent condom use; "sometimes" and "never" were coded as inconsistent condom use.

HIV/AIDS-related knowledge and awareness was assessed with the five questions from UNGASS[9] (a healthy-looking person can have HIV, condom use and a monogamous relationship with an uninfected partner can prevent HIV, transmission is possible via mosquitoes and sharing a meal with a person who has HIV). Responses to knowledge questions were classified as correct or incorrect. Total scored were converted to percentages. A score of 90-100% was classified as adequate knowledge and a score less than 30% was considered inadequate knowledge as applied in the earlier study[10].

Statistical analysis

Descriptive statistics considered of frequency tabulations. Bivariate association between prior HIV

testing and independent variables include potential confounders were assessed via cross-tabulation and Chi-square tests. Those variables associated with VCT for HIV/AIDS use at $p<0.05$ were subsequently included in multiple logistic regression models to identify significant factors associated with HIV testing. Adjusted odds ratios (AOR) and their 95% confidence intervals were reported for all independent variables in the logistic regression model. All analyses were done using STATA version 11 (Statacorp, College Station, Texas, USA). Significance levels reported are 2 sided, and *p*-values less than 0.05 were considered statistically significant.

Results

A total of 56 men out of 60 approached (response rate 93.3%) agreed to be study participants. 51.8% of them reported prior HIV testing. The sociodemographic of study participants are shown in Table 1.

Their ages ranged from 18-33 years with a mean of 23.8±3.6 years and 66.1% of men were aged lower 25 years old. Regarding the educational level and working status, the majority of respondents had attained vocational school or higher educational level (83.9%) and 91.1% of men were employed or being full-time students. When asked about high risk behaviors for HIV infections, 26.8% of participants reported history of non-injection drug use, 37.5% reported history of sexually transmitted infection, and 12.5% mentioned that they have had sexual intercourse for gift/money-exchange. While 80.4% of men believed that they have had been at low risk for HIV infection, but the majority of them also reported having had multiple sex partners and performed receptive and dual role while having an anal intercourse. Furthermore, inconsistently condom use was reported by 44.6% of them.

Regarding with the reasons for seeking for HIV, total of 29 previous testers were reported "as part of job recruitment process", "self-concerned about HIV infection", "advised by doctor", and "as part of health insurance process" by 69.0%, 58.6%, 24.1%, and 24.1%, respectively. In other hand, the reasons for avoiding from HIV testing were obtained from remainders who never having had HIV testing. Of those men 63.0% and 40.7% were reported "perceived at low risk for HIV infection" and "fear of test result", respectively. In addition, "conflict time of work for visit clinic", "afraid of stigma and discrimination in case of positive test result" were reported by 25.9% and 22.2% of men. None of men was reported "because it was no cure" as a reason for avoiding from HIV testing.

HIV related Knowledge

With regards to clinical appearance, 40% of the participants reported that a healthy-looking person could be infected with the virus (Table 2). When asked about the mode of transmission, most respondents (80%) reported sexual intercourse, while 30% commented on sharing needles and unsterilized blades. Similarly, 70% of the respondents said HIV could be transmitted through unscreened blood transfusion. In addition, 60% of men reported HIV could be transmitted.

Regarding to condom use, almost all of these men (55/56) reported that condom use may confer protection from HIV infection. With regarding to clinical appearance, 7.1% of these men reported that a man who looking healthy could be infected with HIV viruses. According to misconceptions, 7.1% reported that mosquitoes possibly were vector to transmit the infection, only 1.8% reported that people can get HIV infection by sharing a meal with HIV-infected person (Table 2). When asked about their preferences of VCT location, 48.3%, 34.4% and 20.7% preferred government hospitals, private hospitals and anonymous clinics, respectively. Majority of them reported that confidentiality was the main reason for their choice.

Factors associated with HIV testing

Table 3 shows that after adjusting with potential sexual behaviors and other confounders, the logistic regression revealed that the older age was positively associated with prior HIV testing. In contrast, being perceived at low risk for HIV infection was inversely associated with prior HIV testing among the sample of MSM. Although men who reported higher number of sex partners appeared to be more likely to having history of HIV testing than those who reported lower number of sex partners, total number of sex partner and anal sex positioning were not a statistically significant factor associated with history of previous HIV among these men.

Discussion

The present study aimed to examine the associated factors of HIV testing among young MSM in Bangkok. These findings may guide to designing the effective HIV prevention and control programs targeting increase uptake of HIV testing and linkage to appropriate cares and services for young MSM in Thailand. Overall, about half of participants (51.8%)

Table 1. Demographic and behavioral characteristics among a sample of young men who have sex with men (MSM) by history of HIV testing in Bangkok, 2009

Characteristic	Having a history of HIV testing; n (%)			*p*-value
	No n = 27	Yes n = 29	Total n = 56	
Age group (years)				0.006
18-19	12 (44.4)	4 (13.8)	16 (28.6)	
20-24	11 (40.7)	10 (34.5)	21 (37.5)	
25-33	4 (14.8)	15 (51.7)	19 (33.9)	
Education				0.871
Secondary or less	5 (18.5)	4 (13.8)	9 (16.1)	
Vocational	6 (22.2)	8 (27.6)	14 (25.0)	
University	16 (59.3)	17 (58.6)	33 (58.9)	
Working status				0.210
Unemployed	3 (11.1)	2 (6.9)	5 (8.9)	
Full-time student	16 (59.3)	8 (27.6)	24 (42.9)	
Employed	8 (29.6)	19 (65.5)	27 (48.2)	
Non-intravenous drug use				0.889
Never	20 (74.1)	21 (72.4)	41 (73.2)	
Ever	7 (25.9)	8 (27.6)	15 (26.8)	
History of self-reported STI				0.240
Never	19 (70.4)	16 (55.2)	35 (62.5)	
Ever	8 (29.6)	13 (44.8)	21 (37.5)	
History of self-reported sex exchange				0.062
Never	26 (96.3)	23 (79.3)	49 (87.5)	
Ever	1 (3.7)	6 (20.7)	7 (12.5)	
Total number of sex partners				0.018
0	7 (25.9)	1 (3.5)	8 (14.3)	
1-50	10 (37.0)	8 (27.6)	18 (32.1)	
>50	10 (37.0)	20 (69.0)	30 (53.6)	
Usual anal sex role				0.020
No sexual intercourse or insertive	11 (40.7)	7 (24.1)	18 (32.1)	
Receptive	13 (48.2)	9 (31.0)	22 (39.3)	
Dual role of anal sex	3 (11.1)	13 (44.8)	16 (28.6)	
Perceived lifetime risk of HIV				0.112
Moderate/high	3 (11.1)	8 (27.6)	11 (19.6)	
Low	24 (88.9)	21 (72.4)	45 (80.4)	
Consistent condom use				0.977
No sexual intercourse and always	15 (55.6)	16 (55.2)	31 (55.4)	
Sometimes	12 (44.4)	13 (44.8)	25 (44.6)	

STI = sexually transmitted infections; HIV = human immunodeficiency virus

reported having had prior HIV testing. The analysis presented from this study found that MSM who were older was independently associated with HIV testing which confirm findings from other studies indicated that increased likelihood of HIV testing with increasing age[5,7,11,12]. These findings may suggest that to date MSM perceiving at higher risk for HIV infection than in the earlier year and therefore more likely to seek for HIV testing. Although, an increased proportion of HIV testing among MSM has been observed, it was far below the minimal requirement. Therefore, promoting behavior risk reduction program and HIV related knowledge, with emphasized the importance and benefits of HIV testing, should be undertaken to target the overall of MSM population.

As similar to findings from others that routine

Table 2. Knowledge on modes of transmission and methods of prevention among young men who have sex with men in Bangkok, 2009

HIV/AIDS related questions	No n (%)	Yes n (%)	Don't know n (%)
Does limiting sex to one uninfected partner prevent a person from contracting HIV/AIDS?	24 (43.6)	27 (49.1)	4 (7.3)
Does the use of condom protect against HIV transmission?	1 (1.8)	55 (98.2)	0
Do you think a healthy looking person can be a carried of HIV?	4 (7.1)	52 (92.8)	0
Do mosquitoes transmit HIV from an infected individual to an uninfected person?	49 (87.5)	4 (7.1)	3 (5.4)
Can a person get HIV by sharing a meal with someone who is infected?	55 (98.2)	1 (1.8)	0

HIV = human immuno deficiency virus; AIDS = acquired immune deficiency syndrome

Table 3. Univariate and multivariate analyses for factors associated with history of HIV testing among young men who have sex with men in Bangkok, 2009

Characteristic	OR	95% CI	*p*-value	AOR	95% CI	*p*-value
Age group (years)						
18-19	1					
20-24	2.7	(0.66-11.27)	0.166	3.6	(0.58-22.16)	0.168
25-33	11.3	(2.32-54.63)	0.003	14.4	(1.88-111.22)	0.01
Total number of sex partners						
0	1					
1-50	5.6	(0.57-55.43)	0.141	3.3	(0.18-60.62)	0.416
>50	14	(1.51-130.01)	0.020	6.9	(0.34-139.73)	0.211
Usual anal sex role						
No SI or insertive	1			1		
Receptive	1.1	(0.30-3.89)	0.897	0.6	(0.09-3.48)	0.542
Dual role of anal sex	6.8	(1.41-32.83)	0.017	3.7	(0.43-31.12)	0.235
Perceived lifetime risk of HIV						
Moderate/high	1			1		
Low	0.3	(0.08-1.40)	0.132	0.1	(0.02-0.94)	0.043

OR; odds ratios, AOR; adjusted odds ratios, 95% CI; 95% confidence interval

testing has been noted as an important facilitator across population, we found that the majority the previous testers reported that the testing was required from administrative process[5,13]. This may have been the result of most of the common practice in Thailand with pre-employment HIV screening. In addition, it may explain by HIV-testing was not required from educational institutions from school-aged MSM. From our findings, challenging to promote first HIV testing among the school-aged MSM. Moreover, maintaining adherence the regular testing together with returned for test result among those sought for HIV testing caused it was required document from other but not for individuals' concern of HIV serostatus.

There was the evidence from previous studies that mistakenly perceived HIV-serostatus was common among HIV-positive men[14]. In the present study, high-risk sexual practices were commonly reported by study participants. While participants reported suboptimal condom use, had multiple sex partners and had prior STI, these data demonstrated that having a lower perception at risk for HIV was inversely associated with HIV testing. This finding raised the considerable issue of underdiagnosed among HIV-infected men who may fear for identified as HIV positive and stigma after knowing the result. In other situation, some men who avoid for regular testing since they already know they were HIV-infected.

However, the majority of men in this project reported HIV negative test results and attained in high educational level. These results are similar as those seen in other studies, showing that persons who seek for HIV test result were more often HIV-negative and attained higher education. These findings suggest that planning and designing interventions should consider to the differences in situation and life-style of the men. These findings may suggest that barriers to testing do not all need to be addressed with the same frequency and urgency of testing. Since, it can be argued that men who regularly received information about risk reduction are unlikely to be person who at high risk of HIV infection. This may support from the previous study indicated that able to promote more testing frequency but only few new cases of HIV were identified[13].

The authors found that the preference locations for HIV testing among the previous testers were included public and private hospitals or clinics. In addition, the common reasons for failure of testing among non-testers were including stigma and fear of disclosure, inconvenient of service hours, distance and traffic, and poor quality of service. Furthermore, more than half of men reported perceived of discrimination and characteristic of testing service as the reason to avoid HIV testing. This also appears to be consistent with other studies that highlighting the role of stigma and discrimination and lower HIV testing rates among MSM[8]. The MSM-clinic setting should be a safe space to have open discussions about sexual[30]. These findings support the importance role of innovative interventions or outreach services such as clubs, bars, fitness centers or saunas. Taking account of these factors may help in planning and evaluating interventions to promote the uptake of testing. Moving forward, integrating clinical and cultural competency training for health care providers as well as increasing support for peer driven and community-led HIV testing programs may address this and increase testing rates.

There are several limitations to the present study. The authors cannot assume causality of the statistically significant associations with HIV testing in this study given the cross-sectional design. In addition, the information of the variable interested had relied on previous information which may be sensitive to recall bias, which may not represent the reasons Thai MSM who seek specific tests. The recruitment of the study participants based on the convenience sampling prevention program, which considered as a non-probability sample of MSM in Bangkok and thus caution should be applied when interpreted the results to all MSM in Bangkok. There may be challenges in generalizing over small number of sample size, so the geographical scope of the evidence may be limited. This sample was fully accrued in the camping to promote the HIV related knowledge for MSM in Thailand and thus may overestimate HIV testing rates among MSM who do not attending the camp.

Conclusion/Summary

The present study reveals prevalence and correlates of HIV testing among MSM in Bangkok are similar to those observed among MSM in other locations of Thailand and elsewhere[5-8]. However the coverage of HIV testing was suboptimal. In addition, these data highlight the need for a multifaceted, targeted HIV prevention strategy that integrates behavioral, biomedical and structural components, and addresses the current special needs of the MSM community in Bangkok, Thailand.

Acknowledgement

The authors gratefully acknowledge the Rainbow Sky Association of Thailand (RSAT) staffs for their cooperation in this project and Phramongkutklao College of Medicine for their mentorship and support. Authors dedicate this work to all participants who participating in the conquer AIDS, life skills camp, whose devoted their time and provided valuable information. The support of the Ministry of Science and Technology, Thailand, the Parasitology Department of Phramongkutklao College of Medicine, Thailand and the Johns Hopkins University Fogarty AIDS International Training & Research Program (Hopkins AITRP) in providing a doctoral scholarship to Dr. Phunlerd Piyaraj is also greatly appreciated (Grant Number: D43 TW000010-25). The views and opinions expressed are those of the authors alone and do not reflect the official opinion of Phramongkutklao College of Medicine or any guidance issued by Phramongkutklao College of Medicine.

Potential conflict of interest

None.

References

1. Baral S, Sifakis F, Cleghorn F, Beyrer C. Elevated risk for HIV infection among men who have sex with men in low- and middle-income countries 2000-2006: a systematic review. PLoS Med 2007; 4: e339.
2. van Griensven F, Thienkrua W, McNicholl J,

Wimonsate W, Chaikummao S, Chonwattana W, et al. Evidence of an explosive epidemic of HIV infection in a cohort of men who have sex with men in Thailand. AIDS 2013; 27: 825-32.
3. Yuntadilok N, Timmuang R, Timsard S, Guadamuz TE, Heylen E, Mandel J, et al. Eroding gains in safe sex behavior, HIV/AIDS knowledge, and risk perceptions among royal Thai Navy conscripts after 28 years of the AIDS epidemic in Thailand. AIDS Behav 2014; 18 (Suppl 1): S42-9.
4. Wilson DP, Hoare A, Regan DG, Law MG. Importance of promoting HIV testing for preventing secondary transmissions: modelling the Australian HIV epidemic among men who have sex with men. Sex Health 2009; 6: 19-33.
5. Wimonsate W, Naorat S, Varangrat A, Phanuphak P, Kanggarnrua K, McNicholl J, et al. Factors associated with HIV testing history and returning for HIV test results among men who have sex with men in Thailand. AIDS Behav 2011; 15: 693-701.
6. McDaid LM, Hart GJ. Increased HIV testing and reduced undiagnosed infection among gay men in Scotland, 2005-8: support for the opt-out testing policy? Sex Transm Infect 2011; 87: 221-4.
7. Lau JT, Gu J, Tsui HY, Wang Z. Prevalence and associated factors of intention to participate in HIV voluntary counseling and testing for the first time among men who have sex with men in Hong Kong, China. Prev Med 2013; 57: 813-8.
8. Yasin F, Delegchoimbol A, Jamiyanjamts N, Sovd T, Mason K, Baral S. A cross-sectional evaluation of correlates of HIV testing practices among men who have sex with men (MSM) in Mongolia. AIDS Behav 2013; 17: 1378-85.
9. Catumbela E, Certal V, Freitas A, Costa C, Sarmento A, da Costa PA. Definition of a core set of quality indicators for the assessment of HIV/AIDS clinical care: a systematic review. BMC Health Serv Res 2013; 13: 236.
10. Iliyasu Z, Abubakar IS, Kabir M, Aliyu MH. Knowledge of HIV/AIDS and attitude towards voluntary counseling and testing among adults. J Natl Med Assoc 2006; 98: 1917-22.
11. Prevalence and awareness of HIV infection among men who have sex with men-21 cities, United States, 2008. MMWR Morb Mortal Wkly Rep 2010; 59: 1201-7.
12. Nel JA, Yi H, Sandfort TG, Rich E. HIV-untested men who have sex with men in South Africa: the perception of not being at risk and fear of being tested. AIDS Behav 2013; 17 (Suppl 1): S51-9.
13. Lorenc T, Marrero-Guillamon I, Llewellyn A, Aggleton P, Cooper C, Lehmann A, et al. HIV testing among men who have sex with men (MSM): systematic review of qualitative evidence. Health Educ Res 2011; 26: 834-46.
14. Sirivongrangson P, Lolekha R, Charoenwatana-chokchai A, Siangphoe U, Fox KK, Jirarojwattana N, et al. HIV risk behavior among HIV-infected men who have sex with men in Bangkok, Thailand. AIDS Behav 2012; 16: 618-25.

ความชุกและปัจจัยที่เกี่ยวข้องกับการตรวจหาการติดเชื้อเอชไอวี ในกลุ่มชายอายุน้อยที่มีเพศสัมพันธ์กับชายในกรุงเทพมหานคร

พศวัต วุฒิไกรวิทย์, บัญชา เลิศนิมิต, ปิยวัฒน์ ฉลาดสกุล, วรรัชนี อิ่มใจจิตต์, พันเลิศ ปิยะราช

ภูมิหลัง: เนื่องจากในปัจจุบันยังไม่มีวัคซีนป้องเอชไอวีที่มีประสิทธิภาพและปลอดภัย "การตรวจโรคติดต่อทางเพศสัมพันธ์และให้คำปรึกษาโดยสมัครใจเกี่ยวกับการติดเชื้อเอชไอวี (วีซีที)" จึงเป็นวิธีที่ได้รับการยอมรับว่าเป็นวิธีที่มีประสิทธิภาพสูงสุดในการป้องกันการติดเชื้อเอชไอวี (ยกเว้นในประเทศที่มีการใช้วิธีการใช้ยาต้านไวรัส เพื่อการป้องกันในกลุ่มผู้ไม่ติดเชื้อ) เนื่องจากวีซีทีเป็นส่วนประกอบหลักที่สำคัญมากที่สุดในการกำหนดกลยุทธ์เพื่อป้องกันการติดเชื้อเอชไอวี โดยมีเป้าหมายหลักคือการมุ่งเน้นการให้คำปรึกษาโดยการสมัครใจ เพื่อมุ่งหวังให้เกิดการปรับเปลี่ยนและลดลงของพฤติกรรมเสี่ยงในระดับตัวบุคคล ส่งผลให้โอกาสในการแพร่กระจายโรคน้อยลงและนำไปสู่การลดจำนวนของการติดเอชไอวีในที่สุด ถึงแม้ว่าวีซีทีจะได้รับการยอมรับอย่างแพร่หลายทั่วโลก ว่ามีประโยชน์และเป็นตัวแปรสำคัญที่สุดในการวางแผนยุทธศาสตร์และกำหนดกลยุทธ์เพื่อลดปัญหาของเอชไอวีแต่ในประเทศไทยพบว่าข้อมูลพื้นฐานเกี่ยวกับวีซีทีมีอยู่จำกัด และองค์ความรู้ในปัจจุบันไม่เพียงพอในการอธิบายประเด็นความสัมพันธ์ของการตรวจหาการติดเชื้อเอชไอวีในกลุ่มชายรักชายได้อย่างชัดเจน โดยเฉพาะอย่างยิ่งในกลุ่มชายรักชายที่มีอายุน้อยซึ่งเป็นกลุ่มที่มีความเสี่ยงสูงสุดในการติดเชื้อเอชไอวี

วัตถุประสงค์: เพื่อศึกษาความชุกและปัจจัยที่เกี่ยวข้องกับการตรวจหาการติดเชื้อเอชไอวีในกลุ่มชายรักชายที่มีอายุน้อยในกรุงเทพมหานคร

วัสดุและวิธีการ: ดำเนินการวิจัยโดยใช้งานวิจัยเชิงพรรณนาชนิดภาคตัดขวางในปี พ.ศ. 2552 ในพื้นที่จังหวัดกรุงเทพฯโดยวิเคราะห์ข้อมูลแบบสถิติเชิงพรรณนาและหาขนาดความสัมพันธ์ในการตรวจหาการติดเชื้อเอชไอวี ในกลุ่มชายรักชายด้วยค่า Crude-odds ratios (OR) และ adjusted odds ratios (AOR) ที่ค่าความเชื่อมั่นร้อยละ 95 (95% confidence interval, 95% CI) ของค่าความสัมพันธ์นั้น และใช้ logistic regression เพื่อระบุปัจจัยที่เกี่ยวข้องกับการตรวจหาการติดเชื้อเอชไอวี

ผลการศึกษา: มีผู้เข้าร่วมโครงการทั้งสิ้นจำนวน 56 ราย ทั้งนี้ร้อยละ 51.8 ของอาสาสมัครเคยตรวจหาการติดเชื้อเอชไอวีมาก่อนและหลังจากวิเคราะห์ทางสถิติเพื่อปรับค่าความสัมพันธ์ โดยการควบคุมตัวแปรอื่น ๆ ที่มีกระทบต่อผลงานวิจัย พบว่าอายุที่เพิ่มขึ้นมีความสัมพันธ์ทางบวกกับการตรวจหาการติดเชื้อเอชไอวี อย่างมีนัยสำคัญทางสถิติ (AOR = 14.4, 95% CI 1.88-111.22) ในขณะที่การรับรู้ว่าตนเองมีความเสี่ยงต่ำในการติดเอชไอวีมีความสัมพันธ์ผกผันอย่างมีนัยสำคัญทางสถิติกับการตรวจหาการติดเชื้อเอชไอวี (AOR = 0.1, 95% CI 0.02-0.94) ในประชากรกลุ่มนี้

สรุป: กลุ่มชายอายุน้อยที่มีเพศสัมพันธ์กับผู้ชายในประเทศไทย เป็นผู้ที่มีความเสี่ยงสูงในการติดเอชไอวี แต่ในประเทศไทยกลับพบว่าอัตราการรับบริการวีซีทีในประชากรกลุ่มเสี่ยงอยู่ในระดับต่ำกว่าเป้าหมายที่กำหนด ดังนั้นการศึกษาเกี่ยวกับตัวแปรสำคัญที่เป็นแรงจูงใจและอุปสรรคในการเข้าถึงบริการของประชากรกลุ่มนี้ จึงมีความสำคัญอย่างมากในการวางแผนและการพัฒนากลยุทธ์การป้องกันและควบคุมเอชไอวีได้อย่างมีประสิทธิภาพ โดยคำนึงถึงสถานะของผลการตรวจหาการติดเชื้อเอชไอวีในประชากรกลุ่มเสี่ยง