Personal History of Voluntary HIV Counseling and Testing (VCT) Among Adults Aged 19–35 Years Living in Peri-urban Communities, Chiang Mai, Northern Thailand

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This study investigates the self-reported history of HIV voluntary counseling and testing (VCT) among adults, aged 19–35 years, in northern Thailand. Participants were interviewed about their HIV testing history and risk behavior. Overall, 47% of 2251 participants had previously been tested, of whom 64% were tested at government clinics. Of those tested at private clinics, 50% reported not receiving pre- and post-test counseling, compared to 15% of those tested in government clinics. Ten percent of those tested had not received their test results. Among those who had never been previously tested for HIV, 66% believed they were not at risk, although 1.5% (2.7% among men) were HIV infected. Although VCT is widely available and utilized by the population of northern Thailand, substantial numbers of HIV infected persons have not been tested for HIV and among those tested many have not received comprehensive counseling. A Thai government policy enforcing effective counseling to accompany HIV testing is urgently needed.

KEY WORDS: AIDS; voluntary counseling and testing; Thailand; sexual transmission; prevention.

INTRODUCTION

HIV voluntary counseling and testing (VCT) has been important in the prevention and treatment of HIV in both developed and developing countries (Irwin et al., 1996; Kamenga et al., 1991; Campbell et al., 1997; Kellerman et al., 2002; Allen et al., 1992a,b). VCT provides individuals with the opportunity for personal risk assessment, education about HIV/AIDS, and the prospect of reducing high-risk behaviors (UNAIDS, 1998; Kamenga et al., 1991; Higgins et al., 1991). VCT is an entry point to care and support for the HIV infected individual including treatment of HIV, prophylaxis to prevent opportunistic infections, prevention of sexual, parenteral and mother-to-child transmission, and social support. UNAIDS has encouraged countries to establish national policies on VCT because of its vital role in HIV/AIDS prevention and treatment (UNAIDS, 1997). In the United States, the Centers for Disease Control and prevention has recently launched a major effort to provide testing for persons at high risk who are unaware of their infection status in order to prevent transmission (Janssen et al., 2001).

The Thai Red Cross Society established the first anonymous VCT clinic in Thailand in mid-1991 in Bangkok as soon as HIV infection was removed from the list of reportable diseases. In 1992, confidential or anonymous VCT services were made available at all government health clinics in all provinces in

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Thailand (Phanuphak et al., 1994). VCT has been an important component of the nation’s HIV/AIDS prevention and control plan since that time. The Thai government also established a policy to provide free VCT to all pregnant women, and for those HIV positive, a short course AZT regimen to reduce mother-to-child transmission, AZT syrup for six weeks for the newborn, and a one year supply of infant formula (Kanshana and Simonds, 2002).

The Thai Ministry of Public Health (MOPH) Institute for Mental Health played a central role in improving the standards of HIV/AIDS counseling and in training counselors (Ungphakorn and Sittitrai, 1994). In September 1996, the Institute founded the AIDS Counseling Center for Training and Research (ACCTaR) in Chiang Mai province. The ACCTaR’s responsibilities included development of effective HIV/AIDS counseling strategies for the country, training HIV/AIDS counselors, and conducting research on VCT to foster the development of more effective VCT services. At present, VCT is available in every government hospital, in STD clinics and in some health centers. HIV testing is also widely available in private settings, including NGOs, clinics, hospitals and private laboratories.

In this report, we evaluate the self-reported history of HIV testing and determine receipt of counseling as part of HIV testing, disincentives to testing, reasons for seeking testing, and factors associated with obtaining an HIV test among adults aged 19–35 years who lived in peri-urban communities around the city of Chiang Mai, Thailand in 1999. Chiang Mai province, in northern Thailand, has been severely affected by the epidemic of HIV/AIDS since 1988. This study of VCT was nested within a study determining the prevalence and incidence of HIV in the general young adult population of northern Thailand in preparation for possible HIV vaccine or other intervention trials to prevent HIV. An evaluation of HIV testing history in this general population could assist government officials and NGOs in planning more effective VCT services at the community level to control the spread of HIV.

METHODS

The study participants were recruited to evaluate HIV risks in the general adult population using a multi-pronged “snowball” recruitment network. The study team approached a diverse group of residents—village leaders, local health officers, youth group leaders and housewife group leaders—to enroll participants. These leaders developed recruitment plans that enrolled young adult residents of the communities. The recruiters received 50 baht ($1.25) for their effort and transportation cost per individual enrolled.

Eligibility Criteria

Participants were between 19 and 35 years of age, held Thai national identity cards, resided in the target communities, intended to remain in the community for at least 6 months, and were willing to give informed consent to participate.

Study Process

The data reported here are the baseline results from a prospective study, which consisted of two phases, a baseline and a six month followup.

At baseline, potential participants were seen at community study sites. They received group pre-test counseling and explanation of the study objectives and procedures. Experienced HIV/AIDS counselors from the community’s hospital and MOPH staff provided HIV counseling. The pre-test counseling followed the Thai MOPH HIV/AIDS guidelines which include education about HIV/AIDS and other sexually transmitted diseases (STD), methods of HIV transmission, individual risk assessment, personalized risk reduction plans, and meaning of HIV test results. Those who decided to participate were asked to meet with the study staff individually for explanation of the study and to give their consent to participate without the presence of their recruiter. Participants’ right to decline to participate was emphasized to assure there was no coercion to participation. After the participants had signed the consent form, they were issued a study ID card with a unique study identification number. The participants then had blood drawn for testing for HIV antibodies, and one-on-one gender-matched interviews using a structured questionnaire. The interview included socio-demographic data, HIV risk perception, lifetime and recent (past 6 month) HIV risk behavior, a history of STD infection, and HIV counseling and testing history. Participants were scheduled to receive their individual HIV test results and confidential individual post-test counseling 2–3 weeks later at a community health clinic or hospital. For all participants, the counselors re-assessed the client’s risk behavior and discussed a personalized risk reduction plan, as