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HIV/AIDS RISKY SEXUAL BEHAVIOR AMONG URBAN POOR IN NORTHEAST THAILAND

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ABSTRACT

This study was aimed to identify the HIV/AIDS risky sexual behavior of urban poor in Northeast Thailand. Participants, consisted of 440 urban poor, were randomly selected and responded to questionnaires. The average age for these urban poor who had the first sexual intercourse was 18.3 ± 3.3 years old. Most of them had first sexual intercourse with girlfriend or boyfriend (81.1%). The rate of condom use during the first sexual intercourse was only 17.9%, whereas most of them did not use condom (76.7%) during the latest sexual intercourse. The rate of condom use, when having sexual intercourse with sex workers, was statistically significant higher than that with spouse, where the adjusted OR = 43.9; 95 % and CI = 14.8 to 130.8. The rate of condom use, when having sexual intercourse with casual partners, was also statistically significant higher than that with spouse, where the adjusted OR = 6.4; 95 % and CI = 2.8 to 14.5. This can be concluded that unprotected sexual behavior was critical among urban poor. Authorities should reorient condom use campaign and safe sex for this venerable group.

Keywords: HIV/AIDS, risky sexual behavior, urban poor.

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INTRODUCTION

The HIV/AIDS pandemic remains the most serious of infectious disease challenges to public health (World Health Organization and United National Programme on HIV/AIDS, 2007). There were critical risky behaviors such as having unsafe sex earlier (WHO, 2006), low condom use rate (Meekers et al., 2003; UNAIDS/WHO/UNFPA, 2004; Hong et al., 2009), and there was virtually no correlation between HIV/AIDS knowledge and the practice of safer sexual behaviors (Tanaka et al., 2008).

There has been an increasing trend of urban population because of the outcome of economic development. The urban poor have less opportunity to receive information about HIV/AIDS (Dodoo et al., 2007). In addition, they have high risky behavior concerning HIV/AIDS, such as having sex before marriage especially male workers with the prostitutes, and also living in the slum area. These particular groups of people contribute to the impacts on the national economic growth (Hare and Villarruel, 2007). Socioeconomic status emphasizes that there are important hardship differences among these people (Hattoric and Dodoo, 2007) as well as poverty and economic distress that are contributing to the growth of risky behaviors for HIV/AIDS infections (Tanaka et al., 2008).

The Northeast urban poor shared similar characteristics with other urban poor settings of poverty with depressed living conditions in Thailand. The number of AIDS victims in the Northeast was increasing at a frightening rate. The estimate of infected persons had risen to 62,006 in the respective years of 1984 to 2007, and was increasing to 63,524 in 2008 (Epidemiological Information Section Bureau of Epidemiology, 2008). In addition, there is a rapid change in urbanization in Northeast Thailand, where most of its population live in rural settings. Its accompanying ill effects as manifested in such conditions of slum life as extremely low income, malnutrition and illnesses, the proliferation of criminality, drug addiction, and prostitution, which lead to high risk to HIV/AIDS transmission. Therefore, the urban poor citizens are still in risk of suffering from HIV/AIDS. In order to minimize infection rate of HIV/AIDS, it is important to identify the HIV/AIDS risky behaviors for the urban poor in Northeast Thailand. The debate about appropriate approaches to behavioral change, especially the priority of divergent components, is an indication of the difficulties in overcoming cultural, social, political, and religious barriers to comprehensive behavioral change prevention measures (WHO, 2006). Thus, this study was aimed to identify the HIV/AIDS risky sexual behaviors.

METHODOLOGY

The participants were recruited from urban poor area of Northeast Thailand. The sample size was calculated using the estimating population proportion (known population) with the proportion of HIV prevention in an Indian metropolitan slum dwellers equals to 0.60 (Kalasagar et al., 2006) with an allowable error, where the absolute value of different acceptance (d) was 0.04. The participants were randomly selected according to the following eligibility criteria, i.e., they should be Thai nationality living in community not less than six months, their ages were equal or older than 15 years, they should be able to communicate in Thai, and were willing to participate in this study.

The constructed questionnaires were carried out based on urban poor risky sexual behaviors. The questionnaires were reviewed and quality control of content validity by five experts. All parts of the questionnaire were pre-tested to check the understanding of the participants to the questions and whether we would get the answers that we aimed to achieve.

Four hundred and forty participants were interviewed to collect the data on demographic and socioeconomic; HIV/AIDS risky sexual behavior and prevention practices. The ethics committee of Khon Kaen University approved the study.

Data analysis

Regarding the data; descriptive and influential statistics were applied to analyze the data, such as percentage, mean, and standard deviation. As well, the logistic regression was also used to analyze

and quantify the risk of the HIV/AIDS risky sexual behaviors. The adjusted odds ratio (OR) and 95% confident interval were presented.

RESULTS

Of the 440 respondents, an average age was 38.8 ± 13.8 years old, 64.8% were married, and 55.7% finished primary education, whereas 5.5% had no formal education. Almost half of them had temporary jobs (48.6%), 20.2% were in private business, trade, courier, dustman, but 8.6% were jobless. Their average monthly income ranged between 300 and 18,000 baht per month with the median of 6,000 baht per month. The average family sizes were 4.5 ± 2.1 persons per family.

Sexual behavior among the urban poor

In term of their sexual orientation, almost all of the respondents have had sex and identified themselves as heterosexual, while some were bisexual (having sex with either women or men). It showed that the average age of respondents who experienced first sexual intercourse was 18.3 ± 3.3 years. The youngest age of respondents who experienced first sexual intercourse was 10 years old and the highest one was 32 years old. Most of their first sexual intercourse was occurred between 15 and 19 years old. Their sexual partners were either boyfriend or girlfriend with some of them indicated that they had sex with sex workers and with friends. The most common reasons for their first sexual intercourse were love, good opportunity, and getting drunk. Most of them did not protect themselves during the first sexual intercourse activities, whereas only 17.9% using condoms during their first sexual intercourse activities. Results are summarized in Table 1.

Table 1. Number and percent of sexual behavior of participants (n=440).

Sexual behavior	Number	Percent
Sexual experience		
Yes	408	92.7
Never	32	7.3
Sexual orientation		
Heterosexual (sex with women)	395	96.8
Bisexual (sex with either women and men)	10	2.5
Homosexual (sex with men)	1	0.2
Homosexual (sex with women)	2	0.5
Age at the first sexual intercourse		
< 15 yrs	32	7.8
15-19 yrs	247	60.5
20-24 yrs	105	25.7
≥ 25 yrs	24	5.9
Mean (SD)	18.3	(3.3)
Median (min-max)	18.0	(10-32)
Person who had sex with the first		
Boyfriend/girlfriend	331	81.1
Sex worker	27	6.6
Friend	26	6.4
Acquainted	21	5.1
Homosexual (male or female)	3	0.7
Reason for first sexual intercourse (could answer more than one)		
Love	328	80.4
Got opportunity	92	22.5
Drunk	52	12.7
Persuasion	21	5.1
Group's fashion	20	4.9
Other; coercion, want reward, innocent	6	1.5
Protection for the first sexual intercourse		
Unprotected	327	80.1
Using condom	73	17.9
External ejaculation	6	1.5
Oral sex	2	0.5

Latest sexual intercourse

For the latest sexual intercourse activities, most of the respondents indicated that they had sexual intercourse with boyfriends and/or girlfriends. Most of them were not practiced safe sexual behaviors, while only 20.8% of them used condoms. The most common reason for not practicing safe sexual behaviors was that they had sexual intercourse with spouse, which afraid of showing distrust with their partner, and inconvenience to buy condoms. The common reasons for using condom during sexual activities were being afraid of getting infected with infectious diseases, whereas some of them were not used condom in the case of having sex with boyfriend and/or girlfriend, and with partners who refused to use them.

In term of sex partners during the previous one year, most of the respondents indicted that they had only one sex partner, whereas 24.3% of them had two to four sex partners, with the median of one sex partner (min-max of 0-36 sex partners).

Concerning the accessibility and availability of condom for use, the respondents indicated that they could access to condoms from various sources. About a quarter of them bought condoms from Seven Eleven Shop, 22.8% got from health center/primary care unit, and 22.1% obtained from drug stores. Results are summarized in Table 2.

Table 2. Number and percent of the latest sexual behavior of participants (n=440).

Latest sexual behavior	Number	Percent
Latest person who had sex		
Boyfriend/girlfriend	343	84.1
Sex worker	29	7.1
Acquainted	25	6.1
Friend	6	1.5
Homosexual (male or female)	5	1.2
Protection for the latest sexual intercourse		
Unprotected	313	76.7
Using condom	85	20.8
External ejaculation	8	2.0
Oral sex	2	0.5
Reason to unprotected of having sex in the latest	287	91.7
Had sex with boyfriend/girlfriend	14	4.5
Afraid of showing distrust to partner	12	3.8
Inconvenience to buy condom		
Reason to protected at the latest sexual intercourse	45	47.4
Be afraid of infection	22	23.2
Had sex with boyfriend/girlfriend	13	13.7
Partners refuse	8	8.4
Had sex with sex workers	7	7.4
Others: prevention of pregnancy		
Number of partners who had sex during 1 year		
None	29	7.1
1 partner	268	65.7
2-4 partners	99	24.3
≥ 5 partners	12	2.9
Median (min-max)	1.0	(1-36)
Source of condoms		
Never use	136	33.3
7-Eleven	105	38.6
Health center / Primary care unit	62	22.8
Drug store	60	22.1
Condom vending machine	28	10.3
Hospital	17	6.3

Factors influencing condom use during the latest sexual intercourse activities

The most common risky sexual behavior of the urban poor was unprotected sexual intercourse. This study was interested in factors influencing condom use in the latest sexual intercourse among the urban poor. The results indicated that only sexual partners were the main factor that had influences on condom use in those urban poor. It was found that the use of condom when having sexual intercourse with sex workers was statistically significant, which about 44 times higher than that with spouse in which the value of adjusted OR=43.9; 95 % CI = 14.8 to 130.8. The use of condom when having sexual intercourse with casual partners was statistically significant about 6 times higher than that with spouse with the value of adjusted OR = 6.4; 95 % CI: 2.8 to 14.5. Results are summarized in Table 3.

Table 3. Relationships between factors and the condom use for the latest sexual intercourse activities of the urban poor (n=440).

Factors	The condom use for the latest sexual intercourse activity				Crude OR	Adjusted OR	95% CI of adjusted OR	p-value
	Used (n=85)		Did not used (n=323)					
	Number	%	Number	%				
Marital status								
Single	31	58.1	43	41.9	1	1	-	0.01
Married	41	14.4	243	85.6	0.2	0.24	0.1-0.5	
Widow/divorced	13	32.5	27	67.5	0.5	0.43		
Sexual partners								
Spouse	40	11.7	303	81.3	1	1	-	0.01
Sex worker	24	82.8	5	17.2	36.4	43.9	14.8-130.8	
Casual partners	21	58.3	15	41.7	10.6	6.4	2.8-14.5	

DISCUSSION

Demographic and socio-economics

The respondents in this study were almost on equal proportion of male and female (50.5: 49.5%). Their average age was 38.8 ± 13.8 years old. Most of these urban poor were married. They were in the rather low socioeconomic status of education, job and income. Most of them (64.8%) finished primary education (55.7%), whereas 5.5% had no formal education, which could affect risky behaviors of HIV/AIDS. The different level and different field of education have an effect on HIV/AIDS perceptions because people will have different thoughts, goals, and needs. Marital status is a crucial factor of chance to having sex with regular partner or non-regular partner of married and unmarried persons(Harrington et al., 2002). Almost half of them had temporary jobs (48.6%), 20.2% were in private business, trade, chauffeur, courier, dustman. Occupation is an important factor because the status of socio-economic makes the difference in term of people, culture, experiences, attitudes, value judgments, thoughts, beliefs, goals, and other behaviors (Slonim-Nevo and Mukuak, 2007).

In addition, their average monthly income ranged between 300 and 18,000 baht per month, with the median of 6,000 baht per month. The highest proportion had average monthly income of between 3,001 and 6,000 baht (35.5%), whereas 21.1% earned less than 3,000 baht per month. The

study of Nash and Elul (2006) identified virtually all women in slum communities had extremely low socioeconomic status that the economic hardship lowers sexual exclusivity. The socioeconomic status emphasized that there were important hardship differences, even among very poor slum residents (Hattoric and Dodoo, 2007). In addition, according to Tanaka et al. (2008) poverty and economic distress are contributing to the growth of risky behaviors for HIV/AIDS infection in the resource-scarce post-emergency refugee camp.

Sexual behavior among the urban poor

Almost all of these urban poor ever have had sexual experiences (92.7%). The average age when had sexual intercourse was 18.3 ± 3.3 years old, the youngest age of first sexual intercourse was 10 years old and the highest was 32 years old. Most of their first sexual intercourse (60.5%) was between the age of 15 and 19 years old. This indicated that they had sexual experiences when they were young, they might have poor judgment for preventing consequent problems. It was different from the earlier study finding that the first sexual experience was between 15-24 years old (Thomas et al., 2004). Most of them (81.1%) had first sexual intercourse with boyfriend/girlfriend. The most common occasions for their first sexual intercourse were just being together (58.6%), getting married (12.3%), and being together during the festival (11.3%). These environmental circumstances showed that they might lack of supervision of parents, which gave them opportunity for sexual activities. The most common reasons for their first sexual intercourse were love (80.4%), getting opportunity (22.5%), and getting drunk (12.7%).

Only 19.9% of the urban poor protected themselves for the first sexual intercourse activity, which was much lower than those found in the study of Thomas et al. (2004), that 83% of them used condoms. During the past one year, only 17.9% using condom. Furthermore 21.6% of participants had sexual intercourse with other partners, 25% were unprotected, and 16.2% of them had sexual intercourse with sex workers. In addition, for the latest sexual intercourse, 84.1% had sexual intercourse, with 76.7% not using condom. The most common reasons for not using condom were because they having sexual intercourse with spouse (91.7%), which being afraid of showing distrust with their partners (4.5%). These practices and attitude contributed to high risk of HIV infection. Early sexual experimentation, multiple partners, and low and irregular use of condoms were common. A substantial number of the men indicated that it was advisable to use a condom with one's spouse for AIDS protection and yet only 8% had ever used a condom (Kalipeni and Ghosh, 2007; Hong et al., 2009). In order to reduce HIV/AIDS infection, it must be 100 % condom use, since even only 1% of unprotected sexual intercourse could transmit HIV/AIDS. Involving education on condom use and provision of free condom increased the condom usage rate among slum-dwellers (Bhatia et al., 2005). Condom used among urban poor with high educational attainment was statistically significant higher than those with low educational attainment. This result was similar with the previous study of Kalichman et al. (2005), which found that in poor community HIV risk was related to poor education.

In term of factors influencing condom use for the latest sexual intercourse, only 'sexual partner' had influences on condom use of the urban poor. Condom use when having sexual intercourse with both sex workers (adjusted OR=43.9; 95% CI: 14.8 to 130.8) and casual partners (adjusted OR=6.4; 95% CI: 2.8 to 14.5) were statistically significant higher than that with spouse. It was consistent with the previous study, which indicated that individuals were more likely to use condoms with casual partners than with main partners (Noar et al., 2009). However, having even one unprotected sex is also having risk for HIV/AIDS infection, since we could not know who is infected or not infected. These practices were high risks for the spread of HIV/AIDS.

This study revealed that a crucial risky behavior of the urban poor was unprotected sex. Most of the urban poor did not use condoms when having sexual intercourse with their spouse because they believed that having sex with spouse were

safe which is wrong. Currently, more than 50% of new infections are among the husband and wife or casual sex (UNAIDS, 2008). Most of these urban poor had to purchase condom from various sources, which could be a burden and reduced the condom used. It is clear from the results of this study that it is essential to support free condom distribution in order to achieve 100% condom use. Condom provision must be accompanied by campaigns to raise awareness of its effectiveness in preventing sexually transmitted infection, appropriate use, and where to obtain condom. To improve accessibility, condom vending machine should be placed in each community. Improving health service system by integrating health services, with proactive approaches of both HIV/AIDS prevention and curative, is the most appropriate strategy for the limitation of shortage of health personal.

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