

HIV Testing as a Sexual Health Behavior among Filipino Men: Findings from a 2003 National Survey

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Current reported HIV infection rates among Filipino men may be relatively low, but so is HIV testing, a necessary behavioral step for determining one's serostatus. Using data from a nationally representative sample of $N = 3,519$ sexually active Filipino men ages 15 to 54 who participated in the National Demographic & Health Survey (2003), we explored HIV testing as a sexual health behavior. Results indicated that overall testing rate was extremely low (4.7%). HIV tests were more commonly taken as part of a requirement than as voluntary, self-initiated action. One out of four tested Filipino men failed to return for their test results. Other sexual health behaviors like recent condom use were associated with having been tested, unlike HIV-related cognitions. Among those never been tested, half reported wanting to undergo HIV testing, although many did not know where the test was available. The significance of HIV testing for personal and public health, as well as implications for psychological research and practice, are discussed.

Sexuality is a fundamental domain of a person's overall well-being, as well as a critical area of study of psychologists and other mental health professionals interested in health promotion (Marks, Murray, Evans, Willig & Woodall, 2005). A person's sexuality involves many areas of psychological life, from self-knowledge and identity, to powerful affective states like desire and pleasure, to feelings

of self-worth and comfort with one's body, to sexual and romantic intimacy and close relationships.

Because sexuality is so fundamental, sexual health and its promotion have been a key intersection of interventions as well as research in psychology and the social sciences. These interventions and research points have included topics like the contexts for sexual risks of Filipino adolescents (e.g., Ujano-Batangan, 2003), Filipino men's sexual health-related knowledge and practices (e.g., Ramos-Jimenez & Lee, 2000), and the state of sexuality education in the Philippines (see special issue of *UP-CWS Review of Women's Studies*, 2005, volume 15). A common, if implicit, theme in these lines of social research is that sexual health is a goal that can be achieved when individuals are in supportive social contexts that enable them to engage in behaviors that promote sexual well-being.

HIV-Testing as a Sexual Health Behavior

A person's actions to ensure and maintain her or his sexual well-being are called *sexual health behaviors*. These behaviors include practices such as regular self-checks (e.g., testicular self-exams for men and breast self-exams for women), help-seeking for sexual health matters (e.g., going to a medical health practitioner to treat a sexually transmitted infection), correct and consistent condom use during interpersonal sex, and being tested for STIs, including human immunodeficiency virus (HIV) infection.

The standard test for HIV infection is one of the most accurate medical tests available, with sensitivity and specificity rates of >99% (Mylonakis et al., 2000; Kalichman, 2005). Typically the procedure begins with pre-test briefing and counseling, during which the person interested in being tested is informed about the test, what it consists of, and what the possible results mean. After consent is given, a small blood sample from the arm is drawn similar to other blood tests and is sent to a certified

laboratory for analysis. The first screening, usually using a technique called the enzyme-linked immunosorbent assay (ELISA), is performed. If this test does not detect the presence of any HIV antibodies, the procedure is completed and the person tested is diagnosed as HIV-negative. If the ELISA test is positive, it is repeated. If this second screening is positive, a second type of test (typically a technique called a Western blot or indirect immunofluorescence assay) is performed in order to confirm the presence of HIV antigens. Results notification, within an hour after testing has also been developed but tends to be more expensive, limits the amount of counseling that can be received, and is not as widely available (Kalichman, 2005).

HIV testing, which has been publicly available since 1985, stands as an important sexual health behavior for personal and public health reasons. Knowledge of one's serostatus, whether HIV-positive or -negative, can enable individuals to engage in informed health behaviors to protect themselves and prevent the transmission of the infection; for example, lowering one's sexual risk behaviors, seeking further medical assistance to stay healthy, or deciding whether to begin a regimen of anti-retroviral drug treatment (Chesney & Smith, 1999). In one meta-analysis of 27 studies involving 19,597 participants, individuals engaged in less unprotected sexual intercourse and increased their condom use after HIV testing and counseling, particularly when they tested HIV-positive (effect sizes: Cohen's $d = 0.47$ and 0.65 ; Weinhardt, Carey, Johnson & Bickham, 1999). Such research suggests that HIV testing plays a "pivotal role" as an effective secondary strategy for HIV/AIDS management and prevention at the public health level (UNAIDS/WHO, 2004).

Correlates of HIV Testing

Because of the importance of HIV testing, health psychologists and other HIV social researchers have explored factors associated with being tested for HIV, especially self-initiated, voluntary counseling and testing (VCT). One common starting point has been HIV/AIDS knowledge, based on the hypothesis that when

people are educated and informed, they will act in rational ways to ensure their well-being. Unfortunately, knowledge variables have shown to have very inconsistent associations with actual sexual health behaviors like HIV testing (e.g., Kalichman & Simbayi, 2003; Lau & Wong, 2003) and are now considered by social and health psychologists as poor foci for intervention (Marks, Murray, Evans, Willig & Woodall, 2005).

On the other hand, engaging in behaviors that put one at higher risk for HIV infection, like unprotected sex with multiple partners, has been associated with higher levels of testing (Anderson, Carey & Taveras, 2000; Hart et al., 2002), but individuals must perceive themselves to be at sufficient risk for HIV in light of their sexual behavioral history. Otherwise, high-risk behaviors alone do not predict the likelihood of having undergone testing (Nyamathi, Stein & Swanson, 2000). In fact, risk perception has been found to be a necessary but insufficient condition for having oneself tested for HIV (Lekas, Schrimshaw & Siegel, 2005).

This may be due to the presence of a number of factors that act as barriers to HIV testing. These include structural barriers (e.g., differential access to services, availability of private-sector facilities) and social psychological ones such as denial of exposure to HIV, fatalism regarding HIV infection, concern for confidentiality of test results, fear of testing HIV-positive, and overall stigma related to HIV/AIDS (Awad et al., 2004; Chesney & Smith, 1999; Kalichman & Simbayi, 2003; Lekas, Schrimshaw & Siegel, 2005; Myers et al., 1996).

Apart from social research into seeking HIV testing, a number of studies have also looked into rates of returning versus failing to return for HIV test results (Anderson, Carey & Taveras, 2000; Tao et al., 1999). Because traditional procedures do not provide on-the-spot results and individuals tested have to come back for them one to two weeks later, not all HIV test results reach those who went in for testing. Figures for failure to return for HIV test results in various populations have ranged from 13% in the US

(Tao et al., 1999) to 38% in Cape Town, South Africa (Kalichman & Simbayi, 2003) to 58% among adolescents provided free anonymous testing in Cleveland, Ohio. Those whose tests were self-initiated (i.e., VCT) have been observed to be more likely to return for results (Tao et al., 1999), suggesting that motivational factors may play a role in this phenomenon and that it is critical to distinguish between voluntary counseling and testing (VCT, also known as client-initiated testing) and provider-initiated testing and counseling (UNAIDS/WHO, 2007).

HIV/AIDS: The Philippine Context

The spread of HIV in the Philippines has been described as "low" and "slow" (Mateo, Sarol & Poblete, 2004; HAIN, 2005). Estimates in 2002 put the number of infected Filipino adults at 13,000 or an infection rate of <1%, as opposed to the more extreme rates in other developing countries, for example, 37% in Zimbabwe (HAIN, 2003). Even within the Southeast Asian region, our prevalence rate is low compared to countries like Thailand, with 1.5% (HAIN, 2005). The Philippines, together with Bangladesh, Hong Kong, Laos, and South Korea, has one of the lowest HIV rates in Asia, with rates in the usual high-risk groups (sex workers, men who have sex with men, returning overseas workers, etc.) generally remaining below 1% (Mateo, Sarol & Poblete, 2004).

The first reported case of HIV infection in the Philippines occurred in 1984 (HAIN, 2005). According to official figures from the HIV/AIDS registry of the National Epidemiology Center of the Department of Health (NEC, 2007), as of April 2007 the cumulative number of HIV seropositive cases is $N = 2,818$, with the vast majority being asymptomatic (2,056 cases, 72.3%). Sixty-five per cent (1,827 cases) are male, and sexual intercourse (87%) is the leading reported mode of transmission (NEC, 2007).

Several explanations for the relatively low HIV rates in the country have been suggested. One is that human movement

between Philippine islands and across the Philippines and the rest of Southeast Asia is impeded by the archipelagic geography, which may consequently delay the spread of HIV (HAIN, 2003). Other explanations presented have included the relatively low number of full-time sex workers, the low proportion of injection drug users, an early multisectoral response to HIV/AIDS that began as early as 1988, and the presence of so-called "social hygiene" clinics for sex workers (Mateo, Sarol & Poblete, 2004).

In the context of limited voluntary testing and counseling services and the absence of mandatory testing, experts have cautioned that the HIV/AIDS registry may be insensitive to the actual number of cases (Mateo, Sarol & Poblete, 2004). Because HIV testing is a necessary behavioral step in determining one's serostatus and subsequently in the overall accounting of HIV/AIDS cases, limited HIV testing suggests the number of cases reported will be underestimated and serves as a serious qualification of the official HIV infection rates of the Filipino population.

Public health experts and HIV researchers in the Philippines have argued that while the spread of HIV has been slow, this is unlikely to remain the case because of the presence of the "ingredients for an explosive epidemic" (HAIN, 2005). These conditions include low consistent use of condoms among sex workers and in the general population, increasing practice of high-risk sex, and the increasing prevalence of sexually transmitted infections (Mateo, Sarol & Poblete, 2004). Other factors that can contribute to the spread of HIV/AIDS and exacerbate its negative impact are a large number of vulnerable Filipinos working overseas because of poverty, unemployment, and rapid population growth; underexposure to HIV/AIDS awareness programs due to low completion rates for schooling; and strong influence on public health policy of a Roman Catholic Church that is ideologically opposed to condom use (HAIN, 2003, 2005). For example, seafarers, through engaging in high-risk sex overseas and then in unprotected sex with partners in the Philippines,

may "bridge" the Filipino population with populations with higher HIV infection rates abroad (Mateo, Sarol & Poblete, 2004).

Problem

The goal of this study was to provide a baseline description of HIV testing as a sexual health behavior among Filipino men using a statistically representative sample. We used secondary analysis of an existing national survey dataset in order to (1) determine the prevalence of HIV testing among Filipino men, (2) compare the characteristics of Filipino men who have been tested for HIV versus those who have not, and (3) explore other patterns surrounding the practice of HIV testing among Filipino men to provide a baseline picture of this particular sexual health behavior.

METHOD

Dataset

We used data from the 2003 National Demographic and Health Survey (NDHS), an interview-based structured survey conducted by the National Statistics Office (NSO) from June to September 2003. The NDHS was originally designed to collect national data for calculating demographic rates, analyze factors and trends in fertility, measure levels of contraceptive knowledge and practice, collect data on knowledge of sexually transmitted infections including HIV/AIDS and on patterns of condom use; and provide information on overall Filipino family health. This survey employed stratified three-stage cluster sampling to reach 13,914 households in the 17 administrative regions of the Philippines, with a household response rate of 99%. For this paper, we examined HIV testing data, which is available from the Men's Subset of the 2003 NDHS (female respondents were not asked for data on HIV). The men's questionnaire was administered to 5,009 Filipino men ages 15 to 54 years old eligible for interview, with 4,776 successfully surveyed (response rate of 95%).

Variables

This study was centered on whether sexually active Filipino male respondents had been tested for HIV, determined through the survey item *“I don’t want to know the results, but have you ever been tested to see if you have the AIDS virus?”*. Responses were coded dichotomously as “yes” or “no”. Men who reported having been tested were probed regarding return for results with the item *“I don’t want to know the results, but did you get the results of the test?”*. Responses to this follow-up were also coded as “yes” or “no”. Respondents were assured that the questions did not concern their serostatus per se, only whether they had been tested and whether they had obtained their results or not. Furthermore, men who did not report HIV testing were asked if they wanted to be tested for HIV (responses coded trichotomously as “yes”, “no”, or “don’t know/not sure/depends”) and if they knew of a place where the test could be obtained.

In addition, other available variables in the dataset were identified and then explored using bivariate analysis to obtain a fuller baseline picture of HIV testing among Filipino men. We organized these variables into the following:

1. self-reported sexual behaviors (whether respondents had had sex at least once with a woman, with a man, or with both; and whether respondents had any experiences of having paid for sex),
2. HIV-related cognitions (whether respondents believed that condoms could protect against HIV, that one be infected with HIV from a mosquito bite, that one could be infected by sharing food with a person with HIV/AIDS, that one could tell simply by looking if a person had HIV/AIDS, and that mothers could transmit HIV/AIDS to their children),
3. other sexual health behaviors, namely communicating with one’s sexual partners about ways to avoid HIV/AIDS, condom use during their most recent heterosexual sex,

their most recent gay sex, and their most recent paid sex,

4. demographic variables, namely age, educational attainment, civil status, and socioeconomic status (measured by the NDHS Wealth Quintile Index).

RESULTS

Respondents

Of the 4,776 Filipino men ages 15 to 54 in the 2003 NDHS Men's dataset, majority ($N = 3,519$ or 73.9%) were sexually active and included in the analysis. Most respondents reported having at least one episode of sexual intercourse with a woman (93%), some had sex with another man at least once but had never had sex with a woman (2%), and the rest had had sex with a woman and sex with another man both at least once (5%). In addition, 11.3% of these sexually active Filipino men reported having paid for sex at least once (gender of the paid sexual partner, unfortunately, could not be determined from the data). The average age of the respondents was 31.05 years ($SD = 11.2$). About half were currently married (50.4%), some cohabiting with a woman (7.2%), and the rest were single (42.4%). A fifth of the sample had university-level educational attainment or higher (20.3%), about half reached up to high school (47.7%), and the rest up to elementary school or lower (32.0%).

HIV-Testing among Filipino Men

Overall, the rate of having ever been tested for HIV among sexually active Filipino men was extremely low: only 4.7% ($N = 166$ out of 3,519). This indicates that the vast majority of sexually active Filipino men, 95.3%, have no actual information about their serostatus, whether they are HIV-negative or not (see Figure 1).