

Background and Methodology

In 2013, the National Epidemiology Center of the Department of Health (DOH-NEC) led the fifth round of the Integrated HIV Behavioral and Serologic Surveillance (IHBS) in 21 sites among Males who have Sex with Males (MSM) and two sites among Injecting Drug Users (IDU).

The objective of the IHBS is to determine the: (a) prevalence of HIV and syphilis among the key affected populations and establish trend over time, (b) behavioral factors that are associated with STI and HIV transmission and their effect on the HIV epidemic in the country, (c) outcome of STI and HIV intervention programs and (d) to provide strategic information to guide STI and HIV policies, programs and services.

MSM are defined as those who were born male, 15 years or older, and reported having oral or anal sex with a male in the past 12 months. Meanwhile, male IDU are defined as those who were born male, 15 years or older, who injected drugs not prescribed by a physician, in the past 6 months.

Accessing Key Affected Populations (KAP) requires different sampling methods depending on the best way to reach them. For MSM, Time Location Sampling (TLS) was utilized where members of the targeted population are drawn into the study by sampling venues based on the day and time when the venue is most frequented by the persons of interest (MSM).

On the other hand, the methodology used for IDU is Respondent Driven Sampling (RDS). RDS is a chain-referral sampling method designed to obtain probability-based samples of hidden populations. Recruitment in RDS is initiated with a small number of eligible persons, referred to as *seeds* who were selected non-randomly to recruit other IDU through a coupon redemption process.

There were 6,305 MSM and 767 male IDU included in the surveillance.

MSM Sites: Angeles, Bacoar, Baguio, Batangas, Butuan, Bacolod, Cagayan de Oro, Cebu, Davao, General Santos, Iloilo, Mandaue, Puerto Princesa, San Jose del Monte, Zamboanga, Caloocan, Makati, Manila, Marikina, Pasay, Quezon
IDU Sites: Cebu, Mandaue

Males who have Sex with Males (MSM)

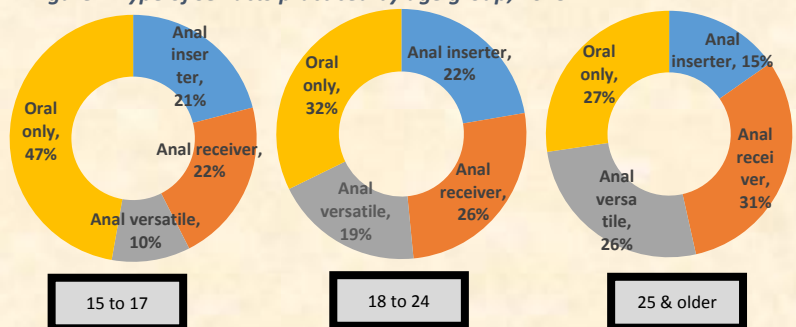
There were a total of 6,305 respondents among Males who have sex with Males (MSM) from 21 sites. The age ranged from 15 to 75 years old (median 22 years old). Thirty-four percent of the respondents belonged to the 20-24 age group. Most (96%) MSM were single. Only 16% of the respondents were living with a partner. Eighty percent of MSM had at least finished high school.

Forty-five percent of the MSM had sex with both males and females. Thirty-one percent of the respondents identified themselves as female.

The median age of first sex with a male was 16 years old. Ninety-eight percent of MSM engaged in oral sex while 67% engaged in anal sex (29% were inserters, 41% were receivers, and 30% were versatile).

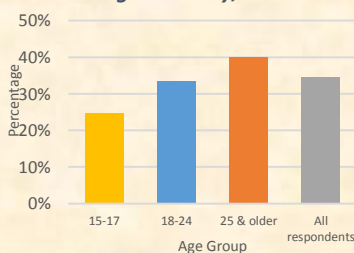
Forty-seven percent of the youngest population (15 to 17 years old) only had oral sex. The percentage who practiced anal versatile sex increased with age (see Figure 1).

Figure 1 Type of sex acts practiced by age group, 2013



Older respondents were more knowledgeable on HIV

Figure 2 Percentage of MSM who answered five questions on HIV knowledge correctly, 2013



Thirty-five percent of MSM answered all five knowledge questions correctly (Figure 2) compared to 41% in 2011. Knowledge score is highest among the 25 & older age group (40%). Majority (86%) of MSM knew that condom use can prevent HIV transmission.

Eighty-four percent believed that having one faithful partner can lower their risk of HIV. Eighty percent of respondents

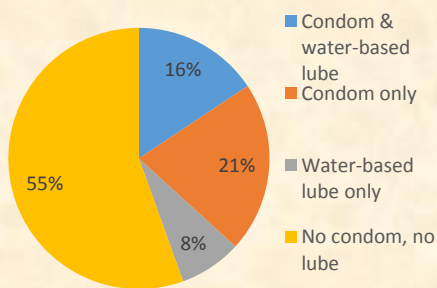
knew that a healthy-looking person may have HIV. Meanwhile, thirty-seven percent of MSM had misconceptions that mosquito bites can transmit HIV. Thirty-seven percent also believed that HIV can be transmitted through the use of public toilet.

Around 18% of MSM received information on HIV/STI transmission and prevention from the Social Hygiene Clinic (SHC). Seventeen percent received these information from peer educators or outreach workers. Eighteen percent attended a seminar about HIV prevention either in the SHC or those conducted by peer educators.

Condom use increased by 2%

Fifty-seven percent of MSM felt that they were at risk of having HIV. Out of those who felt they were at risk, 55% responded that it was because they had multiple sex partners and 37% said it was because they did not always use condoms.

Figure 3 Percentage of MSM who used a condom or a water-based lubricant during last anal sex in the past 12 months, 2013

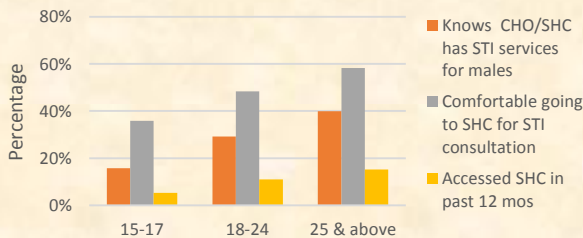


Median age of first condom use among MSM was 18 years old. Condom use during last anal sex with a male was 37% in 2013 compared to 35% in 2011. Both are far below the national target of 80%. The use of water-based lubricants increased to 31% in 2013 from 24% in 2011. Sixteen percent of MSM used condoms with water-based lubricants during their last anal sex. Thirty-one percent only used saliva as their lubricant and the rest (38%) used oil-based lubricants such as oil, lotion, shampoo or soap.

Seventeen percent of MSM received free condoms from the SHC while 16% received free condoms from peer educators. Meanwhile, only 11% received free lubricants from the SHC while 12% received lubricants from peer educators.

More MSM in the older age group accessed STI services

Figure 4 STI services at SHC by age group, 2013

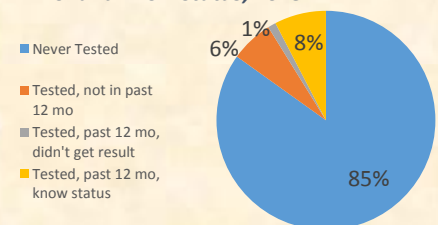


Thirty-one percent were aware that the SHC offers STI services for males. Half of the respondents said that they were comfortable to go to the SHC for STI consultation - lower than the 68% in 2011. Moreover, only 12% accessed the SHC in the past 12 months. Figure 4 shows that access to STI services increased with age.

8% of MSM had an HIV test and knew their status

Eight percent of MSM got tested in the past 12 months and knew their status. This is an increase from the 5% in 2011. For those who did not get an HIV test in the past 12 months, 34% felt there was no need to get tested, 30% were afraid to get tested, and 23% said they did not know where to get tested.

Figure 5 Percentage of MSM who (a) never had an HIV test, (b) tested but not in the past 12 mo., (c) tested past 12 mo., didn't get result, (d) tested past 12 mo. and know status, 2013



National HIV prevalence among MSM increased

The national HIV prevalence among MSM increased from 1.68% in 2011 to 2.93% in 2013. Syphilis prevalence also increased from 1.57% in 2011 to 1.95% in 2013.

Table 1. Serologic results by age group, 2013

HIV Prevalence	15 to 17	18 to 24	25 & older	Total
2011	0.00	1.84	2.03	1.68
2013	0.85	2.47	4.41	2.93

Syphilis Prevalence	15 to 17	18 to 24	25 & older	Total
2011	1.02	0.69	2.86	1.57
2013	0.42	1.24	3.54	1.95

Male Injecting Drug Users (Male IDU)

A total of 767 male IDU were included from only two surveillance sites among injecting drug users (IDU), Cebu City and Mandaue City. Ages ranged from 15 to 56 years old (median 30 years old). Majority (83%) of the respondents were single. Thirty percent of male IDU were living with a partner at the time of the survey. Of those living with a partner, 11% had a partner who was also an IDU. Thirty-two percent finished high school.

The median age of first drug use among male was 16 years old. Meanwhile, the median age of first injected drugs was 19 years old. Almost all (98%) injected nalbuphine (Nubain). Majority (85%) injected every month in the past 6 months with an average of 18 days in a month. They reported between 1 and 12 injections a day with an average of 3 injections per day.

Still practiced risky injecting behaviors

Figure 6 Sharing of Needles among male IDU, 2013

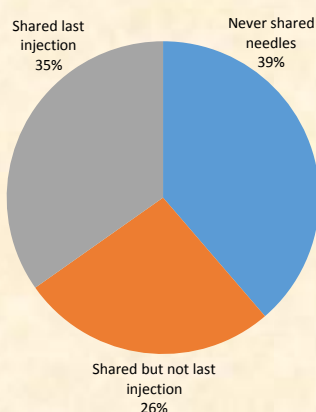
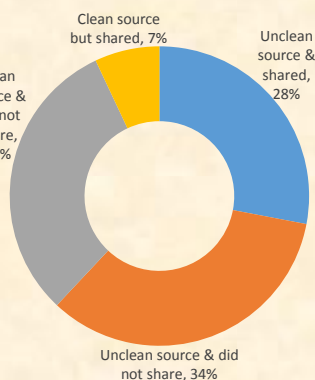


Figure 7 Injecting Practice among male IDU, 2013



Seventy percent of Male IDU usually injected drugs in a shooting gallery in Cebu City while 10% usually injected drugs in their own houses. Thirty percent of those who injected in shooting galleries during last injection used service needles (i.e. needles provided in shooting galleries). Sixty-one percent practiced needle sharing.

Figure 7 shows that 31% got needles from a clean source and at the same time did not share needles in their last injection. Thirty-three percent either kept the needles they used or gave the needles back to the shooting gallery. Fifty-four percent threw them into public trash bins after use.

HIV knowledge increased by 6% compared to 2011

Figure 8 Percentage of IDU who answered the five questions on HIV knowledge correctly, 2013

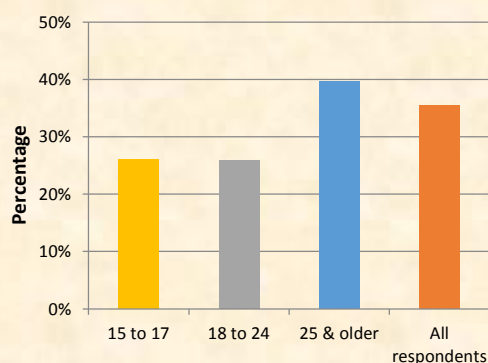
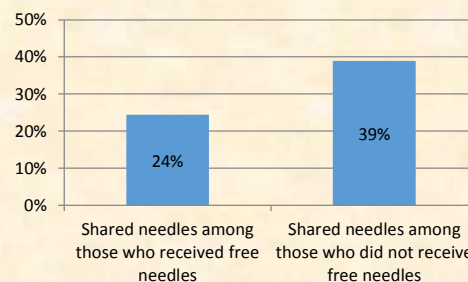


Figure 8 shows that there were only 35% who answered 5 knowledge questions correctly. This was higher compared to 29% in 2011. Majority (74%) of the respondents knew that condom use can prevent HIV transmission while 69% believed that a healthy looking person may have HIV. Seventy-four percent of IDU knew that having only one faithful partner can lower the risk of HIV. Twenty-six percent had misconceptions that mosquito bites can transmit HIV while 22% believed that HIV can be transmitted through the use of public toilet. Thirty percent were informed on HIV and STI prevention either through the SHC or by outreach HIV peer educators.

Access to free needles lessened risky injecting practice

Twenty-nine percent received free needles from either SHC or peer educators compared to 20% in 2011. Figure 9 shows that sharing of needles is 15% lower among those who were given free needles and syringe compared to those who did not receive free needles (24% and 39% respectively).

Figure 9 Sharing of needles among IDU by access to free needles from SHC/PE, 2013



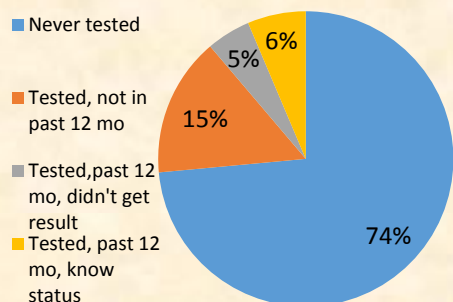
Many IDU were comfortable to access SHC services

There were 46% who knew about the HIV testing services at the SHC. Likewise, 67% said they were comfortable to have their HIV test at the SHC. However, data shows that only 10% of the respondents had their HIV test in the past 12 months at the SHC.

The same trend was noted on STI services at the SHC. Fifty-three percent of the respondents knew that there were STI services for males in the SHC and 75% said they were comfortable to go to SHC for STI consultation. However, only 10% actually visited a SHC.

6% of IDU had an HIV test and knew their status

Figure 10 Percentage of IDU who (a) never had an HIV test, (b) tested but not in the past 12 mo., (c) tested past 12 mo., didn't get result, (d) tested past 12 mo. and know status, 2013



Fifty-three percent of the respondents felt that they were at risk of HIV infection. However, only 26% were ever tested for HIV. Eleven percent were tested in the past 12 months compared to 16% in 2011. The most common reasons why male IDU did not have an HIV test were because they felt no need to get tested (38%), did not know where to get tested (37%), and afraid to get tested (11%).

The percentage of male IDU who got their HIV test result in the past 12 months was 6% in 2013 compared to 9% in 2011. Common reasons why they did not get their result were: forgot to get results (43%), afraid to know the result (11%) and do not want to know the result (6%).

Increased risky sexual behaviour

Condom use with permanent female partner decreased from 27% in 2011 to 17% in 2013. Likewise, condom use with one-time female sex partners decreased from 30% in 2011 to 25% in 2013.

HIV and Syphilis prevalence increased

The HIV prevalence of male IDU in Cebu and Mandaue increased from 27% in 2011 to 48% in 2013. Likewise, the syphilis prevalence increased to 5% in 2013 compared to 2% in 2011.

Table 2. Serologic results by age group, 2013

HIV Prevalence	15 to 17	18 to 24	25 & older	Total
2011	9.52	19.27	39.83	26.94
2013	4.35	44.98	51.4	48.24

Syphilis Prevalence	15 to 17	18 to 24	25 & older	Total
2011	0	1.33	2.54	1.73
2013	0	3.83	5.42	4.82

Discussion

In 2013, the HIV and STI prevalence increased to 2.95% and 1.95%, respectively, among males who have sex with males. Male IDUs even have higher HIV and STI prevalence compared to MSM at 48.2% and 4.82%, respectively. This is now very alarming and unless corrective actions with locally-feasible, cost-effective community-based interventions are implemented in high risk vulnerable areas, then the current HIV situation will face serious challenges in terms of reversing trends.

There are opportunities that the health sector may want to pursue in terms of improving access to preventative health services and reducing individual risk factors at the community level. It is advised that targeted or focused interventions be implemented and monitored instead of introducing varied means of prevention and control.

For a start, there is a need to look at HIV education in terms of raising knowledge and skills of key affected populations on HIV prevention. Providing an enabling environment, which promotes health-seeking behaviour including HIV testing thru enacted national laws or those adopted through local ordinances, is in itself a step in the right direction but which may face many barriers along the way.

The 2013 survey has not uncovered any new practical interventions aimed at improving access to health services and reducing behavioural risks basically because there appears to be fragmented efforts at introducing immediate reforms at addressing the current HIV situation.

Efforts should focus on accelerating condom use and reducing unsafe sex practices among MSM and immediately introducing harm reduction strategies that will end HIV transmission and spread through contaminated needle sharing among IDUs. Information on budget and health human resource allocations and distribution for specific interventions are needed to support clear, enhanced national laws and decisive and aggressive local actions and which, together with these findings will result in short- and long-term benefits.

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