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Increasing the Reach of HIV Testing to Young Latino MSM: Results of a Pilot Study Integrating Outreach and Services

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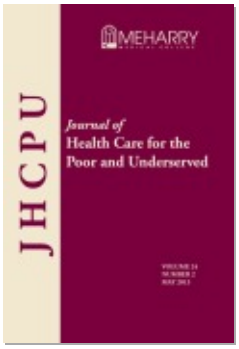

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Increasing the Reach of HIV Testing to Young Latino MSM: Results of a Pilot Study Integrating Outreach and Services

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Abstract: **Background**. In the U.S., HIV infections are increasing among men who have sex with men (MSM), particularly young, racial/ethnic minority MSM. **Objective**. To examine the feasibility of increasing HIV testing among young Latino MSM by integrating tailored outreach strategies with testing, counseling, and HIV medical services. **Design**. Descriptive study comparing demographic characteristics, behaviors, and HIV test results of clients from the intervention period with clients who tested during other time periods. **Results**. Clients in the intervention period were younger and more likely to be Latino than those in other time periods. In addition, clients who received outreach were more likely than those who did not receive outreach to report methamphetamine use, sex with an HIV-positive person, and sex with a sex worker. **Conclusion**. Venue-based and selective media outreach, in combination with linking rapid testing to HIV care, may help overcome some of the barriers to testing among high-risk young Latino MSM.

Key words: HIV/AIDS, men who have sex with men (MSM), Latino, community-based organization.

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In the United States, men who have sex with men (MSM) continue to be disproportionately affected by HIV/AIDS. These men make up 46% of all new diagnoses of HIV and AIDS, and 63% of new diagnoses among men.[1,2] Despite declines in risk behavior in the 1980s and 1990s as more MSM used condoms and reduced their number of sexual partners,[3,4] recent data indicate that HIV infections and AIDS cases are on the rise among this population. From 2001 to 2006, HIV/AIDS diagnoses among MSM increased 8.6% in the 33 states using confidential name-based reporting.[2] In addition, HIV in MSM is increasingly concentrated among African American and Latino men, and among young men.[1,2,5–7] Latino and African American MSM make up 55% of the HIV/AIDS infections reported among MSM in the U.S.[2] Although the estimated annual percentage change in HIV/AIDS cases from 2001–2006 was 0.7 for White MSM, it was 1.9 for both Latino and African American MSM.[2] For MSM under age 25, the annual percentage change was 12.4, compared with −1.1 for MSM ages 25–44, suggesting a shift in patterns of infection towards younger men.

One important factor contributing to the sexual transmission of HIV among MSM and the increasing prevalence of HIV among young, racial/ethnic minority MSM is lack of awareness of HIV infection.[8] People who are HIV-positive and unaware of their infection (designated as *HIV-positive/unaware* or *having an unrecognized infection*) are unlikely to change their behaviors in ways that reduce the risk of HIV transmission to uninfected partners. A meta-analysis of risk behavior and awareness of HIV status showed that HIV-positive/unaware men and women are nearly twice as likely as HIV-positive/aware men and women to report unprotected anal or vaginal sex.[9] Further, HIV-infected/unaware individuals are 3.5 times more likely to transmit HIV to partners than those who are aware of their HIV infection.[10] Among MSM, men with unrecognized HIV infection have 49% greater odds of engaging in unprotected anal intercourse than men who are aware of their infection.[11] Multi-city studies of MSM have shown that Latino, African American, and young MSM are most likely to be HIV infected and unaware.[11–13]

These data on lack of awareness of HIV infection are alarming because the benefits of knowing one's HIV serostatus are well established. HIV-positive individuals live longer and report an increase in their quality of life with early knowledge of the disease and treatment with antiretroviral medications.[14,15] Awareness of HIV serostatus can also reduce risk behaviors and thereby decrease HIV transmission.[16,17] In addition, HIV medical treatment decreases HIV viral load and thus infectivity to others.[18,19]

A number of programs and policies have attempted to increase HIV testing and awareness of infection, but few have effectively targeted young, racial/ethnic minority MSM. In 2003 the Centers for Disease Control and Prevention (CDC) announced new strategies to promote HIV testing, including incorporating HIV testing into routine medical care, expanded use of rapid testing, and increased opportunities for testing outside of medical settings.[20,21] In many urban areas where ethnic populations are concentrated, additional strategies are necessary to reach young and at-risk MSM, who frequently do not use a regular source of health care and are reluctant to test for HIV in clinics or mobile vans in neighborhoods where their peers and family may see them.[22,23]

Young Latino MSM, the focus of this study, frequently face barriers to HIV testing

due to socioeconomic status, ethnicity, and sexual behavior.[7,24,25] Socioeconomic status may decrease access to medical care, including testing for HIV. Experiences or fear of homophobia and racism may increase social isolation and poor self-esteem, which in turn reduce HIV testing and protective behaviors.[22,24] In addition, young Latino MSM may be further marginalized due to their age. Young MSM are often concerned with concealing their sexual behavior and may be less likely to seek out information, condoms, or HIV testing, particularly if such services are not located in settings where youth can be reached easily.[23,26]

In an effort to increase HIV testing among young Latino MSM at risk for HIV infection, the Los Angeles Gay and Lesbian Center collaborated with a team of academic researchers to develop and implement an innovative pilot intervention. This study's unique contribution is that it integrates tailored outreach strategies with testing, counseling, and HIV medical services.

Methods

Setting. The Los Angeles Gay and Lesbian Center (LAGLC) is an established community-based organization that provides a broad range of health and social services for the lesbian, gay, bisexual, and transgender community. Since the beginning of the HIV epidemic, LAGLC has worked to promote care of HIV-infected persons, and has been a leader in community HIV testing and prevention efforts. The LAGLC is situated within Los Angeles County, where 43% of new AIDS cases are among Latinos,[27] and 70% of Latino AIDS cases are among men who have sex with men.[28] In recognition of the need to improve awareness of HIV serostatus among young and Latino MSM, LAGLC staff contacted local university researchers for assistance in developing and implementing a pilot intervention.

Project design. In the formative stage of this project, focus group interviews were conducted with young Latino MSM. The focus group data indicated that Latino MSM at risk for HIV may be marginalized by their ethnicity, sexual behavior, and lack of economic and social-environmental resources. Many participants mentioned reasons for avoiding HIV testing such as fear of a positive HIV test result and not knowing where to go for HIV care. The focus group data suggested that a constellation of factors limited this population's access to health services and their knowledge of where to seek services that are gay-friendly, youth-friendly, and culturally sensitive. It was learned that many young Latino MSM are unable to access HIV testing services, a circumstance contributing to the disproportionate number of HIV-positive young Latino MSM who are unaware of their HIV serostatus. The pilot intervention was designed to address this cycle of vulnerability by increasing awareness of free testing services, providing incentives for getting test results, and improving access to treatment by integrating HIV medical care with testing.

Targeted outreach was provided to young Latino MSM. Trained staff and volunteers recruited participants at Latino-oriented gay club and event nights in the Los Angeles and West Hollywood area. From August through October 2004, trained outreach volunteers that shared characteristics with the target population (young, gay/bisexual, Latino) distributed bilingual outreach cards to encourage young Latino MSM to test

for HIV at LAGLC's Service, Prevention, Outreach, Treatment (SPOT) center in West Hollywood. Potential clients were informed that the testing location was within walking distance, that rapid HIV test results would be available in about 20 minutes, and that outreach cards could be traded for a movie pass at the time of testing. In addition to the venue-based outreach, testing information was advertised on two Internet sites and in three widely available gay/bisexual-oriented magazines. The Internet postings included a printable outreach coupon and the magazine advertisements had a coupon that could be exchanged at the time of testing for a movie pass.

The second component of the pilot intervention involved HIV counseling and testing, and early entry into medical care for individuals who tested HIV-positive. Free HIV counseling and testing was provided at the SPOT. The SPOT is a storefront clinic located in the heart of West Hollywood, close to clubs and bars that attract a large gay and bisexual crowd. The clinic has evening hours and, during the intervention period, offered rapid HIV tests (finger prick blood tests with OraQuick®) that allowed clients to receive their results in 20 minutes. All individuals with preliminary positive test results had their preliminary positive test results confirmed with Western blot and were linked to HIV medical care within 72 hours. The HIV medical care was offered at the LAGLC's HIV care clinic or at another clinic convenient for the patient.

Data collection and statistical analysis. The SPOT center gathers standard demographic and risk assessment information from all clients as part of their HIV testing and counseling. This process remained unchanged during the intervention period. A trained staff counselor gathered this information using a California standardized risk assessment form, on which client's age, ethnicity, HIV risk behaviors, reason for testing, previous HIV tests, sexually transmitted disease (STD) history, and the result of the current HIV test are entered. During the intervention period, additional information was gathered regarding the presence of an outreach card or coupon, and the outreach source code identifying the place where the card or coupon originated.

Data from the intervention period (August–October 2004) were entered into a database that also included data from MSM testing for HIV during two comparison periods: May–July 2004 and August–October 2003. These comparison groups were selected in order to reduce the likelihood of mistakenly attributing temporal or seasonal trends to an intervention effect. Statistical analyses were conducted using Stata 9.2/SE.[29] First, data from the intervention period was compared with data from the two comparison periods, using one-way Analysis of Variance (ANOVA) for continuous variables (e.g., age, number of sexual partners) and chi-squared analysis or Fisher's exact test for categorical variables (e.g., Latino ethnicity, HIV test result). Next, data from the intervention period was further analyzed, for differences between MSM who had received outreach and those who had not. One-way ANOVA, chi-squared analysis, and Fisher's exact tests were used, as appropriate.

Results

Table 1 shows descriptive demographic and behavioral characteristics, as well as HIV test results, for the intervention period and two comparison periods. Results are limited to male HIV testing clients age 25 and under who reported sexual activity with a male.

Table 1.

DEMOGRAPHIC CHARACTERISTICS, BEHAVIORAL CHARACTERISTICS, AND HIV TEST RESULTS OF MALE CLIENTS AGE 25 YEARS OR YOUNGER OVER THREE PERIODS OF TIME

Characteristic	Fall 2003 (n=86)	Summer 2004 (n=97)	Intervention period, Fall 2004 (n=95)
Demographic characteristics			
Age*	22.2 ± 2.4	22.5 ± 1.8	21.8 ± 2.2
Number of sexual partners	6.1 ± 6.9	9.2 ± 14.4	10.2 ± 16.0
Latino ethnicity (%)*	36.4	16.8	33.0
Behavioral characteristics			
Methamphetamine use	11.4	8.3	16.8
Anal sex without a condom (%)	53.9	61.1	69.4
Sex with an HIV-positive person (%)	20.5	12.4	16.1
Sex with a sex worker (%)	—	6.2	7.6
Sex with an injection drug user (%)	6.8	6.2	11.0
Sex in exchange for money or drugs (%)	—	6.2	10.5
Test result			
HIV positive (%)	4.6	6.2	5.8

*$p<.05$

During the intervention period, 95 young MSM tested for HIV. They had an average age of 22 years, and reported an average of 10 partners (range: 1–100) in the prior two years or since their last negative HIV test. One-third of testing clients in the intervention period self-reported Hispanic/Latino ethnicity. Clients reported a variety of risk behaviors, including methamphetamine use (16.8%); sometimes not using or never using a condom for anal sex with a male (69.4%); having sex with an HIV-positive individual (16.1%), a sex worker (7.6%), or an injection drug user (11.0%); and exchanging sex for money or drugs (10.5%). Five clients (5.8%) tested positive during the intervention period. Tests of comparison across the intervention period, Summer 2004, and Fall 2003 indicated that MSM clients testing in the intervention period were significantly younger [$F(2, 233)=3.13$, $p=.045$] and more likely than clients in Summer 2004 to report being Latino ($\chi^2(2)=8.83$, $p=.012$).

Data from the intervention period, stratified by outreach, are presented in Table 2. About half of young MSM testing clients during the intervention period were outreach participants, as evidenced by presenting an outreach card or coupon. The cards and

Table 2.

DEMOGRAPHIC CHARACTERISTICS, BEHAVIORAL CHARACTERISTICS, AND HIV TEST RESULTS OF MALE CLIENTS AGE 25 YEARS OR YOUNGER DURING THE INTERVENTION PERIOD, BY OUTREACH STATUS

Characteristic	Outreach recipients (n=46)	Clients who did not receive outreach (n=49)
Demographic characteristics		
Age*	21.2 ± 2.1	22.3 ± 2.1
Number of sexual partners	11.2 ± 16.4	9.2 ± 15.9
Latino ethnicity (%)*	44.2	22.9
Behavioral characteristics		
Methamphetamine use (%)*	28.3	6.1
Anal sex without a condom (%)	72.5	66.7
Sex with an HIV-positive person (%)*	23.9	8.5
Sex with a sex worker (%)*	13.0	2.2
Sex with an injection drug user (%)	15.2	6.7
Sex in exchange for money or drugs (%)	13.0	8.2
Test result		
HIV positive (%)	5.0	6.5

*$p<.05$

coupons indicated that 78% [36/46] of outreach recipients received in-person outreach; the remainder saw Internet postings, magazine advertisements, or both [results not reported in table]. Outreach recipients significantly differed from clients who did not receive outreach on several key characteristics. Outreach recipients were younger [$F(1, 93)=27.08$, $p=.015$] and were more likely than clients who did not receive outreach to be Latino ($\chi^2(1)=4.64$, $p=.031$). Outreach recipients also were more likely to report a number of HIV risk behaviors. Strikingly, while 6.1% of other clients reported methamphetamine use, 28.3% of outreach recipients reported using this drug ($\chi^2(1)=8.30$, $p=.004$). Outreach recipients were also more than twice as likely to report having had sex with an HIV-positive person (23.9% compared with 8.5%; $\chi^2(1)=4.08$, $p=.043$) and more than six times as likely to report having sex with a sex worker (13.0% compared with 2.2%; $\chi^2(1)=3.87$, $p=.049$). The proportion of clients testing positive did not differ significantly by outreach. All clients testing positive during the intervention period, regardless of receipt of outreach, were linked to HIV medical care, that is, they received an appointment with an HIV specialist heath care provider. Information on how many actually showed up for their appointment was unavailable.

Discussion

The purpose of this study was to describe the effects of a pilot intervention on reaching high-risk, young, and Latino MSM with HIV testing. The intervention, which combined venue-based outreach and targeted media advertisements with testing, counseling, and HIV care, was successful in motivating the target population to test for HIV. The intervention resulted in more testing among young Latino clients. In addition, the outreach strategies were successful in that a higher proportion of outreach recipients (than of clients who did not receive outreach) was Latino. Furthermore, compared with HIV testing clients who did not receive outreach, more outreach recipients reported behaviors that put them at risk for HIV infection. Despite a relatively low prevalence of HIV infection across all study groups, HIV risk behaviors tended to be higher among outreach recipients. A higher proportion of outreach recipients reported HIV risk behaviors, including methamphetamine use, having sex with an HIV-positive person, and having sex with a sex worker. These findings suggest that the intervention was able to motivate high-risk, young, and Latino MSM to test for HIV.

This study demonstrates that it is feasible to create an effective, integrated outreach and service intervention for young Latino MSM at risk for HIV infection. The results are consistent with other studies of MSM in the United States, which show that Latino MSM have high rates of unprotected anal intercourse and other sexual risk behaviors.[7,8,13,30–33] Collaboration between a community-based organization and university researchers facilitated use of novel strategies for motivating at-risk young men to test for HIV. Importantly, the intervention design and its implementation accounted for the characteristics and needs of the target population. Expansion of late-night hours for HIV testing and making rapid tests available seemed to be effective strategies. In addition, targeted outreach to clients through in-person, venue-based recruitment and advertisements on selected Internet sites and in magazines appeared successful. Future intervention studies targeting young Latino MSM should assess additional, sustainable community-based strategies for reaching this population with HIV testing and linking those who test positive to HIV medical care.

The results of this study are also relevant in light of recent efforts to expand HIV testing in the U.S. In 2006, the CDC released new recommendations for testing, which emphasized that not only should testing in health care settings be routine, but it should be offered on an opt-out, rather than opt-in, basis.[34] These recommendations have yet to be implemented by most health care providers, and many young adults, particularly men, do not seek primary or preventive care. In order to increase HIV testing among groups such as young and racial/ethnic minority men, prevention providers may need to tailor their efforts based on the targets' age and culture.[11,22,35–38] Innovative strategies will be needed to reach at-risk men, and to help men overcome barriers to testing, such as fears about testing and about follow-up care. The results of this pilot intervention suggest that venue-based and selective media outreach, in combination with linking rapid testing to HIV care, may help overcome some of these barriers.

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