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The Sex Check: The Development of an HIV-Prevention Service to Address the Needs of Latino MSM

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Abstract

The Sex Check is a brief, telephone-delivered, HIV-prevention intervention tailored for individuals who are at high risk of HIV infection or transmission but who are neither reducing their risk on their own nor seeking support for this purpose. Because the intervention is delivered on a one-to-one basis, permits anonymity, is marketed to “men who have sex with men,” and is brief, it may be particularly responsive to cultural, structural, and attitudinal barriers to serving Latino MSM. Because many Latino MSM continue to engage in high risk sexual behaviors, developing and testing prevention interventions with this population is a public health priority.

Keywords

HIV prevention; Latino MSM; high-risk sexual behaviors; risk reduction

The impact of sexually transmitted Human Immunodeficiency Virus (HIV) is felt disproportionately in communities made vulnerable by social and economic inequalities and discrimination. Latino men who have sex with men (MSM) are one such group that experiences this elevated HIV risk due to cultural stigma, as well as economic, social, and legal barriers. In 2004, the most recent year for which data are available, the most prevalent mode of HIV transmission among Latino men in states with confidential, name-based reporting, was same-sex sexual activity. As many as 47% of HIV positive Latino men reported being infected in this manner. An additional 19% of HIV positive Latino men did not report a mode of transmission (CDC, 2005), but it can be assumed that at least a portion of these unknown cases involved transmission via homosexual activity. Withholding of this information may be due to stigma attached to homosexuality in Latino cultures.

Prior studies have confirmed the high prevalence of high-risk sexual behaviors, including unprotected anal intercourse (UAI), among Latino MSM which underscores the high prevalence of HIV among Latino MSM. Diaz and Ayala (2001) found an HIV prevalence estimate of 22% in a sample of gay and bisexual men at gay Latino venues in an urban setting. In a study of young Latino MSM, Dean and Meyer (1995) found an HIV prevalence of 30%, an estimate significantly greater than among white MSM. Finally, a seven-year

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multi-site assessment of HIV incidence among men aged 15 to 22, indicated that Latino MSM were more than twice as likely to be HIV positive as white MSM (Valleroy et al., 2000).

In addition to presenting a health risk for Latino MSM, the high prevalence of HIV also contributes to an elevated HIV risk for Latina women for whom AIDS is now the fourth leading cause of death in the United States (CDC, 2002). The most prevalent mode of HIV transmission to these women is unprotected sexual intercourse with heterosexually identified Latino men (CDC, 2003). Many of these men, however, despite their heterosexual identity, participate in same-sex sexual activity. Within many Latino cultures, heterosexually identified men can participate in same-sex sexual activity without being labeled as gay, provided that they only act as the insertive partner (Diaz, 1998). The insertive partner is then able to maintain his heterosexual identity. This construct of sexual identity has created a pervasive culture of silent Latino bisexuality, and is substantively different from cultures in which men engaging in sexual activity with other men are considered to be bisexual or homosexual, both in their own estimation as well as that of others. This pattern underscores the importance of HIV prevention programs that target Latino MSM, including those who are gay—and bisexual-identified and those who are not.

CULTURAL, STRUCTURAL, AND ATTITUDINAL BARRIERS TO RISK REDUCTION BY LATINO MSM

The high prevalence of sexually transmitted HIV among Latino MSM is believed to be due to a variety of factors. Those who do not self-identify as gay or bisexual are less likely to benefit from normative peer supports for HIV risk-avoidance available to men in the broader gay and bisexual community. Among Latino MSM who do self-identify as gay or bisexual, many have experienced racism and ethnically driven sexual objectification that have left them disenfranchised with and disconnected from the majority white gay community (Diaz, 1998). Diaz and Ayala (2001) found that experiences of homophobia, racism, and poverty have been linked to higher rates of HIV risk among Latino gay and bisexual men. In their study of the social factors associated with HIV risk for Latino MSM, a quarter of participants reported having experienced discomfort in gay spaces due to their ethnicity, and 62% had been sexually objectified because of their ethnicity.

Barriers to healthcare may also contribute to the increased HIV risk of Latino MSM. The average household income for Latinos is nearly \$10,000 below that of Americans overall and they are nearly twice as likely to have reduced access to healthcare (U.S. Census Bureau, 2003). The result is that 21.8% of Latinos live below the poverty line, a rate nearly double the 12.1% found among the U.S. population as a whole (Proctor & Dalaker, 2002). Their limited financial resources, as well as their overrepresentation in minimum wage and non-benefit jobs, minimize Latinos' access to preventative healthcare and health treatment.

Many Latino immigrants experience additional obstacles to accessing health services. In addition to relocation into economically depressed neighborhoods with poor social service systems, the lack of social support, and a lack of information and knowledge about existing social and health services contribute to the underutilization of the healthcare system in the Latino community. Additionally, monolingual Spanish speakers experience difficulty in discovering both services which are advertised to a majority English-speaking audience, and communicating with providers who do not speak their language. This is an alarming situation given that of all reported AIDS cases among Latinos in 2000, at least 50% of infections occurred in people born outside of the United States (CDC, 2001). Many Latino immigrants have no permanent legal immigration status in the United States, and are unaware of their rights, civil and otherwise, thus fearing that seeking healthcare and other

social services could lead to their deportation. Additionally, there are significant risks for undocumented immigrants with regard to HIV testing, because being HIV positive is grounds for visa refusal and deportation (Timor, 1998).

For Latino MSM with heavy employment demands and/or family obligations, participating in lengthy interventions may not be possible. Similarly, when services are delivered in in-person sessions, the need to travel to the session site at a prescribed time may be problematic. For those who are located outside urban centers, or who work multiple or late-shift jobs, this constraint can be prohibitive. A limitation of group-oriented HIV-prevention programs is the public nature of the intervention. While many benefit from developing supportive relationships in groups with other members of their community, many others prefer to maintain their anonymity. This is particularly true for those Latino MSM who do not identify as gay or bisexual or who are closeted about their sexual behavior. Additionally, when services are marketed to “gay and bisexual men,” MSM who are heterosexually identified may perceive themselves as unwelcome.

A final barrier, common to MSM of all ethnic backgrounds, pertains to the ambivalence some MSM have about their HIV infection/transmission risk and whether or not to commit to consistent risk reduction behaviors. For men who hold such ambivalent attitudes, a program that is perceived as expecting that participants will be willing at the outset to commit to behavior change may be unappealing.

MODEL HIV-PREVENTION SERVICES FOR LATINO MSM

Several HIV-prevention programs have been developed that cater specifically to the needs of Latino MSM, although a review of the literature highlights the limited number of programs that specifically incorporate the social risk factors identified above into behavioral risk reduction interventions (Marin & Gomez, 1999).

Hermanos de Luna y Sol (Brothers of Moon and Sun) is a San Francisco based HIV-prevention project for Spanish-speaking Latino gay and bisexual men. This group intervention is based on Bandura’s theory of self-regulation and empowerment education to promote self-esteem, social support, sexual self-knowledge, community involvement and activism, and awareness of cultural and social factors which impact participants’ lives (Diaz, 1998). The intervention is delivered through structured workshops and informal social gatherings. Program graduates are also given tools for self-monitoring to support them in maintaining their positive changes. An evaluation of 87 early participants suggest that they experienced significant behavioral change as a result of the intervention (Diaz, 2001; Marin, 2003).

Another HIV-prevention intervention specifically targeting Latino MSM was developed in Puerto Rico (Toro-Alfonso, 2002). Delivered entirely in Spanish and incorporating a number of components culturally relevant to Puerto Rican MSM, the program was designed with a particular consideration of the social and political realities that face program participants. The strongly religious Puerto Rican culture has defined MSM behaviors as immoral, and this factor has likely discouraged many men from participating in HIV-prevention interventions. To engage eligible participants, this community-based intervention was designed by and for the MSM community and was implemented by an organization with strong ties to that community. Men involved in the program attended group meetings in which discussions focused on such topics as intimacy, drug abuse, relationships, sexual behavior, HIV/AIDS, and other STDs. The intervention’s design was based on concepts drawn from the Health Belief Model (Rosenstock, Strecher, & Becker, 1994). Workshops were designed to strengthen community, develop and strengthen social support networks, and increase safer sex behavior.

While these tailored programs appear to be making substantial contributions to HIV prevention among Latino MSM, remaining barriers include the burdens of time and travel imposed by in-person service delivery and lengthy programs, the disclosure threats perceived by some as a consequence of group participation, the sense of not being welcomed when programs are marketed as intended for gays and bisexuals, and a hesitation to approach risk reduction programs when one has ambivalent attitudes about committing to behavior change.

MOTIVATIONAL ENHANCEMENT TREATMENT

An adaptation of a modality first developed in the alcoholism field offered the potential of overcoming several of these barriers. The Drinker's Check-Up (Miller, Sovereign, & Krege, 1988) was a two-session intervention that was marketed as not for alcoholics in order to reduce stigma associated with the label "alcoholism," not being treatment in order to emphasize that participants were not expected to be committed to changing, and respectful of the individual's right to decide whether and how to use the feedback. The Drinker's Check-Up was tailored for individuals who were neither seeking treatment for alcohol abuse nor self-initiating change, but who had some concerns about their drinking behavior. It is the first example of a modality that has come to be known as motivational enhancement treatment (MET).

Personalized feedback drawn from an initial assessment was provided to each participant in a single individual session. The feedback included normative comparisons of the participant's alcohol use pattern vis-à-vis that of other adults and the individual's risk factors for the development of alcohol disorders. The clinician delivering the Drinker's Check-Up used motivational interviewing (MI) strategies to assist clients in resolving ambivalence and increasing commitment to change. MI is a collaborative counseling style with the purpose of evoking the client's intrinsic motivations while respecting the individual's autonomy in making decisions related to their health (Miller & Rollnick, 2002). When evaluated, the Drinker's Check-Up was found to have successfully recruited individuals whose drinking patterns resembled those of alcohol treatment seekers. When followed up, many participants had made significant decreases in drinking compared to a control group (Miller et al., 1988).

THE SEX CHECK

With funding from NIMH, "The Sex Check" was adapted from the Drinker's Check-Up to provide HIV-prevention services to MSM who were at high risk of HIV transmission yet might be ambivalent about making a commitment to reducing sexual risk-taking behaviors. A number of this intervention's features are responsive to the barriers discussed above vis-à-vis reaching and serving Latino MSM: (1) The service is brief, (2) all contacts are by telephone, (3) the intervention is one-to-one, and (4) participants have the option of retaining their anonymity. The Sex Check incorporates the following principles of motivational enhancement treatment: (1) The intervention is marketed as an opportunity to "take stock" of one's experiences, with no pressure to change; (2) it begins with an assessment session that focuses on behaviors, positive and negative consequences, attitudes favoring and opposing change, and self-efficacy for change; (3) feedback is delivered by a counselor who employs motivational interviewing skills; and (4) support in setting goals and selecting change strategies is offered to those who express motivation to reduce their HIV infection or transmission risk.

Participants are recruited through a variety of methods. Advertisements are run in local print media, both mainstream and gay specific. Local agencies serving at-risk populations include listings about the Sex Check in their print and electronic bulletins, provide links on their websites, distribute brochures, and make personal referrals to potential participants.

Additionally, the Sex Check employs a team of recruiters to publicize the project at local bars, bathhouses, and community events. The recruitment message emphasizes that the Sex Check is an opportunity for MSM to talk about their decisions on sexual safety in a non-judgmental space, free of pressure to change their behavior, with members of a multi-cultural and bilingual staff.

Potential participants undergo an initial risk assessment by telephone which determines their eligibility for the intervention. After deciding to participate, clients complete a self-report questionnaire by mail and a baseline assessment interview by telephone. Then, during the first session of the intervention, the counselor and participant review a personalized feedback report (PFR) that summarizes information gleaned from these initial assessments. The PFR includes information about the participant's recent sexual behaviors, HIV status, HIV status of recent partners, statistics concerning STD and HIV rates in the local MSM community, alcohol and drug use behaviors, intentions to use condoms, perceptions of the costs and benefits of condom use, confidence in practicing safer sex, and safer sex goals. The PFR serves as a guide to a detailed discussion about the participant's sexual behaviors and safety. Additionally, the PFR provides a context for examining the ways in which a participant's behavior contrasts with his stated goals and values, a process which is believed to nurture motivation for change.

Relevant STD and HIV misinformation is corrected in two ways over the course of the session. Throughout the review of the PFR, the counselor provides accurate and objective information about STDs and HIV, both at the participant's request and with permission at other relevant moments to augment or enhance a participant's knowledge base. For example, in the case of a participant who reports being HIV positive and engaging in unprotected sex with other HIV positive men, a counselor will ask, "What have you heard about re-infection?" If the participant's response indicates he might be unaware of some critical issues with regard to this subject, the counselor will then ask for the participant's permission to provide new information: "Would you be interested in knowing how the Public Health Department is thinking about this?" A second way knowledge is transferred to participants is by reviewing the correct answers to questions to an HIV Knowledge Test that is administered to each participant during the course of the baseline assessment interview.

At the end of reviewing the PFR, the counselor asks the participant specific questions that are tailored to assess his readiness for change. If the participant expresses an interest in making alterations in his behavior, change of planning is initiated. At this time, participants can also choose to proceed with any of the following skills-training topics for the second and third feedback sessions: Setting Safer Sex Goals, Identifying Triggers for Unsafe Sex, Coping with Triggers, Action Strategies, Social Support, Assertiveness and Safer Sex, and Assertiveness and Empowerment in Relationships. These skills-training sessions are designed both to elucidate the barriers the client faces in his efforts to achieve his safer sex goals and provide him with specific tools to confront these barriers. In addition to selecting any of these modules that are relevant to his needs, participants can also choose to discuss topics that are directly related to reducing their risk of contracting or transmitting HIV/STDs (e.g., ambivalence about HIV/STD testing; obstacles to condom use). Counselors offer local resources and referrals when appropriate or requested. For participants who indicate an interest in getting tested, information concerning STD and HIV testing resources is provided and reviewed. Similarly, if the participant desires ongoing support for sexual safety issues, appropriate referrals are provided and discussed. In recognition of the relationship between risk-taking behavior and substance use and abuse, the Sex Check counselors utilize the PFR not only to review recent sexual behavior, but also to discuss the roles that alcohol and other drugs might have in the decision to engage in risky behaviors.

Throughout the conversation, motivational interviewing skills are utilized by the counselor to evoke and foster readiness to change risky sexual behavior, develop discrepancy between current and ideal behavior as identified by the participant, and strengthen the participant's self-efficacy for making behavioral changes. The Sex Check offers clients the opportunity to review their intentions to be safer, provides them with normative comparisons to contextualize their behavior, and allows each participant to select topics of discussion to guide his own counseling experience. In doing so, the Sex Check offers each participant an opportunity to have a discussion about his life experiences and his sexual decision-making process, and provides each of these men with an experienced counselor who has been trained to utilize MI techniques to facilitate a process of identifying and building intrinsic readiness to change.

As discussed above, the structure and content of the Sex Check model has the potential for being a culturally appropriate program to address the particular prevention needs of Latino MSM. In a pilot study of this intervention, men of color were found to experience higher levels of behavior change than the overall sample, indicating that the Sex Check experience may be particularly efficacious for motivating HIV risk reduction in Latino MSM (Picciano, 2001). A randomized clinical trial to assess the efficacy of the Sex Check is currently underway to explicate these preliminary findings.

ENHANCING CULTURAL RELEVANCE FOR LATINO MSM

Particular attention was paid, prior to the start of the trial, to ensuring the cultural competency and relevance of the intervention. Two consultants were hired to identify the specific challenges that Latino MSM face, and to help develop strategies both for overcoming these challenges and for making the intervention as useful, effective, and culturally competent as possible. These consultants convened focus groups which examined and critiqued draft marketing materials, as well as offered insight into ways to increase the cultural competency of the intervention. The focus groups stressed the importance of recognizing the diversity of the Latino MSM population, and cautioned against the use of stereotypes with regard to immigration status, class, education, or religion. They stressed the idea that many Latino MSM do not self-identify as gay or bisexual, and said that they preferred the use of the term "men who have sex with men" over "gay or bisexual men" or "hombres de ambiente" (literally, "men of environment"), a term that has been used in various parts of the United States to identify Latinos who have same-sex sexual partners. Finally, the focus groups stressed the particular importance of confidentiality when working with Latino clients. The findings of the focus groups were discussed by the entire project staff to increase cultural awareness of the specific challenges facing Latino men and to facilitate the integration of the findings into the execution of the intervention.

Two of the Sex Check counselors are bilingual Latino men with extensive experience working with Latino populations. Counselors' training consisted of reading motivational interviewing literature, watching a series of training videotapes, engaging in intensive role-playing of MI techniques and the delivery of the educational and skills-building content. Each counselor completed 4–8 pilot cases and received written and verbal feedback on these sessions prior to seeing study participants. The bilingual counselors' training took place in both English and Spanish, and throughout the trial they collaboratively reviewed audiotapes of their counseling sessions and engaged in ongoing clinical consultation. All written materials were professionally translated into Spanish, including six skills-training brochures that had been written specifically for the intervention and covered a variety of themes including assertiveness, recognizing and coping with triggers, and developing change plans. Once translated into Spanish, the materials were reviewed by a team of three Spanish-

speaking staff to ensure that both the tone and the content of the materials had been maintained.

The intervention protocol permits and encourages the discussion of particular topics related to Latino culture. For example, at the beginning of sessions with Latino participants, counselors reveal personal background information regarding their country of origin, how long they have lived in the United States, and their bilingual status. Latino participants are specifically asked about their background and are offered the opportunity to discuss issues related to immigration, visas, and the intersection of immigration status and HIV testing and healthcare. A common query posed to Latino participants includes, "Tell me about how being a Latino gay man is in this society. What has your experience been?" The meta-message of such questions is intended to be, "I understand that your cultural background may affect your sexual decision making. I welcome your thoughts and concerns on this." Counselors initiating discussion specifically related to the Latino experience reveal to participants a willingness and openness to engage in these topics from the beginning of the intervention and throughout.

CONCLUSION

The Sex Check offers a number of benefits that may be particularly salient for Latino MSM. As a telephone delivered intervention, it is accessible to men across a wide range of geographic areas. The establishment of a toll-free telephone number removed possible financial barriers to service participation. By offering the sessions to individuals rather than groups and marketing it to "men who have sex with men" rather than just those who identify as gay or bisexual, the intention is to make the service accessible to men of all sexual identities. An added benefit of individual sessions is that they enable men to retain their anonymity. For closeted men in small or tight-knit communities, the disclosure associated with attending group sessions may constitute a barrier to accessing services. Additionally, rather than needing to accommodate the schedule of a group, men can arrange for individual sessions to occur at times that are most conducive to their schedules, early in the morning, late at night, or on weekends, removing an additional obstacle. Because the service is brief in design, it allows men who are unable or uninterested in participating in a long-term, high-intensity intervention to receive services without making a substantial commitment of time. For men who desire a more extensive intervention, the Sex Check counselors offer an array of referrals to existing community resources. Finally, because the counselors are familiar with both the needs of the client as well as the particular strengths and focuses of local prevention programs, this referral provision hopefully can lead to increased utilization of already established services.

In addition to the strengths outlined above, the flexible and adaptive content model of the Sex Check is designed to enable the counselors to tailor each client's counseling experience to respond specifically to his needs. Motivational interviewing, by definition, rejects the paradigm of behavior change through judgment, confrontation and direction, and instead aims to motivate change by highlighting inconsistencies between beliefs and negative consequences of risky behaviors and resolving ambivalence. As such, it potentially offers an ideal model for a sex-positive, HIV-prevention intervention with Latino MSM. Counselors utilizing motivational interviewing employ warmth, genuineness, and empathy, qualities which are of particular importance when working with men who have experienced rejection, oppression, hostility, and discrimination from both the gay and the Latino communities.

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