Overview of a gay men's STI/HIV testing clinic in Ottawa: Clinical operations and outcomes

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ABSTRACT

OBJECTIVES: To 1) create a space where men who have sex with men (MSM) feel comfortable accessing sexually transmitted infection/human immunodeficiency virus (STI/HIV) testing, and 2) reduce STI/HIV incidence.

PARTICIPANTS: Gay men in Ottawa and its surrounding regions.

SETTING: A preponderance of diagnoses of sexually transmitted infections and HIV continue to occur among MSM. Meanwhile, other literature identifies that many MSM are reluctant to access STI/HIV testing services or to disclose their sexual practices to primary care practitioners.

INTERVENTION: In Ottawa, in an effort to surmount these issues and decrease STI/HIV incidence among MSM, the local public health unit in collaboration with community partners created "GayZone", a three-hour-per-week STI/HIV testing and STI treatment clinic for gay men. In this paper, we report on the uptake and STI/HIV diagnosis outcomes for this clinic from January 2010 through December 2013.

OUTCOMES: GayZone is a well-utilized clinic that yields a number of STI/HIV diagnoses per year. Overall, the positivity rates of the STI/HIV tests at this clinic are above-average, although lower than what might be expected by local epidemiological data. While the results of this clinic validate anonymous HIV testing, they bring into question the utility of pharyngeal swabs to test for gonorrhea and chlamydia.

CONCLUSION: The results of our study demonstrate the utility of a gay men's STI/HIV testing clinic and highlight some areas for improvement. Public health practitioners, frontline clinicians, and community workers in other regions who wish to implement such an STI/HIV clinic would do well to consider our results beforehand.

KEY WORDS: Clinical services; gay men; HIV; MSM; public health; sexually transmitted infections

La traduction du résumé se trouve à la fin de l'article.

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In Canada, men who have sex with men (MSM) account for a large proportion of incident HIV and sexually transmitted infections (STIs).^{1,2} In Ottawa, in 2010 (most recent published data), STI/HIV diagnoses among men who reported "sex with same sex" were 42 for infectious syphilis, 50 for gonorrhea, 61 for chlamydia and 24 for HIV (representing 91%, 34%, 9% and 60% of citywide diagnoses respectively).³ For HIV, this means that, while the estimated prevalence rate is 0.3% among Canadian adults, it is likely greater than 10% among MSM in Ottawa*.^{4,5} In response to this burden of STIs/HIV, we helped develop "GayZone", a walk-in STI/HIV testing clinic for MSM.⁶ The objectives of this clinic were to 1) create a space where MSM felt comfortable accessing STI/HIV testing, and 2) reduce STI/HIV incidence.⁶ Our hypothesis was that GayZone could contribute to the broader attainment of these goals, in the latter case by reducing onward transmission by facilitating STI/HIV testing, diagnosis and treatment.^{7,8} In this article, we provide an overview of the clinic and discuss its outcomes in relation to the stated objectives.

Understanding STI/HIV transmission and prevention

The Anderson-May equation,⁹ $R_0 = \beta cd$, highlights that three factors affect population-level STI/HIV transmission: " β ", the probability of

* In O'Byrne et al.'s survey of 721 MSM, 10% identified as HIV-positive, 9.2% were unsure of their status, and 5% did not answer the question. Remis and Liu's analysis of public health laboratory data suggested that 11.2% of MSM in Ottawa were HIV-positive. Finally, 12.9% of participants in the *M-Track Study* noted being HIV-positive.

transmission per exposure; " c ", the number of contacts between infectious and susceptible persons; and " d ", the period of infectiousness.⁹ This equation highlights that, because infectiousness (both degree and duration) and the number of exposures determine the rate of ongoing transmission, these parameters should be targets to achieve STI/HIV prevention. Testing^{7,8} can influence these factors by: lowering " β ", because people often change sexual practices¹⁰ or initiate medications after an STI/HIV diagnosis;¹¹ diminishing " c ", by reducing numbers of sex partners or by eschewing practices that transmit these infections;¹¹ and shortening " d ", by treating curable STIs. These outcomes, however, are predicated on individuals accessing services.

Barriers to Care

Many factors affect access to STI/HIV testing; e.g., levels of knowledge or concern,¹² or embarrassment about STIs/HIV¹³ or STI/HIV testing.^{14,15} People are apprehensive, moreover, about being seen accessing STI/HIV

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Table 1. Clinic usage data and testing plus diagnosis figures

Items	2011	2012	2013
Total number of visits	987	1062	1161
Number of unique patient visits	617	608	676
Number of patients seen for anonymous HIV testing (only)	163	151	226
Number of HIV-positive patients [per patients]	19 (3.1%)	25 (4.1%)	23 (3.4%)
1 st -time patients [per visits]	213 (21.6%)	202 (18.9%)	111 (9.6%)
Patients with GP [per visits]	481 (48.7%)	533 (49.9%)	589 (50.7%)
Symptoms [per visits]	293 (29.7%)	282 (26.6%)	315 (27.1%)
Condoms for last anal sexual contact	57.8%	58.4%	50.4%
Gonorrhea [total positive]	n=3	n=5	n=14
Gonorrhea [positive/performed]	Pharynx 0/576 (0%)	1/570 (0.2%)	0/730 (0%)
	Rectum 1/381 (0.3%)	1/356 (0.3%)	1/465 (0.2%)
	Urine 2/670 (0.3%)	3/628 (0.5%)	13/827 (1.6%)
Chlamydia [total positive]	n=21	n=23	n=48
Chlamydia [positive/performed]	Pharynx 1/576 (0.2%)	0/575 (0%)	4/730 (0.5%)
	Rectum 7/387 (1.8%)	7/375 (1.9%)	21/480 (4.4%)
	Urine 13/669 (2.4%)	16/628 (2.5%)	24/833 (2.9%)
Syphilis (positive/performed)	16/629 (2.5%)	14/585 (2.4%)	7/774 (0.9%)
HIV [total positive]	7/792 (0.9%)	14/800 (1.8%)	7/970 (0.7%)
HIV (nominal) [positive/performed]	4/426 (0.9%)	2*/470 (0.4%)	1/604 (0.2%)
HIV (total anonymous) [positive/performed]	3/366 (0.8%)	12/330 (3.6%)	6/366 (1.6%)
HIV (only anonymous) [positive/performed]	3/163 (1.8%)	7/151 (4.6%)	3/226 (1.3%)

* 1 case POC HIV negative; p24 antigen positive.

clinics.¹⁶ Concerns about invasive testing, such as swabs or examinations, also impede testing.¹⁷ Similarly, being asked one's sexual health history (i.e., when clinicians ask about sexual contacts) makes some persons, primarily sexual minorities, less willing to undergo testing.^{18,19} Other barriers relate to health care provider behaviour, such as judgemental attitudes or limited knowledge – for instance, when clinicians do not offer HIV testing when persons, particularly sexually-active MSM, present for care with HIV seroconversion symptoms (e.g., rash, fever, fatigue, flu-like symptoms).^{20,21} Researchers have further identified that gender norms of masculinity affect testing.^{17,19} For men to undergo testing, they must reject norms about masculinity, which dictate that they should be autonomous and invulnerable.¹⁷ Often during testing, however, men follow a clinician's direction, and by simply accessing testing, must admit that they could have an infection and thus that they are vulnerable. Taken as a whole, therefore, the reasons people do not access STI/HIV testing are 1) a lack of desire to do so (whether this relates to lack of concern, feelings of immunity, or incomplete understandings) and/or 2) an inability to obtain the STI/HIV testing they seek.

Reasons for Accessing an STI/HIV Clinic

Researchers have also explored why people attend STI/HIV clinics. Rationales included: same-day access through walk-in services; perceived comprehensiveness of testing and specialized knowledge; desires not to discuss sexual practices with general practitioners (GPs); availability of anonymous or point-of-care testing; and referral, e.g., for a second opinion or specialized treatment.²²⁻²⁴ In one study, obtaining testing for all STIs/HIV (comprehensiveness) and perceived specialized knowledge at STI clinics resulted in some persons who first sought care with their GPs subsequently visiting STI/HIV clinics to obtain the testing they felt their GPs missed.²⁵ In this study, STI/HIV testing with GPs resulted in duplicate service utilization. Thus, although certain factors undermine people's willingness to access STI/HIV clinics, these services have attributes that nevertheless entice attendance.

Participants and intervention: The GayZone Clinic

In September 2008, Ottawa Public Health established GayZone, which is an STI/HIV testing clinic for MSM at Centretown

Community Health Centre. While health promotion activities – fairs, cooking clubs, yoga – are ongoing aspects of GayZone, this report focuses solely on the clinic, which is open three hours/week on Thursday evenings, and typically has, per shift, two physicians, one nurse practitioner, three registered nurses and one outreach worker. These staff offer free-of-charge: STI/HIV testing[†], STI treatment (gonorrhea, chlamydia, syphilis, genital herpes and warts), vaccination for hepatitis A/B, HIV post-exposure prophylaxis (PEP), counselling about STIs/HIV and their prevention, and condoms. Patients who attend GayZone are offered STI/HIV testing as warranted based on sexual history and symptoms.

In terms of clinic flow, patients indicate on a self-directed intake form the services they want and whether or not they have symptoms. Patients who request PEP are assessed immediately. All others are seen on a first-come-first-served basis by one clinician who provides all care. Physicians and nurse practitioners assess patients who report symptoms; nurses screen self-identified asymptomatic patients (under medical directives) and refer patients to the physicians or nurse practitioner as warranted (e.g., when signs are identified). The outreach worker performs anonymous[‡] point-of-care HIV testing.

For follow-up of name-based testing, a clinic nurse contacts patients within 2-3 weeks as required (e.g., if a result is identified in the laboratory as positive or contaminated). Such follow-up occurs first by phone and then by e-mail or text message, if clients consent.

[†] At GayZone, the following testing is available: HIV serology (4th generation Abbot ARCHITECT); HIV point-of-care (INSTI); syphilis serology (CLIA, RPR, and TP.PA); hepatitis A, B, and C serology (for immune status, acute infection, or chronic infection, as indicated based on exposure factors and vaccination status); gonorrhea and chlamydia urine testing (Gen-Probe Aptima NAAT assay); chlamydia pharyngeal and rectal swabs (culture using Copan Universal Transport Media); gonorrhea pharyngeal and rectal swabs (culture using Amies Charcoal transport media); and, when indicated based on symptoms, HSV swab (culture using Copan Universal Transport Media) and LGV testing (through the Public Health Agency of Canada National Laboratory).

[‡] In Ontario, anonymous HIV testing circumvents mandated name-based reporting of positive test results. Instead, public health units receive a report indicating the age and exposure category of the person who tested positive. Across Ontario, the positivity rate of anonymous HIV testing is higher than that for name-based testing.

Table 2. Positivity rates and diagnostic yield*

	City			
	2011	2012	2013	Average %
Gonorrhea	3/220 (1.4%)	5/242 (2.1%)	14/259 (5.4%)	3%
Chlamydia	21/2556 (0.8%)	23/2550 (0.9%)	48/2411 (2%)	1.2%
Syphilis	16/53 (30.2%)	14/40 (35%)	7/29 (24.1%)	29.8%
HIV	7/86 (8.1%)	14/73 (19.2%)	7/66 (10.6%)	12.6%
	Public Health Unit			
	2011	2012	2013	
Gonorrhea	3/57 (5.3%)	5/70 (7.1%)	14/82 (17.1%)	9.8%
Chlamydia	21/575 (3.7%)	23/640 (3.6%)	48/621 (7.7%)	5%
Syphilis	16/21 (76.2%)	14/19 (73.7%)	7/7 (100%)	83.3%
HIV	7/18 (38.9%)	14/10 (140%)	7/6 (116.7%)†	98.5%

* The denominators (i.e., total number of diagnoses) in this table arise from the Integrated Public Health Information System (iPHIS), which is the provincial infectious disease database for reportable infections in Ontario.

† These figures are >100% because of the anonymous tester at GayZone. The result is that GayZone now yields more diagnoses than would have occurred in OPH programs otherwise.

For STIs, all treatment is done at GayZone, and for HIV, referral to local HIV care physicians is arranged. For anonymous testing, when point-of-care HIV test results are non-reactive and serology is not performed, follow-up is not required. The client receives the non-reactive result immediately and is discharged. In the event of serological specimen collection (e.g., as a client's preferred testing strategy or to confirm a reactive point-of-care test result by Western blot), clients receive a code that identifies their specimen, and are instructed to return to the clinic with this code after three weeks to obtain their test result. Failure on the client's part to produce this code at the three-week follow-up visit precludes disclosure of test results.

RESULTS

The total number of patient visits during 3 clinical hours per week for 50 weeks per year from January 2011 through December 2013 (for testing, treatment, examination, results and vaccination) increased from 987 (in 2011) to 1,062 (2012) to 1,161 (2013). Over this time, the percentage of visits from first-time patients decreased: 21.6% (2011), 18.9% (2012), and 9.6% (2013), with the result that in 2013, 676 patients accessed care 1,161 times. Moreover, of these patients, approximately 50% had a GP, less than 4% reported being HIV-positive, and less than 30% reported symptoms (dysuria, discharge, lesions, rashes). For sexual contacts, consistently greater than 50% reported condom use during their last anal sexual contact: 57.8% (2011), 58.4% (2012) and 50.4% (2013).

For STI diagnoses, yield varied. Gonorrhea diagnoses were 3 (2011), 5 (2012) and 14 (2013). In 2013, 5.4% of all gonorrhea diagnoses in Ottawa occurred at GayZone; this proportion was 1.4% in 2011. In 2013, 30.8% (4/13) of patients with urethral gonorrhea were asymptomatic; the 1 patient with rectal gonorrhea was asymptomatic. Chlamydia diagnoses were 21 (2011), 23 (2012), and 48 (2013). The proportion of citywide chlamydia diagnoses identified at GayZone increased from 0.8% (2011) to 2% (2013). In 2013, 37.5% (8/24) of patients with urethral chlamydia were asymptomatic, and 61.9% (13/21) with rectal chlamydia were asymptomatic. Syphilis diagnoses were 16 (2011), 14 (2012) and 7 (2013), which corresponded with citywide decreases in such diagnosis. Indeed, the proportion of citywide syphilis diagnoses that occurred at GayZone only marginally decreased from 30.2% (2011) to 24.1% (2013). HIV diagnoses were 7 (2011), 14 (2012) and 7 (2013), with 3 of 7 (2011), 12 of 14 (2012) and 6 of 7 (2013) of these tests having been undertaken as anonymous tests. This

resulted at GayZone in overall HIV positivity rates (for both anonymous and name-based testing) of 0.9% (2011), 1.8% (2012) and 0.7% (2013). When separated by reporting modality, these positivity rates were as follows: for anonymous HIV testing, 0.8% (2011), 3.6% (2012) and 1.6% (2013); for nominal HIV testing, 0.9% (2011), 0.4% (2012) and 0.2% (2013). The proportion of citywide HIV diagnoses that occurred at GayZone ranged from 8.1% (2011) to 19.2% (2012) to 10.6% (2013). All of these positive results were first-time diagnoses involving patients previously unaware they were HIV-positive.

Finally, the gonorrhea and chlamydia pharyngeal swabs identified 5 infections from 3,757 tests (0.13% positivity rate). There was 1 case of pharyngeal gonorrhea from 1,876 tests and 4 cases of pharyngeal chlamydia from 1,881 tests. Four of these cases (all chlamydia) had a positive urine ($n=2$) and/or rectal swab ($n=3$) result, reducing the number of unique diagnoses from pharyngeal swabs to 1 (0.02% positivity rate). For the rectal swabs, there were 5 cases of rectal gonorrhea from 1,202 tests and 34 cases of rectal chlamydia from 1,242 tests, yielding 39 (1.6%) diagnoses from 2,444 tests. The urine testing identified 18 cases of gonorrhea from 2,125 tests and 53 cases of chlamydia from 2,130 tests, for a total of 71 (1.67%) cases from 4,255 tests.

DISCUSSION

Regarding our objectives of 1) creating a culturally sensitive STI/HIV testing site for MSM and 2) decreasing STI/HIV transmission by reducing the period of infectivity, our data suggest we were partially correct in our hypotheses. For objective 1, the usage numbers indicated an increase in both the uptake and proportion of patients undergoing repeat testing, which suggests, as previous research with men from GayZone identified,²⁴ that this clinic is well liked by MSM. Further supporting that GayZone is well used are the public health laboratory figures from 2011 (most recent available),²⁶ which indicate that GayZone accounted for 15-37% of all HIV testing among MSM in Ottawa⁸. These data, and the finding that half of

§ The variability in these proportions relates to the fact that >50% of HIV requisitions in Ontario are submitted to the public health laboratory without details about the test recipient's exposure classification. Accordingly, the high number (37%) relates to the proportion of tests done at GayZone among men identified as MSM during initial submission; the low number (15%) relates to the proportion of tests believed to have been MSM after follow-up with the practitioners who ordered the test. However, the poor response rate for this follow-up process leaves a proportion of HIV tests still being from persons of unknown exposure category, although all are classified through an adjustment process.

GayZone patients have GPs, led us to believe that some MSM may simply prefer accessing STI/HIV testing at GayZone, thus satisfying objective 1. The limitations of our data (in that they do not directly measure this outcome), however, highlight the need for future research on this topic.

For objective 2 (reducing incidence), our data were less clear. Although infections were identified among asymptomatic patients, thus reducing forward transmission in these instances, we are unsure if this process was sufficient to actually affect STI/HIV transmission at the community level. Suggesting that GayZone may have influenced community-level transmission were the data showing that, between 2011-2013, an average of 12.6% of all HIV diagnoses in Ottawa occurred at this clinic. If one uses the historical figures that 50-60% of HIV diagnoses in Ottawa occur among MSM,^{2,4,26} then GayZone is the location for approximately 22-25% of all HIV diagnoses among MSM during 2011-2013. As far as we know, no other testing initiatives have produced similar yields in Ottawa. Likewise, the positivity rate for urine gonorrhea testing at GayZone in 2013 (1.6%) was over double that of urine and cervical gonorrhea testing in the community and at the city's main STI clinic (0.6-0.81%).

However, other positivity rates indicate that GayZone may not have affected STI/HIV transmission at the community level as much as had been hoped for. For example, in 2011, the GayZone positivity rate for nominal HIV tests (0.9%) virtually matched the rate among MSM across Ottawa (0.89%). Because the estimated HIV prevalence rate among MSM in Ottawa is greater than 10%,^{4,5} with roughly 20% of these men unaware they are HIV-positive,² one would reasonably expect higher positivity rates at our clinic than were observed. Further undermining the possible community-level effect that GayZone could have had was that approximately 75-78% of HIV diagnoses among MSM in Ottawa occurred elsewhere. Similarly, notwithstanding that, in 2010, 91% of infectious syphilis diagnoses involved MSM, only an approximate 30% of these infections were diagnosed at GayZone from 2011 to 2013.

Such unremarkable, albeit important, diagnosis outcomes led us to believe that GayZone attendance may have been low among MSM who are most susceptible to STIs/HIV; i.e., MSM who primarily engage in unprotected sex, yet infrequently undergo testing. The majority of GayZone patients, in contrast, reported condom use, and many underwent STI/HIV testing more than once per year. Thus, although testing could reduce duration of infectivity and STI/HIV incidence,^{7,8} recurrent testing among a small cohort of MSM who often use condoms may limit GayZone's effectiveness as a community-level prevention initiative. Widespread testing among larger groups of MSM might be required to substantially reduce the duration of infectivity and STI/HIV incidence. Specifically, efforts need to be made to maintain current testing strategies among the men who visit GayZone, while also expanding uptake to other men, including men previously diagnosed with HIV and men who are less attached to the gay community and/or gay identity (i.e., straight-identifying MSM).

This is not to say that GayZone was ineffective; many diagnoses did occur, and the percentage of undiagnosed HIV infections (i.e., 0.7-1.8%) was higher than the Centers for Disease Control screening threshold of 0.1%.²⁷ Simply, the number of diagnoses at GayZone was not as high as we hypothesized it would be based on available incidence and prevalence data. Nevertheless, an

important consideration is that GayZone only operates 3 hours per week. Because limited hours constrain attendance, it is possible that GayZone's ability to affect STI/HIV incidence at the community level may be restricted by time and service availability.⁸

Recommendations

First, we believe that anonymous HIV testing should be maintained. Seventy-five percent of HIV diagnoses at GayZone during 2011-2013 were among persons who chose anonymous testing, demonstrating the utility of this testing modality. However, because people cannot easily access HIV treatment anonymously, since treatment is typically linked with patient names, it may be worthwhile to consider revising access-to-care stipulations for HIV treatment, at least for the period immediately following diagnosis. If the goals of HIV testing are to improve health outcomes for persons living with HIV and to decrease transmission, and anonymous testing corresponds with such outcomes, should we not scale up and facilitate access to such services?^{3,4}

Second, the low yield of our pharyngeal swabs warrants reflection. Only one additional chlamydia infection was identified from 3,757 tests, which must be considered in the light of the time taken to complete these tests and the fact that people leave GayZone without being seen due to increasing wait-times. While researchers²⁸ have reported higher rates of pharyngeal infection than we identified, these other studies relied on nucleic acid amplification testing (NAAT). Our results, which report on the findings of standard clinical practice that uses culture-based testing for extra-genital specimens – the only method currently available in most jurisdictions in Canada – suggest that this testing may not be worthwhile when performed using culture media. Accordingly, efforts should be made to expand the use of NAAT for extra-genital testing for gonorrhea and chlamydia. In the meantime, researchers should identify clinical indicators that predict the need for culture-based pharyngeal testing.

Third, efforts should be made to ensure that sexually active HIV-diagnosed MSM are informed about STI testing. If the estimated HIV prevalence rate among MSM in Ottawa exceeds 10%,^{4,5} and only roughly 4.0% of GayZone patients were HIV-positive, one must question why this proportion was so low. While some HIV-positive MSM may not be sexually active, and others may undergo testing with their HIV care providers, it is important to address STIs among these men; STIs can both compromise the health status of HIV-positive MSM and exacerbate HIV transmission.²⁹ Within the Anderson-May equation,⁹ this could modify the probability of transmission (β) and thus should be a priority area for intervention. Further, researchers should establish if and where HIV-diagnosed MSM want to seek and obtain STI testing, or if initiatives are needed to develop and promote specialized clinics, such as GayZone.

Fourth, to expand access to persons not currently attending GayZone, clinic capacity should likely increase by a) developing a novel STI/HIV testing approach, in which asymptomatic patients, who are neither STI cases nor contacts, could undergo testing without providing sexual histories, and b) creating additional clinic time on a different day. The availability of testing without history-taking could allow GayZone to not only accommodate more patients but also provide a testing option for persons who do not access testing due to concerns about having to provide and/or discuss their sexual histories. Based on the extant literature, we

speculate that some men avoid testing because they believe that clinicians will not view their sexual choices in an approving light. We would further hypothesize that if these men knew there would be no questions or judgement, they might be more inclined to seek testing. While there may be a lost opportunity for counselling, there would be an increased opportunity for STI/HIV diagnosis and thus for reducing transmission according to the Anderson-May⁹ equation. This would represent a substantial improvement as currently neither counselling nor testing occurs when such men outright avoid STI/HIV testing services. Meanwhile, a second clinic at a different time and on a different day could permit access to care for persons who are so inclined.

CONCLUSION

Based on the Anderson-May equation,⁹ it is possible that STI/HIV testing can reduce transmission of these infections as a result of treatment and the behaviour changes that typically occur after diagnosis; i.e., by shortening the period of infectivity.^{7,8,10} This process could, therefore, improve the health status of both persons and communities. However, testing will not induce such outcomes if infections are not identified. We thus believe that positivity rates and diagnostic yield^{||} are appropriate measures for evaluating STI/HIV clinics. If positivity rates and diagnostic yields are poor in relation to local epidemiological data, consideration must be made about why this occurs, including a review to identify unforeseen barriers to testing.

In relation to GayZone, local data indicate that MSM are an appropriate priority population for STI/HIV services, but that the clinic's diagnostic yields require refinement; e.g., expanded service delivery, the delivery of NAAT-based pharyngeal swabs, and the identification of ways to serve diverse groups of MSM. In the absence of such changes, we suspect that the number of diagnoses at GayZone will continue to be more than adequate in relation to general STI/HIV screening guidelines (and thus warranting continuation of services), but unremarkable in relation to estimated population STI/HIV prevalence figures (and thus insufficient to decrease STI/HIV transmission among MSM). Service delivery changes are, therefore, warranted, and we encourage STI/HIV prevention workers, irrespective of role, to consider such findings when implementing new testing initiatives.

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|| While positivity rates are typically reported and compared for STI/HIV testing initiatives, our data suggest that the idea of *diagnostic yield* – i.e., the entire number of diagnoses – is also important for analysis. This concept permits the review of not only what proportion of tests were positive, but also the total number of diagnoses that occurred. This helps control for high positivity rates, which can reflect high numbers of diagnoses or be an artefact of a low denominator (i.e., few people tested).

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RÉSUMÉ

OBJECTIFS : 1) Offrir un endroit où les hommes ayant des relations sexuelles avec d'autres hommes (HARSAH) n'hésitent pas à se rendre pour obtenir des services de dépistage des infections transmises sexuellement (ITS) et du virus d'immunodéficience humaine (VIH); et 2) réduire l'incidence des ITS et du VIH.

PARTICIPANTS : Hommes gais d'Ottawa et des environs.

CONTEXTE : Alors même que les diagnostics d'ITS et de VIH demeurent nombreux pour les HARSAH, il y a différentes indications à l'effet que ces hommes sont réticents à recourir aux services de dépistage ou à divulguer leurs pratiques sexuelles aux pourvoyeurs de soins primaires.

INTERVENTION : Dans le but de surmonter ces difficultés pour parvenir à diminuer la prévalence des ITS et du VIH chez les HARSAH, les services de santé publique de la ville d'Ottawa ont mis sur pied, en collaboration avec des partenaires communautaires, la Zone gaie, une clinique spécialisée où les hommes gais ont accès trois heures par semaine à des services de dépistage des ITS et du VIH et de traitement des ITS. Le présent rapport traite du taux de fréquentation de cette clinique et des diagnostics d'ITS et de VIH qui ont pu y être établis entre janvier 2010 et décembre 2013.

RÉSULTATS : La Zone gaie est une clinique abondamment utilisée qui établit chaque année un bon nombre de diagnostics d'ITS et de VIH. La proportion de tests de dépistage positifs y est au-dessus de la moyenne, bien qu'inférieure à ce que l'on pourrait attendre selon les données épidémiologiques locales. Le travail de la clinique a mis en lumière l'importance du dépistage anonyme du VIH, mais nous amène par ailleurs à nous interroger sur la pertinence des prélèvements pharyngés pour dépister la gonorrhée et la chlamydia.

CONCLUSION : Non seulement les résultats obtenus témoignent-ils de l'utilité d'une clinique semblable, mais ils font également ressortir quelques points à améliorer. Les praticiens en santé publique, les cliniciens de première ligne et les travailleurs communautaires qui envisagent l'établissement d'une telle clinique spécialisée dans leur région seraient bien avisés de prendre d'abord connaissance des résultats de notre travail.

MOTS CLÉS : services cliniques; homes gais; VIH; HARSAH; santé publique; infections transmissibles sexuellement