



HHS Public Access

Author manuscript

Health Educ Behav. Author manuscript; available in PMC 2016 January 04.

Published in final edited form as:

Health Educ Behav. 2014 December ; 41(6): 673–681. doi:10.1177/1090198114537064.

HIV Testing Patterns Among Urban YMSM of Color

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Abstract

The heightened level of risk for HIV infection among African-American and Latino young men who have sex with men (YMSM) is driven by multi-level influences. Using cross-sectional data, we examined HIV testing patterns among urban YMSM of color in a high HIV sero-prevalence area (ages 16 to 21 years). Self-reported frequency of testing was high with 42% of youth reporting testing at a greater frequency than recommended guidelines. There were no differences between less frequent and high frequent testers on sexual risk behaviors. Most (80%) youth cited reassurance of HIV-negative status as a reason for testing. Further, over half of the sample reported numerous other reasons for HIV testing, which spanned individual, partner, social, and structural levels of influence. Approximately half of respondents indicated that peers, family members, and counselors influenced their motivation to get tested. Of concern, youths' first HIV test occurred approximately two years after their first sexual experience with another male. These results indicate the need to consider developmental issues as well as for comprehensive, multi-level efforts to ensure that YMSM of color test at the CDC-recommended frequency, but not less than this or too frequently.

Keywords

HIV Testing; YMSM; urban; Black; African; American; Latino; adolescent; men who have sex with men

Introduction

Black/African-American and Latino adolescents and young adult men who have sex with men (YMSM) are among those at highest risk for acquiring HIV infection in the United States (Centers for Disease Control and Prevention (CDC, 2010). Between 2006 and 2009,

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HIV incidence increased by over 45% among Black and Latino YMSM between the ages of 13 and 29 (CDC, 2010). The vast majority of these infections are due to unprotected (without a condom) male-to-male sexual contact.

This heightened level of risk among YMSM is driven by complex and interdependent individual, partner, social, and structural influences (Halkitis, Wolitski, & Millett, 2013). At the individual and partner levels, YMSM consistently evidence high rates of substance use (Celentano et al., 2006; Salomon et al., 2009) which is strongly associated with unprotected anal sex, particularly with sexual partners who are considered 'casual' versus serious (Salomon et al., 2009; Stueve et al., 2002). Although alcohol and marijuana are the most widely used substances in this population, methamphetamine use among YMSM has been associated with unprotected sex with older male partners, having sex while high, or using drugs in response to pressure from a sex partner (Freeman et al., 2011; Garofalo, Mustanski, McKirnan, Herrick, & Donenberg, 2007). Despite the higher prevalence of HIV among YMSM of color compared to White YMSM, the frequency of risk behaviors among Black and Latino YMSM, particularly substance use and unprotected sexual contact, has been found to be lower than or similar to rates evidenced by their White peers (Magnus et al., 2010; Millett, Flores, Peterson, & Bakeman, 2007; Valleroy et al., 2000). Further, Black YMSM report less methamphetamine use when compared to Latino and White YMSM (Garofalo et al., 2007). Yet high rates of stress and mental health problems, particularly depression and anxiety (Mustanski, Newcomb, & Garofalo, 2011; Salomon et al., 2009), add to the complex relationships among substance use, partner type, and sexual risk behavior. As with their heterosexual peers, the vast majority of unprotected sex and HIV transmission events among YMSM occur within serious relationships (Mitchell & Horvath, 2013; Sullivan, Salazar, Buchbinder, & Sanchez, 2009).

For YMSM, developmentally normative sexual exploration exists within the social and structural context of homophobia where youth are often stigmatized, rejected and socially isolated from conventional buffering systems of family, school, and community. For YMSM of color, particularly those from lower socioeconomic communities, these factors contribute to a constellation of risk factors including high rates of homelessness, foster care placement, depression and adaptations to homelessness including substance use and trading sex for drugs or money (Clatts, Goldsamt, Yi, & Gwadz, 2005; Gwadz et al., 2006; Halkitis et al., 2013). Most importantly, YMSM of color often reside in areas of high HIV seroprevalence where their social-sexual networks contain high rates of HIV and other STIs (Adimora & Schoenbach, 2005).

HIV testing is an important component of prevention and care, as early diagnosis of HIV is associated with better health, greater longevity, and decreased chances of sexual transmission to others (CDC, 2013). Further, among youth uninfected with HIV, routine testing affords the opportunity to discuss risk reduction with a health professional (Marks, Crepaz, Senterfitt, & Janssen, 2005). While the CDC recommends annual testing for YMSM, more frequent testing, every 6 to 12 months, is recommended for sexually active YMSM as well as individuals who live in areas with generalized (>1%) HIV epidemics (CDC, 2011a).

Since 2005, an estimated 54% – 85% of YMSM report being tested for HIV at least once in their lifetime (CDC, 2010) although a recent report suggest that only approximately two-thirds of YMSM had been tested within the past year (Finlayson et al., 2011). However, compared to their White peers, YMSM of color are less likely to test regularly, more likely to have undiagnosed HIV infection, are diagnosed later in the course of the disease, and less likely to test because of recognized risks (CDC, 2011a; MacKellar et al., 2006). The Young Men’s Study, a large multi-city HIV testing effort found that among Black and Latino YMSM, over 75% of 18–19 year olds and 68% of 20–24 year olds who tested HIV-positive were previously unaware of their infection (CDC, 2011a).

Correlates of testing

Many reports have documented demographic and behavioral correlates of HIV testing among YMSM, which have included older age, White race, higher income, substance use, multiple sexual partners, social support and being asked to test by a sexual partner (Cohall et al., 2010; (MacKellar et al., 2006; Sumartojo, et al., 2008)). Adult YMSM of color who have main or serious partners may be more likely to engage in regular testing (Mitchell & Horvath, 2013). Among YMSM, Sumartojo and colleagues (2008) identified several social and structural variables associated with ever and recent testing, which included perceived social support, knowing a comfortable HIV testing site, and exposure to prevention messages.

Frequency of HIV testing

Several reports have documented a high frequency of HIV testing among YMSM (MacKellar et al., 2002; Schrager, Wong, Weiss, & Kipke, 2011; Sifakis et al., 2007; Sumartojo et al., 2008) particularly those who are well connected to community based services (Gwadz et al., 2010). High frequency testing, that is, at a greater frequency than every 6 to 12 months, may suggest that YMSM view testing as a normative health protective behavior (Fernandez, Perrino, Bowen, Royal, & Varga, 2003). Yet, this raises a concern that frequently being found HIV uninfected may serve to reinforce continued risk behaviors. Indeed, several reports have documented higher rates of HIV risk behaviors among YMSM who test for HIV frequently (MacKellar et al., 2002; Sifakis et al., 2007), while other studies find no relationship (Schrager et al., 2011; Sumartojo, et al., 2008).

While an understanding of the prevalence and correlates of HIV testing are important for targeted testing and prevention efforts among YMSM, few reports have documented youths’ reasons for obtaining HIV testing at the multiple levels of influence that contribute to their risk of infection. Thus, the main objectives of this study are to characterize the demographic, behavioral, and psychosocial correlates of HIV testing among YMSM of color, and to examine reasons why youth obtain testing.

Methods

Participants and Procedures

The data for this study were drawn from the baseline interview of a longitudinal study of an HIV-prevention intervention for YMSM which was conducted in the Bronx, a borough of

New York City that is the poorest county in New York State (United States Census Bureau, 2012) and has a high (1.7%) HIV prevalence rate (New York City Department of Health and Mental Hygiene [NYCDOH], 2011). The population of the Bronx is composed mainly of Black/African-Americans and Latinos (86.9%; (United States Census Bureau, 2012), the racial/ethnic groups most heavily, and disproportionately, affected by HIV (NYCDOH, 2011).

The sample was recruited between June 2008 and July 2010. All participants were screened for eligibility using a brief written screener. Youth were eligible for participation if they were, a) an adolescent male (biological male at birth if transgender), b) between the ages of 14 and 21 years, c) could complete an interview in English, and d) either reported sexual activity with another male on at least one occasion in their lifetime or reported a desire to engage in same-sex sexual activity. Approximately 93% (89/95) of youth screened were eligible and agreed to participate. The primary reason for ineligibility was age greater than 21 years.

A peer referral sampling method was used for recruitment as follows: Male youth who attended a Bronx-based community based organization (CBO) serving sexual minority youth were recruited using IRB-approved flyers posted at the CBO, and through word of mouth. Interested youth were screened for eligibility as described above. Eligible youth ($n = 45$) then provided signed informed consent and participated in the baseline interview. These youth were then asked to recruit peers for possible participation in the study. Approximately 95% ($n = 43$) of youth recruited one eligible peer and 5% ($n = 2$) recruited two eligible peers. Similar to the youth recruited through the CBO, peers were screened for eligibility, signed informed consent, and received the baseline interview. Among all eligible youth, 96.6% ($n = 86$) reported sexual activity with another male on at least one occasion in their lifetime and 3.4% ($n = 3$) reported a desire to engage in same-sex sexual activity. Although the study was open to 14 and 15 year olds there were no 14 or 15 year olds from either the CBO or via peer recruitment who presented for screening. The interview was conducted in a private room by a trained research assistant using Questionnaire Development System (Nova Research, 2001) audio computer-assisted self-interviewing (ACASI). Participants entered responses directly into a computer. The interview lasted approximately 1 hour and participants received \$25 as compensation, as well as round-trip public transportation. All study activities took place at the Bronx-based CBO. The study was approved by the Institutional Review Board at the National Development and Research Institutes, which included procedures to allow 16 and 17 year olds youth to sign informed consent.

Measures

Background and demographic characteristics were collected including age, sex, current zip code, transgender status, sexual orientation, race/ethnicity, history of foster care and homelessness, affiliation with YMSM-friendly CBO, and frequency of utilizing each CBO in the past year (*never, less than monthly, monthly, several times a months, several times a week, several times a day*).

Symptoms of depression were assessed using the eight-item Center for Epidemiological Studies Depression Scale (CES-D; $\alpha = .88$; Radloff, 1977). Scores were dichotomized (*yes/no*) and summed to indicate clinically significant level (score ≥ 7).

Perceived susceptibility for HIV was assessed using the 12-item Revised Sexual Risks Scale (DeHart & Birkimer, 1997), which was measured on a 5-point scale (*strongly disagree to strongly agree* ($\alpha = 0.84$, range 0–20).

Sexual behavior was evaluated with the National Alcohol Survey for adolescents (Graves, 1995), which assessed sexual orientation; sexual experiences with another male age (“*any kind of sex with another male*”) including age at first sexual experience total number of lifetime sexual partners; sex work (*yes/no*); frequency of condom use during anal sex (either receptive or insertive) with serious (romantic), casual, and paid male sexual partners (*never, some or about half the time, most or all of the time*); and sexual concurrency (*yes/no*).

Alcohol and drug use (Des Jarlais, Friedmann, Hagan, & Friedman, 1996) was measured by assessing the frequency of use (*yes/no*) in the past 6 months across five substances [alcohol, marijuana, cocaine, club drugs (methamphetamines, ecstasy, GHB, ketamine) heroin, and non-medical use of prescription drugs].

HIV testing experiences (Gwadz et al., 2010) were assessed by a count of the number of times tested for HIV over youths’ lifetime and in the past year; their age at first HIV test, frequency of testing (*never, less than once per year, once per year, every 6 months, every 3 months, greater than every 3 months*), and HIV status (*positive, negative, unknown*).

Reasons for obtaining HIV testing (Gwadz et al., 2010) was assessed with a modified version of the HIV testing scale from Project FIO (Ehrhardt et al., 2002). Participants were asked to indicate *yes* or *no* to each of 21 individual, partner, social, and structural-level reasons (Table 2) for getting tested ($\alpha = 0.88$).

Data Analysis—Analyses were conducted using SPSS (version 21.0). Participants were included in the current analyses if they reported having at least one HIV test in their lifetime. Data were screened for possible outliers and logical inconsistencies. In examining the pattern of responses, the veracity of responses regarding sexual behavior for two of the participants appeared to be exaggerated and these two participants were removed from the data set. Together, this process resulted in a total sample size of 80. Chi-square analyses and corresponding significance levels were computed to explore the relationship between reasons for HIV testing and testing frequency. To examine differences between participants who engaged in HIV testing with greater frequency than current recommended guidelines (once a year to every 6 months), we dichotomized this variable into: 1) minimum or less than minimum testing (less than once per year to every 6 months; or 2) high frequency testing (every 3 months or more) for all analyses.

Results

Participants were between the ages of 16 and 21 years with a mean age of 19 years (SD = 2.2 years). Close to 90% of participants were youth of color (African-American or Latino or

mixed) and 87% reported residing in the Bronx. Almost 60% reported their sexual orientation as homosexual/gay and approximately 30% were bi-sexual. Risk factors include a history of homelessness (35.4%), foster care (28.7%), and approximately 43% evidenced symptoms of depression at clinically significant levels. In addition, most youth (91.0%) reported being the active client of at least one CBO although less than 10% reported utilizing these services on a monthly or more frequent basis.

HIV testing frequency

Approximately 64% of youth reported getting tested between 1 and 6 times in their lifetimes and 36% reported testing between 7 and 30 times. Frequency of testing was reported by participants as less than once per year (3.4%); once per year (7.9%); every 6 months (37.1%); every 3 months (37.1%); and greater than every 3 months (4.5%). About half tested at the minimum or less than minimum frequency (less to once per year to every 6 months; 53.8%) and the remainder at a high frequency (every 3 months or more; 46.3%). Table 1 describes the demographic and background characteristics of the total sample by testing frequency (minimum vs. high). There were no demographic differences between minimum and high frequency testers. Overall, participants reported an average of approximately six HIV tests over their lifetime (mean = 6.64, SD= 5.72, range 1 to 30). Nearly two-thirds (65%) of youth had been tested at least once within the past year. The mean age of first testing was 15.5 years (SD = 2.7). Three participants reported testing positive for HIV (3.8%).

Sexual behavior

Nearly all participants reported being sexually active with at least one male partner in their lifetimes (96.3%, n = 77). Participants reported their first sexual experiences with another male at a mean age of 13.4 years (SD = 3.0). The median number of lifetime male sexual partners was 5 (range 1 – 83). Approximately a quarter reported having concurrent sexual partners at any given time and close to 20% reported trading sex for money or drugs at least once over their lifetime. Close to 85% of youth reported using condoms during anal sex most or all of the time with romantic partners, and 82% of youth reported a similar rate of condom use with casual partners. There were no differences between minimum and frequency testers in patterns of sexual behavior. Youth had their first HIV test close to two years after their first sexual experience with another male; the difference between the mean age of youths' first HIV test (15.5 years) and age at sexual debut with another male (Mean = 13.4 years) was 1.83 years (SD = 3.72).

Substance use

Similar to their New York City peers (CDC, 2011b), alcohol (95%) and marijuana (93%) were the most frequently reported substances used in the past 6 months, however, a substantial number of participants declined to answer questions about substance use resulting in missing data. Of youth that did report, there were no differences between minimum and high frequency testers on alcohol use, but high frequency testers were less likely to report marijuana use compared to minimum frequency testers ($\chi^2 = 18.8$, $p = .027$). The use of club drugs (e.g., methamphetamine, ecstasy, ketamine, GHB) was reported by

approximately 15% of the sample, cocaine and other hard drugs including heroin, prescription drugs (e.g., oxycontin) were reported by less than 10% of the sample with no difference based on testing frequency (data not included in Table 1 due to significant amount of missing data for these questions).

Reasons for HIV Testing

As reported in Table 2, youth endorsed multiple reasons for obtaining HIV testing, at every level of influence – individual, partner, social, and structural. At the *individual* level, the overwhelming majority of youth (79%) reported getting tested in order to reassure themselves that they were not HIV positive. Similarly, over half endorsed getting tested because they were worried that they might be infected with HIV. However, there were no differences between high and minimum frequency testers on either of these individual level reasons for testing. Close to half the sample (49%) cited getting tested because they felt at risk due to their own behavior, and high frequency testers were significantly more likely to cite this as a reason in comparison to minimum frequency testers ($\chi^2 = 4.956$, $p = .026$). Although the difference between minimum and high-frequency testers for reporting wanting to have children as a reason to get tested for HIV did not reach statistical significance, high frequency testers were more likely to cite this as a reason at a marginally statistically significant level (35.1% versus 16.3%, respectively; $\chi^2 = 3.771$, $p = .052$). *Partner* level reasons for getting tested that were cited by approximately half the sample included having a new sexual partner (50%), concern over their partners' behavior (48%), and suspecting that a partner was HIV positive (45.6%). Although the difference between minimum and high-frequency testers reporting suspecting their partner was HIV positive as a reason for testing was not significant, high frequency testers were tended to be more likely to cite this, but at a marginally statistically significant level (56.7% versus 35.7%, respectively; $\chi^2 = 3.512$, $p = .061$). Less than 30% of all youth endorsed being asked by a sexual partner to get tested for HIV as a reason to obtain testing. At the *social* level, close to half the sample (48%) endorsed testing because family and friends were getting tested, and high frequency testers were significantly more likely to cite this as a reason ($\chi^2 = 5.934$, $p = .015$). Finally, at the *structural* level, over half of the youth (53.8%) endorsed getting tested because a counselor or other professional suggested testing. Minimum frequency testers tended to be more likely to cite reporting that HIV testing offered during a medical visit was a reason to test although this did not reach significance [58.1% versus 38.9%, respectively; $\chi^2 = 2.905$, $p = .088$]. The majority of participants, regardless of testing frequency, did *not* report other structural factors related to testing such as receiving a stipend, participating in a research study or being in foster care.

Discussion

We examined the prevalence, correlates, and reasons for HIV testing among a sample of YMSM of color in one of the highest HIV seroprevalence areas in the United States. Overall, we found high rates of HIV testing; over 90% of youth tested at least once in their lifetime, a rate similar to an earlier report of YMSM of color in New York City who had some connection to community-based services (Cohall et al., 2010). While close to half of youth in our sample reported testing every 3 months or more, similar to other reports

(Schrager et al., 2011; Sumartojo et al., 2008), we did not find greater HIV risk behaviors among high frequency testers compared to those with less frequent testing.

While over 85% of youth reported getting tested at least once per year, only 65% indicated that they were tested within the past year. Although youth reported relatively high rates of condom use, they also reported numerous sexual and substance use risk factors and high rates of depressive symptoms, all of which are associated with risk for HIV. Thus, despite self-reports of frequent testing among a subset of YMSM, these findings signal the need for increased attention to YMSM to help them establish consistent testing routines.

We also examined reasons for testing at the individual, partner, social, and structural levels of influence. The most frequently cited reason for testing was reassurance that they were not HIV positive and this did not differ by frequency of testing. High frequency testers however were more likely to endorse testing because of their behavior. While there were few differences between minimum and high frequency testers, all youth endorsed multiple reasons for testing highlighting the considerable diversity in factors that motivate youth to test. Future studies with larger samples are encouraged to consider individual differences in motivators for testing among YMSM of color in an effort to more effectively tailor strategies for increasing routine testing.

While most youth indicated a connection to a YMSM-friendly CBO, they utilized these CBOs infrequently. Yet professionals, peers, and family members – relationships that CBOs typically strive to cultivate among the youth they serve – were influential in supporting HIV testing. High frequency testers in the current study were significantly more likely than minimum frequency testers to cite testing by peers and family members as motivating their own testing behavior. These results are consistent with other reports of YMSM and adult MSM of color (Lauby et al., 2012; Mashburn, Peterson, Bakeman, Miller, & Clark, 2004; Sumartojo, et al., 2008) that have found positive associations between HIV testing and high levels of perceived social support. For highly vulnerable youth like those in the current sample, making connections with other YMSM of color through CBO's may facilitate social support for these youth who are challenged by familial, societal and structural institutions that fail to provide developmentally appropriate protective influences. In turn, this support may influence positive social norms about HIV testing and positively impact other protective behaviors including problematic substance use, psychological distress, and condom use (Mutchler et al., 2011; Traube, Holloway, & Zhang, 2013). CBOs may be well situated to expand HIV testing and condom distribution programs to include developmentally and culturally tailored programs for YMSM that address protective sexual behaviors at the individual, partner, and social level. In addition to promoting regular testing, other protective sexual behaviors might include negotiating sexual agreements and mutual routine testing with sexual partners as well as exploring the connections between sexual intimacy, substance use, and mental health (Mitchell & Horvath, 2013; New York State Department Of Health, 2006). Moreover, framing HIV testing as a routine component of maintaining general health and wellness, rather than risk- or 'worry'-based testing, is in line with the goals of the National HIV/AIDS Strategy (Millett, et al., 2010). While the outreach efforts of YMSM-focused CBOs and their funders often focus on finding youth who have never tested, our results suggest that vigilance regarding routine testing for

YMSM who have some connection to services is just as important. These efforts are even more crucial for YMSM of color in urban settings who have significant social and structural risk factors such as homelessness and symptoms of depression and whose sexual risk and protective behaviors are embedded within a high HIV seroprevalence community.

Of concern, we found that most youth had their first HIV test close to 2 years after their first sexual experience with another male, a finding similar to Phillips and colleagues (Phillips et al., 2012). Same-sex sexual activity typically begins between the ages of 13 and 15 (Savin-Williams & Diamond, 2000), corresponding to the transitional years between middle and high school. Although youth may not initially engage in receptive or insertive anal sex, these findings strongly suggest that outreach to youth in the middle school years is vital for providing information and education regarding sexual risk reduction and HIV testing. Young adolescent males, particularly those of color, who start having sex with other males face enormous challenges negotiating this period safely as they are less likely to present at CBOs and less likely to disclose their sexual behavior and concerns with health care providers, other trusted adults, or similarly minded peers (Mustanski et al., 2011).

The present study has several limitations. The small sample size limits the generalizability of the findings and the cross-sectional analysis limits the conclusions we can draw about reasons for testing in actual testing situations. In addition, we relied on retrospective self-report that is subject to recall and disclosure biases particularly around sensitive topics such as sexual behavior. While our list of reasons for testing was not exhaustive, it covered a wide range of reasons, many of which were endorsed by over half the sample. Frequency of testing may be overestimated although the percentage of youth who reported testing at least once in their lifetime mirrors findings from a similar cohort (Cohall et al., 2010). In addition, there was a great deal of missing data on the substance use items, however, of the youth that did report, the high prevalence of alcohol and marijuana mirrors findings from the Youth Risk Behavior Survey (CDC, 2011b). Moreover, our findings also support a large number of studies that have identified significant and problematic use of methamphetamine among YMSM of color (Freeman et al., 2011; Young & Shoptaw, 2013). Additionally, since most youth reported some connection to a CBO, the sample may not be representative of the larger population and is likely missing hard-to-reach youth who do not access community services and/or testing venues. Finally, due to our sampling strategy where youth recruited their peers, some of the findings reported may be due to the similarities between peers as they are in the same social networks.

Despite these limitations, few studies have documented reasons for HIV testing among Black and Latino YMSM, a group that is at the highest risk of acquiring HIV. Testing is the first step in the HIV continuum of care and a critical component of sexual wellness for sexually active YMSM particularly those living in high HIV seroprevalence areas. In sum, in order to stem the tide of new HIV infections among these vulnerable youth, it is vital that targeted testing efforts are embedded in comprehensive, multi-pronged programs and occur across the wide age range of early adolescence to emerging adulthood.

Acknowledgments

This study was supported by a grant from the New York State AIDS Institute to the Bronx Community Pride Center. The authors would like to thank the young men who participated in the study, Holly Hagan for conceptual guidance, and Christopher Hilliard for editorial assistance.

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Table 1

Demographics and Risk Behavior Characteristics by HIV Testing Frequency

	Minimum Frequency HIV Testers 53.8% (N = 43)	High Frequency HIV Testers 46.3% (N = 37)	Total (N = 80)
Demographics			
Age (M, SD) (n = 80)	19.3 (2.18)	18.7 (2.1)	19.0 (2.2)
Race/Ethnicity (%) (n = 80)			
African-American	41.5	37.1	39.5
Hispanic	39.0	37.1	38.2
Mixed (African-American/Hispanic)	7.3	14.3	10.5
Other	12.2	11.4	11.8
Sexual Orientation (%) (n = 79)			
Bisexual	35.7	21.6	29.1
Homosexual/Gay	52.4	67.6	60.0
Other	11.9	10.8	11.4
Shelter (%)			
Ever homeless (n = 79)	40.8	34.4	35.4
Ever in foster care (n = 78)	30.2	27.0	28.7
CBO involvement (%)			
Affiliated with CBO (n = 80)	88.4	94.0	91.2
Active client (n = 80)	9.3	8.1	8.8
Psychosocial			
Depression symptoms (7) (%) (n = 76)	43.9	42.9	43.4
Perceived Susceptibility to HIV (M, SD) (n = 78)	4.80 (3.0)	4.11(3.7)	4.48 (3.3)
Sexual Behavior			
Age first sex (any type of sex) with male (M, SD)	13.8 (3.6)	13.3 (3.0)	13.4 (3.0)
Total lifetime male partners (any type of sex) (median, range) (n = 80)	5.0 (1 – 83)	6.0 (1 – 74)	5.0 (1 – 83)
Sexual Concurrency (ever) (%) (n = 75)	46.3	55.9	50.7
Sex Work (ever) (%) (n = 79)	23.2	13.9	18.9
Condom Use (most/all of the time past 3 months) (%)			
Romantic Partner (n = 80)	82.9	86.1	84.4
Casual Partners (n = 80)	81.0	83.9	82.2
HIV Testing Experiences			
Age at first HIV test (M, SD) (n = 78)	15.8 (2.0)	15.0 (3.3)	15.1 (3.3)
Tested Positive for HIV (%) (n = 65)	6.25	3.03	4.61
Lifetime number of tests* (M, SD) (n = 78)	5.19 (4.72)	8.43 (6.26)	6.64 (5.67)
Substance Use – any use in the past 6 months (%)			
Alcohol (n = 56)	93.3	96.2	94.6
Marijuana* (n = 44)	100.0	84.2	93.2

* p < .05.

Table 2

Reasons for HIV Testing by HIV Testing Frequency

	Minimum Frequency HIV Testers % (N = 43)	High Frequency HIV Testers % (N = 37)	Total % (N = 80)
Individual Influences			
Want to be reassured not HIV positive (n = 79)	73.8	83.8	78.5
Feel anxious or worried about being HIV positive (n = 80)	48.8	64.9	56.3
Feel at risk due to own behavior* (n = 80)	37.2	62.1	48.8
Diagnosed with an STD (n = 79)	31.0	37.8	34.2
Wanted to stop using condoms (n = 80)	25.6	40.5	32.5
Want to have children† (n = 80)	16.3	35.1	25.0
Partner Level Influences			
Have a new sexual partner (n = 80)	46.5	54.1	50.0
My partner's sexual behavior	42.9	54.1	48.1
Suspect my partner is HIV positive† (n = 79)	35.7	56.8	45.6
A new partner asked† (n = 80)	20.9	37.8	28.8
Risk from my partner's HIV status (n = 79)	19.0	32.4	25.3
Risk from my partner's drug use (n = 79)	19.0	21.6	20.3
Might have exposed partner to HIV (n = 79)	11.9	24.3	17.7
Social Influences			
Friends or family members were getting tested* (n = 80)	34.9	62.2	47.5
Friends or family were HIV positive (n = 80)	11.6	24.3	17.5
Structural Influences			
A counselor or other professional suggested (n = 80)	48.8	56.8	53.8
Offered as part of my regular medical care† (n = 79)	58.1	38.9	49.4
Research study (n = 80)	20.9	27.0	23.8
Received a stipend (n = 80)	20.9	27.0	21.3
In foster care (n = 80)	9.3	18.9	13.8

* p < .05.

† p < .10