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HIV

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PARENTAL MONITORING AS A MODERATOR OF THE EFFECT OF PARENT-ADOLESCENT SEXUAL COMMUNICATION ON UNPROTECTED ANAL INTERCOURSE AMONG YOUNG MEN WHO HAVE SEX WITH MEN

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Purpose: Among heterosexual adolescents, sexual risk behavior is moderated by caregiver parenting styles and practices including permissiveness, monitoring, and parent-adolescent communication regarding adolescent sexual behavior. The protective nature of these parenting factors may be especially complex in young men who have sex with men (YMSM) because, unlike their heterosexual counterparts, YMSM may prefer to conceal sexual behavior from their parents for fear of parental rejection or other negative psychosocial health outcomes. Given the concentrated HIV prevalence in this population, it is important to examine how monitoring, permissiveness, and parent-adolescent sexual communication interact and influence sexual risk in YMSM. This study examined the extent to which perceived parental monitoring and perceived parental permissiveness (i.e., parenting style) moderated the relationship between parent-adolescent communication about sex and sexual risk outcomes in YMSM.

Methods: This study was comprised of 233 cases selected from a community-based, longitudinal sample of YMSM (N = 450; aged 16–20) recruited through modified respondent-driven sampling. Participants completed computer-assisted self-interviews assessing male-male sexual risk behavior, their caregivers' parenting style, and parent-adolescent sexual communication. Parental permissiveness and parental monitoring scale items were modified for YMSM and their scale scores were dichotomized based on median values (e.g., high vs. low). Parent-adolescent sexual communication was also dichotomized (e.g., communication vs. no communication), as were sexual risk outcomes (e.g., risk vs. no risk). Bivariate analyses were conducted between the measures of parenting style, and parent-adolescent sexual communication. Significant bivariate outcomes informed subsequent multivariable logistic regression models predicting the likelihood of sexual risk behavior by parenting style, and parent-adolescent sexual communication.

Results: Results indicated that parenting style and parent-adolescent sexual communication influence sexual risk behavior in YMSM. Neither level of parental permissiveness was directly associated with sexual risk behavior; however, high parental permissiveness was associated with a lack of parent-adolescent sexual communication ($p < 0.05$). In contrast, YMSM who reported high parental monitoring also tended to report parent-adolescent sexual communication ($p = 0.09$). A higher proportion of YMSM with low parental monitoring reported unprotected anal sex with casual male partners ($p = 0.07$), although this association did not reach statistical significance. Adjusted for age and race/ethnicity, YMSM with high parental monitoring were less likely to engage in unprotected anal sex with casual male partners (OR = 0.46; 95% CI = 0.22, 0.97); however, this

effect was only observed in those who also reported parent-adolescent sexual communication (OR = 0.36; 95% CI = 0.12, 1.04). Among participants reporting no parent-adolescent sexual communication, high parental monitoring alone was not associated with unprotected anal sex with casual male partners (OR = 1.03; 95% CI = 0.31, 3.44).

Conclusions: Consistent with literature in heterosexual adolescents, for parents to merely have "the talk" about sex is not enough as adolescent sexual behavior is most effectively influenced by parents who both monitor and talk openly to adolescents about their sexual behavior. These findings imply that HIV prevention programming could benefit from YMSM-specific, family-based interventions aimed at improving both parenting skills and practices pertaining to YMSM.

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INTERACTIVE VOICE RESPONSE SYSTEM (IVRS): DATA QUALITY CONSIDERATIONS AND LESSONS LEARNED DURING A MICROBICIDE PLACEBO ADHERENCE TRIAL WITH YOUNG MEN WHO HAVE SEX WITH MEN

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Purpose: Young men who have sex with men (YMSM) account for most new HIV infections in the United States. Forthcoming biomedical prevention approaches (e.g., microbicides) may aid in reducing HIV incidence among YMSM; however, the demonstration of rectal microbicide efficacy and effectiveness is contingent on correct and consistent product use and accurate measurement of adherence. Delays in self-report, in particular, may affect the accuracy of behavioral data. Capitalizing on YMSM's mobile phone use, we examined the acceptability and use of IVRS for measuring adherence to product use with receptive anal intercourse (RAI) in a microbicide safety and acceptability trial with YMSM (ages 18–30) and documented the challenges experienced by trial participants with the system.

Methods: We enrolled 124 YMSM across three sites (Boston, Pittsburgh, San Juan). We provided them with up to 40 applicators pre-filled with 4mL of hydroxyethylcellulose placebo gel for use prior to RAI and counseled them repeatedly that the study focused on product adherence and that the gel would not protect against HIV. We asked YMSM to self-report product use through an IVRS, available in Spanish and English, during a 12-week trial. Twenty-nine participants discontinued due to early termination (N = 13) or loss to follow-up (N = 16). Using IVRS data and end-of-trial interviews, we documented YMSM's IVRS experiences and their implications for data collection.

Results: We observed 1,728 calls to the IVRS over 3 months. After developing an IVRS data quality system, we found that 427 (24.7%) entries required inspection. Of these, we excluded 324 entries due to data entry errors (18.8%). Most participants (n = 71; 75.5%) did not report problems using IVRS. Of those who reported a problem (N = 24), most experienced one (N = 14; 14.9%) or two (N = 7; 7.4%) problems. Problems included phone-specific problems (e.g., dropped calls due to limited cell signal when calling into the system), and/or system-specific issues (e.g., having to answer the same question repeatedly or having incorrect answers registered if IVRS didn't recognize their voice). One participant indicated that he stopped using IVRS because it reminded him that he hadn't had any recent sexual activity. In a

multivariate logistic regression model, YMSM who reported an IVRS problem were more likely to indicate greater educational attainment (OR = 2.08, 95%CI: 1.21, 3.57; $p < .05$) than those who did not. We found no differences in IVRS problems by study site, age, or race/ethnicity.

Conclusions: IVRS in an acceptable and useful data collection technology for microbicide trials with English or Spanish speaking YMSM; yet, careful attention to phone signal reliability, data cleaning, questionnaire design, and participant fatigue are needed. We discuss strategies to optimize future development of IVRS data quality protocols based on lessons learned.

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DEMOGRAPHIC AND BEHAVIORAL RISK FACTORS AMONG ADOLESCENTS TESTING FOR HIV AT COMMUNITY BASED VENUES IN BROOKLYN, NEW YORK

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Purpose: Adolescents make up a disproportionate number of new HIV infections in the U.S. In 2010, adolescents aged 13–24 years made up 25.7% of new HIV infections, despite representing only 21% of the population. HIV/AIDS remains a leading cause of morbidity and mortality in New York City, and the borough of Brooklyn is particularly affected. Health & Education Alternatives for Teens (HEAT) is a clinical care and community outreach program for HIV infected and high-risk adolescents in Brooklyn, New York. We aim to evaluate the demographic and risk profiles of adolescents tested for HIV through HEAT's venue-based testing in Brooklyn in 2011. We compare this profile with adolescents tested in Brooklyn through New York City Department of Health and Mental Hygiene (DOHMH)-funded programs. An in-depth risk profile of youth tested by the HEAT Program in 2011 is described, based on a random sample of risk-assessment intake forms.

Methods: Demographic and exposure data from HEAT Program HIV testing was obtained from an administrative database. Demographic and exposure data for NYC DOHMH-funded HIV testing programs in Brooklyn in 2011 were obtained from the DOHMH. Comparisons of HEAT Program and NYC DOHMH testing data were conducted using t-tests. HIV exposure risks between groups were compared with chi square tests. Statistical significance was set at 0.05. Analysis was conducted using Stata 10.

Results: In 2011, the HEAT Program tested 575 adolescents through the venue-based testing program, with a 0.84% positive test rate. Among adolescents tested at Brooklyn NYC DOHMH-funded sites, 0.34% tested positive. The median age of HEAT testing participants was 18; 71% self-identified as African-American, 18% Hispanic, 4% biracial and 4% as other race/ethnicity. At the neighborhood level, 64% of HEAT testing participants resided in areas where > 20% of families live below the poverty line, and 6 (1%) were homeless. Self-reported risk factors were MSM sex (20%), heterosexual sex (70.1%), WSW sex (6%) and unknown/other (1.5%). The proportion of MSM tested at HEAT Program venues was greater than DOHMH-funded sites ($P < 0.001$). All participants with positive test results from HEAT

HIV testing venues listed MSM sex as their potential exposure; these individuals were linked to medical care. Among the random sample of HEAT Program intake forms reviewed, 82% of participants reported any sexual experience; 73% reported recent sexual activity. Adolescents reported a median of 1 recent partner, and 17.5% reported over 3 recent partners. Among sexually active youth, 40% reported condom use all of the time, 21% most of the time, and 28% sometimes, rarely, or never.

Conclusions: The HEAT venue-based HIV testing program in Brooklyn, New York successfully targeted a population of adolescents at risk for HIV in 2011. Demographic characteristics were similar to those tested at New York City DOHMH-funded sites. However, HEAT included a greater proportion of adolescents reporting MSM sex. In the HEAT subgroup analysis, over 80% reported sexual activity and only 40% reported consistent condom use. All positive tests were among males with MSM exposure; additional strategies may be needed to reach the most high-risk heterosexual adolescents, particularly young women of color.

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HOW ARE YOU FEELING? ASSESSING THE AGREEMENT BETWEEN HIV+ ADOLESCENTS' REPORTS OF QUALITY OF LIFE WITH THEIR FAMILIES'

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Purpose: To examine the effect of an intervention on QOL improvement and agreement between adolescents and family ratings.

Methods: Data were collected from the FAMily CEntered (FACE) Advance Care Planning randomized clinical trial between July 2011 and August 2013. Eligibility criteria were HIV positive, knew diagnosis, and a consenting family member. Participants were recruited from hospital-based outpatient adolescent clinics at three urban sites. Adolescent/family dyads were randomized into either the FACE intervention or the Healthy Living Control (HLC). We analyzed adolescent self-report ($n = 72$) and family ($n = 72$) self-report of perception of child's QOL, using the Peds Quality of Life Inventory™4.0 (PedsQoL) at Baseline and 3-month post intervention. Four domains – Physical, Emotional, Social, and School, as well as Total Score were assessed. Higher scores equal higher QOL.

Results: 144 participants ($n = 72$ adolescent/family dyads) were enrolled. Adolescents' mean age was 18 years; 43% female; 94.4% Black/African American; 70.8% perinatally infected. Family participant's mean age was 44 years (range 20 – 77). Randomization was successful. The intervention did not statistically significantly increase QOL among Control vs. FACE adolescents in a 3-month observation period (Total Score–Control = 82.1 vs. FACE = 77.9; Physical–84.6 vs. 84.1; Emotional–78.0 vs. 69.8; Social–94.3 vs. 86.9; School–69.8 vs. 66.1). However, agreement between adolescents' and family's ratings increased from Baseline to 3-month follow-up in two domains for FACE adolescents: 1. Emotional QOL Congruence increased from 0.21 to 0.61 (ICC Difference = 0.41) for FACE dyads vs. decrease in congruence for HLC dyads from 0.49 to 0.41 [Interclass Correlation Coefficients (ICC) difference -0.09]. 2. Social QOL Congruence increased from 0.41 to 0.62 (ICC Difference = 0.21) for FACE dyads with a comparable increase for