



Original article

Community Engagement and Venue-Based Sampling in Adolescent Male Sexually Transmitted Infection Prevention Research



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ABSTRACT

Objectives: Middle adolescent males are a difficult group to recruit for community sexually transmitted infection (STI) prevention research. We describe a process of community engagement, and venue-based sampling of 14–17-year-old adolescent males, and compare rates of STIs and STI risk behaviors by venue.

Methods: Community engagement consisted of (1) informational meetings with organizations; (2) participation in community meetings and events; (3) hiring community members as study personnel; and (4) an adolescent advisory board recruited from the community. Venues were identified and assessed at different times of the day and days of the week using a structured tool. At selected venues, males ages 14–17 years were invited to participate in a brief survey and provide a urine sample and an optional anal swab for DNA-based STI testing.

Results: Venues were assessed (n = 249), and 31 were selected for recruitment, including parks, apartment complexes, community events, entertainment venues, a community school, and community programs for LGBT (gay, lesbian, bisexual, transgender) and adjudicated youth. We enrolled 667 participants, average age 15.7 years. Participants reported high rates of sexual and STI risk behaviors, but had low rates of STIs. These rates differed by venue, with more structured venues recruiting youth reporting fewer STI risk behaviors and less structured venues within the highest STI prevalence zip code recruiting youth reporting more STI risk behaviors.

Conclusion: Venue-based sampling is a feasible mechanism to target recruitment and enrollment adolescent males with high STI risk behaviors in community settings, with risk profiles varying by setting.

IMPLICATIONS AND CONTRIBUTION

Middle adolescent males in high STI prevalence communities are a hidden population. This study describes an approach to community engagement and venue-based sampling that is a feasible alternative to institution- and household-based sampling, and then provide data on infection and STI risk behaviors by type of venue.

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Because most sexually transmitted infections (STIs) are asymptomatic, STI prevention efforts need to target community, rather than clinical, settings. This is particularly important for adolescent males, who are much less likely to use outpatient services, compared with adolescent females [1,2]. Most of the STI research that attempts to reach community samples of adolescent males recruits through institutions, such as schools [3] or juvenile justice facilities [4], which may under- or overestimate the actual community prevalence of infection and STI risk behaviors.

Public health and researchers struggle with ways to achieve community-based samples adolescent boys for sexual health and STI studies. Traditional methods of recruitment for community-based studies, such as school- or household-based recruitment, carry significant limitations. Adolescents do not answer phones, door-to-door sampling raises concerns about confidentiality, school-based samples miss out of school youth, and sampling places such as juvenile detention capture only the highest risk group. A newer area, online social network-based samples, is generally not reflective of geographic communities, making them less useful for geographic community-based interventions.

Of particular importance to adolescents are concerns regarding breaches of confidentiality, which may lead to recruitment of lower risk adolescents. In research regarding sensitive adolescent behaviors, such as STIs and substance use, parental knowledge of study participation and/or requirements for parental consent made it more difficult to recruit adolescents with the highest risk behaviors (and thus most likely to benefit from the study) [5,6]. The challenges to recruitment of adolescent males is magnified in communities with a high prevalence of STIs because adolescent males in these communities also experience high rates of poverty, low rates of school attendance, and unstable housing [7]. Thus, adolescent males in communities with high rates of STIs, in some respects, behave like a hidden population, not easily accessible through the usual approaches.

Alternate approaches to access difficult to reach populations have been increasingly used to reach hidden populations at highest risk of STIs, such as injection drug users, commercial sex workers, or men who have sex with men [8]. The two most commonly used methods include respondent-driven sampling and venue-based sampling. Respondent-driven sampling has been used to successfully recruit adolescents in a five-city comparative study [9]. Venue-based sampling, used in adult STI and human immunodeficiency virus (HIV) research [8,10], is less commonly applied to adolescent populations. However, venue-based sampling has the advantage of allowing a focus on a single community, which can be translated into a community-based intervention.

Youth-focused studies using venue-based sampling have demonstrated that it can tap into at-risk groups, that gender is important, and that venue-based sampling can provide important information about place and location to inform interventions. A venue-based study with homeless youth demonstrated higher than expected rates of mortality [11]. Venue-based sampling of adolescents in Atlanta demonstrated differential rates of STIs (low rates of HIV and high rates of bacterial STIs), providing important information for targeted interventions in the social settings where sexual behaviors and STI transmission occur [12]. Venue-based sampling for a community-level HIV intervention demonstrated gender differences in venues, and emphasizes the interaction between gender and space in STI risk [13]. However, this intervention was extensive and costly, and it is unclear how

these results would translate into small to midsized cities and lower budgets.

Effective venue-based sampling requires community engagement to facilitate access to community locations and events. A high level of community engagement preceded an STI screening intervention in San Francisco neighborhoods using a combination of venue-based and street intercept sampling to assess the effectiveness of a peer-led community-level screening program [14]. Less is known about the process of community engagement necessary for entry into youth venues.

Our objectives are to (1) describe the process of community engagement and venue-based sampling to reach a large population of 14–17-year-old males in neighborhoods at highest risk of STI in a midsized Midwestern city, and (2) describe differences in risk behavior and infection by venue.

Methods

Step 1: Mapping high-STI risk neighborhoods

Our first step in venue-based sampling was to identify the neighborhoods at highest risk of STIs. The research team used county-level gonorrhea and chlamydia surveillance data regarding infection for adolescent males for the previous 5 years in the 15–19-year age range, and the most recently available census data broken down by 5-year age increments. Five-year data were requested because the actual numbers of infections were low. The smallest geographic unit for the STI surveillance data was a zip code. Because areas where adolescent males live, participate in activities, and congregate are organized around neighborhoods, a more organic and less well-defined geographic area, we then identified the city neighborhoods in or adjacent to these zip codes as targets for community engagement and venue identification. The study was conducted in Indianapolis, IN, during 2011–2012.

Step 2: Community engagement

The research team identified and was granted access to appropriate venues where adolescent males lived, congregated, or participated in activities through a process of community engagement and community investment. Consistent with our group's previous experience with community-based research, leaders and youth workers in the target communities demonstrated a high level of protectiveness for both their organizations and the youth they served. The goals of the community engagement process were to educate community members about the study, build trust between the community and university-based research team, collaborate with communities to maximize the benefit to study participants and the community, and obtain input on research procedures to be sensitive to community concerns. Our community engagement activities consisted of (1) informational meetings with community organizations; (2) participation in community meetings and events; and (3) recruitment of a diverse adolescent advisory board and hiring study staff from these community organizations and venues.

The community engagement was rolled out in three phases (Figure 1), starting 6 months before entry into the field, and continuing until data collection was complete. First, we introduced ourselves in the community by attending community meetings

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