UCSF Center for AIDS Prevention Studies
AIDS Research Institute

what is the role of rapid testing for US-Mexico border and migrant populations?

why test for HIV?

Until recently, HIV rates in Mexico and among Mexican migrants in California appeared to be stable and relatively low; however, recent studies show that HIV may be expanding more aggressively in some populations, especially in border communities.[1] One study of 374 young Latino men who have sex with men (MSM) in the San Diego/Tijuana region found high rates of HIV: 19% in Tijuana and 35% in San Diego.[2] Another study of 1,068 pregnant women in labor in Tijuana found a 1.12% HIV rate.[3] Yet a study of 1,041 Mexican migrants at border crossing locations in Tijuana found a 0% HIV rate.[4]

Getting tested for HIV is key to preventing the spread of HIV. Persons who test HIV+ can access counseling, prevention education, support services and medical care to stay healthy and not progress to AIDS. HIV- persons can access counseling and education to remain HIV-. It is estimated that 31% of all HIV+ persons in the US do not know they're infected.[5]

Border and migrant populations may be at great risk for HIV yet they are less likely to be tested for HIV or return for test results. Many do not have access to (or fear accessing) traditional healthcare systems, lack transportation and frequently change address.[6]

why rapid testing?

Even when people are able to test for HIV, many never return for their results. In public test sites, up to 33% of persons who test HIV- and 25% of persons who test HIV+ never return for their results.[7] This may be especially true for border and migrant populations because they may not have stable housing or legal status in the US.

The rapid HIV test is a new approach to HIV testing that helps address many of these issues. Conventional HIV testing has been done with needle blood draws or mouth swabs which are sent to a laboratory for analysis. Clients need to return to the test site 1-2 weeks later to find out their results. With rapid tests, clients can take the test, receive counseling, and find out their results all in one visit. This can help increase the number of persons who take an HIV test and reduce the number of persons who don't return for their results.[8]

Rapid testing can be done in most clinics and in non-traditional healthcare and outreach settings such as mobile vans, bars, parks and health fairs. One study of seasonal farmworkers found that men and women were more likely to accept a free HIV test if it used a finger stick and they could get results in 30 minutes.[9]

Many government and non-governmental agencies are moving towards rapid testing instead of conventional testing. The Centers for Disease Control and Prevention's (CDC) Strategic Plan for 2005 seeks to increase the number of people who know their HIV status to 95%—using rapid testing is an integral part of the plan.[5] In California, the goal is to have 80% of all state-funded HIV test sites use rapid tests by the end of 2006.[10]

how is it done?

Rapid testing uses a finger stick, blood draw or mouth swab to collect samples. The test counselor places the sample in a tube with chemicals to process it, and can read the results in 20 minutes or less. Counseling and risk reduction planning with the client can take place during the waiting time, or can be done before or after sample collection.

There are four FDA-approved rapid HIV tests in the US: Reveal, OraQuick, Multispot and Uni-Gold.[11] All tests are extremely accurate, with 99.6-100% sensitivity rates.[12] OraQuick Advance uses a mouth swab and can be used in a wider range of settings and temperatures.

Rapid testing can change the way HIV testing is done. Most HIV test sites currently have counselors and separate phelobotomists who take the blood or oral sample. With rapid testing, the test counselor can also take the sample and analyze it, becoming counselor, technician and laboratory all in one. In some sites, test counselors do the consent and counseling and a separate staff person still collects the sample and reads the results.

Within 20 minutes, the OraQuick Rapid test will either be non-reactive—a negative test result—or reactive—a preliminary positive result. Currently, if a result shows preliminary positive, a second conventional blood or oral sample is required to confirm it. Final confirmation still takes 1-2 weeks. National data indicate that with rapid testing, 95% of clients who received a preliminary positive result returned for their confirmatory results.[13]

Says who?

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is rapid testing rapid counseling?

No. One study found no difference in STD rates after counseling with rapid tests and conventional tests.[14] Rapid testing still allows for plenty of counseling time. A counselor has about 20 minutes between taking a sample and receiving the results to provide focused and specific counseling about the client's risks and possible exposure to HIV. Counseling can be more intense due to the immediacy of hearing results.[15]

Clients who receive a preliminary positive result and must return for their confirmation result may be more prepared to deal with their diagnosis. Clients often have had a week to think about what testing positive means and may be more emotionally prepared to listen to and digest referrals and options the counselors can provide.

Test counselors need in-depth knowledge of referral resources for client's that may emerge in new, more focused HIV counseling sessions. Referrals should be specifically tailored to the needs of border and migrant populations, including basic needs such as healthcare, housing, legal assistance and jobs. Materials should be available in Spanish and counselors should have culturally-relevant knowledge and training in migrant and immigrant issues. Because many persons travel back and forth between the US and Mexico, referrals may need to focus on resources in both countries.

Counselors typically may have concerns about the new testing procedures and counseling initially, but after they've been trained and have provided a number of counseling sessions, they become more comfortable and often say they wished they had become involved in HIV rapid testing sooner.[16]

what's being done?

Rapid testing is relatively new in most border settings. A 2003 survey of 85 border health centers (community and migrant health centers, tribal organizations and programs for homeless people, among others) found that 64 (75%) offered HIV testing. Of these, 45 also provided HIV medication and counseling services. None of the sites in any state offered rapid HIV testing.[17]

Currently, San Diego County offers rapid testing, prevention education and linkage to medical care along the Mexico/California border in various settings such as churches, homeless shelters, parks and beaches. Staff members underwent additional training on rapid testing and single-session HIV counseling. Since offering rapid testing at all anonymous test sites, client return rates have increased from 72% to 93%.[18]

La Fe CARE Center in El Paso, TX, offers rapid testing at their clinic and through a mobile van that visits gay bars, nightclubs and adult bookstores downtown. The mobile van has two counselors and uses the OraQuick Advanced mouth swab HIV test. The clinic uses the OraQuick finger stick HIV test. Clients prefer getting results quickly and not having a blood draw. Since offering rapid testing, the number of clients testing at La Fe has increased from 500 in 2002 to over 2,000 currently.[19]

what is the future of rapid testing?

The future is now. Outside of the US, rapid testing is widely used and confirmatory tests are also done with the rapid test, eliminating any waiting period for persons who test HIV+. Manufacturers have been slow to seek approval for tests in the US because the FDA has strict policies about licensing new HIV tests.

Rapid testing has been met with great enthusiasm in some areas and great trepidation in others.[20] As federal and state governments increase requirements for rapid testing, resources for training, technical assistance and funding need to increase for the agencies that implement rapid testing. State and federal reimbursement protocols, as well as public and private insurance, need to be changed to encourage rapid testing.

It is not enough simply to offer HIV testing to Mexican and other immigrants. Rapid testing may facilitate better epidemiological monitoring of HIV in border and migrant populations, giving a more accurate picture of the magnitude of HIV infection. Persons who test positive will need quality HIV care and treatment, and persons at risk for HIV will need culturally specific education and prevention programs. Because many persons travel back and forth between the US and Mexico, continued bi-national cooperation is key in addressing these issues to improve public health in both countries.

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