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Incentivized HIV Testing--Is It Needed and Effective? Developing an Evaluation Tool

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**INCENTIVIZED HIV TESTING—IS IT
NEEDED AND EFFECTIVE? DEVELOPING
AN EVALUATION TOOL**

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PIM 69

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requirements of a Master of Arts in Intercultural Service,
Leadership and Management

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Definitions

AIDS Diagnosis—People are diagnosed with AIDS when they have certain signs or symptoms defined by the U.S. Centers for Disease Control and Prevention (CDC)

Antiretroviral Therapy—The use of at least three antiretroviral (ARV) drugs to maximally suppress HIV and stop the progression of HIV disease

AZT—The first drug to be approved by the U. S. Food and Drug Administration (1987) for the purpose of prolonging the lives of AIDS patients

Bathhouse—A commercial bathhouse for men to go to have sex with other men

Group-Level Intervention—HIV prevention intervention education targeted at groups

HIV Test—Commonly known as testing for antibodies for HIV

Incidence—Measure of the risk of acquiring HIV within a specified period of time

Individual-Level Intervention—HIV prevention intervention education targeted at individuals

Morbidity—Illness or disease

Mortality—Death

Prevalence—Total number of cases in the population, divided by the number of individuals in the population

Rapid HIV Test—Antibody test that gives results in 20 minutes

RNA HIV Test—A blood test to determine the presence of the virus known as HIV

Sero-Discordant—One person has HIV and the other does not

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ABSTRACT

The following is a case study of agencies in Seattle, WA who provide HIV testing followed by an evaluation tool for the agencies to determine the role of incentivizing HIV testing. Some agencies I interviewed provide incentives for the testing and others do not.

This Capstone will focus on six agencies currently providing HIV testing and provides a tool for agencies to use to attempt to answer the following question: In the face of reduced funding for HIV prevention and a mandate to continue to push for increasingly getting more Men who have Sex with Men (MSM) tested for HIV, what role does providing an incentive play?

Through key informant interviews with implementing agency staff it was discovered that none of the agencies are evaluating the effectiveness of providing an incentive for HIV testing. However all of them felt if funding were to be reduced the first thing to be cut would be the HIV testing incentive.

None of the agencies interviewed were interested in implementing a monitoring and evaluation plan, inclusive of log-frames and budget. They all agreed that they did not have the time, budget or expertise to monitor a plan. They were also clear that they would not be interested if this plan was not going to be required by Public Health Seattle-King County, who funds most of the programs.

Through discussions with the agencies that were interviewed and contract monitoring staff with Public Health, they all felt that if they had a simple tool to measure the effectiveness of incentivized HIV testing it would be valuable in their program planning.

With feedback from implementing agencies, the author has developed a short, client administered survey in both English and Spanish, that will assist Community Based Organizations (CBOs) in determining the effectiveness of a client receiving an incentive, free testing or donation request for HIV testing.

Knowing that most of the CBOs do not have extra funding, staff or expertise to implement a large-scale evaluation, the tool that has been developed does not require extra staff time, expertise or funding.

This analysis links the author's professional, graduate school course-work and practicum experience. Recommendations include utilizing the evaluation tool to determine the effectiveness of incentivized HIV testing.

Question: In the face of reduced HIV prevention funding and pressure to continue to test MSM, especially Latino and Black MSM, does providing an incentive for testing increase the likelihood that MSM will get tested for HIV?

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Introduction

I began my professional career in Spokane, WA working in HIV prevention in public health in 1990. Until 2005, I worked at different public health departments and one CBO throughout Washington and Oregon, where I was responsible for a variety of HIV prevention activities. At various times I was responsible for jail education, HIV counseling and testing, street outreach, created a gay/lesbian/transgender/bisexual youth group and center, managed syringe exchange programs and peer-led HIV testing program, CDC trainer for HIV counseling and testing of all new counselors in Washington state, managed a peer-based HIV prevention project with Gay and Bisexual men who are also using crystal methamphetamines and finally working at Public Health Seattle-King County on HIV, Hepatitis B and C research projects.

My passion for learning and experiencing different cultures had always driven me to want to work internationally. After much thought and realizing how difficult it was to secure international employment without any experience, I left my domestic public health career and joined the Peace Corps at the age of 40.

I was initially placed in Zambia in a village where I served as a community development worker for the HIV/AIDS program. After six months I was transferred to a small town in the same province and assigned to a small local non-governmental organization (NGO) where I assisted in streamlining their mobile volunteer HIV counseling and testing program. Six months later I was again transferred to Lusaka, the capital, and assigned as the HIV/AIDS (PEPFAR) monitoring and evaluation officer for United Nations High Commissioner for Refugees (UNHCR). I spent about 50% of my time in one of four refugee camps in Zambia. In addition to working with our

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implementing partners with monitoring and evaluation tools, I served primarily as a technical advisor.

I was with UNHCR as a Peace Corps Volunteer for one year, and then stayed as a staff member for an additional year. My entire Zambia experience pushed me even further to continue with international employment. Once my Zambia contract was finished with UNHCR, I again took a 1-month consultancy contract with them, however this time I was based in the refugee camp in Namibia where I assisted with an HIV/AIDS Behavioral Surveillance Survey.

After returning to the States and working on a few short-term consultancies and finishing my coursework for graduate school, I returned to Seattle to work on a CDC funded National HIV Behavioral Surveillance Survey with the epidemiological division with Public Health of Seattle-King County.

My years of working in this field have been both rewarding and frustrating. When I first entered this field, people were dying quickly from AIDS. There were no ‘cocktails’ or anti-retroviral medicines. Some were taking AZT, but this also proved to be very toxic, short-term and came with its own host of difficulties. There is medicine now and those infected can expect to live a fairly normal, long-term life span if they have access to treatment. However people are still getting infected. In the wake of a cure for HIV, if people can get tested and if found to be HIV positive and get HIV anti-retroviral treatment, the outlook is not as dismal.

During my coursework at SIT I had the opportunity to research Conditional Cash Transfer (CCT) Programs. Ever since then providing people and/or communities a cash incentive in exchange for behavior change has fascinated me. Conditional Cash Transfer

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programs aim to reduce poverty by making welfare programs conditional upon the receivers' actions. The main requirement of CCT programs is that recipients commit to undertaking certain behavioral changes in return for the transfers, such as enrolling children in school and maintaining adequate attendance levels, getting prenatal and postnatal health care treatments and encouraging young children to undergo growth monitoring, immunization and periodic checkups.

A presumption embedded in the CCT approach is that the supply of social services for education and health is in place and that stimulating demand through income transfers is necessary to induce major changes in human capital investment. This explains why the success of CCT programs in some countries is no guarantee that they can be reproduced in others with the same performance. For instance, in many developing countries, children, particularly in rural areas, face supply-related problems, i.e., there are not enough schools, classrooms or teachers to offer adequate education to those who need or want them. In such circumstances, pouring resources into a CCT program may not be able to achieve the educational objective (Son, 2008).

Researchers have embarked upon an experiment that, if not for the tragic circumstances of the African AIDS epidemic, might be familiar to many parents: paying kids to follow the rules. South African schoolchildren 13 years and older in the study could earn up to \$400 if they manage to stay HIV-free for 24 months. In South Africa, which has the most HIV/AIDS-infected people of any country in the world, more than 17 percent of the population has HIV, with girls at especially high risk. The experiment began September 2010, when the Centre for the AIDS Program of Research in South

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Africa (CAPRISA) started a research project in 14 schools in KwaZulu-Natal, with students at seven schools who were offered payments and the others serving as controls.

The study, which will run until the end of 2012, is unusual in that it engages both females and males. Since women have the highest rates of HIV—of HIV-infected people aged 15–24, 76% are women—many attempts to bring down infection have focused on them, but since they rarely hold the power in sexual relationships, changes in men’s behaviors are needed as well (Shetty, 2011).

As I was exploring my options for a capstone idea I became aware of agencies in Seattle who have incentivized HIV prevention programs. I decided to research this more closely to see why agencies had decided on this route and how they were measuring the success of these incentives in their HIV prevention programs.

Methodology

This Development Management I Course Linked Capstone will focus on the six agencies in Seattle who are currently providing HIV testing. These include Entre Hermanos, Center for Multicultural Health, Lifelong AIDS Alliance, Gay City Health Project, STD Clinic at Harborview Medical Center and Project HANDLE.

My main source of inquiry for this capstone was through secondary document analysis and informal and formal interviews. I conducted formal interviews with staff members from each agency. This included: Paul McGee and Garland D. Jarmon, Comprehensive Risk Counseling & Services Coordinators with Lifelong AIDS Alliance; Austin Anderson, Project Coordinator and Vanessa Grandberry, Health Educator with Center for Multicultural Health; Marcos Martinez, Executive Director and Rafael

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Velazquez, Peer Educator with Entre Hermanos; Warya Pothan, Project Director with Project HANDLE; Mark Fleming, Public Health Advisor with Harborview Medical Center STD Clinic and Fred Swanson, Executive Director and Jeff Rinderle, Wellness Director with Gay City Health Project.

For each of my interviews I included a statement of confidentiality. Since I am currently employed by Public Health Seattle-King County and many of the agencies I interviewed receive funding from Public Health, I included a statement of confidentiality before conducting the interviews.

I am a master's degree student at the School for International Training (SIT)-Graduate Institute in Vermont and am writing a paper about incentivized HIV prevention programs in Seattle. I believe your experience in this area can provide valuable information for understanding historical, current and future HIV prevention programs. I would like to interview you at a time that is convenient.

Currently, I am also a staff member of Public Health with Seattle-King County, however, I am not representing Public Health in any capacity while interviewing you or in any other part of my research. My work with Public Health is completely independent of my research paper.

If you agree, I will observe the following guidelines. If you prefer that I not use your name in my paper, I will only note your organization and role when listing persons interviewed. You may decline to answer any of my questions and you can indicate if you would like any answers to either be confidential or be reported in a manner that the information cannot be traced directly to you.

In addition to implementing agencies, I also conducted informal interviews with Seattle-King County Public Health staff members. This includes Linda Coomas, Contract and Program Monitor; Jim Jorgenson, HIV Prevention Manager and Hanne

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Thiede, Epidemiologist and Principle Investigator for the Seattle area National HIV Behavioral Surveillance Survey.

Through my interviews I found that four agencies were conducting different types of incentivized HIV prevention. These interventions consisted of group-level interventions, individual-level interventions and incentivizing HIV testing. When conducting my interviews I found that most all did not have an in depth formal evaluation of their prevention programs. They could all report the progress of their target numbers that were required of them based on their funder, which in the case of all but one agency, the funder was Public Health Seattle-King County.

What I found is that most agencies are not evaluating the incentivized component of their programs. After consulting with the different agencies it was agreed that if they had a way of evaluating the HIV incentives component of their programs this could help determine future budget decisions.

Literature Review

Current available literature has not addressed clients' attitude towards incentivized testing. The available research examined the efficacy of incentives in encouraging particular behaviors, such as following up on outpatient HIV testing referrals and encouraging adherence with HIV treatment regimens. In one study conducted by Haukoos, Witt, Coil, Lewis, (2005), 372 participants were provided outpatient HIV counseling and testing referrals. These participants were identified for testing based upon the Voluntary Counseling & Testing (VCT) testing guidelines of the CDC. Testing referrals were done in three segments. In the first and third segment, no incentives were

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offered. In the second period, a \$25 incentive was offered for completion of the outpatient testing and counseling referral. During the two control periods, only a total of 8% of participants completed the testing referral while 23% of participants offered incentives completed counseling and testing.

After controlling for the incentive, African American patients were less likely to complete testing. It is unclear whether the use of a financial incentive increases the proportion of patients identified as HIV infected or if it is cost-effective.

Background: Demographics and Funding

The following section will focus on national and Washington State demographics and statistics in addition to the current funding stream for CBOs implementing HIV prevention activities in Washington State. Special attention will be given to the Black and Latino population and Men who have Sex with Men (MSM) who are disproportionately represented in both incidence and prevalence rates of HIV.

National statistics

The first cases of what would later become known as AIDS were reported in the United States in June of 1981 (CDC. MMWR, Vol. 30, 1981). Since then, 1.7 million people in the U.S. are estimated to have been infected with HIV, including over 600,000 who have already died and more than 1.1 million estimated to be living with the disease today. (CDC. MMWR, Vol. 60, No. 21; 2011). The response to the U.S. epidemic has yielded numerous successes, but challenges remain.

While the number of new HIV infections (incidence) is down from its peak in the

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1980s, estimates indicate that there have been approximately 50,000 new HIV infections annually in recent years. (Prejean, Song, Hernandez, Ziebell & Green, 2011) (CDC. Fact Sheet, August 2011).

HIV testing is important for both prevention and treatment efforts and rapid testing is now much more widely available. Routine HIV testing is now recommended for all people ages 13–64, yet 20% of those infected with HIV do not know it and many people with HIV (33%) are diagnosed late in their illness (CDC. MMWR, Vol. 60, No. 21; 2011).

Treatment advances have substantially reduced AIDS-related morbidity and mortality and extended the lives of many. Still, not all who need treatment have access to it and treatment is not a cure (Gardner, McLees, Striner, del Rio & Burman, 2011).

The epidemic continues to have a disproportionate impact on certain populations, particularly racial and ethnic minorities and gay and bisexual men.

Snapshot of the U.S. Epidemic

- Number of new HIV infections, 2009: **48,100**
 - Number of people living with HIV/AIDS: **1.1 million**
 - Number of AIDS deaths since beginning of epidemic: **617,025**, including more than **16,000** in 2008
 - Percent of people infected with HIV who don't know it: **20%**
- (CDC. MMWR, Vol. 60, No. 21; 2011) (Prejean et al., 2011) (CDC. Fact Sheet, August 2011)

Impact on Racial and Ethnic Minorities

Racial and ethnic minorities have been disproportionately affected by HIV/AIDS since the beginning of the epidemic and represent the majority of new AIDS diagnoses,

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new HIV infections, people living with HIV/AIDS and AIDS deaths (CDC. MMWR, Vol. 60, No. 21; 2011) (Prejean et al., 2011).

Blacks and Latinos account for a disproportionate share of HIV infections, relative to their size in the U.S. population (Prejean et al., 2011) (CDC. Fact Sheet, August 2011) (U.S. Census Bureau. Population Estimates, 2009). Based on the CDC's estimate of HIV/AIDS prevalence, there are approximately 545,000 Blacks living with HIV/AIDS in the U.S. Analysis of national household survey data found that 2% of Blacks in the U.S. were HIV positive, higher than any other group (CDC. MMWR, Vol. 60, No. 21; 2011) (McQuillan & Kruszon-Moran, 2011).

Blacks also have the highest rate of new HIV infections and new AIDS diagnoses of any racial/ethnic group. The AIDS diagnosis rate per 100,000 for Blacks in 2009 was more than 9 times that of whites. The rate of new HIV infections was nearly 8 times greater among Blacks than among whites in 2009 (Prejean et al., 2011).

Blacks accounted for 57% of deaths due to HIV in 2007; Latinos accounted for 13% (Xu, Kochanek, Murphy & Tejada-Vera, 2010). Survival after an AIDS diagnosis is lower for Blacks than for most other racial/ethnic groups and Blacks have had the highest age-adjusted death rate due to HIV disease throughout most of the epidemic (CDC. Slide Set, 2007).

HIV was the 4th leading cause of death for Black men and 3rd for Black women, ages 25–44, in 2007, ranking higher than their respective counterparts in any other racial/ethnic group (CDC. Slide Set, 2007).

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Impact on Gay and Bisexual Men

While estimates show that Men who have Sex with Men (MSM) comprise only about 2% of the U.S. population, this group accounts for most new HIV infections (61% in 2009) (Prejean et al., 2011) (CDC. Fact Sheet, August 2011).

White gay and bisexual men accounted for the largest number of new infections (11,400) in 2009, followed by Black gay and bisexual men (10,800) (Prejean et al., 2011).

Younger gay and bisexual men (ages 13–29) are at particular risk. In 2009, this group accounted for 27% of all new HIV infections and 44% of infections among all gay and bisexual men, it was even higher among Blacks (60%) (Prejean et al., 2011) (CDC. Fact Sheet, August 2011).

Gay and bisexual men between 13 and 29 are the only group for whom new HIV infections increased between 2006 and 2009. The increase was largely driven by a significant rise in new infections among young, Black gay and bisexual men—a group that experienced a 48% increase between 2006 and 2009 (Prejean et al., 2011).

Studies have also found high HIV incidence and prevalence among gay and bisexual men in some cities, particularly Black and Latino men, many of whom did not know they were infected (CDC. Slide Set, 2009).

Seattle, WA Statistics

According to the U.S. Census, American Community Survey, 1-year estimates for 2009, King County, which includes Seattle, WA has an estimated population of 1,916,441 (U.S. Census. 2009). Located on Puget Sound in western Washington, King

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County is home to 29% of Washington's population and ranks as the 12th most populous county in the country. It spans an area of 2,126 square miles (Thiede, 2011).

Whites are by far the largest racial/ethnic group in King County, comprising an estimated 73.6% of the population. Asians constitute the second largest group at 12.2% of the King County population. The Hispanic population estimate in King County is 8.1% and Blacks account for an estimated 5.2% of the population (U.S. Census, 2009).

When addressing the race/ethnicity demographics rates of those diagnosed with HIV infection the majority of cases were among Whites (56.7%). However for Blacks (20.2%) and Hispanics (14.8%) were reported at levels substantially higher than their representation in the King County population as a whole. Asians were disproportionately under-represented among reported HIV/AIDS cases relative to their numbers in the King County population (CDC, HIV/AIDS Reporting System, 2010).

During the time frame of 2005-2009, incidence rates for HIV of Men who have Sex with other Men (MSM), the majority of cases were White (69.2%), followed by Hispanic (13.5%) and Black (9.2%). The proportion of White cases was slightly lower than their proportion in the county as a whole. Blacks were overrepresented among HIV incidence rates and Hispanic even more disproportionately overrepresented. Among the 118 Hispanic cases, 73 (61.9%) were born outside the U.S. An unknown proportion of these could represent imported rather than locally acquired infection. Among non-Hispanics, 7.8% were foreign born (Thiede, 2011).

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Funding

In King County, HIV prevention services are delivered by Public Health Seattle-King County (PHSKC) and by Community Based Organizations (CBOs). PHSKC provides written and web-based HIV education and prevention materials and distributes free and subsidized condoms to agencies that serve high-risk populations and to venues where high-risk populations congregate. PHSKC provides HIV counseling and testing at the bathhouses in Seattle, the needle exchange and district clinics, in addition to partner counseling and referral services at the STD clinic at Harborview Medical Center. PHSKC also operates a needle exchange program. In 2011, PHSKC contracted with community based organizations for HIV prevention services for a total of \$1,557,724.

The funding is from federal, state and local sources and is in line with the National HIV/AIDS Strategy for the United States. In July 2010, the U.S. Government released the National HIV/AIDS Strategy, the first comprehensive plan for addressing the epidemic in the U.S. The strategy has three primary goals: reduce new HIV infections; increase access to care and improve health outcomes; and reduce HIV-related health disparities (The White House, 2010).

The Center for Disease Control and Prevention (CDC) awards funding to the Washington State Department of Health (DOH). Through epidemiological incidence and prevalence rates data, an assessment is made by the State Planning Group on the level of HIV/AIDS impact throughout the state; High, Moderate or Low. King County is the only High impact area in Washington State.

King County receives funding from the DOH who then sub-contracts to community-based organizations who directly implement HIV prevention programs.

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Agency's Background

I interviewed six agencies that currently provide HIV prevention and testing. I was unable to interview two agencies.

The first agency I was unable to interview was Consejo, who provides *Vida Nueva: Comprehensive Risk Counseling and Services*. This program is an individual-level intervention that provides intensive HIV prevention counseling and case management services to HIV positive and some HIV negative Latino MSM.

The second agency I was unable to interview was People of Color Against AIDS Network (POCAAN), who provide services, including HIV prevention, for persons transitioning from correctional facilities to the community.

Each of the agencies I interviewed is unique in their target population they are trying to reach and methods they are using. Even though some were using the same CDC recommended HIV prevention tools, they were all adjusted specifically for the target population.

Center for Multicultural Health (CMCH)

The interview was conducted with Austin Anderson, Project Coordinator and Vanessa Grandberry, Health Educator (A. Anderson and V. Grandberry, personal communication, November 2, 2011).

Since 1976, the Center for Multicultural Health (CMCH) has worked in partnership with individuals, groups and organizations in the community to promote health and well being in diverse communities. Their mission is to promote the health and well being of diverse communities—specifically individuals from communities of color,

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individuals with limited English proficiency, immigrants and refugees—through innovative health advocacy, health promotion, disease prevention and immigrant and refugee service programs.

CMCH's approach is firmly grounded in the principle that effective responses to health issues must be generated in partnership with the community and meet evolving community needs. Therefore, they hire staff that reflect and understand the communities with which they work and who work through and within community networks to ensure support for their programs and services.

Initially there were a group of low-income clinics and CMCH had a representative in each of these clinics to promote health promotion with communities of color. In addition they had a specific outreach program to immigrant communities to assist and serve as a go-between between for individuals and clinics.

In 1995 the low-income clinics consolidated and CMCH centralized their programs, however, continued to provide outreach and services to the Southeast Asian community. They provide health promotion and case management services to immigrants from Africa, Eastern Europe and Southeast Asia.

In 1993, CMCH received a grant from the U.S. Department of Health and Human Services, Office of Refugee Resettlement through the Washington State Department of Social and Health Services, Office of Refugee and Immigrant Assistance to implement a model program that was designed to assist refugee families in overcoming barriers to self-sufficiency that are caused by difficulties in accessing and appropriately utilizing the health and human service systems. Today, the Refugee Health Advocacy Project's (RHAP's) Case Managers (CMs) continue to work with clients to complete assessments

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and service plans and provides intensive case management to address the full spectrum of needs (e.g. child care, education, employment/job training, food, health, housing, legal, transportation). RHAP has three CMs who work with Amharic-, Cambodian-, Russian- and Tigrigna-speaking clients and a Refugee Advocate who provides in-home citizenship and English language training to clients throughout King County.

In the spring of 2008, CMCH received funding from Public Health Seattle-King County for two 9-month pilot programs; Brothers Link and African American Testing Project (AATP).

Brothers Link is a program that reaches Black Men who have Sex with Men (MSM) who may or may not identify as gay or bisexual with an adaption of a Center for Disease Control (CDC) approved group-level intervention called Many Men Many Voices (3MV). Through a series of bi-monthly educational events and quarterly forums, participants address factors that influence the behavior of Black MSM, such as values, perceived risk, cultural and social norms and sexual relationship dynamics. Emphasis is placed on the importance of regular HIV testing and Sexually Transmitted Disease (STD) screening, as well as linkage to treatment for those diagnosed with HIV/STD. This intervention also includes outreach via social media and distribution of targeted educational recruitment materials.

Two-Session Educational Events are an intensive, multi-session, group-level intervention that uses behavioral skills practice, group exercises, facilitated discussions, role playing and lectures to address factors that influence the behavior of Black MSM, such as values, perceived risk, cultural and social norms and sexual relationship dynamics. At the end of the 2-3 hour session, HIV testing is offered.

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The Quarterly Educational Forums, known locally as the Brunch Community Forum, further expand on the topics and discussions from the two-session Educational Events. These Brunches address topics relevant to Black MSM and connect then to HIV risk behaviors such as dual identity of Black MSM, the relationship between the Black church and HIV risk and sero-discordant relationships in the Black community. The Brunches include a panel presentation and community discussion. At the end of the Brunches HIV testing is offered.

The African American Testing Project provides community based HIV testing for African American men, with a particular focus on African American MSM. HIV testing for African American men is offered in conjunction with other health screening testing to promote a wellness approach to testing in order to reduce the stigma associated with HIV testing in this population.

CMCH conducts a brief health assessment to collect client information on a variety of health indicators, including history of high blood pressure, high cholesterol and diabetes and HIV testing. The screening, when appropriate, may include a blood pressure check, cholesterol test, glucose test and a recommendation for HIV testing. If the participant gets an HIV test they are paid a \$20 cash incentive. MSM engaging in high-risk behaviors are encouraged to come back every 3-6 months for follow up HIV testing and receive a paid incentive. If a client tests positive to an HIV test he will receive an additional \$20 incentive for going to Seattle's local STD clinic. Harborview STD Medical Center provides a One-on-One program that assists newly diagnosed people with health services and care.

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Participant information that is tracked include; gender, if they identify as Hispanic, race, age, previous test, how they heard of the program, do they have sex with men/women/both, risk history, health insurance, where they slept last night (measuring homelessness), if they have traded sex for money/drugs/other reason, history of STDs, history of Injection Drug Use (IDU) and if they have been diagnosed with hepatitis A/B/C.

The agency's goal is to create a "health home" for communities of color and immigrants. CMCH has a holistic approach and they are concerned about the whole health of the individual. They often will refer out of agency and assist their clients with services they do not provide.

The AATP's process objectives (for funding purposes) are to screen 400 African American men per year for wellness testing and provide them with an HIV test. This is an objective that they have easily met annually.

Austin Anderson and Vanessa Grandberry stated other observations are used to distinguish if the programs are being successful. Grandberry stated that Black gay/bisexual men, especially those over 25 years of age, do not feel comfortable in traditional gay agencies where by just crossing the threshold they feel like they are "putting their business out in the street." They both said that CMCH's programs are helping Black MSM to be more proactive in their health by first being an agency that is not gay identified and therefore allowing Black MSM to feel safe coming in since CMCH is an agency serving mostly the Black community.

Anderson said,

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“For the most part, Black men over 25 years are not comfortable identifying as gay or bisexual. These men are not necessarily on the ‘down-low’—men who have sex with other men but are hiding this lifestyle and living a traditionally heterosexual lifestyle—But are men who do have gay relationships and are out with their lifestyle with other Black MSM.”

Both Anderson and Grandberry agreed that they feel like the programs are successful because they are able to identify new HIV positive men who most likely would not have gone for an HIV test otherwise. In addition, the men continue to come back and refer others to both the testing and Brother’s Link program.

The Brother’s Link program’s process objectives as stipulated by the funder, Public Health of Seattle-King County are to;

- Conduct nine, two-session Educational Events (2-3 hours each), addressing 3MV curriculum, reaching 12 participants at each 2-session Educational Event.
- Conduct six quarterly Educational Forums to promote sexual safety and regular HIV testing and to recruit participants for Educational Events, reaching 20-25 participants at each Educational Forum.
- Convene a Community Advisory Board on a quarterly basis.

Again these objectives have been easily met annually.

Up until the spring of 2011, the two-session educational events were instead 3-day, 2-night weekend retreats. Due to less funding the weekend retreats were changed to two-session Educational Events. Also, the staff have found it is difficult to have participants come back for the second day of the two-session educational event and are currently exploring holding the event in one day.

One limitation of the AATP is it is almost impossible to know if a client who presents himself as not knowing his HIV status is coming in for an HIV test and truly

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already knows he is HIV positive and only coming in for the incentive. However Anderson was quick to point out that they also do not feel this happens very often and if it does, often the client is not hooked up to care services, so this becomes a link for them and HIV services. Another limitation is because their funding is just for King County, they are limited in being able to reach a large majority of the Black MSM community who, due to increasing housing costs, are moving south of Seattle just out of King County. Currently there are no services in this area that is focusing or outreach to Black MSM.

The staff also felt that the weekend retreats were very successful and extremely sad to have to discontinue them due to less funding. The weekend retreats were events that allowed Black men to have an opportunity to address factors that influence the behavior of black MSM, such as values, perceived risk, cultural and social norms and sexual relationship dynamics. Especially how the 'dual identity' (being both a Black man and also a man who has sex with other men) plays a role in their behavior.

The retreats often led to the participants themselves building a community beyond the events. It allows them to be social in a healthy environment. Since they had all participated in the retreats, these men have a common language, understanding and supportive friendship that has survived for months and years beyond the retreats.

With respect to sustainability, since funding for HIV is not increasing and in most cases decreasing, Anderson and Grandberry both felt that in another year that the AATP would not need to provide an incentive for Black MSM to get an HIV test at CMCH.

Initially, it was felt incentives were very important in building support in the community. However the program has been very successful and is almost totally

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dependant on referrals. The AATP has an excellent reputation in the Black MSM community. In addition, since CMCH is not identified as a 'gay service agency,' but a 'multicultural health promotion agency,' Black MSM will continue to seek general health services and when appropriate have a very quick and discreet linkage to the Black MSM program.

If money were not an object the staff felt that having weekend retreats would be one of the best ways to for HIV prevention with Black MSM. They did not feel like an incentive would be needed that the men would come regardless. Having a weekend retreat then followed up with 2-3 hour topic discussions would be the most effective. It was also discussed that a drop-in center would be useful for Black MSM. Currently there are space limitations at CMCH.

Grandberry talked about a successful post-bar pancake breakfast that had been hosted by another organization. From about midnight until 5 AM an agency would provide free breakfast on the weekends. These breakfasts also had a variety of HIV prevention material and would hold HIV discussions at the same time. Since funding was eliminated this program no longer exists. I asked if guys were asked to pay \$5 for the breakfast to offset the cost would it still be successful. It was felt that the men would not come if there were a cost at all.

It was felt that young guys need more, older Black MSM mentors. Grandberry described it as a sort of Post Traumatic Stress Disorder; the older men have already 'made it,' through the initial HIV/AIDS discovery without treatment, have reconciled church and family and now did not feel like they owed anything to the younger generation. "They have to figure it out on their own."

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Another barrier is not being able to measure success with their programs. They can count numbers and determine how many people get tested or attend the educational events but being able to measure if their programs are having an effect on Black MSM incident rates is difficult if not impossible.

Finally, it was very strongly felt that with the decrease in HIV funding, unless there is a robust demand from the Black MSM community most services would not be funded and go away.

A network of Black MSM providers would be beneficial so as to be able to work together and not duplicate services. It was felt that a major barrier for having the best services for Black MSM was territorial. Anderson stated, "Agencies are territorial when it comes to funding and sharing services can make collaboration very difficult."

Entre Hermanos

The interview was conducted with Marcos Martinez, Executive Director and Rafael Velazquez, Peer Educator (M. Martinez and R. Velazquez, personal communication, November 7, 1011).

Entre Hermanos came into being by the initiative of a group of gay, lesbian, bisexual and transgender Latinos/as that saw the need for social, educational and health support services in their community in the spring of 1991. By December of 1992, the group was organized and carried out various activities to raise funds to cover the operating costs.

These activities were done in cooperation with the Washington Latino AIDS Coalition, a group affiliated with People of Color against AIDS (POCAAN). In April of

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1993, the group functioned independently, directing several activities for the community. That year, Entre Hermanos affiliated itself with POCAAN, a nonprofit organization that offers prevention and educational services for people of color. In May of the same year, the first contest was held to elect a Latina Queen. That same summer, Entre Hermanos incorporated a lesbian group and participated for the first time in Seattle's LGBT Pride Parade.

Toward the end of 2001, Entre Hermanos received a charter by the State of Washington to operate as a nonprofit organization, through the corporate status offered by IRS Section 501(C)3. Since then, Entre Hermanos continues to grow as they are progressing and offering more services to Latinos/as in the State of Washington.

Their mission is to promote the health and well being of the Latino Gay, Lesbian, Bisexual, Transgender and questioning community in a culturally appropriate environment through disease prevention, education, support services, advocacy and community building. The following objectives assist in meeting their mission.

- Develop leadership and mobilization of resources within the community.
- Encourage participation in programs that provide support, prevention and treatment for HIV/AIDS, sexually transmitted diseases and other diseases.
- Build the Latino community's capacity with the necessary tools to achieve a better quality of life.
- Help the LGBTQ community express its ideals and achieve them as individuals.
- Encourage the participation of the members of the LGBTQ community in activism and human rights.

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- Provide educational, recreational, cultural and social services.

When working with Latino MSM culture is very important. There is a dual identity that is addressed—being both a gay man and Latino.

The goals in the MSM HIV prevention programs are to increase knowledge and reduce high-risk behavior with Latino MSM. They have two main interventions, a group-level intervention and an incentivized HIV testing program.

Many Men, Many Voices (3MV) is a community-level intervention targeting Latino Men who have Sex with Men (MSM). It is an effort to prevent the spread of HIV/AIDS among a diverse group of Latino men, including young men. The primary focus population is low-income, non-acculturated, often undocumented immigrants who speak mostly Spanish. The program employs a variety of strategies to influence community norms supporting consistent use of condoms during sexual intercourse, regular HIV testing, treatment access for HIV positive clients and the further reduction of unsafe sexual behaviors among Latino MSM.

Program activities include community outreach, a social media presence, educational workshops and forums, 3MV groups and provision of referrals to counseling and testing.

Incentivized HIV testing referrals to Gay City Health Project or at the Harborview STD clinic. Interested clients will undergo a brief screening by Entre Hermanos outreach staff to determine their eligibility, which is as follows:

- HIV negative or sero-status unknown
- Have not received a test in the previous 6 months
- Belongs to a high-risk population

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Clients who participate will receive a cash incentive of \$20 once Entre Hermanos verifies that the client actually received an HIV test. A \$20 incentive will also be paid to an agency client who refers a third party to testing, provided that third party has not received an HIV test in the previous six months and successfully undergoes testing at Entre Hermanos, Gay City Health Project or the Harborview STD Clinic.

Entre Hermanos has been referring clients to either Gay City Health Project or Harborview STD Clinic for incentivized testing since July 2010. In September 2011, while utilizing a Gay City HIV counselor/tester, a pilot project was started to test clients one afternoon a week at Entre Hermanos. They are not sure if clients will choose to get tested on-site since it is a small community and culturally sensitive. They may prefer the anonymity of being tested off-site.

The antidotal belief is it has increased new Latino positives getting tested. Rafael Velazquez's belief is that the incentive "gives the extra nudge to coming in for testing." Marcos Martinez and Velazquez believe without the incentive clients would continue to come to Entre Hermanos because it is a Latino/a center.

"Twenty dollars can make a difference-but not that much. It is probably not the biggest factor in people coming for testing." Martinez stressed. He also acknowledged that they do not have any solid data to justify this belief.

Both Martinez and Velazquez stated that there has been better networking with other agencies and sharing resources since funding has reduced. An example is Gay City Health Project, who now provides an HIV testing counselor once a week to do testing at Entre Hermanos. The agency staff are talking a lot more about testing once it started

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being provided on-site. The staff have learned about testing standards, structure, procedures and consistency. “It has raised everyone’s awareness.” Martinez said.

Even though Entre Hermanos is not having any problems meeting their process objectives for Public Health, who funds them, they are always looking to see what more could be done to increase testing. There is always the need to continue to stay fresh and effective.

If money were not an objective Entre Hermanos would address social determinants of health that effect Latino MSM—stigma, homophobia, cultural barriers, housing, education and food. They would have more comprehensive programs that include ESL and job training. Most clients are Spanish speaking and are recent immigrants who do not have access to services

They currently co-host HIV positive support groups for Latino MSM at POCAAN. In addition Entre Hermanos has collaborated on federal HIV prevention proposals with CMCH and Gay City Health Project. Unfortunately they have not been funded.

Neighborhood House/Project Handle

The interview was conducted with Warya Pothan, Project Director (W. Pothan, personal communication, November 14, 2011).

Since 1906, Neighborhood House has helped immigrants, refugees and low-income people overcome economic, educational and employment challenges.

Neighborhood House was founded by the National Council of Jewish Women, Seattle Chapter in 1906 as a settlement house that provided services to Jewish immigrants from

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Turkey, Greece and other European countries. Not long after, Seattle and King County began developing low-income housing and Neighborhood House began providing a range of services to families moving into public housing.

Today, their programs are located in public housing communities in Seattle and King County, Work Source centers and public schools. Their services are based on extensive experience and deep understanding of the role language and culture play reaching out to multilingual communities. They provide first language services in Vietnamese, Cambodian, Oromo, Tigrinya, Amharic, Somali, Spanish, Russian and several other languages.

Project Handle is a program that started in 2003 and is housed within Neighborhood House. They currently receive two federal grants for HIV prevention.

Since 2006 they have been implementing a U.S. Department of Health and Human Services, Substance Abuse Mental Health Services Administration (SAMHSA)/Center of Substance Abuse Treatment (CSAT) grant funded HIV prevention program.

This program is a series of workshops that target women and youth to reduce HIV and substance abuse among high-risk African Americans, East Africans (Ethiopian, Eritrean, Somali and Oromo), Cambodian and Vietnamese refugee communities.

The goals of this program are:

- Reduce the risk/spread of HIV/Substance Abuse by expanding and enhancing NIDA Community-based Outreach Model, SAMHSA's Model Program, treatment services for the targeted population.

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- Create linkages between HIV/SA prevention with pre-treatment, treatment and other wrap around services.

Participants are encouraged to participate in a survey for evaluation purposes. They are paid a \$20 gift card incentive to complete the 45-minute assessment survey at initial participation. They will be paid an additional \$20 for completing the follow up survey at 6 months. They are also offered a free HIV test at this time.

Project Handle also has a grant from the CDC to provide HIV prevention education using the VOICES intervention and HIV counseling and testing services. This intervention targets African American communities (US and foreign born- primarily Ethiopian, Eritrean and Oromo) men and women 18 years and older who are HIV negative or do not know their status.

VOICES is a single session video based prevention tool serving 4-8 people at a time. Information on HIV risk behavior and condom use is delivered by videos and facilitated group discussion. Groups are gender, ethnic and risk groups specific, so that participants can develop prevention strategies appropriate for their circumstances. The VOICES program has been chosen for this intervention because it has been proven to provide participants with increased knowledge about the transmission of HIV and other STDs while allowing them to make realistic assessments of their own personal risk.

Participants receive a \$5 Safeway gift card for participating in the two-hour video presentation and an additional \$5 gift card if they choose to get an HIV test. In addition a Peer Recruiter, (someone who has already participated in the program and recruits others) will also receive a \$5 gift card for each referral.

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Project Handle monitors their testing numbers quarterly to see if there are areas that need extra attention. Utilizing the survey, Project Handle is able to evaluate the effectiveness of their program. Warya Pothan was uncomfortable sharing the survey results with me.

Pothan shared that she thought the \$5 Safeway gift card incentives were not really much of an incentive for their clients. “This doesn’t even cover the bus fare for most of our participants.” Stated Pothan. She believes the food is the biggest incentive for their clients. Due to not having unrestricted funds, they are not able to purchase food from local, culturally appropriate vendors. This is something she would like to see change. However, Pothan was quick to praise a staff member who is able to find prepared food from Safeway and “fix it up right” to prepare much of the cultural food that their participants are used to and “remind them of home.”

Lifelong AIDS Alliance

Interview conducted with Paul McGee and Garland D. Jarmon, Comprehensive Risk Counseling & Services Coordinators (P. McGee and G. Jarmon, personal communication, November 9, 2011).

Lifelong AIDS Alliance was formed in 2001 through the merger of Chicken Soup Brigade and Northwest AIDS Foundation. They have come a long way since their beginnings in 1983, when a soup can was passed around Volunteer Park and collected the first \$42 to help people living with HIV/AIDS in the Seattle community.

Today, they are staffers, volunteers, donors and community members from many different backgrounds. They are united in their determination to make sure that society

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will never forget that HIV/AIDS still exists. They are proud to say they will be here until there is a cure.

Lifelong does whatever it takes to improve the lives of people living with HIV/AIDS. They provide health insurance so that people can get the care they need. They cook and deliver healthy meals. They ensure that people have a safe place to live. Case managers help people every step of the way.

Lifelong distributes hundreds of thousands of condoms each year, along with safer-sex messages aimed at stopping thousands of new infections. They also counsel those at risk of spreading or acquiring HIV.

Decisions made in Olympia, WA and Washington, DC have a profound effect upon people living with HIV/AIDS in Seattle and King County. Lifelong represents those living with HIV/AIDS and ensure that their voices are heard at the local, state and federal levels.

Lifelong builds a strong network of support for programs and services. Events, like the annual Seattle AIDS Walk & 5K Run and Dining Out For Life, raise both awareness and financial support for people living with HIV/AIDS in Seattle and King County.

Lifelong currently implements an individual-level HIV prevention intervention. Comprehensive Risk Counseling and Services (CRCS) program is an individual-level intervention that provides intensive HIV prevention counseling to Men who have Sex with Men (MSM) and stimulant using men who have sex with men (SUMSM) clients, who are engaging in high-risk behaviors.

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An assessment tool is utilized to screen for high-risk men. Criteria included for screening men who in the past year report any of the following: a bacterial STD, stimulant (meth, cocaine) and/or popper use, 10 or more partners and unprotected sex with a partner of unknown or different status. Within these priority populations, approximately 20% will be Black MSM (BMSM) and approximately 55% will be HIV-positive.

The program uses a risk assessment tool and motivational interviewing to help clients assess and discuss issues such as condom use, risk activities, environmental barriers and sero-status disclosure. Through a series of feedback sessions (that are between 30-60 minutes long), CRCS seeks to increase a client's sense of personal risk, improve communication/negotiation skills, increase self-efficacy and decrease unprotected anal, vaginal and/or oral sex. The program includes approximately three to four feedback sessions, as determined by need, with sessions one to two weeks apart. Clients receive incentives (\$20 gift card) after the initial assessment and then after all feedback sessions are completed. After the final feedback session, the client is discharged with a prevention plan. The program reevaluates the clients' needs and risks after six months at which time clients receive another \$20 incentive. Additional three to four feedback sessions may follow as needed. Treatment adherence information will be provided to HIV positive clients as a complement to the treatment adherence counseling they receive from care case managers and physicians. HIV positive clients not currently receiving HIV case management services will be referred to Lifelong's medical case management program.

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McGee and Jarmon felt that the incentives were helpful in getting the clients in the door, but do not feel like that is what keeps them coming. They also acknowledged that they have never evaluated the incentive component of the intervention. In this economy they felt the incentives were especially important. They believe that they will lose high-risk men if the incentive was not provided. They approximate about 50% of their clients are either homeless or in transition. Very few people are coming into the program just for the money and with little participation.

They felt if the incentive did not exist then that their client participation numbers would probably drop in addition to getting a different clientele. They are exploring providing bus passes for people to come to Lifelong for services. McGee stated, “If there were more services offered i.e. testing for HIV/STDs and more sessions, it is possible to let go of incentives.”

Lifelong is exploring ways to expand services to south King County, where many Black MSM are moving due to housing in the city becoming too expensive. In addition, they are also examining the possibility of providing HIV and STD testing. Currently, an HIV testing counselor from Gay City Health Project goes to Lifelong once a week for about 4 hours. This has been helpful but it is felt that they are missing an opportunity to test men on demand while they are at Lifelong for the CRCS counseling.

An unforeseen benefit is that they get most of their clients from previous client referrals. There is no incentive for the initial client to refer. Some concerns of the CRSC program are they are limited to 4 feedback sessions. For many clients this is not enough. With the potential for less funding, Lifelong has started reaching out and networking with other agencies. “Less money forces more networking and collaborating.” Jarmon stated.

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They would like to start offering toiletries to clients, especially since most of them are homeless. In addition, they would like to see organized group events, both social and support. Relationship issues are one of the biggest themes with their clients. If there were some social and support groups it is felt these issues might be better addressed in those settings.

Harborview STD Medical Center

Interview conducted with Mark Fleming, Public Health Advisor (M. Fleming, personal communications, November 21, 2011).

The Harborview Sexually Transmitted Disease (STD) Clinic is a Public Health Seattle-King County service that provides confidential STD and HIV evaluation, screening, testing, treatment and counseling on a sliding fee basis. In addition they have a One-on-One program for newly diagnosed HIV positive people. This program provides a T-cell count, RNA test STD screen and treatment, Hepatitis A & B vaccinations, help with partner notification and one hour consultation with a medical doctor.

Fleming feels like they “run the gamut” when it comes to clients that are seen at the clinic. Most are un/underinsured or patients that do not want their primary doctor to treat them for STDs. He stated that because the clinic provides “one stop shopping” it is beneficial for those seeking services. The clinic provides testing and diagnosis for HIV and in addition provides treatment for STD infections. Fleming also said that he believes the success of the STD Clinic is that they see many client referrals. Roughly, Fleming thinks that about a quarter of their clients are MSM. He thinks that some men prefer to access services through a predominately gay organization.

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For those who test HIV positive and do not have insurance are then referred to Madison Clinic who provides a case manager to help assist in utilizing the state drug assistance program.

With respect to incentivized HIV testing, Fleming was not sure how useful or not it is. He stated that it would be nice for the agencies to have some way of evaluating the incentive component of testing.

Gay City Health Project

Interview conducted with Fred Swanson, Executive Director and Jeff Rinderle, Director of Wellness (F. Swanson and J. Rinderle, personal communication, November 28, 2011).

Gay City's mission is to promote the health of gay and bisexual men, including those who are transgender, and prevent HIV transmission by building community, fostering communication and nurturing self-esteem.

Gay City brings people together to work toward creative solutions to common problems. They were founded in April of 1995, with a grant from Public Health Seattle-King County. Dedicated to bold, innovative programming, Gay City continues to present provocative forums that were initially presented by the MSM Task Force and expanded to include a variety of groups, workshops and other educational and community events. These highly successful forums cover topics that initially were not being addressed by local public health. The initial forum presented "Why Are Fags Still Fucking Without Condoms?" This public forum drew over 300 men, who speak of grief, loss, depression,

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survivor guilt and disconnection from the community. Men expressed how prevention tactics failed to address their concerns.

They employ the concept of social marketing to get out its community mobilization and empowerment message. By using business sector marketing strategies, they are able to engage the community at various levels.

To aggressively address the need for expanded community based and accessible testing services, Gay City Health Project Wellness Center opened in 2004. They begin providing the community access to the latest HIV and STD testing technologies in an inviting and welcoming community space. Opening the Wellness Center tripled the availability of community based HIV and STI testing in Seattle. In addition to free HIV, STD testing of gonorrhea, syphilis, chlamydia and RNA, Gay City also provides hepatitis A & B vaccinations. Connecting the community to health workshops, groups and wellness activities to basic health screenings, Gay City Health Project provides a space where men can invest in their personal health at the same time as building and investing in a strong gay men's community.

Currently, Gay City is providing outreach HIV testing at various sites. This includes; Sea-Mar Community Health Center, the Mexican Consulate, Consejo Counseling & Referral, Lifelong AIDS Alliance, Seattle Counseling Services, Entre Hermanos and People of Color Against AIDS Network (POCAAN).

Gay City is the leading provider of free HIV and STI testing and counseling in King County, operating in English and Spanish five days a week. In 2010 they provided more than 2,300 HIV tests reaching a record number of gay, bi, and trans men who have sex with men. Gay City continues to reach historically marginalized, underserved or

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high-risk populations. In 2010, 40% of those tested were men of color, 41% are age 30 or under, 11% tested for the first time and over one-third are uninsured, stated Swanson.

With the funding from Public Health Seattle-King County, Gay City Health Project provides HIV counseling and testing services targeted to populations at increased risk for HIV infection, with a particular focus on the population of Men who have Sex with Men (MSM). Funding also supports other targeted screening of MSM for sexually transmitted diseases.

Gay City provides all of their testing and vaccination services for free. However, a donation envelope is provided to the client when they fill out their intake form. Rinderle said that it a soft approach for donations that has continually increased. Currently Gay City averages \$12.50 donation per client who utilizes the HIV/STD testing and vaccination services.

Being the largest provider of HIV and STD testing in Seattle has elevated the agency's status in the community and has expanded fundraising. "When donors can see tangible results, it is easier for them to get behind the programs." Stated Swanson.

One limitation is not having the therapeutic expertise to provide couples counseling. It is a service they would like to start providing but realize that due to the special dynamics, the staff would need to have more training.

Swanson and Rinderle are not in favor of incentivizing HIV testing. They believe it is not sustainable and is "Setting up a dynamic where people expect to be paid." Currently about 1/3 of their testing clients are Latino. Some of these men are clients that have been referred from Entre Hermanos—and paid an incentive from Entre Hermanos

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for a test. Gay City does not track and were not sure how many of the Latino clients were direct referrals from Entre Hermanos.

Swanson was in favor of exploring other options where incentivizations could play a positive role. He suggested paying a client to bring in their sex partner(s) or other members of their social circle.

Recommendations

When I asked the various agencies that are currently providing HIV testing incentives, “What would you first start cutting from your programs if your budget was reduced?” All but one agency stated they would cut the incentives for HIV testing. Project HANDLE, the one agency that did not say they would start with cutting incentives, currently provide only a \$5 incentive compared to \$20 provided by other agencies. Project HANDLE also acknowledges that \$5 is really not seen as an incentive by the clients who are accessing services.

All of the agencies that are funded by Public Health Seattle-King County have minimal monitoring and evaluation reporting requirements. In addition to reporting quarterly numbers of events held or clients seen or referred et cetera, Public Health requires all HIV prevention programs that they fund to complete a mid-cycle and final evaluation report. Programs are expected to answer the following questions in their evaluations:

1) What is the purpose of your evaluation? What questions are you trying to answer?

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2) How are you going to answer your evaluation questions? What data are you going to collect? How are you going to collect them? Who are you going to collect the data from?

3) Once you have the data, how are you going to analyze it? How will this information be useful for your program?

Entre Hermanos, one of the Public Health funded agencies, received a small grant from University of Washington's Center for AIDS Research (CFAR) in late spring of 2010 to expand evaluation efforts associated with their HIV incentivized testing program. The purpose of the evaluation was to investigate the effectiveness of their incentivized HIV testing program.

Data collected from participants were mostly demographic data such as place of birth, primary language and current zip code. This was collected to gain additional information about Latino MSM they are serving and help further refine services.

Participants also completed a simple screening questionnaire, which is used in order to qualify the participants for the HIV testing incentive. In addition to the questionnaire, two focus groups were conducted in order to gain further insights into incentivized HIV testing.

According to Marcos Martinez and Rafael Velazquez they were able to gather good demographic information on their participants but not able to evaluate the effectiveness of the incentivized component for their HIV testing program.

When conducting my interviews I found that most all of the agencies did not have an in depth formal evaluation of their prevention programs. They could all report the

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progress of their target numbers that were required of them based on their funder, which in the case of all but one agency, the funder was Public Health Seattle-King County.

What I found is that the agencies are not evaluating the incentivized component of their programs. After consulting with the different agencies and the contract monitoring staff with Public Health Seattle-King County, it was agreed that if they had a way of evaluating the HIV incentives component of their programs this could help determine future programming and budget decisions.

With feedback from implementing agencies and Public Health Seattle-King County, I developed a short, client administered survey in both English and Spanish, that will assist Community Based Organizations (CBOs) in determining the effectiveness of a client receiving an incentive for HIV testing, free testing or donation request for HIV testing.

I piloted the survey at the agencies and made a couple of adjustments in the order of the questions. Otherwise clients did not have a problem in answering the questions and completing the survey in less than 5 minutes.

I have recommended that Public Health Seattle-King County create an Access data base system in order to analyze the data. The surveys should be collected for 1 month, two times a year in correlation with the semi and annual evaluation reports required by PHSKC.

Knowing that most of the CBOs do not have extra money, staff or expertise to implement a large-scale evaluation, the tool should require limited staff time, expertise or funding.

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Conclusion

I was disappointed that I was unable to meet with POCAAN and Consejo, however I do not believe it took away from the information I was able to gather from the agencies I was able to interview. All of the agencies I met with were able to provide agency and program background, however none of them were able to provide any evaluation regarding their programs. After much dilemma I narrowed my research focus to incentivized HIV testing. For funding purposes, all of the agencies are now reporting targeted client HIV testing numbers to Public Health Seattle-King County. Examples include: How many clients tested? How many clients referred? All disaggregated by sex, race/ethnicity and age.

I suggested to each agency that I could work with them to design a monitoring and evaluation plan, inclusive of log-frames and budget. None of the agencies were interested. They all agreed that they did not have the time, budget or expertise to monitor a plan. They were also clear that they would not be interested if this plan was not going to be required by Public Health, who funds most of the programs.

Most of my difficulties with this project were agencies not returning my emails, phone calls or personal office visits. It took much longer than I anticipated to initially meet with the agencies for key informant interviews, then getting their feedback regarding the survey tool and finally being able to pilot the survey at their agency. In addition all of them were reluctant to share agency reports or statistics.

Through discussions with the agencies that I interviewed and contract monitoring staff with Public Health, they all felt that if they had a simple tool to measure the effectiveness of incentivized HIV testing it would be valuable in their program planning.

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With feedback from implementing agencies, I developed a short, client administered survey in both English and Spanish, that will assist agencies in determining the role of a client receiving an incentive for HIV testing, free testing or donation request for HIV testing. The survey takes less than 5 minutes to complete and will be offered to HIV testing clients after they get a test. The survey will be administered for 1 month at each agency two times a year to coincide with Public Health dates for semi and annual agency evaluations. Using Access, Public Health will be able to query and analyze data that will help CBOs to evaluate and make program decisions regarding incentivized, free or donation requested HIV testing.

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Appendix A-Testing Survey, English

HIV Testing Client Survey

Date _____

Today's Testing Site_____

1. How old are you?

- 20 years or younger
- 21-25 years old
- 26-35 years old
- 36-45 years old
- 46 years or older

2. Are you Hispanic or Latino?

- Yes
- No
- Decline to answer
- Don't know

If you answered No, skip to question 4.

3. If Hispanic or Latino which ethnicity best describes you? (check all that apply)

- Central American
- Cuban
- Dominican
- Mexican
- Puerto Rican
- South American
- Other_____
- Decline to answer
- Don't know

4. What race or races best describes you? (check all that apply)

- White
- Native American/Alaskan Native
- Black or African American
- Pacific Islander/Native Hawaiian
- Asian
- Other_____
- Decline to answer
- Don't know

INCENTIVIZED HIV TESTING EVALUATION TOOL

5. Do you consider yourself to be male, female or transgender? (choose 1)

- Male
- Female
- Transgender—Male to Female
- Transgender—Female to Male
- Decline to answer
- Don't know

6. What best describes your current monthly income? (choose 1)

- \$902 or less
- \$903 - \$1,353
- \$1,354 - \$1,805
- \$1,806 - \$2,256
- \$2,257 - \$2,707
- \$2,708 - or more
- Decline to answer
- Don't know

7. Have you tested at this site before today?

- Yes
- No
- Decline to answer
- Don't know

8. How did you hear about HIV testing at this site? (check all that apply)

- From an outreach staff in the community
- From family/friends
- Through flyers/media
- I did not know about testing until I came in today
- Internet
- Other_____
- Decline to answer
- Don't know

9. How many times have you been tested for HIV in the past 2 years, not including today?

- None
- 1 time
- 2 times
- 3 times or more
- Decline to answer
- Don't know

If you answered None, skip to question 11.

INCENTIVIZED HIV TESTING EVALUATION TOOL

10. Where do you USUALLY go to get an HIV test? (choose 1)

- Entre Hermanos
- CMCH
- Gay City
- Lifelong AIDS Alliance
- Harborview STD Clinic
- Private Provider
- Never had an HIV test
- Other _____

Comments: _____

11. Where do you PREFER to go to get an HIV test? (choose 1)

- Entre Hermanos
- CMCH
- Gay City
- Lifelong AIDS Alliance
- Harborview STD Clinic
- Private Provider
- Other _____

Comments: _____

12. Where do most of your gay or bisexual friends PREFER to go to get an HIV test? (choose 1)

- Entre Hermanos
- CMCH
- Gay City
- Lifelong AIDS Alliance
- Harborview STD Clinic
- Private Dr. or Community Clinic
- Other _____

Comments: _____

13. What language do you prefer to use when speaking with family and friends?

INCENTIVIZED HIV TESTING EVALUATION TOOL

14. Do you prefer your HIV testing counselor be someone from your own race or ethnic background?

- Yes, I very much prefer
- Yes, I prefer
- It does not matter
- No, I do not prefer
- No, I very much do not prefer
- Decline to answer

Comments: _____

15. Do you prefer your HIV testing counselor be a gay or bisexual man?

- Yes, I very much prefer
- Yes, I prefer
- It does not matter
- No, I do not prefer
- No, I very much do not prefer
- Decline to answer

Comments: _____

16. Why did you choose to get an HIV test from the agency you tested with today? (check all that apply)

- I am most comfortable here.
- I was referred.
- I came in for other services and chose to get an HIV test while I was here.
- I also wanted a full STD screening.
- I was offered an incentive to get an HIV test.
- Other _____

17. From the checked boxes above (question 16), please select your 2 top reasons for choosing the agency you were tested with today. (choose 2)

- I am most comfortable here.
- I was referred.
- I came in for other services and chose to get an HIV test while I was here.
- I also wanted a full STD screening.
- I was offered \$20 to get an HIV test.
- Other _____

Comments: _____

INCENTIVIZED HIV TESTING EVALUATION TOOL

18. What are the two (2) MOST IMPORTANT reasons for choosing to get an HIV test at this agency? (choose 2)

- The days and times work best for me.
- Gay friendly staff and agency.
- Culturally friendly staff and agency
- I was paid \$20 to get an HIV test
- I was able to get other services.
- I like that the staff is my same race/ethnicity/sexual orientation.
- I don't know where else to go.
- The test was free.
- Other _____

Comments: _____

19. How important are incentives when deciding to get an HIV test? (choose 1)

- Extremely important
- Very important
- Moderately important
- Slightly important
- Not at all important
- Decline to answer
- Don't know

Comments: _____

20. How important is it that your HIV test is free? (choose 1)

- Extremely important
- Very important
- Moderately important
- Slightly important
- Not at all important
- Decline to answer
- Don't know

Comments: _____

21. How likely are you to pay a small donation to get an HIV test? (choose 1)

- Extremely likely
- Very likely
- Moderately likely
- Slightly likely
- Not at all likely
- Decline to answer
- Don't know

Comments: _____

INCENTIVIZED HIV TESTING EVALUATION TOOL

22. How likely are you to refer a friend for HIV testing? (choose 1)

- Extremely likely
- Very likely
- Moderately likely
- Slightly likely
- Not at all likely
- Decline to answer
- Don't know

Comments: _____

23. How likely are you to refer a friend for HIV testing if you were paid an incentive? (choose 1)

- Extremely likely
- Very likely
- Moderately likely
- Slightly likely
- Not at all likely
- Decline to answer
- Don't know

Comments: _____

24. What BEST describes your opinion of PAID, FREE or DONATION to get an HIV test? (choose 1)

- Everyone should be paid an incentive to get an HIV test.
- Everyone should be paid an incentive to get an HIV test and also have STD screening available.
- HIV testing should be provided for free.
- HIV testing should be free and also have STD screening available for free.
- People should be willing to pay a donation amount of their choosing to get an HIV test.
- People should be willing to pay a donation amount of their choosing to get an HIV test and also have STD screening available.
- People should pay full price for HIV testing.
- People should pay full price for an HIV test and STD screening.
- Decline to answer
- Don't know

Comments: _____

INCENTIVIZED HIV TESTING EVALUATION TOOL

25. What BEST describes your HIV testing experience today? (choose 1)

- I was paid when I got an HIV test today.
- My HIV test was free today.
- I was asked to pay a donation for my HIV test today.
- Decline to answer
- Don't know

Thank you for completing the survey!

INCENTIVIZED HIV TESTING EVALUATION TOOL

Appendix B - Testing Survey, Spanish

Estudio sobre quien se hace la Prueba del VIH

Fecha: _____ Cita de la Prueba: _____

1. ¿Cuántos Años Tiene?

- 20 años o menos
- 21-25 años
- 26-35 años
- 36-45 años
- 46 años o más

2. ¿Es usted Hispano o Latino?

- Sí
- No
- Rehúso contestar
- No sé

Si contesta No, sigue a pregunta 4.

3. Si usted es Hispano o Latino, ¿cuál origen étnico le describe mejor? (marque lo que corresponda)

- Centro Americano
- Cubano
- Dominicano
- Mexicano
- Puertorriqueño
- Sudamericano
- Otro _____
- Rehúso contestar
- No sé

4. ¿Cuál raza o razas le describen mejor? (marque lo que corresponda)

- Blanca
- Nativo Americano/ de Alaska
- Afroamericano
- Pacífico / Nativo de Hawái
- Asiático
- Otro _____
- Rehúso contestar
- No sé

5. ¿Se considera usted ser hombre, mujer o transgénero? (elija uno)

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- Hombre
- Mujer
- Transgénero—Hombre a Mujer
- Transgénero—Mujer a Hombre
- Rehúso contestar
- No sé

6. ¿Cuál describe mejor su ingreso mensual actual? (elija uno)

- \$902 o menos
- \$903 – \$1,353
- \$1,354 – \$1,805
- \$1,806 – \$2,256
- \$2,257 – \$2,707
- \$2,708 o más
- Rehúso contestar
- No sé

7. ¿Se ha echo la prueba en esta cita antes de hoy?

- Sí
- No
- Rehúso contestar
- No sé

8. ¿Cómo se enteró acerca de las pruebas del VIH en este sitio? (marque lo que corresponda)

- De un trabajador en la comunidad
- De familiares o amigos
- A través de volantes o medios de comunicación
- No sabía acerca de las pruebas hasta que me encontré hoy
- Internet
- Otro _____
- Rehúso contestar
- No sé

9. ¿Cuántas veces se ha hecho Ud. la prueba del VIH en los últimos 2 años, sin incluir el día de hoy?

- Ninguna
- 1 vez
- 2 veces
- 3 veces o más
- Rehúso contestar
- No sé

Si la respuesta es Ninguna, sigue a pregunta 11.

10. ¿Dónde usualmente va para hacerse la prueba del VIH? (elija uno)

- Entre Hermanos

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- CMCH
- Gay City
- Lifelong AIDS Alliance
- Clínica Harborview de enfermedades de transmisión sexual
- Cita Privada
- Nunca me he echo la prueba del VIH
- Otro _____

Comentarios: _____

11. ¿Dónde prefiere hacerse la prueba del VIH? (elija uno)

- Entre Hermanos
- CMCH
- Gay City
- Lifelong AIDS Alliance
- Clínica Harborview de enfermedades de transmisión sexual
- Cita Privada
- Otro _____

Comentarios: _____

12. ¿En dónde la mayoría de sus amigos gays o bisexuales prefieren ir a hacerse la prueba del VIH? (elija uno)

- Entre Hermanos
- CMCH
- Gay City
- Lifelong AIDS Alliance
- Clínica Harborview de enfermedades de transmisión sexual
- Doctor privado o Clínica Comunal
- Otro _____

Comentarios: _____

13. ¿Qué idioma prefiere usar al hablar con familiares y amigos?

14. ¿Prefiere que su consejero de pruebas del VIH sea de su propia raza o grupo étnico?

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- Sí, lo prefiero bastante
- Sí, lo prefiero
- No importa
- No lo prefiero
- No lo prefiero bastante
- Rehúso contestar

Comentarios: _____

15. ¿Prefiere que su consejero de pruebas del VIH sea gay o bisexual?

- Sí, lo prefiero bastante
- Sí, lo prefiero
- No importa
- No lo prefiero
- No lo prefiero bastante
- Rehúso contestar

Comentarios: _____

16. ¿Por qué eligió hacerse la prueba de VIH en la agencia de hoy? (marque lo que corresponda)

- Estoy muy cómodo aquí.
- Me refirieron.
- Vine por otros servicios y decidí hacerme la prueba del VIH, mientras que yo estaba aquí.
- También quería un examen de ETS completo.
- Me ofrecieron un incentivo para hacerme la prueba del VIH.
- Otro _____

17. De las cajas marcadas arriba (pregunta 16), por favor seleccione sus dos principales razones por la elección de la agencia donde se hizo la prueba. (elija dos)

- Estoy muy cómodo aquí.
- Me refirieron.
- Vine por otros servicios y decidí hacerme la prueba del VIH, mientras que yo estaba aquí.
- También quería un examen de ETS completo.
- Me ofrecieron un incentivo de \$20 para hacerme la prueba del VIH.
- Otro _____

Comentarios: _____

18. ¿Cuáles son las dos (2) razones MÁS IMPORTANTES por cuál ha elegido hacerse la prueba del VIH en esta agencia? (elija dos)

- Los días y horas de operación son ideales para mí.
- La personal de esta agencia muestra ser aceptable de los gays.
- Personal amable y la agencia culturalmente sensible.

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- Me pagaban \$20 por hacerme la prueba de VIH.
- Fui capaz de obtener otros servicios.
- Me gusta que la personal es de mi misma raza / origen étnico / orientación sexual.
- No sé a dónde más ir.
- La prueba fue gratis.
- Otro _____

Comentarios: _____

19. ¿Qué tan importante son los incentivos a la hora de decidir hacerse la prueba del VIH? (elija uno)

- Bastante importante
- Muy importante
- Medio importante
- Poco importante
- No es importante
- Rehúso contestar
- No sé

Comentarios: _____

20. ¿Qué tan importante es que su prueba sea gratis? (elija uno)

- Bastante importante
- Muy importante
- Medio importante
- Poco importante
- No es importante
- Rehúso contestar
- No sé

Comentarios: _____

21. ¿Qué probabilidad hay de que usted dé una pequeña donación por una prueba del VIH? (elija uno)

- Bastante probable
- Muy probable
- Moderadamente probable
- Tal vez probable

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- No es probable en lo absoluto
- Rehúso contestar
- No sé

Comentarios: _____

22. ¿Qué probabilidad hay de que refiera a un amigo para hacerse la prueba del VIH? (elija uno)

- Bastante probable
- Muy probable
- Moderadamente probable
- Tal vez probable
- No es probable en lo absoluto
- Rehúso contestar
- No sé

Comentarios: _____

23. ¿Qué probabilidad hay de que refiera a un amigo para hacerse la prueba del VIH si le pagaran un incentivo? (elija uno)

- Bastante probable
- Muy probable
- Moderadamente probable
- Tal vez probable
- No es probable en lo absoluto
- Rehúso contestar
- No sé

Comentarios: _____

24. ¿Qué describe MEJOR en su opinión el servicio de la prueba del VIH PAGADO, GRATIS o CON DONACIÓN? (elija uno)

- Todo el mundo debería ser pagado un incentivo por hacerse la prueba del VIH.
- Todo el mundo debería ser pagado un incentivo por hacerse la prueba del VIH y también tener la disposición de la detección de ETS.
- La prueba del VIH debe ser proporcionada de forma gratuita.
- La prueba del VIH debe ser gratuita y también de detección de ETS disponible de forma gratuita.

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- La gente debe estar dispuesta a pagar una donación de su elección para la prueba del VIH.
- La gente debe estar dispuesta a pagar una donación de su elección para la prueba del VIH y también tienen a disposición la detección de ETS.
- Las personas deben pagar el precio completo para la prueba del VIH.
- Las personas deben pagar el precio completo para la prueba del VIH y la detección de ETS.
- Rehusó contestar
- No sé

Comentarios: _____

25. ¿Cuál describe MEJOR su experiencia hoy en hacerse la prueba del VIH? (elija uno)

- Fui dado un incentivo por la prueba del VIH hoy.
- Mi prueba del VIH fue gratuita hoy.
- Me pidieron una donación hoy por la prueba del VIH
- Rehusó contestar
- No sé

¡Gracias por haber completado el cuestionario!