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# "I don't want it public": Voluntary HIV testing in a public setting

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RUNNING HEAD: I DON'T WANT IT PUBLIC" VOLUNTARY HIV TESTING...

"I don't want it public": Voluntary HIV testing in a public setting

By

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A Capstone Project submitted in partial fulfilment of the requirements for the degree of

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University of San Francisco

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### **Abstract**

**Purpose:** The purpose of this project was to create awareness of the importance of HIV prevention and testing among clients of St. Anthony's Foundation. While the aims of this project were to test different recruitment strategies and to propose a protocol for ongoing HIV awareness and testing at St. Anthony's Foundation through St. Anthony Medical Clinic.

**Methods:** A key informant interview was conducted to assess the acceptability and feasibility of HIV voluntary counseling and testing among clients of St. Anthony's Foundation. Strategies for recruitment of participants were developed and implemented. Two hundred and five individuals were approached for HIV counseling and testing, and HIV testing was carried out on those who accepted.

**Result:** Of the 205 individuals spoken to, seven carried out HIV testing and there was 14.28% HIV seropositive prevalence in the population. One hundred percent of participants reported ever having sex without condom while 28.58% reported ever using PrEP for prevention.

**Discussion:** Voluntary counseling and testing (VCT) is a good tool for knowledge of HIV status and prevention. However, good strategies for recruiting these population is important for the success of VCT in any given population.

**Conclusion:** The importance of HIV voluntary counseling and testing among various populations in the society can never be over emphasized. The HIV prevalence in this population shows that there are hidden positive cases among hard to reach populations.

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**Keywords:** Human immunodeficiency virus (HIV), Voluntary counseling and testing (VCT), homelessness, low-income, harm reduction, sex life, drug/substance use.

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## Literature Review

### Global Prevalence of HIV

Human immunodeficiency virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS) is a viral infection that attacks the body's immune system, specifically the CD4 cells (T cells), that helps the immune system fight off infections. HIV, if not treated, gradually reduces the number of CD4 cells (T cells) in the body, exposing the individual to numerous infections or infection-related cancers. When so many of these CD4 cells are destroyed by HIV, the immune system weakens and the body fails to fight off infections thus being susceptible to opportunistic infections leading to AIDS, the last stage of HIV infection (CDC, 2019).

HIV is one of the leading causes of death globally and has been named a global health problem (Fajardo-Ortiz, Lopez-Cervantes, Duran, Dumontier, Lara, Ochoa, & Castano, 2017). It was estimated in 2017 that about 70 million people have been infected with HIV since it was detected 3 decades ago, and 35 million have died, while 36.7 million are currently living with HIV infection (Fajardo-Ortiz et al. 2017 & Global Health Policy, 2019). In 2017, global estimates showed that HIV/AIDS deaths have significantly reduced to about 940,000 people dying of AIDS as compared to 1.4 million deaths in 2010, that is a 33% decrease in deaths. HIV prevalence has been on the decline since the 1990s largely due to increase in HIV voluntary counseling and testing, availability of highly active antiretroviral medications, increase use of condoms, and in recent years the emergence and use of PrEP and PEP both being prophylactic medications for pre/post exposure to HIV, harm reduction practices among injection drug users, aggressive screening and treatment of sexually transmitted infections (STIs) and reduction in mother-to-child transmission (WHO, 2019). These measures have significantly reduced the spread of HIV. Although HIV has been on the decline since the 1990s due to the above-

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mentioned interventions, there were an estimated 1.8 million infected persons in 2017. That is about 5,000 new infections per day, although HIV testing capacity has increased over time, enabling more people to learn their HIV status, about one in four people with HIV are still unaware of their HIV status (HIV.gov, 2019).

**History of HIV/AIDS.** HIV was first reported in the early 1980s, however, it is generally believed that HIV originated from the Democratic Republic of Congo in central Africa in 1920 when the virus crossed species from chimpanzee to humans (Avert: Global information on HIV and AIDS, 2018). Cases of HIV/AIDS were first reported in the early 1980s by gay men and it was thought to be a disease associated with homosexuals until it started manifesting in heterosexual individuals. The most common diseases associated with HIV/AIDS at this period were a form of skin cancer known as Kaposi's Sarcoma and a viral infection called *Pneumocystis carinii pneumonia* (PCP). By mid 1990s highly active antiretroviral drugs were developed which began to reduce deaths caused by AIDS. Global estimates show the following geographic regions with the highest HIV prevalence; Eastern and Southern Africa being the highest followed by Western and Central Africa, Asia and the Pacific, Western and Central Europe and North America, Latin America, Eastern Europe and Central Asia, The Caribbean, and Middle and North Africa respectively (CDC, 2019).

### **HIV Prevalence in the United States**

HIV was first seen in the United States (US) in the early 1980s when individuals in California and New York presented with skin cancer, *Kaposi's Sarcoma* and *Pneumocystis carinii pneumonia* infections which were already at the full-blown AIDS stage (Avert: Global information on HIV/AIDS, 2019). With this discovery, advances were made nationally and state

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wise to understand and combat the virus. In the US about 1.1 million people were estimated to be living with HIV in 2017 and about 15% (1 in 7) of these were unaware that they were infected with HIV (HIV.gov, 2019), and 38,700 people were newly infected with HIV in the same year. According to the CDC, the annual number of new HIV infections has remained stable at 39,000 since 2013. According to the CDC, this stable decline means that effective HIV prevention and treatment are not adequately reaching those who would benefit most. Those who are disproportionately lacking these services have been identified as Black/African Americans, who account for 43% and Hispanics/Latinos who account for 26% of new diagnosed HIV cases respectively. The most vulnerable groups affected by HIV infection are gay, bisexual men, and men who have sex with men (MSM) with 66% of new HIV diagnosed cases (HIV.gov, 2019). Although the statistics above show an increase in HIV prevalence in recent years, HIV prevalence has been stable since 2013 and more advances in medication therapy like PrEP, PEP, scaled up prevention strategies such as voluntary counseling and testing and harm reduction practices suggests that spread of HIV will continue to decline.

### **HIV Prevalence in California**

In 2018, the California Department of Public Health HIV surveillance report stated that the number of persons living with HIV in California increased from 121,000 (2012) to 132,000 (2016) and the prevalence rate was 336.4 per 100,000 population as compared to 319.1 in 2012. An increase rate of 5.4%. (California Department of Public Health, Office of AIDS, California HIV Surveillance Report - 2016). Of these cases, 78% HIV positive patients were men who have sex with men (MSM) and 8% out of these were men who have sex with men and are also injection drug users (MSM + IDU). Statistics show that the youth of California are most affected

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by HIV those within the ages of 18-29 with a percentage prevalence of 29%. African Americans and Latinos who make up 6.6% and 38% of California population respectively are most disproportionately affected by HIV as compared to Whites who are the largest race in California.

### **HIV Prevalence in San Francisco**

Since the beginning of HIV pandemic in the early 1980s, San Francisco has remained the city with the highest population of those living with HIV/AIDS. From 1981 to 2000 there has been rise and fall of HIV prevalence in the city with several full-blown AIDS deaths (Department of Health Office). With the emergence of highly active antiretroviral therapy (HAART), from 1996 to date, there has been great decline in disease progression to AIDS and AIDS-related death. Even though AIDS cases and AIDS-related deaths have continued to decline in recent years, the rate of decline has slowed. As of 2001, there were about 17,838 people living with HIV/AIDS in San Francisco and this number has slowly reduced to 15,952 in 2017. San Francisco remains the city in California with the highest populations of people living with HIV (San Francisco AIDS Foundation, 2019). Fifteen thousand, nine hundred and fifty-two people were estimated to be living with HIV in 2017 and 9,227 of these were already classified as having AIDS. There were about 221 new HIV diagnosis in 2017 in San Francisco, and 86% of these identified as men. 74% out of these men were MSM, between the ages of 25-39 years old and 38% were White. Although Whites seem to have a high percentage of prevalence, African American and Latino Americans are most disproportionately affected by HIV in San Francisco, given their few numbers as compared to the larger population of Whites. (California department of public health, Office of AIDS, California HIV Surveillance Report - 2016).

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### **Risk factors of HIV**

Risk factors for HIV transmission include low socioeconomic status, poverty, limited access to quality healthcare, lack of housing, lack of HIV prevention education, and infection with sexually transmitted diseases (STDs). (Pottie, Medu, Welch, Dahal, Radar & Well, (2016). Pottie et al. (2016) states that those who are at high risk for HIV exposure are injection drug users (IDU), men who have sex with men (MSM), persons from HIV epidemic countries, street youth, pregnant women, sex workers, low-income and socially disadvantaged people and the homeless. HIV can be transmitted through sexual intercourse, needle sharing, from mother to child, breastfeeding and blood transmission. HIV is found in body fluids like blood, semen, vaginal fluids and breast milk (CDC, 2017). In San Francisco, those who are disadvantaged and disproportionately affected by HIV are homeless individuals who are exposed to any of the risk factors of HIV mentioned above.

### **Homelessness and HIV in San Francisco**

A greater percentage of new HIV infections in San Francisco are among the homeless. This percentage has increased, a total of 31 people diagnosed with HIV (14%) were experiencing homelessness in 2017 as compared to 9% in 2011 (Land, 2018). Most of the neighborhoods experiencing new cases of HIV diagnosis are in the central part of the city, such as the Castro, the Tenderloin, and South of Market districts. The Tenderloin and South of Market having the highest number of homeless individuals. As of 2017, Castro had the highest new HIV diagnosis rate of 181 per 100,000 people, followed by the Tenderloin with 171 per 100,000 people and South of Market with 136 per 100,000 people (San Francisco AIDS Foundation, 2019).

In a publication by Associated Press published in the MarketWatch, it was suggested that the reason for increased homelessness in San Francisco is due to too little housing stock and a

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roaring tech economy that has widen the inequity gap. It was estimated that the median price of a two-bedroom home costs \$1.3 million for a family of four earning \$117,400 a year (MarketWatch, 2019). This high cost of housing is assumed to be the cause of homelessness in San Francisco. Homelessness has been associated with HIV as a result of risky behaviors of those undergoing homelessness. Homeless individuals sometimes exchange sex for shelter, drugs, money, and food (MarketWatch, 2019).

### **Ways of preventing HIV**

HIV can be prevented by taking precaution and avoiding risky behaviors. In order to adequately prevent HIV infection, individuals need to avoid the following: sharing of injection needles, injecting drugs, multiple sex partners, and having sex without condom. Other precautions include getting tested for STIs and having sex partners get tested since STIs increase the chances of contracting HIV. Individuals are also advised to talk with health care providers about use of pre-exposure prophylaxis (PrEP) medication for HIV prevention (US department of health and human services, 2019). PrEP is a HIV prophylactic medication that prevents HIV transmission, when it is taken a few hours before exposure to risky behaviors. One of the most effective ways of preventing infection and the spread of HIV is through periodic voluntary counseling and testing (VCT).

### **Voluntary counseling and testing (VCT)**

Voluntary counseling and testing (VCT) are an HIV prevention tool that allows individuals to learn their HIV status through pre-test counseling and post-test counseling and testing for HIV infection. VCT is used to increase the availability of HIV testing and treatment

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among marginalized or disadvantaged populations. It involves voluntary enrollment, rapid testing, counseling, giving of the test results and linkage to treatment (Pottie et al. 2016).

**VCT procedures.** The VCT program according to Anderson and Louw-Potgieter (2012) consists of three steps; 1) Pre-test counselling which takes about 15–25 minutes, introduces the participant to the VCT process. This first part describes the roles and responsibilities of the participant and counsellor and establishes rapport with the participant. This is followed by a risk assessment aimed at exploring HIV risk behaviors of the participant. With the risk behaviors ascertained, prevention counselling is given based on the participant's stage of willingness to effect harm reduction. 2) Then the administration of the Rapid HIV test which lasts for 20 minutes by a nurse or a medical practitioner. This process is done by collecting blood from the participant's finger onto a test kit, a buffer fluid is then added to the test kit. The test result is observed by the lines on the test kit (one line = negative; two lines = positive; no lines = indeterminate, one line = control samples, two lines = control + Ab or Ag strips, three lines = Control + Ab + Ag). 3) The last part is the post-test counselling which is supposed to last for about 5 –10 minutes. Counseling takes place while waiting for results, then the test result is disclosed to the participants, followed by reiteration of the key points of counseling based on the test result. For a negative result, counseling is focused on harm reduction in order to maintain this status. While for a positive result, the participant is given clear information concerning the positive result and offers compassion and support. Post-counseling is centered on status disclosure, partner referral, identification of support resources and linkage to medical care. Finally, the participant is helped to draw up a harm reduction plan.

**Where is VCT takes place.** VCT can be provided through stand-alone clinics or offered through community-based approaches. Bowles et al. (2008) posits that implementing rapid HIV

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testing programs in outreach and community settings, is a way of reaching the hard to reach who are unaware of their HIV positive status. These non-clinical testing venues are successful in client's reception of test results on the same day of testing as compared to conventional ways of testing where individuals fail to return for test results. These authors also say that acceptance of rapid HIV testing in these outreach settings outside the clinic has increased from 14% to 70% or more depending on the project and venue. Even though reactive rapid test results require confirmatory testing and return to receive confirmatory test results, individuals who test positive at these outreach posts can receive HIV post-test counseling immediately and linkage to medical care.

Furthermore, Gwadz et al. (2010) says that rapid HIV testing is encouraging changes in testing venues. Conventional HIV testing has been predominantly taking place in clinical settings, while rapid HIV testing is more commonly conducted in community-based outreach settings and organizations. These rapid HIV testing that are carried out at community-based settings or organizations serve those at high risk of HIV infection such as street youth and homeless individuals. When these testing are done at community-based settings, it increases access to testing and early detection of HIV.

Consequently, VCT is designed to motivate people to change their behaviors in order to prevent the acquisition and transmission of HIV; reduce anxiety over possible infection, facilitate safe disclosure of infection status, future planning and improve access to HIV prevention and treatment services (USAID, 2012), it has been considered the most widely accepted way of detecting and preventing HIV infection. Since the beginning of the HIV epidemic, serostatus knowledge has been a means to motivate harm reduction behavior changes to avoid future infection if uninfected. If infected, VCT helps avoid practices that could spread the disease to

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others and initiates antiretroviral therapy (ART) care (St. Lawrence et al, 2015). St. Lawrence et al. (2015), explain that the initial step in HIV care and control of its spread is testing to detect HIV infections early; since HIV treatment cannot be initiated without diagnosis. Community based outreach (CBO) approach is the most popularly used VCT method used to engage hard to reach populations like homeless individuals, injection drug users, commercial sex workers, etc. (Bowles et al. 2008). Studies have shown that men are generally hard to reach for HIV testing, but in a study review by Pottie et al. (2014), it was found that men accepted the uptake of HIV testing better than found in other studies.

**Recruitment for VCT.** There are various strategies employed in recruiting clients for VCT in non-clinical settings. In a study conducted by Ayana et al. (2015) on implementing rapid HIV testing and linking homeless youth to care, these authors distributed flyers and made loudspeaker announcements to advertise the program and recruit participants. Another strategy used by Bucher et al. (2007), was by approaching clients while they lined up for meals and explaining to them about HIV testing and those who were interested were recruited. A third strategy was employed by Gwadz et al. (2016), these researchers used the respondent-driving sampling (RDS), a peer-to-peer social networking-based recruitment method. In RDS, clients are trained to recruit their peers for HIV testing. This method of recruitment has been found to appropriate for hidden or hard to reach populations like homeless individuals. Recruitment is started through a small number of initial clients who recruit peers through their social networks (Gwadz et al. 2016). These recruitments' strategies are summarized in the table below

Table 1

*Summary of Recruitment Strategies*

- Recruiting volunteers while lining up to enter the dining room
- Distributing flyers in the dining room and on the streets
- Making loud announcements in the dining room about HIV testing
- Using respondent-driven sampling (RDS), a peer-to-peer sampling method

**Disparities in VCT uptake.** The Center for Disease Control and prevention (CDC) advocates universal opt-out and routine HIV testing at points of contact with health care systems, this means that individuals are free to accept or refuse HIV testing and no one is to be coerced into testing. However, it has been observed that disparity occurs in racial and minority groups, who often have little contact with health service providers (St. Lawrence et al, 2015). Yet, frequent VCT is advocated for as an important strategy for the early detection of HIV infections, for early initiation of infected persons into care, and for successful suppression of viral load (St. Lawrence et al. 2015, pp.2). The CDC guidelines for implementing voluntary HIV testing in nonclinical settings states that of the 1.2 million Americans estimated to be living with HIV in 2012, an estimated 156,000 did not know their HIV status. The CDC believes that new HIV infection spread results from HIV infected individuals who do not know their status and are undiagnosed (CDC 2016).

**Referral to treatment.** In carrying out VCT, it is important to refer HIV positive (HIV+) volunteers for treatment and ongoing care. Statistics show that as of 2013, 73% of those who tested positive to HIV antibody tests were linked to medical care within one month and 83% in three months in the United States (CDC 2016). Therefore, knowing one's HIV status is very

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important as it helps early diagnosed, and early initiation of ART resulting in viral suppression.

This also helps to modify lifestyle by avoiding risky behaviors and preventing the spread of HIV infection (Matovu & Makumbi, 2007).

**Impact of VCT.** Many studies have been carried out to show the impact of VCT in the fight against the HIV pandemic. Holtgrave & McGuire (2007), carried out an evaluation to determine the impact of VCT on those at risk for HIV infection or living with HIV infection. It was discovered that VCT had a beneficial impact on both seropositive and seronegative individuals. From their evaluation, they found a 68% reduction of spread of HIV infection when persons are aware of their HIV status. In this evaluation, individuals aware of their HIV positive status accounted for 30% - 46% of newly sexually transmitted HIV infections in the United States, while those unaware of their HIV status accounted for 54% - 70% of new cases. Holtgrave & McGuire (2007), concluded by recommending quality VCT for persons at risk of HIV infection as this helps to reduce risky behaviors and incidence of sexually transmitted diseases (STD).

**VCT and at high risk population.** An evidence-based intervention was carried out by Bowles et al. 2008 where they engaged in community-based outreaches (CBO) sponsored by the CDC for the prevention of spread of HIV. This intervention showed that VCT carried out during CBO is a good way of reaching minorities and those at high risk of HIV infection. As a result of doing the outreach, Bowles et al. (2008), found that those mostly at high risk for HIV infection were members of racial/ethnic minority groups, those who have multiple sex partners, men who have sex with men (MSM), members of the LGBTQ community, and homeless individuals in shelters and on the streets. Bucher et al. (2007), in their research of community-based rapid HIV testing in homeless and marginally housed adults in San Francisco, California, found a 15.4%

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HIV seroprevalence in the overall population and 65.2% were injection drug users and 80% MSM. These researchers also had a 95% HIV VCT acceptability among the population and had 86.7% linkage to treatment.

**VCT and incentives.** Finally, the VCT approach was used in a study in Botswana to recruit hard to reach populations, such as those who use illicit drugs to test for HIV. The researchers used mass media campaigns to advertise the study recruitment within identified marijuana user clusters and referrals from detoxification program centers, many of whom were likely to be HIV-infected. They emphasized confidentiality and the benefits of HIV testing. The participants were incentivized for participation and adherence to study visits with free laboratory testing, clinical follow-up, and reimbursement for transportation (Baum et al. (2015). Similarly, Nglazi et al. (2012), conducted a study to ascertain the effect of incentives on hard to reach population such as men for HIV testing. They found that those who were incentivized participated more in HIV testing program than those who were not incentivized. They had three groups of participants; clinic based, mobile outreach incentivized, and mobile outreach non incentivized. There was 10.2% HIV prevalence among the clinic based, 16.5% HIV prevalence among the mobile outreach incentivized, and 5.5% HIV prevalence among the mobile outreach non incentivized. In the same study, they had a subgroup of incentivized and non-incentivized self-reported first time and repeat testing participants. The incentivized self-report first time and repeat group had 18.5% and 13.6% HIV prevalence respectively while the non-incentivized self-report first time and repeat group had 7% and 4.5% HIV prevalence respectively. This research indicated that the VCT is good for community-based outreach to reach the difficult to reach to have access to care (Baum et al. 2016).

**Barriers to testing**

Bowles et al. (2008), conducted an HIV testing program among high risk populations within community outreach and street outreach settings and found that participants who refused testing gave the following reasons: (a) some claimed they had taken a test recently; (b) they didn't have enough time to take the test; (c) they were not ready to receive test results on the same day testing was being carried out; (d) and some said that it was because they did not want to be tested at the venue where testing was being offered.

Schwarcz et al. (2011), also stated in a study conducted to identify barriers to HIV testing that underestimation of risk behaviors was high among homosexual individuals who thought they were not at risk of HIV infection due to the belief that unprotected insertive anal sex and ejaculation were safe. Other barriers stated by the same authors were; fear of stigma, fear of lack of confidentiality of test results, fear of a positive result, risk of perceived negative consequences to testing, lack of awareness about improved treatment, and lack of knowledge about the availability of low-cost or free HIV treatment (Schwarcz et al. 2011).

**Fear of stigma among peers, family members, and neighbors.** Stigma has been rated as one of the major barriers to HIV testing worldwide (Odimegwu, Adedini, & Ononokpono, 2013). In a study conducted in Nigeria to determine the effect of stigma on VCT uptake, Odimegwu et al. (2013) found that most individuals refused VCT uptake for fear of stigma which is characterized by rejection, ostracization and abandonment by spouse, isolation, labelling, and blame by both family and the community. These researchers also found that responders believed those who are living with HIV are living ghosts walking around. In other words, they are already dead. In a related studies Anderson and Louw-Potgieter (2012) posits

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that the fear of HIV related stigma, discrimination and disclosure of one's HIV status are the most perceived barriers to HIV testing. Individuals are anxious about how their partners, families and communities will react to an HIV positive result. Women most fear domestic violence, and many fear losses of social status, abandonment and rejection.

### **Targeted populations**

This program aims to provide HIV counseling and testing among clients of St. Anthony's Foundation in the Tenderloin district. As mentioned earlier, HIV infection is common among gay and bisexual men who have sex with men, those of racial and ethnic minorities, and the homeless population. The homeless and low-income individuals who are experiencing imminent homelessness fall into the above-mentioned categories of people vulnerable to HIV infection and the clients of St. Anthony's Foundation are made up these categories. The CDC encourages HIV testing in the homeless, especially youth who are at a high risk of contracting HIV infection due to a high rate of mental health issues, substance use, living on the street, and continuous nomadic way of living (Gwadz et. Al. 2010). This project aims at VCT outreach among the homeless and low-income earners dining in the St. Anthony's dining room and those undergoing alcohol/drug rehabilitation at Fr. Alfred's drug recovery center, the technology lab, social work center and food and clothing center of St Anthony Foundation. These clients of St. Anthony's Foundation fall within the populations most at high risk of HIV infection.

### **Agency Profile**

#### **History**

This fieldwork was conducted at the St. Anthony's Foundation in San Francisco, California. St. Anthony's was started in October 1950 by Franciscan Fathers, the primary founder

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was Fr. Alfred Boeddeker, who had the vision of uniting the vulnerable populations in San Francisco's Tenderloin neighborhood (St. Anthony's Foundation). They started with a dining room to feed the needy and hungry poor for seven days of the week and offered warm course meals for free to every needy person that walked in irrespective of age, color, race or religion. No questions were asked of those who walked in, it was assumed that every person who walked in was hungry. The first day the dining room opened, Fr. Alfred was expecting to serve 150 people, but ended up serving 400 people. This marked the beginning of a vision that has expanded to include a Medical Clinic, Clothing Program, Social Work Center, Addiction Recovery, Tenderloin Technology Lab, Justice Education and Advocacy program. All the services listed above are available for free to those who need them.

### **Mission Statement of value**

St. Anthony's mission is to feed, heal, shelter, clothe, lift the spirits of those in need, and create a society in which all person's flourish. This mission is guided by five values: healing, community, personalism, justice, and gratitude. These values are expressed as follows:

1. Healing, they are committed to a healing ministry serving the spiritual, emotional and physical needs of those who are poor.
2. Community, they seek to be an integral part of the community they serve.
3. Personalism, they seek to honor diversity and treat all people with dignity and respect.
4. Justice, they seek ways to eliminate injustice and to educate and empower people so that all may claim their rights in society.
5. Gratitude, they celebrate the wonder of life and beauty of creation.

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### **Staff**

St. Anthony's Foundation has a total number of 150 staff with 21-member board of directors and eight management team members. The management team members are; executive director, director of human resources, director of programs, director of development, director of mission integration, director of assets management and facilities, director of medical clinic, and director of finance and informational technology. There is a wide range of volunteers and a special volunteer group called Young Professional Council. These are young volunteers who offer their professional skills for free to serve the underserved.

### **Funding**

St. Anthony's does not accept funding from the government and relies solely on private donations. It has 26 corporate donors such as Bank of America, Craigslist Foundation, Dignity Health, Google, Dodge & Cox, Dolby, Hilton, Kaiser Permanente, Sutter Health, PG & E etc. St. Anthony's also has 'In Kind Donors' like American Giant, Marine Layer, Old Navy, Safe Way (food & Drugs), Starbucks Coffee, Third Love, and Trader Joe's. Pro Bono donors are Bains & Company, Carta, Ne Timeas, Okta, and Optimizely.

### **Services/Programs**

St. Anthony's offers the following programs and services: (a) Dining room, (b) Medical clinic, (c) Clothing center, (d) Alcohol/drug recovery center, (e) Social center, (f) Technology Lab, (g) Justice education program, (h) Advocacy program. However, this research was focused around the following service outlined in the table below.

Table 2

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Services/program

|                            |   |
|----------------------------|---|
| Dining Room                | The dining room welcomes every guest with respect and dignity and serves the poor and homeless of the Tenderloin neighborhood of San Francisco. It opens from 10.00am - 1.35pm. For the residents, it is not just a dining room but a community where they share their lives.               |
| Medical Clinic             | The medical clinic serves those who cannot afford medical services anywhere else. They offer basic screening for preventive care like diabetes, cancer, cardiovascular diseases etc. and special medical care for children of low-income families   |
| Social Center              | The social work center helps clients to address issues like California ID card to secure employment, childbirth certificate to enroll children in school, applying for benefits and finding housing, pantry visitation to seniors, disabled individuals and needy families etc.             |
| Fr. Alfred Recovery Center | The alcohol/drug recovery center offers services to adults of 18years and above to stabilize them. To be eligible for the center one must be homeless, jobless and clean for three days. It empowers men to overcome addiction and supports them to establish productive and healthy lives. |

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|                 |  |
|-----------------|--|
| Clothing Center | St. Anthony's provides clothing for interviewing, for outside work, and children's clothing to homeless and low-income families. |
|-----------------|--|

### **Stakeholders**

St. Anthony's stakeholders are the Tenderloin community groups, corporate donors, In Kind Donors, Pro Bono Donors and the general public.

### **The Project**

This project hopes to propose HIV prevention and testing awareness to St. Anthony's foundation to encourage their numerous clients at the different sections to avail of HIV testing at the medical clinic. This will assure reduction in risky behaviors and prevent transmission of HIV among the homeless and those of low socioeconomic status undergoing transience homelessness.

### **Problem Statement**

St. Anthony Foundation is in the Tenderloin district which is an HIV high risk neighborhood due to high rate of homelessness and poverty in the area. This population are at high risk of HIV contraction due to street life, substance use, risky sexual behavior and needle sharing. The medical clinic offers HIV testing only upon request by physicians or individuals. There is a gap in this operation because despite these risky behaviors these clients do not come forward for HIV voluntary counseling and testing (VCT). Also, there hasn't been a designed HIV

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VCT protocol at St. Anthony's clinic to integrate these hard to reach populations or disadvantaged group into their HIV services.

## **Methods**

### **Question**

The question is: How can St. Anthony's Clinic bridge this gap by encouraging HIV VCT through outreach awareness among St. Anthony's Foundation clients?

### **Purpose and aims**

HIV testing and counseling has been part of St. Anthony Medical Clinic and they test based on patients and physician requests. Clients who access free services at St. Anthony's Foundation include; homeless individuals, alcohol and drug users, and those of low

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socioeconomic status. The purpose of this project was to create awareness of the importance of HIV prevention and testing among these clients. While the aims of this project were to test different recruitment strategies and to propose a protocol for ongoing HIV awareness and testing at St. Anthony's Foundation through St. Anthony medical clinic.

### **Training of HIV VCT counselor/tester**

To achieve this, the intern was trained on HIV counseling and testing for a period of three months, to qualify as a certified counselor and tester. This training involved having a broad knowledge of HIV infection, prevention, transmission, linkage to treatment, and learning counseling skills and harm reduction techniques. It took weeks of learning about HIV, stages of HIV infection and progression, harm reduction for HIV and drug use. This was followed by role plays on different scenarios both on alcohol/drugs use, risky sex behaviors which include having sex with multiple partners without protection, lack of condom use, and lack of PrEP use. The last phase of the training consisted of doing control tests on HIV test kits to validate them and practicing how to draw blood and doing actual testing on volunteer individuals.

### **Key Informant interviews**

In order to carry out key informant interview of the acceptability and feasibility of HIV testing in this population, a literature review search was done to find evidence-based strategies for recruiting hard to reach populations like the homeless to avail of HIV testing. This search covered peer-reviewed journals, websites and news articles. The strategies on how to recruit volunteers for HIV testing were selected based on literature review in Table 1 and as shown below:

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- Recruiting volunteers while lining up to enter the dining room
- Distributing flyers in the dining room
- Making loud announcements in the dining room about HIV testing
- Using respondent-driven sampling, a peer-to-peer sampling method

Key informant interviews were conducted with three members of St. Anthony's Foundation, the director of patient navigation, the spiritual director, and the dining room manager to ascertain the acceptability and feasibility of client's uptake of HIV testing and best strategies for recruitment.

This interview was conducted using a checklist (Appendix A) of open-ended questions and responses were transcribed for two of the key informants while the other was recorded.

### **Implementation of strategies and testing**

Two weeks prior to the implementation of testing and counseling, flyers (Appendix B) were distributed to clients while lining up to enter the dining room, after they finished eating and were leaving the dining room, at the clothing/social centers, and on the streets. Also, notices were placed at the reception desks of the dining room, social/clothing centers notice board, medical clinic front desk, laboratory technology notice board, and St. Anthony's Foundation lobby front desk. Clients at the Fr. Alfred alcohol and drug recovery center (FAC) were informed of testing at their weekly in-house meeting. Unfortunately, we could not advertise on the dining display screens as the dining room officials would not permit the use of their display screens for HIV testing messages.

**Data collection**

Data was collected using a survey instrument (See Appendix C) given to clients to fill out during counseling for demographic data and risky behaviors. HIV testing was done using Determine Rapid HIV test kit to obtain results. The result was used to determine the prevalence of HIV among clients of St. Anthony's foundation. Counseling sessions were aimed at harm reduction for alcohol/drug use, and sexual lifestyle.

**Results**

During the key informant interviews, all key informants agreed that HIV testing for the clients was a good idea given the lifestyle in the Tenderloin district (See Table 3). One interviewee said that sometimes clients are not aware of available services at the clinic, especially HIV testing, so they might not avail of them especially HIV testing. Therefore, they supported talking to clients while they lined up for meals, street outreach, distribution of flyers, they also suggested the use of screen displays in the dining hall to advertise the program and

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setting up a table in the dining room for distribution of flyers and one on one interaction with clients. Table 3 below summarizes the strategies used for recruitment of participants. The dining room manager who was one of the key informants said:

“When people see a table set up, they go to find out what it is all about”

All key informants were of the opinion that making an announcement in the dining room was not allowed, and that even if it was allowed the clients will not turn up for testing because they would not want others to know that they were going for an HIV test. One of the key informants said:

“A lot of people might not want it public”

Again, the strategy of using respondent-driven sampling, a peer-to-peer sampling method was not feasible as we didn't have gift card incentives to incentivize both recruiters and testing volunteers.

Table 3

*Key Informants Quotes About HIV Testing*

---

Concept

Quotes

Acceptability of testing

“A lot of people might not want it public”

“It is a good idea, and everything works after a trial”

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Importance of HIV status awareness

"It is good to carry out HIV testing here because of risky behaviors around"

Recruitment Strategy

"When people see a table set up, they are going to find out what is all about"

Table 4

*Strategies for Recruitment of Participants*

Strategies

Results

Clothing Center (Flyers)

27 individuals

Dining room line (Flyers)

93 individuals

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|   |                       |
|---|-----------------------|
| Street outreach (Flyers)                | 20 individuals        |
| Posters                                 | placed at 5 locations |
| Announcement at Fr. Alfred Center (FAC) | 65 individuals        |

---

### Participants Characteristics

From table 4 above, a total of 205 individuals were given flyers and talked to at the dining room, clothing/social center, on the street and at FAC to participate in the HIV testing program. There was very poor response at the dining room, clothing/social center and the streets as no one came forward for HIV rapid test. Twenty individuals accepted to be tested but not all could be tested due to unforeseen administrative set back. Table 5 below shows the socio-demographics and risk assessment of participants who were tested.

Table 5

#### *Demographics*

---

| <u>Variables</u> | <u>Total Number</u> | <u>Percentage (%)</u> |
|------------------|---------------------|-----------------------|
|------------------|---------------------|-----------------------|

Age

|       |   |       |
|-------|---|-------|
| 30-39 | 2 | 28.57 |
|-------|---|-------|

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|                        |   |        |
|------------------------|---|--------|
| 40-49                  | 2 | 28.57  |
| 50 +                   | 3 | 42.85  |
| Sex                    |   |        |
| Male                   | 7 | 100.00 |
| Female                 | 0 | 0.00   |
| Sexual Orientation     |   |        |
| Heterosexual           | 5 | 71.42  |
| Gay/Lesbian            | 1 | 14.28  |
| Bisexual               | 1 | 14.28  |
| Marital Status         |   |        |
| Married                | 1 | 14.28  |
| Never married          | 4 | 57.14  |
| Separated/Divorced     | 1 | 14.28  |
| Living with a Partner  | 1 | 14.28  |
| Race/Ethnicity         |   |        |
| Black/African American | 5 | 71.42  |
| Hispanic               | 1 | 14.28  |

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|   |   |        |
|---|---|--------|
| White   | 1 | 14.28  |
| Education                                       |   |        |
| Less than 12 <sup>th</sup> grade                | 1 | 14.28  |
| Equal to or greater than 12 <sup>th</sup> grade | 1 | 14.28  |
| Complete High School                            | 2 | 28.57  |
| College/University                              | 3 | 42.85  |
| Prison  |   |        |
| Yes   | 5 | 71.42  |
| No  | 2 | 28.57  |
| Injection Drug Use                              |   |        |
| Yes   | 3 | 42.85  |
| No  | 4 | 57.14  |
| Drugs/Substance Use                             |   |        |
| Yes   | 7 | 100.00 |
| No  | 0 | 0.00   |
| Alcohol Use last 30 days                        |   |        |
| Yes   | 0 | 0.00   |

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|                                 |   |        |
|---------------------------------|---|--------|
| No                              | 7 | 100.00 |
| Housing                         |   |        |
| On the street                   | 4 | 57.14  |
| Apartment                       | 3 | 42.85  |
| Unprotected sex last 30 days    |   |        |
| Yes                             | 0 | 0.00   |
| No                              | 7 | 100.00 |
| Sex without Condom (ever)       |   |        |
| Yes                             | 7 | 100.00 |
| No                              | 0 | 0.00   |
| Sex partners last 30 days       |   |        |
| One                             | 5 | 71.42  |
| Two                             | 1 | 14.28  |
| ≥ Five                          | 1 | 14.28  |
| Exchange sex for money or drugs |   |        |
| Yes                             | 2 | 28.57  |
| No                              | 5 | 71.42  |

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## Previous HIV testing

|     |   |       |
|-----|---|-------|
| Yes | 6 | 85.71 |
| No  | 1 | 14.28 |

## Reason for not testing for HIV

|                               |   |       |
|-------------------------------|---|-------|
| Lack of access to health care | 2 | 28.57 |
| Fear of positive result       | 3 | 42.85 |
| Not applicable                | 2 | 28.57 |

## Reason for testing HIV

|                                  |   |       |
|----------------------------------|---|-------|
| Because of risky behavior        | 1 | 14.28 |
| It is important to know          | 4 | 57.14 |
| Not afraid of knowing status     | 1 | 14.28 |
| If positive, to start medication | 1 | 14.28 |

## Knowledge of PrEP

|     |   |       |
|-----|---|-------|
| Yes | 5 | 71.42 |
| No  | 2 | 28.57 |

## Use of PreP

|     |   |       |
|-----|---|-------|
| Yes | 2 | 28.57 |
|-----|---|-------|

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|                 |          |              |
|-----------------|----------|--------------|
| No              | 5        | 71.42        |
| Test Result     |          |              |
| Positive        | 1        | 14.28        |
| <u>Negative</u> | <u>6</u> | <u>85.71</u> |

Of the tested population, 28.57% were within the ages of 30-39, 28.57% ages 40-49, while 42.85% were within ages 50 and above. Seventy one percent (71.42%) of these participants were heterosexual while Fourteen percent individuals were homosexual and bisexual respectively. Fifty seven percent (57.14%) of the participants agreed to being homeless on the street prior to admission at the facility and 42.85% lived in apartments before being admitted. Black/African Americans were 71.42%, while Hispanics and White were both 14.28% respectively. Seventy one percent of them had ever been in prison. Forty two percent had college/university education, 28.57% completed high school, while 14.28% had less than 12th grade and equal to/greater than 12th grade respectively.

### **Acceptability of HIV Rapid Testing**

Of the 205 individuals approached for HIV testing, 9.75% agreed to test but only 3.41% eventually got tested. The remaining 5.85% were not able to test due administrative problems. One hundred and ninety-eight (96.58%) individuals out of 205 did not show for testing.

**HIV Prevalence**

Eighty five percent (85.71%) were HIV negative, 71.42% were heterosexual and 14.28% bisexual. Fourteen percent (14.28%) were HIV seropositive (Table 5), of homosexual sexual orientation with history of injection drug use.

**Risky behavior assessment**

Hundred percent (100.00%) of the participants reported ever having sex without condom and only 28.26% reported ever using PrEP for prevention. Likewise, all participants (100%) were substance/drug users with 42.85% doing injection drug use (IDU). Fourteen percent (14.28%) reported having more than five sex partners in a month and 28.57% had exchanged sex for money or drugs. Also, these participants gave reasons why they did not test for HIV regularly, 42.85% reported fear of a positive result while 28.57% did not test due to lack of access to health care facility, and 28.57% reported regular testing. Eighty five percent (85.71%) reported previous HIV testing with negative results. The reasons for accepting to test at this project were 57.14% saying it is important to know one's HIV status, 14.28% participants said it was because they were exposed to behaviors known to increase the chances of contracting HIV, 14.28% said they wanted to know so that if positive, they would initiate treatment, and another 14.28% said they were not afraid of testing so they always avail of opportunities to test.

### **Discussion**

Two hundred and five (205) clients from the different programs of St. Anthony's Foundation were spoken to and given flyers about HIV testing and the importance of knowing one's HIV status. Twenty clients volunteered for testing but only seven could be tested. The other twelve were not tested due to organizational issues that came up and the researchers time was up.

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All participants tested were within the ages of 30 and above. There was 14.28% HIV positive seroprevalence among the population who were MSM +IDU and this agrees with the findings of Bucher et al. where they found 15.4% HIV seroprevalence among the homeless and marginally house population and mostly MSM + IDU (Bucher et al. 2007). This seropositive result also corresponds with the 2017 US HIV statistics that says 15% (1 in 7) persons out of the estimated 1.1 million infected with HIV, in the US, do not know their status (HIV.gov, 2019). One hundred percent of the participants reported not using condom during sex, this agrees with a study conducted by Zhang et al. (2009) which showed that 61.6% of participants never used condom during sex despite knowledge of risk of infection.

One hundred and ninety eight out of 205 declined testing saying that HIV is not for them and some refused to be tested on the grounds that they do not consider themselves to be at risk of HIV infection. This lack of awareness of behaviors known to increase the chances of contracting HIV infection was reported in a study conducted by Schwarcz et al. (2011), where participants who tested positive to HIV infection said they did not see the need for testing before because they did not consider their behaviors as exposing them to HIV infection. An example of this was where homosexual individuals thought that unprotected insertive anal sex and unprotected insertive anal ejaculation were not risky for HIV transmission.

Furthermore, this refusal to testing is contrary to the findings of Bucher et al. (2007) where they had 98% homeless individuals who participated in HIV VCT testing. Their success was largely due to the cooperation of SRO hotel managers, homeless shelter managers and meal line managers (Bucher et al. 2007). Some individuals refused to test because there were no gift cards to motivate them. This agrees with literature where Nglazi et al. (2012) found that giving incentives motivated hard to reach population such as men to participate in VCT programs.

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Similarly, this population is also a hard to reach population and would have responded better with incentives. Moreover, giving of gift cards or money incentive has been one of the successful ways of recruiting hard to reach populations for VCT as shown by a study conducted by Bucher et al. where the researchers used the respondent driven sampling (RDS) to recruit homeless and marginally housed participants by offering a \$15 gift card and transport reimbursement to participants (Bucher et al. 2007). However, use of gift card was not possible due to the large population of clients at St. Anthony's and lack of external sponsorship, also, St. Anthony Medical Clinic has stopped incentivizing for HIV and Hepatitis C testing because these tests are being offered for free.

This refusal to testing again is found in a study conducted by Anderson & Louw-Potgieter, (2012), where individuals with multiple sex partners within a period of 12 months failed to utilize VCT services. Homeless individuals have been considered one of the populations at high risk of contracting HIV infection as homeless individuals are frequently involved in behaviors known to increase the chances of HIV infection. These activities include commercial sex work, multiple sexual partners, and injection drug use (Douaihy, Stowell, Bui, Daley & Salloum, 2005). These same authors stated that a study conducted in Houston of homeless population showed that more than two thirds of the study population was at risk for acquiring HIV infection and about half of the population had two or more risk factors and the most common risk factors were unprotected sex with multiple partners and injection drug use.

Others refused testing due to wrong ideas about VCT, such as 'HIV is for dead people' (These statements were made during conversation as flyers were being distributed). The idea of HIV is for dead people corresponds with the findings of Odimegwu et al. (2013) in the literature, where their survey respondents believed that those living with HIV were ghost moving

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around. This misinformation about HIV infection and testing is largely due to misconceptions based on stigma. Odimegwu et al. (2013) points out that individuals who refuse HIV testing are afraid of family and community rejections and labelling. The researchers also said stigma arises as a result of blaming and lack of knowledge about how HIV is contracted.

Therefore, this attitude of homeless individuals refusing testing indicates that individuals who are at high risk of HIV infection due to risky lifestyle or low socioeconomic conditions are slow at making use of VCT services (Anderson & Louw-Potgieter, 2012).

### **Implications for Practice**

This study was aimed at proposing an HIV testing protocol for St. Anthony Medical Clinic. However, there was low utilization of VCT by clients of St. Anthony's Foundation. This calls for better program design and implementation of strategies. Comments like "HIV is for dead people" shows lack of adequate understanding of HIV and benefits of HIV testing. It was not possible to carry out this educational outreach during this study because it was generally opined that the dining room is not suitable for carrying out talks and announcements while the clients ate their meal as this is their time to socialize as a family. However, this policy could be made flexible for 10-15minutes talk when there is a need for it. Based on evidenced based literature, incentivizing for HIV testing in this population is vital for VCT uptake thus, there was little uptake of VCT due to lack of incentives.

To design an HIV protocol at St. Anthony, the clinic would have to include educational instructions at the dining room for a period of two weeks before offering VCT services to the clients. Also, the clinic would have to come up with sponsorship for incentives as most clients

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asked for gift cards as motivation to testing. There is also need for flexibility in organizational policy such as allowing messages to be displayed on display screens when there is a need for it.

### **Limitations**

There were some limitations that affected this study that are worth mentioning for future research to take into consideration. St. Anthony Medical Clinic is in the Tenderloin district and it is surrounded by a lot of agencies offering similar services to the Tenderloin populace. Examples such as the Larkin Street Youth Center next door to St. Anthony's, offers HIV testing for youth 25 years and below. They have inviting attractions like playing music, socializing and working on art, these activities lure youth to them more than coming to St. Anthony Medical Clinic. The San Francisco AIDS Foundation is also less than two blocks away and they carry out a lot of HIV counseling, testing, and linkage to care. Others are; Tom Waddell Clinic on Golden Gate Avenue, City Impact on Turk street, Curry Senior Center, Glide Memorial on Ellis street, Department of Health (DPH) drop in clinic by City Hall, Project Homeless Connect at Bill Graham Civic Center, St. James mobile HIV testing van, etc. All these agencies have a limiting effect on this study as some of the clients might have availed of HIV services at any of these organizations.

The inability to access the display screen at St. Anthony's foundation to advertise for HIV testing, limited the dissemination of information about testing thereby missing out on some clients who might have missed out on getting the flyer. Also, there was little time for advertisement due to the length of time it took to train the researcher as counselor and tester. Another limitation observed was that carrying out testing in the evenings outside the clinic hours was not ideal, because confirmatory reactive testing can only be carried out in the laboratory and

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in the event of a reactive case, there would be delay in linkage to care. Institutional drawbacks such as change in management also affected the flow of testing activity. Finally, the researcher's religious habit must have been a limitation in this study as some clients might not feel free discussing their sexual or drug lifestyle with a nun.

### **Recommendations**

The following recommendations would be good for future research in this population. Educating on the benefits of HIV testing prior to testing will improve uptake of HIV testing among the clients of St. Anthony's Foundation. This could be done through periodic talks at the FAC, clothing/social center and the dining room. Incorporating HIV messages on strategic display screens would also increase HIV knowledge and availability of HIV test at the clinic. Similarly, outreaching for HIV testing at the different programs of St. Foundation regularly will be key to successful recruitment of clients given that there are so many organizations around St. Anthony Medical Clinic offering the same services. In developing a protocol for on-going HIV testing at the clinic, two volunteers should be on this HIV program. One counselor and tester and one outreach navigator. In this way, the counselor/tester will be available for testing as planned on the clinic HIV testing schedule while the outreach navigator continues with the outreach. Finally, sourcing for sponsorship for incentives is vital for the success of this program among this population.

### **Future Research**

Future research among this population will require exploration of various strategies of recruitment for better uptake of VCT. One method will be to conduct a focus group meeting with the managers of the dining room, meal line, clothing center, FAC, technology lab, Social Center,

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volunteer coordinator, patient navigator director and the foundation spiritual director to share ideas about best strategies to use. Through this focus group meeting managers will get to better understanding of the benefits of HIV testing in this population. They will also see themselves as part of the program and be more willing to cooperate and make it a success. If possible, a focus group meeting or key informant interview with regular clients at the dining room would also be beneficial in spreading information about the program and in recruiting participants. Another, strategy worth exploring would be the respondent driven sampling (RDS), using peer to peer recruitment method. This strategy requires use of incentives, therefore, getting sponsorship for incentives will be beneficial to the success of the program.

### **Conclusion**

The importance of HIV voluntary counseling and testing among various populations in the society can never be over emphasized. The purpose of this project was to create awareness of the importance of HIV prevention and testing among St. Anthony Foundation numerous clients and the aims were to test different recruitment strategies and to propose a protocol for ongoing HIV awareness and testing through St. Anthony medical clinic.

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A key informant interview was conducted to find out the acceptability and feasibility of this program and to determine what best strategies to use for recruitment of participants. The strategies of distribution of flyers, posters and announcements were then employed for recruitment of participants. These strategies produced a small sample size of participants for HIV testing and there was 14% HIV seropositive prevalence in the population.

The implications of this study are that there is need for on-going HIV testing among the clients of St. Anthony's Foundation and regular education on the benefits of HIV prevention and testing would help to eliminate bias and stigma about HIV test, with a beneficial outcome of increased HIV testing and decrease spread of HIV. Some limitations of this program were inadequate publicity of program due to lack of time and inability to use St. Anthony's display screens to advertise the program. Also, the numerous organizations in the Tenderloin district offering HIV counseling and testing services contributed to low turnout of participant who might have received service at these organizations.

Therefore, the researcher recommends that future researchers should employ focus group meetings involving relevant program managers and clients to find better strategies of recruiting participants.

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**Appendix**

Appendix A

Participants Name: .....

Date: .....

**University of San Francisco School of Nursing and Health Populations/St. Anthony's  
Clinic San Francisco**

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You have been identified as a key informant in the issue of HIV and/or client service in St.

Anthony's foundation. As a key informant, your views on these issues are of importance in our efforts to encourage and improve HIV testing among clients of St. Anthony's. We appreciate you taking time to provide us with answers on this brief survey. Your responses to this confidential survey will help in designing an HIV voluntary counseling and testing protocol for use at St.

Anthony's clinic to promote HIV prevention among its clients in the Tenderloin district.

Job Title: .....

1. Briefly explain what your current job title entails
  
2. Currently how important do you consider the idea of providing HIV rapid testing among the homeless?
3. Would you recommend other organizations such as yours the Tenderloin district to encourage HIV testing?
4. What strategies do you think will help to recruit clients for HIV testing?
  
5. How do you think this on-going HIV testing in St. Anthony's clinic will promote HIV prevention in this population?
6. From your experience how do you think it will be possible to link positive cases to primary care immediately?
7. What ways if any, can implementation of HIV rapid testing in homeless population be improved?

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8. The following are our proposed strategies for recruiting voluntary testing among the homeless. What are your opinions about them and which of them do you think will work best?
- Recruiting volunteers while line to enter the dining room
  - Distributing flyers in the dining room and making loud announcements about testing and how to enroll
  - Using respondent-driven sampling, a peer-to-peer sampling method
9. What other strategies would you recommend for recruiting participants?

Appendix B

Name of Participant: .....

1. What age group below do you belong?
  - a) 18-29
  - b) 30-39
  - c) 40-49
  - d)  $\geq 50$
2. How do you identify yourself?
  - a) Male
  - b) Female
3. What is your sexual orientation?
  - a) Transgender male to female
  - b) Transgender female to male
  - c) Gay/Lesbian
  - d) Bisexual
  - e) Heterosexual (Straight)
  - f) Others..... Specify.....
4. What is your marital status?

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- a) Married
- b) Divorced/ Separated
- c) Never Married
- d) Living with a partner
5. What is your race or ethnicity?
  - a) African American
  - b) Asian
  - c) Hispanic
  - d) Native American
  - e) Pacific Islander
  - f) White
  - g) Others..... Specify.....
6. What level of education do you have?
  - a) Less than 12<sup>th</sup> grade
  - b) Equal to or greater than 12<sup>th</sup> grade
  - c) Complete high school
  - d) College/University
7. Have you ever been in prison?
  - a) Yes
  - b) No
8. Have you ever used injection drugs?
  - a) Yes
  - b) No
9. Have you ever used drugs/substances?
  - a) Yes
  - b) No
10. Have you used alcohol/substance in the last 30 days?
  - a) Yes
  - b) No
11. What is your housing status?
  - a) Homeless (on the Street)
  - b) Single Room Occupancy
  - c) Apartment
  - d) Doubling
  - e) Sleeping in the car
12. Have you ever had sex without condom?
  - a) Yes
  - b) No
13. Have you had unprotected sex in the last one month?
  - a) Yes
  - b) No
14. What value best describes the number of sex partners you would have in a month?
  - a) 1
  - b) 2
  - c) 3
  - d) 4

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- e)  $\geq 5$
15. Did you ever engage in sex for money or drugs?
- a) Yes
  - b) No
16. Have you ever tested for HIV before?
- a) Yes
  - b) No
17. What made you not to test for HIV before?
- a) Fear of stigma
  - b) Lack of access to testing facility
  - c) Fear of positive result
  - d) Fear of lack of confidentiality from healthcare personnel
  - e) Low perception of high-risk behavior
18. Why are you testing for HIV today?
- a) Because of risky behaviors
  - b) Because it is important to know
  - c) Because I tested before, so I am not afraid of knowing my status
  - d) So that if I am positive, I can start treatment immediately
19. Have you ever heard of PrEP?
- a) Yes
  - b) No
20. Have you ever used PrEP for HIV prevention?
- a) Yes
  - b) No
21. Do you have any form of health insurance coverage?
- a) Yes  
Specify
  - b) No

Appendix C

**ST. ANTHONY'S**  
Hope Served Daily



**Free HIV and Hepatitis C testing  
and counseling for Adults**

Place: St. Anthony Medical Clinic  
150 Golden Gate Avenue

Days: Mondays, Wednesdays, &  
Fridays

Time: 10.30am – 2.00pm

Appendix D

St.  
Anthony

MRN:

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**HIV Test Counseling Process Summary/Contact and Linkage Form**

|   |   |
|---|---|
| First: _____  | Last: _____   |
| Age: _____ DOB: ____/____/_____ Last 4 digits of SSN for positives: _____                   |   |
| Testing Location: _____<br>____/____/_____  | Date of risk assessment: _____                                  |
| Test Type: <input type="checkbox"/> HIV (Determine) <input type="checkbox"/> HCV (Oraquick) |   |
| SAMC Counselor Name: _____ Thermometer ID: _____  |   |
| Email Address: _____<br>No  | ID OK: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Other: _____  | ID OK: <input type="checkbox"/> Yes <input type="checkbox"/> No |

**Consent to Confidentially test for HIV Antibodies and Antigens**

**Client Initials**

\_\_\_\_\_ I have been informed that this test screens for HIV Antibodies and Antigens present in whole blood through finger stick and that I will receive my HIV results before I leave today.

\_\_\_\_\_ I have been informed that this is a confidential test and that all positive results will be forwarded by name and social security number to California Department of Health Services; this information will be maintained confidentially. I understand that provision of my SSN is voluntary and that I will not be declined services for not providing it.

\_\_\_\_\_ I understand that the information I provide during this test counseling session, including my identity and test results, may be shared with other members of St. Anthony Medical Clinic HIV test counseling team for the sake of data entry. If I have a reactive result, the testing site coordinator will be notified and my identity shared to ensure full support for me and the test counselor. No information about this test counseling session will be shared with other St. Anthony Medical Clinic staff without written consent from me.

\_\_\_\_\_ I have been informed that if I have been recently infected with HIV there may not be enough antibodies or antigens present for the test to detect. I understand that the accuracy of the HIV test is not 100% certain.

\_\_\_\_\_ I have been informed that a negative test does not require confirmation. I understand that if my test today is reactive my blood will be drawn for additional off-site testing which may include RNA testing. I may also be offered linkage to St. Anthony Medical Clinic.

\_\_\_\_\_ I consent to be contacted by St. Anthony Medical Clinic and/or a linkage specialist from the Department of Public Health on St. Anthony Medical Clinic's behalf in the event that I miss a follow-up appointment or need to be informed about important information regarding my health status. I also understand that this person will provide me with additional support regarding linkage to medical care.

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By signing below, I acknowledge that I have been given information concerning the benefits and risks of HIV testing, and have had a chance to ask questions which were answered to my satisfaction. I consent to submit a blood sample to be tested for HIV if necessary.

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_-\_\_\_\_-\_\_\_\_  
SSN

\_\_\_\_\_  
Signature

For Reactive Results:  Referral for confirmatory Test  Linkage to Primary Care @SAMC  Other