HIV TESTING TOOLKIT

DATA DRIVEN TARGETING AND RECRUITMENT

NASTAD
NASTAD is a member of the CBA Provider Network and has a long history of providing technical assistance and Capacity Building Assistance (CBA) to health departments to support HIV testing. This document is the third in a series of HIV Testing Toolkits, following Selecting a Strategy and Productivity and Yield Analysis, which were released in 2015. These and other resources are available for download at www.NASTAD.org.
Introduction

The central goal of an HIV testing program is to identify undiagnosed HIV infection in order to link individuals to HIV medical care. Testing programs can also identify previously diagnosed individuals and provide opportunities to link them to care. Treatment with antiretroviral (ARV) medications, especially early in the course of infection, has important primary and secondary prevention benefits. For individuals with HIV infection, ARV treatment can reduce their viral load and help them live longer, healthier lives, particularly among disproportionately impacted populations. HIV treatment also reduces the likelihood of transmission to HIV negative individuals.

In order to maximize return on investment, health departments should focus HIV testing efforts in ways that will identify as many undiagnosed infections as possible, particularly given limited resources. Targeting and recruitment of high-risk populations is a strategy that health departments can use to improve their ability to identify undiagnosed HIV infection. Targeting refers to the use of data to focus program efforts on the right populations, in the right settings, to maximize the identification of undiagnosed HIV infection.

Once focus populations are identified, HIV testing programs need to determine how to get members of focus populations to participate in HIV testing services. Recruitment refers to the strategies (e.g., promotion methods, service locations, service modalities, messaging/messengers) used to contact and engage members of focus population(s) in HIV testing services. Even when well-designed, HIV testing programs may find it challenging to recruit members of focus populations into HIV testing services unless the recruitment strategies are deemed appropriate by the populations health departments (and their funded partners) are seeking to reach.

This tool will help HIV testing program managers to improve targeting of and recruitment into HIV testing services through the application of data to program planning and refinement.

**Targeting** is the process for defining how you will direct your HIV testing services to identify persons who are unaware of their HIV status and who are at greatest risk for HIV infection (i.e. identifying who should be reached, where, and how).

**Recruitment** begins once you have defined your focus population and identified where and how to reach them (i.e., targeting). It is the process of implementing recruitment strategies to reach the focus population as identified through targeting.
Segmentation is a term borrowed from marketing. Segmentation, in the context of planning HIV testing services, refers to dividing a population into subgroups similar in specific ways related to HIV risk. It is a strategy that program planners can use to help to more precisely define and locate focus populations. Segmentation is done because populations may be in different places at different times, they may need different messages, and thus recruitment strategies may vary based on populations segments. There are a variety of individual characteristics (e.g., race, gender, sexual orientation), behaviors (e.g., drug injecting), situational or environmental factors (e.g., incarceration, unemployment, stable housing, residing in a neighborhood with high HIV prevalence), and social factors (e.g., interests, social networks) which influence risk for HIV. Segmentation requires program planners to identify the characteristics, behaviors, and situational factors most associated with (but not necessarily causative of) HIV risk. Program planners should seek to describe focus populations, at minimum, in terms of gender, age, race and ethnicity, HIV risk, and location. For example, based on HIV prevalence data, program planners may decide to scale-up engagement strategies for people who inject drugs (PWID). However, PWID are likely not a homogenous group. Using other data may suggest segmenting PWID into several distinct subgroups such as “PWID, under age 30 years and who reside East of Main Street in River City,” and “PWID, older than age 40, who live west of Elm and south of Brook in Plainville.”

Using multiple data sources is an important strategy for reaching focus populations. Most program planners minimally use HIV prevalence data for targeting. Many also use data about HIV risk behavior. However, there are many other sources of data that can also be useful in targeting including, incidence and prevalence of sexually transmitted infections (STIs) and hepatitis C (HCV), health services data, and relevant social and environmental factors. Suggested data sources are presented in Table 1, on the next page.

Program planners often rely on state or county data to refine approaches to reach focus populations. To the greatest extent possible, program planners should obtain local-level data (e.g., neighborhood-level).
### Table 1: Data for Targeting and Recruitment Planning

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| HIV, HCV, STD surveillance | Data are available from state and local public health agencies (e.g., HIV epidemiologic profiles, disease surveillance reports).  
Data are available according to a variety of demographic and risk characteristics  
Typically, data are available at various levels (e.g., state, county, city, zip code, and neighborhood)  
Cluster and networking analysis of disease surveillance data may be available  
Data collected by public health disease intervention specialists may be useful in identifying behaviors and venues associated with transmission  
Geo-mapping may be available |
| Behavioral surveillance and other behavioral data | Behavioral surveillance data are available from state/local public health agencies. Behavioral surveillances include data on sexual behaviors, adoption of prevention strategies (e.g., condom use), and drug use.  
Data are available according to a variety of demographic and risk characteristics  
Nationally-supported data sets include:  
National HIV Behavioral Surveillance  
Behavioral Risk Factor Surveillance System  
Youth Risk Behavior Surveillance System  
National Survey on Drug Use and Health  
Other sources of behavioral data include:  
Community needs/health assessments (e.g., conducted by HIV planning groups, community health centers, or other groups)  
Community health needs assessments (CHNA) are required of tax-exempt hospitals as a result of the Patient Protection and Affordable Care Act. Planning and data resources are available from the CDC.  
State, tribal, local, and territorial health departments develop community health assessments and health improvement plans related to accreditation, non-profit hospital collaboration, and other reasons. Planning and data resources are available from the CDC. |
| Health and psychosocial data | Health services data from hospitals, community health centers, and health and social service providers (e.g., number patients receiving HIV and STD screening, number of patients receiving HIV treatment, patients receiving publically-funded mental health services).  
Community health center data are available online from HRSA’s Uniform Data System (UDS). Data are available by various demographic, risk, and other (e.g., health insurance status) characteristics.  
Data regarding substance use and treatment, including emergency room admissions associated with drug overdoses, and substance use treatment admissions. National data sets (local analysis may be available) include:  
The Treatment Episode Data Set (TEDS)  
The National Survey on Substance Abuse Treatment Services (N-SSATS)  
The Drug Abuse Warning Network (DAWN)  
State/local correctional health data (e.g., percent of inmates with HIV, co-infected with HIV and HCV).  
State/local law enforcement data (e.g., drug arrests)  
Data from local service providers (e.g., shelters, drug treatment) that describes health and relevant psychosocial factors (e.g., drug use, housing stability)  
Community needs/health assessments (e.g., conducted by HIV planning groups, community health centers, focus population focus groups and surveys)  
Evaluation conducted by your program or other agencies/programs in the area (e.g., surveys conducted in community, interviews with proposed target population, ethnographies) |
Once the focus population(s) is defined program planners must determine how to recruit for HIV testing services. In general, targeting is often led by the health department, which uses data to identify focus populations and allocates resources to meet their testing needs. Recruitment is often conducted by community based organizations, though health departments are involved in working with them to strengthen their efforts. In deciding how to recruit, program planners should consider the following:

- Where and when recruitment will be conducted:
  - In which venues or settings will recruitment be conducted?
  - Should recruitment be conducted at the same location where HIV testing services are offered or should recruitment occur in other locations?
  - Should recruitment be conducted on specific days of the week and/or during specific hours based on focus population needs?

- The recruitment methods that will be used:
  - Will recruitment be conducted face-to-face, or will other means of communication, such as social media, be used?
  - Will recruitment be conducted one person at a time, or will recruitment be conducted in a group(s)?

- Who will conduct recruitment:
  - Will recruitment be performed by trained peers, health educators, clinic staff, by individuals who represent the focus populations that health departments are seeking to engage?

- The messages that will be most effective in recruiting for HIV testing services:
  - What are the benefits and drawbacks of testing focus populations?
  - What other services — particularly those services highly valued by focus populations — are available?

Recruitment efforts will be most effective when strategies are tailored to the focus population. Using data from multiple sources is essential to gaining an understanding of the needs, interests, and focus population priorities as they relate to engagement in HIV testing services. To the greatest extent possible, local data should be used in tandem with focus population recommendations to identify appropriate recruitment strategies. Ideally, data used to decide how to recruit should come from primary data sources (i.e., data that the program collects in conjunction with planning to implement and/or evaluate HIV testing services). A summary of potential data sources that may be used for targeting and recruitment planning is available in Table 1.

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**CDC’s Six Recruitment Strategies**

1. Street-based and venue-based outreach
2. Internet outreach
3. Internal referrals
4. External referrals
5. Social networking
6. Social marketing
A tool, available in Appendix A, was developed for program planners to use as a guide in identifying and describing focus population recruitment strategies. The tool will also assist program planners at health departments and community based organizations with organizing and applying data.

A completed version of the tool is included as an example. The case study below is a companion to the example. It illustrates how program planners interpreted and applied data presented in the example to decisions about targeting and recruitment strategies.

CASE STUDY

The River City Community Coalition conducted a productivity and yield analysis of its HIV testing programs. Over the prior three years, they noticed a decline in the number of newly identified HIV positives. In 2015, the overall seropositivity was 0.5% compared to 2.5% in 2012. During the same time, while the number of HIV tests that it conducted increased by 20%, the number of men who have sex with men (MSM) tested decreased by 40%. The Coalition realized that it needed to improve targeting and recruitment for their HIV testing programs.

The Coalition drew upon many sources of state and local data for this purpose. Local epidemiologic data were used to help to define and describe the focus population. In addition to epidemiologic data, the Coalition also looked at survey data from the STD clinic, partner services data from the health department, data from a community survey, and data from the Youth Risk Behavior Surveillance System. Synthesis and analysis of these data indicated that young Black MSM under the age of 29 years old is the population most impacted by HIV in River City. Geocoding data helped them to narrow down specific areas of River City on which to focus. Health department partner services data and a local community survey confirmed the appropriateness of focus in this area. The Coalition identified their target population as Black MSM, under the age of 29 years old, who live or socialize in the neighborhoods North of Main Street, particularly the Roscommon neighborhood.

To identify appropriate recruitment strategies, the Coalition reviewed service data from member agencies and health assessment data from other health and social service agencies in the area. Based on synthesis and analysis of these data, the Coalition decided to conduct venue-based recruitment in Club Felix and Barbosa Community Center. Testing will be offered on site Mondays and Thursdays, by teams of trained peer educators and public health nurses. Testing for STDs and screening for PrEP will also be offered as well as access to housing and employment programs. The Coalition will collaborate with the Overbrook Community Health Center (OCHC) to implement a social media campaign, leveraging online resources such as MUSED and Soule.LGBT and developing partnerships based on programs like CRUSH to increase awareness of the health services provided by OCHC. Planned Parenthood and OCHC will begin offering HIV PrEP. Peer educators will conduct education and outreach at Riverwalk Park (Thursday, Friday, and Sunday nights) to increase awareness and understanding of HIV risk and prevention, and to provide assistance in linking young men with HIV testing and other health and human needs resources.
Monitoring and Improvement

n-going monitoring of targeting and recruitment strategies is essential to the success of HIV testing programs. The factors that influence risk for HIV are dynamic, and population needs, priorities, and interests change over time. Similarly, the environment and factors that influence risk also change over time. Therefore, to ensure the on-going effectiveness of HIV testing services, program managers should implement a data-driven process for regularly (e.g., monthly) reviewing HIV testing program data to ensure that services are reaching the focus populations and that the recruitment strategies used continue to be effective in terms of engagement. Please refer to the Productivity and Yield Analysis Toolkit for additional information and tools.

Additional Resources

Implementing HIV Testing in Nonclinical Settings
A Guide for HIV Testing Providers

This document was published by CDC in 2016 as a complement to the 2012 Program Managers Guide below and as an update to CDC’s 2001 Revised Guidelines for HIV Counseling, Testing, and Referral. It is intended to support implementaiton of HIV testing in non-clinical settings. Chapter three specifically focuses on targeting and recruitment strategies.

Planning and Implementing HIV Testing and Linkage Programs in Non-Clinical Settings: A Guide for Program Managers

This document provides detailed guidance for planning and implementing an HIV testing program. While focused on non-clinical settings, the information and guidelines included are applicable across other settings. Chapter three of this guide addresses targeting and recruitment strategies, and includes practical tools and tips to aid in program planning.

Evaluation Guide for HIV Testing and Linkage Programs in Non-Clinical Settings

This document provides detailed guidance for evaluating an HIV testing program. While focused on non-clinical settings, the information and guidelines are applicable across other settings. Chapter three, Step four (“Gather Credible Evidence”) addresses data, and describes the sources which are valuable for program planners and the benefits and drawbacks of various data sources.
## APPENDIX A: EXAMPLE: IDENTIFICATION OF FOCUS POPULATIONS AND RECRUITMENT STRATEGIES

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| Who is at risk for HIV transmission? | - Black MSM <29 yo are 75% of new diagnoses in River City vs 50% statewide.  
- Prevalence rate for Black MSM <29 yo is 5x ≥29 yo.  
- 45% of new HIV diagnoses reside north of Main Street; 63% of Black MSM diagnoses reside north of Main Street. | River City Public Health Department (RCPHD) — 2015 HIV and STD Epidemiologic Profile  
Geocoding of HIV cases by River City University School of Public Health Department of Epidemiology (July 2015) |
| What are they doing that places them at risk? | - Anal sex, multiple partners, low condom use (75% Black MSM < 29 yo report unprotected receptive anal intercourse vs. 20% ≥29 yo).  
- Anonymous sex, meeting partners via DateMe app (90% of surveyed Black MSM who used DateMe app reported unprotected receptive anal intercourse with anonymous partners compared with 15% who did not use DateMe app).  
- YRBSS respondents who reported Black MSM 5x more likely than non-MSM respondents to report sex without a condom, 12x more likely to report methamphetamine use | Analysis of risk assessment data of clients attending the River City Health Department STD Clinic (FY 2015)  
RCPHD HIV/STD partner services program data (July–December 2015)  
Youth Risk Behavioral Surveillance System |
| What factors influence risk for HIV infection? | - Lack of access to free/low cost condoms (82% of Black MSM <29 yo reported difficulty in accessing condoms vs 15% of Black MSM ≥29 yo).  
- Heroin (<1%), methamphetamines (4%), poppers (12%) marijuana (53%).  
- Knowledge/belief of HIV treatment efficacy (87% of Black MSM <29 yo believe that HIV ARV treatment prevents transmission vs. 49% of Black MSM ≥29 yo; MSM who believe that ARV treatment prevents transmission 4x more likely to report unprotected anal sex). | Survey of MSM by River City AIDS Services at Gay Pride Festival (June 2015) |
| **Part 2: Identifying Recruitment Strategies** | | |
| Where does the focus population live? | - Dispersed throughout River City | Youth Imperatives outreach program service statistics (FY 2015) |
| Where does the focus population socialize? | - Roscommon neighborhood (North of Main)  
- Club Felix  
- Barbosa Community Center | RCPHD HIV/STD partner services program data (July–December 2015)  
Youth Imperatives program survey of MSM participating in their Young Men’s Group |
| Where does the focus population meet sex partners? | - DateMe app  
- Riverwalk Park  
- Club Felix | RCPHD HIV/STD partner services program data (July–December 2015)  
Survey of MSM by River City AIDS Services at Gay Pride Festival (June 2015)  
Youth Imperatives outreach program service statistics (FY 2015) |
| Where does the focus population use/share drugs? | - 88% of Black MSM who met sex partners in Riverwalk Park also reported drug use in the context of sex. | RCPHD HIV/STD partner services program data (July–December 2015) |
| Where does the focus population get health and dental care? | - Planned Parenthood reports 2% of clinic visits during 2015 were from MSM 13–24 yo.  
- Overbrook Community Health Clinic (OCHC) runs an STD clinic 2 nights per week. During 2015 14% of clinic visits were MSM. OCHC recently established an LGBT health initiative. | Planned Parenthood of River City 2015 service statistics  
2014–2015 Community Health Assessment of Overbrook County |
| Where does the focus population get health information? | - Of Black MSM <29 yo 23% receive health information from Planned Parenthood, 55% from friends, and 89% from the internet. Of Black MSM ≥29 yo 66% receive health information from friends and 23% from the internet. | Survey of MSM by River City AIDS Services at Gay Pride Festival (June 2015) |
| What issues or factors are barriers to HIV testing for the focus population? | - 21% of Black MSM report receiving lower quality health care than non-MSM patients. | National HIV Behavioral Surveillance |
| What other kinds of health or preventive services are of interest to the focus population? | - Of Black MSM responding to OCHC patient survey 50% want STD screening, 44% want free condoms, and 39% are interested in HIV PrEP. Informal interviews with patients indicate that the OCHC clinic is seen as “friendlier” to youth, particularly sexual minorities. | 2014–2015 Community Health Assessment of Overbrook County (OCHC survey of STD clinic patients) |
Instructions for Using the Identification of Focus Populations and Recruitment Strategies Tool

**About this Tool:** This tool will help you to organize and synthesize data in order to make well-informed decisions about targeting and recruitment. It may also help you to identify gaps in your knowledge and point to additional data needs. The left column provides “guiding questions.” These are the kinds of questions that you should answer in your planning process in order to make well-informed decisions about targeting and recruitment. The middle column is to be used to summarize key data points. The column on the right should be used to record the data sources associated with key data points. The tool is not intended as a guide on the types of methods you should use or the specific questions that you should include in focus group scripts, interview guides, or survey questionnaires.

It is recommended that “Part 1: Identifying and Segmenting Focus Populations” be completed first because multiple focus populations may be indicated. Depending on the scope of your program, it may be appropriate to complete a separate “Part 2: Identifying Recruitment Strategies” section for each of the focus populations. If, for example, the data entered in Part 1 indicate two focus populations “female PWID under age 30, living in Plainville” and “MSM over age 30, living/socializing in Plainville” and your agency focuses on Lesbian, Gay, Bisexual and Transgender (LGBT) health, you will likely only need to complete the recruitment analysis for the MSM population. If the scope of your program is broader, you may want to prioritize both PWID and MSM populations identified through the analysis. In this case, you should complete a separate part two worksheet for each focus population identified.

**Gather and Organize Data:** Before you begin to use this tool, you will need to gather the data that you intend to use. Use the tool to record key data points as well as the source of those data. Source documents may be helpful to have available when presenting the tool to stakeholders, as they will include additional information about the methods for data collection and other relevant findings.

**Interpret and Apply Findings:** After data are organized and summarized, present the findings to stakeholders. As discussed above, it is recommended that interpretation and application occur in two steps (i.e. focus populations, followed by recruitment strategies).

The completed tool will serve as the basis for discussion about what the data tell you regarding which population(s) should be prioritized, and what recruitment strategies are likely to be effective. Including a range of perspectives and sources of experience in this discussion will result in a richer discussion, a better understanding of the issues and challenges associated with targeting and recruitment, and more ideas regarding how to address these challenges. Stakeholders should include program staff, including line staff directly involved in recruitment, supervisors and managers, representatives of other agencies providing services to the population, and, most importantly, representatives of the focus population.
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