Community Survey Report

by

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November 2014

Acknowledgements

HARC would like to thank intern Kiara Felix for her invaluable assistance during the data collection, data entry, and reporting phases of this project. HARC would also like to thank Cristal Salcido and Luis Cardenas, GTCV interns, for their assistance in data collection and data entry. HARC would also like to thank the students from Future Physician Leaders who volunteered their time to do in-person data collection on this project. Finally, HARC would like to thank all of the partners and community sites that allowed data collection to take place on their premises. Without their assistance, this project would not be nearly as representative of our entire community.

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Executive Summary

Background

Get Tested Coachella Valley (GTCV) is a region-wide public health campaign dedicated to dramatically reducing HIV by making HIV testing standard and routine medical practice, and by ensuring that those who test positive are linked to care (www.gettestedcoachellavalley.org). The campaign is driven by a coalition of 50 community partners under the leadership of Desert AIDS Project (D.A.P.)

GTCV officially launched a three-year campaign to the general public in January of 2014, although there was an 18-month period of research, design, and planning prior to the public launch. Part of these preparations included hiring Health Assessment Resource Center (HARC, Inc.) to design and implement a variety of research and evaluation activities.

This report details one of those research and evaluation projects: a community survey designed to assess the attitudes, knowledge, and behavior of our Coachella Valley community in regards to HIV testing.

The results of this study will provide information regarding who has been tested for HIV (and why they chose to get tested), as well as who has not been tested for HIV (and what prevents them from being tested). This information will help guide the GTCV campaign to overcome barriers and encourage people to be tested.

Methods

The survey tool was designed by HARC staff, and subsequently reviewed and revised several times with GTCV staff and D.A.P. staff. The survey was provided in both English and Spanish, and was offered both online and in print. The English version of the survey can be found in Appendix A, and the Spanish version of the survey can be found in Appendix B. The online survey was promoted via HARC's social media and mailing list. In-person data collection was coordinated by HARC intern Kiara Felix, and included in-person recruiters with hard copy surveys at a variety of locations throughout the Coachella Valley. In-person data collection was designed to reach populations that were unlikely to take an online survey, specifically low-income and elderly participants. Data collection spanned approximately one month, July 2014.

Results

A total of 995 valid surveys were retained (33.9% of which were collected online, and 66.1% were collected on paper). Participants represented each of the nine cities in the Coachella Valley, as well as outlying unincorporated areas (such as Bermuda Dunes, Mecca, Salton Sea, Sky Valley, Thermal, and Thousand Palms). The overall distribution of responses closely mirrored the actual population distribution of the Coachella Valley, and thus, no one area is overrepresented in this sample.

Approximately one third of the surveys were completed in Spanish, while the remaining two-thirds were collected in English.

Demographics
Approximately 62.4% of the participants identified their gender as female. Only one person in the sample identified as transgender (female to male). Thus, the results of this survey likely underrepresents the transgender perspective on HIV testing.

A total of 545 participants identified their ethnicity as Hispanic/Latino (55.8% of all participants). This closely mirrors the U.S. Census Bureau's estimates (~50.8% of Coachella Valley is Hispanic/Latino, according to the 2010 Census), providing further evidence that the survey sample is relatively representative of the Coachella Valley population as a whole.

Age of participants ranged from 12 to 93, with a median age of 49. This is very comparable to the median age of adults in the Coachella Valley as a whole (53 years old, according to HARC's 2013 Community Health Monitor), further supporting the suitability of this sample as a representative of the Coachella Valley population in its entirety.

About half of participants (50.8%) lived in households with an annual pre-tax income of less than $25,000. Thus, the perspective of low-income residents is likely over-represented in this sample, while the perspective of wealthy residents may be neglected.

Sexual Behavior
About 15% of participants have not had any form of sexual intercourse (including oral, anal, or vaginal) within the past decade. Approximately 14.6% of the sexually active participants were men who engaged in sex with other men (MSM), a group with an especially high risk of HIV.

Media Use
Most of the participants watched television and used the internet on a daily basis, making these valuable methods for reaching the general population. Newspaper was the least commonly used form of media, in fact, over a quarter of participants report never reading the newspaper.

Health Screenings
The majority of participants have had basic health screenings in the past five years. Specifically, 79.5% have had a test for high cholesterol, 81.6% have had a test for high blood pressure, and 73.9% have had a test for diabetes or high blood sugar. The majority (77.7%) also report getting an annual check-up each year, and 84.7% state that they have access to healthcare when they need it. Thus, it appears that the majority of participants could easily and seamlessly be tested for HIV at their primary care check-ups, in addition to the existing tests that are conducted there.

HIV Testing
However, only 56.0% of participants have been tested for HIV. This is significantly lower than the rates of testing for cholesterol, blood pressure, and diabetes.

Of those participants who have been tested for HIV, the most common motivators behind testing include, "my healthcare provider offered to do the test", "it was offered for free at an event or community location," and "experts recommend that everyone get tested, so I did". Thus, it is clear that easy access to testing (such as those tests offered by a primary care provider or offered at an event or community location) are key components to getting tests done.

Most of the participants who have been tested for HIV (67.8%) received a test within the past four years. Most of these tests were conducted either at a doctor's office (42.7%) or a community clinic (23.6%). It is worth noting that the third most common source for HIV tests was at a health fair, testing van, or event (9.2% of tests were conducted at such a location), evidence which supports GTCV's strategy of providing testing in the community through mobile or "pop-up" test sites.

Of those participants who have not been tested for HIV, the top three barriers include, "I don't think I'm at risk for getting HIV", "My healthcare provider never offered to test me", and "I'm not sexually active". Thus, it is clear that GTCV needs to educate the public on the need for everyone to get tested, as well as educating providers on the importance of offering the test to their regular patients. Thankfully, many of the stigma-related barriers (e.g., "I don't want my doctor or anyone else to judge me", "I'm too embarrassed to get tested") were relatively rare, indicating that stigma may be less of a barrier than in previous eras.

When asked, "Who do you think should be tested for HIV?", 42.0% of participants indicated that they believe all adults and teens need to be tested for HIV. Once again, this underscores the need for GTCV to educate the public on the need for everyone to have at least one HIV test.

The most appealing HIV testing location for all participants was at a doctor's office—67.7% of participants indicated that they would be comfortable getting an HIV test within the next year at this location. Only 4.3% of participants stated that they would not be comfortable getting tested at any of the common locations, indicating that they may have other barriers keeping them from testing rather than comfort level.

HIV Testing Discrepancies

Female and Hispanics are significantly less likely to be tested for HIV than males and non-Hispanics. Age is also significantly related to HIV testing behavior. Participants at either end of the spectrum (teens and the elderly) were unlikely to have been tested for HIV. In contrast, most adults between the ages of 20 and 60 have been tested for HIV.

Next Steps

GTCV should use these findings in order to target messaging to various populations more accurately. This information will allow for customization of messaging as well as message modes (in regards to mass media).

Thus survey will be repeated in 2016, at the conclusion of the GTCV's three year campaign. The survey items will be virtually identical, allowing for comparison over time, and an assessment of change in attitudes, beliefs, and behaviors surrounding HIV testing.

Introduction

According to the latest estimates from the Centers for Disease Control and Prevention (CDC), over 1.1 million people in the United States are living with HIV (CDC, 2013). An additional 50,000 people are infected with HIV each year in the United States (CDC, 2013). Approximately 70% of sexually-transmitted HIV cases are attributed to people who are unaware of their HIV-positive status (Marks, 2006), and thus, HIV testing is a critical first step in halting the AIDS epidemic, as this will increase the percent of our population who are aware of their HIV status. In the Coachella Valley, over half of adults (55.1%) have never been tested for HIV, presenting a major barrier to ending the AIDS epidemic (HARC, 2014).

Get Tested Coachella Valley (GTCV) was launched in an attempt to combat the HIV epidemic in the Coachella Valley region of Southern California. GTCV is a regional public health campaign that strives to dramatically reduce HIV by making HIV testing standard and routine medical practice, and by ensuring linkage to care for those who test positive (www.gettestedcoachellavalley.org). The GTCV campaign is multi-pronged, including efforts to:

- Educate medical professionals about HIV testing and encourage them to incorporate HIV testing as a routine practice for all patients;
- Increase the number of non-clinical tests (i.e., tests offered in non-medical settings) that are offered throughout the Coachella Valley;
- Increase public awareness and decrease stigma such that more people seek out HIV tests; and;
- Provide a Linkage to Care network that can help refer any Valley residents who have been diagnosed with HIV to the specialized care that they need.

While GTCV has been several years in the making, for the purposes of data analysis, GTCV was officially launched to the public in 2014, and will be a three-year project initially (that is, the calendar years of 2014, 2015, and 2016).

In 2013, GTCV partnered with Health Assessment Resource Center (HARC) to evaluate the many facets of the GTCV campaign. This particular report covers one of these evaluation components: a community survey designed to assess the attitudes, knowledge, and behavior of Coachella Valley residents in regards to HIV testing.

The results of this study will provide information regarding who has been tested for HIV (and why they chose to get tested), as well as who has not been tested for HIV (and what prevents them from being tested). This information will help guide the GTCV campaign to overcome barriers and encourage people to be tested.

This survey will be replicated once more in 2016, at the conclusion of the GTCV campaign. This design will allow for assessment of potential change in attitudes and testing behavior over the course of the campaign.

Methods

The survey tool was designed by HARC staff, and subsequently reviewed and revised several times with GTCV staff and D.A.P. staff. The team agreed that the tool needed to be brief (suitable for a single sheet of paper, front-and-back).

The survey was subsequently translated into Spanish by HARC staff, and then back-translated into English for comparison purposes. Small edits were made to the wording of the Spanish version, which was then finalized.

The survey was created in two formats: the online format (programmed into English and Spanish on SurveyMonkey.com) and the paper format (also provided in both English and Spanish, designed to be distributed in person). While the content was identical in each format, the layout was somewhat different. The English version of the survey can be found in Appendix A, and the Spanish version of the survey can be found in Appendix B.

Recruitment began on Wednesday June 25th at the community partner outreach meeting held at Desert Regional Medical Center. HARC staff briefly described the survey and the purpose of the survey, as well as outlining the need for community partner participation in sending out the survey. All community partners that had representatives present were given a packet of hard-copy surveys in both English and Spanish, accompanied by an instruction sheet, pre-paid return envelopes, and a poster that partners could use to publicize the survey.

After the partner meeting, HARC staff sent emails to the partners that were present at the meeting. The email reiterated the need for partner participation, the purpose of the survey, and the data collection window. Attached to the email was the links to the live survey in English and Spanish, as well as a Word document with templates that partners could use to easily share the survey with others via email and social media. At least two community partners sent the email out to their entire contact list (HARC and the Clinton Health Matters Initiative).

The survey links were posted to several forms of social media, including the Desert Sun's LGBT blog, HARC's Facebook and Twitter accounts, and various other personal pages of social media.

To reach populations that are unlikely to access an online survey, in-person data collection was conducted as well. HARC's intern, Kiara Felix, coordinated data collection sites that focused on the low income population as well as the senior population, as these two are less likely to have access to the internet. Data collection sites included senior centers, community centers, libraries, Laundromats, food distribution sites, and healthcare clinics. Pairs of bilingual data collectors visited each site with paper copies of the survey, clipboards, pens, waters, and healthy snacks. Passersby were invited to participate in the survey, and completed surveys were either returned to data collectors or mailed back in prepaid return envelopes.

Online data collection closed on Monday, August 21st. The last day of in-person data collection occurred on Saturday, August 19th. The data from the hard copy forms were keyed into a database, which was then merged with the online data downloaded from SurveyMonkey.

Data were entered into the Statistical Package for the Social Sciences (SPSS) and cleaned. Data from participants living outside of Coachella Valley were removed, as was data for those who did not indicate their city of residence. This left a total of 995 valid participants, all of whom lived in the Coachella Valley.

Approximately 33.9% of respondents took the survey online. The remaining 66.1% of participants took the survey on paper (either in person at one of the sites listed in Table 1, or on their own and then mailed in using the prepaid return envelopes).

Table 1. Data Collection Sites

Location	*n*	%
Calvary Bible Church-Food Distribution Site	28	2.8
Catholic Charities	31	3.1
Clinicas de Salud del Pueblo-Coachella	31	3.1
Clinicas de Salud del Pueblo-Indio	17	1.7
Clinicas de Salud del Pueblo-Mecca	60	6.0
Coachella Senior Center	16	1.6
Coachella Valley Volunteers in Medicine	36	3.6
Coachella Walgreens	3	.3
Connected to the Vine - Food Distribution Site	33	3.3
Desert Hot Springs Senior Center	26	2.6
Desert Regional Medical Center	23	2.3
Eisenhower Medical Center	17	1.7
Eisenhower Urgent Care (Cathedral City)	7	.7
First Assembly of God Church - Food Distribution Site	34	3.4
Food Now (Desert Hot Springs)	14	1.4
Galilee Center	42	4.2
Indio Community Center	25	2.5
Indio Walgreens	4	.4
JFK Memorial Hospital	10	1.0
Joslyn Senior Center	12	1.2
La Quinta Senior Center	4	.4
Mail-In	33	3.5
Mecca Library	17	1.7
Mizell Senior Center	33	3.3
Online	338	33.9
Palm Desert Oasis Church - Food Distribution Site	19	1.9
Future Physician Leaders Training	22	2.2
Volunteers in Medicine - Indio	2	.2
Volunteers in Medicine – Indio/ Family Worship Center Food Bank	56	5.6
Well In The Desert - Food Distribution Site	2	.2
Total	**995**	**100.0**

Results

Demographics

Results indicate that the survey participants closely resemble the overall population of the Coachella Valley.

Geographic Location

All cities in the Coachella Valley, plus some unincorporated areas, were represented in the sample, as illustrated in Table 2.

Table 2. Location

City	*n*	%
Bermuda Dunes	8	0.80%
Cathedral City	102	10.25%
Coachella	113	11.36%
Desert Hot Springs	73	7.34%
Desert Shores	1	0.10%
Indian Wells	10	1.01%
Indio	180	18.09%
La Quinta	68	6.83%
Mecca	96	9.65%
North Shore	24	2.41%
Palm Desert	72	7.24%
Palm Springs	166	16.68%
Rancho Mirage	35	3.52%
Salton Sea	3	0.30%
Sky Valley	2	0.20%
Thermal	29	2.91%
Thousand Palms	13	1.31%
Total	**995**	**100.00%**

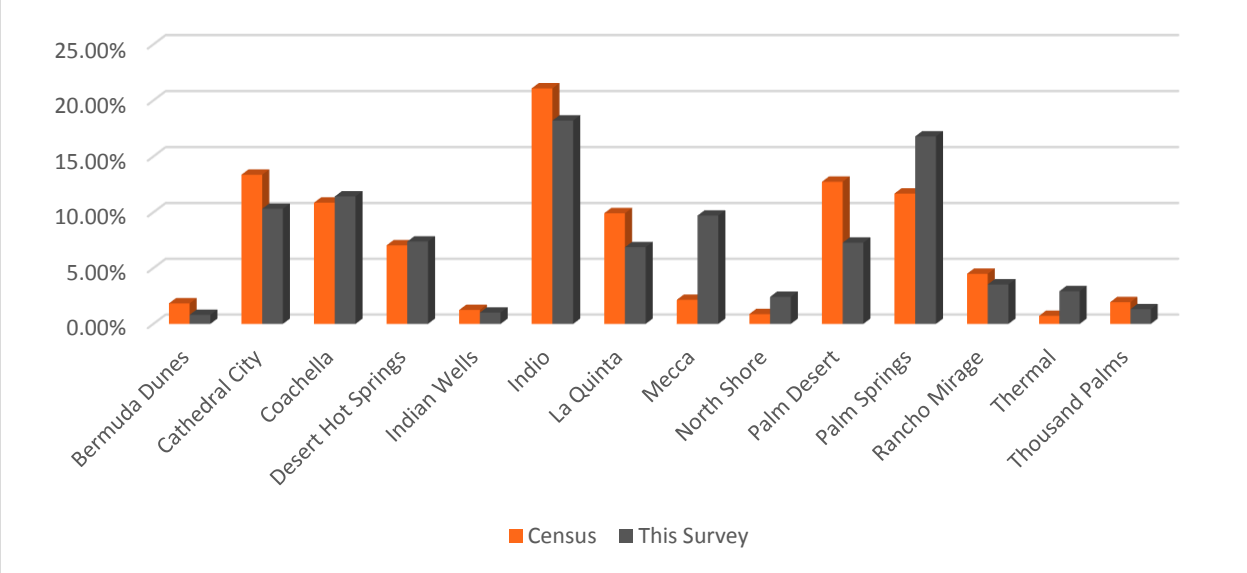
As illustrated in Table 3 and Figure 1, the number of survey participants closely matches the actual geographic distribution of the population in the Coachella Valley. The cities of Mecca, Thermal, and Palm Springs are relatively over-represented in this survey sample when compared to the actual geographic distribution of population. The cities of Cathedral City, Indio, and Palm Desert are relatively under-represented in this survey sample when compared to the actual geographic distribution of the community. However, overall, the distribution is closely matched, indicating that the survey sample includes perspectives from residents in all areas of the valley, and that no one geographic area contributed a disproportionate amount of input.

Table 3. Geographic Distribution of Survey Participants

	This Survey Sample		Actual Population as per U.S. Census Bureau	
City	***n***	**%**	***n***	**%**
Bermuda Dunes	8	0.80%	7,282	1.84%
Cathedral City	102	10.25%	52,977	13.37%
Coachella	113	11.36%	43,092	10.87%
Desert Hot Springs	73	7.34%	27,902	7.04%
Desert Shores	1	0.10%	N/A	N/A
Indian Wells	10	1.01%	4,958*	1.25%
Indio	180	18.09%	83,539	21.08%
La Quinta	68	6.83%	39,331	9.92%
Mecca	96	9.65%	8,577*	2.16%
North Shore	24	2.41%	3,477*	0.88%
Palm Desert	72	7.24%	50,508	12.74%
Palm Springs	166	16.68%	46,281	11.68%
Rancho Mirage	35	3.52%	17,799	4.49%
Salton Sea	3	0.30%	N/A	N/A
Sky Valley	2	0.20%	N/A	N/A
Thermal	29	2.91%	2,865*	0.72%
Thousand Palms	13	1.31%	7,715*	1.95%
Total	**995**	**100.00%**	**396,303**	**100.00%**

Note. Population numbers in the "Actual Population as per U.S. Census Bureau" column are from the 2013 estimates, unless noted with an asterisk. Those noted with an asterisk are from the 2010 Census, as no 2013 estimates are yet available for these areas.

Figure 1. Geographic Distribution of Survey Participants



Gender

Participants were asked to identify their gender as either male, female, transgender (male to female), and/or transgender (female to male). Participants could select multiple genders; however, the vast majority of participants selected only one. About two-thirds of these participants identified their gender as female, as illustrated in Table 4. Only one participant identified their gender as transgender. Thus, this survey sample likely underrepresents the transgender perspective on HIV testing.

Table 4. Gender

Gender	*n*
Male	372
Female	621
Transgender – Male to Female	0
Transgender – Female to Male	1

Race and Ethnicity

Race and ethnicity were assessed using two separate questions, consistent with the methodology used by the U.S. Census Bureau. In response to the question of ethnicity, a total of 545 participants identified their ethnicity as Hispanic/Latino (55.8% of participants), while 431 identified as not Hispanic/Latino (44.2%). When compared to the 2010 Census estimates of the Coachella Valley, this is very similar—50.8% identified as Hispanic/Latino, while 49.2% identified as non-Hispanic.[1] Thus, both Hispanics and non-Hispanics are well-represented in this sample, and the ethnic breakdown is very similar to Census estimates, lending credibility to this sample as a representation of the valley as a whole.

As illustrated in Table 5, the majority of participants identified their race as "White". However, a significantly proportion (230 participants) identified their race as "Other". In HARC's experience, this is typically because many community members have trouble distinguishing race from ethnicity, and many Hispanic participants do not know what race to select. This was supported by the open-ended answers that accompanied the "Other" option, most wrote in "Mexican", "Hispanic", "Latino", "Chicano", and other similar terms.

Table 5. Race

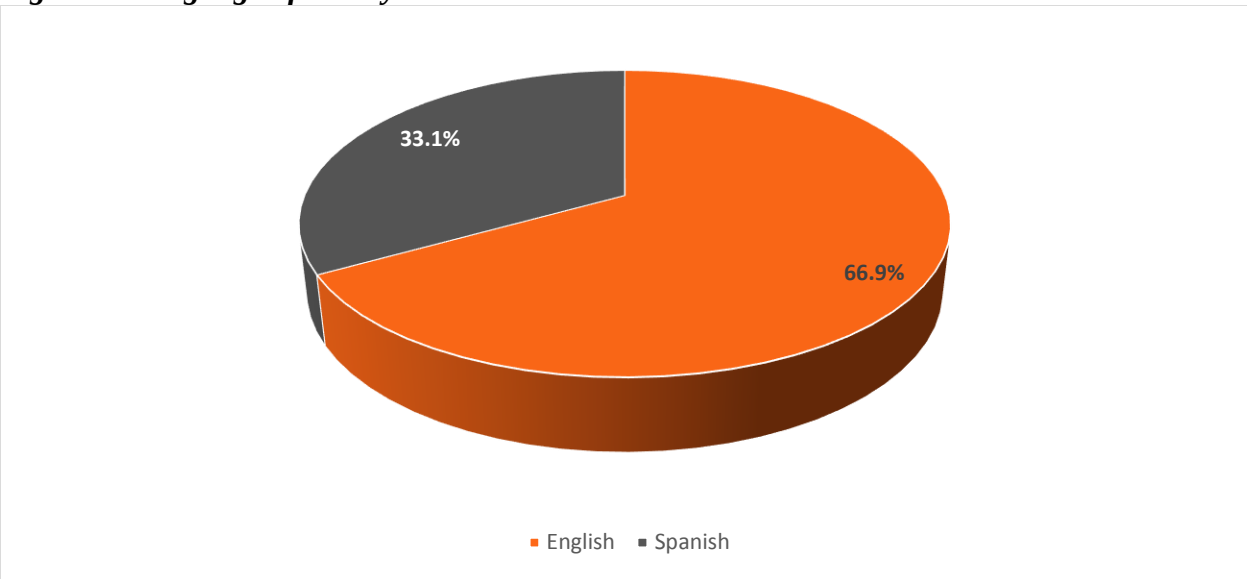
Race	*n*
White	580
Black	29
Asian/Pacific Islander	19
American Indian/Alaska Native	17
Other	230

[1] These figures are compiled from the 2010 Census Bureau's Demographic Profiles for the following cities and census-designated places (CDPs): Bermuda Dunes, Cathedral City, Coachella, Desert Hot Springs, Indian Wells, Indio, La Quinta, Mecca, North Shore, Palm Desert, Palm Springs, Rancho Mirage, Thermal, and Thousand Palms.

Primary Language

About a third of participants chose to take the survey in Spanish, as illustrated in Figure 2. This likely reflects participants' primary language of choice.

Figure 2. Language of Survey

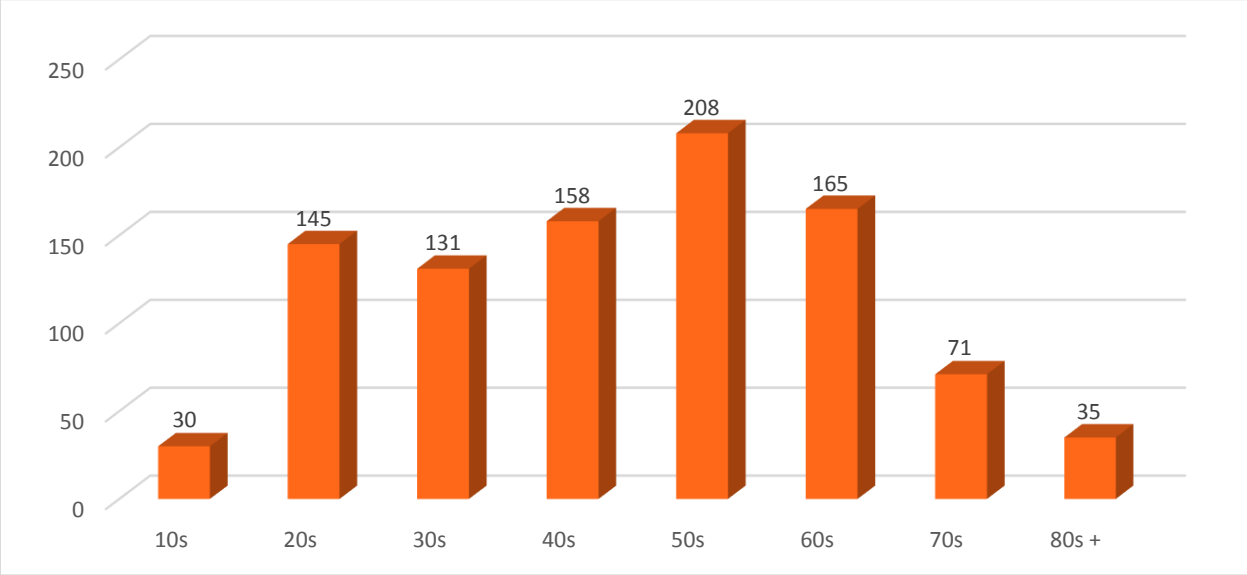


Note. $N = 995$

Age

The age of participants ranged from 12 to 93, with a median age of 49 years old. This is very comparable to the Coachella Valley adult population, which has a median age of 53 years of age[2]. As illustrated in Figure 3, 145 participants are in the highest risk age group (20s).

Figure 3. Age



[2] HARC (2013) Community Health Monitor Executive Report.

Income

Participants were asked to report their household's annual pre-tax income into one of four categories. For this section, the responses from survey participants are compared to Coachella Valley residents overall to assess how representative the current sample is of the entire population. This comparison data comes from HARC's 2013 Community Health Monitor (CHM). However, the CHM strives to include seasonal residents, or "snowbirds", in the sample (approximately 26.1% of the adult sample are snowbirds). Since the present survey was conducted in July, a time when very few snowbirds are in residence, a more accurate sample to compare to would be the permanent residents only. Thus, Table 6 compares the income distribution from the present survey to the permanent adult residents from HARC's 2013 CHM.

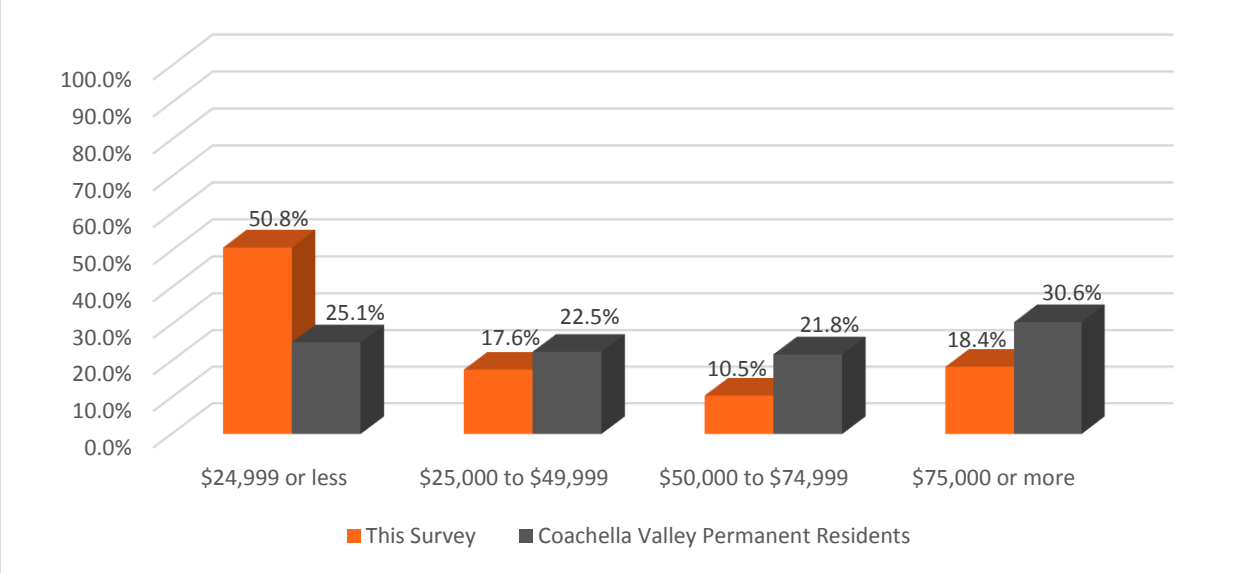
As is visible in Table 6 and Figure 4, the sample in this survey over represents those in the lowest income bracket, while under representing those in the higher income brackets.

Table 6. Income

Income Group	This Survey Sample		Coachella Valley Permanent Residents (HARC, 2013)	
	n	%	*n*	%
$24,999 or less	479	50.8%	59,393	25.1%
$25,000 to $49,999	175	17.6%	53,320	22.5%
$50,000 to $74,999	104	10.5%	51,615	21.8%
$75,000 or more	183	18.4%	72,350	30.6%
Total	**941**	**100.0%**	**236,677**	**100.0%**

Note. The Coachella Valley data in this table are from the 2013 Community Health Monitor and only pertain to permanent residents (i.e., living in the Coachella Valley for 12 months out of the year) that are adults age 18 and over.

Figure 4. Income



Sexual Partners

To assess sexual activity, participants were asked, "In the past ten years, have you had any type of sex (including oral, anal, or vaginal) with men only, women only, both men and women, or not applicable—no sex in the past 10 years."

As illustrated in Table 7, results indicate that about 15.2% of participants had not been sexually active within the past year. A very small proportion of participants (2.6%) had sexual partners of both genders within the past decade.

Table 7. Sexual Partners

	Men		Women		Total	
Sexual Partners	***n***	**%**	***n***	**%**	***n***	**%**
Men only	116	12.1%	437	45.5%	**553**	**57.6%**
Women only	205	21.4%	31	3.2%	**236**	**24.6%**
Both men and women	3	0.3%	22	2.3%	**25**	**2.6%**
No sexual partners in past 10 years	38	4.0%	108	11.3%	**146**	**15.2%**
Total	**362**	**37.7%**	**598**	**62.3%**	**960**	**100.0%**

Sexual Orientation

An approximation of sexual orientation can be extrapolated by combing in the sexual behavior information with the gender information. Using this method, 119 participants fall into the high risk MSM category, as illustrated in Table 8.

Table 8. Sexual Orientation

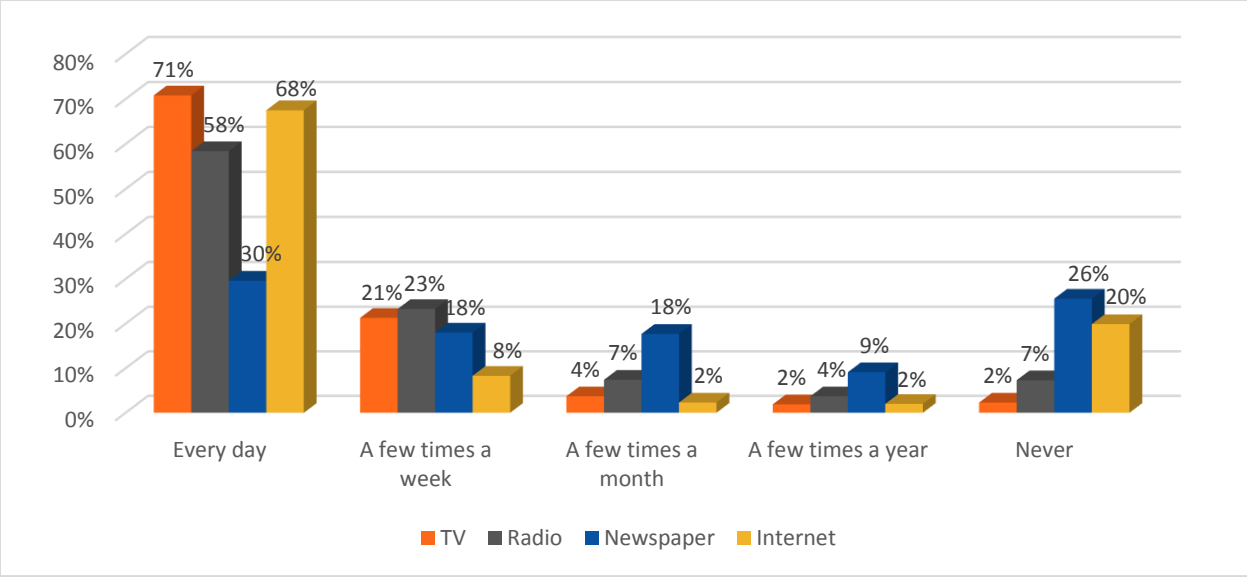
Sexual Orientation	***n***	**Percent of sexually active participants**
Gay men	116	14.3%
Bisexual men	3	0.4%
Straight men	205	25.2%
All sexually active men	***324***	***39.8%***
Lesbian women	31	3.8%
Bisexual women	22	2.7%
Straight women	437	53.7%
All sexually active women	***490***	***60.2%***
All sexually active participants	**814**	**100.0%**

Media Use

Participants were asked to rate how often they utilized several different forms of media. This information will be useful in determining how the GTCV campaign can reach different people.

As illustrated in Figure 5, most participants utilized TV and Internet every day. The newspaper was the least commonly used form of media—over a quarter of participants stated that they never read the newspaper.

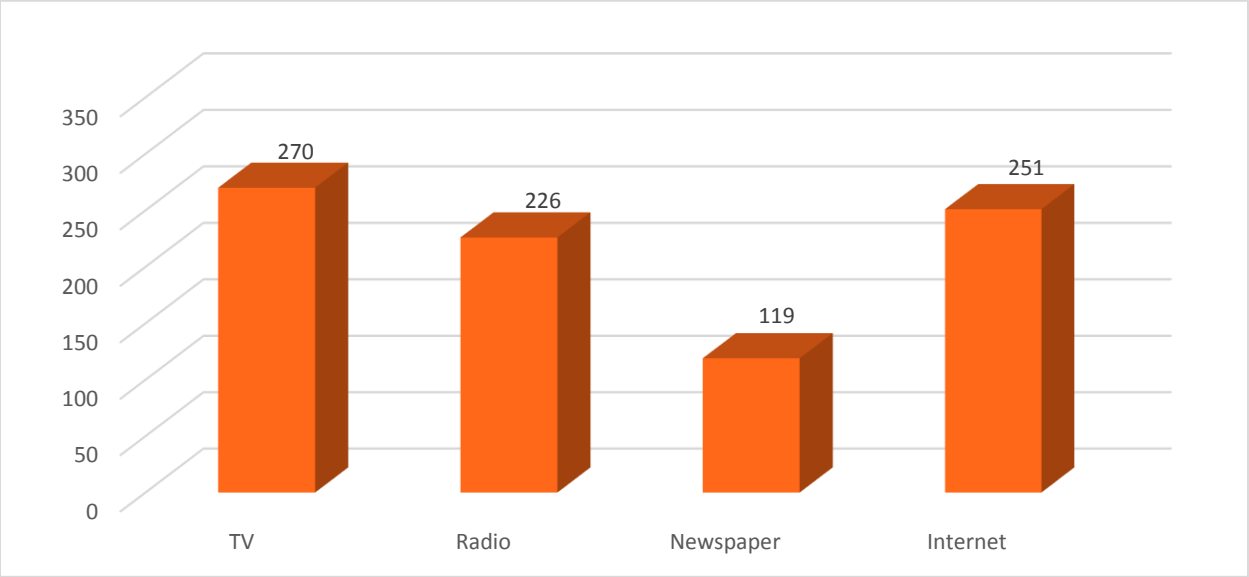
Figure 5. Frequency of Media Use



In order to quantify viewership more linearly, these responses were weighted. An "every day" response was given a weight of 365 (the number of days in a year). The "a few times a week" was given a weight of 52 (the number of weeks in a year). The "a few times a month" response was given a weight of 12 (the number of months in a year). The "a few times a year" was given a weight of one, and the "never" response was given a weight of zero. These weighted scores were then summed and divided by the number of valid participants for each type of media, thus providing a single score for each source of media that approximates the number of days per year this sample utilized this type of media.

Using this method, scores for each media could theoretically range from zero (no one in the sample used that particular form of media ever) to 365 (every person in the sample used that form of media on a daily basis). As illustrated in Figure 6, television is the most popular form of media. On average, our sample watches television approximately 270 days out of the year. Although many people (n = 183) never use the internet, these are balanced out by the many people who use the internet on a daily basis (n = 620), making Internet the second-most commonly used form of media. Newspaper remains the least-often utilized form of media.

Figure 6. Weighted Frequency of Media Use



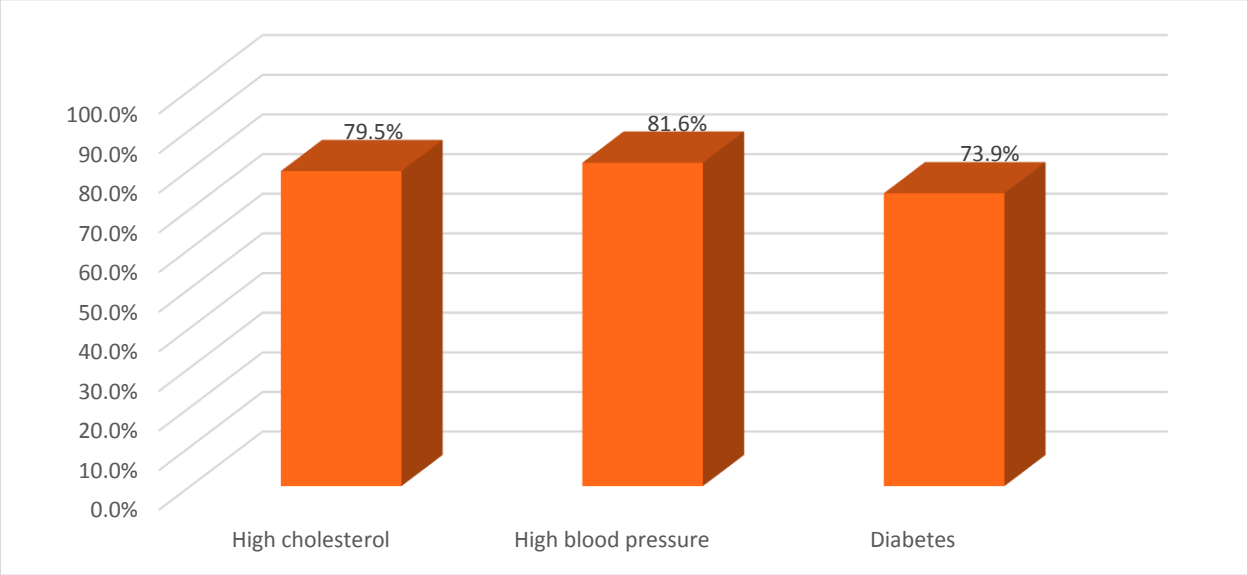
Health Screenings

Ideally, HIV testing would be a part of general preventative care. Patients who see their doctor regularly would be tested for HIV along with other typical tests. However, to date, few healthcare providers regularly screen for HIV when doing general preventative care.

Routine Health Screenings

To assess the level of preventative care participants typically receive, participants were asked to report whether they had had several common preventative exams within the past five years. As illustrated in Figure 7, the majority of participants have been tested for high cholesterol, high blood pressure, and diabetes/high blood sugar within the past five years.

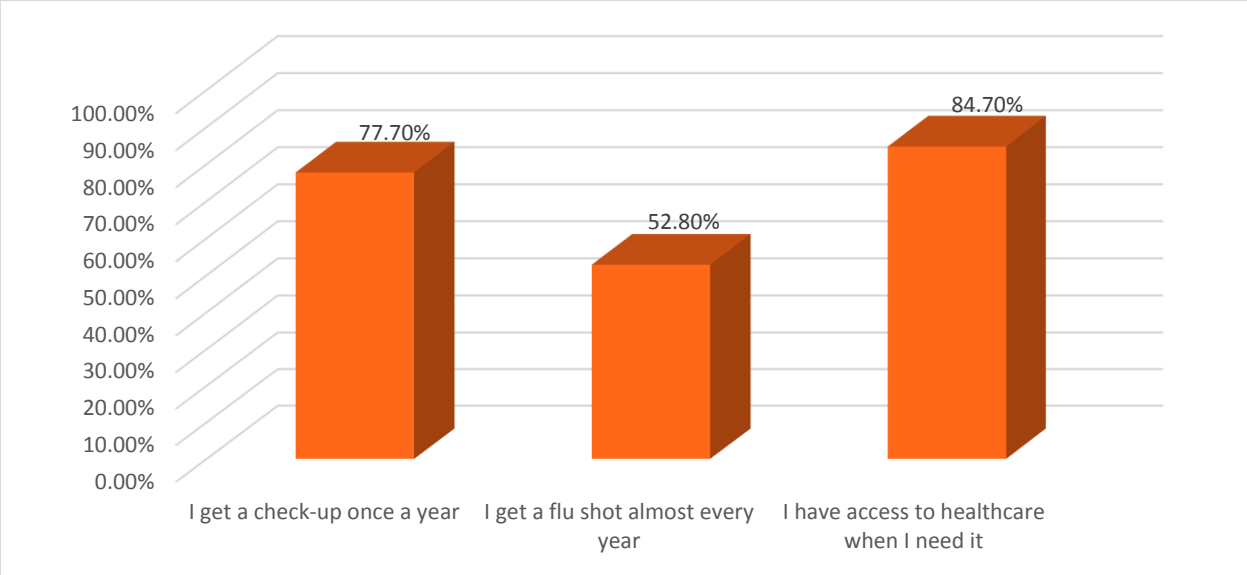
Figure 7. Routine Health Screenings



Access to Care

To further assess participants' preventative care, participants were asked to categorize several statements as "true" or "false" for their general experience. As illustrated in Figure 8, the majority of participants have access to healthcare when needed, and most get a routine check-up about once a year. About half receive a flu shot every year. Overall, it seems that most participants have access to care and receive general preventative care. Thus, access to care should not be keeping these people from being tested for HIV.

Figure 8. Access to Care



HIV Testing

Results show that 56.0% of participants have been tested for HIV, while the remaining 44.0% have never been tested for HIV. This is somewhat higher than the HIV testing rate reported in HARC's 2013 Community Health Monitor (44.9% of adults had been tested for HIV). This may be due to the fact that the sample in the current study is not a random sample (and therefore, may reflect a bias towards people who are more likely to have been tested for HIV), or it may reflect an actual increase in HIV testing behavior in the year between the two surveys. Without conducting another randomized, community-wide survey (such as will be done in 2016 by HARC), it is impossible to say which of these two is the cause of the increased rate of HIV testing.

Overall, the HIV testing rate is significantly less than rates of testing for cholesterol, high blood pressure, and diabetes, indicating that Coachella Valley residents are getting tested for HIV with much less frequency than for other chronic health conditions.

Participants Who Have Been Tested for HIV

Participants who indicated that they have been tested for HIV before were subsequently asked, "Why did you choose to get tested for HIV?" Participants were encouraged to check all responses that applied to them, and to enter additional "other" reasons for testing.

As illustrated in Table 9, the majority of participants grouped onto four reasons. The most common reason for being tested was because a healthcare provider offered the test. This confirms the importance of provider education in the GTCV campaign, as that appears to be a strong avenue for increasing the number of people who have been tested for HIV.

Table 9. Reasons for Getting Tested for HIV

Reason	*n*	%
My healthcare provider offered to do the test	141	26.4%
It was offered for free at an event or community location	120	22.5%
Experts recommend that everyone get tested, so I did	117	21.9%
I was concerned I might have been exposed to HIV	106	19.9%
My friend or family member said testing is a good idea, so I got tested	46	8.6%
It was required by my employer or insurer	35	6.6%
My sexual partner is HIV positive	16	3.0%
Other	112	21.0%

A sizeable portion of participants selected an "other" reason, and entered their own particular reason for being tested. The overarching themes from these open-ended questions are presented here. Pregnancy was by far the most commonly entered "other" response, indicating that perhaps this should be included on the list of reasons for testing in the 2016 survey.

Themes from the "Other" responses include:

- Pregnancy: "Is a routine test when pregnant"; "It was a part of my pregnancy screening"; "Cuando estaba emarazada (When I was pregnant)"
- Blood donation: "Blood drive"; "Donated blood"
- Marriage: "I think I had it done as required part of marriage license process..?"; "My husband and I thought it was important to get tested before we got married"; "Part of test before getting married".
- Immigration: "Test was required to acquire Alien Registration Card"; "Cuando aregle mis papeles de imigracion (When I fixed my immigration papers)"; "Immigration"
- Cheating spouse: "Husband cheated so I got treated 9 years ago"; "This was years ago when I left my husband I wasn't sure of his loyalty so I did a full std type test"; "Es que me engano y solo queria chequearme de todo (It's because he cheated on me and I wanted to get checked)"
- Surgery: "Required by physician to be tested before having surgery"; "It was routine prior to surgery"; "Prior to survery".
- Routine testing: "I get a test every 6 months"; "I did it as a part of my regular healthcare regimen at the time";

- Prior to starting a new relationship: “Always test when I have a new girlfriend”; “Before getting into a sexual relationship”; “New sexual partners, wanted to ensure we were negative”.
- Serious illness: “I got very sick so my doctor checked”; “I got very sick and my family and physician asked/recommended that I be tested”; “Chronic fatigue in 1990 and low T cell count garnered an HIV test. Test was negative. Cause was Epstein Barr.”
- Risks: “I participate in risky sex”; “Needle user”, “The father of my children was a heroin user and been tested”.
- Situations where testing is mandatory: “Jail”; “Military”; “Prison”.
- Responsibility: “As gay man is a responsibility”; “It’s the responsible thing to do when sexually active”; “I believe in always knowing your status. Every year I am checked.”

Of the 534 participants who have been tested for HIV, most have been tested within the last four years, as illustrated in Table 10. In fact, 126 participants indicated that their most recent test was in 2014, indicating that they had been tested within the past six months. A total of 84 participants did not enter the date of their most recent test or indicated that they could not remember.

Table 10. Date of Most Recent HIV Test

Date of most recent test	*n*	%
1980s	18	4.0%
1990s	42	9.3%
2000s	92	20.4%
2010 or more recently	296	65.8%
Total	**450**	**100.0%**

As illustrated in Table 11, the vast majority of participants who have been tested for HIV were tested either at a doctor’s office or a community clinic. Of note, health fairs and other testing events in the community were the third most common type of testing site. This supports GTCV’s strategy of providing on-site testing at events and health fairs.

Table 11. Location of Most Recent HIV Test

Location	*n*	%
At a doctor’s office	228	42.7%
At a community clinic	126	23.6%
At a health fair, testing van, or event	49	9.2%
At the hospital or emergency room (ER)	25	4.7%
At a local business or store	9	1.7%
At home	8	1.5%
In jail or prison	4	0.7%
At a drug treatment facility (rehab)	4	0.7%
Other	43	8.1%

Participants Who Have Not Been Tested for HIV

Participants who indicated that they have not been tested for HIV before were subsequently asked, "Why haven't you been tested for HIV?" Participants were encouraged to check all responses that applied to them, and to enter additional "other" reasons for lack of testing.

As illustrated in Table 12, the majority of participants who have not been tested for HIV cite that they don't believe they are at risk, their healthcare provider has not offered to test them, and that they are not sexually active.

Based on these results, it is clear that the GTCV campaign's focus on encouraging healthcare providers to routinely offer the test would likely have a significant impact on testing rates. It is also clear that more education needs to be done regarding risk factors for HIV and who can be infected, as the majority of participants who have not been tested don't believe they are at risk for HIV.

Some education likely also needs to be done regarding the availability of free testing throughout the valley as well, as some participants indicated that not having health insurance and/or not being able to afford the test were barriers to being tested. Thankfully, relatively few people indicated that stigma kept them from being tested ("I don't want my doctor or anyone else to judge me" and "I'm too embarrassed to get tested").

Table 12. Reasons for Not Getting Tested

Reason	*n*	%
I don't think I'm at risk for getting HIV	239	57.0%
My doctor/healthcare provider has never offered to test me	111	26.5%
I'm not sexually active	98	23.4%
I don't know where to get tested	29	6.9%
I don't have health insurance	24	5.7%
I don't want my doctor or anyone else to judge me	15	3.6%
I can't afford to get tested	14	3.3%
I don't WANT to know if I have HIV	12	2.9%
I'm too embarrassed to get tested	11	2.6%
I don't have the transportation needed to get to a testing site	11	2.6%
Other	35	8.4%

Of the 419 participants who had never been tested for HIV, the majority (n = 285) reported that they would get tested if their doctor or healthcare provider offered the test (assuming the test was free and/or covered by insurance). However, 95 participants indicated that even if their healthcare provider offered them a free HIV test, they would not be tested.

Attitudes towards HIV Testing

Participants were asked, "Who do you think should be tested for HIV?" and asked to select one of four populations. A total of 119 people did not answer this question. Of the 876 participants who did answer the question, 42.0% agreed with the statement that follows CDC guidelines ("all adults and teens need to be tested for HIV"). However, as illustrated in Table 13, about 8.6% of participants believe only high-risk people should be tested for HIV, and 1.5% believe that no one needs to be tested for HIV. Thus, it is clear that there is much progress to be made regarding attitudes and beliefs about the need for HIV testing.

Table 13. Attitudes towards HIV Testing

Group	*n*	%
No one needs to be tested for HIV	13	1.5%
Only those people with high risk of getting HIV, like gay men or drug users, need to be tested	75	8.6%
All sexually active people need to be tested for HIV	420	47.9%
All adults and teens need to be tested for HIV	368	42.0%
Total	**876**	**100.0%**

Future HIV Testing

All participants were asked, "If you were to be tested for HIV in the next year, which of these locations would be a comfortable testing site for you?" Participants were encouraged to select all that applied. The majority of participants reported that they would be comfortable being tested at a doctor's office, which was also the number one location for recent tests (for those participants who had been tested for HIV in the past). This further emphasizes the importance of healthcare providers as a vehicle for change in HIV testing behaviors. As illustrated in Table 14, 43 participants indicated that they would not be comfortable getting tested in any of the common testing situations.

Table 14. Comfortable Future Testing Sites

Location	*n*
Doctor's office	674
Community clinic	397
Health fair, testing van, or other community event	219
Hospital or ER	204
Home	189
Drug treatment facility (rehab)	79
I would not be comfortable getting tested at any of these sites	43

Profiles

In order to obtain further depth of knowledge about the participants of this survey, several profiles are presented here next. This method "cuts" the data to compare two or more separate groups of people on all the survey topics. The following eight profiles are included here:

1. HIV Testing Behavior: People who have been tested for HIV compared to those who have never been tested for HIV
2. Gender: Men compared to women
3. Age: Young participants compared to adults compared to older adults
4. Income: Low-income participants compared to higher-income participants
5. Ethnicity: Hispanic participants compared to non-Hispanic participants
6. Sexual Behavior: MSM compared to other sexually active participants (excludes those who have not been sexually active in the past decade)
7. Geographic Location: Participants living in the East Valley compared to participants living in the West Valley
8. Willingness: Participants who have never been tested for HIV, but would be willing to be tested if their provider offered them a free test versus participants who have never been tested for HIV and would ***not*** be willing to be tested if their provider offered them a free test (excludes those who have been tested for HIV in the past)

Note that the most of these profiles compare sub-sections of the entire sample, with two exceptions. Profile 6, sexual behavior, compares two groups of sexually active participants (that is, those who have not been sexually active in the past decade are not captured in this profile). Profile 8, willingness, compares two groups of people who have never been tested for HIV (that is, those who have previously been tested for HIV are not captured in this profile).

Profile 1: HIV Testing Behavior

For the purposes of this profile, participants who have previously had an HIV test are compared to participants who have never had an HIV test.

Demographic Differences

Participants who have never been tested for HIV are significantly more likely to be female than male, χ^2 (1) = 6.995, $p < .01$. Specifically, 58.6% of participants who have been tested are female. This proportion is 67.0% in the population that has never been tested for HIV.

Language differed significantly by HIV testing behavior, χ^2 (1) = 30.593, $p < .001$. Only a quarter of participants who have been tested for HIV (25.1%) took the survey in Spanish. In contrast, 42.0% of participants who have never been tested took the survey in Spanish.

Ethnicity distribution was significantly different based upon HIV testing behavior, χ^2 (1) = 12.390, $p < .001$. Specifically, 50.3% of participants who have been tested for HIV identify as Hispanic/Latino, compared to 61.8% of participants who have never been tested for HIV.

Age group differed significantly based upon HIV testing behavior, χ^2 (2) = 40.668, $p < .001$. Specifically, 42.6% of participants who have been tested for HIV are older adults, compared to 59.7% of participants who have never been tested for HIV.

Participants who have never been tested for HIV are significantly poorer than participants who have been tested for HIV, χ^2 (3) = 18.107, $p < .001$. For example, 43.9% of participants who have been tested for HIV live in households with an annual pre-tax income below $25,000, compared to 57.4% of participants who have never been tested for HIV.

There was no significant difference in geographic location based on testing behavior at the $p < .05$ level. That is, people who have been tested for HIV are no more likely to live in the East Valley than people who have never been tested for HIV.

Participants who have been tested for HIV are significantly more likely to be sexually active than participants who have never been tested for HIV, χ^2 (3) = 92.822, $p < .001$. Only 6.6% of participants who have been tested for HIV are sexually inactive (have not had any type of sex within the past 10 years), compared to 25.6% of participants who have not been tested for HIV.

Similarly, participants who have been tested for HIV are significantly more likely to be MSM than participants who have never been tested for HIV, χ^2 (1) = 63.610, $p < .001$. Nearly a quarter of participants who have been tested (22.8%) are MSM, compared to only 2.0% of participants who have never had an HIV test.

Differences in Media Use

Television viewing habits did not differ significantly by HIV testing behavior at the $p < .05$ level. However, radio use did differ significantly based on HIV testing behavior, χ^2 (4) = 14.086, $p < .01$. Specifically, participants who have been tested for HIV are more likely to listen to the radio than those who have never been tested for HIV. A total of 61.1% of participants who have been tested for HIV listen to the radio every day, compared to 54.3% of those who have never been

tested. At the other end of the spectrum, only 4.9% of participants who have been tested for HIV report never listening to the radio, compared to 9.8% of participants who have never been tested for HIV.

Participants who have been tested for HIV also read the newspaper significantly more often than participants who have never been tested for HIV, χ^2 (4) = 13.536, $p < .01$. While 21.3% of participants who have been tested for HIV say that they never read the newspaper, this figure is 31.8% for those who have never been tested for HIV.

Participants who have been tested for HIV are also more likely than participants who have never been tested for HIV to frequently use the internet, χ^2 (4) = 35.753, $p < .001$. The majority of participants who have been tested for HIV (75.3%) use the internet every day, compared to 59.4% of participants who have never been tested for HIV. At the other end of the spectrum, only 12.6% of participants who have been tested for HIV report never using the internet, compared to 28.0% of participants who have never been tested for HIV.

Differences in Preventative Health Screenings and Access to Care

Both groups report similar levels of access to care. Specifically, about 85% of all participants report having access to healthcare when they need it, this does not differ significantly based on HIV testing behavior. However, as illustrated in Table 15, participants who have been tested for HIV are also significantly more likely to have received other routine screening procedures.

Table 15. Routine Health Screenings by HIV Testing Behavior

Test	Tested for HIV	Never Tested for HIV	Statistics
High cholesterol	84.6%	72.2%	χ^2 (1) = 21.285, $p < .001$
High blood pressure	87.3%	73.0%	χ^2 (1) = 30.786, $p < .001$
Diabetes	80.6%	64.4%	χ^2 (1) = 30.521, $p < .001$

Annual check-up habits did not differ significantly based on HIV testing behavior; about 77% of both groups received an annual check-up each year. Similarly, participants who have been tested for HIV are no more likely to receive an annual flu shot than those who have never been tested—rates for both are about 52%.

Attitudes towards HIV Testing

Beliefs regarding who should be tested for HIV differed significantly based on prior HIV testing behaviors, χ^2 (3) = 29.083, $p < .001$. As illustrated in Table 16, participants who have been tested for HIV before are more likely to believe the broader population needs to be tested.

Table 16. Attitudes towards HIV Testing by HIV Testing Behavior

Belief	Tested for HIV	Never Tested for HIV
No one needs to be tested for HIV	0.8%	2.5%
Only those people with high risk of getting HIV, like gay men or drug users, need to be tested	4.3%	13.4%
All sexually active people need to be tested for HIV	48.7%	46.8%
All adults and teens need to be tested for HIV	46.2%	37.3%

Future HIV Testing Comfort

Not surprisingly, participants who have already been tested for HIV were significantly more likely than those who have never been tested to say that they would be comfortable getting tested at common testing sites. As illustrated in Table 17, this was the case for all of the common testing sites covered in the survey.

Table 17. Comfort Getting an HIV Test by HIV Testing Behavior

Location	Tested for HIV	Never Tested for HIV	Statistics
Doctor's office	71.9%	65.4%	χ^2 (1) = 4.6664, $p < .05$
Community clinic	44.9%	35.8%	χ^2 (1) = 8.120, $p < .01$
Hospital or ER	24.9%	16.7%	χ^2 (1) = 9.417, $p < .01$
Rehab	6.1%	2.2%	χ^2 (1) = 10.567, $p < .01$
Home	24.5%	13.8%	χ^2 (1) = 16.873, $p < .001$
Health fair, testing van, or other community event	29.4%	14.6%	χ^2 (1) = 29.316, $p < .001$

However, participants who had previously been tested for HIV and those who had never been tested were equally likely to say "I would not be comfortable getting tested at any of these sites". Specifically, 3.9% of participants who had previously been tested were uncomfortable with the sites listed, as were 4.8% of participants who had never been tested for HIV.

Profile 2: Gender
For the purposes of this profile, men and women are compared.

Demographic Differences
Women were significantly more likely than men to have taken the survey in Spanish, χ^2 (1) = 11.410, $p < .01$. Specifically, 37.0% of women took the survey in Spanish, compared to 26.6% of men.

Female participants were significantly more likely than male participants to be Hispanic, χ^2 (1) = 20.469, $p < .001$. Over half of the female participants identified as Hispanic (61.4%), while approximately 46.6% of male participants identified as Hispanic.

There was no significant difference between genders in regards to age distribution. That is, each age segment of the participants had a similar split between men and women.

Income varied significantly based on gender, χ^2 (3) = 15.095, $p < .01$. Overall, women were significantly less well-off than men. For example, while 23.9% of male participants lived in households with a pre-tax annual income at or above $75,000, only 16.8% of women lived in these wealthier households. Over half of the female participants (53.3%) lived in households with an annual pre-tax income below $25,000.

Female participants were significantly more likely than male participants to live in the East Valley, χ^2 (1) = 12.397, $p < .001$. A total of 47.8% of female participants lived in the East Valley, compared to 36.2% of male participants. Most male participants (63.8%) lived in the West Valley.

Men are significantly more likely than women to have had sex within the past decade, χ^2 (3) = 324.197, $p < .001$. About 10.5% of male participants report not having sex within the past ten years, compared to 18.1% of women. By definition, only men fall into the MSM risk category.

Differences in Media Use
Most media usage had relatively similar frequency patterns across genders. Frequency of use of television, radio, and internet did not differ significantly between genders at the $p < .05$ level. That is, both men and women have relatively similar frequencies of watching TV, listening to the radio, and using the internet.

Results show that female participants read the newspaper with significantly less frequency than male participants χ^2 (4) = 10.542, $p < .05$. For example, 32.9% of men and 27.4% of women report reading the newspaper every day. At the other end of the spectrum, 22.2% of men and 27.8% of women report never reading the paper.

Differences in Preventative Health Screenings and Access to Care

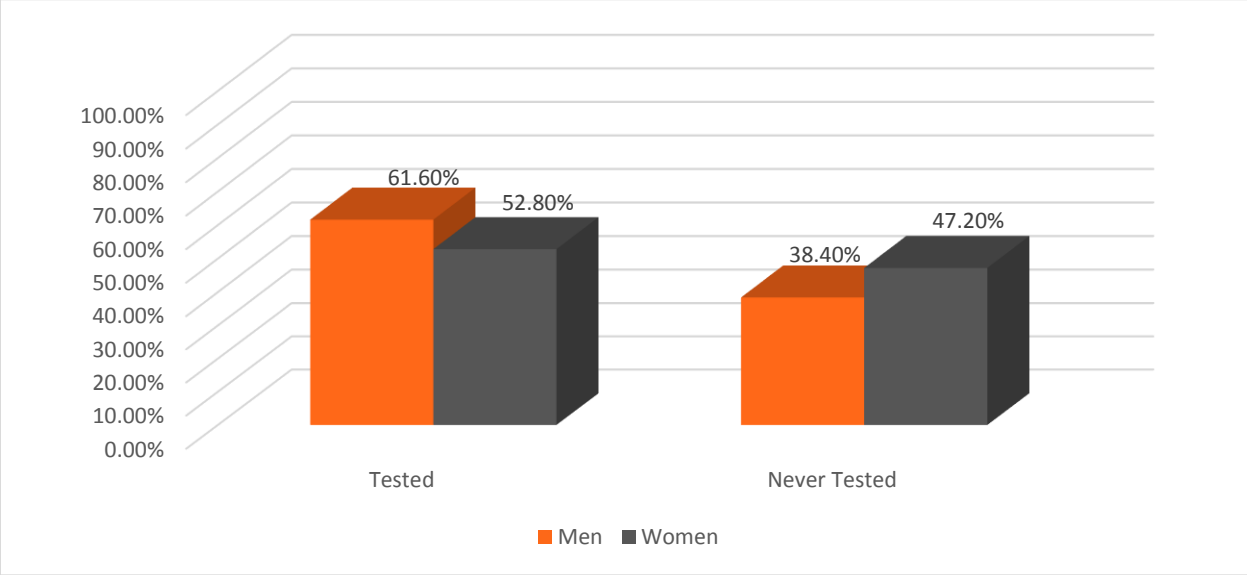
There were no significant differences in access to care between the two genders that the $p < .05$ level. That is, the majority of both men and women believe that they have access to healthcare when they need it.

Men and women had similar rates of testing for most preventative health screenings, including high cholesterol, high blood pressure, and diabetes. They were also equally likely to have had an annual check-up. However, as illustrated in Table 18, male participants were significantly more likely than female participants to have had an annual flu shot and to have had an HIV test. Specifically, while 61.6% of men have been tested for HIV, only 52.8% of women have had the test, as illustrated in Figure 9.

Table 18. Routine Health Screenings by Gender

Test	Men	Women	Statistics
Annual flu shot	58.5%	49.3%	χ^2 (1) = 7.505, $p < .01$
HIV test	61.6%	52.8%	χ^2 (1) = 6.995, $p < .01$

Figure 9. HIV Testing by Gender



Reasons for Getting an HIV Test

Participants who indicated that they have been tested for HIV before were subsequently asked, "Why did you choose to get tested for HIV?" Participants were encouraged to check all responses that applied to them, and to enter additional "other" reasons for testing.

As illustrated in Table 19, men are significantly more likely to cite, "I was concerned I might have been exposed to HIV", "my sexual partner is HIV positive", and/or "experts recommend that everyone get tested, so I got tested" as reasons behind their HIV test.

Table 19. Reasons for Getting an HIV Test by Gender

Reason	Men	Women	Statistics
I was concerned I might have been exposed to HIV	18.8%	6.4%	χ^2 (1) = 36.673, $p < .001$
My sexual partner is HIV positive	4.0%	0.2%	χ^2 (1) = 21.992, $p < .001$
Experts recommend that everyone get tested, so I got tested	18.5%	8.2%	χ^2 (1) = 23.393, $p < .001$

Other reasons for getting tested (my healthcare provider offered to do the test, offered for free at a community event, required by employer or insurer, friends or family recommended it, other) were not significantly different between genders at the $p < .05$ level.

Reasons for Not Getting Tested

Participants who indicated that they have not been tested for HIV before were subsequently asked, "Why haven't you been tested for HIV?" Participants were encouraged to check all responses that applied to them, and to enter additional "other" reasons for lack of testing.

As illustrated in Table 20, females were more likely than males to cite the top three barriers to getting tested.

Table 20. Reasons for Not Getting Tested by Gender

Reason	Male	Female	Statistics
I don't think I'm at risk for getting HIV	21.2%	28.2%	χ^2 (1) = 5.892, $p < .05$
I'm not sexually active	7.5%	12.6%	χ^2 (1) = 7.783, $p < .05$
My provider never offered	7.5%	14.0%	χ^2 (1) = 9.548, $p < .01$

Other barriers to testing (I don't want to be judged, I'm too embarrassed, I don't want to know if I have HIV, I don't know where to go, I don't have transportation, I can't afford to get tested, I don't have health insurance, other) did not differ significantly between the two genders at the $p < .05$ level.

Men and women were equally likely to report that they would get a future HIV test if their provider offered it to them for free.

Attitudes towards HIV Testing

Beliefs about who should be tested did not differ significantly between the two genders at the $p < .05$ level.

Future HIV Testing Comfort

Male and female participants were equally likely to say they would be comfortable being tested in a doctor's office, the hospital or emergency room, or at a drug treatment facility. However, as illustrated in Table 21, men are significantly more likely than women to state that they would be comfortable being tested at a community clinic, at their own home, or at a health fair or community event.

Table 21. Comfort Getting an HIV Test by Gender

Location	Men	Women	Statistics
Community clinic	44.6%	37.2%	χ^2 (1) = 5.346, $p < .05$
Home	22.8%	16.7%	χ^2 (1) = 5.621, $p < .05$
Health fair	26.9%	19.2%	χ^2 (1) = 8.064, $p < .01$

Profile 3: Age

For the purposes of this profile, three age groups will be compared: young (12 to 24), adult (25 to 49) and older adult (50 and over).

Demographic Differences

Adults were significantly more likely to have taken the survey in Spanish (40.1%) than either young participants (16.5%) or older adults (30.1%), χ^2 (2) = 23.349, $p < .001$. Young participants are the most likely to have taken the survey in English (83.5%).

Young participants were significantly more likely to be Hispanic (84.3%) than adults (67.9%), which in turn were more likely to be Hispanic than older adults (38.4%), χ^2 (2) = 112.990, $p < .001$. The majority of older adults identified as non-Hispanic (61.6%), which was not the case for the other two age groups.

Young participants were significantly more likely to live in the East Valley (61.0%) than adults (53.1%) or older adults (31.3%), χ^2 (2) = 54.010, $p < .001$. The majority of older adults live in West Valley (68.7%), which was not the case for the other two age groups.

Older adults are significantly wealthier than adults and young participants, χ^2 (6) = 50.529, $p < .001$. About 27.8% of older adults live in households with annual pre-tax incomes of $75,000 or more, compared to 38.1% of adults and 11.6% of young participants. At the other end of the spectrum, 63.5% of young participants live in households with an annual pre-tax income of less than $25,000. In contrast, 49.6% of adults and 47.2% of older adults live in these low-income households.

There were no significant differences in gender distribution by age group at the $p < .05$ level.

Adults were more likely to be sexually active in recent years than older adults and younger participants, χ^2 (6) = 49.770, $p < .001$. Specifically, only 5.2% of adults had not had sex within the past decade, compared to 21.1% of young participants and 20.2% of older participants.

Age was significantly related to MSM behavior, χ^2 (2) = 17.125, $p < .001$. Specifically, 20.7% of older adults identified as MSM. This number dropped to 11.2% for adults, and again to 7.0% for young participants.

Differences in Media Use

Television habits vary significantly by age group, χ^2 (8) = 65.672, $p < .001$. While only 41.7% of young participants watch TV every day, 67.3% of adults and 79.6% of older adults report watching TV every day. Young participants are more likely than adults and older adults to watch TV a few times a week (43.5%, 23.6%, and 14.4%, respectively).

Adults tend to listen to the radio significantly more than participants on the ends of the age spectrum, χ^2 (8) = 28.488, $p < .001$. Specifically, while 54.7% of young participants and 54.3% of older participants listen to the radio every day, 65.9% of adults listen to the radio every day.

Age is significantly related to the frequency of newspaper use, χ^2 (8) = 56.396, $p < .001$. Approximately 40.2% of older adults read the newspaper every day. This number drops to 21.1% for adults, and again to 13.0% for young participants.

Age is also significantly related to the frequency of internet use, but in the opposite direction, χ^2 (8) = 62.836, $p < .001$. Approximately 84.4% of young participants use the internet every day. This number drops to 71.0% for adults and again to 62.4% for older adults.

Differences in Preventative Health Screenings and Access to Care

Older adults are significantly more likely than other participants to have access to care when they need it, χ^2 (2) = 33.302, $p < .001$. Approximately 91.6% of older adults say they have access to care when they need it. This number is 77.3% for adults and 80.2% for young participants.

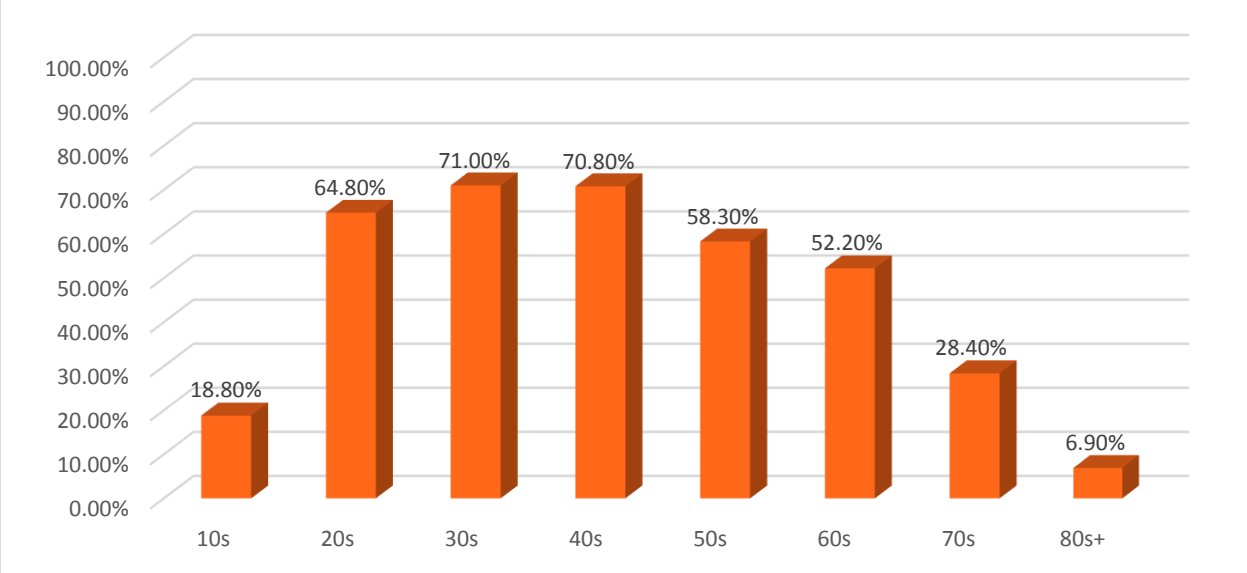
Results show that age is significantly related to the likelihood of health screenings, such that older adults are more likely to have had general preventative screenings than adults and young participants. As illustrated in Table 22, the exception is HIV testing; adults are significantly more likely to have had an HIV test than young or old participants.

Table 22. Routine Health Screenings by Age

Test	Young	Adult	Older Adult	Statistics
High cholesterol	53.2%	72.4%	90.8%	χ^2 (2) = 93.021, $p < .001$
High blood pressure	54.1%	76.3%	92.1%	χ^2 (2) = 95.416, $p < .001$
Diabetes or high blood sugar	47.7%	68.9%	83.4%	χ^2 (2) = 64.175, $p < .001$
Annual check-up	70.2%	66.1%	88.9%	χ^2 (2) = 65.206, $p < .001$
Annual flu shot	35.2%	39.5%	66.2%	χ^2 (2) = 69.929, $p < .001$
HIV	49.5%	70.2%	48.5%	χ^2 (2) = 40.668, $p < .001$

Looking at HIV testing and age in more depth, it is evident that participants in their 30s and 40s had the highest rates of HIV testing, such that over 70% of participants in this age range have been tested for HIV. In contrast, as illustrated in Figure 10, very few of the pre-teen/teen group has been tested, and very few of the elderly group have been tested.

Figure 10. Age and HIV Testing



Note. n = 909.

Reasons for Getting an HIV Test

Participants who indicated that they have been tested for HIV before were subsequently asked, "Why did you choose to get tested for HIV?" Participants were encouraged to check all responses that applied to them, and to enter additional "other" reasons for testing.

As illustrated in Table 23, older adults are significantly less likely to cite "My healthcare provider offered to do the test" and/or "It was offered for free at an event or community location" as motivation for getting an HIV test.

Table 23. Reasons for Being Tested by Age

Reason	Young	Adult	Older Adult	Statistics
My healthcare provider offered to do the test	20.2%	20.7%	9.8%	χ^2 (2) = 21.428, $p < .001$
It was offered for free at an event or community location	15.6%	15.7%	9.8%	χ^2 (2) = 7.30, $p < .05$

Other reasons for being tested (I was concerned I was at risk, partner is positive, required by employer or insurer, expert recommendation, family/friend recommendation) were not significantly different across age groups at the $p < .05$ level. That is, roughly equal proportions from each age group selected those reasons as the motivation behind their tests.

Reasons for Not Getting Tested

Participants who indicated that they have not been tested for HIV before were subsequently asked, "Why haven't you been tested for HIV?" Participants were encouraged to check all responses that applied to them, and to enter additional "other" reasons for lack of testing.

As illustrated in Table 24, two of the most common barriers ("I don't think I'm at risk" and "I'm not sexually active") were predominantly barriers experienced by the young and the old—not the mid-age-range adults. The barrier of lack of insurance, in contrast, was heavily skewed towards the younger participants.

Table 24. Reasons for Not Being Tested by Age

Reason	Young	Adult	Older Adult	Statistics
I don't think I'm at risk for getting HIV	27.5%	16.5%	32.8%	χ^2 (2) = 28.194, $p < .001$
I'm not sexually active	19.3%	2.2%	14.8%	χ^2 (2) = 45.508, $p < .001$
I don't have insurance	7.3%	3.1%	1.0%	χ^2 (2) = 14.898, $p < .01$

The other potential barriers to testing (my provider never offered, I don't want to be judged, too embarrassed, I don't want to know if I have HIV, I don't know where to go, I don't have the transportation, I can't afford it, other) did not differ significantly by age at the $p < .05$ level.

For those participants who had never been tested for HIV, age was significantly related to likelihood of getting future testing, χ^2 (2) = 18.947, $p < .01$. While 91.3% of young participants

indicated they would be willing to be tested for HIV if their provider offered them a free HIV test, only 85.5% of adults agreed with the same statement. This number dropped further to 73.1% for older adults. Thus, it appears that older adults are less open to the idea of getting tested for HIV in the future.

Attitudes towards HIV Testing

Attitudes toward testing vary significantly by age group, χ^2 (6) = 13.654, $p < .05$. Only 2.0% of young participants believe that, "Only those people with high risk of getting HIV, like gay men and drug users, need to be tested for HIV". This number increases with age: 6.1% of adults and 10.7% of older adults believe this statement. As illustrated in Table 25, young participants and adults are more likely than older adults to hold beliefs that are congruent with the CDC's recommendations.

Table 25. Attitudes towards HIV Testing by Age

Belief	Young	Adult	Older Adult
No one needs to be tested for HIV	0.0%	1.3%	1.4%
Only those people with high risk of getting HIV, like gay men or drug users, need to be tested for HIV	2.0%	6.1%	10.7%
All sexually active people need to be tested for HIV	52.0%	46.6%	48.5%
All adults and teens need to be tested for HIV	45.9%	46.0%	39.4%

Future HIV Testing Comfort

There were no significant differences in comfort of potential future testing locations at the $p < .05$ level. That is, the proportions of age groups that find each location comfortable is relatively similar to the overall population.

Profile 4: Income

For the purposes of this profile, low income participants (those living in households that have a household pre-tax income of less than $25,000) are compared to higher income participants (those living in households that have an annual household pre-tax income of $25,000 or more).

Demographic Differences

Low income participants were significantly more likely to have taken the survey in Spanish than higher-income adults, χ^2 (1) = 219.517, $p < .001$. Specifically, 54.5% of low-income participants took the survey in Spanish, while only 9.3% of higher-income participants chose to take the survey in Spanish.

Low-income participants were significantly more likely than higher-income adults to identify as Hispanic/Latino, χ^2 (1) = 158.215, $p < .001$. Approximately 75% of low-income participants (75.7%) were Hispanic, compared to only 34.6% of higher-income participants.

Low-income participants were significantly more likely to live in the East Valley than higher-income participants, χ^2 (1) = 106.981, $p < .001$. Results how that 60.1% of low-income adults live in East Valley, while only 26.2% of higher-income adults live in the East Valley.

Low-income participants are significantly less likely to have had sex in the past 10 years than their higher-income counterparts, χ^2 (3) = 33.469, $p < .001$. Specifically, 21.1% of low-income participants have not had sex within the past 10 years, compared to 8.1% of higher-income participants.

Low-income participants are also significantly less likely to have engaged in MSM than higher-income participants, χ^2 (2) = 55.854, $p < .001$. Only 6.3% of low-income participants are MSM, compared to 19.2% of higher-income participants.

Differences in Media Use

There was no significant difference in frequency of television viewing between the two income groups; both groups were equally likely to watch television every day. However, the low-income participants had significantly lower frequency of listening to the radio than the higher-income participants, χ^2 (4) = 29.789, $p < .001$. Specifically, 67.1% of higher-income participants listen to the radio every day, compared to 50.7% of low income adults. In contrast, only 4.3% of higher-income participants never listen to the radio, while 10.6% low-income participants report never listening to the radio.

Newspaper reading also varied based on income group, χ^2 (4) = 145.013, $p < .001$. Low-income participants read the newspaper significantly less frequently than higher-income adults. Specifically, only 15.4% of low-income adults read the newspaper every day, but 42.6% of higher-income adults report reading the newspaper every day. At the other end of the spectrum, 41.2% of low-income participants have never read the newspaper, compared to only 10.1% of higher-income participants. Clearly, the newspaper is not an effective way to reach low-income residents in the Coachella Valley.

Unsurprisingly, Internet use was also varied based on income. Low-income participants were significantly less likely to use the Internet frequently than their higher-income counterparts, χ^2

(4) = 192.629, $p < .001$. Specifically, less than half of low-income participants (46.5%) report using the Internet every day, while 89.5% of higher-income participants use the Internet every day. At the other end of the spectrum, 34.1% of low-income participants have never used the Internet, compared to only 5.1% of higher-income participants.

Differences in Preventative Health Screenings and Access to Care

Low-income participants are significantly less likely to have access to healthcare when they need it, χ^2 (1) = 63.612, $p < .001$. Specifically, 75.1% of low-income participants report that they have access to healthcare when they need it. In contrast, nearly all higher-income participants (94.1%) say they have access to healthcare when they need it.

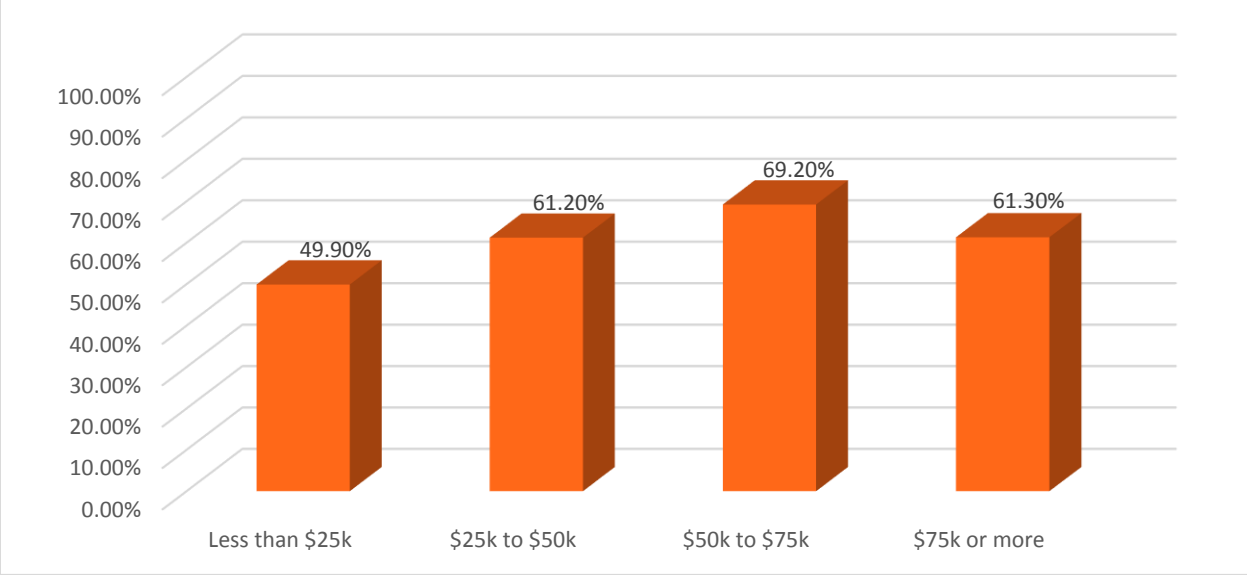
As illustrated in Table 26, low-income participants are significantly less likely than higher-income participants to have received all of the preventative health screenings covered on this survey, including HIV.

Table 26. Routine Health Screenings by Income

Test	Low-Income	Higher-Income	Statistics
High cholesterol	72.7%	87.2%	χ^2 (1) = 29.981, $p < .001$
High blood pressure	75.8%	88.1%	χ^2 (1) = 23.772, $p < .001$
Diabetes or high blood sugar	68.8%	79.6%	χ^2 (1) = 13.887, $p < .001$
Annual check-up	72.8%	82.5%	χ^2 (1) = 12.466, $p < .001$
Annual flu shot	47.0%	58.3%	χ^2 (1) = 11.519, $p < .01$
HIV	49.9%	63.1%	χ^2 (1) = 16.029, $p < .001$

To examine HIV testing behavior and income in more depth, Figure 11 illustrates all four levels of income and their likelihood of HIV testing. Here it is evident that participants in the lowest income bracket were the least likely to have been tested for HIV.

Figure 11. Income and HIV Testing



Note. n = 906.

Reasons for Getting an HIV Test

Participants who indicated that they have been tested for HIV before were subsequently asked, "Why did you choose to get tested for HIV?" Participants were encouraged to check all responses that applied to them, and to enter additional "other" reasons for testing.

Of those participants who have been tested for HIV, the rationale behind testing varied significantly between income groups. As illustrated in Table 27, low-income participants were significantly less likely than higher-income participants to cite the following reasons as motivators for being tested: "I was concerned I might have been exposed to HIV", "It was required by my employer or insurer", and, "Experts recommend that everyone get tested, so I got tested".

Table 27. Reasons for Getting Tested by Income

Reason Why	Low-Income	Higher-Income	Statistics
I was concerned I might have been exposed to HIV	7.5%	14.7%	χ^2 (1) = 13.299, $p < .01$
Required by employer	2.5%	5.2%	χ^2 (1) = 4.624, $p < .05$
Experts recommend that everyone get tested, so I did	7.7%	17.5%	χ^2 (1) = 20.628, $p < .001$

Other reasons for getting tested (having a partner that is HIV positive, offered for free at an event, offered by a provider, friends or family recommended it, other) were not significantly different between the two income groups at the $p < .05$ level. That is, low-income participants and higher-income participants were equally likely to have cited each of those reasons as the motivation behind getting tested.

Reasons for Not Being Tested

Participants who indicated that they have not been tested for HIV before were subsequently asked, "Why haven't you been tested for HIV?" Participants were encouraged to check all responses that applied to them, and to enter additional "other" reasons for lack of testing.

Of those participants who have never been tested for HIV, barriers to testing varied significantly between the two income groups. As illustrated in Table 28, low-income participants were significantly more likely to cite some of the rarer barriers than higher-income participants.

Table 28. Reasons for Not Getting Tested by Income

Reason Why Not	Low-Income	Higher-Income	Statistics
I'm not sexually active	12.9%	8.0%	χ^2 (1) = 7.105, $p < .05$
My provider never offered	14.2%	9.3%	χ^2 (1) = 5.402, $p < .05$
I don't want my doctor or anyone else to judge me	2.5%	0.6%	χ^2 (1) = 5.164, $p < .05$
I'm too embarrassed	2.1%	0.4%	χ^2 (1) = 5.115, $p < .05$
I don't WANT to know if I have HIV	2.5%	0.2%	χ^2 (1) = 9.042, $p < .01$
I don't know where to go to get tested	5.2%	0.4%	χ^2 (1) = 19.331, $p < .001$
I don't have transportation	2.5%	0.0%	χ^2 (1) = 11.724, $p < .01$
I can't afford to get tested	2.9%	0.2%	χ^2 (1) = 10.980, $p < .01$
I don't have insurance	4.0%	0.9%	χ^2 (1) = 9.483, $p < .01$

Interestingly, the most commonly cited reason for not being tested, "I don't think I'm at risk", was the only barrier that did not significantly differ between the two income groups at the $p < .05$ level. This indicates that roughly equal proportions of low-income and higher-income participants cited this as a reason why they have not yet been tested.

Of those participants who have never been tested for HIV, attitudes towards future testing varied significantly by income group, χ^2 (1) = 16.003, $p < .001$. Specifically, 85.9% of low-income participants indicated they would be willing to get tested if their provider offered the test (and the test was free or covered by insurance). In contrast, only 71.7% of higher-income participants indicated that they would be willing to get tested if their provider offered a free HIV test. Thus, it appears that low-income participants who have not been tested are more willing to be tested in the future than their higher-income counterparts.

Attitudes towards HIV Testing

Attitudes towards HIV testing populations varied significantly by income group, χ^2 (3) = 13.487, $p < .01$. As illustrated in Table 29, low-income participants are significantly more likely to believe that all adults and teens need to be tested for HIV than their higher-income counterparts (48.2% versus 36.8%, respectively). In contrast, higher-income participants are significantly more likely than low-income participants to believe that sexually active people need to be tested for HIV (53.8% versus 41.9%, respectively).

Table 29. Attitudes towards HIV Testing by Income

Belief	Low - Income	Higher-Income
No one needs to be tested for HIV	1.9%	1.2%
Only those people with high risk of getting HIV, like gay men or drug users, need to be tested	8.0%	8.2%
All sexually active people need to be tested for HIV	41.9%	53.8%
All adults and teens need to be tested for HIV	48.2%	36.8%

Future HIV Testing Comfort

As illustrated in Table 30, low-income participants were significantly less likely than higher-income participants to be comfortable getting tested at any of the common testing sites.

Table 30. Future Testing Comfort by Income

Site	Low-Income	Higher-Income	Statistics
At a doctor's office	57.2%	79.2%	χ^2 (1) = 52.407, $p < .001$
At a hospital or emergency room	16.1%	25.8%	χ^2 (1) = 13.370, $p < .001$
At rehab	6.1%	9.7%	χ^2 (1) = 4.410, $p < .05$
At home	9.0%	29.9%	χ^2 (1) = 66.082, $p < .001$
At a health fair or community event	13.6%	31.2%	χ^2 (1) = 42.158, $p < .001$

The only testing site that did not differ significantly by income was the community clinic; both low-income and higher-income participants felt equally comfortable getting tested at a community clinic.

Profile 5: Ethnicity

For the purposes of this profile, Hispanic participants are compared to non-Hispanic participants. Race (i.e., White, Black, Asian, Other) is not accounted for in this profile.

Demographic Differences

Unsurprisingly, Hispanic participants were significantly more likely than non-Hispanic participants to have taken the survey in Spanish, χ^2 (1) = 353.785, $p < .001$. Specifically, 58.5% of Hispanic participants took the survey in Spanish, compared to only 1.4% of non-Hispanic participants.

Hispanic participants were significantly more likely than non-Hispanic participants to be female, χ^2 (1) = 20.469, $p < .001$. A total of 69.0% of Hispanic participants identified as female, compared to 54.9% of non-Hispanic participants.

Age was significantly related to ethnicity, χ^2 (2) = 112.990, $p < .001$. Approximately 17.8% of Hispanic participants were younger than 25, compared to only 4.1% of non-Hispanic participants. At the other end of the age spectrum, only 35.0% of Hispanic participants were age 50 and over, compared to 68.7% of non-Hispanic participants.

Hispanic participants had significantly lower income than non-Hispanic participants, χ^2 (3) = 232.101, $p < .001$. The majority of Hispanic participants (69.1%) lived in households with an annual pre-tax income below $25,000, compared to 27.5% of non-Hispanic participants. At the other end of the spectrum, only 4.9% of Hispanic participants lived in households with an annual pre-tax income at or above $75,000 compared to 37.4% of non-Hispanic participants.

Hispanic participants were significantly more likely than non-Hispanic participants to live in the East Valley, χ^2 (1) = 369.920, $p < .001$. The majority of Hispanic participants (71.6%) live in the East Valley, compared to only 9.3% of non-Hispanic participants.

Hispanic participants were significantly less likely to engage in MSM than non-Hispanic participants, χ^2 (1) = 64.227, $p < .001$. Only 5.3% of Hispanic participants engage in MSM, compared to 25.4% of non-Hispanic participants.

Differences in Media Use

There was no significant difference in television use between ethnicities. However, Hispanic participants listen to the radio significantly less often than non-Hispanic participants, χ^2 (4) = 13.651, $p < .01$. Approximately 9.7% of Hispanic participants report that they never listen to the radio, compared to 4.3% of non-Hispanic participants.

Hispanic participants were also significantly less likely to read the newspaper than non-Hispanic participants, χ^2 (4) = 147.405, $p < .001$. Only 16.2% of Hispanic participants read the newspaper every day, compared to 44.9% of non-Hispanic participants.

Hispanic participants were also significantly less likely to use the Internet than non-Hispanic participants, χ^2 (4) = 119.541, $p < .001$. Specifically, 52.8% of Hispanic participants use the Internet every day, compared to 84.9% of non-Hispanic participants. At the other end of the

spectrum, 32.1% of Hispanic participants report never using the internet, compared to only 6.0% of non-Hispanic participants.

Differences in Preventative Health Screenings and Access to Care

Results indicate that significantly fewer Hispanic participants have ready access to healthcare when compared to their non-Hispanic counterparts, χ^2 (1) = 73.324, $p < .001$. Specifically, 75.4% of Hispanic participants report having access to healthcare when they need it, compared to 95.7% of non-Hispanic participants.

As illustrated in Table 31, Hispanic participants are also significantly less likely than non-Hispanic participants to receive preventative screenings, including HIV.

Table 31. Routine Health Screenings by Ethnicity

Test	Hispanic	Non-Hispanic	Statistics
High cholesterol	71.2%	89.3%	χ^2 (1) = 46.417, $p < .001$
High blood pressure	74.8%	89.9%	χ^2 (1) = 35.761, $p < .001$
Diabetes or high blood sugar	68.9%	80.0%	χ^2 (1) = 14.839, $p < .001$
Annual check-up	70.6%	85.8%	χ^2 (1) = 30.997, $p < .001$
Annual flu shot	42.8%	64.2%	χ^2 (1) = 42.100, $p < .001$
HIV	51.5%	62.5%	χ^2 (1) = 12.390, $p < .001$

Reasons for Being Tested

Participants who indicated that they have been tested for HIV before were subsequently asked, "Why did you choose to get tested for HIV?" Participants were encouraged to check all responses that applied to them, and to enter additional "other" reasons for testing.

As illustrated in Table 32, Hispanic participants are significantly less likely than non-Hispanic participants to select most common reasons for getting tested. The exception is "my provider offered to do the test"—in this instance, Hispanic participants are more likely than non-Hispanic participants to cite this as a motivator for testing, further emphasizing the importance of the provider's role for this audience.

Table 32. Reasons for Being Tested by Ethnicity

Reason	Hispanic	Non-Hispanic	Statistics
I was concerned I might have been exposed to HIV	7.3%	16.2%	χ^2 (1) = 19.777, $p < .001$
Partner is HIV positive	0.2%	3.5%	χ^2 (1) = 16.222, $p < .001$
My provider offered to do the test	17.2%	12.1%	χ^2 (1) = 5.082, $p < .05$
It was required by my employer or insurer	2.4%	5.1%	χ^2 (1) = 5.147, $p < .05$
Experts recommend that everyone get tested, so I did	8.3%	17.2%	χ^2 (1) = 17.856, $p < .001$

Other potential reasons for getting tested (it was offered for free at an event, my family or friends recommended it, other) did not differ significantly by ethnicity.

Reasons for Not Getting Tested

Participants who indicated that they have not been tested for HIV before were subsequently asked, "Why haven't you been tested for HIV?" Participants were encouraged to check all responses that applied to them, and to enter additional "other" reasons for lack of testing.

As illustrated in Table 33, some of the less common barriers to testing are cited almost exclusively by the Hispanic audience. Additionally, "my healthcare providers has never offered to test me" was cited significantly more often by Hispanic participants than by non-Hispanic participants, underscoring the importance of provider influence for this population.

Table 33. Reasons for Not Getting Tested by Ethnicity

Reason	Hispanic	Non-Hispanic	Statistics
My healthcare provider has never offered to test me for HIV	13.8%	9.5%	χ^2 (1) = 4.148, $p < .05$
I don't want my doctor or anyone else to judge me	2.4%	0.7%	χ^2 (1) = 4.259, $p < .05$
I don't want to know if I have HIV	2.2%	0.5%	χ^2 (1) = 5.141, $p < .05$
I don't know where to go to get tested	4.8%	0.7%	χ^2 (1) = 13.859, $p < .001$
I don't have the transportation needed to get to a testing site	2.0%	0.2%	χ^2 (1) = 6.324, $p < .05$
I don't have insurance	4.0%	0.7%	χ^2 (1) = 10.761, $p < .01$

Other potential barriers (I don't think I'm at risk, I'm not sexually active, I'm too embarrassed, I can't afford it, other) did not differ significantly based on ethnicity.

Hispanic participants who had never been tested for HIV were significantly more open to the idea of future testing than their non-Hispanic counterparts, χ^2 (1) = 23.305, $p < .001$. Specifically, 13.6% of Hispanic participants state that they would not get an HIV test in the future if offered for free by their healthcare provider. In contrast, 31.3% of non-Hispanic participants indicated that they would refuse a free HIV test provided free by their provider.

Attitudes towards HIV Testing

Attitudes towards the need for HIV testing varied significantly by ethnicity, χ^2 (3) = 15.642, $p < .01$. As illustrated in Table 34, Hispanic participants were significantly more likely than non-Hispanic participants to believe that all adults and teens need to be tested for HIV (47.6% versus 35.8%, respectively).

Table 34. Attitudes towards HIV Testing by Ethnicity

Belief	Hispanic	Non-Hispanic
No one needs to be tested for HIV	1.3%	1.8%
Only those people with high risk of getting HIV, like gay men or drug users, need to be tested for HIV	9.1%	7.5%
All sexually active people need to be tested for HIV	42.0%	55.0%
All adults and teens need to be tested for HIV	47.6%	35.8%

Future HIV Testing Comfort

Comfort for testing in future settings varied significantly by ethnicity. As illustrated in Table 35, Hispanic participants are less comfortable getting tested than non-Hispanic participants at nearly every one of the common locations. The exception is community clinics—more Hispanic participants would be comfortable being tested for HIV at a community clinic when compared to non-Hispanics. Thus, this may be an especially effective testing site for this population.

Table 35. Future HIV Testing Comfort by Ethnicity

Setting	Hispanic	Non-Hispanic	Statistics
A doctor's office	58.2%	80.7%	χ^2 (1) = 56.505, $p < .001$
At a community clinic	43.3%	36.7%	χ^2 (1) = 4.413, $p < .05$
At a hospital or emergency room	16.1%	26.7%	χ^2 (1) = 16.216, $p < .001$
At a drug treatment facility	6.4%	10.2%	χ^2 (1) = 4.639, $p < .05$
At home	9.9%	31.1%	χ^2 (1) = 69.436, $p < .001$
Health fair, testing van, or other community event	16.7%	29.2%	χ^2 (1) = 21.878, $p < .001$

Profile 6: Sexual Behavior

This profile compares men who have sex with men (MSM) to other sexually active participants. For the purposes of this profile, those participants who have not had sex within the past decade are excluded.

Demographic Differences

MSM were significantly less likely than other sexually active participants to have taken the survey in Spanish, χ^2 (1) = 44.438, $p < .011$. Only 5.0% of MSM took the survey in Spanish, compared to 35.7% of other sexually active participants.

This is likely attributable to the significant difference in ethnicity by sexual activity, χ^2 (1) = 64.227, $p < .001$. Approximately 19.5% of MSM identify as Hispanic, compared to 59.3% of other sexually active participants.

MSM were significantly older than other sexually active participants, χ^2 (2) = 17.125, $p < .001$. A total of 63.9% of MSM were age 50 and older, compared to 43.9% of other sexually active participants.

Income varied significantly by sexual partner, χ^2 (3) = 28.479, $p < .001$. Overall, MSM were significantly less likely to live in extreme poverty than other sexually active participants. While 50.2% of other sexually active participants live in households with an annual pre-tax income of less than $25,000, only 25.0% of MSM live in such poverty.

MSM were significantly less likely than other sexually active participants to live in the East Valley, χ^2 (1) = 57.228, $p < .001$. Only 10.9% of MSM live in the East Valley, but 48.1% of other sexually active participants call the East Valley home.

Differences in Media Use

MSM and other sexually active participants had roughly equal usage levels for television and radio. However, MSM were significantly more likely than other sexually active participants to be frequent newspaper readers, χ^2 (4) = 13.885, $p < .01$. Specifically, 41.1% of MSM read the paper every day, compared to only 28.6% of other sexually active participants.

MSM were also significantly more likely than other sexually active participants to use the Internet on a daily basis, χ^2 (4) = 24.111, $p < .001$. Nearly all MSM (89.6%) report using the internet on a daily basis, compared to 68.4% of other sexually active participants.

Differences in Preventative Health Screenings and Access to Care

MSM were significantly more likely than other sexually active participants to have access to care when they need it, χ^2 (1) = 5.824, $p < .05$. Specifically, 92.3% of MSM say they have access to healthcare when they need it, compared to 83.7% of other sexually active participants.

As illustrated in Table 36, MSM were significantly more likely than other sexually active participants to have received many common preventative tests, including HIV. However, there were no significant differences in the rates of annual check-ups between groups.

Table 36. Routine Health Screenings by Sexual Behavior

Test	MSM	Other sexually active	Statistics
High cholesterol	93.2%	78.7%	χ^2 (1) = 13.688, $p < .001$
High blood pressure	95.8%	81.1%	χ^2 (1) = 15.502, $p < .001$
Diabetes or high blood sugar	84.6%	73.1%	χ^2 (1) = 6.966, $p < .01$
Annual flu shot	73.5%	46.8%	χ^2 (1) = 28.466, $p < .001$
HIV	94.9%	56.3%	χ^2 (1) = 63.610, $p < .001$

Reasons for Getting Tested

Participants who indicated that they have been tested for HIV before were subsequently asked, "Why did you choose to get tested for HIV?" Participants were encouraged to check all responses that applied to them, and to enter additional "other" reasons for testing.

As illustrated in Table 37, MSM were more likely than other sexually active participants to cite exposure concern and an HIV positive partner as motivation for testing. Similarly, MSM were more likely than other sexually active participants to get tested because it was offered at an event, or based on expert recommendations.

Table 37. Reasons for Getting Tested by Sexual Behavior

Reason	MSM	Other sexually active	Statistics
I was concerned I might have been exposed	42.9%	7.9%	χ^2 (1) = 109.608, $p < .001$
My partner is HIV positive	10.9%	0.1%	χ^2 (1) = 69.858, $p < .001$
It was offered for free at an event or community location	24.4%	12.2%	χ^2 (1) = 12.432, $p < .001$
Experts recommend that everyone get tested, so I did	33.6%	9.6%	χ^2 (1) = 51.145, $p < .001$

Other reasons for getting tested (my healthcare provider offered to do the test, required by employer or insurer, friends or family recommend testing, other) did not differ significantly based on gender of sexual partners.

Reasons for Not Getting Tested

Participants who indicated that they have not been tested for HIV before were subsequently asked, "Why haven't you been tested for HIV?" Participants were encouraged to check all responses that applied to them, and to enter additional "other" reasons for lack of testing.

As illustrated in Table 38, MSM were significantly less likely to have selected the most common barriers to testing than other sexually active participants.

Table 38. Reasons for Not Getting Tested by Sexual Behavior

Reason	MSM	Other sexually active	Statistics
I don't think I'm at risk for getting HIV	2.5%	27.3%	χ^2 (1) = 34.595, $p < .001$
I'm not sexually active	0.8%	5.5%	χ^2 (1) = 4.769, $p < .05$
My provider never offered	0.8%	11.9%	χ^2 (1) = 13.532, $p < .001$

Other potential barriers to testing (I don't want to be judged, I'm too embarrassed, I don't want to know if I have HIV, I don't know where to go to get tested, I don't have transportation to get to a testing site, I can't afford it, I don't have insurance) did not differ significantly between the two groups based on gender of sexual partners.

Attitudes towards HIV Testing

MSM were significantly less likely than other sexually active participants to have attitudes towards testing that were congruent with the CDC recommendations, χ^2 (3) = 13.800 $p < .01$. As illustrated in Table 39, a third of MSM believe "All adults and teens need to be tested for HIV", compared to 44.5% of other sexually active participants. Most MSM believe that all sexually active people should be tested for HIV.

Table 39. Attitudes towards HIV Testing by Age

Belief	MSM	Other sexually active
No one needs to be tested for HIV	0.9%	0.8%
Only those people with high risk of getting HIV, like gay men or drug users, need to be tested for HIV	2.6%	8.8%
All sexually active people need to be tested for HIV	63.2%	45.9%
All adults and teens need to be tested for HIV	33.3%	44.5%

Future HIV Testing Comfort

MSM were significantly more likely than other sexually active participants to predict that would be comfortable getting tested for HIV at common testing sites, as illustrated in Table 40.

Table 40. Future Testing Comfort by Sexual Behavior

Site	MSM	Other sexually active	Statistics
Doctor's office	71.9%	65.4%	χ^2 (1) = 4.664, $p < .05$
Community clinic	44.9%	35.8%	χ^2 (1) = 8.120, $p < .01$
Hospital or ER	24.9%	16.7%	χ^2 (1) = 9.417, $p < .01$
At a drug treatment facility (rehab)	10.9%	5.0%	χ^2 (1) = 10.567, $p < .01$
Home	24.5%	13.8%	χ^2 (1) = 16.873, $p < .001$
At a health fair, testing van, or other community event	29.4%	14.6%	χ^2 (1) = 29.316, $p < .001$

There was no significant difference in the proportion of people who selected "I would not be comfortable getting tested at any of these sites" by sexual behavior—about 4% of each group selected the "none of the above" option in response to the future testing question.

Profile 7: Geographic Location

For the purpose of this profile, the Coachella Valley geography is broken up into two regions: West Valley (Desert Hot Springs, Palm Springs, Cathedral City, Rancho Mirage, Palm Desert, Indian Wells, La Quinta, Bermuda Dunes, Thousand Palms) and East Valley (Indio, Coachella, Mecca, Thermal).

Demographic Differences

Residents of the East Valley were significantly more likely to have taken the survey in Spanish, χ^2 (1) = 241.839, $p < .001$. Specifically, 58.6% of East Valley participants took the survey in Spanish, compared to only 11.5% of West Valley participants.

East Valley participants were also significantly more likely than West Valley participants to identify as Hispanic/Latino, χ^2 (1) = 369.920, $p < .001$. Nearly all of the East Valley participants (90.3%) identified as Hispanic, compared to only 27.5% of West Valley participants.

Age was significantly related to geographic location, χ^2 (2) = 54.010, $p < .001$. A total of 16.3% of East Valley participants are under the age of 25, compared to only 7.8% of West Valley participants. In contrast, only 37.4% of East Valley participants are older adults, compared to 61.5% of West Valley participants.

East Valley residents were significantly less wealthy than West Valley residents, χ^2 (3) = 154.504, $p < .001$. The majority of East Valley participants (69.9%) live in households with an annual pre-tax income of less than $25,000, compared to only 35.3% of West Valley participants. In contrast, only 5.3% of East Valley participants live in households with an annual pre-tax income of $75,000 or more, compared to 31.1% of West Valley participants.

Participants living in East Valley were significantly more likely to be female than West Valley participants, χ^2 (1) = 12.397, $p < .001$. A total of 68.2% of East Valley participants are female, compared to 57.1% of West Valley participants.

Sexual habits are relatively similar between the two geographic regions. Approximately 15% of participants in both groups have not has sex within the past ten years. However, East Valley participants were significantly less likely to be MSM than West Valley participants, χ^2 (1) = 57.228, $p < .001$. Only 3.9% of East Valley participants were MSM, compared to 23.4% of West Valley participants.

Differences in Media Use

There was no significant difference in television viewing habits based upon geographic location—participants on both sides of the valley were equally likely to watch television every day.

East Valley participants listen to the radio significantly less often than West Valley participants, χ^2 (4) = 9.993, $p < .05$. About 56.8% of East Valley participants listen to the radio every day, compared to 60.2% of West Valley participants. At the other end of the spectrum, 9.7% of East Valley participants never listen to the radio, compared to 4.9% of West Valley participants.

Participants living in the East Valley also read the newspaper significantly less often than West Valley participants, χ^2 (4) = 86.232, $p < .001$. Only 18.2% of East Valley participants report reading the newspaper every day, compared to 39.2% of West Valley participants. In contrast, 38.5% of East Valley participants never read the newspaper, compared to 14.6% of West Valley participants.

Internet use also significantly differs based on geographic location, χ^2 (4) = 111.716, $p < .001$. About half of East Valley participants (50.1%) use the Internet every day, compared to 81.8% of West Valley participants. At the other end of the spectrum, 33.5% of East Valley participants never use the internet, compared to only 8.5% of West Valley participants.

Differences in Preventative Health Screenings and Access to Care

Participants in the East Valley are significantly less likely to have access to healthcare when they need it, χ^2 (1) = 30.938, $p < .001$. Specifically, 77.3% of East Valley participants believe that they have access to healthcare when they need it, compared to 90.5% of West Valley participants.

Roughly equal proportions of participants have been tested for diabetes—about 74% across the board have been tested. However, East Valley participants are significantly less likely to have received other preventative screenings, as illustrated in Table 41. Interestingly, there were no significant differences in HIV testing behavior by geographic location at the $p < .05$ level. That is, roughly similar proportions of residents in each half of the valley have been tested—53.4% in East Valley, and 58.6% in West Valley.

Table 41. Routine Health Screenings by Geographic Location

Test	West Valley	East Valley	Statistics
High cholesterol	83.6%	74.0%	χ^2 (1) = 12.974, $p < .001$
High blood pressure	86.2%	76.6%	χ^2 (1) = 14.340, $p < .001$
Annual check-up	81.1%	73.6%	χ^2 (1)= 7.502, $p < .01$
Annual flu shot	58.8%	45.1%	χ^2 (1) = 17.003, $p < .001$

Reasons for Getting Tested

Participants who indicated that they have been tested for HIV before were subsequently asked, "Why did you choose to get tested for HIV?" Participants were encouraged to check all responses that applied to them, and to enter additional "other" reasons for testing.

As illustrated in Table 42, participants in the East Valley were significantly less likely than participants in the West Valley to cite a variety of common reasons for getting tested. The notable exception to this was the "my healthcare provider offered to do the test" rationale—this motivated significantly more people in the East Valley to get tested, when compared to those in the West Valley.

Table 42. Reasons for Getting Tested by Geographic Location

Reason	West Valley	East Valley	Statistics
I was concerned I might have been exposed to HIV	14.6%	6.5%	χ^2 (1) = 17.234, p < .001
My sexual partner is HIV positive	2.6%	0.5%	χ^2 (1) = 6.293, p < .05
My healthcare provider offered to do the test	11.3%	19.4%	χ^2 (1) = 12.144, p < .001
Experts recommend that everyone get tested, so I got tested	15.7%	7.7%	χ^2 (1) = 14.365, p < .001
My friend or family member said testing is a good idea, so I got tested	6.2%	3.1%	χ^2 (1) = 4.932, p < .05

Other reasons for getting tested (it was offered for free at an event, it was required by an employer or insurer, other) did not differ significantly based on geographic location.

Reasons for Not Getting Tested

Participants who indicated that they have not been tested for HIV before were subsequently asked, "Why haven't you been tested for HIV?" Participants were encouraged to check all responses that applied to them, and to enter additional "other" reasons for lack of testing.

As illustrated in Table 43, East Valley participants were significantly more likely than West Valley participants to list several of the less common barriers to HIV testing.

Table 43. Reasons for Not Getting Tested by Geographic Location

Reason	West Valley	East Valley	Statistics
I don't want to know if I have HIV	0.7%	2.4%	χ^2 (1) = 4.573, p < .05
I don't know where to go to get tested	1.6%	4.5%	χ^2 (1) = 7.073, p < .01
I don't have the transportation needed to get to a testing site	0.5%	1.9%	χ^2 (1) = 3.920, p < .05
I can't afford to get tested	0.9%	2.6%	χ^2 (1) = 4.286, p < .05

Other barriers to testing (I don't think I'm at risk, I'm not sexually active, my provider never offered to test me, I don't want anyone to judge me, I'm too embarrassed to get tested, I don't have insurance, other) were not significantly different based on geographic location.

East Valley participants who have never been tested for HIV are significantly more open to the idea of being tested in the future than their West Valley counterparts, χ^2 (1) = 18.846, p < .001. Specifically, 87.1% of East Valley participants say that they would get an HIV test in the future if their provider offered them one free of charge. In contrast, only 72.1% of West Valley participants are similarly open to the idea—meaning nearly 28% of West Valley participants who have never been tested before would refuse a free HIV test offered by their healthcare provider.

Attitudes towards HIV Testing

Attitudes toward testing vary significantly by geographic location, χ^2 (3) = 10.202, $p < .05$. As illustrated in Table 44, participants living in the East Valley are significantly more likely than West Valley residents to have attitudes that are consistent with the CDC's recommendations.

Table 44. Attitudes towards HIV Testing by Geographic Location

Belief	West Valley	East Valley
No one needs to be tested for HIV	1.8%	1.1%
Only those people with high risk of getting HIV, like gay men or drug users, need to be tested for HIV	7.3%	10.5%
All sexually active people need to be tested for HIV	52.7%	42.8%
All adults and teens need to be tested for HIV	38.1%	45.6%

Future HIV Testing Comfort

Residents of the East Valley are significantly less likely than West Valley residents to be comfortable getting tested at nearly all common HIV testing locations, as illustrated in Table 45.

Table 45. Future HIV Testing Comfort by Geographic Location

Site	West Valley	East Valley	Statistics
Doctor's office	77.7%	56.7%	χ^2 (1) = 48.500, $p < .001$
Hospital or ER	23.8%	16.7%	χ^2 (1) = 7.106, $p < .01$
Drug treatment facility (rehab)	9.7%	6.0%	χ^2 (1) = 4.386, $p < .05$
At home	26.0%	11.2%	χ^2 (1) = 32.579, $p < .001$
Health fair, testing van, or other community event	28.0%	14.8%	χ^2 (1) = 23.619, $p < .001$

The exception was that residents of both sides of the valley would be equally as comfortable getting tested at a community clinic.

Profile 8: Willingness

This profile is slightly different from the previous profiles, as it compares two groups of participants who have never been tested (rather than two groups of the entire sample). This sample does not cover those participants who have been tested for HIV in the past. For the purpose of this profile, participants who have never been tested for HIV are separated into two groups: those who would get an HIV test if their provider offered them one for free ("accepters"), and those who would not get an HIV test if their provider offered them one for free ("refusers").

Demographic Differences

Refusers were significantly less likely to have taken the survey in Spanish, χ^2 (1) = 10.245, p < .01. Specifically, 26.3% of refusers took the survey in Spanish, compared to 44.9% of accepters.

Refusers were also significantly less likely than accepters to identify as Hispanic/Latino, χ^2 (1) = 18.817, p < .001. Specifically, 42.1% of refusers were Hispanic/Latino, compared to 67.3% of accepters.

Similarly, refusers were also significantly less likely to live in the East Valley than accepters, χ^2 (1) = 13.895, p < .001. Only 28.0% of refusers lived in the East Valley, compared to half of accepters (50.2%).

Refusers were also significantly more wealthy than accepters, χ^2 (1) = 12.425, p < .001. Less than 40% of refusers (39.5%) live in households with an annual income below $25,000, but 61.2% of accepters live in such impoverished households. Thus, it is clear that, as a group, refusers are non-Hispanic, English-speaking people living in the West Valley with relatively stable finances.

There were no significant differences between refusers and accepters in terms of gender. However, refusers were significantly older than accepters, χ^2 (3) = 10.226, p < .01. A full 73.0% of refusers were age 50 and over, compared to 54.9% of accepters. At the other end of the spectrum, only 6.7% of refusers were under the age of 25, compared to 17.2% of accepters.

Sexual habits were relatively similar between the two groups. About 33% of refusers and 23% of accepters had not had sex within the past year. In both groups, there were very few MSM—1.1% and 1.8%, respectively.

Differences in Media Use

There was no significant difference in television viewing habits based upon willingness to be tested in the future—refusers and accepters were equally likely to watch television every day. The same was true for radio—refusers and accepters alike both tended to listen to the radio at least a few times a week. Internet use also did not differ significantly based upon willingness to be tested in the future; most participants, refusers and accepters alike, used the Internet at least once a week.

Differences in Preventative Health Screenings and Access to Care

Overall, refusers and accepters have very similar habits in terms of preventative health screenings and access to care. There were no significant differences between the two groups in the rates of screening for high cholesterol, high blood pressure, or diabetes. Similarly, most participants who had never been tested for HIV—regardless of whether they were a refuser or an accepter—had yearly routine check-ups, annual flu shots, and access to healthcare when they need it.

Reasons for Not Getting Tested

Participants who indicated that they have not been tested for HIV before were subsequently asked, "Why haven't you been tested for HIV?" Participants were encouraged to check all responses that applied to them, and to enter additional "other" reasons for lack of testing.

The most common reason for not getting tested for both groups was, "I don't think I'm at risk for getting HIV" (63.2% of refusers, 58.6% of accepters). This difference was not statistically significant. Similarly, roughly equal proportions of both refusers and accepters cited, "I'm not sexually active" as a reason for not getting tested (27.4% and 23.5%, respectively).

However, the third barrier that was commonly cited in the general population, "My provider has never offered to test me", varied significantly between the two groups. As illustrated in Table 38, 36.1% of accepters say that their provider has never offered to test them, compared to only 8.4% of refusers. Thus, it is possible that the refusers have been offered a test for HIV before, but have refused it because they do not believe they are at risk.

As illustrated in Table 46, other potential reasons for not getting tested that varied significantly between the two groups included, "I don't know where to go", "I can't afford to get tested", and "I don't have insurance". Thus, the accepters may simply need to be educated on where they can go to receive free HIV tests in order to get them to take the test. In contrast, such education is unlikely to do much for the refusers: they know where to go to get free HIV tests, but they do not do so because they don't believe they are at risk. Changing beliefs like this will require more effort than simply imparting knowledge of where to go to get tested.

Table 46. Reasons for Not Getting Tested by Willingness

Reason	Refusers	Accepters	Statistics
My provider never offered	8.4%	36.1%	χ^2 (1) = 26.475, $p < .001$
I don't know where to go to get tested	0.0%	10.2%	χ^2 (1) = 10.465, $p < .01$
I can't afford to get tested	0.0%	4.9%	χ^2 (1) = 4.845, $p < .05$
I don't have insurance	1.1%	7.7%	χ^2 (1) = 5.569, $p < .05$

Other barriers to testing (I don't want anyone to judge me, I'm too embarrassed to get tested, I don't want to know, I don't have transportation, other) were not significantly different based on geographic location.

Attitudes towards HIV Testing

Refusers were significantly less likely than accepters to have beliefs that were consistent with the CDC's recommendations for HIV testing, χ^2 (3) = 64.919, $p < .001$. As illustrated in Table 47, only 7.1% of refusers agreed with the statement "All adults and teens need to be tested for HIV at least once". In contrast, nearly half of the accepters held this belief—48.6%.

Table 47. Attitudes towards HIV Testing by Willingness

Belief	Refusers	Accepters
No one needs to be tested for HIV	6.0%	1.2%
Only those people with high risk of getting HIV, like gay men or drug users, need to be tested for HIV	31.0%	7.0%
All sexually active people need to be tested for HIV	56.0%	43.2%
All adults and teens need to be tested for HIV	7.1%	48.6%

This indicates that the accepters do believe in the importance of HIV testing, and that they have not yet done so simply due to barriers that can either be overcome by providers offering the test, or by receiving simple education regarding where to go in the community for free HIV testing.

However, the refusers will need more than these relatively simple interventions in order to get them to take the test. This is especially true for the 31.0% of refusers who believe that only high-risk people, like gay men and IV drug users, need to be tested for HIV. An additional 6.0% of refusers believe that no one needs to be tested for HIV. These people are unlikely to get tested for HIV, even with significant education.

Future HIV Testing Comfort

Refusers are significantly less likely than accepters to be comfortable with the idea of future testing in a community clinic, a hospital or ER, or in rehab. As illustrated in Table 48, refusers are significantly more likely to say that they would not be comfortable getting tested for HIV in any location.

Table 48. Future HIV Testing Comfort by Willingness

Site	Refusers	Accepters	Statistics
Community clinic	17.9%	43.5%	χ^2 (1) = 20.030, $p < .001$
Hospital or ER	10.5%	19.6%	χ^2 (1) = 4.132, $p < .05$
Drug treatment facility (rehab)	1.1%	6.7%	χ^2 (1) = 4.504, $p < .05$
None of these sites would be comfortable for me	9.5%	3.5%	χ^2 (1) = 5.337, $p < .05$

There was no significant difference between refusers and acceptors in terms of comfort being tested at a doctor's office, at home, and at a health fair or other community event.

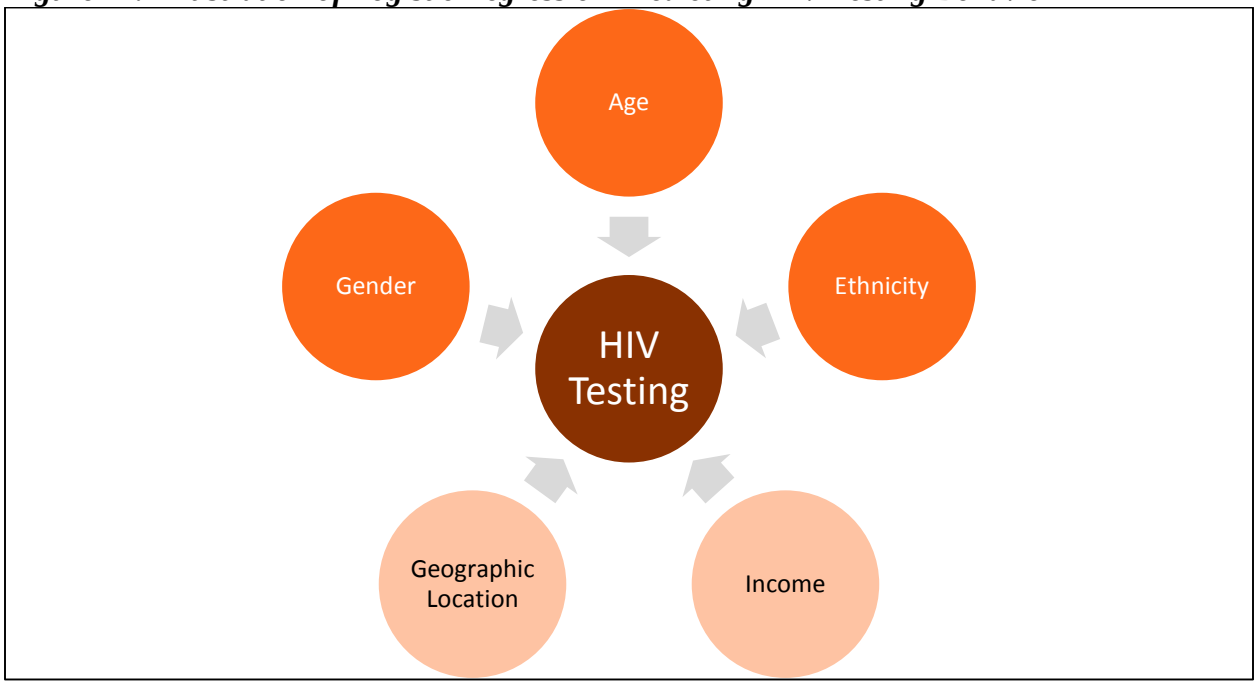
Logistic Regression

Many times, demographic factors such as those presented above tend to covary. That is, in many situations, women are significantly more likely to be low income than men, and Hispanic people are more likely to be low income than non-Hispanic people, etc. To account for this, and to determine which demographic factors are truly barriers to being tested, a logistic regression was used to assess the impact of the demographic factors together (gender, age, ethnicity, income, and geographic location) on the likelihood of being tested for HIV.

Results show that these five factors combined explain approximately 7.3% of the variance in HIV testing behavior. That is, these five factors combined predict 7.3% of whether an individual has or has not been tested for HIV. The remaining 92.7% of the variance is predicted by other factors not in this dataset (for instance, factors such as sexual orientation, number of sexual partners, etc.). An illustration of this model is provided in Figure 11.

As illustrated in Figure 11, gender, ethnicity, and age are significant drivers of HIV testing behavior. In contrast, when accounting for the other demographics, income and location (east valley versus west valley) do not significantly predict whether or not a person has been tested for HIV. Based on these analyses, along with the profiles presented earlier, it is clear that Hispanics, women, the very young, and the very old are the least likely to have been tested for HIV, and thus, need some of the most educating and testing services.

Figure 12. Illustration of Logistic Regression Predicting HIV Testing Behavior



Note. Light orange circles indicate factors that are not statistically significant predictors of HIV testing behavior in this model, while bright orange circles indicate factors that are statistically significant predictors of HIV testing behavior in this model, even when controlling for the other factors in the model.

Conclusion

Overall, the results of the community survey have demonstrated several facts that can be utilized by the GTCV team. Despite the fact that the present study was not a randomized sample, demographic results indicate it is still a solid approximation of the Coachella Valley population as a whole. Thus, results can be reported with confidence to represent the Coachella Valley community, despite the fact that only 995 were surveyed (instead of all 400,000 or so residents).

The majority of participants are getting routine health screenings, such as those checking for high cholesterol, high blood pressure, and diabetes. Additionally, most participants are receiving a routine check-up each year, and feel that they have access to healthcare when they need it. Thus, making HIV testing a routine part of annual check-ups would likely reach many people, and be an effective strategy to increase the number of people who have been tested for HIV in Coachella Valley.

Further reinforcing the importance of buy-in from healthcare providers, the number one reason participants give for why they have been tested for HIV is, "my healthcare provider offered to do the test". This is especially powerful for the Hispanic community—significantly more Hispanics than non-Hispanics cited this as the motivating factor behind their test. "My doctor/healthcare provider has never offered to test me" is the second-most commonly cited barrier to testing, and is especially prevalent for the Hispanic community. Overall, it is clear that primary care providers have a huge role to play in testing the Coachella Valley community, especially for Hispanics.

Approximately 42% of participants held beliefs about HIV testing that were consistent with the CDC's recommendations that all adults and teens be tested for HIV at least once in their lives. Thus, it is clear that GTCV has significant progress to make in educating the general public as to the need for HIV testing. Further evidence supporting this is the fact that the number one reason for not getting tested was, "I don't think I'm at risk for getting HIV". Clearly, more education needs to be done regarding risks and the need to be tested even if an individual does not fall into one of the high-risk categories.

Older adults may be a particularly difficult population for the GTCV to reach. Over half of adults in the Coachella Valley are age 50 and older. However, older adults are significantly less likely to have been tested for HIV, and significantly less willing to get an HIV test in the future, if offered for free by their healthcare provider. Nearly a third of older adults who have not been tested say they don't believe they are at risk for HIV, and over 10% of older adults believe that only high-risk people should be tested for HIV. Thus, it is clear that this is a population that will take more time to educate about the need for HIV testing, as their beliefs are strongly entrenched.

It is worth noting that low-income participants cited significantly different barriers to HIV testing than higher-income participants. While the most common reason for not being tested ("I don't think I'm at risk") remains at the top of the list for low-income participants, several barriers exist for this community that are virtually non-existent for higher-income participants. Examples include, "I don't know where to get tested", "I don't have insurance", and "I can't afford to get tested". While the numbers of participants who cited these barriers are small, it is

worth noting that they are nearly all low-income, and thus, targeted outreach can be designed and provided for this population.

Results indicate that television and Internet will be especially useful modes of communication for the GTCV campaign. Television in particular is popular across all demographic groups; the majority of participants, regardless of their age, ethnicity, gender, or income level tend to watch television every day. The newspaper is a less effective mechanism for reaching Coachella Valley residents, especially for women, Hispanics, and low-income participants, and thus, publicity resources should be directed appropriately.

As mentioned previously, this survey will be repeated in 2016, with virtually identical survey tools. This will allow for GTCV and HARC to assess change in attitudes, beliefs, and behaviors over time. Ideally, the second survey will demonstrate that more Coachella Valley residents have been tested, and that more residents believe that there is a need for everyone to be tested for HIV.

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Appendices

Appendix A: English Survey
Appendix B: Spanish Survey

Appendix A: Coachella Valley Health Screening Survey

Please complete this confidential survey to help us understand health screening behaviors in Coachella Valley. By completing this survey, you will be entered to win one of TEN $50 Visa cards! Please mail your completed survey to: Get Tested Coachella Valley, ATTN: Susan Unger, 1695 N. Sunrise Way, Palm Springs, CA, 92262.

1. What is your gender?

- ☐ Male
- ☐ Female
- ☐ Transgender: Male to Female
- ☐ Transgender: Female to Male
- ☐ Other: _____

2. How would you describe your ethnicity?

- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino

3. How would you describe your race? Please check all that apply.

- ☐ White/Caucasian
- ☐ Black/African American
- ☐ Asian/Pacific Islander
- ☐ American Indian/Alaska Native
- ☐ Other: _____

4. How old are you? _____

5. What is your household income before taxes?

- ☐ $24,999 or less
- ☐ $25,000 to $49,999
- ☐ $50,000 to $74,999
- ☐ $75,000 or more

6. What city do you live in?

- ☐ Bermuda Dunes
- ☐ Cathedral City
- ☐ Coachella
- ☐ Desert Hot Springs
- ☐ Indian Wells
- ☐ Indio
- ☐ La Quinta
- ☐ Mecca
- ☐ Palm Desert
- ☐ Palm Springs
- ☐ Rancho Mirage
- ☐ Thermal
- ☐ Thousand Palms
- ☐ Other: _____

7. On average, how often do you…

	Every day	A few times a week	A few times a month	A few times a year	Never
Watch TV					
Listen to the radio					
Read the newspaper					
Use the internet					

8. Have you been tested for any of the following health conditions in the past 5 years?

	Yes, I have been tested	No, I have not been tested
High cholesterol		
High blood pressure		
Diabetes		

9. Please indicate if the following statements are true or false.

	True	False
I get a routine check-up with a doctor about once a year		
I get a flu shot almost every year		
I have access to healthcare when I need it		

10. In the past 10 years, have you had any type of sex (including oral, anal, or vaginal) with:

- ☐ Men only
- ☐ Women only
- ☐ Both men and women
- ☐ Not applicable—I have not had sex in the past 10 years

11. Have you EVER been tested for HIV, the virus that causes AIDS?

Do NOT count tests you may have had as part of a blood donation, but DO include all other types of HIV tests.

- ☐ Yes (skip to question #12 on the other side)
- ☐ No (skip to question #15 on the other side)

If you have any questions or concerns about this survey, please contact Dr. Jenna LeComte-Hinely, the Director of Research and Evaluation, at Health Assessment Resource Center (HARC, Inc.): 760-404-1945, jlecomte-hinely@harcdata.org

If you HAVE been tested for HIV:

12. Why did you choose to get tested for HIV? Please check all that apply.

- ☐ I was concerned I might have been exposed to HIV
- ☐ My sexual partner is HIV positive
- ☐ My healthcare provider offered to do the test
- ☐ It was offered for free at an event or community location
- ☐ It was required by my employer or insurer
- ☐ Experts recommend that everyone get tested, so I did
- ☐ My friend or family member said testing is a good idea, so I got tested
- ☐ Other: _____

13. What YEAR was your last HIV test?

_____

14. Where was your last HIV test?

- ☐ At a doctor's office
- ☐ At a community clinic
- ☐ At the hospital or emergency room (ER)
- ☐ In jail or prison
- ☐ At a drug treatment facility (rehab)
- ☐ At home
- ☐ At a health fair, testing van, or event
- ☐ At a local business or store
- ☐ Other: _____

If you HAVEN'T been tested for HIV:

15. Why haven't you been tested for HIV? Please check all that apply.

- ☐ I don't think I'm at risk for getting HIV
- ☐ I'm not sexually active
- ☐ My doctor/healthcare provider has never offered to test me for HIV
- ☐ I don't want my doctor or anyone else to judge me
- ☐ I'm too embarrassed to get tested
- ☐ I don't WANT to know if I have HIV
- ☐ I don't know where to get tested
- ☐ I don't have the transportation needed to get to a testing site
- ☐ I can't afford to get tested
- ☐ I don't have health insurance
- ☐ Other: _____

16. If your doctor or other healthcare provider offered to test you for HIV (and the test was free and/or covered by your insurance), would you get tested?

- ☐ Yes
- ☐ No

FOR EVERYONE:

17. Who do you think should be tested for HIV? Please choose the response that best fits your feelings.

- ☐ No one needs to be tested
- ☐ Only those people with high risk of getting HIV, like gay men or drug users, need to be tested
- ☐ All sexually active people need to be tested
- ☐ All adults and teens need to be tested

18. If you were to be tested for HIV in the next year, which of these locations would be a comfortable testing site for you? Please check all that apply.

- ☐ At a doctor's office
- ☐ At a community clinic
- ☐ At the hospital or emergency room (ER)
- ☐ At a drug treatment facility (rehab)
- ☐ At home
- ☐ At a health fair, testing van, or other community event
- ☐ I would not be comfortable getting tested at any of these sites

Thank you for participating! If you would like to be entered to win one of ten $50 Visa cards, please give us your contact info. This info will ONLY be used to contact the winner and will NEVER be linked to your individual responses or shared with anyone.

First Name: _____ Phone or email address: _____

If you have any questions or concerns about this survey, please contact Dr. Jenna LeComte-Hinely, the Director of Research and Evaluation, at Health Assessment Resource Center (HARC, Inc.): 760-404-1945, jlecomte-hinely@harcdata.org

Appendix B: Encuesta de Salud para el Valle de Coachella

Por favor complete esta encuesta confidencial para ayudarnos a entender los comportamientos de detección de salud en el Valle de Coachella. Al completar esta encuesta, se le inscribirá para ganar una de diez tarjetas Visa $ 50! Por favor envíe su encuesta completada a: Hágase la prueba de Coachella Valley, Atención: Susan Unger, 1695 N. Sunrise Way, Palm Springs, CA, 92262.

1. ¿Cuál es su genero?

- ☐ Hombre
- ☐ Mujer
- ☐ Transgénero: macho a hembra
- ☐ Transgénero: Hembra a macho
- ☐ Otros: _____

2. ¿Cómo describiría su origen étnico?

- ☐ Hispanos/Latinos
- ☐ No Hispano/Latino

3. ¿Cómo describiría su raza? Por favor, marque todas las que apliquen.

- ☐ Blanco / Caucásico
- ☐ Negro / Afroamericano
- ☐ Asiático / Islas del Pacífico
- ☐ Los Indios Americanos / Nativos de Alaska
- ☐ Otros: _____

4. ¿Cuántos años tiene?_____

5. ¿Cuál es su ingreso familiar antes de impuestos?

- ☐ $24,999 o menos
- ☐ $25,000 a $49,999
- ☐ $50,000 a $74,999
- ☐ $75,000 o más

6. ¿En qué ciudad vive usted?

- ☐ Bermuda Dunes
- ☐ Cathedral City
- ☐ Coachella
- ☐ Desert Hot Springs
- ☐ Indian Wells
- ☐ Indio
- ☐ La Quinta
- ☐ Mecca/ La Meca
- ☐ Palm Desert/ Desert Palm
- ☐ Palm Springs
- ☐ Rancho Mirage
- ☐ Thermal/ Termal
- ☐ Thousand Palms/ Mil Palmas
- ☐ Other: _____

7. En promedio, ¿con qué frecuencia ...

	Cada dia	Varias veces a la semana	Varias veces al mes	Varias veces al año	Nunca
Ve la television					
Escucha el radio					
Lee el periodico					
Usa la internet					

8. ¿Se ha echo la prueba de cualquiera de las siguientes condiciones de salud en los últimos 5 años?

	Si, me he hecho la prueba	No, me he hecho la prueba
Colesterol alto		
Alta presion		
Diabetes		

9. Indique si las siguientes frases son verdaderas o falsas.

	Verdadera	Falsa
Me hago un chequeo de rutina con un médico una vez al año		
Recibo una vacuna contra la gripe casi todos los años		
Tengo acceso médico cuando lo necesite		

10. En los últimos 10 años, ¿ha tenido algún tipo de sexo (incluyendo sexo oral, anal o vaginal) con:

- ☐ Sólo hombres
- ☐ Sólo mujeres
- ☐ Tanto los hombres como las mujeres
- ☐ No es aplicable - no he tenido relaciones sexuales en los últimos 10 años

11. ¿Alguna vez se ha hecho la prueba del VIH, el virus que causa el SIDA? No cuente las pruebas que pueda haber tenido, como parte de una donación de sangre, pero si incluya a todo otro tipo de pruebas de VIH.

- ☐ Sí (pase a la pregunta # 12 en el otro lado)
- ☐ No (pase a la pregunta # 15 en el otro lado)

Si usted ha hecho la prueba del VIH:

12. ¿Por qué decidió hacerse la prueba del VIH? Por favor, marque todas las que apliquen.

- ☐ Me preocupaba que podría haber estado expuesto al VIH
- ☐ Mi pareja sexual es VIH positivo
- ☐ Mi proveedor de atención médica se ofreció a hacer la prueba
- ☐ Se ofrecio de forma gratuita en un evento o ubicación de la comunidad
- ☐ Se requiere por mi empleador o asegurador
- ☐ Los expertos recomiendan que todas las personas se hagan la prueba, así que lo hice
- ☐ Mi amigo o miembro de la familia dijeron que la prueba es una buena idea, así que me dieron prueba
- ☐ Otros: _____

13. ¿En qué año fue su última prueba de VIH?

_____

14. ¿Dónde fue su última prueba de VIH?

- ☐ En el consultorio de un médico
- ☐ En una clínica de la comunidad
- ☐ En el hospital o sala de emergencia (ER)
- ☐ En la cárcel o prisión
- ☐ En una instalación de tratamiento de drogas (rehabilitación)
- ☐ En la casa
- ☐ En una feria de salud, una van de pruebas, o evento
- ☐ En un negocio local o tienda
- ☐ Otros: _____

Si usted no ha hecho la prueba del VIH:

15. ¿Por qué no se la ha echo? Por favor, marque todas las que apliquen.

- ☐ No creo que estoy en riesgo de contraer el VIH
- ☐ No soy sexualmente activa/o
- ☐ Mi médico / proveedor de cuidado de la salud nunca ha ofrecido a la prueba del VIH
- ☐ Yo no quiero que me juzgan mi médico o cualquier otra persona
- ☐ Estoy demasiado avergonzado como para hacerse la prueba
- ☐ No quiero saber si tengo el VIH
- ☐ No sé dónde hacerme la prueba
- ☐ No tengo el transporte necesario para llegar a un lugar de la prueba
- ☐ No puedo darme el lujo de hacerme la prueba
- ☐ No tengo seguro de salud
- ☐ Otros: _____

16. Si su médico o otro profesional de salud le ofrecen a usted la prueba del VIH (y la prueba fuera gratis y / o cubierta por su seguro), se haría la prueba?

- ☐ Si
- ☐ No

PARA TODOS:

17. ¿Quién cree usted que debería hacerse la prueba del VIH? Por favor, elija la respuesta que mejor se adapte a sus sentimientos.

- ☐ Nadie debe se la debería de hacer
- ☐ Sólo las personas con alto riesgo de contraer el VIH, como los hombres homosexuales y asadores de drogas, deben hacérsela
- ☐ Todas las personas sexualmente activas
- ☐ Todos los adultos y los adolescentes necesitan hacerce la prueba

18. Si se va a hacerse la prueba del VIH en el próximo año, ¿cuál de estos lugares sería un sitio de pruebas cómodo para usted? Por favor, marque todas las que apliquen.

- ☐ En el consultorio de un médico
- ☐ En una clínica de la comunidad
- ☐ En el hospital o sala de emergencia (ER)
- ☐ En una instalación de tratamiento de drogas (rehabilitación)
- ☐ En la casa
- ☐ En un evento de feria de la salud, una van de pruebas, u otra comunidad
- ☐ No estaría cómoda hacerme la prueba en cualquiera de estos sitios

Gracias por participar! Si usted desea ser registrado para ganar una de diez tarjetas Visa $ 50, por favor nos da su información de contacto. Esta información será utilizada SOLAMENTE para ponerse en contacto con el ganador y NUNCA será conectado a sus respuestas individuales o compartida con nadie.

Nombre: _____ Teléfono o correo electrónico: _____

Si usted tiene alguna pregunta o inquietud acerca de esta encuesta, por favor póngase en contacto con HARC: Dr. Jenna LeComte-Hinely, jlecomte-hinely@harcdata.org, 760-404-1945