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# Building Stakeholder Partnerships for an On-Site HIV Testing Programme

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## Abstract

Because of the large number of individuals at risk for HIV infection who visit gay saunas and sex clubs, these venues are useful settings in which to offer HIV outreach programmes for voluntary counselling and testing (VCT). Nevertheless, establishing a successful VCT programme in such a setting can be a daunting challenge, in large part because there are many barriers to managing the various components likely to be involved. Using qualitative data from a process evaluation of a new VCT programme at a gay sauna in California, USA, we describe how the various stakeholders overcame barriers of disparate interests and responsibilities to work together to successfully facilitate a regular and frequent on-site VCT programme that was fully utilized by patrons.

### Keywords

HIV/AIDS; Voluntary Counselling and testing (VCT); saunas; sex clubs; USA

## Introduction

Gay sex clubs and saunas (also known in the USA as men's clubs, bathhouses, and tubs) appeal to gay men and other men who have sex with men in part due to the relative physical safety they offer compared to parks and other public venues where attacks by thugs or harassment by police threaten men seeking sexual encounters (Berube, 2003; Haubrich *et al*., 2004). Club owners are aware of the role their establishments play in offering men a safer place to meet and socialize and capitalize on it. It is sadly ironic then that since the 1980s these venues came to be seen in the USA as environments that facilitate the transmission of HIV among gay men (Darrow *et al*., 1981; Institute of Medicine, 1986; Shilts, 1987; Bayer, 1989; Turner *et al*., 1989). Although this perception was not wholly accurate (Binson *et al*., 2001; Berube, 2003; Disman 2003; Woods *et al*. 2007), both patrons and owners share a stake in making the club a "safe" environment from an HIV perspective as well.

One way that clubs address the issue of safety and HIV is to support on-site HIV voluntary counselling and testing (VCT) services. A number of studies confirm the value and feasibility of establishing VCT at clubs (Ritchey and Leff, 1975; Henderson, 1977; Judson *et al*., 1977; Merino and Richards, 1977; Ostrow and Shaskey, 1977; Merino *et al*., 1979; Lister *et al*., 2005; Huebner *et al*., 2006). Of course, club management is not comprised of HIV prevention experts and so the services are always provided by outside providers. As such, a significant obstacle to establishing VCT programmes in these venues is the fact that the project must be undertaken by two separate organizations with very different purposes and goals, requiring both organizations to develop the means to maintain strong interorganizational relations, and specifically a collaborative relationship. As the literature on interorganizational collaboration (IOC) suggests (Galaskiewicz, 1985; Gray, 1985; Wood and Gray, 1991; Dunlop, 2005), this can be a daunting task. Implementing and maintaining a VCT programme requires commitment

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from stakeholders at every level: the club owners, management, staff and patrons; the provider organization that staffs and operates the VCT programme, as well as the local health department and funders. The involvement of various stakeholders in successful programmes has not been examined, leaving each new programme to invent their own models for establishing roles, responsibilities and connections among the various stakeholders.

A recent evaluation of a new VCT programme at a club in California, USA provided an opportunity to look more closely at how the various stakeholders from two independent and very different types of organizations, that is a for-profit, private sex club and a not-for-profit, public health department, collaborated to implement such a health service programme. This case description also is an opportunity to contribute to the growing literature on inter-organizational collaboration (Gray, 1985; Gray and Wood, 1991; Vangen and Huxham, 2003). Since the late 1980s, researchers have examined collaborations between organizations using a “practice oriented” approach and the analysis of case studies to better understand day-to-day interactions in inter-organizational collaboration, and to generate theoretical models to explain the processes involved. Several themes have emerged in this literature: prominent among them are the importance of commitment, communication, and trust.

Ultimately, the VCT programme described here has become the health department’s most successful outreach programme, both for ratio of clients seen per counselling hour (3 clients per hour, compared to 1 to 2 clients per hour at other high volume testing locations) and for identifying men who are HIV-positive (3.7% compared to 1.6% of those tested at other sites). Utilizing qualitative data available from an evaluation of the programme, this paper describes the process of how a local health department established a viable VCT programme to test for HIV and other sexually transmitted infections (STIs) in a club setting, the lessons learned from that process, and implications for developing similar programmes for other clubs.

## Background

### The Club

The club focused on here was a typical North American gay sauna, perhaps among the larger ones in terms of space (7500 sq ft) and number of patrons it can accommodate at one time (more than 100). It was a privately owned and operated business, catering exclusively to men, and was open 24 hours a day, 7 days a week. The venue had the full range of spaces available to customers, namely, a steam room, weight room, showers, whirlpool, an open area for sex designed as a maze, and private rooms to rent. Clients paid a fee to enter for up to six hours. Once inside the club, the only clothing worn was generally a towel provided by the club.

The club attracts a diverse clientele that has been described elsewhere (Woods *et al*., 2007). The club patrons are primarily Caucasian men (59%) with college or graduate degrees (73%). Most men (60%) were between 26 and 45 years of age and were single/never married (74%).

### Local Health Department’s VCT programme

In the mid-1990s, the HIV director at the local public health department began to work directly with the club to expand its prevention programme. After several years working together on smaller prevention programmes, the local health department initiated a weekly VCT programme at the club, offering anonymous HIV tests, confidential STI tests, and site-specific risk reduction counselling. At first, the services were offered for 4 hours once a week. After six months, a second evening per week was added. The VCT team was staffed by two to three HIV test counselors and a public health phlebotomist who also served as the VCT project coordinator. All were certified in HIV test counselling, received special training to work in the sexual environment, and demonstrated skill and sensitivity for working with this population

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in a club setting. The HIV test was administered orally using OraSure ®. Men received test results at the same time a week later in a mobile testing van parked outside the club or during clinic hours at the city clinic a few blocks away. Men testing positive received a confirmatory blood test through the local health clinic.

## Methods

The VCT programme was part of a state-wide "High Risk Initiative" (HRI) that was conducted in several health jurisdictions to reduce behaviour associated with HIV transmission among populations at significant risk, and three of these initiatives were evaluated with funds from the University-wide AIDS Research Program (UARP), a programme of the State of California. The data reviewed for this paper were from a process evaluation of an on-site HIV/STI VCT programme offered by the city health department inside the club. The qualitative data for the evaluation were collected between August 2002 and March 2003 as part of the UARP-funded process and outcome evaluation. A description of the evaluators' role in the collaborative process of the programme is described elsewhere (Binson *et al*., 2005). The data for this secondary analysis are from in-depth interviews with key stakeholders, all chosen for their specific roles and direct involvement in the programme, club management, VCT programme management, counselors and clients. Additionally, information gleaned from meetings the evaluation team members had with the HIV director and the club's health promotion director were included, as well as observations made at the club during testing (Vangen and Huxham, 2003). In-depth interviews were conducted, after informed consent was obtained, with the stakeholders identified in Table 1. These professionals were all gay men, primarily in their thirties (ranging in age from 26 to 44) and primarily Latino (although some were White, non-Hispanic). The club health promotion director and the HIV director stakeholder interviews included questions about the club and health department history of HIV prevention programmes and collaboration, perceptions of the successes and challenges of the VCT programme, and areas for continued programme development and improvement. Interviews with the project coordinator and two of the test counselors included questions about their perceptions of the successes and challenges in conducting VCT at the club. Stakeholder evaluation interviews were conducted during employment hours, and participation was voluntary and not reimbursed.

The process evaluation focused on assessing the development and implementation of the VCT programme through qualitative interviews. The outcome evaluation study was conducted to determine the efficacy of the programme in reducing HIV risk and is reported elsewhere (Huebner *et al*., 2006). The first five client participants to volunteer from the outcome study were recruited into an additional qualitative interview (see Table 2). The client qualitative interview related to behaviour since the last interview, as well as clients' experience accessing the VCT programme in the club. Patron/client participants were reimbursed US$30 for their time.

All qualitative interviews for this and the other programmes included in the larger evaluation were conducted by three interviewers, each of whom participated in an extensive skills-based interviewer training. Each interview lasted 1–2 hours, was tape-recorded, and transcribed. The interview staff coded the transcriptions for themes using EZ Text and Ethnograph qualitative analysis software (version 5.0.8) (Ethnograph, 2001).

The analysis consisted of several stages. In the first stage, the investigators developed a coding scheme and trained the interview staff to code the transcripts and to then test for inter-coder reliability, a process in which pairs of staff coded the same transcripts and then checked for code agreement; disagreements were resolved through consensus. These coded data were used in a report to the State funding agency. The second phase of the analysis was an iterative process

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in which the investigators reviewed the funder report and returned to the original data to identify quotes and confirm the developing stakeholders' model of inter-organizational collaboration. A third phase included a further review of the original data for confirmation of the final model.

## Results

By examining the roles and activities of all those involved in the programme, the analysis indicated that there were three broad stakeholder types (interviewed participants indicated in *italics*), namely: (i) Key Facilitating Stakeholders (the *HIV director* and the *club health promotion director*); (ii) Supportive Stakeholders (health department administration and club executive management); and (iii) Operational Stakeholders (club shift managers and staff, *programme managers and counsellors*, and *clients*).

### Key Facilitating Stakeholders

The local health department HIV director and the club's health promotion director were the primary stakeholders that orchestrated the VCT programme. We label these "key facilitating stakeholders" because both positions held significant responsibility within their respective organizations and were given sufficient authority to develop and implement the VCT programme. In implementing prevention programmes, both were given sufficient managerial support, and each position was held by individuals with significant commitment to the VCT programme. The efforts of the HIV director and the club's health promotion director made the programme possible; they worked cooperatively toward the common goal of fostering an awareness and culture of patron safety at the club.

The HIV director valued VCT at sex settings as an important part of his jurisdiction's response to the HIV epidemic. Prior to approaching the club about the VCT programme idea, he secured support from his local HIV prevention planning group and the health department leadership, and secured funding through the High Risk Initiative from the State HIV office. He recognized that it would take time to establish the strong institutional relationship with the club necessary for a VCT programme, as the club needed to recover from past institutional distrust (Binson *et al*., 2005). To build this trust, health department staff provided almost a year of outreach services at the club (e.g., distributing condoms and talking to patrons) prior to the HIV director proposing a health department run VCT programme at the club.

The role of the health promotion director was to develop strong liaisons with community agencies, making available health services to club patrons that included periodic on-site VCT. By offering health services, the club demonstrated both its commitment to public health and its willingness to collaborate with outside organizations. The services came to be appreciated by the club owners and patrons, and enabled the health promotion director to effectively mediate a trusted relationship between these stakeholders. Although one man held the position during the development phase of the health department's weekly VCT programme (the evaluation participant), another man held the position during its initial implementation, and still a third man had the role for the remaining duration of the programme.

According to the HIV director, the club's impetus to collaborate came from a humanitarian ethic towards patrons, in addition to good business sense, i.e., the club had a good public image to maintain. The HIV director reported that his years of success in collaborating with the club's health promotion director was based on mutual respect for each party's primary concerns, interests and responsibilities, as well as professional trust supported by the maintenance of professional boundaries.

From the club's perspective, the "people-driven" management at the health department provided a very positive relationship in which to work:

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> …it was their interest and their willingness to look at the club in an open and positive way. And the club having some very positive proactive prevention stuff and a good history and reputation during that that allowed [testing] to move forward in a positive way. But had the city not hired [the two succeeding HIV directors] … there wouldn't be any testing [by the health department at the club] (club health promotion director).

The new HIV director recognized the club as a community partner, rather than as a problem. Once the implementation of the programme began, the HIV director started an ongoing dialogue with the club's health promotion director, talking by phone almost daily, maintaining this kind of relationship with each successive health promotion director.

### Supportive Stakeholders

While the roles of the HIV director and club's health promotion director made them the key facilitating stakeholders within each of their organizations, there were a number of other stakeholders that the key facilitators had to consult with in order to successfully launch the VCT programme.

In any successful endeavour, the provider of the financial backing for the project is a significant stakeholder. For the most part, arranging financial support fell to the HIV director. He believed that consistent weekly testing at the club could not be implemented through volunteers, that a paid VCT staff was needed. The health department's plan was in its early stages when the HIV office at the state level initiated its HRI programmes. The HIV director submitted a proposal and was awarded funding of $145,000/year for 3 years. State sponsorship of the club VCT programme was a significant indication of the state's support of the club's efforts, and the club management welcomed the state leadership on the issue and considered it helpful.

The HIV director began his effort by working closely with his own health department leadership, i.e., the health director and the local HIV prevention planning group (HPPG), responsible for prioritizing HIV prevention within the local health department (Centers for Disease Control and Prevention, 2003). The HIV director indicated that he had gained the health department director's support prior to moving forward on any plans and kept her informed about the collaboration and implementation of the programme. On a number of occasions during the evaluation period, the health department director was in a position to express public support for the prevention efforts at the club.

The HIV director also worked with the local HPPG to bring local prevention priorities in line with the epidemiology for the region, which suggested the need for a strong plan for HIV prevention among men who have sex with men. The group developed a plan to provide outreach and VCT to men who meet their partners in various local sex settings, such as the club.

The club's health promotion director negotiated owner and management approval for the VCT programme. Perhaps the most significant indication of the quality of the relationship between the club and health department was the decision of the club management to include the HIV director as one of the trainers for the third health promotion director. This also indicated the importance to the owners of the relationship between the HIV director and the club's health promotion director.

The club's growing commitment to the programme was illustrated not only by the "open door" policy toward the VCT programme, but also by their financial backing. The club took on some of the implementation costs not covered by state funds. One example was the provision of space for the programme, initially in providing rooms that otherwise could be rented to customers and later by building out a permanent room for prevention programming and VCT in particular.

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Other financial support included the club's extensive advertising of the VCT programme, not only in external publications, but also advertising throughout the club on sleek posters, as well as on the club's television monitors and on the multiple LED signs. While VCT staff was available to provide services, hourly announcements were broadcast throughout the club on the public address system. The club also occasionally provided programme promotions, such as a free locker pass for getting a test.

## Operational Stakeholders

Operational stakeholders were those who participated in the direct activities that made the program happen, i.e., the club staff on duty during the programme, the VCT programme staff who provided the services, and the club patrons who used the programme.

Shift managers provided operational support for the programme at the club. For instance, they had to ensure that rooms were set aside and available for the programme's use, but also that club resources were not unnecessarily spent (e.g., by holding rooms longer than necessary).

The frontline staff members at the club, who interacted with patrons mostly as they check in and out of the club, were the ones from the club who had the most immediate responsibilities during the programme. They were the people to whom patrons would go with questions of VCT staff trustworthiness, or complaints about VCT staff arriving late. The frontline staff had to respond to the needs of the VCT staff throughout the programme shifts. They also had to communicate back to the club's health promotion director about the success and problems of each VCT shift. The club's frontline staff appeared to have handled this well:

> We have really good communication. [The club staff is] really open to the fact that we're there, and they're used to us now. If we're five minutes late they'll call, 'Where are the guys that are always there?' – which is great. And they have our rooms ready most of the time. …. They are always there and they want to make sure, you know, everything goes smoothly and we do the same. We respect the rules. They have rules. And you know, they respect ours. … They've really been – it's amazing... (Health department programme coordinator).

The rules referred to in the quote include club rules that VCT staff not go into the areas available for sex during the programme shifts and health department rules about VCT programme staff not going to the club for 24 hours before or after a shift.

The health department programme coordinator was responsible for managing all on-site aspects of the programme. He was responsible for supply inventory, punctuality of the VCT team at the site, the timely delivery of results, handling disgruntled clients, supporting the counselling staff and serving as a counsellor when there was a line of people waiting for VCT. Counsellors, of course, provided the counselling and testing service to the clients.

On programme days, VCT staff set up an outreach table in the lobby and tried to motivate club patrons to get tested. The project coordinator explained:

> We do outreach right there at the lobby at the entrance. We don't go to corridors, to [a maze area for sex] … We have packages with condoms and lube. We pass those [packages out] right there and we invite them to get tested with us. And then we'll say, 'We're here today. We're offering HIV and other STD testing. Are you interested today?' [The patron may respond:] 'Oh maybe later. Yeah, maybe I'll come back,' or 'No, I'm not.' And that's how it goes. Or they come to the table; they express their fear of getting tested. We try to help them overcome the fear but we let them know. 'No pressure. Just go, think about it and when you're ready come back to us.'

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One of the VCT programme's successes was that it became fully integrated into the club environment over a fairly short amount of time:

> … patrons really come to demand it on one level. Some set demand it, another set expects it and another set puts up with it. But it's become wallpaper at the club. And the club actively promotes it so there's a clarity that this is going on with the club's permission and blessing (club's health promotion director).

Indeed, one client noted: "Sometimes I know they're there, and sometimes I forget they're there" (37-year old Hispanic patron). On the other hand, it can be what draws a man to the club, as a 31-year old, white patron who had been to other clubs, spoke about coming to this club for the first time for the sole purpose of testing with a friend.

Another patron, after describing his experiences with VCT programmes at various clinics around town, compared those to testing at the club, "… the environment at [the club] is very different. I find the environment at [the club] to be very relaxing …" (57-year-old white patron).

The evaluation revealed generally high levels of patron satisfaction with the VCT services. In particular, patrons noted the comfort and convenience they felt by having VCT in the club.

> I had never been tested for AIDS before or HIV and I thought it might be a good idea to just get tested, since it was so readily available" (34-year-old, African American patron).

This client's reflection on his experience not only indicated his satisfaction with the easy access to the service, but also indicated that there is reason for optimism that one of the important goals of outreach VCT can be achieved in these environments, i.e., to encourage people at risk for infection who have never tested to test.

## Lessons Learned

### Structure of Stakeholder Relationships

In reviewing the qualitative data, we were interested in identifying the relations between the two organizations, specifically where lines of communication and interaction occurred, and where authority lay for decisions about the programme. We charted the various relationships for creating the VCT programme at the club, illustrated in Figure 1.

The figure shows the three stakeholder roles identified in the analysis, i.e., key facilitating, supportive, and operational. These stakeholder roles are reflected in specific provider and club positions identified under the headings "provider position" and "club position." The arrows in the figure indicate lines of communication and interaction. The single, thick black, angled line indicates the point of service delivery, where the VCT and outreach activities happened between front line programme staff and their clients (i.e., club patrons). The two thick arrows indicate the two significant sets of on-going communication used to manage the programme. The upper one indicates the relationship between the key facilitating stakeholders who together facilitated the communication, trust and commitment of the various stakeholders. The lower thick arrow indicates the relationship between club and provider staff, who had to maintain appropriate relations and communication during a given shift. We note that there will be important occasions for communications between the club staff and the patrons, and the relations between these stakeholders can have a positive or negative impact on patron utilization of the programme.

Clearly, the relationships described in this case will differ in experiences at other clubs; nevertheless we would expect that people in similar positions must accomplish similar tasks to make a programme work. For instance, a manager-level person would lead the club's side

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of negotiations and implementation if there were no "health promotion director." Importantly, the case description shows that the success of the programme was not dependent on the specific people, but rather the continuity and stability of the roles of the facilitating stakeholders. Even though three different men filled the club's health promotion director position, the role's authority and responsibility were unchanged during the planning and implementation of the programme; since the position in the club was stable, these personnel changes did not de-rail the programme.

## The Importance of Commitment

In establishing HIV VCT at the club, each key stakeholder played a crucial role in implementing the programme and ensuring its success. Thus, each of these stakeholders, i.e., providers, clubs, and the patrons themselves, had to make a commitment to the programme and recognize its benefits from the point of view of either individual or organizational self-interest (Wood and Gray, 1991; Vangen and Huxham, 2003). This commitment or "buy-in" took different forms among the multiple stakeholders. For instance, the owner's buy-in meant placing trust, responsibility and authority in the key facilitating stakeholders, and being willing to invest club funds in supporting and promoting the VCT programme. The means of acquiring buy-in also varied from one stakeholder group to the next. In our example, it was the HIV director who initiated the programme and so was the primary facilitating stakeholder. It was up to him to get buy-in from the other stakeholders.

It is important to point out that it need not always be this way. For example, a local community organization initiated the first VCT programme at this club, and a club's management has initiated VCT programmes. The order in which a facilitating stakeholder approaches other stakeholders is also flexible. In this case, the HIV director first organized support among the HPPG and the local health administration, and then acquired funding. The key to provider and club staff buy-in was a two-way communication. The provider staff commitment came though continuing supervision and the knowledge that the site required extensive training to work in this specialized setting and skill in comfortably providing non-judgemental counselling services to men in towels. Similarly the health promotion director developed a constant two-way communication between himself and the shift managers, to adequately deal with problems (e.g., scheduling, rooms being kept available) that occurred and to help avoid problems when possible.

## Recognizing Potential Obstacles

For each of the stakeholder groups there is a potential downside to participating in the collaboration. A health department must be willing to give up some direct control over management of the VCT programme (e.g., the time programme is offered, the size of programme). Club management, admittedly, takes a large risk in allowing VCT on site, as the data can easily be abused by anyone seeking to pressure the club or by creating a public backlash. The club had its own experience with such abuse of data in the 1990s (Binson *et al*., 2005), and highly publicized events in Los Angeles, California (Rodriguez, 2003; Bernstein, 2004; Editorial, 2004; Los Angeles Gay and Lesbian Center, 2004) that resulted from the misinterpretation of testing data from two clubs, prove it is a reasonable concern. Patrons do not want to compromise the club's eroticism or have it take on characteristics of a clinical or policed environment. The provider must find creative ways to work with business owners. Of particular importance is finding appropriate staff; not just anyone trained in counselling and testing skills can go into these environments and provide the approach to VCT required in a club setting. Indeed, one of the greatest potential barriers to implementing VCT may be that fears of these potential downsides blind stakeholders from their commonly shared desire to protect individuals and communities at risk for HIV. Thus, a theme that underscored

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this programme's success was the facilitating stakeholders' effort to maintain other stakeholders' focus on these common goals.

## Discussion

In reviewing the case description, three themes emerged repeatedly in the stakeholder interviews that are key themes in inter-organizational collaboration theory (Vagen and Huxham, 2003). These themes were commitment, trust, and communication. While these attributes are singled out as key components of successful collaborations, they are at the same time tightly intertwined. For example, "trust" has been reported repeatedly to be significant in the nurturing of collaborative processes in literatures across the fields of psychology, economics, sociology and organizational sciences (Vagen and Huxham, 2003). Yet to build trust requires that stakeholders have the ability to cope in situations where trust is lacking and the ability to build trust in situations where this is possible. A key strategy in building trust is to start simple and small, to engage in collaboration with small wins in small increments, to show commitment through frequent communication. This is precisely the strategy used by the HIV Director, as he recognized that the health department's breach of the club's trust years earlier had jeopardized the potential collaborative relationship he had wanted to build. The relations between trust, commitment, and communication, as depicted in Figure 1, underscore the interactive dimension of these three components and the ways in which communication functions to continually nurture collaboration.

This case description highlights a unique collaboration between two organizations, one private and one public, i.e., a gay sauna and a public health department with a mandate to protect the public from infectious disease. Given that mandate and the public perception that saunas are a breeding ground for disease, establishing a VCT programme through a collaborative process between two such organizations is a notable accomplishment.

An important way this case was unique was that a smaller volunteer community based VCT programme had been established and operating for nearly 25 years; thus the community-based programme undoubtedly affected the club's ability to more easily accommodate the health department's programme. Nevertheless, the systematic implementation of VCT on a regular, twice-weekly schedule allowed it to become integrated as "wallpaper" of the club. This required seeing beyond narrow notions of self-interest, towards a broader shared goal of supporting the health of a community and the longer-term benefit of all.

The model presented here may not translate readily in all its details to other places. Although studies in various sex environments in various parts of the world have identified the value of HIV prevention in these locations (Bolton *et al*., 1992; Tewksbury, 2002; Haubrich *et al*., 2004; Lister *et al*., 2005; Ko *et al*., 2006), it is important to remember that cultural differences should be considered when planning a VCT programme (Flowers *et al*., 2000). Attitudes toward VCT vary across regions, countries and continents, as does the access to and availability of medical care; these factors will greatly influence the acceptability and appropriateness of a VCT programme in a club. Additionally, every club is unique in a number of ways (for example the size of the club and the types of space provided) (Weinberg and Williams, 1975), and these factors influence what is possible for offering VCT (Woods and Binson, 2003; Holmes *et al*., 2006). Although it should be noted that some sex clubs, which typically have much less space than saunas, have had VCT programmes (Woods *et al*., 2000; Woods *et al*., 2001). Similarly, health jurisdictions will have their own history and local laws and regulations that may make collaborations more or less difficult. State money was specifically set aside to support the evaluated programme, so funding would conceivably be an important obstacle to developing a programme. These differences may require additional effort and creativity in developing on-site VCT programmes in other locations.

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Collaboration is crucial to effective, innovative prevention programmes. The ongoing success of the programme described in this study is due to the continued cooperation of the facilitating stakeholders in their efforts to meet the needs of men at greater risk for HIV transmission by fostering a safer environment at a club and balancing the impact of VCT on business. This is a useful model for others seeking to implement a programme of their own. It is evident that in order to reach the population at risk, public health officials must consider all solutions to the management of the HIV pandemic, including those that to some citizens may seem radical or appear to be contrary to the mission of public health. Likewise, business owners must be willing to think beyond the immediate potential risks of bringing the health department into their club, to consider how such a move can promote the image of safety at the sauna, improve public relations, and support patron well being. The story underscores the basic notion that helping clients stay healthy is simply good business.

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**Table 1**

Stakeholders Interviewed for the VCT Evaluation Study

| Position | Site | Description |
|---|---|---|
| Health Promotion Director | Club | Full-time, manager-level employee in charge of all health education programmes at the club; the first of three men who held the position in the course of the programme's development and implementation. |
| Client/Patrons | Club | See Table 2. |
| HIV Director | Health Department | Responsible department official for all HIV programming in the health jurisdiction. |
| Project Coordinator | Health Department | Responsible department official hired to run the men's VCT program in sex venues. |
| Test Counselors | Health Department | Trained department personnel who conducted the counselling and VCT in sex venues. |

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**Table 2**

Clients (Patrons) Interviewed for the VCT Evaluation Study

| Age | Race/Ethnicity | Sexual Orientation |
|---|---|---|
| 31 | White | Homosexual |
| 34 | Black/African American | Bisexual |
| 34 | White | Homosexual |
| 37 | Hispanic/Spanish | Homosexual |
| 57 | White | Homosexual |