Incentive-based interventions to increase HIV testing

NATIONAL AIDS TRUST

BIT

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About BIT

BIT is a global research and innovation consultancy which combines a deep understanding of human behaviour with evidence-led problem solving to improve people's lives. We work with all levels of government, nonprofits and the private sector, applying behavioural science expertise with robust evaluation and data to help clients achieve their goals. Find out more at bi.team.

About NAT

National AIDS Trust (NAT) is the UK's HIV rights charity. For more on the issues surrounding HIV in the UK, what's being done to change them and how you can get involved, visit www.nat.org.uk.

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Introduction

The UK government aims to achieve zero new HIV transmissions by 2030. Despite progress in HIV testing among some groups, testing rates have declined among heterosexual men and women, with persistent barriers affecting underserved communities.[1] Innovative strategies are needed to expand testing access and uptake, especially among those facing structural and social disadvantages.

This project, a collaboration between the Behavioural Insights Team (BIT) and the National AIDS Trust (NAT), explored the potential of incentive-based interventions in increasing HIV testing uptake. The work involved a rapid review of existing evidence (Phase 1), followed by qualitative research (interviews, focus groups and a findings validation workshop) with professionals from clinical, policy and voluntary/community sectors (Phase 2).

In this report, BIT presents a summary of findings from Phase 1 (full findings are detailed in the Phase 1 report) followed by the qualitative research findings and associated recommendations.

Key findings

Effectiveness of Incentives

Financial incentives (especially fixed-value ones, such as cash or vouchers) were shown to significantly increase initial HIV testing uptake in the Phase 1 rapid review. However, participants in the Phase 2 interviews suggested that incentives may be less effective for some groups, especially those from ethnic minorities who may experience stigma or do not perceive themselves to be at risk. Incentives were seen

[1] In this project, underserved communities refers to groups facing greater barriers to HIV testing and healthcare, including social stigma, discrimination, financial hardship, housing instability, and lack of culturally appropriate services. Examples include people experiencing homelessness, those living in poverty, sexual minority groups (e.g., GBMSM, transgender people), culturally marginalised groups (e.g., refugees, international students, individuals from Black African, Caribbean, or Asian backgrounds), and people who inject drugs. These populations often have limited engagement with mainstream healthcare, highlighting the need for targeted approaches such as financial incentives.

as most useful for reaching people facing financial hardship or for whom even a small incentive would have a high impact (e.g. intravenous drug users). Evidence on impact in the longer-term or on repeat testing behaviour was limited.

Design and Acceptability

Participants in the interviews and focus groups consistently stated that incentives must be tailored to the needs of specific communities in question, with cash viewed as most effective. Positive framing (e.g. describing the incentive as support or recognition) was seen as important to avoid perceptions of coercion or stigma. Participants in the interviews raised important ethical considerations, including the risk of exploitation among vulnerable groups, and reinforcing stereotypes.

Feasibility and Implementation

Focus group and interview participants expressed that effective delivery requires trained, trusted personnel and would be most effective if integrated with broader support services or community groups. During the qualitative research, participants identified that barriers to effective implementation would be funding constraints, operational logistics (e.g. incentive distribution, confidentiality), limited staff, and physical space for testing in community organisations. There was general acknowledgement that strong governance, clear delivery roles, and attention to sustainability would be vital for implementation.

Community and Public Perception

Phase 2 participants thought that incentives would be acceptable to communities, especially when they reduce immediate barriers to testing. However, concerns were raised about media or public backlash if incentives were perceived as inappropriate or an unfair use of resources.

Conclusion and recommendations

There was promising evidence to suggest that incentive-based intervention could be effective in increasing HIV testing, particularly among underserved populations.

However, there is limited evidence on the long-term impact of incentives, how they compared to other interventions, and their effectiveness in the UK context.

Participants in the interviews and focus groups highlighted that while incentives may motivate certain groups, including people who inject drugs or those facing financial hardship, they are unlikely to overcome deeper barriers like stigma or low perceived disease risk without thoughtful design, ethical framing, and meaningful community involvement.

Based on the findings, BIT recommends:

1. To ensure we are focusing funding on the intervention most likely to elicit an increase in HIV testing in underserved communities, **assess how incentives compare to or could complement other strategies** (e.g., peer support, communication campaigns). This requires reviewing, and if needed, strengthening the evidence to move beyond a one-size-fits-all model and identify which groups within underserved communities would respond most positively, clarifying when and for whom incentives add the most value.
2. If this work indicates that incentives would be a valuable intervention to evaluate, **co-designing interventions collaboratively with the target communities** to ensure they reflect lived experience, local needs, and cultural sensitivity. Piloting incentives with specific groups or local areas would provide valuable further evidence.
3. **Carefully testing and framing how incentives are communicated** through user research to position incentives as supportive resources rather than payments, build community relevance, and reduce the risk of stigma, public misunderstanding, or backlash.

1. Introduction

Following the declines seen during the COVID-19 pandemic, HIV testing in the UK has made notable progress in recent years. Testing rates among gay, bisexual, and other men who have sex with men (GBMSM) have risen significantly, but declines have been observed among heterosexual men and women. Persistent barriers, such as stigma, fear of positive results, and limited awareness of the importance of regular testing remain, particularly for underserved communities, including Black African and Asian populations, people experiencing homelessness, and those living in poverty.

With the UK government's ambition to achieve zero new HIV transmissions by 2030, innovative approaches are needed to increase testing uptake across all populations, particularly among those who remain underserved by traditional healthcare services. Incentive-based interventions, which have shown success in areas like health screening and smoking cessation, may provide a promising strategy for increasing HIV testing uptake.

This project is a collaboration between The Behavioural Insights Team (BIT) and the National AIDS Trust (NAT,)and consisted of two phases:

Phase 1: Rapid Evidence Review

The aim of Phase 1 was to understand the effectiveness, mechanisms, design, and implementation considerations for incentive-based interventions to increase HIV testing in high-income country settings, with a focus on underserved communities. The specific research questions were:

- Are incentive-based interventions effective at increasing HIV testing in high-income country settings?
- What makes incentive-based interventions effective in influencing HIV testing behaviours?
- What is the impact of incentive-based interventions on increasing HIV testing uptake in underserved communities?

Phase 2: Qualitative research

The aim of Phase 2 was to gather insights from professional representatives from the voluntary and community sectors, clinicians, and policymakers to better understand the following:

- Potential effectiveness of the intervention
- Design and format of the intervention
- Acceptability and perception of the intervention
- Feasibility and implementation considerations

2. Methods

2.1. Phase 1 Evidence Review

BIT conducted a rapid evidence review to summarise insights from relevant systematic reviews and meta-analyses.

Relevant evidence databases were searched using pre-agreed search terms and limits. Searches were conducted on Google Scholar, the academic database Pubmed, and AI tools Consensus and Elicit. The search sought to find studies on incentive-based interventions on HIV testing, but was expanded to include sexually transmitted infections and other health outcomes if studies on HIV testing were not available. Studies from the UK and other comparable high-income countries were prioritised.

A title and abstract screening was conducted for all identified studies. The evidence was initially assessed based on this screening, followed by a full-text review to compile the final list of relevant studies for inclusion. Two researchers were involved in the literature review process and to cross-check each other's output to ensure consistency. Data from the included studies were recorded in a spreadsheet and were summarised narratively.

2.2 Phase 2 Qualitative Research

BIT conducted ten semi-structured interviews in April - May 2025. Each interview lasted 45 minutes. . BIT also carried out three focus groups lasting 60 minutes. The National AIDS Trust recruited participants on BIT's behalf. It was decided to conduct both interviews and focus groups to capture a range of individual perspectives as well as observe group dynamics and shared experiences, which provided a richer and more comprehensive understanding of the topic than either method alone could offer. The sample included:

- Seven interviews and one focus group (three participants) conducted with policy and clinical leaders, including commissioners, lead medical professionals, and pharmaceutical industry professionals.
- Three interviews and two focus groups (five participants each) conducted with community and voluntary sector leaders from HIV charities, third-sector organisations, and sexual health community groups.[2]

Interviews were conducted online via video call. Each interview was conducted in a semi-structured manner, using a pre-written topic guide which covered key questions relevant to achieving the aims of this work. The topic guides were informed by insights from our discussions with the National AIDS Trust and our Phase 1 evidence review. Interviews were not recorded but a researcher took detailed verbatim notes. After completing all interviews and focus groups, we analysed the interview and focus group notes using a thematic analysis approach.

In addition, BIT led a stakeholder workshop involving ten stakeholders from both community and policy settings, during which findings from Phase 1 evidence review and the qualitative findings were presented, followed by a facilitated discussion about the findings. This helped BIT refine the emerging themes and integrate stakeholder's perspectives into the overall interpretation of the data. Following this workshop, the findings were synthesised to identify key themes and inform the report's conclusions and recommendations.

[2] We did not include direct target participants (e.g. individuals from underserved communities) in interviews or focus groups. While some community leaders may themselves have relevant lived experience, we acknowledge this creates a gap in understanding how potential users perceive and respond to incentives directly.

Interpreting the evidence: Strengths and limitations

To support the interpretation of our findings, we assessed the strengths and limitations of the two research phases.

- **The Phase 1 rapid evidence review** synthesised high-quality experimental and quasi-experimental studies conducted in high-income settings, providing an overview of whether incentive-based interventions are effective in increasing HIV testing. However, given the scope of the project, this review was not designed to be an exhaustive search or full systematic review and it is possible that some insights were missed.
- **The Phase 2 qualitative research** captured a range of rich, real-world insights from professionals involved in HIV testing delivery and design. While this added important context around feasibility and acceptability, we also acknowledge that it may have been limited by the lack of direct input from people with lived experience and therefore may not fully represent the diversity of community needs.

3. Findings from rapid evidence review

This section presents a summary of the findings from BIT's rapid evidence review. Full findings are detailed in BIT's Phase 1 report.

3.1 Effectiveness of incentive-based interventions

- There was consistent evidence that financial incentives can significantly increase HIV testing uptake in high-income country settings.
- Fixed-value incentives (e.g. cash or vouchers) were found to be more effective than lottery-based incentives. Moderate incentives in the £5–£20 range were effective without raising ethical concerns, while very low-value incentives (<£1) showed minimal impact. This moderate range echoed the

Phase 2 qualitative findings. It is considered a significant motivator for people facing financial hardship , while being low enough to mitigate the ethical concerns of coercion also raised by participants, thereby striking a balance between effectiveness and acceptability.

- Incentives were particularly effective at encouraging initial testing uptake. However, there is limited evidence about their impact on repeat testing.

3.2 What makes incentive-based interventions effective?

- Incentives acted as immediate motivators, overcoming barriers for people to test such as stigma, inconvenience, or low perceived risk.
- Incentives effectively prompted initial testing uptake, but there was limited evidence on whether they lead to sustained testing behaviours over time without ongoing reinforcement.
- Combining incentives with complementary strategies enhanced effectiveness:
    - Peer-led interventions, where trusted community leaders promoted testing alongside incentives, were especially effective among marginalised populations.
    - Community-based delivery models (e.g. local pharmacies) can reduce barriers to access and could increase testing uptake.
    - In some cases, offering incentives alongside other interventions may not be necessary. For example, simple, low-cost behavioural prompts like SMS reminders could be effective in promoting retesting.
    - Shifting from an opt-in to an opt-out screening approach has been shown to significantly improve HIV diagnosis rates, even without incentives.

3.3 Impact on underserved communities

- Incentives can help engage groups that are underserved by traditional healthcare, including:
    - People experiencing homelessness

    - Individuals living in poverty
    - Sexual minority groups (GBMSM, transgender people)
    - Culturally marginalised groups (e.g. refugees, international students and individuals from Black African, Caribbean, or Asian backgrounds).

  While incentives have been shown to increase uptake in these groups, there is limited evidence on whether they have a differential impact compared to better-served populations — that is, whether they help reduce disparities in testing access and uptake or simply raise testing rates across all groups equally. Some interventions have targeted incentives specifically at underserved populations to help close access gaps.

- Responses to incentives varied:
    - Some studies found men more likely to participate, while others found stronger effects among women in targeted schemes.
    - Age-related effects were mixed, with some evidence of stronger impacts on women aged 21–24.
    - Ethnic disparities were noted: African American participants in some US studies were less likely to test, even with incentives.

- Peer-led models were particularly effective in engaging marginalised communities, leveraging trust and reducing stigma.

3.4 Conclusion from the evidence review

Overall, there was promising evidence to suggest that incentive-based intervention could be effective at increasing initial HIV testing uptake in high-income country settings. They may also be useful for supporting engagement among underserved populations to help reduce access gaps. Moderate, fixed-value incentives are effective for the general population in high-income country settings, especially when combined with peer-led outreach, community-based delivery, opt-out approaches, and behavioural prompts such as SMS reminders.

However, gaps remain in the evidence:

- The long-term impact of one-off incentives on repeat testing was unclear.
- Few studies had directly compared short-term versus longer-term incentive models.

- Evidence on the interaction of incentives with broader interventions (e.g. mass media campaigns) was limited.
- There was limited evidence directly comparing the effectiveness of incentives against other types of interventions (e.g. education campaigns, reminder systems, or peer support), making it difficult to determine the relative effectiveness of incentives as a standalone strategy.
- Insights specific to the UK context, particularly qualitative perspectives from service users and providers, were scarce.

4. Findings from qualitative research

4.1 Perceived potential effectiveness of the interventions

Section summary:

- Participants expressed mixed but generally positive views on incentives, seeing them as particularly useful for financially vulnerable groups and those facing structural barriers to HIV testing.
- While incentives were viewed as a way to raise the salience of testing, questions included unnecessary repeat testing, limited impact on deeper barriers like fear or stigma, and ethical considerations around coercion.

Participants across both clinician/policymaker and community/voluntary groups expressed mixed but generally positive views on the potential effectiveness of incentive-based interventions to encourage HIV testing, recognising that incentives could be particularly useful for groups who are financially vulnerable, face structural barriers to healthcare, or have historically low testing rates.

Potential for success

Some participants shared examples or reflections on where incentives had previously been effective. These included the WAND initiative[3] in Glasgow targeting people who inject drugs, which was seen as highly successful in encouraging initial engagement. Others pointed to incentive programmes aimed at pregnant women to support smoking cessation as evidence that such approaches were effective in a health context.

Participants suggested incentives may be particularly helpful in reaching individuals who are wary of healthcare services or do not otherwise see HIV testing as a priority. In these cases, incentives, particularly cash or vouchers, were seen as a way to raise the salience of testing. This was considered especially relevant for people facing financial hardship, for whom even small amounts of money could tip the balance in favour of getting tested.

> *"Cost of living is the biggest thing for people now. Everybody needs that little bit of help… Cash is probably the best thing. £10 pounds for a person, [that is] a meal for someone's kid. So I don't think anyone minds an extra bit of money."*

Participants from the community and voluntary sector also noted financial incentives could be effective for specific populations such as teenagers, students, or in targeted clinic settings. For example, they noted that cash incentives can be especially important for groups such as sex workers or people who use injection drugs, for whom the practical and immediate benefits of testing are often outweighed by daily survival priorities.

> *"From the perspective of working with sex workers, cash can be very important."*

[3] Smith, S., Trayner, K. M. A., Campbell, J., McAuley, A., Craik, J., Hunter, C., ... & Hutchinson, S. J. (2025). A novel, multi-component contingency management intervention in the context of a syndemic of drug-related harms in Glasgow, Scotland: First year of the 'WAND'initiative. *Addictive Behaviors Reports, 21*, 100580.

Considerations and limitations

Despite this optimism, participants also raised a number of considerations. Some clinicians and policymakers questioned whether incentives might encourage people to test unnecessarily or repeatedly for the incentives. Others worried about longer-term impacts, particularly whether offering an incentive might deter people from testing in the future (or testing when required) unless another incentive is offered.

There were also questions about whether financial incentives address the more fundamental barriers to HIV testing. For example, fear of a positive diagnosis, low perceived personal risk, or the fact that some healthcare professionals do not routinely offer HIV tests were all seen as major reasons why people might not get tested. Some participants argued that while incentives might help encourage initial uptake, they do little to address these deeper, more entrenched issues.

Finally, some participants raised ethical considerations, particularly around offering financial incentives to people who inject drugs or others in very vulnerable circumstances. While incentives might increase uptake, there was unease about whether this could be seen as coercive or exploitative if individuals feel pressured to test in order to access money. Ensuring that people are fully informed and free to choose whether to test is essential.

> *"I can confidently say IV drug users will test for money. Particularly sex working women… less sex they have to have to get drugs, which will keep you going. But is it ethical? You do want them testing but testing for the right reasons."*

4.2 Design and format of the intervention

Section summary:

- **Type of incentives:** Incentives should be relevant and meaningful, with a choice of options rather than a one-size-fits-all approach; cash was often seen as the most effective, but linking incentives to wraparound support and broader health engagement was viewed as more ethical and

impactful.

- **Target audience:** Incentives should be targeted toward underserved or at-risk groups while avoiding reinforcing stigma; some participants favoured targeted outreach, while others preferred a broader, universal offer to reduce discrimination and normalise testing.
- **Delivery location and personnel:** There was strong support for delivering testing and incentives outside traditional NHS settings in trusted community spaces, with differing views on whether the same person or separate individuals should deliver the test and the incentive.
- **Messaging and framing:** Messaging should avoid risk-based labels and instead focus on positive health narratives and self-care, using language like "reward" or "support" rather than payment; co-production with communities was seen as essential to ensure cultural relevance and reduce stigma.

Discussions about the design of incentive-based interventions covered several key areas: 1) the **type of incentive** offered, 2) **who should be targeted**, 3) **where testing and incentives should be delivered**, and 4) **how they should be framed or messaged**. While there were differing views on some elements, there was broad agreement on the need for tailored, community-informed approaches.

Type of Incentives

Participants agreed that incentives must be relevant and meaningful to the target population. Offering a choice of incentives, rather than a one-size-fits-all approach, was seen as helpful in increasing uptake.

Financial incentives were frequently raised, including cash, retail vouchers, Oyster cards, Amazon vouchers, and utility top-ups. Cash was often described as the most effective.

> *"Just pay them…Cash is king."*

> *"When it comes to the type of incentive, it needs to be easy to use, to convert into something"*

Some participants noted that non-financial incentives, such as free travel, snacks and giveaways (e.g. T-shirts, condoms, power banks), certification of testing, access to Pre-Exposure Prophylaxis (PrEP), food, or even event access (e.g. parties or music events) could be effective, while others questioned their value, particularly if items were not practically useful or culturally relevant.

> *"Hard to choose something for everyone but it needs to be useful."*

A key point of discussion was whether the incentive should stand alone or be part of a broader offer. **Many emphasised linking the incentive to wraparound support** (e.g. housing advice, benefit support, or health services). This was viewed as more ethical and impactful, especially when engaging people with complex needs. Participants noted that the incentive should support people to overcome barriers such as fear, or lack of perceived risk, although views on the effectiveness of incentives towards overcoming these barriers were mixed. Incentives were seen as a way to open the door to engagement and support wider behaviour change and care access. There was an emphasis from participants that incentive should only be provided within a broader system of health support, good health behaviour education, and with clear pathways around how to provide care after diagnosis.

> *"Is the incentive to get them just tested or more widely into the care they need?... Are we just getting the testing numbers up?"*

> *"Incentive should link to getting them something else they need in their lives… "*

Target audience

There was general agreement that incentives should be targeted towards underserved or at-risk groups, especially those more likely to receive a late diagnosis, experience greater levels of stigma around HIV testing and subsequent diagnosis, or face financial barriers to testing. Groups identified included Black African and Black Caribbean men and women, migrants, women, people who inject drugs, sex workers, and people experiencing homelessness.

However, participants stressed that incentive-based approaches must avoid reinforcing stigma or discrimination by appearing to single out certain groups as

"problems." Some participants advocated for more targeted outreach to groups that are under-tested (e.g. African heterosexuals, rural populations), while others suggested a broader, universal offer might be more effective in reducing stigma and reaching people who do not see themselves as being at risk. One idea was to incorporate HIV testing and incentives into routine health checks for over-40s.

The stakeholder workshop also discussed the scope of who should receive incentives. Participants questioned whether incentives should be limited to patients, or extended to those delivering tests, such as pharmacists, outreach workers, or community caseworkers, echoing insights about the importance of frontline staff in influencing uptake and engagement.

Delivery location and personnel

There was strong support for delivering testing and incentives outside of traditional NHS settings, particularly in trusted community spaces. Suggested locations included places of worship, community centres, hostels, homeless health services, drug and alcohol services, barbershops, nail bars, and salons.

Trusted community organisations were seen as key delivery partners due to their close links and credibility with local populations. These groups often have better access to those who are disconnected from mainstream healthcare services. There was also support for involving GPs, especially to address missed opportunities among women. Faith leaders were also identified as influential messengers in some communities.

> *"Third sector and grassroots have access to the community who don't trust the healthcare system, e.g. sex workers, it's only those people who can reach those people."*

> *"If it's Black African and Caribbean communities… barbers for men-hair are really magical places in terms of the conversations that can happen, they are surprising…they're in a single sex environment, conversations can feel more comfortable, it's in a moment of personal service and care. Getting your hair cut intrinsically is also about your sexuality too - you feel good, look good."*

Views differed on who should deliver the test and who should offer the incentive. Some participants believed a single trusted individual or organisation could provide both, while others felt there should be a clear separation, particularly if confidentiality or perceived bias was a concern. For example, it may be preferable for a community organisation to distribute the incentive, while a health professional administers the test.

Messaging and framing

Participants consistently emphasised the importance of how the intervention is framed. Traditional messaging based on risk was seen as ineffective or alienating, especially when people do not identify with those risk labels. Instead, participants suggested that messaging should focus on positive health narratives, such as "living well" or "taking control of your health", and frame testing as part of self-care. However, there is some evidence that loss-framing messaging may work best for detection behaviours such as health testing in general,[4] and particularly in HIV for those who have low levels of perceived HIV risk.[5] However another study found that gain-framed messaging had a greater effect in women with low perceived risk,[6] so the evidence remains inconclusive. Testing out messages and empirically assessing their effectiveness among target groups should be a vital target moving forwards to ensure the message is clear for target groups.

Similarly, participants noted that the way incentives are described matters. Positioning them as a "reward," "support," or "resource" was seen as more empowering and respectful than framing them as a payment. Messaging should avoid making the process feel transactional, which could reinforce stigma or reduce long-term engagement.

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[4] O'Keefe, D.J., Jakob, D. & Jensen, "The Relative Persuasiveness of Gain-Framed Loss-Framed Messages for Encouraging Disease Prevention Behaviors: A Meta-Analytic Review," *Journal of Health Communication* 12, no. 7: 623–44, https://doi.org/10.1080/10810730701615198.

[5] Bekalu, M. & Eggermont, S., "The Relative Persuasiveness of Gain-Framed Versus Loss-Framed HIV Testing Message: Evidence From a Field Experiment in Northwest Ethiopia," *Journal of Health Communication* 19, no. 8: 922–38, https://doi.org/10.1080/10810730.2013.837557.

[6] Hull, S.J., "Perceived Risk as a Moderator of the Effectiveness of Framed HIV-Test Promotion Messages among Women: A Randomized Controlled Trial," *Health Psychology,* 31, no. 1 (2012): 114–21, https://doi.org/10.1037/a0024702.

Involving community voices in developing messaging was seen as crucial to ensure cultural relevance and resonance. Participants emphasised the need for co-production from the outset, not just consultation, to build interventions that reflect lived experience and avoid top-down assumptions about what works.

There was some concern that targeting underserved groups for testing, while effective, may increase HIV-related stigma towards those groups. Some communities might feel stigmatised, singled out, or treated as a "problem" population. In smaller or rural areas, concerns about confidentiality and visibility were flagged; people might be wary or suspicious of "what's the catch?", particularly if incentives are not a norm in other aspects of their healthcare. To combat this, messaging and design should reflect testing as a right and normalise it for everyone, not just those labelled as underserved.

4.3 Acceptability and perception of the intervention

Section summary:

- **Community acceptance:** Incentives were generally seen as likely to be well received, especially among those facing financial hardship, though acceptance was complex and context-dependent across different communities.
- **Ethical considerations:** Participants raised significant ethical questions, including whether it is right to incentivise testing without follow-up care, risks of reinforcing stigma or HIV exceptionalism, and the vulnerability of migrants with insecure status.
- **General public and media acceptance:** There was broad recognition of the need for strong, clear messaging to avoid perceptions of rewarding "undeserving" groups or misusing public funds - participants spoke to concerns about potential backlash or negative media coverage.

Participants described the acceptability of incentive-based HIV testing as complex and context-dependent. Perceptions varied across different communities and professional groups, with strong views on how incentives should be framed and delivered, and significant ethical considerations raised.

Community acceptance:

In general, incentives were seen as likely to be well received, especially by communities facing financial hardship. Participants noted that, for some individuals such as people who inject drugs or sex workers, receiving an incentive could reduce the need to engage in risky or harmful activities to meet immediate needs. One participant commented that most people would welcome *"something nice"* in exchange for taking a positive step toward their health.

Ethical considerations:

Ethical considerations were raised amongst participants from both the clinician/policy and community/voluntary group, though with slightly different emphasis.

Community and voluntary sector participants focused on the individual-level impact of incentives, highlighting tensions around whether it is ethical for someone to test purely for the incentive, particularly if follow-up support (e.g. treatment or care pathways) is not in place. Additionally, deciding who "deserves" an incentive and who does not was viewed as ethically fraught.

Policymakers and clinicians raised broader systemic issues concerns. Some questioned the fairness of targeting only certain communities, which could risk reinforcing stereotypes or discrimination. There was discomfort around the idea that this could be perceived as "HIV exceptionalism", i.e. treating HIV differently from other health conditions without clear justification.

Migrants with insecure status were highlighted as a particularly vulnerable group, while incentives might encourage them to test, they may still face serious barriers to care or protection. A few participants stressed the risks associated with drawing people into a system through incentives that are not able to then fully support them afterward. The incentive was thus seen as amplifying the importance of having a robust support system.

General public and media acceptance

There was broad recognition of the need for a strong, clear messaging to avoid misperception of the intervention. Participants emphasised the need for any incentive intervention to be able to withstand potential backlash or negative headlines. The intervention could backfire if the incentives are perceived as rewarding "undeserving" groups or as a misuse of public funds. Several participants emphasised that strong, clear messaging would be essential to protect against this risk.

> *"The reputational risk is very very high, you could see the Daily Mail headline 'I found out about killer disease for a 10 pound Amazon voucher."*

> *"They [the general public] will think - is £25k to incentivise 1000 people to take an HIV test better than half a school nurse?"*

4.4 Feasibility and implementation considerations

Section summary:

- **Funding:** Funding was the most consistently cited barrier, with concerns that grassroots organisations could be excluded without dedicated funding, and questions about whether NHS or local authority budgets could sustain incentives without diverting resources from other services.
- **Implementation logistics:** Participants highlighted operational challenges such as distributing incentives without compromising anonymity or benefits, managing increased demand, ensuring sustainability over time, and potentially bundling HIV testing with other tests to improve scalability.
- **Governance and partnerships:** Clear governance, leadership, and strong partnerships between clinical and community providers were seen as essential, though differences in priorities and resources could hinder collaboration.
- **Staffing and training:** Delivering testing and incentives in non-traditional settings would require additional staff and training, as well as capacity to

offer counselling and connect people to follow-up care.

- **Monitoring and evaluation:** Robust evaluation was viewed as crucial but challenging to define, with questions about what success looks like, how to measure cost-effectiveness, and how to account for unintended impacts on testing behaviours.

Incentive-based HIV testing interventions were generally seen as feasible in principle, but participants highlighted a range of practical, financial, and systemic challenges that would need to be addressed for successful implementation.

Funding

Funding was the most consistently cited barrier across all participant groups. Community and voluntary sector members noted that many grassroots organisations already operate under extreme financial pressure and would be unable to deliver incentive-based interventions without dedicated funding. There was concern that such groups might be excluded from future commissioning if incentives became a core requirement but weren't accompanied by additional funding. The high cost of processing tests conducted by community organisations was also raised, with current reimbursement models described as unsustainable.

> *"Small organisation [that] doesn't have funding might be excluded if they can't provide incentives - large organisations have more funds and people go there instead, but it may not always be the best route for them, it will create unnecessary competition."*

Policy and clinical participants focused more on NHS and local authority budget pressures. They questioned where funding for incentives would come from and whether this would mean diverting funds from other essential services.

Implementation logistics

Participants raised a number of operational challenges, including how incentives would be distributed, ensuring that they don't interfere with recipients' benefits or immigration status, and preserving anonymity, especially when distributing physical incentives that require contact details. There were also concerns about managing

increased demand in clinics and the impact on existing staff workloads. Bundling HIV testing with other tests (e.g. Hepatitis B and C) was seen as a practical and potentially scalable option, especially in areas like Scotland where such approaches are already in use. [7]

Sustainability was another major concern. Participants emphasised that one-off pilots may not be effective if incentives cannot be maintained over time.

Governance and partnerships

Participants agreed that clear governance and leadership would be essential. Commissioners, NHS bodies, and local authorities would all need to be engaged, and clarity would be required on how budgets could be used to fund incentives.

Building partnerships between clinical and community providers was seen as essential but not always straightforward. Differences in priorities, language, and available resources could create barriers to collaboration, particularly under tight timelines or funding constraints. To ensure the programme can leverage the unique trust and reach of all partners, a key implementation consideration will be designing the scheme to enable smaller, grassroots groups to participate effectively alongside larger providers.

Staffing and training

Offering testing and incentives in non-traditional settings would require additional staff and training. Participants noted that while many community groups are well placed to reach underserved populations, they may lack the clinical training or safeguarding experience required to deliver testing safely. Clinicians, on the other hand, may need training to build rapport and provide care that is respectful of and responsive to the cultural needs, beliefs and practices of diverse communities. Several participants advocated for non-traditional health settings and building on existing community testing infrastructure, where skilled and trusted teams already operate.

[7] For example, Waverley Care offers free and confidential dried blood test testing for HIV and hepatitis B and C in Greater Glasgow and Clyde. https://www.waverleycare.org/services/greater-glasgow-and-clyde-2/

Participants stressed that staff involved in delivering the intervention must be equipped not just to conduct tests, but also to have sensitive conversations, provide basic counselling, and connect people to follow-up care.

Monitoring and evaluation

There was a shared recognition of the importance of robust evaluation of any incentive-based interventions implemented. However, participants noted that it's difficult to define the metric(s) for success: is the goal more tests, more diagnoses, or simply making sure everyone knows their status? Some questioned how to measure cost-effectiveness and what counts as value, especially when considering indirect benefits like reduced stigma or earlier diagnosis.

Evaluation approaches would also need to consider local variation, unintended effects on testing uptake elsewhere, and the potential for incentives to negatively impact routine behaviours (for example, people who would normally have regularly tested might refuse to test unless receiving an incentive).

5. Recommendations and conclusion

Drawing on the evidence and stakeholder insights summarised above, BIT suggests three priorities for further work and action:

1. Strengthen evidence on incentives vs other approaches

This project did not comprehensively review the comparative effectiveness of incentives versus other strategies (e.g. peer support, communication campaigns, digital reminders) in underserved communities. As such, it remains unclear how incentives compare to, or could best complement, these approaches in practice. This limits the ability of practitioners to assess whether incentives should be used alone or as part of multi-component strategies. It is also unclear whether another approach would be more cost-effective than incentives alone.

Action:

- **Review existing evidence** to assess the relative effectiveness of incentives versus other approaches
- **Conduct further research** to explore whether specific groups within underserved communities (e.g. younger men, recent migrants, people experiencing homelessness) respond more positively to incentives

Why this matters:

- Ensures we are focusing funding on the intervention most likely to elicit an increase in HIV testing in underserved communities (i.e. incentives vs. an alternative approach)
- Clarifies when and for whom incentives add the most value
- Moves away from one-size-fits-all models toward tailored, evidence-based intervention design

2. Co-design interventions with the target communities

Incentive-based interventions should be developed collaboratively with the communities they aim to reach, particularly underserved groups such as women, older Black African heterosexual men, people who inject drugs, and/or people in deprived areas.

Action:

- **Involve communities meaningfully** in selecting the type of incentive (e.g. voucher vs. support), delivery settings (e.g. barbers, recovery cafés), and communication strategies.
- **Piloting incentives with specific groups or local areas** would

Why this matters:

- Prevents misalignment with local needs and preferences and maximises the chance of success
- Reflects lived experience—participants noted motivation often stems more from being respected and

provide valuable further evidence.

supported than from receiving money

- Builds trust and legitimacy, especially for groups with historical reasons to mistrust the health system

3. Carefully test and frame how incentives are communicated

Language and framing shape how incentives are perceived, both by target communities and the wider public. Poorly framed messages risk undermining trust or reinforcing stigma.

Action:

- **Conduct user testing of behaviourally-informed communications**. For example, BIT can support the design and testing of different framing strategies:
    - Emphasising autonomy (e.g. positioning incentives as supportive resources rather than payments for compliance)
    - Building community relevance (e.g. linking to wider health concerns such as prostate cancer or wellbeing)

Why this matters:

- Community groups raised concerns about incentives being seen as coercive or patronising
- Policymakers highlighted the need for ethical framing to secure public and political backing
- Behavioural insights research suggests messaging can influence engagement, especially among groups with deep-rooted mistrust

- Using peer-led communications to shift norms and model behaviour

Conclusion

This report presents the findings of a two-phase project investigating incentive-based interventions for HIV testing: a rapid evidence review (Phase 1) and qualitative research (Phase 2). The Phase 1 literature review indicated that incentive-based testing holds potential for increasing initial HIV testing uptake in high-income settings, particularly among underserved populations. However, an outstanding question remains on whether incentives are more effective and/or cost-effective than other interventions.

The Phase 2 qualitative findings revealed mixed views on the effectiveness of incentive-based interventions. Participants generally perceived incentives as acceptable, especially for communities facing financial hardship, and saw their potential to reduce some immediate practical barriers to testing.

However, ethical considerations were raised on how incentives would need to be designed and rolled out to avoid the potential for coercion or exploitation of vulnerable groups, and the risk of reinforcing stereotypes. Feasibility and implementation considerations were also highlighted, with concerns about funding constraints, operational logistics, staffing and training requirements, and the need for robust governance and partnerships. There was also a notable apprehension about potential public and media backlash if incentives were perceived as inappropriate or a misuse of resources.

Overall, the role for incentives in HIV testing has potential to be a valuable intervention, but their success would depend on careful design, ethical framing, and meaningful community involvement.

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