



Published in final edited form as:

Ethics Hum Res. 2024 ; 46(1): 14–25. doi:10.1002/eahr.500196.

Positive and negative social consequences of participating in a sexual network study

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Abstract

Objective: We longitudinally tracked social risks and benefits of participation in a sexual health study to improve participants' experiences and enhance understanding of participant motivations to enroll and attend follow-up.

Study Design and Setting: A cohort of 241 men who have sex with men (MSM) attended quarterly follow-up visits over two years which included an assessment of perceived social consequences resulting from study participation. We used descriptive statistics to highlight patterns in the frequency of consequences reported over time.

Results: Of the participants who returned for at least one follow-up visit (n=217, 90%), most (n=185, 85%) reported positive consequences resulting from participation. The most commonly-cited benefits were "gained knowledge" (76%, n=165), "financial improvement" (69%, n=149), and "life improvement" (68%, n=148). Generally, the reporting of positive consequences trended downward over time. Reporting of negative social consequences was rare, and all concerned a stigmatized reaction from someone learning about the participant's involvement in a sexual health study.

Conclusion: The high frequency of reported benefits and low frequency of negative consequences adds new information about participant perspectives in sexual health research. Better identification of both positive and negative consequences may improve how researchers design, recruit, and conduct research.

Keywords

Men who have sex with men; Risks and benefits; Social consequences; Sexual networks

1. INTRODUCTION

Ethical research involves a careful assessment of the risks and benefits to participants. The potential positive and negative consequences of participating in research must be well understood by investigators, research staff, review boards, research participants, and others involved in the research enterprise. Participation benefits may be tangible outcomes of the research. For example, patients may be motivated to enroll in a clinical trial if they perceive that their health may improve through participation, and positive health outcomes are assessed as a part of the study protocols. Participants are also informed about the potential negative health outcomes or side effects which may result from the experimental treatment. But in non-treatment focused research, health or other personal benefits to participants are less commonly measured, and the benefits of participating may be more difficult to quantify. The same is true for risks of participation. In observational research, potential risks may not be as easily anticipated.

Understanding the range of potential benefits and risks from study participation may help inform investigators about participant motivation to join the research, including when direct personal benefits are not expected. Motivation to participate in research is understudied, especially for research beyond randomized controlled trials.¹ Though the decision to participate is complex, varies based on the type of research, and differs with the intensity or invasiveness of procedures, altruism, financial compensation, and personal medical benefit likely play a role.² Perceived benefits, as well as participants' views of their membership in and loyalty to a longitudinal research study, are also likely to be important motivators for continued participation.³ Understanding people's motivations for research participation and their perceived personal gains from participation may inform study recruitment and retention.

Researchers' understanding of participants' motivation to participate is limited by a lack of understanding of participants' positive experiences. Unlike the emphasis placed on the collection of adverse event data in clinical research, participants are rarely asked about benefits experienced over the course of their participation. Outside of clinical trials, risks resulting from research participation are also rarely collected. Implementing surveys that collect information about perceived risks and benefits may improve the quality of risk-benefit analysis for future research and uncover unexpected direct or indirect benefits.

Social consequences, outcomes that affect how a person experiences society or their relationship with others, are one component of risk-benefit evaluation that may have implications for research participation. Potential social consequences are ideated by research staff prior to study initiation to be listed on the consent form, but they are not typically collected from research subjects themselves during the time they are participating. In the limited research discussing these consequences, they may also be referred to as positive social impacts (PSIs), beneficial social impacts (BSIs), or negative social impacts (NSIs).⁴ The potential societal impacts of research on a broad scale may be well described in the consent form and other study documents, but the personal social consequences resulting from research participation is poorly understood.⁵ Social consequences, both positive and negative, may be intrinsically linked to perceived risks and benefits from a

participant perspective. But identifying these potential outcomes in the early stages of study development can be difficult, as they may be abstract. Collecting data on perceived social outcomes as part of research participation may inform a more nuanced view of risk-benefit assessments.

The objective of the current analysis was to examine social consequences – positive and negative – reported by participants in a two-year, longitudinal sexual network study. We implemented a brief survey at each quarterly follow-up visit that captured the positive and negative consequences that participants experienced due to their involvement in the research. We also assessed whether reporting positive consequences at first follow-up was associated with improved retention in the study.

2. METHODS

2.1 Sample

The Network Epidemiology of Syphilis Transmission (NEST) Study was a multi-site longitudinal sexual health study that followed men who have sex with men (MSM) over two years in three U.S. cities: Columbus, Ohio; Baltimore, Maryland; and Chicago, Illinois.⁶ The current analysis is restricted to Columbus participants. Eligible men were adults aged 18 or older who reported anal or oral sex with a man in the past six months; lived, worked, or received medical care within 1 hour of Columbus, Ohio; and reported male sex assigned at birth and male gender identity.

2.2 Recruitment

We enrolled a convenience sample between February 2019 and February 2020. Initially, we used respondent driven sampling (RDS) with 20 seeds, who were identified during a pilot study preceding the project, to recruit the sample.⁷ All enrolled participants were given coupons with a unique code and were encouraged to share this code along with study details with their social and sexual contacts. We supplemented RDS starting in April 2019 by recruiting via flyers posted at local, predominantly LGBTQ+-centered establishments; referrals from clinicians serving MSM; in-person recruitment at community events; and advertisements on social media and hookup apps. Recruitment materials directed interested men to contact the study by phone, text or email to schedule an eligibility screening over the phone.

2.3 Consent

Prior to enrollment, each participant signed a paper informed consent form after staff reviewed study procedures.

2.4 Study visit overview

Participants attended study visits quarterly for up to two years. Visits were completed in two parts: survey administration and biological specimen collection for HIV and STI testing. Our primary objective was to understand how the structure and composition of networks of MSM at increased risk of syphilis, that are composed of sexual and social connections, change over time and contribute to syphilis transmission.

2.4.1 Sexual network survey: At each visit, participants completed a 1-hour REDCap survey that captured demographic characteristics, sexual behavior, healthcare access and utilization, substance use, and sexual network information.⁸ While most of the survey was self-administered, study staff verbally administered the most complex portions that captured detailed sexual network and partner data.

2.4.2 Social consequences survey: During the planning phase for this study, we anticipated the potential for negative social consequences resulting from participants sharing study information with others, which is inherently built into the RDS recruitment design. Because communicating with others about involvement in a sexual health study that recruits a stigmatized population has the possibility to negatively impact personal relationships or other aspects of a person's life, we conducted a brief assessment to capture participants' experiences of both social harms and benefits at each follow-up visit. Staff administered the survey verbally, and assessed positive consequences by asking the question, "Since your last study visit, has your participation in this study had any positive or beneficial impact on your life?" If the participant answered yes, staff asked directly about several prompted options developed by the investigators (Table 1).⁹ Participants could also describe other positive consequences, which we aggregated and categorized into common themes for analysis (Table 2). Staff captured negative social consequences by asking the question, "Since your last study visit, have you had negative consequences from other people learning about your participation in the study?" If the participant answered yes, staff went through a list of potential negative outcomes (Table 3). Participants could also contribute unlisted negative consequences.

2.4.3 Biological specimen collection: By design, all NEST participants underwent testing for HIV, syphilis, and both urethral and extragenital chlamydia and gonorrhea via nucleic acid amplification testing at enrollment and each follow-up visit.

2.5 Compensation

Participants received \$60 for completing the enrollment visit and each quarterly study visit. Additionally, they received \$15 as compensation for each eligible RDS referral, up to six referrals, who came in for screening, even if the referred individual did not enroll. Men received compensation in cash at quarterly visits.

2.6 COVID-19 modifications

In-person research activities were suspended at the start of the COVID-19 pandemic in March 2020. Study visits were paused entirely for one week to allow study staff to pivot to remote data collection. For the remainder of the study, staff remotely administered all proctored survey items over the phone, including the behavioral and social consequence surveys, through the conclusion of data collection in December 2021. Participants completed a portion of the survey items themselves through an email link provided at the end of their phone call appointment. HIV and STI testing were paused in March 2020, before being resumed in November 2020. From that time through the end of the study, we made in-person testing optional to accommodate participants who did not feel comfortable appearing in-person, and offered an additional \$40 as compensation for attending in-person HIV and

STI testing. Post-March 2020, compensation was generally given as a check sent via the US Postal Service.

2.7 Ethical review

The Ohio State University Institutional Review Board reviewed and approved the study.

2.8 Analysis

Using descriptive statistics, we analyzed the frequency and trends of reported positive and negative consequences of study participation. We used logistic regression to compute unadjusted odds ratios (ORs) and 95% confidence intervals (CIs) for the association between listing any positive consequence at the first follow-up visit (3 months after enrollment) and completing at least one subsequent visit, and separately, between listing any positive consequence at the first follow-up visit and completing the final follow-up visit (24 months after enrollment). Given the small number of participants reporting negative consequences (n=7 participants, n=9 negative experiences), we did not measure associations between reported negative consequences and retention.

3. RESULTS

3.1 Participant demographics and retention

Overall, 241 participants enrolled in the study. Most identified as white (n=166, 69%), while 26% (n=63) identified as Black, and other racial identities were reported less often (Table 4). At baseline, most identified as gay (n=190, 79%) and reported some college education or a technical degree (n=200, 83%). At the first follow-up visit, retention was 88% (n=211). Retention slowly declined with time, to approximately 70% by the end of the study (Table 5).

3.2 Frequency of positive consequences

Of the 217 participants who came back at least once, 185 (85%) reported a total of 3,958 positive consequences resulting from participation. Of these, most (n=177, 82%), reported two or more positive consequences over follow-up. The most common positive consequence was “gained knowledge,” reported by 76% (n=165) (Table 1). Other common responses were “financial improvement” (n=149, 69%) and “life improvement” (n=148, 68%). All listed consequences were reported by over half of participants returning for at least one follow-up visit, except for “employment improvement” (n=41, 19%).

3.3 General trends of reported positive consequences

Respondents endorsed positive consequences more early in the study, at either follow-up 1 (3 months after enrollment) or follow-up 2 (6 months after enrollment); the exception was “employment improvement” (Figure 2). Generally, as the study progressed, the number of positive consequences reported declined. The lowest reporting of each positive consequence, except “employment improvement,” occurred at the penultimate follow-up visit (21 months after enrollment). At the final follow-up visit (24 months after enrollment), the number of participants reporting positive consequences increased for every option listed.

In an additional exploratory analysis, we examined patterns of reporting of positive consequences by employment status, education, and race/ethnicity. We observed that unemployed people generally reported each positive consequence at a higher proportion than employed people. Similarly, those without a bachelor's degree generally reported each positive consequences at a higher proportion than those with a bachelor's degree or more education. Finally, Black and Hispanic participants generally reported positive consequences at higher frequency than White participants.

3.4 Unlisted positive consequences

The most common unprompted positive consequence identified by participants (n=49, mentioned at 74 visits) was “getting regular HIV/STI testing and/or treatment for free” as part of study participation (Table 2). Also common (n=36, mentioned at 57 visits) was “more awareness about sexual behavior, sexual health risk, and/or STI testing frequency”. Other examples of participant-generated positive consequences mentioned at multiple follow-up visits included: “extra financial help” (n=7, mentioned at 7 visits), “being more responsible about sexual behavior” (n=7, mentioned at 7 visits), and “opening up conversations with others about importance of sexuality and/or sexual health” (n=5, mentioned at 5 visits).

3.5 Negative consequences of participation

Seven participants (3%) reported negative social consequences a total of nine times during the study. Although they were asked about social harms at every visit, negative consequences were reported only during the first and second follow-up visits (3 and 6 months after enrollment). All instances involved a negative reaction from someone in the participant's life after learning of their study participation. These included: (1) accusations or suspicion about HIV/STI status; (2) assumptions that the participant was engaging in risky sex; or (3) reactions from friends and family who held stigma about sex or the participant being MSM. In one instance, a participant reported becoming housing insecure after a family member became hostile; the participant suspected, but did not know with certainty, that the family member had learned about their study participation from the participant's appointment card (Table 3). Every participant that reported a negative consequence also reported at least one positive consequence at the same study visit. All but one participant who reported a negative consequence completed the full two years in the study.

3.6 Association between positive consequences and retention

Reporting a positive consequence at the first follow-up visit was not associated with completing at least one additional follow-up visit (unadjusted OR=2.9, 95% CI: 0.4 to 129.5) but this estimate was very imprecise. Similarly, we found no association between reporting positive consequences at the first follow-up visit and retention in the study for 24 months (OR=1.6, 95% CI: 0.6 to 4.3).

4. DISCUSSION

Among this community-based sample of MSM, reporting positive consequences due to study participation was common. More than three-fourths of the sample reported

experiencing benefits at one or more points throughout the study. Negative consequences were reported rarely; the most common were related to negative reactions after someone in the participant's life learned about the study. Generally, these events were linked to stigma surrounding sex or sexuality. Contrary to what we had hypothesized, we found no link between reporting benefits and study retention.

Evaluating risks and benefits of research is imperative to the protection of human subjects. Though monitoring risk via reporting of adverse events is standard practice in clinical research, benefits assessments of participation are not common. Having a comprehensive understanding of both direct and indirect risks and benefits resulting from participation may aid the conduct of research at all stages of the research process. Additionally, this understanding can inform investigators about potential motivations to participate in research, especially in cases where benefits are not explicitly built into the study design. The gap in assessing indirect benefits of participation in observational and other non-treatment focused research has been minimally explored.¹⁰ This gap extends to indirect risks and unanticipated negative outcomes. Most research exploring risks and benefits is concentrated among clinical trials that have expected positive health outcomes.¹¹ In non-treatment studies, altruism has been reported inconsistently as a motivator to participate.¹² The high frequency of reported benefits in this study is consistent with the few instances of related research in the literature.¹³ In an analysis of indirect benefits in a small HIV clinical study, psychological benefits, HIV knowledge, more intimate relationships, and positive behaviors were all expressed as benefits resulting from participation.¹⁴ These secondary benefits may play a role in encouraging continued active participation in research.

Several benefits in the present analysis, such as "gained knowledge," "awareness about sexual behavior, sexual health risk, and/or STI testing frequency," "improved mental health," and "improved relationships," echo the psychological and behavioral benefits observed in other sexual health and HIV research.¹⁵ These benefits may be more present for sexual and gender minorities, as this population is disproportionately affected by HIV/STIs and stigma, which may result in mental health burden.¹⁶ The present study is unusual in longitudinally tracking reported consequences.⁹ The proportion of participants reporting positive consequences trended downward over time, with an uptick at the final visit. This pattern suggests that participants may experience study-related benefits more in the first several months of participation or that they only felt the need to report that benefit at the study's start, even if the benefit continued. The increase in positive consequences at the final follow-up visit may be explained by acquiescence bias, with participants wanting to end participation in a positive or agreeable way. The increase may also capture a broader positive experience of their total time in the study.

The unlisted positive consequences reported by participants provide some key insights, especially related to sexual health promotion. Participants highly valued receipt of free HIV and STI testing and treatment, indicating that this testing may have been a strong motivation for continued study participation. The prioritization of clinical-related outcomes as benefits aligns with other research looking at participant-reported consequences of participation.¹⁷ Additionally, participants highlighted the impact that study participation had on taking more responsibility for their sexual behavior and on prompting conversations with others about

sexual health. Several participants also emphasized the “extra financial help” which the study was able to provide, as also displayed by “financial improvement” being among the top listed positive consequences selected by participants. This may indicate that financial compensation is a primary motivator for attending follow up.

Negative consequences were rarely reported by participants in this project. In two prior studies, both focused on HIV vaccine efficacy trials, negative social outcomes of participation were reported at 8% and 18%, with negative reactions from friends, family, and partners making up the vast majority, which is markedly higher than the 3% in the present study.¹⁸ This difference may be explained by study design or by environmental, social, and temporal differences between studies. These studies illustrate the need for continued sensitivity in research enrolling people from stigmatized populations. Participation in sexual health research can lead to reduced self-stigma, allowing sexual and gender minority individuals to feel more confident sharing their experiences with others. However, it’s important to be mindful of the potential for negative reactions and advise participants to be cautious when sharing study information. Stigma affects people at multiple levels – the personal experience of those facing stigma, those who perpetuate it, and institutions that play a role in creating an inclusive or exclusive culture.¹⁹ We captured the personal experiences of a small subset of participants who faced stigma, but these experiences may have limited generalizability to other research involving stigmatized populations.¹⁸

All negative consequences were reported at either the first or second follow-up visits. Participants may have been more at risk of social harms in the early stages of participation when they were more likely to share study information (intentionally, if they were recruiting contacts through RDS, or unintentionally) with others. At the same time, “reduced stigma” was a positive consequence reported by more than half of study participants. Considered together, participants may have opened themselves up to potential stigma at the study’s start when first speaking about their study experiences. These conversations may have led to creating a less stigmatized personal environment, which may be driving the lack of social harms reported during the latter half of the study.

This analysis highlights the importance of understanding both the perceived harms and benefits of participating in sexual health research. In this study, because the reporting of positive consequences was so common and negative consequences so rare, analyzing associations between consequence reporting and outcomes such as retention was challenging and imprecise. This could be, in part, due to the fact that the question about positive consequences was worded more expansively on the survey than the question about negative consequences. Future research can expand upon potential indirect negative consequences outside of those resulting from negative social interaction. Because consequence reporting did not occur until the first follow-up visit, participants who did not come back after enrollment were unable to contribute, which may have resulted in an underrepresentation of negative consequences experienced by participants who chose not to return. As has been pointed out in similar research looking at self-reported benefits of participation, participants may be more likely to report benefits when being interviewed by staff, as opposed to answering survey questions alone, because of social desirability bias.¹⁷

Our analysis uncovered several themes which are important considerations for bridging the gap between researchers and participants. Understanding what incentivizes and demotivates participants from being actively engaged with the research might lead to improved retention and more valuable findings. In this study, participants highly valued gaining knowledge, heightened awareness of risk behavior, and free medical care. Additionally, many emphasized compensation for their time as a primary benefit. Others appreciated how participation improved their communication and relationships with people in their life. Gaining a better understanding of unexpected indirect benefits provides a participant-centered perspective and allows for more informed decision making. These positive themes should be taken into account during informed consent and regulatory processes to fully educate participants and others involved in the research enterprise of what benefits may indirectly result from participation. More importantly, tracking these benefits across research disciplines may help reveal a fuller picture of the participant experience. The same is true for negative outcomes. This study highlights the ongoing impact of stigma on sexual minorities and the importance of considering this in research, but more exploration of indirect risks of participation is needed. By examining both positive and negative consequences, we can gain a deeper understanding of the real-life impact of research and align researchers' expectations with participants' experiences.

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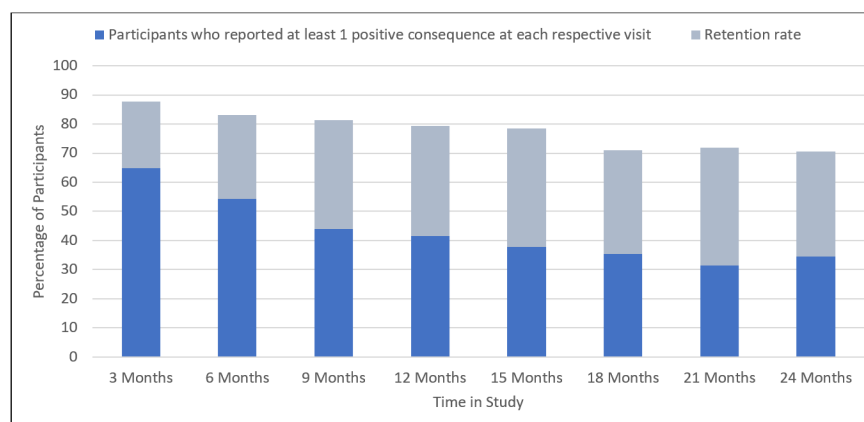


Figure 1: Retention and reporting of positive consequences over time in study.

The height of the grey bar shows the percentage of participants out of the total $n=241$ enrolled who completed each follow-up visit, up to final follow-up 24 months after baseline. The height of the blue bar shows the percentage of participants out of the total $n=241$ enrolled who reported at least one positive consequence at each respective follow-up visit.

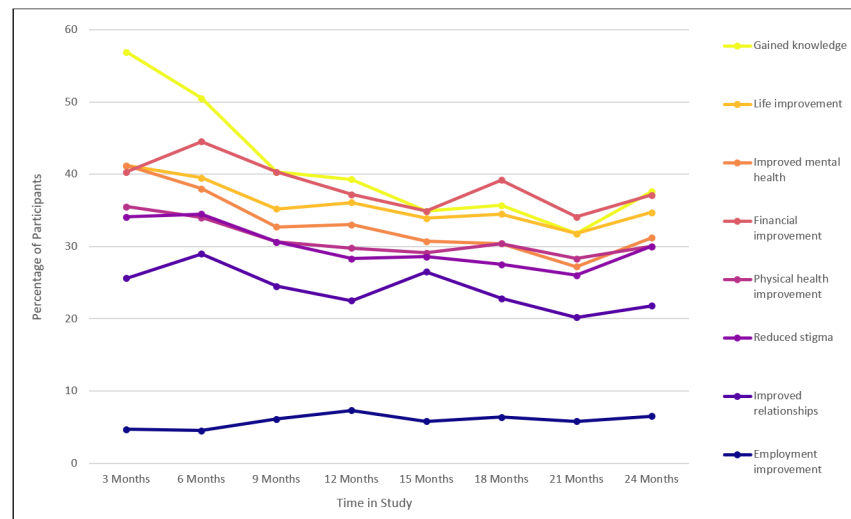


Figure 2: Frequency of listed positive consequences over time in study.

Each line displays the percentage of participants over time reporting each respective positive consequence out of the total number of participants who completed each respective study visit.

Table 1:
Percentage of participants reporting positive consequence at least once

Prompted positive consequence	n (%) [*]	Total number of times consequence was reported
Gained knowledge	165 (76)	621
Financial improvement	149 (69)	579
Life improvement	148 (68)	541
Physical health improvement	140 (65)	467
Improved mental health	140 (65)	500
Reduced stigma	127 (59)	452
Improved relationships	116 (54)	364
Other (unlisted)	94 (43)	159
Employment improvement	41 (19)	88

^{*} %'s were calculated using number of participants who completed at least one follow-up visit (n=217) as denominator. Participants could select more than one response, so percentages may total more than 100%.

Table 2:
Frequency of unlisted positive consequences reported across all follow-up visits

Unlisted positive consequence	3 Months - Visit 2 (n)	6 Months - Visit 3 (n)	9 Months - Visit 4 (n)	12 Months - Visit 5 (n)	15 Months - Visit 6 (n)	18 Months - Visit 7 (n)	21 Months - Visit 8 (n)	24 Months - Visit 9 (n)	Total Number of Visits Consequence Was Reported
Getting regular HIV/STI testing and/or treatment for free	31	16	11	3	2	4	1	6	74
"Awareness" (about sexual behavior, sexual health risk, and/or STI testing frequency)	12	8	10	8	1	5	5	8	57
Extra financial help	4	1	0	2	0	0	0	0	7
Being more responsible about sexual behavior (cautious about anonymous or "risky" sex practices)	2	2	0	0	1	0	0	2	7
Participation opened up conversations with others about importance of sexuality and/or sexual health	3	1	0	1	0	0	0	0	5
Helping serve community through research/ contributing to science	2	1	0	1	0	0	0	0	4
Peace of mind	1	2	0	0	0	1	0	0	4
Better keeping track of sexual partners	1	1	0	0	0	2	0	0	4
Getting on PrEP or getting back on PrEP	1	0	0	0	0	1	0	1	3
Decreased number of sex partners	2	0	0	1	0	0	0	0	3
Access to PrEP information	2	0	0	0	0	0	0	0	2
Received positive feedback from others about the study	0	2	0	0	0	0	0	0	2
Better PrEP adherence	0	0	0	1	0	0	0	0	1
Being more open with friends and family	0	0	0	1	0	0	0	0	1
Less anxiety about needing to schedule testing	1	0	0	0	0	0	0	0	1
Knowing there are researchers concerned about HIV/STI issues	0	0	1	0	0	0	0	0	1
Free t-shirt	0	0	1	0	0	0	0	0	1
More proactive about getting tested	0	1	0	0	0	0	0	0	1
Meeting study staff	1	0	0	0	0	0	0	0	1

Unlisted positive consequence	3 Months - Visit 2 (n)	6 Months - Visit 3 (n)	9 Months - Visit 4 (n)	12 Months - Visit 5 (n)	15 Months - Visit 6 (n)	18 Months - Visit 7 (n)	21 Months - Visit 8 (n)	24 Months - Visit 9 (n)	Total Number of Visits Consequence Was Reported
More clarity about life	0	0	0	0	0	1	0	0	1
Realized importance of monogamy with partner	0	1	0	0	0	0	0	0	1
Happy that people of color are included in the research	1	0	0	0	0	0	0	0	1
Self confidence	0	0	0	0	0	0	1	0	1
Sense of pride from completing study	0	0	0	1	0	0	0	0	1
Sexual health improvement	0	0	0	1	0	0	0	0	1
Staying healthy	0	0	0	1	0	0	0	0	1
Not specified	1	0	0	0	0	0	0	0	1

Table 3:
Frequency of negative consequences reported by study visit

Listed negative consequence *	3 Months - Visit 2 (n) **	6 Months - Visit 3 (n) **	Total (n)
Had personal trouble with sex partners, family members, friends or acquaintances?	2	3	5
Had trouble getting or keeping housing?	0	1	1
Had trouble getting or keeping a job or trouble with income or economic support?	0	0	0
Had trouble getting health care or with health insurance?	0	0	0
Been arrested or had trouble with the police or other legal problems?	0	0	0
Had any other type of problem?	4	0	4

* Participants could select more than one negative consequence.

** Negative consequences were reported at visits 2 and 3 only.

Table 4:
Demographics reported at baseline for 241 enrolled participants

	n	%
Highest level of education		
Less than high school diploma	5	2
High school diploma or GED	36	15
Some college, Associate's degree, or technical degree	87	36
Bachelor's degree	66	27
Any post graduate studies	47	20
Employment status*		
Full-time	121	5
Part-time	39	1
Self-employed	23	10
Retired	11	5
Full-time/part-time student	58	24
Unemployed	12	5
Sexual identity		
Gay	190	79
Straight	4	2
Bisexual	39	16
Something else	8	3
Race identity/ethnicity*		
American Indian, Alaska Native	6	2
Asian	8	3
Black, African American	63	26
White	166	69
Native Hawaiian or Other Pacific Islander	2	0.8
Hispanic	24	10
Don't know/refused to answer	11	5
Marital status		
Single, never married	197	82
Married, civil union or domestic partnership	25	10
Separated	1	0.4
Divorced	15	6
Widowed	3	1

	n	%
Relationship status		
In a monogamous relationship with one partner	43	18
In an open relationship with one partner	36	15
In a closed polyamorous relationship with two or more partners	3	1
In an open polyamorous relationship with two or more partners	10	4
Casually dating one or more than one person	34	14
Not currently in a relationship	107	44
Don't know/refused to answer	8	3
Age (mean, SD)	34	12

* Participants could select more than one response, so percentages may total more than 100%.

Table 5:

Retention of participants and number reporting at least one positive consequence from participating by study visit.

Time passed since study start (study visit)	Enrolled at baseline - Visit 1 (n = 241)			
	Completed study visit	Retention %*	Reported positive consequence from participating in the past 3 months (%)**	Reported negative consequence from participating in the past 3 months (%)**
3 Months - Visit 2	211	88	156 (74)	5 (2)
6 Months - Visit 3	200	83	131 (66)	2 (0.1)
9 Months - Visit 4	196	81	106 (54)	0 (0)
12 Months - Visit 5	191	79	100 (52)	0 (0)
15 Months - Visit 6	189	78	91 (48)	0 (0)
18 Months - Visit 7	171	71	85 (50)	0 (0)
21 Months - Visit 8	173	72	76 (44)	0 (0)
24 Months - Visit 9	170	71	83 (49)	0 (0)

* %'s were calculated using enrolled at baseline (n=241) as denominator

** %'s were calculated using "completed study visit" column as denominators