



Published in final edited form as:

AIDS Care. 2015 ; 27(2): 182–188. doi:10.1080/09540121.2014.963009.

Knowing is not enough: a qualitative report on HIV testing among heterosexual African-American men

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Abstract

Despite having higher rates of HIV testing than all other racial groups, African-Americans continue to be disproportionately affected by the HIV epidemic in the United States. Knowing one's status is the key step to maintaining behavioral changes that could stop the spread of the virus, yet little is known about the individual- and socio-structural-level barriers associated with HIV testing and communication among heterosexual African-American men. To address this and inform the development of an HIV prevention behavioral intervention for heterosexual African-American men, we conducted computerized, structured interviews with 61 men, focus group interviews with 25 men in 5 different groups, and in-depth qualitative interviews with 30 men living in high HIV prevalence neighborhoods in New York City. Results revealed that HIV testing was frequent among the participants. Even with high rates of testing, the men in the study had low

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levels of HIV knowledge; perceived little risk of HIV; and misused HIV testing as a prevention method. Factors affecting HIV testing, included stigma, relationship dynamics and communication, and societal influences, suggesting that fear, low perception of risk, and HIV stigma may be the biggest barriers to HIV testing. These results also suggest that interventions directed toward African-American heterosexual men must address the use of “testing as prevention” as well as correct misunderstandings of the window period and the meaning of HIV test results, and interventions should focus on communicating about HIV.

Keywords

African-American men; heterosexual; HIV testing; sexual communication

African-Americans have higher rates of HIV testing than other racial/ethnic groups, yet 31% have never been tested (Centers for Disease Control and Prevention [CDC], 2008) and are more likely to present for HIV testing late in the course of their infection (CDC, 2012). Heterosexual exposure is the means by which HIV infection occurs among one in nine newly HIV-infected men in the USA and 68% of these men are African-American (CDC, 2013). It is estimated that about 24% of HIV infections among African-American men attributable to high-risk heterosexual contact are undiagnosed (CDC, 2012). HIV testing is critical in order to reduce the risk of transmission, and awareness of HIV serostatus is a strong determinant of condom use and sexual partnering patterns (Ebrahim, Anderson, Weidle, & Purcell, 2004), yet little is known about HIV testing behaviors among heterosexual African-American men (Marks, Crepaz, & Janssen, 2006). As part of a CDC-funded study designed to develop and test an HIV prevention intervention for African-American heterosexual men, we conducted a formative research study using mixed methods (Frye et al., 2012). Here, we adopt a social cognitive perspective to inform an analysis of how heterosexual African-American men make sense of HIV testing, the influence of their female partners on HIV testing, and the impact of communication about HIV testing in heterosexual relationships.

Methods

Study sample

The study sample consisted of men between 18 and 45 years old, living in the South Bronx or Central Harlem who identified themselves as African-American, black, Caribbean black, or multiethnic black, with a self-reported HIV-negative or unknown HIV status. Recruited men were screened as either higher or lower risk. Higher risk men self-reported unprotected vaginal or anal intercourse with two or more female partners or 100% protected sex with more than two partners; lower risk men self-reported unprotected vaginal or anal intercourse with only one female partner or 100% protected vaginal or anal sex with no more than two female partners. Men were ineligible if they reported oral or anal sex with a man in the past five years; identified as an injection drug user in the last three years; reported no sexual activity with a female partner in the past three months; or participated in any HIV or substance use prevention studies in the previous six months.

Procedures

Eligible men in the two focal neighborhoods were recruited using street recruitment methods to participate in a Brief Risk Assessment (BRA) administered by audio computer-assisted self-interview, which included demographics, sexual behaviors, partnership characteristics, substance use, HIV testing history, and other factors related to HIV risk behaviors, and either a focus group or an in-depth qualitative interview, or both. The formative research was conducted in three stages: exploratory focus groups, qualitative in-depth interviews, and confirmatory focus groups. The first set of focus groups explored the men's perceptions of normative sexual behaviors, intimate relationships, and sexual risk, including approaches to risk reduction and the personal, behavioral, and socio-structural factors that influence risk and risk-reduction attitudes and behaviors. The goal of the in-depth interviews was to solicit detailed descriptions of the experiences of, perceptions of, feelings about, and cognitions around the focal behavioral outcomes: condom use, concurrent partnerships, and HIV testing. The purpose of the second set of focus groups was to discuss our findings from the qualitative interviews, and to assess the validity of analyses of the interview data and elicit feedback on preliminary thinking regarding intervention characteristics for the target population.

Analysis

Descriptive analyses were conducted on the BRA data to contextualize the qualitative approach. Analysis of BRA data used PASW Statistics 18 (SPSS, Inc., 2009, Chicago, IL). Analysis of the focus groups was thematic, focusing on dominant themes that emerged and organized by the questions asked. For the qualitative in-depth interviews, we used a grounded theoretical approach and categorizing strategies to code and analyze the data (Patton, 1990; Strauss & Corbin, 1997). A more detailed description of the analytic procedures can be found in a previous manuscript, describing the larger study (Frye et al., 2012).

Results

Sample characteristics

The sample included 61 men who completed the BRA. Of these 61 men, 56 unique participants completed an in-depth interview ($n = 30$) and/or a focus group ($n = 34$; Table 1). Table 2 describes demographic characteristics of the study participants. Table 3 describes the sexual risk behaviors, including HIV testing.

Qualitative analysis—We found that nearly all of the men had been tested in their lifetime and most had tested in the past year. Thus, we focused our analysis on circumstances that influence HIV testing, which revealed three themes: (1) HIV testing as prevention, (2) motivation to test, and (3) barriers to HIV testing.

HIV testing as prevention

A dominant theme through the formative research was that individuals who perceived themselves as having low HIV risk after receiving negative HIV test results were not motivated to use condoms. When asked how it felt to receive negative HIV test results, one

participant stated that it was acceptable to have unprotected sex because he was HIV-negative. “Well I think it’s good because now I can hit the skins without the company, you know what I am saying?” There were many misconceptions regarding HIV testing and infection, more specifically about the window period in HIV testing. Descriptions of this process revealed that some men were unaware of the delay between exposure to HIV and seroconversion, as well as the period of infectivity immediately following exposure or during acute HIV infection.

You know, if you have some type of trust in her like that you know, like you dealt with her the first time, ya’ll used the condoms and then the second time, you know, ya’ll talk and like if she can show you papers that she took it last week, two weeks ago, then you know, and you know, that she didn’t deal with nobody because she’s, she’s more like you, she’s looking for a long-term relationship; that’s understandable.”

HIV testing results, commonly referred to as “papers” by participants, were used by some of the men as a rationale for engaging in unprotected sex. Some men stated that their sexual partners would prefer to have unprotected sex if they showed their “papers.”

Like when we got in a relationship you know, and we started really talking about condoms, we’re going to use condoms for birth control and stuff like that I said well you know, if you want you know, we can use condoms. She said no, “We’ll both get checked out so you know, we show each other papers.”

Some stated that their sexual partner’s discomfort with using condoms was an excuse to rely on HIV testing as the sole method of HIV prevention.

And if we really want to sleep together that bad. And there’s just some women that just don’t like the feel of condoms. Some of ’em give ’em, you know, rashes or different – you know, different stuff. So ... hey, we can go to the doctor together and both get checked. If we both check good, we’re good, you know.

However, a few men did describe accurate knowledge of the risk associated with unprotected sex even with negative HIV test results, typically due to being close to someone with HIV, and described the “papers” method as “corny.”

I think it’s corny. You know, who knows who you had sex with the night before? If you had sex the night before and you got to wait on the three-month report, technically you had unprotected sex with that person. So it’s corny you know, that shit don’t work out. My sister was in there, that’s how my sister got it. She was in a committed relationship with a man and he was having sex with his ex and he got HIV and he gave it to her.

Motivation for HIV testing

There were several standard reasons why men got tested, such as recent exposure risk, fear, routine care, availability of testing, and having a new sexual partner. Some men decided to get tested after having an unprotected sexual experience. “Cause I didn’t have the condom when I hit that girl, so I wanted to make sure that I didn’t come up with nothing, you know

what I am saying?” One participant stated that he has been tested several times and the motivation for him was the fact that he has had unprotected sex in the past.

Cause I had a scare. Um, I was dealing with somebody. Um, using protection, but, um, the person who [I] was having intercourse with, the condom popped and, um, I didn't get tested after that. Like, I went about, like, five, six months without getting tested. Started dealing with somebody else and a friend of mine, um, bumped into me in the streets and told me about the girl I used to deal with, how she got AIDS ... I mean, HIV or whatever.

Some men felt that knowledge of their status was the biggest motivator to get tested. One participant stated that he did not want to live with doubt and got tested with his partner at the start of their relationship, because they wanted to make sure they were both negative. “Yeah, actually when I first got my girl I made her go and take a test. Nah, I wanted to make sure – you know – I'm good before I get into a relationship – you know?” Protecting not only themselves, but also their partners by not spreading a disease because of their past and current sexual activity was also a motivator for HIV testing.

If you're having sex with, you know, different partners that's what motivates you, you know, to get tested so you won't spread it. You won't spread disease. One partner shouldn't be a problem but if you're out you know, out sleeping with other people, yeah, you should get checked.

Several participants believed that a bad experience would motivate African-American men to get tested. “From my experience and opinion, it's always something bad that happens to make a [person]-really motivate a person to change and do better.”

Barriers to testing

Although the majority of the participants reported testing, they were able to describe circumstances that would create barriers to HIV testing among their peers. Dominant barriers to HIV testing were fear, low perception of risk, and stigma associated with HIV/AIDS. When asked why some men would not be receptive to taking an HIV test, they stated that some men did not feel the need to take an HIV test, because they did not see themselves as being at risk.

Exactly, it's like if I don't have it why do I need information about it? All I gotta do is like I don't fuck a bitch that have AIDS. That's how a lot a dudes look at it, like why should I go in there and get information, I know what's out there, I know that it could kill me, it could fuck my life up, but fuck that I don't need that.

Stigma associated with HIV was expressed as a barrier to taking an HIV test. Men expressed that there was stigma associated with HIV testing in the communities that they lived in. For example, one participant expressed that people fear any association with HIV, so he preferred to go to a blood drive for HIV testing to separate himself from the stigma associated with HIV testing in the community clinics.

People are probably just scared of the word. When I was in high school, I used to cheat to get my blood tested. Like I never used to go to the clinic like everybody else, or nothing like that. But when the blood banks came to the school, whatever,

like the Blood Centers would come get blood, I would always be the first one in line or whatever because you got to get your blood checked before you can give blood.

Anxiety over having a positive HIV status was another deterrent to HIV testing among African-American men in our sample.

So some people think they might have it or there's a chance they might have it but don't want to find out because the average person probably can't live with the thought knowing that I got it. Especially if I'm one of the people that think it couldn't happen to me. So now I'm living with two realities that could really break my world.

Some men felt that they would prefer not to know their status. "Well me personally, I was the type where this was my thinkin,' if I got it, I would rather not know."

Discussion

This study supports previous research that found a high proportion of African-Americans testing for HIV (Ebrahim et al., 2004; Ford, Daniel, & Miller, 2006; Liddicoat, Losina, Kang, Freedberg, & Walensky, 2006). Despite the frequency of unprotected sex and concurrent partners, most participants perceived themselves as having low or no HIV risk, an alarming finding that other studies have also reported (Adams et al., 2003; Kellerman et al., 2002; Nunn et al., 2011; Vermund & Wilson, 2002). Many participants lacked knowledge of the risk associated with engaging in unprotected sex during the window period following HIV testing and perceived themselves as being at low risk of acquiring HIV, because they had received negative HIV results. Negative test results for these men implied a false sense of security that their partners did not have HIV and it was safe for them to engage in unprotected sex. The idea of exchanging their "papers" with their sexual partners to provide security within those relationships was used to justify not using condoms and perpetuate the idea that negative HIV results meant that you were not at risk for contracting HIV. This approach has been identified in previous studies where condoms were often not used consistently after couples transitioned from being casual sex partners into exclusive relationships (Abraham, Macaуда, Erickson, & Singer, 2011; Carey, Senn, Seward, & Venable, 2010). Other studies have demonstrated that relationship characteristics, including the type of relationship (primary vs. casual), familiarity with a partner, duration of the relationship, and sharing negative HIV test results, are key factors that inform perception of risk (Chatterjee, Hosain, & Williams, 2006; Katz, Fortenberry, Zimet, Blythe, & Orr, 2000). The commonness of this behavior among the men in our sample showed that there are misconceptions about key elements of HIV testing and their risk of HIV transmission.

Recent exposure risk, having a new sexual partner, and gaining knowledge of their status were identified as motivating factors that influenced HIV testing in this sample. The primary motive for HIV testing among the participants was concern about their risk of contracting HIV due to their own sexual behaviors or behaviors of their sexual partners, such as having unprotected sex with multiple partners. Many of the men stated that a "tragic" or "scary" event would motivate other African-American men to get tested. This finding is supported

by other studies that identified persistent behavioral risk (Ford et al., 2006, 2009; Swenson et al., 2010) as individual-level motivating factors for HIV testing.

Even though nearly all of the men in the study had tested for HIV, they expressed that having a low perception of HIV risk was not only seen as a reason not to use condoms, but also as a barrier to testing. According to the Kaiser Family Foundation (KFF, 2011), among African-Americans who never tested for HIV, the number one reason for not getting tested was because they did not think that they were at risk. Low perceived HIV risk and limited HIV knowledge in this population may explain inconsistent condom use and the normative practice of concurrent partnering, which potentiates the spread of HIV infection in this population (Adimora et al., 2004, 2006; Coleman & Ball, 2007; Doherty, Schoenbach, & Adimora, 2009).

HIV stigma associated with the fear of being HIV-positive was also identified as another major barrier to HIV testing. One study among African-Americans found that stigma was among the most common reasons for avoiding HIV testing (Hutchinson, Corbie-Smith, Thomas, Mohanan, & del Rio, 2004). Many of our participants felt that their peers would prefer not knowing their status to getting an HIV test with a positive result. The men in our study felt that their peers avoided testing because of the stigma that they would be subjected to the community if they test positive. Stigma and misconceptions about HIV testing remain important issues, especially in the African-American community (Chesney & Smith, 1999; Herek, Capitanio, & Widaman, 2002; Obermeyer & Osborn, 2007; Yang et al., 2006). Positive HIV diagnosis is still associated with stigma among African-Americans (KFF, 2012).

There are several limitations of the present study. First, the data only represent the perspectives of a select group of men, living in high HIV prevalence areas and are not representative of all heterosexual African-American men. Second, testing behavior was determined by self-reports and may result in under- or overestimates of actual behavior. Last, the data presented do not go into depth on the connections between the ranges of personal, behavioral, and socio-structural factors that impact sexual risk behavior, and HIV testing. However, the larger research project explicitly recognized the role of socially structured experiences on men's behavior.

In conclusion, HIV testing is situated within the complex web of social and cultural factors surrounding the HIV epidemic in the African-American community. In this report, we explore the different motivations for and barriers to HIV testing among African-American men, including how HIV-negative diagnosis leads to continued risky sexual activities. Interventions directed toward African-American heterosexual men must address the use of "testing as prevention" as well as correct misunderstandings of the window period and the meaning of HIV test results. Future research should explore how HIV testing influences communication among sexual partners and peers, knowledge, attitudes, risk perceptions, and behaviors.

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Acknowledgments

Funding

This study was supported by cooperative agreement from the Division of HIV/AIDS Prevention, CDC award number [1-UR6/PS-000667-01]. The findings and conclusions in this report are those of the authors and do not necessarily represent the views of the Centers for Disease Control and Prevention.

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Table 1

Straight Talk formative phase: focus group participants, New York City, 2009.

Focus group	Number of participants	Risk level	Focus group content
1	6	Low	Sexual behavior
2	9	High	Sexual behavior
3	5	High	Sexual behavior and intervention content and approaches
4	6	Mixed	Intervention content and approaches
5	8	High	Intervention content and approaches

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Table 2

Straight Talk formative phase: selected sociodemographic characteristics by risk group, New York City, 2009.

Variable	Total % (n = 56)	Risk group		p-value
		High risk % (n = 36)	Low risk % (n = 17)	
Age, year (SD)	32.9 (7.9)	33.82 (6.90)	31.35 (9.81)	0.42
Heterosexual (self-described)	96	100	88	0.09
Born in USA	98	97	100	1.00
Education (High School/Equivalency Diploma)	75	74	76	1.00
Income (\$10,000 annually)	66	69	59	0.54
Employment status (unemployed)	62	60	67	0.610
Public assistance	61	64	53	0.547
Incarceration lifetime	86	92	71	0.047
Incarceration in the past year (n = 48)	69	72	58	0.37
Have child(ren)	66	69	59	0.54
Live with children (n = 37)	24	28	20	0.360
Financially supports children (n = 28)	89	95	75	0.19

Table 3

Straight Talk formative phase: behavioral risk characteristics by risk group, New York City, 2009.

Variable	Risk group			<i>p</i> -value
	Total % (<i>n</i> = 56)	High risk % (<i>n</i> = 39)	Low risk % (<i>n</i> = 17)	
Primary female partner, past 3 months ^a	71	67	81	0.34
Female sex partners, past 3 months (<i>n</i> = 48; SD)	4.61 (6.00)	5.28 (6.87)	3.06 (2.86)	0.029
Female sex partners, no condom use (mean, SD)	2.60 (2.82)	3.06 (3.17)	1.38 (0.65)	0.001
At least one episode of vaginal/anal sex, no condom use	87	90	80	0.40
HIV test, ever	98	97	100	1.00
HIV test, past year ^a	82	82	82	1.00
Discussed his HIV status with some/all partners ^b	78	74	100	0.54
Discussed his partners' HIV status(es) with some/all partners ^a	69	64	81	0.34

^a *n* = 55 due to missing data.^b *n* = 27 due to missing data.