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African American Patient Experiences with a Rapid HIV Testing Program in an Urban Public Clinic

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Abstract

Background—Of 1,174 new HIV cases diagnosed in Philadelphia in 2008, 771 (66%) were among African Americans. In 2007, Philadelphia introduced a citywide rapid HIV testing program in public clinics.

Methods—We conducted a prospective qualitative study among 60 African Americans undergoing rapid HIV testing in one of Philadelphia's public clinics located in a zipcode with high HIV incidence. Employing grounded theory, we used semi-structured interviews to assess patients' motivations, perceptions and clinical experiences with rapid HIV testing. Interviews were transcribed and coded; 20% were double coded to enhance reliability.

Results—Primary motivations for undergoing rapid HIV testing included: testing during routine clinical care, presenting for care with symptomatic STIs or opportunistic infections, knowing someone living with HIV/AIDS, and perceiving oneself at risk for HIV. Most patients reported positive experiences with rapid testing and preferred it to conventional testing because it eliminated the need for return visits and decreased anxiety; however, many expressed concerns about accuracy of rapid HIV testing. Barriers to HIV testing among this population included low self-perceived risk, HIV stigma and reported homophobia in respondents' communities.

Conclusion—This rapid testing program was acceptable, convenient, and preferred over conventional HIV testing. Providing educational information about rapid and confirmatory HIV testing may further enhance acceptability of rapid HIV testing in this population. Nationwide expansion of rapid HIV testing in public health centers is an important and acceptable means of

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achieving President Obama's National AIDS Strategy goals of reducing racial disparities in HIV infection and HIV/AIDS treatment services.

Keywords

Rapid HIV testing; African American; HIV/AIDS

Introduction

More than 1 million people in the United States live with HIV/AIDS, 21% of whom do not know they are infected.¹ Although more than 50,000 individuals in the United States become newly infected each year,² only 45% of adults have ever been tested for HIV.³ HIV-positive individuals unaware of their HIV status are 3.5 times more likely to transmit the virus than individuals who know they are HIV positive.⁴

African Americans are disproportionately infected with HIV. They represent 12% of the American population,⁵ but account for approximately 45% of newly acquired HIV infections and have HIV infection rates seven times higher than those of white Americans.²

African Americans face considerable disparities in access to HIV/AIDS treatment and care services, are more likely to present for HIV testing late in their course of infection,⁶ and are less likely to receive highly active antiretroviral therapy (HAART) than people of other races.⁷ In 2006, AIDS-related mortality in African Americans was almost double that of white Americans.² However, African Americans test for HIV at higher rates than individuals of other races;^{8–12} a 2010 CDC analysis of nationwide HIV testing trends finds that 62% of African Americans had ever undergone HIV testing, compared to 41% of whites and 48% of Hispanics.³

To reduce HIV infection rates, the Centers for Disease Control and Prevention (CDC) endorsed routine, opt-out HIV testing in medical settings in 2006.⁶ This new strategy eliminated requirements for pre-test counseling and separate written informed consent included in previous HIV screening guidelines.⁶ This strategy aimed to enhance HIV prevention, as individuals who test HIV-positive are more likely to reduce risk-taking behaviors.⁴

Philadelphia's HIV incidence rates are more than 5 times the national average. Among 1,174 new HIV cases diagnosed in Philadelphia in 2008, 771 (66%) occurred in African Americans; two percent of Philadelphia's African American population lives with HIV/AIDS.^{13, 14} To address this issue, the Philadelphia Department of Public Health launched a city-wide rapid HIV testing program in public health clinics in 2007. Seven of the Philadelphia's city-sponsored public sexually transmitted infection (STI) and primary care clinics began routinely offering rapid HIV tests during all clinical visits. The program focuses on uninsured or underinsured individuals, many of whom have limited access to health services. The program uses the Oraquick® ADVANCE Rapid HIV-1/2 Antibody Test, in which an oral mucosal swab specimen is obtained and results are delivered within 30 minutes. Approximately 13,000 people were tested from August 2007 until January 2010, and approximately 88% of all testers were African American.^{15, 16} A recent analysis of HIV

risk behaviors and outcomes finds that this population engages in high-risk behaviors. For example, 24% of respondents reported a history of cocaine use, 10% reported having ever had a same sex partner, and 18% report having ever had an STI.^{15, 16} Of all individuals diagnosed with HIV through the rapid testing program, approximately 92% of individuals with more than 5 sex partners reported that they never or only sometimes used condoms.^{15, 16}

Patient experiences with rapid HIV testing in urban health clinics have not been well explored with qualitative research, particularly among high-risk, urban African Americans. Expanding rapid HIV testing in urban clinics is particularly important in light of President Obama's National AIDS Strategy and commitment to reducing racial disparities in HIV infections in the United States.¹⁷ To better understand patient motivations for testing, patient experiences with rapid testing, and opportunities for improving HIV testing and prevention programs, we conducted sixty qualitative interviews among African Americans who underwent rapid testing for HIV in a public urban health center in a high-incidence zone of North Philadelphia.

Methods

Sixty African American patients were recruited by a trained medical assistant during the course of regular clinical care at a public clinic in North Philadelphia. Recruitment and interviewing took place two afternoons per month between March and December 2009. Patients were offered an opportunity to participate and declining to participate did not impact clinic care. Because Pennsylvania law requires written consent and HIV counseling,¹⁸ standardized risk reduction counseling was also provided to all participants. Qualitative interviews took place immediately after an HIV test or within approximately one week of testing at a convenient time for the patient. Interviewers and patients were aware of patient test results at the time of interview. Participants were 18 or older, self-identified as African-American, and provided written and verbal informed consent. To ensure some demographic diversity among our group of respondents, we made every effort to recruit heterosexual, homosexual and bisexual individuals. We also oversampled individuals who tested HIV-positive in order to incorporate their perspectives into our findings. This research was approved by the Lifespan and Philadelphia Department of Public Health Institutional Review Boards.

We used the "grounded theory" qualitative interviewing approach in which data collection informs development of theory building and subsequent data analysis.¹⁹ A semi-structured interview guide was developed and informed by literature on HIV testing among African Americans,⁸⁻¹² data on Philadelphia's HIV/AIDS epidemic,¹⁴ and perceived and actual HIV infection risks reported among individuals undergoing rapid HIV testing in Philadelphia (Nunn, 2010). Participants were first asked a series of standardized demographic questions. The semi-structured interview guide was then used to explore patients' experiences with rapid HIV testing, primary patient motivations for testing, and opportunities for improving HIV testing and prevention programs. The semi-structured interview consisted of open-ended questions, was designed to elicit a wide range of responses, and allowed the respondent as well as the interviewer to freely introduce new topics.²⁰ Interviews were

conducted by trained research assistants, digitally recorded and captured electronically on computer software, and professionally transcribed. Identifying information was removed from transcripts and demographic questionnaires to ensure patient confidentiality.

Interview transcripts were analyzed using a comprehensive coding process. The first reading was deductive and allowed coders to read and capture participants' answers to individual questions. The second review looked for themes in the text. In accordance with grounded theory,¹⁹ the study employed an "open coding" process in which themes were grouped according to topics that arose during the interview, rather than using predetermined topics chosen prior to the interview.²¹ To help ensure reliability and validity of the study's findings, approximately 20% of the interviews were coded by more than one data analyst. Double-coded transcripts were then reviewed for concordance. We identified discrepancies in coding for only two interviews; these discrepancies were discussed and resolved among data analysts.

Results

Participant demographics are summarized in Table 1. Two-thirds of participants were male and unemployed; the average age was 32. Seventy percent (42/60) of participants self-identified as heterosexual. The overwhelming majority of patients (53/60) were single. Twenty percent of participants (12/60) had reactive rapid HIV tests; all twelve received confirmation of positive test results and were newly diagnosed with HIV as a result of the rapid HIV testing program. Just over half reported having stable housing (35/60) and health insurance (36/60). Nearly two-thirds (39/60) of participants reported being incarcerated one or more times.

Motivations for testing

Patients visiting the health care center reported a variety of motivations for undergoing rapid HIV testing (Table 2). The two most common reasons patients underwent testing is that they requested an HIV test while being treated for symptoms of an STI (15/60), and that an HIV test was offered during the course of a routine health care visit (14/60). Other common motivations included perceiving themselves at risk for HIV infection (10/60) or having a family member test positive for HIV (9/60). Several patients reported completing testing as part of a drug treatment program (7/60); others reported testing regularly for HIV (5/60).

Testing during the Course of Routine Clinical Care

Many patients tested for HIV because it was offered during the course of routine clinical care, and many remarked that they otherwise would not have tested. For example, one patient remarked:

The lady came and asked me if I wanted to take an HIV test. And I said, sure, why not? So I took it.

Women in particular frequently mentioned they tested for HIV because it was convenient and bundled with other clinical services. One woman diagnosed with HIV during the course of routine testing remarked:

I didn't know [my status], but I was just making sure. I've been doing that [testing] for the past few years. Any time I go to a clinic for something I just get one done, but I just never expected it to come up positive, but I always get it done just to make sure.

Symptomatic STIs or Opportunistic Infections

Oftentimes, patients chose to test for HIV because they were being treated at the clinic for another STI. One male patient remarked:

Well, I'm bisexual, so me and my partner... I kind of contracted something and when I came in she asked me if I would take an [HIV] test and I said 'no problem' because I couldn't remember the last time I took one. And it came out positive.

Many male patients understood their HIV risks but only presented for testing after experiencing STI symptoms. Another male patient remarked:

What brought me in to get tested was another problem dealing with outbreaks in my mouth and something that turned out to be another STD.

In some cases, patients decided to test only after presenting with symptoms of opportunistic infections associated with AIDS. One patient remarked:

I pretty much knew the signs and symptoms [of AIDS]. I had white patches in my mouth, which I knew that my immune system had to be compromised in order to be getting thrush. I couldn't breathe at all and they were sending me to the hospital, and I told the nurse I didn't want to go. I had too many things, loose ends I had to tie up. I couldn't leave my car outside; I couldn't do this or that. I just had every excuse in the book. And then I finally asked for an AIDS test, an HIV test.

Perceived HIV Risks

Several participants commented that they routinely completed HIV testing because they perceived themselves to be at risk for HIV. This was particularly common among women who perceived they might be at risk for contracting HIV because of their partner's risk-taking behaviors. For example, one woman commented:

[He and I] live together. But it's better to be safe than sorry, and I just wanted to know.

Another woman whose partner was an injection drug user explained why she decided to test:

Just to make sure. I do it [test] more than I'm supposed to.

On the other hand, some patient's risk perceptions were based on their own recent risk behaviors. Two patients commented:

I needed an HIV test because I was [engaging in] risky behavior. I knew I had to have it done because I've used drugs intravenously and I had a sex partner that was HIV-positive.

I was scared. So scared! Because I had unprotected sex and I knew that the women were out there doing with other people what they were doing before they were

doing it with me. I was on pins and needles. I actually started crying and went to the bathroom because I thought I had AIDS.

Several participants also explained that having family or friends diagnosed with HIV affected their HIV risk perceptions and decisions to get tested. One man explained his motivations for testing regularly:

Well, now I get tested; before I didn't. My cousin died of AIDS and I was really scared to get tested. And finally I just said, "Let me go ahead and get myself tested." And I got myself tested and from then on, I knew it was okay. Now I know I have to get myself tested every couple months.

Another respondent commented:

[When I got tested], I was nervous. I thought, "Lord, please don't let me have HIV." My father passed away of AIDS in 1996. Before he passed away, he was incoherent, but I understood everything he was saying. He basically was telling me don't be sleeping with this person and this person and going around sleeping around. After he told me that I always tried to stick with not having a whole bunch of sexual partners but I was worried because I was having and have had unprotected sex.

Similarly, one female patient who presented with STI symptoms and was newly diagnosed with HIV commented:

I'm glad that the HIV test was included...because my sister is HIV-positive and she's had it for twenty years. In my nursing, I have worked with a lot of people with HIV, and I didn't want to get it [HIV].

Another man commented:

I got a sister with AIDS and it just seems like everybody is popping up with AIDS, so I decided to stop using drugs and get tested to make sure I was good.

Barriers to Seeking HIV Testing

In general, individuals understood how HIV is transmitted; knowledge about HIV/AIDS transmission was not an obstacle to HIV testing among this population.

Some patients cited their partner's HIV-negative status as a reason they hadn't previously tested for HIV and for their own low perceived HIV risk. One man commented:

My son's mother would always get tested and hers would always be negative. I was thinking that because she's negative, I'm negative. But then when I took the test and it came back positive, it really took me by surprise.

Several participants commented that HIV prevention initiatives encouraging African Americans to get tested should incorporate more messages about personal responsibility and community pride to stimulate more demand for testing. One man remarked:

I bring up personal responsibility – because there really isn't a real strong campaign advocating personal responsibility. I know, and most of the ads that I saw were

informative ads. I don't really need to know any of the statistics. I don't really need to know any of the possible outcomes, because I already know that! You need to let me know, you need to grab me by the collar, and say "You know what the right thing to do is!"

Perceived Community and Individual HIV Risks

While most individuals perceived the African American community at large to be at risk for HIV infection, many patients did not perceive themselves to be individually at risk. This finding was common even among individuals engaging in high-risk behavior. For example, one heterosexual woman with four concurrent sexual partners perceived her own HIV risk as low, but commented on young African Americans' high risks:

I'm a grown woman, so I'm aware of what's out there. I'm a mother, I'm somebody's woman, I'm a daughter, I'm a sister, I'm a niece. So I want to live to be around. I have something to live for. But in my circle of friends you have people that express themselves through getting high, drinking and obviously through sex and money. Let me say that, let me just put that out there. In the black community the younger generation, they're careless, and I see it a lot and I hear it a lot. Now the older people, we're a lot more careful because we're aware of what's going on and what's out there. But the younger generation in my neighborhood, it's like the young kids, they express themselves with sex. You see it outside; you see it on the corner, in the schools. The young generation, they don't care if you can get HIV or an STD. Everybody in the younger generation thinks "not me, it couldn't happen to me." But I can say that there is a lot of unprotected sex going around in the younger generation because even my neighbor's daughter, she's had Chlamydia maybe four or five times.

Individuals who understood community HIV risks often expressed surprise and disbelief at their positive HIV test results. One woman commented:

You see the commercials every day... And that's the whole reason I took the test. I came here to get my physical filled out and thought I might as well take the HIV test, so I took the mouth swab, and when I came back she told me I was positive. And when she first said it like it didn't really hit me like... like positive! It was like... positive?

Patient Perceptions about Conventional vs. Rapid HIV testing

Rapid testing was well-received by patients visiting the health center. Several patients identified the return visits required for conventional testing result delivery as a key reason for not receiving previous HIV test results. When asked whether they preferred rapid HIV testing to conventional HIV testing, patients generally preferred using the rapid HIV test. The majority of patients expressed satisfaction with the rapid test, understood the meaning of their test results, and did not feel that any changes needed to be made to the counseling or testing process. One patient commented about the rapid testing process:

I don't really think there's anything you can do to improve the (rapid) testing. I think it's the best thing you guys have got so far.

Another patient commented:

It was a really positive experience. The person giving the test gave the usual warnings that they tell you right before you take the test, but in a positive manner. I felt comfortable taking [the rapid test]. The blood draw almost makes you feel like you have something.

Receiving results within 30 minutes was the most common reason cited by participants for preferring the rapid test. Patients often explained that the fast results of the rapid HIV test helped reduce anxiety and stress that is often experienced with traditional HIV testing methods:

I prefer to have it right then and there so I won't set up with worries, sweating and can't sleep, can't eat, wondering if I got it... I'd rather have [the result] the same day, that's why I like the mouth test better.

I like the rapid test. It's best to know right away so you won't be worried.

If I wait, then I'm going to think something that they going to tell me I'm positive; if I wait too long, then I'll think that I have HIV.

When I was waiting for them to test the blood [for the conventional method] my heart was racing and I'd think "Oh, come on, please, no, no." When they came out with the rapid test, I would know right then and there and how to prepare if it was positive, what to do from there.

Some patients who preferred oral rapid testing attributed their preferences to fear of needles. Others cited oral rapid testing as less invasive, while others noted health care providers had previously experienced difficulty drawing blood:

The rapid test is a lot easier because sometimes [the person drawing blood] misses.

I'd rather do the oral test because it's easier; you don't have to worry about... some people are scared and I'm not really scared of needles, but they aren't exactly comforting. Not to mention the fact it's always in the back of your mind, wondering if the needle is even clean or not, so I definitely would rather just do an oral test.

Notably, several patients commented that learning their HIV status on the same day of their visit impacted their sexual risk behaviors and could play a role in preventing HIV transmission. One man responded:

I just want to know right then. It's scary because, you know... but then that week or two before you come back, you think "Am I ok?" And then during that time others may go out and do stuff and next thing you know, it comes back and you're positive, and you've slept with a few people.

Another man expressed a similar sentiment:

I'd rather know early than not know so I won't spread it to anyone else. Despite patient satisfaction with quick results associated with the rapid test, numerous patients believed that

rapid testing is less accurate than conventional HIV test. Two patients expressed concern about the rapid test:

I hear that's not really accurate. Some come up positive and they take the real test and it's negative, so they've got the antibodies or something.

I wanted them to do the blood test, you know, because blood...your blood doesn't lie. And it was like a rapid test--twenty minutes--I really didn't know. I never took it before, so I didn't know what it was.

Other patients commented:

Um, I would prefer the blood. I think it's accurate, more accurate than... I mean if I could do both I would be satisfied because one may not show, the other may show.

I prefer the best thing. I think the blood draw is better than the swab because, it's your blood, so like nothing can go wrong, right?

Many patients did not understand the difference between the rapid test and the conventional blood test. For example, one patient inquired,

I don't understand the mouth swab completely. What's that for?

Another remarked:

Well, I don't know whether there is a difference between a rapid test and a blood test because the blood test is actually the blood itself. And the rapid test is like the swab. So I think the blood test would be more efficient than the swab test. I don't know the intent of it but I guess because it came up negative, I was cool.

The Impact of Stigma on HIV Testing

Many patients mentioned they hadn't tested previously because of the heavy stigma associated with HIV/AIDS in the African American community. One individual explained that homophobia in the black community contributed to his decision and the decisions of other African American MSM not to test or publicly disclose their HIV status:

There is a lot of pressure in the black community. The black community is not as receptive to variations in lifestyle. They will deny their own. Other races will not necessarily say that they are respectful of HIV; however, they are more tolerant of HIV than African Americans.

One man who tested positive explained that he postponed testing for HIV because he suspected he was positive and would not feel comfortable disclosing his status to his friends and family:

I know they are going to view me differently. I mean, everybody will say, I'm not going to look at you differently, but actions speak louder than words. You can say one thing and then do something to push me off all the time...One of my friends, he's 24, and he was just telling me one of his friends had found out that he was positive, and he looked at his friend differently...so, my closest friends, I really can't tell them. And like my immediate family, no.

Similarly, many individuals who tested HIV-positive explained that they hadn't disclosed their status to their families or partners because of fear of social stigma associated with HIV. One individual explained:

My mom and my grandmother know and they help me the best way they can, but they don't really know how to... they don't know what to say to me about it or how to address it...because it's a touchy issue. When you tell certain people, it's like they even look at you differently or like back up from what you like... like it's like an ill factor.

Clinical Care and Social Support for Newly Diagnosed Individuals

Patients testing HIV-positive often reported that counselors provided information that helped them understand the clinical and social implications of their diagnosis. One HIV-positive patient commented:

I'm doing good. I've got the information that lets me know it's not a death sentence. So I was not ready to jump off a cliff -- because it's not fatal-- and I'm informed enough to know that if I get treatment and take care of myself, then it'll be all right.

Some patients expressed gratitude to the counselors they spoke with, commenting that the experience with the counselor helped them to better cope with a positive HIV diagnosis.

A lot of people just don't know that you can live a long time with HIV. And I was ignorant myself until I talked to the testing counselor. She explained a lot to me. It's like having diabetes, cancer, it's like any other disease you may have. So I've learned to look at it like that. I'm dealing with it.

Ripple Effects of the Testing Program

The testing and counseling experience also prompted several individuals to encourage their partners and children to change their behaviors and test for HIV. Women in particular expressed desires to encourage others to undergo HIV testing. Several women commented that they encouraged their partners to test:

I ask him do he go to the doctor...I ask him if he gets tested. I tell him to go be tested every three to six months to make sure he's fine.

Another woman said that after her testing experience, she encouraged her children to use condoms and test for HIV:

I told them, "Protect yourself. If you're going to have sex, use a condom. I'm not going to force you to do anything you don't want to do but I hope you will be getting tested every three to six months."

Another explained how he urged his friends to get tested:

I tell them, don't be scared. It's not going to hurt to get tested. If you don't know, you might have HIV. That's the risk you take. So get tested!

Discussion

All study respondents understood how HIV is transmitted; knowledge about HIV transmission was not a barrier to HIV testing in this population. In spite of this knowledge and patients' general understanding of the African American community's higher risk for HIV, many members of this population engaged in high-risk behaviors yet perceived their own HIV risk as low. This finding is supported by other quantitative research on the population of patients undergoing rapid testing for HIV in Philadelphia, which found that high rates of self-reported HIV-risk taking behaviors do not correlate with patients' low self-perceived HIV risks (Nunn, 2010).¹⁶ In spite of perceiving community HIV risks as high, many patients perceived their own risks as low, and this perception influenced participants' past and current decisions to undergo HIV testing. This suggests that complex social phenomena underlie self-perceived HIV risk, HIV risk-taking behaviors and HIV testing trends in this population. These phenomena may contribute to widening HIV/AIDS disparities in the city of Philadelphia.

Philadelphia's rapid testing program has nevertheless successfully reached high-risk African Americans with limited access to health services and insurance and high prevalence of STIs (Nunn, 2010).¹⁶ We found that routine rapid HIV testing was well-received among a diverse group of African Americans in an inner-city public clinic. Most of these patients are at high risk for HIV because of their risk-taking behaviors, high prevalence of other STIs, or simply because they reside in areas of high HIV prevalence.¹⁴⁻¹⁶

Several studies show that patients who undergo conventional HIV testing often do not return for test results.²²⁻²⁴ Urban populations are more likely to utilize emergency departments and city clinics for non-urgent health care,^{25, 26} and are also at higher risk for contracting HIV.²⁷ Inner-city emergency departments and health clinics are therefore prime venues for HIV testing for undiagnosed patients living with HIV and those at risk for contracting HIV.^{28, 29} Rapid HIV testing reduces waiting time for test results and is an effective means to identify new HIV cases and link more people living with HIV/AIDS to medical care, particularly high-risk populations with limited access to medical services.³⁰⁻³³ Rapid, routine HIV testing has been shown to be effective in diagnosing new HIV cases.³⁴⁻³⁶

This study underscores these findings for a high risk, inner-city African American population. Many patients presented with symptoms of opportunistic infections or STIs and reported that they likely would not have tested for HIV in the absence of routine testing. Our findings suggest that providing routine rapid HIV testing in public health centers in urban areas represents an important opportunity to reach high-risk African Americans, and a potentially important opportunity to link HIV-positive patients to HIV/AIDS treatment and care services.

Nevertheless, fear and stigma were common barriers to HIV testing in this population, even for individuals who perceived themselves at high risk. Moreover, homophobia in this African American community contributed to individuals' failure to disclose their HIV status as well as historical decisions to forego HIV testing. These findings underscore other research that highlights high rates of stigma related to HIV/AIDS³⁷⁻⁴⁰ and homosexuality⁴¹

in the African American community. African Americans report higher rates of stigma and discrimination against people living with HIV and AIDS than individuals of other races⁴² and higher rates of stigma associated with homosexuality.⁴¹ Other research finds that stigma undermines HIV prevention and risk-reducing behaviors such as condom use, HIV testing, and disclosure of serostatus to partners.⁴⁰

Our findings about patients' positive experiences with HIV testing and counseling suggest that integrating HIV testing into routine clinical care may help mitigate stigma associated with HIV/AIDS in the African American community. Our findings underscore the feasibility, acceptability, and importance of expanding rapid HIV testing as part of routine clinical care to reach African Americans at high risk for contracting HIV, particularly those with limited access to health services. Importantly, our findings also suggest that providing routine opt-out testing in community health centers may have positive ripple effects in the community, as many patients, particularly women, reported that testing for HIV also prompted them to encourage family, friends and other contacts to test for HIV.

Nearly all patients preferred rapid to conventional HIV testing, citing the convenience of providing immediate results, preference for non-invasive procedures, and reduced anxiety about waiting for test results. It is worth noting, however, that misperceptions about the accuracy of rapid HIV testing were very common. These findings suggest it may be important to provide more verbal or written information about the accuracy of the rapid HIV test during testing programs and the role of confirming reactive rapid tests with further blood testing.

Our study is subject to several limitations. First, our findings are limited to African American patients who underwent rapid testing in a public health clinic in Philadelphia. Secondly, although we made every effort to recruit a diverse group of both HIV-positive and HIV-negative individuals, as well as heterosexual, homosexual and bisexual individuals, this study focused on a targeted population of 60 high-risk African Americans at an urban public clinic in Philadelphia, so the results may not be generalizable to all African Americans or even to all African Americans undergoing rapid HIV testing in Philadelphia. As with any qualitative study, interpretation of the results may be subject to the biases of the interviewers, data analysts and principal investigator. However, we made every effort to bolster validity by informing our analyses by the peer-reviewed literature and double-coding and discussing analyses within the team. In spite of the aforementioned limitations, our findings offer important lessons about the experiences and opinions of urban African Americans about a large-scale rapid HIV testing program.

Conclusion

The Philadelphia rapid testing program successfully tested many individuals who reported engaging in high-risk behaviors but did not perceive themselves to be at risk for contracting HIV. Most of these individuals also had limited access to health services. Our study suggests that African Americans undergoing rapid HIV testing at Philadelphia's public health clinics preferred rapid testing to conventional testing and were generally pleased with the rapid HIV testing program. However, misconceptions about the accuracy of rapid HIV testing persist,

and many reported that HIV-associated stigma was a critical impediment to more widespread HIV testing in the African American community.

Expanding rapid HIV testing among urban African Americans is feasible and well-received. Expanding rapid HIV testing, improving awareness and health literacy about rapid HIV testing technology, and addressing HIV/AIDS stigma in the African American community should be critical components of strategies for reducing racial disparities in HIV diagnosis and treatment in the United States.

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Table 1

Demographic Information

Variable	N	%
Gender		
Male	40	67
Female	20	33
Self-reported Sexual Orientation		
Heterosexual male	24	40
Homosexual male	7	12
Bisexual male	7	12
Heterosexual female	18	30
Homosexual female	2	3
Bisexual female	2	3
Average Age	32	
Employment		
Employed	20	33
Unemployed	40	67
HIV Status		
Positive	12	20
Negative	48	80
Marital Status		
Single	53	89
Married	5	8
Divorced	2	3
Ever Incarcerated		
Yes	39	65
No	21	35
Permanent Housing		
Yes	35	58
No	25	42
Health Insurance		
Yes	36	60
No	24	40

Table 2

Primary Motivations for Testing

	Respondents
Presented with STI symptoms	15
Tested during routine (non-HIV related) clinical care	14
Perceived personal HIV Risk	10
Partner or family member living with HIV	9
Testing as part of drug treatment program	7
Tests regularly for HIV	5
TOTAL	60