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Attitudes Toward HIV Voluntary Counseling and Testing (VCT) Among African American Men Who Have Sex with Men: Concerns Underlying Reluctance to Test

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Abstract

Contemporary antiretroviral therapy (ART) can produce viral suppression of HIV, maintain health, and prevent onward HIV transmission from infected persons to their sexual partners, giving rise to the concept of treatment as prevention. Successful implementation of test-and-treat strategies rests on the early detection of HIV infection through voluntary counseling and testing (VCT) followed by entry and retention in care, ART initiation and adherence, and subsequent viral suppression. In the United States, African American men who have sex with men (MSM) bear a disproportionate burden of HIV and have high rates of undetected and untreated HIV infection. However, little research has examined racial minority MSM's views about HIV testing. In this study, in-depth interviews were conducted with 96 key informants knowledgeable about racial minority MSM as well as 100 African American MSM community members in Milwaukee, Cleveland, and Miami. Most men in the sample were aware of the availability of testing and knew testing locations, but many voiced great personal ambivalence about being tested, feared knowing their HIV status, expressed concern about stigma and loss of confidentiality, and held beliefs indicative of medical mistrust. Participants did not spontaneously cite benefits of being tested, risk reduction behavior changes made as a consequence of testing, nor the benefits of testing to get early medical care for HIV infection. There is a gap between the public health field's perception of testing benefits and the beliefs about testing held by racial minority MSM in this sample. To increase the desired outcomes from VCT for minority MSM, VCT promotion should address the concerns of African American MSM and underscore the benefits of early entry into medical care.

Introduction

Voluntary counseling and testing (VCT) has long been a cornerstone of public health efforts to prevent HIV infection. Since early in the epidemic, serostatus knowledge has been seen as a means to motivate risk reduction behavior changes to avoid future risk if uninfected, and — if infected — to refrain from practices that could transmit the disease to others and to

enter into care. Numerous studies have examined the impact of VCT on risk behavior patterns, generally confirming reductions in sexual risk practices among persons who learn they are HIV-positive, but less often showing risk behavior reduction among those who learn they are HIV-negative.

The role and public health significance of VCT now extends much further than motivating changes in risk behaviors. Contemporary antiretroviral therapy (ART) regimens, if initiated early, can dramatically reduce HIV-related illnesses, lessen risk of premature death, and maintain health and quality of life over sustained periods. Viral suppression produced by ART also greatly reduces infectivity and the likelihood of transmitting the disease from an infected person to sexual partners, giving rise to the conceptualization of HIV treatment as a potentially powerful means of prevention (Cohen et al., 2011; Dieffenbach & Fauci, 2009). Mathematical models show that wide scale viral suppression among persons living with HIV (PLH) can substantially reduce downstream disease incidence at a community level (Granich et al., 2009). Consequently, a major new direction in HIV prevention is to employ treatment, and especially early initiation of ART, as a strategy for HIV prevention.

Gardner and colleagues (2011) articulated a continuum of steps needed to achieve viral suppression beginning with HIV testing, progressing through engagement and retention in medical care, and ending with sustained ART treatment adherence resulting in viral suppression. The initial step in this care continuum is testing to detect HIV infections early, since HIV treatment cannot be initiated without diagnosis. Although the CDC now advocates universal opt-out and routine HIV testing at points of contact with health care systems (CDC, 2006), young high-risk men—and especially racial and minority men—often have little contact with health service providers. Therefore, regular and frequent VCT continues to be a strategy important for the early identification of HIV infections, for engaging infected persons into care, and—potentially—for moving a greater proportion of PLH toward the goal of viral suppression.

Nearly one in five PLH in the United States remain unaware of their HIV infection (CDC, 2013) and a large number of persons continue to be diagnosed at late, rather than early, stages of their disease course. Prior studies with MSM identified factors associated with not having an HIV test that included fear of learning about one's positive status, risk underestimation, perceived negative consequences of testing, lack of awareness about improvements in treatment, and lack of knowledge about the availability of low-cost or free HIV treatment (Adams et al., 2003; Hoyt et al., 2012; MacKellar et al., 2011; Mikolajczak et al., 2006; Schwarcz et al., 2011). However, and with the exception of Hoyt et al. (2012), these samples were not composed primarily of racial minority MSM.

Because they are disproportionately burdened by HIV, an important question is whether testing efforts are adequately reaching African American MSM and, if so, whether they are yielding the desired public health benefits. From the time when the disease first appeared in the United States, gay or bisexual men consistently have been most affected by HIV infection. In 2010, for example, more than 50% of incident HIV infections in the US and more than 75% of infections diagnosed among men were attributed to sexual contact by men with other men (CDC, 2012). This disparity is even greater among racial minority MSM.

Although African Americans comprise approximately 12% of the U.S. population, they represent 47% of incident infections (MMWR, 2008). The most shocking disparity is evidenced at the intersection of sexual orientation and race. African American MSM constitute no more than a small fraction of a percent of the general population, yet represent over 25% of incident infections and more than 30% of infections diagnosed among gay and bisexual men (CDC, 2009). Decades of sentinel surveillance studies consistently establish higher HIV incidence and prevalence among African American MSM than among MSM of other races and ethnicities (Blair et al., 2002; Catania, et al., 2001; Harawa, et al., 2004; Torian et al., 2002; Balaji et al., 2008).

A number of quantitative and epidemiological studies have compared MSM from different racial and ethnic groups in an effort to explain this persistent racial disparity. Literature reviews and published meta-analyses have not yielded persuasive evidence that African American MSM have more frequent unprotected intercourse, more sex partners, or lower rates of condom use than white MSM (Millett et al., 2007; Millett et al., 2006), nor have they identified differences in individual-level mediating variables such as HIV-related knowledge, attitudes toward condom use, or self-efficacy beliefs (Crawford et al., 2002). More recently, research is broadening its lens to examine contextual factors that may contribute to greater HIV vulnerability for African American MSM, including attention to whether sexual networks may increase the probability that African American MSM will encounter partners with undiagnosed or untreated HIV infection or STDs that increase the risk of contracting HIV (Bingham, et al., 2003; Murrill et al., 2008; Peterson et al., 2009; Raymond & McFarland, 2009). Other research has examined the influences of racism and discrimination, homophobia in the African American community, social and economic oppression, limited health care access, substance use, and beliefs about masculinity as contextual factors that contribute to greater HIV vulnerability for African American MSM (Brooks et al., 2005; Fields et al., 2012; Kraft et al., 2000; Mays et al., 2004; Stokes & Peterson, 1998; Teunis, 2007). These contextual influences may also affect the willingness of African American MSM to seek VCT.

If the goals of the National HIV/AIDS Strategy to reduce HIV incidence and health disparities are to be realized, there is compelling need to clarify whether VCT is effectively reaching African American MSM and whether it is achieving its aims (Office of National AIDS Policy, 2010). In the qualitative research reported here, African American MSM and key informants in three cities were interviewed to elicit their views about VCT, its perceived benefits and costs, and the extent to which testing influences preventive behaviors. We explored, but did not put forth *a priori* hypotheses concerning, African American MSM's beliefs about VCT and its impact on their personal behaviors in order to allow men's perspectives to freely emerge.

Methods

Men in this study were participants in formative research that preceded "Connections Creating Change (C3)," a social network HIV prevention intervention trial currently underway with African American MSM.

Sampling and Recruitment

In-depth interviews were conducted from February through November, 2011 in three US cities. Interviews were undertaken with 96 key informants knowledgeable about the African American MSM community (Milwaukee, n=23; Cleveland, n=39, and Miami, n=34) and with 100 African American MSM (Milwaukee, n=31; Cleveland, n=39; and Miami, n=30). Along with other topics, these in-depth interviews elicited the men's views regarding VCT as well as their beliefs regarding the acceptability and perceived impact of testing.

Initial key informants were identified by staff at two AIDS service organizations and an NIMH-funded HIV research center, each with years of experience working in their local African American MSM community. Each site identified approximately 20 local key informants including key health department staff, HIV/STD clinical health care providers, leaders of community-based organizations, managers of clubs and social venues, parents of house balls, and other leaders within the African American MSM community. At the end of these first round interviews, key informants were asked to identify other key persons who were knowledgeable about the African American MSM community to participate in the in-depth key informant interviews. This iterative process continued until saturation was reached and no new information was emerging.

Additionally, we recruited African American MSM community members in each city. Potential participants were accessed through venues and locations that were identified by the key informants as local gathering places for African American MSM. African American men were sampled purposively to maximize heterogeneity in age, degree of "outness" or hiddenness, gender identity, and self-identified sexual orientation. All participants provided informed consent prior to the interview and received an \$80 incentive for their time. Project protocols were approved by the IRBs at the Medical College of Wisconsin, Mississippi State University, and each participating agency.

Interview Guides

Interviews asked participants about a broad range of social and behavioral issues including: (1) how they believed African American MSM felt about VCT; (2) the availability of VCT in their communities; and (3) views about VCT. Participants who had been tested were asked additional questions about their experiences living with the disease (if seropositive), disclosure of their status to existing or potential sex partners, and how learning their serostatus had influenced their personal behavior. Appendix A lists the relevant questions that were posed during the interviews. All interviews were conducted by African American MSM study staff who were trained in qualitative interviewing and who worked collaboratively with project co-investigators to construct the interview guide. Interviews took from 40 to 90 minutes to complete.

Data Analysis

Interviews were transcribed verbatim and then coded collaboratively by co-investigators and research staff from the three study sites. The coding tree was developed using an iterative and collaborative process. All team members first read transcripts and identified preliminary themes such as, for example, VCT, condom use, disclosure, and sexual agreements, which

were then discussed as a group. After forming an initial coding tree, team members individually coded up to 20 interviews in MAXQDA. After discussion, the coding tree was revised and the process repeated until all team members were satisfied with the final coding scheme and were coding consistently with one another. Thereafter, approximately 20% of the interviews were checked for consistent use of codes by coauthors J. Dickson-Gomez, J. Owczarzak and C. Sitzler who supervised the formative phase of the research, which confirmed codes were being applied consistently across all study sites and team members..

We used constant comparison to analyze the data to discover patterns of relationships among codes. For example, the codes “VCT,” “HIV testing” and “HIV seropositive” (or seronegative) were examined individually and in combination in relation to HIV disclosure to sex partners, serosorting, sexual positioning, sexual agreements, condom use, and sexual behavior. We compared responses from key informants and community members to see if they differed. We also compared tested versus untested men and seropositive versus seronegative or status-unknown men as these groupings also might reflect different perspectives. We found no differences between key informants and community members, tested versus untested men, younger vs. older men, or seropositive versus seronegative or status-unknown men. The lack of differences between key informants and community members may be because a high proportion of key informants were found, as their interviews progressed, to be African American MSM. The only exception was among key informants who worked as VCT counselors and who promoted testing in their communities. Those individuals had experience using different strategies to promote VCT and could comment on the reactions of African American MSM. In the results, we specify whether participants were key informants or community members and indicate in which city they lived and their age.

Results

Awareness of Locations for VCT

All men in the sample said they were aware of locations where VCT was available and were familiar with public health initiatives to promote testing, although individuals differed in terms of their preference for testing at a community agency, a location within the Black community or a health department or care clinic. Overall, men felt that the VCT sites were welcoming to African American MSM and were appropriately located. The single exception was a faith-based site in one city that, according to participants, supplemented its counseling with religious judgments about the sinfulness of their lifestyle. That site was not well regarded or trusted.

Attitudes Toward VCT

Key informants who were VCT counselors believed that most African American MSM are not getting tested regularly and described a generalized resistance to HIV testing among the men they encountered.

“If you give a person a way to say no, they'll say no. If you say well, you have to come down to —for us to test you, then, ...I'm too busy for that or I ain't got no bus

fare. ...if you give a person a way to say no, they will say no.” (Key informant, age 28, Cleveland)

The most common response from to the question of how Black MSM feel about HIV testing and counseling was that most men do not want to know their status. There was widespread agreement among in each city that only “a small percentage” of men access VCT, despite knowing that testing is widely available. For example, one interviewee in Cleveland responded:

“I don't think they're getting tested on a regular basis, I really don't,...I think we might see a very small percentage getting tested and I know with the testing at the bath house, not very many, not very many at all and there's a lot of African/American men here. So, I don't think we're getting tested as we should, but then there are some African/Americans who have the thought process that, what I don't know won't hurt me and I don't want to know.” (Key informant, age 55, Cleveland)

One interviewee suggested that there is a wide gap between public health goals and African American MSM's desire for testing. He estimated that, among African American MSM, desire to be tested was about “1.5 on a 10-point scale” (where 10 was strong desire to be tested) in contrast to the public health goal of getting wide uptake of VCT in communities at risk (Community member, age 33, Cleveland). Some felt that men experienced ambivalence, wanting to be tested but not really wanting to learn the results: “you just don't want to know” (Community member, age 29, Cleveland) and, as a result, did not seek out VCT.

One interviewee suggested that African American MSM generally avoid doctors and the health care system, but might seek VCT in response to learning that they might have been exposed to HIV.

“The average Black man period, whether gay or not gay, don't like to go to the doctor...We never get to it or we think “it will not happen to me.” We take it in a very personal way. Therefore, Black men are leery of getting counseling and being tested....Usually when you get tested, you have some type of reason to want to get tested because someone you've been with that you're leery of or you're skeptical of or you have some doubts about, but I think that we are a little more sensitive....There's been campaigns to tell us to get tested, but we think we're Superman or we can't get it or we won't get it or I am one out of a million who can't contract it for whatever reason.” (Key informant, age 54, Miami)

The participant above suggests that even with real fear of exposure, many African American MSM choose not to be tested by convincing themselves that “it can't happen to me.”

Another participant articulated more clearly that many African American MSM are afraid of knowing their status, especially if they have engaged in risky sexual behavior.

“It [VCT] ...makes gay men nervous just because you, even if you practice safe sex and are, I mean I'm not going to lie, I had a time when I had unprotected sex and, I mean, I knew this person's status but I still was nervous when I was going to get tested because you never know. Thank God, it came back negative, but as far as you know, gay people in general just feel like getting tested is like always the moment of truth. It could either go up or down hill from here. You don't know

what to expect. Maybe you thought you could....you didn't know this one day the condom broke and it could have been that moment. You always hear about that happening, taking only one time. So, the more sexually active you get, the more nervous you are to go forth with it [VCT]." (Key informant, age 20, Cleveland)

This fear caused a great deal of ambivalence among men who, on the one hand, felt concerned that they might have been exposed, but, on the other hand, were afraid of learning their test results. This ambivalence, in turn, often led to procrastination.

"Those first time testers are always like, so should I or shouldn't I? I've had a lot of friends that said, oh yeah, I'm going to get tested. I'm going to get tested. I'm going to get tested.....and never will. ... They just keep telling themselves I'm going to go, I'm going to go, I'm going to go, but in between that time, they're still doing all those things that they've been doing that led to them saying to themselves, I'm going to go get tested. I'm going to go get tested. I'm going to go get tested.....but it never happens, you know." (Key informant, age 33, Milwaukee)

While a small minority of the participants described getting regular HIV tests, the vast majority of participants who accessed VCT indicated that they were motivated by two primary reasons. For a few participants, VCT was approached jointly with a partner to justify discontinuing condoms if they were seroconcordant. For others, the onset of illness symptoms became the precipitant for testing. Even getting tested did not ensure following through to learn the test results. For example, one participant described waiting literally years after his first test before he returned to find out the results, not wanting the result to affect his sexual life. Another participant, after being advised that a sex partner was diagnosed with HIV infection, reported waiting nine years before seeking testing until he experienced the onset of symptoms that raised the possibility of HIV infection.

"How long was it from the phone call to the blood test, the lapse? About nine years. I lived with not really knowing for nine years. And it wasn't until I developed shingles, you know, about nine years later and then started developing boils and different things that, you know, I had never dealt with previously." (Community member, age 53, Milwaukee)

Views of Different HIV Testing Strategies

The interviews also revealed local implementation of different strategies to increase HIV testing and minimize barriers to testing. For example, many participants described venue-based HIV testing in locations such as bathhouses, bars, or house ball events. However, most commented that few men took advantage of the availability of testing in those locations. Another strategy mentioned by several key informants was social network HIV testing (MMWR, 2005), an approach in which VCT counselors conduct outreach to find a "seed" who is offered a rapid HIV test and a financial incentive. He, in turn, recruits people he knows to get tested, and receives an incentive payment for each person he recruited who takes an HIV test. Those who were recruited also receive an incentive and, in turn, are encouraged to recruit others to get a test. Ideally, this chain of referrals continues for several waves through high-risk social networks. However, key informants familiar with this

method expressed the opinion that the financial incentive, more than desire to know personal serostatus, was responsible for testing.

“We have to literally have giveaways or give money away for someone to get tested. They just wouldn't want to do it just because it's about their health and about living longer and living a prosperous life. They - I mean, it was all an incentive. If we wasn't offering nothing, they wasn't getting tested.” (Key informant, age 35, Cleveland)

Another key informant who worked for an agency that routinely provided financial incentives to African American MSM agreed that approaching men who were unemployed and needed financial resources was key.

“I go right to the hood. I go right into the heart of things and a lot of times they're not working and they need money. I try to hit up ones who don't have a job, who are hard up for money, and that are more open to do things like that. Those are the ones that will go out and actually get other people to get tested. Number one, I think it's because of financial reasons; they'll do anything to get that gift card.” (Key informant, age 44, Milwaukee)

Aside from the opportunity to receive financial incentives, there was little consensus about which Black MSM were more or less likely to test. For example, some participants in the sample felt that men who were more hidden or on the “down low” and younger MSM were more receptive to HIV testing, while other said that these same subgroups were less receptive.

“... younger generation. It's really not on their minds. The down low and closeted really don't want to talk about it [VCT] because it kinda opens up the door because it's kinda like puttin' them in the spotlight, you know, or puttin' a light on them when they really trying to be discrete, you know. So even though it should be on their mind, it's not. It's really not. You know, they really don't want to be attached to that [being considered MSM].” (Key informant, age 43, Cleveland)

Perceived Benefits and Barriers to VCT

Several participants reported that knowing one's HIV status was a benefit or cited the health benefits of early treatment to prevent progression.

“Just let them know that it's a lot better to know your status and know what's wrong with you than not know, because if you're positive for HIV you can get medicine. You can get treated. If you have it and you don't know, your lifespan is going to be way shorter than it's going to be if you know you have it and you're getting treated for it.” (Cleveland, age 22, Community Member)

However, another participant commented that Black MSM who tested positive often did not enter medical care:

“That's what the issue, it's not getting people tested, it's getting people into care. Because once we start getting people to an undetectable level, I guarantee to you that the spread of HIV would not be as high.” (Miami, age 24 Key Informant)

However, this participant and others who expressed these attitudes were generally people who worked or volunteered in AIDS service organizations. By contrast, most community members and key informants who were not involved in HIV prevention or treatment described disadvantages of learning their serostatus, and primarily raised concerns about emotional and structural barriers to accessing care grounded in historic discrimination and stigmatization.

For some men, fear of what they might learn was a strong deterrent to getting testing. One key informant responded:

“How do Black MSM feel about HIV testing and counseling? Don't want to know. They rather not know than know because they feel like it's a death sentence and... - it's so glorified, like, "Oh, my God. I've got HIV. What am I going to do? I'm going to die tomorrow..." (Key informant, age 35, Cleveland)

The belief that one has a terminal disease can lead to depression. This participant, for example, described being so depressed after he learned his status that he was unable to function normally.

“...Just overwhelmed, became depressed. You know, I became really depressed. I got to the point where I couldn't do things at my job that I normally did. I was manager of a nightclub. I could fill out the staff's schedule, chat with them on the phone, and count money at the same time. It got to the point I couldn't. I couldn't figure out how to do the schedule. ...Then I started to waste, my weight from like 200 and some down to 100 and some and just all kinds of things that was going on. My driving skills. I found myself going into the wrong lanes, you know, and not understanding why I'm going into those lanes, you know. I'm a master cook. I couldn't cook anymore... “(Community member, age 53, Milwaukee)

Other interviewees who learned they were seropositive voiced similarly strong emotional reactions.

“In the beginning, it was really rough. I thought I was going to die. I thought I was going to look like the pictures of people in Africa. I just thought it was all over. And I thought I would never date again. But as time progressed, I realized, like oh my God, I'm still alive. All the wasted money I spent thinking I was about to die partying. I'm still alive and everybody still wants to “talk” to me.” (Community member, age 20, Cleveland).

Even some participants who knew about the availability of effective medications reported depression after learning that they were HIV positive.

“I thought I would never live to see 25. I don't know why I felt that way because I knew better [that medications were available]. And then, after that, I started becoming depressed because I'm like, well, I didn't think I'd live this long and I really started drinking. And then, about 28, I got myself together. I was like... I'm almost 30. I have not accomplished anything with my life. It don't seem like I'm going to die any time soon, so I decided to get myself together. I put myself in rehab. I put myself back in school....It took me a long time to get myself back to

where I was before, but now I know just because I'm HIV positive don't mean that I'm going to die." (Cleveland, age 29, Community Member)

Even though HIV medications are available, some men expressed doubt that they can live a long and relatively normal life after receiving a seropositive test result, a belief that may also stem from a backdrop of general mistrust of the health care system. Some men related their distrust back to historical mistreatment of African Americans, others to a generalized distrust of government, and still others were wary about the confidentiality of their test results given public health reporting requirements.

"Like as far as our community..., it goes back to, you know, our ancestors to where the whole, you know, syphilis scare. You know, it plays a part. You know, we already, as a culture, don't trust doctors, you know, especially if you're from an older home to where, like, you know, you're all perfectly healthy, and then you go to the doctor, and all of a sudden, you're in the hospital. Like that whole myth is like really prevalent. And it even boils down to like our society 'cause like, you know, if you get tested honestly and you come up positive, then you know, but nobody else know versus confidential where, yeah, your doctor know, which means the state knows, which means you're on a list,..." (Community member, age 28, Miami)

The "syphilis scare" to which this participant referred was the infamous Tuskegee experiment, when African American men with syphilis were followed for years with treatment withheld without patients' knowledge in order to observe syphilis' progression. He also seems to imply that doctors are associated with illness in the statement "you're all perfectly healthy, then you go to the doctor and all of a sudden you're in the hospital."

Learning that one is HIV seropositive can also have negative consequences for relationships that one partner had assumed was monogamous.

"They had been together for four years. They should have got tested, but they probably weren't thinking about that or he wasn't thinking about that. He is 22 and was with someone for four years. The third year they decided not to use a condom. His boyfriend had been messing around and he wasn't aware, you know." (Community member, age 19, Miami)

Another potential negative consequence of learning of one's HIV-positive status raised by the men in our study was the risk of unwanted disclosure of that information by others in their personal social networks. Some men even acknowledged withholding or misrepresenting personal information from a counselor during the VCT session, either because they were concerned that their results would be divulged or because of perceived racial, sexual orientation, or ethnic differences between the VCT counselor and themselves. Other men were unsure how partners or friends might use the information should they disclose their seropositive status. One man described his loss of employment when his partner acted out and told his employers of his seropositivity.

I've lost two jobs because of my HIV. My partner called them and told them that I ...had AIDS. I got fired five days later for stealing five dollars after I was the third highest [inaudible] in the company. It hurt. (Key informant, age 22, Milwaukee)

A number of participants related similar stories of others to whom they had disclosed their status with detrimental personal consequences. In some cases, the negative consequences affected their employment, as in the above example or, as one participant noted, “And the lady that I work for, she put out that I had HIV so every – you know, all my clients left. And every job I went to, they were calling and telling ‘em that I was sick.” (Community member, age 27, Milwaukee)

Others described times when trusted friends to whom they had disclosed their test results did not keep the information private. For example, one participant’s best friend “outed” the participant’s serostatus to others:

“I met this guy in a park and we walked my dog. We ended up clicking and messing around like every week. He never told me he had a partner. I didn’t have one. Well, my best friend found out that he had a partner....and he went to his partner and told him that he was cheating on him with me and that I was HIV-positive. Do keep in mind, this was my best friend, come to find out he was HIV, diagnosed with full blown AIDS.” (Key informant, age 22, Milwaukee)

As the above examples illustrate, men cited an array of perceived barriers and negative consequences of HIV testing. Some of these were personally experienced, some were hearsay, and still others were anticipatory and had never actually occurred to the informant.

Behavioral Consequences of HIV Testing

Among the expected consequences of HIV testing are that men will adopt strategies to avoid transmitting or contracting HIV infection; disclose their serostatus to sex partners; or use behavioral strategies such as consistent condom use, sexual agreements, serosorting, or strategic positioning to reduce risk. Most participants in the sample did not link any of these behaviors to HIV testing or cite testing as the impetus for making behavior changes. The exception was a small number of men who indicated they had gone for testing with a partner in order to ascertain whether they were seroconcordant and could stop using condoms.

The sample was diverse in terms of reported personal condom use, although condom decisions appeared to operate independently of testing. Some men reported consistently using condoms with every sex partner. Other men indicated they never used condoms, whether or not they knew their own serostatus or that of their partner. Still others acknowledged that they were inconsistent, sometimes using condoms and other times foregoing condom use. Whether seropositive or seronegative, no participant spontaneously reported changing condom use as a result of having been tested. One man who was HIV-positive claimed that his failure to use condoms resulted from learning of his serostatus:

“I’ve been positive since I was 19...so that’s about – that’s ten years. I was completely devastated. I know exactly who I got it from. I didn’t cope with it. I became an alcoholic at the age of 19. I stopped being focused on school. I started not caring about anybody. Like I changed and I just – I didn’t tell nobody. I did a lot of things that I’m not proud of. It makes you depressed and feel alone to put on a condom. Ain’t scared of no AIDS. That’s the reason why, you know, all of us keep getting infected or we would be using condoms. Condoms are not being used,

you know, and most men don't even know how to put on a condom" (Community member, age 29, Cleveland)

Many men expressed the belief that serostatus disclosure was independent of whether or not condoms were used during an encounter. Overall, condom use seemed to reflect what men believed was normative and accepted in their social networks rather than a decision based on their HIV status. For example, one participant noted:

"Honestly, I don't really think that too many are that concerned. I don't think the thing, people really care anymore, from what I notice, because they just sleep with anybody. They don't care. You – I like – you could tell somebody – I would tell somebody I'm positive and they are even still trying to take the condom off and say they're negative or they'll just go like – why would you do that [put on a condom]– and they're like – the fact that if I'm telling you I'm positive and I may know for a fact that you may be negative. But you still trying to have unprotected sex, that means you're doing that with not only me but with so many other people..." (Community member, age 29, Cleveland)

None of the men who were interviewed spontaneously raised the use of strategies known in the field as negotiated safety (having only protected sex with any partner other than one's primary partner), strategic positioning, or serosorting as methods for risk reduction as a consequence of testing or even independent of testing. Most believed that use of sexual agreements for risk reduction was uncommon among African American MSM:

"Sexual agreements...maybe some do, but very low. Very low. If they're meeting on a first date." (Key informant, age 35, Cleveland)

A few participants reported that they had sexual agreements about whether they could have extra-relationship partners or whether they would engage together in group sex. None reported explicitly negotiating agreements with his partner as a protective strategy for the two of them.

Discussion

Advances in HIV treatment mean that individuals diagnosed at early disease stages who access and adhere to contemporary antiretroviral therapy regimens can now expect to live long and healthy lives. Virologic suppression also sharply reduces the likelihood of onward disease transmission. As a result, test-and-treat strategies are now a prominent component of the national HIV public health agenda. In this light, the study's findings are of concern. There was little evidence that racial minority men in the sample were aware of the benefits of testing nor that accurate serostatus knowledge is a gateway for early entry into care, treatment, and a path towards sustained good health. Although these interviews were conducted in 2011-2012, men's attitudes, fears, and the perceived negative consequences of testing are reminiscent of perspectives that were common in the 1980s before effective treatment became available. Much needs to be done to increase awareness of the benefits of HIV testing and treatment among African American MSM, a challenge that is time-sensitive and critical given their continued disproportionate HIV burden.

Men in this sample were aware of HIV test availability and of locations where VCT could be accessed. There was favorable reaction to having testing available in a variety of clinic, outreach, and community-based settings, and men were generally positive concerning their experiences with agencies that offered VCT. Access and structural barriers to testing were rarely mentioned. However, men described anticipated strong negative emotional and social consequences if they learned that they were HIV-infected, and fear of negative consequences appears to be a major deterrent to accessing VCT. These fears centered on HIV “as a death sentence;” stigma associated with being HIV-positive including disruption of social relationships, sexual relationships, and employment; and the perception that life is better by not knowing one’s HIV status. Although many men reported using condoms, not always consistently, condom use did not appear to be linked to serostatus knowledge. Other potentially protective steps such as sexual positioning, serosorting, and the establishment of sexual agreements were generally not raised at all or—if mentioned—involved sexual activity preferences rather than protective steps following testing.

Because young men — and especially racial and ethnic minority men — often do not have frequent contact with health care settings and because routine HIV testing still does not regularly take place in these settings, VCT remains critical for the early detection of HIV infection. It is unlikely that any single testing strategy will be sufficient to accomplish public health objectives. Clinic-based, outreach, and social network testing strategies are widely employed and have been shown to reach different segments of the racial minority MSM population (Baytop et al., 2014; Halkitis et al., 2011). While campaigns in some cities are underway to urge African American MSM to obtain testing and learn their serostatus, these findings suggest that increased attention must be directed to emphasizing health benefits of early treatment for persons who have HIV infection. Men in this study’s sample primarily described fear and adverse emotional outcomes associated with positive serostatus knowledge, and many believe that HIV treatment is still futile. Community interventions are needed to counter these outdated misperceptions and explicitly present HIV testing as the vehicle for receiving effective treatment and for living a long and healthy life. Although care linkage and retention were not the focus of the present investigation, this study and other recent research suggest that VCT may not be providing the desired bridge into care, especially for African American MSM (El-Sadr et al., 2013; Courtenay-Quirk et al., 2013; Rao et al., 2011; Lansky, 2014; Oster et al., 2011; Simoni et al., 2012).

There are a variety of intervention models that might be used to better disseminate information about the benefits of testing and treatment, as well as for correcting outdated misperceptions and fears. Social marketing campaigns to encourage HIV testing among racial minority MSM can be framed to more directly emphasize personal health benefits of knowing one’s HIV-positive serostatus, the effectiveness of contemporary antiretroviral treatment, the availability of HIV care at little or no cost, and the now-manageable nature of treated HIV disease. Lessons can also be drawn from past community-level interventions used to promote risk behavior reduction but—in the present context—with the objective of now encouraging regular HIV testing. For example, the CDC AIDS Community Demonstration Projects (1999) used the dissemination of role model stories to encourage and create movement toward condom adoption among high-risk persons in minority communities. Popular Opinion Leader (POL) interventions (Kelly et al., 1991; 1997) and

interventions directed toward high-risk community social networks (Amirkhanian, 2014) have both been shown to shift risk behavior change and normative perceptions among MSM, including African American MSM (Jones et al., 2008). Such approaches can potentially be adapted to encourage uptake of regular VCT by racial minority MSM and thereby meet public health objectives related to HIV treatment as prevention. Many studies have noted the dense, racially homophilous nature of the social and sexual networks of African American MSM and the association of these networks with identifiable venues (Hurt & Dennis, 2013; Oster et al., 2013; Newcomb & Mustanski, 2013; Sullivan et al, 2014). This underscores the potential value of both venue-based and social network-level interventions to encourage testing uptake among racial minority MSM.

A number of key informants in the present study described their experiences with incentive-based social network HIV testing in their communities. Although financial incentives for testing have shown effectiveness in identifying previously undiagnosed HIV infections (MMWR, 2005; Halkitis et al., 2011), the key informants expressed cynicism because low-income men agreed to testing and recruited others solely to gain tangible incentives rather than to learn their HIV status. A large body of operant contingency management research shows that health behavior changes motivated solely by external rewards are not well-maintained once those reward contingencies cease. Especially because regular and frequent HIV testing is recommended for high-risk MSM, it is critical to also promote testing, by conveying its benefits to personal health rather than relying solely on financial incentives.

Finally, this study's findings point to the continuing stigma associated with HIV/AIDS in the lives of African American MSM. A substantial number of men in the sample described stigma and worried about possible abridgement of the confidentiality of their positive HIV status, citing both as reasons they did not want to test. Efforts to increase the willingness of racial minority MSM to test are inextricably linked with the success of broader efforts to reduce HIV-related stigma within both the African American and gay communities.

Several limitations of this qualitative study must be acknowledged. We interviewed both key informants and African American MSM community members assuming that they would have different perspectives. However, their responses were very similar, probably because many key informants were themselves African American MSM. In addition, interview probes were open-ended and intentionally did not guide the direction of responses, allowing interviewee beliefs to emerge freely. For example, we asked how Black MSM felt about VCT. Had we instead asked specifically what benefits they saw in VCT, different information might have emerged. Finally, this study was conducted in three cities—Milwaukee, Cleveland, and Miami—and used purposive rather than representative sampling. Different findings may have emerged if the study was conducted in different cities that had a history of other testing promotion programs for racial minority men. We also do not know the generalizability of results to other African American MSM even in the three cities where the research was undertaken although we purposively recruited a diverse sample of racial minority men.

While the public health importance of VCT is compelling, the present study illustrates concerns among African American MSM about testing and learning one's HIV serostatus,

especially fears of being infected and ramifications of those fears. Further research is needed to assess how widespread these beliefs and concerns may be among a larger and representative sample of African American MSM. These results also show the need for community interventions that more effectively promote the benefits of serostatus knowledge as a step for care entry and protective behavior changes. As a result, these findings can guide the development of more effective strategies promoting testing, highlighting the important health benefits that now result from early testing, and improving subsequent entry into care for African American MSM who learn they are seropositive.

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Appendix A: Relevant interview questions

1. How concerned would you say Black MSM are about HIV/AIDS? How open are they to talking about HIV/AIDS? What are common perceptions/beliefs about HIV/AIDS among Black MSM?
2. How do Black MSM feel about HIV testing and counseling?
3. How accessible do you think HIV testing and prevention services for Black MSM are? Probes: For example, are there enough testing locations? Are they located in the right places? Are they welcoming to Black MSM?
4. How culturally appropriate are HIV testing and prevention services for Black MSM?
5. How do Black MSM protect themselves from getting HIV? Probes: condoms, getting tested, sexual agreements, sero-sorting, using appearances. Which groups of Black MSM are likely to use these different methods?
6. What are some of the ways Black MSM put themselves at risk for becoming infected with HIV? How does this vary among different groups?
7. How do Black MSM feel about condom in general? In what types of relationships are condoms more or less acceptable? In what situations are they more or less acceptable? How does the acceptability of using condoms vary for different groups of Black MSM?
8. How do you negotiate condoms or safer sex practices? What other types of safer sex practices do you use? Probe: For example, strategic position, sero-sorting, sexual agreements, testing?
9. How do the kinds of sex you have (anal receptive, anal insertive, oral) vary with different types of partners?
10. How do you decide whether to use condoms or not with different partners? Have you ever disagreed with a partner about whether to use condoms? What happens when you disagree?

11. Do you have sexual agreements with any of your partners? Probe: For example, having sex only in the relationship, only having sex outside the relationship using a condom. Tell me about any agreement you may have and how you came to this agreement. Probe: Have you or has your partner ever broken an agreement? What happened?

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