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HIV Stigma and the Experiences of Young Men with Voluntary and Routine HIV Testing

Rod Knight¹, Will Small², and Jean A. Shoveller¹

¹School of Population and Public Health, University of British Columbia, Canada

²Faculty of Health Sciences, Simon Fraser University, Burnaby, British Columbia, Canada

Abstract

As routine HIV testing approaches are implemented to enhance participation rates in HIV testing, it is often widely believed that these approaches are socially and ethically justifiable given the underlying assumption that these practices will result in the widespread reduction of HIV-related stigma. Nonetheless, a variety of empirical and theoretical gaps regarding how HIV testing practices may impact HIV stigma remain, raising questions about the social underpinnings of the public health rationale. We draw on 50 interviews with 18-24-year-old men to determine how HIV-related stigma is experienced differentially across subgroups of young men in relation to both voluntary and routine testing practices. Men's experiences with routine testing highlight how (mis)interpretations of universal, routine testing practices may serve to (unintentionally) burden disadvantaged population subgroups of men; however, when sufficiently explicated, the universal dimension of a routine offer greatly diminished these concerns. These findings also highlight that, under the right conditions, a routine offer can provide transformative opportunities for individuals to reconceptualise expectations pertaining to HIV and HIV-related stigma.

Keywords

HIV; Public health; Stigma; Screening

Introduction

Background

Individuals unaware of their HIV seropositive status continue to represent a key 'driver' of the HIV epidemic within many global contexts (Public Health Agency of Canada 2013, Lima *et al.* 2010). As a result, there is a strong public health impetus to enhance testing participation rates among those unaware of their HIV status. For example, many settings, including Vancouver, Canada, have implemented routine testing – in which patients presenting at health care facilities are routinely offered an HIV test – thereby representing a

Address for correspondence: Rod Knight, University of British Columbia - School of Population and Public Health, 2206 East Mall Vancouver British Columbia V6T 1Z3, Canada. rod.knight@ubc.ca.

¹Notes: Men who indicated they had tested more than five times are reported as “ 5”.

³Cisgender refers to those individuals whose biological sex aligns with their gender identity; for example, a biological male who identifies as a man is referred to as being cisgender.

departure from the emphasis of approaches that focused on voluntary testing and counselling in which a patient must request a test (predominantly used during the late 1980s to early 2000s). As various public health approaches are implemented to enhance participation rates in HIV testing, it is often widely believed that these approaches are socially and ethically justifiable given the underlying assumption that these practices will result in the widespread reduction of HIV-related stigma by enhancing public awareness and normalizing HIV (Jurgensen *et al.* 2013). Nonetheless, a variety of gaps in empirical and theoretical understanding regarding how interventions such as HIV testing practices may serve to impact HIV stigma remain (Jurgensen *et al.* 2013, Sengupta *et al.* 2011, Durojaye 2011, Mahajan *et al.* 2008, Earnshaw and Chaudoir 2009, Parker and Aggleton 2003), raising questions about the social and ethical underpinnings of enhancing HIV testing among various populations (Jurgensen *et al.* 2013, Durojaye 2011, Powers and Faden 2006, Bayer and Fairchild 2006).

Young men and HIV testing

Young men represent a unique population in terms of sexual health needs broadly and HIV-related interventions specifically (Knight *et al.* 2012, Knight *et al.* 2013, Shoveller *et al.* 2010, Gahagan *et al.* 2011). While HIV testing participation rates vary globally, within many settings *young* men represent a group with disproportionately low testing rates (Shoveller *et al.* 2010). These low rates of HIV testing among young men have been attributed to structural conditions within health care service delivery systems, including a tendency for health systems to focus on women's sexual and reproductive health from the onset of puberty, as well as men's gendered health-seeking behaviour (Knight *et al.* 2012, Knight *et al.* 2013, Shoveller *et al.* 2010). Theory regarding gender relations, masculinities and men's health suggests that men's sexual health experiences are strongly influenced by the wider set of social relations and expectations that men experience and contribute to in their everyday lives (Doull *et al.* 2013, Connell 2012, Knight *et al.* 2012, Knight *et al.* 2013, Oliffe *et al.* 2012, Robertson 2007, Courtenay 2000a).

Young men's experiences with HIV testing have been particularly linked to broader (stigmatised) societal expectations regarding their sexual health-related practices. For example, sexual health clinical encounters frequently represent a unique anxiety-inducing experience in which men's (hetero)sexuality is explicitly 'interrogated' (Knight *et al.* 2013), as well as a process in which young men experience multiple vulnerabilities associated with seeking 'help' (Shoveller *et al.* 2010). Recent research exploring men's experiences with HIV testing has also revealed how broader societal expectations pertaining to young men's sexual health practices and self-assessed risk lead some men to feel 'expected' to test (particularly queer-identified men), thereby (re)stigmatizing queer identities, while alleviating notions of risk among heterosexual men (Knight *et al.* 2012, Knight *et al.* 2013). Nonetheless, little is known about how the expansion of routine testing approaches may influence young men's experiences with HIV-related stigma in clinical encounters (or beyond), opening a space for new sociologically informed investigations.

HIV testing, HIV-related stigma and young men

While much empirical work positions HIV stigma as a key barrier to HIV testing, treatment and care, efforts to attenuate HIV-related stigma through various interventions have had limited impact. A recent systematic review (Stangl *et al.* 2013) of HIV-related interventions found that most HIV stigma-reduction interventions remain somewhat individually focused. Generally, these interventions tend to concentrate on changing individual attitudes, knowledge or skills through the provision of information, such as through training initiatives or the distribution of brochures. While such programs frequently report pre-post reductions in stigma among the individuals involved in the interventions, the capacity for these interventions to influence long-term change is unlikely given the “downstream” orientations and the emphasis on changing individual characteristics, rather than the underlying cultural or social conditions that cultivate HIV-related attitudes and behaviour. Given these findings, these studies advance calls for more structural-level interventions, including institutional-level and/or policy changes that can have a larger reach within and across various populations.

From a variety of sociological perspectives, the shortcomings of HIV-related stigma reduction interventions are also frequently attributed to the cross-cultural complexity and specificity of the dynamic social processes and mechanisms – labeling, stereotyping, status loss, discrimination, separation – that are associated with HIV stigma and founded on social inequalities and the operation of power (Mahajan *et al.* 2009, Parker and Aggleton 2003, Link and Phelan 2001). For example, many theories from the 1990s through to the early 2000s pertaining to HIV-related stigma have been criticised for their exclusive focus on individual-level attitudes and beliefs without sufficient consideration of the socio-cultural contexts which frame social and cultural norms (Scambler 2009, Parker and Aggleton 2003), thereby highlighting a disregard for the causal ‘inputs’ of social and structural conditions such as gender, socioeconomic status and public policy (Scambler 2009). Instead, the relational dimensions of stigma are emphasised, using empirical examples to highlight both: (i) the social *processes* that (re)produce social inequalities, such as HIV-related stigmatization and experiences of stereotyping (Scambler 2009); and (ii) the *effects* of these processes, such as the associated health outcomes with various income and housing opportunities and programs (Link and Phelan 2001, Scambler 2009). For example, within the realm of young men's sexual health, HIV-related stigma intersects with social and structural hierarchies, whereby individual enactments of prejudice, discrimination and stereotyping also are shaped by the broader social and structural contexts, including features of power, culture, privilege and social difference (Parker and Aggleton 2003, Scambler 2009). Some have suggested that those who cannot or do not enact ‘idealized’ or hegemonic masculinity, such as men who display ‘effeminate’ characteristics, are the most conspicuous among subordinated masculinities (*c.f.* Connell 1995) and that their relational subordination reinforces HIV stigmatization (Knight *et al.* 2013). Thus, we conceptualize HIV stigma as being dialectically related with both socio-cultural influences and individual-level phenomena (Cook *et al.* 2014, Parker and Aggleton 2003, Knight *et al.* 2013).

Empirical work in this area could thus provide important opportunities to identify socially and ethically robust public health practices that might serve to attenuate the effects of stigma

among various groups of young men. To date, few empirical studies have explored how various HIV testing policies and service delivery practices affect experiences associated with HIV stigma (Knight *et al.* 2014a, Jurgenson 2013). Some research has been conducted in high-prevalence and low-income settings and examined the association of stigma and voluntary testing and counselling (Kalichman and Simbayi 2003, Koku 2011, Pettifor *et al.* 2010, Sambisa *et al.* 2010, Visser *et al.* 2009, Young *et al.* 2010). Within these studies, cross-sectional study designs have limited the capacity to identify causal relations (Jurgensen *et al.* 2011) or social processes over time. This work has tended to draw on individualistic theoretical frameworks and methods that measure and report individual-level beliefs and attitudes (Stang *et al.* 2013). And, while findings from some studies provide important, provisional insights within high-prevalence and low-income settings (Obermeyer *et al.* 2013), to date, no research has investigated the social and structural influences potentially contributing to stigma within a context of expanding routine HIV testing efforts in settings such as Vancouver, Canada – a high-resource setting with a concentrated epidemic. Furthermore, within studies pertaining specifically to men, HIV testing and HIV-related stigma have tended to focus exclusively on men who have sex with men (*c.f.* Flowers *et al.* 2012), revealing the importance of gendered analyses. Nonetheless, empirical and theoretical work focusing on and appreciating *young* men's gendered practices in this realm remains conspicuously absent.

Because HIV is distributed inequitably among young men, and owing to the fact that HIV-related stigma differentially (re)produces social and structural inequalities related to the intersections of culture, power and difference, there are important social questions that arise within the context of evolving and expanding HIV testing practices (Knight *et al.* 2014a). Specifically, concerns related to whether routine testing policies and service delivery practices serve to attenuate or exacerbate HIV-related stigma among young men in the context of existing voluntary testing approaches requires additional empirical evidence and sociological analysis. The aim of this study is therefore to determine how HIV-related stigma is experienced differentially across subgroups of young men within voluntary and routine testing practices.

Methods

Study setting

Vancouver, British Columbia (BC) provides a context within which to explore these questions, presenting an opportunity to gather and analyze data generated via an ongoing 'natural experiment'. In Vancouver, the norm until recently has been voluntary testing. Since 2011, there has been a policy and practice shift towards institutionalizing routine testing approaches on a more universal basis within Vancouver. For example, in 2010 the provincial government committed to supporting BC's Seek and Treat for Optimal Prevention of HIV/AIDS (STOP HIV) program which includes scaling up routinised HIV testing and the expansion of highly-active antiretroviral therapy (HAART). In 2011, several of the larger hospitals within Vancouver's local health authority (Vancouver Coastal Health) began offering routine testing to all patients, including those requiring blood work for other non-HIV related indications. In 2012, it was recommended that routine testing be offered to all

patients upon admission to acute care settings (Gustafson *et al.* 2012). More recently (May 2014), the Provincial Health Officer put forward a revised set of HIV testing guidelines, thereby “scaling up” the implementation of routine testing practices province-wide (British Columbia Ministry of Health 2014).

To further characterise the setting for the study (particularly for the international reader), it is helpful to describe the local, epidemiological context of HIV. In BC, it is estimated that there are approximately 12,300 HIV+ individuals, with up to 2,500 unaware of their status (Lima *et al.* 2010). In 2012, men accounted for 88% of all new HIV diagnoses in BC. While many other risk groups have begun to experience reductions in HIV incidence, young men have not experienced such a trend. In 2012, HIV incidence rates for men between the ages of 20-24 years and 25-29 years were significantly higher than the provincial average at 7.7 and 22.0 per 100,000 cases (compared to the provincial average of 5.2 per 100,000) (British Columbia Centre for Disease Control (BCCDC) 2012). And, men who have sex with men (MSM) continue to bear a disproportionate burden of the disease. For example, MSM represent 63% of all new HIV diagnoses in 2012 (BCCDC 2012). Men who inject drugs also have recently experienced declining rates of HIV (43 cases in 2008 compared to 20 cases in 2012 among men), likely reflecting the success of sustained prevention efforts with this population (BCCDC 2012). Heterosexual contact now represents the risk category with the second greatest number of new HIV diagnoses among men (32 new cases among heterosexual men in 2012) (BCCDC 2012).

Recruitment of participants and interview procedures

Men ages 18-24 years were recruited between June and November 2013 to participate in in-depth, semi-structured interviews using a range of recruitment strategies, including online approaches (e.g., Facebook advertisements) and posters and pamphlets at both clinical (e.g., within sexual health clinics) and non-clinical (e.g., bus stops; community bulletin boards) locations, as well as at the At-Risk Youth Study (ARYS), a prospective cohort study of street-involved youth (for details on the ARYS cohort, see: Wood *et al.* 2006). Interviews took place in private locations (e.g., research offices; clinical spaces), lasting between 1-1.5 hours each. Interviewers explained the purpose of the study and obtained written informed consent before commencing the interview. Participants were also asked to complete a brief socio-demographic questionnaire, and all participants received a CDN\$25 honorarium.

Interviews

Semi-structured, in-depth interview guides were conducted to elicit participants' perceptions of and experiences with voluntary and routine HIV testing practices. Participants were asked about their experiences with voluntary and/or routine testing, as well as their perceptions about how various HIV testing practices influence their comfort levels and considerations of privacy. Men who had been tested with a specific approach were asked to reflect on interactions in clinic spaces, including discussions and comfort levels. Men who had never voluntarily and/or routinely tested were asked about their perceptions pertaining to each approach, including how these interactions could influence their future considerations to test, how the approach might influence their comfort levels, and whether they would prefer various approaches and/or practices associated with each testing approach. Men also shared

perceptions about broader features of the social and structural contexts in which they live, as well as the effects these influences might have on their testing experiences.

Data analysis

Interviews were audio-recorded and transcribed with identifying details removed. A research assistant checked each transcript for accuracy. *QSR NVivo 10™* was used to manage the data. Using a modified grounded theory approach (Strauss and Corbin 1998) to code the data and compare themes across interviews, a constant comparative technique was used to develop a set of codes (Dey 1999), avoiding, where possible, preconceived theoretical constructs (Glaser and Strauss 1967), such as masculinities theory. This process includes coding the raw data line-by-line, and iteratively developing interpretations about recurring, converging and contradictory ideas/codes within and across the interview data. Key concepts and preliminary themes, along with illustrative examples from the data, were analyzed and coded iteratively to test emergent ideas about the connections between concepts and to identify new themes; as additional interviews were completed, coding was organised into 'trees' to group the open codes into more abstract conceptual categories pertaining to the objectives of this manuscript, with a particular emphasis on the various ethical issues that have been identified previously in the literature. Thus, both inductive and deductive approaches were used to identify and interrogate each thematic outlined within the findings below.

Study participants

In total, 50 young men completed interviews. Participants were purposefully recruited to reflect varying social positions and lived experiences, including men from a range of socio-economic statuses and sexual identities. Participants were also recruited who could provide a variety of perspectives regarding their experiences with either, both or neither voluntary and routine approaches to HIV testing. Participants either selected or were assigned a pseudonym, for the purposes of reporting. Table 1 provides details on the socio-demographic characteristics of the study sample.

Findings

The findings begin with a description of men's experiences with voluntary testing and then their experiences with routine testing. These sections are followed by descriptions of participants' perceptions about HIV and HIV-related stigma. Details regarding participants' self-identified ethnicity, sexual identity, previous experiences with voluntary and/or routine testing approaches and the number of times tested² are provided in brackets following each illustrative quote.

Experiences with voluntary testing

Interviews began with a discussion of men's experiences with voluntary testing. Some participants described the act of voluntarily seeking out testing as an anxiety-inducing

²The term Two-Spirit (a term derived from interpretations of Aboriginal languages) is used to describe individuals who house both male and female spirits, as well as an identity of LGBTQ people of Aboriginal origin.

experience, stemming from a tacit acknowledgement of one's 'regretful' or 'shameful' behaviour associated with the need to test. For example, Frank described:

If I do get tested, then it means I *should* get tested, and if I *should* get tested, it means I might have HIV. [...] With the voluntary approach, it's more like I have to kind of come to the decision that I should be tested and so there might be more stigma attached with that. Like, do I have a *reason* to be tested? (Frank, 24, Euro-Canadian, straight, voluntary, *n*=1)

Some men also said that young men would be most likely to voluntarily seek testing if they had engaged in same-sex sexual behaviour, had sex under the influence of drugs or alcohol, or shared syringes to inject drugs – all actions they frequently associated with societal disapproval. Participants described how societal-level 'moral expectations' regarding how men *should* behave with respect to sexuality and sexual health could influence their views of 'themselves'. For example, Herbert described:

It's sort of like that morality police – people disapprove. There's a stigma around HIV because people think that people who have HIV are people who engage in morally incorrect behaviour. I think a lot of people probably think that 'Well if You're getting tested for HIV, you probably think that you might have HIV which means that you probably took part in some sort of behaviour that I don't condone. And as a result I'm judging you for getting tested because that tells me that you probably did some sort of activity that I disapprove of'. (Herbert, 23, Euro-Canadian, straight, voluntary, *n*=2)

Narratives like these reveal how socio-cultural expectations regarding young men's sexual health behaviour (particularly in relation to the 'act' of seeking HIV testing) have the capacity to become internalised and influence men's conceptions of self-identity, as well as their health-related practices. Some men also described how the effects of HIV-related stigma affect their experiences within clinical encounters. For example, some described that in order to 'convince' their clinician that they needed to be tested, they had to reveal the (stigmatised) risk behaviour that prompted their request for a test. For example, Kaiser described a clinical encounter in which he asked to be tested for HIV:

So I was like, 'Okay, so I was having sex and the condom broke.' And she [the nurse] was like, 'Well, you're not at risk'. And I was like, 'Well-ll-ll, I might be. I just wanna get tested.' And, she was like, 'Oh, who were you with?' And, I was just like 'This guy.' And she had this look on her face, like 'Oh, you're gay.' And then it was like very awkward in the room 'cause I could like tell she was judging me kind of. [...] And I was uncomfortable, because I just wanted her to give me the requisition form so I could go to get test, and like *end* this questioning. (Kaiser, 22, gay, Euro-Canadian, voluntary, *n* = 5)

Among the men in this study who had previously accessed voluntary testing, many also described how their previous life experiences influenced the extent to which notions of HIV-related stigma affected their internalization of stigma. For example, Robert explained:

When I was going to get STI testing for instance and then eventually got the HIV testing, when you're in the room of the clinic, are you smiling at everyone around

you and going, 'Hey, I'm Robert, nice to meet you...Robert. No, You're keeping to yourself, You're very quiet and you're probably looking at the ground, embarrassed that you're there, not proud of what you're doing.' Why that is so? I feel like there is a bit of maybe some guilt, some blame. 'Well, I'm here because this is my fault I did things that have led me into this situation.' But, I know that now that I'm older, now that I'm no longer a teenager, I know that it's a normal thing that any responsible person should do. [...] The first time you go is completely different from the second time. (Robert, 22, Euro-Canadian, bisexual, voluntary, $n=2$)

Robert's narrative reveals how both becoming more mature and having previous experiences with testing attenuated his experiences with experiencing and internalizing feelings of shame and guilt.

These narratives distil a set of social processes by which external (societal) notions of stigma, including stereotypes about sexualities and HIV risk, become internalised through acts associated with voluntary testing. These data also reveal how previous experiences with voluntary testing can serve to lessen the degree to which stigma is internalised within subsequent testing experiences.

Experiences with routine testing

For many of the participants, routine testing offered an opportunity to alleviate barriers associated with HIV-related stigma that prevents them from regularly accessing voluntary testing. For example, Nicholas compared the barrier/facilitator thresholds associated with seeking voluntary testing versus being offered a routine test as follows:

I feel like stigma keeps a lot of people from going out and doing a voluntary [test], and I feel like for the for the routine test [...] like, if someone offered me an HIV test while I was at the doctor anyway, I'd definitely take it. (Nicholas, 22, Aboriginal, bisexual, voluntary, $n=2$)

Many of the young men also described how routine testing practices serve to de-stigmatise HIV testing and HIV. For example, Kaiser, explained how a routine offer might influence his perceptions of HIV-related stigma:

I feel like it eliminates the stigma if someone is offering it to you, and you don't have to go out of your way to ask for it, you know what I mean? It's very sheepish, I feel, to have to raise your hand and ask for extra medical attention that maybe isn't necessary. I think if they offer it across the spectrum, it makes people more aware that this is something they should be doing regardless of who they're sleeping with. (Kaiser, 22, Euro-Canadian, gay, voluntary, $n=5$)

Kaiser's narrative reveals how the universal dimension of a routine offer can serve to alleviate stigma associated with voluntary testing. These data also reveal the complex packaging of gay masculinities as they relate to sexual health practices; for example, Kaiser's narratives reveal how he is both 'expected' to regularly test as a gay man, while concurrently deferring to a set of normative masculine dispositions that often prescribe stoicism and avoidance of help-seeking behaviour by positioning help-seeking practices as emasculating.

Other participants expressed concern that some men are incorrectly assessing their own levels of risk for acquiring HIV and therefore may be unlikely to voluntarily seek testing. As a result, routine testing was described as a practice that could particularly benefit these men. For example, Nicholas, described how routine testing could concurrently 'reach' his straight friends, as well as serve to normalise or 'de-queer' HIV among them:

It would just make it accessible to people who might not otherwise think of testing. Especially with a lot of my heterosexual friends, they don't consider it something they have to do or it's something that they don't feel concerned about. [...] It would probably normalise it and make it less of a life event than it is. (Nicholas, 22, Aboriginal, bisexual, voluntary, $n=2$)

Similarly, some men described that routine testing could benefit them because, due to a set of expectations within their community surrounding young men and sexual health, they had not been afforded opportunities to seek testing (though testing was frequently positioned as an important health practice in which they would like to engage in more frequently). For example, Charles explained that within his family and friend networks (whom he identified as 'Chinese'), routine testing might normalise the notion that anyone could benefit from knowing their HIV status. As Charles described:

Like it should be part of something we see regularly. Like if you go to a health care professional, get tested, you know. I mean, the more you say 'Oh, young, gay men should go for testing' the more there's a stigma surrounding it then that becomes a problem, you know? When you go to the doctor you're like 'oh I'm not young, I'm not gay. I don't want to get tested.' If you can make it more like a regular thing. 'Just do it, it's part of your health check-up. (Charles, 22, Chinese, straight, never tested)

Charles' narrative highlights how HIV and HIV testing can be positioned as 'queer' issues for straight men and therefore potentially 'dangerous' activities for 'non-queer' identities to engage in, as HIV testing experiences can represent a potentially emasculating or 'queering' experience. His narrative also reveals how public policy and service delivery practices related to routine testing have the capacity to alleviate the barriers stemming from the broader stigmatizing cultural and familial factors that influence his perceptions of HIV.

While many were in favour of routine testing, some expressed serious reservations that some men could feel 'targeted' within a clinical encounter in which a test is offered because they would perceive the offer as a form of stereotyping or profiling. For example, Jeremy described how these experiences could be perceived as being based on a set of assumptions or stereotypes about social identities:

People don't want to be told that they need HIV testing... The person [clinician] who's targeting them assumes certain things and it comes across as being, "You think I'm high risk because I have, you know, whatever it is, drug use, you think I'm sleeping around a lot. You're targeting me because I'm gay." Being targeted is not positive. (Jeremy, 22, Euro-Canadian, transgender, bisexual, voluntary and routine, $n=2$)

Among the straight-identified men in the study, none said that they would feel ‘targeted’ as being potentially ‘queer’, although some worried they were being offered an HIV test because they were perceived to be ‘poor’ or ‘someone who uses drugs’. For example, John Smith, a man with a history of drug use and street-entrenched experiences, described how one’s social identity influenced his perceptions of a routine offer of HIV testing:

HIV is associated with poor people, gay people, drug users. So those are the demographics that are going to feel really discriminated against. Because if they’re already part of that demographic and they know that demographic is susceptible, then if a doctor comes up to them and is like, “Well, do you want HIV testing?” It’s like, “Are you asking me that question because I’m poor?” (John Smith, 23, Euro-Canadian, straight, voluntary, $n=4$)

John Smith’s concerns pertaining to targeted practices underscore the extent to which one’s social positioning can serve to influence their experiences and perceptions in clinical encounters. His narrative also reveals how men experiencing multiple intersecting social vulnerabilities may experience or perceive a routine offer differentially based on perceptions of profiling or stereotyping, thereby illuminating the importance of the social-relational features within clinical interactions.

All of the men who expressed concern about being the ‘subject’ of targeted practices also indicated that in the cases where a health care practitioner had explained clearly: ‘It is now recommended that we offer *everyone* an HIV test’, their anxieties or concerns about being ‘targeted’ had been either eliminated or dampened. For example, while Nickolai initially said he would feel targeted in a routine offer, he later explained how understanding that the test was offered universally would:

...remove any sort of doubts about any sort of behaviour of mine that might have caused it and it would remove a lot of the social stigma from it because [...] if everybody’s getting tested anyway then it just removes any sort of negativity.
(Nickolai, 22, Euro-Canadian, bisexual, routine, $n=1$)

Men’s descriptions of their experiences with and perceptions of routine testing highlight how a routine offer can serve to reduce experiences of HIV-related stigma and voluntary testing, as well as potentially serve as a mechanism to reduce barriers associated with HIV stigma to testing. However, these data also reveal how the degree to which stigma may be alleviated, mitigated or exacerbated is contingent upon equitable social-relational features within clinical encounters.

Discussion

Despite decades of efforts to reduce HIV-related stigma, these data reveal the extent to which young men continue to be influenced by (and contribute to) the social and structural conditions that influence various individual-level social processes and experiences associated with HIV testing. These data also underline the key levels at which societal norms interrelate with individual-level attitudes and behaviours (Heijnders and van der Meij 2006); namely: at the individual level (knowledge, behaviour); interpersonal (within clinical interactions); organizational (institutional policies in health care settings, such as the

expansion of routine testing); and community (cultural values). As a result, these data also provide opportunities to explore how young men experience HIV-related stigma within voluntary and routine testing in order to determine the extent to which HIV testing policies and programme delivery practices may attenuate or ameliorate the effects of HIV stigma.

Voluntary testing and HIV stigma

Given the benefits associated with the availability of universal HAART within many settings (including Vancouver), some scholars previously argued that voluntary testing represents an overly 'exceptionalistic' approach, leading to HIV being treated differently in comparison to other infectious diseases that do not emphasise informed consent or pre-test counselling practices (April 2010, Bayer and Fairchild 2006). As a result, these arguments have suggested that, rather than operating as a means to decrease HIV-related stigma, voluntary approaches may unintentionally position HIV as being socially different from other infectious diseases, representing a potential barrier to care (De Cock *et al.* 2002) – particularly among socially vulnerable and disadvantaged populations.

While a majority of the men in the current study report having 'taken up' messaging regarding the importance of regular HIV testing, many men also have 'taken up' so-called 'exceptionalistic' perspectives on HIV testing that might differentiate HIV from men's other health-related practices and experiences. The data from the current study also reveal that many men either avoid testing or experience the effects of HIV-related stigma when they engage in testing, highlighting how the internalization of broader community and cultural norms regarding HIV influences some men's capacity to voluntarily access testing services. However, these experiences related to HIV stigmatization did not appear to be concentrated exclusively within the most 'vulnerable' or 'disadvantaged' groups of men. For example, many men from relatively 'privileged' and/or middle- and upper-class heterosexual identities described how societal expectations related to their sexual health negatively influenced their experiences with HIV testing in ways that frequently 'exceeded' those of men who might be characterized as being far more socially vulnerable and/or disadvantaged. These findings underline the extent to which heterosexual, masculine 'privilege' is continuously 'at stake' and, ultimately, how experiences with voluntarily accessing HIV testing 'disrupts' dominant masculine ideals that tend to prescribe stoicism, independence, denial of vulnerability or risk to illness and lack of care in (sexual) health-seeking practices (Connell 1995, Courtenay 2000a, Courtenay 2000b). These data reveal the profound social and experiential *effects* that community and cultural expectations can have on some men, including their inability to transgress idealized norms of masculinity in order to access sexual health services. For example, these findings highlight how voluntary testing continues to be positioned (and 'taken up') as a 'non-heterosexual' or risk-based concern (e.g., drug use) that does not include heterosexual sexual activity. In doing so, these findings reveal how community expectations regarding HIV stigma and dominant norms regarding heterosexual masculinity interact to negatively impact the experiences – as well as potential health and social outcomes – of straight-identified men, while concurrently positioning the act of voluntarily seeking testing as one that 'other' men engage in.

HIV stigma and routine testing

Routine approaches to HIV testing have also been criticised in the previous literature, with some worrying HIV-related stigma could be (unintentionally) exacerbated within these approaches – particularly among already vulnerable populations. For example, some have suggested that routine HIV testing approaches will unfairly disadvantage some population sub-groups, including gay and bisexual men or people who inject drugs (Smith 2011, Powers and Faden 2006). Others suggest that decontextualised approaches to routine testing that disregard clinician-patient power relations or contemporary gender regimes fail to appreciate and consider the social conditions in which individuals live and experience HIV-related issues and risks – and that this may inadvertently increase HIV-related stigma (Durojaye 2011, Kippax 2006). These latter arguments would suggest more emphasis should be put on understanding (and responding to) how societal expectations regarding HIV will influence how individuals experience HIV testing policies and practices.

While theoretical work in this area has traditionally conceptualised clinical interventions as having limited capacity beyond the individual level to reduce HIV stigma (McLaren et al. 2009), these data corroborate arguments (Knight *et al.* 2014a, Knight *et al.* 2014b, Knight *et al.* 2012) suggesting social processes associated with clinical encounters also can have the potential to move “upstream” by transforming the social and cultural contexts in which experiences of HIV stigma occur. For example, these findings highlight how institutional-level testing policies and practices can provide experiences for men to reconceptualise and/or interrogate pre-existing and -conceived stereotypes about HIV and HIV-related stigma. In doing so, these data reveal how a routine test offer may be helpful in both reducing barriers to testing that are associated with HIV stigma, as well as serve to diminish some of the external stigmatizing conceptions that HIV testing is a so-called ‘exceptional’ experience.

Despite the promising findings suggesting routine testing can ameliorate notions of HIV stigma, these findings also highlight how (mis)interpretations of universal, routine policies and service delivery practices can serve to (unintentionally) burden already disadvantaged population subgroups. Men's interpretations of routine testing practices as being ‘targeted’ based on pre-existing stereotypes about HIV risk have important consequences for delivery practices regarding routine HIV testing policies. In the context of the current study, these data highlight how understanding the universality of a routine offer can be perceived as conferring respect to everyone in that it avoids social practices associated with HIV stigmatization, such as stereotyping, labelling or discrimination. However, these data also underscore how broader socio-cultural stereotypes regarding young men's sexuality and sexual behaviour can influence how routine testing can be perceived as being a form of ‘targeting’, thereby leading men to (re)internalise these conceptions about HIV. However, when sufficiently understood, the universal dimension of a routine offer tended to diminish these concerns.

Strengths, limitations and future research

The current study has several strengths and limitations. For example, the findings are specific to the participants in this study (i.e., not generalizable), and other young men may

have other perspectives not captured here. The heterogeneity of the sample, however, provides opportunities to explore a diverse set of experiences pertaining to HIV stigma and HIV testing experiences and is therefore well suited to address the objectives of this article. Future research should seek to expand understandings of how heterogeneous and diverse social identities have the potentially differential capacity to deploy a range of causal powers, including the capacity to decline a routine offer if they do not want a test. For example, important criticisms of routine testing have suggested that patients may feel pressured into testing depending on how testing is presented by their clinician and that socially vulnerable individuals may be especially likely to feel pressured given the influence of clinician-patient power differentials (Rennie and Behets 2006). Finally, future research could also seek to identify *how* routine offers can best explicate the universal dimension of a routine offer through the delivery of wording and/or pre-test counselling in clinical practice. While the current study is limited in its capacity to illuminate these complex issues, future research could address these concerns.

Conclusion

While much of the previous literature in this area has rested on the assumption that various HIV testing policy and programme delivery practices may attenuate or exacerbate HIV-related stigma, these assumptions are frequently premised on arguments related to stigma that suffer from significant empirical and theoretical limitations and/or ‘gaps’, including uncertainty as to how HIV testing policy can influence individual- versus structural-level change (and how these interrelate) (Knight *et al.*, 2014a). The current study provides an analysis of HIV-related stigma that conceptualizes HIV-related stigma as a product of systemic social and structural inequalities as expressed through community norms and experienced (and co-constructed) by young men. These findings reveal various experiences that men can have in clinical interactions that serve to either attenuate or exacerbate HIV-related stigma and how these experiences are, in part, mediated by HIV testing policies and programme delivery practices. In doing so, these findings reveal how, when the universal dimension of the routine offer is sufficiently communicated, experiences with routine HIV testing can serve to diminish HIV-related stigma.

While these findings indicate that young men's experiences with routine testing have the capacity to diminish (or inadvertently increase) HIV-related stigma at the level of the individual, they also suggest routine testing policies can provide a set of *social* and *structural* conditions to influence HIV stigmatisation. As others suggest (Lancaster et al., 2014; Ingram & Schneider 2005), experiences with public policies and programme delivery practices shape the subjectivities available to individuals and collectives – particularly when these policy operate along the lines of pre-existing stereotypes or at socially vulnerable populations who bear the burden of disease. For example, policy can tend to divide (deliberately or incidentally) socially constructed population sub-groups into discrete categories along the lines of identity, group ‘conduct’, and circumstance, and also provides ‘clues’ for how various groups ‘should’ be treated (Stone, 2005). Our findings reveal how routine HIV testing policy can serve to ‘intervene’ on these experiences by providing opportunities for young men to reconceptualise or interrogate pre-conceived stereotypes and assumptions about HIV and HIV stigma. In doing so, routine testing policies can provide

‘new’ subjectivities for young men to occupy, including masculine dispositions that can feature or invoke more equitable gender relations. This, we suggest, may have vast implications for influencing long-term social and structural change regarding HIV stigma.

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Table 1
Socio-demographic characteristics of study participants

Ethnicity	(n)	(%)
Aboriginal	6	12
African-Canadian	1	2
Euro-Canadian	26	52
Latin	2	4
South East Asian	7	14
Middle Eastern	1	2
Other	7	14
Living arrangement		
With parents	9	18
With friends or partner	22	44
Alone	7	14
In a shelter or on the street	11	22
In a recovery house	1	2
Previously tested		
Never	5	10
One or more	45	90
Testing approach experienced		
Voluntary testing	32	66
Routine testing	5	10
Both Voluntary and Routine	8	14
None	5	10
Sexual Orientation		
Bisexual	8	16
Gay	7	14
Heterosexual/straight	34	68
Two-Spirit ²	1	2
Gender Identity		
Transgender man	1	2
Cisgender man ³	49	98
Recruitment medium		
Online advertising	23	46
Posters	2	4
ARYS	24	48
Other	1	2