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To test or not to test: A psychosocial perspective of HIV testing

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Research questions

- What are main barriers and facilitators of HIV testing as reported in the published scientific literature?
  - Descriptive and correlation research
- Is there evidence to suggest that (factors explaining) testing practices vary significantly in community sub-groups?
  - Socio-demographics; risk indicators and behaviors
- What is the respective contribution of socio-epidemiological and psychosocial factors that may explain differences in HIV testing?
  - Socio-demographics; risk indicators and behaviors
  - Risk perception and vulnerability; costs and benefits

Characteristics of reviewed studies

k=38 studies post-HAART	Type of determinants	Research design psychosocial studies	Main outcomes
General public (4)	4/4 epidemiology 4/4 psychosocial	3/4 descriptive 2/4 correlational	Ever tested, or last (5) year(s)
Diverse high risk (6)	3/6 epidemiology 6/6 psychosocial	5/6 descriptive 3/6 correlational	Ever, last year or acceptance
Young people (4)	2/4 epidemiology 4/4 psychosocial	1/4 descriptive 3/4 correlational	Intention test, seeking test
MSM (11)	10/11 epidemiol. 7/11 psychos.	4/7 descriptive 4/7 correlational	Ever tested
Ethnic minorities (5)	5/5 epidemiology 4/5 psychosocial	1/4 descriptive 4/4 correlational	Ever tested
Pregnant women (8)	6/8 epidemiology 7/8 psychosocial	7/7 descriptive 2/7 correlational	Acceptance of HIV test
Total	*30/38 epidemiol.* *32/38 psychos.*	*21/32 descript.* *18/32 correlat.*	

Socio-demographics

- Differences in terms of HIV testing practices according to socio-demographic characteristics are limited:
  - No gender differences (excluding pregnant women)
  - Minor effect of ethnicity (mostly US): possibly more testing in minorities
  - Some effect of higher educational achievement, mostly in minorities
  - Clear increase with age, but leveling off
- Ever having tested for HIV is higher in older age groups, but the increase seems to level off at highest age:
  - Differential exposure/selective survival, and/or methodological constraints
- The idea that HIV testing practices differ substantially according to socio-demographic sub-groups was not strongly supported by the literature, at least not in relatively well-adjusted populations.
  - The range of socio-demographic characteristics is selectively studied

Risk indicators and behaviors

- Descriptive studies suggest that risk-taking is an important personal reason to test; the main reason for not testing is no risk-taking.
- Individuals are more tested for HIV when they report having tested for STD, had an STD or visited an STD clinic:
  - It is unclear how these factors are related in time and decision-making
  - The relationship with previous testing for HIV is equivocal
- When reported findings for sexual risk-taking are considered on a general level, an association can be noted with HIV testing.
  - Indicators of risk-taking vary strongly and differ per population, as do findings
- A substantial proportion of non-tested individuals equally reported risk-taking, and in some populations, such as MSM, most non-tested individuals may also report any risk.

Risk perception and vulnerability

- Perceiving personal risk may promote testing, but findings are mixed:
  - 6 studies found more testing with higher perceived risk
  - 7 studies found no association; 1 study found negative relation
- Longitudinal studies need to establish influence of risk perception.
  - Level of perceived risk, measurement instruments
- ‘Risk appraisal may reflect defensive reactions to minimize threat.’
  - Limited evidence for negative effect on health behavior and HIV testing
  - Worry promotes health behavior, including screening of different types
- The second-most important personal reason not to test for HIV is fear of consequences of testing positive (e.g., fears of being stigmatized).
  - No indicator of strength of this relationship, if any
  - Suggests awareness of potential risk, not outright denial
  - Differences in how individuals cope

Costs and benefits

- Few studies are available on perceived costs and benefits.
- Perceived benefits are taken into account in the decision process that leads to requesting an HIV test or not:
  - Perceiving more benefits promotes HIV testing
  - Perceived costs/barriers/self-efficacy are less likely to be associated
- The precise benefits and costs to be addressed in research and interventions need to be considered carefully:
  - Unspecified, trivial or idiosyncratic what was assessed
  - Benefiting from new treatments may not be central in the decision-making
- Personal reasons for not testing for HIV that are labeled as fears can be more precisely construed as social costs/barriers
  - The risk of loosing one's partner seems particularly salient
  - In addition, wider social concerns relate to stigma and privacy

Conclusions

- Barriers and facilitators mostly located in individuals
  - System characteristics are under-researched and need addressed.
- Focusing on socio-demographics/risk provides limited understanding.
  - Explanations beyond description of obvious differences between communities
  - Differences between sub-groups are small in well-adjusted communities
- Psychosocial factors contribute to the explanation of HIV-testing.
  - Vulnerability may moderate the association between risk-taking and HIV testing
  - Perceived benefits may exert more influence than perceived costs/barriers
- Lay perceptions of costs/benefits may be different from expert opinion.
  - Perspective of those concerned needs to be taken into account
- Stigma and other social concerns seem crucial barriers.
  - Those close to us rather than anonymous social context at large
  - Promotion of testing needs to encompass fighting social stigma

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