

# Behavioral, Normative, and Control Beliefs of Filipino Men Who Have Sex with Men on Repeat HIV Testing and Counseling

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## ABSTRACT

**Introduction.** The Philippines faces an increasing incidence of HIV. Timely and regular HIV testing can be a preventive method against HIV infection because early detection of the virus leads to early access to treatment. This can lead to viral suppression in which the virus becomes undetectable and untransmittable. Repeat HIV testing is recommended to men who have sex with men (MSM) and other individuals with previous or ongoing risk of acquiring HIV. Following the Reasoned Action Approach model, providing behavioral interventions in promoting retesting among MSM first needs the identification of their salient beliefs toward a repeat test.

**Method.** A qualitative cross-sectional study was conducted. Thirty HIV non-reactive MSM from a community-based HIV testing and counseling center took part in the study. Participants were asked questions designed to elicit salient behavioral, normative, and control beliefs toward a repeat HIV test three to six months following the receipt of the non-reactive HIV screening test result.

**Results.** The most salient belief on the positive consequence of a repeat test was having peace of mind with one's status; while the most salient belief on the disadvantages was investing in time and travelling as well as experiencing pain from the needlestick. Close friends were the most cited normative referent. Accessibility of facilities and time were believed to be the most salient facilitator and barrier, respectively.

**Conclusion.** HIV/AIDS counselors and administrators can become key persons in increasing regular HIV testing by bringing messages that address the unearthed salient beliefs of MSM toward repeat testing. The salient beliefs extracted from the participants can provide basis for behavioral interventions; however, a formal test through a quantitative study of a larger sample is warranted to identify beliefs that significantly affect attitudinal, normative, and control factors of retest intention.

*Key Words: behavioral beliefs, normative beliefs, control beliefs, prevention and control, HIV testing and counseling, men who have sex with men*

## INTRODUCTION

### Epidemiology of HIV in the Philippines

There has been a rising incidence of HIV in the Philippines. According to the Department of Health (DOH)<sup>1</sup>, an average of two cases of HIV infection per day were documented in 2009 which increased to seven cases in 2011, 13 in 2013, 22 in 2015, and 32 in 2018. In December 2018 alone, 877 new cases of HIV seropositive individuals were recorded which comprised 8% of the 11,427 new cases in the year 2018. Most of the recorded cases in December were males (96%). Median age was 28 years old where half of the cases belonged to the 25-34 age cohort; while about one-third was aged 15 to 24. Highest incidence was recorded in the National Capital Region (NCR) as well as

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its peripheral regions, CALABARZON (i.e., Region IV-A) and Central Luzon (i.e., Region III). These demonstrate that individuals who tested positive come from the youth sector and major metropolitan areas.

Sexual contact among men who have sex with men (MSM) has also been reported as the most predominant mode of transmission of the virus from January 1984 to December 2018. This confirms that the rate of HIV is exploding among the MSM subpopulation in the Philippines.<sup>2</sup> The high probability of transmitting the virus through receptive anal intercourse gives an important explanation to the high incidence of HIV among MSM.<sup>3</sup>

Identifying one's HIV status can be attained through HIV testing. It can either be client-initiated voluntary counseling and testing (VCT) or provider-initiated testing and counseling (PITC).<sup>4</sup> In VCT, clients seek HIV testing and counseling (HTC) services in order for them to know their HIV status on their own initiative. Thus, testing relies on the clients' intention. On the other hand, in PITC, health care providers recommend HIV testing to individuals visiting health facilities to be part of their medical care.

A surveillance report from the DOH revealed that MSM are engaging in risky sexual behaviors.<sup>5</sup> Age at first sex was during 15 years of age. About a quarter did not use condom or lubricant for anal sex for the past 12 months. Around a quarter also reported to be a client of a male sex worker in the past twelve months. Despite engaging in high risk behaviors, 78% reported to have never tested for HIV. Studies have documented personal and structural barriers in engaging in VCT among Filipino MSM.<sup>6-8</sup> Among these are not seeing the need to get tested despite engaging in risky sexual behaviors, issues of morality, expenses, time, distance, and fear of side effects of anti-retroviral drugs.

In the USA, the Centers for Disease Control and Prevention recommends at least annual HIV testing for sexually active gays or bisexual men; although they mentioned that some sexually active gays and bisexual men may benefit from a more frequent HIV testing, specifically every three to six months.<sup>9</sup> It is not advisable to recommend the general population to undergo retesting.<sup>10</sup> The WHO listed situations and settings where retesting is warranted. Among listed candidates for repeat tests include key populations including men who have sex with men, those with indeterminate status, and those who have previous and ongoing risk of acquiring HIV.

Repeat testing among the key population and those who are in ongoing risk of HIV exposure is important because early detection of the virus means that the person living with HIV can be linked to care early. Thus, the virus will be managed immediately and progression to Acquired Immunodeficiency Syndrome (AIDS) could be prevented. When left untreated, very high viral load also makes people living with HIV highly contagious to their sexual partners.<sup>11</sup> In order to promote repeat testing to the key populations, interventions for behavior change is warranted.

## Beliefs and The Reasoned Action Approach

The Reasoned Action Approach (RAA) is a behavior change model which states that behavioral change can be attained by providing interventions that target the salient beliefs of the target population.<sup>12</sup> Thus, in order to provide interventions aiming to increase routine VCT, it is a must to identify the target population's beliefs toward a repeat test.

RAA posits beliefs play a vital role in explaining behavioral intentions and actual behavioral performance. It states that the immediate antecedent of performing a behavior is one's intention to do it; while intention is driven by attitude toward the behavior, injunctive and descriptive norms, and perceived behavioral control. Attitude toward the behavior refers to the positive and negative evaluations (i.e. instrumental attitude) and experiences (i.e. experiential attitude) one might have when engaging in the behavior of interest. Injunctive norm refers to the perceived social pressure to perform the behavior; while descriptive norm reflects what others typically do with regard to the said behavior, i.e. whether they would perform it or not. Finally, perceived behavioral control refers to the perceived ease or difficulty in the conduct of behavior.

Personal characteristics, according to the model, shape beliefs which serve as the foundations of the intention's determinants. Beliefs about the instrumental and experiential consequences of behavioral performance form attitude toward the behavior. Beliefs on who would approve or disapprove such performance form injunctive norms; while beliefs on who would also conduct or not conduct the said behavior form descriptive norms. Finally, beliefs about the facilitating factors and barriers in doing the behavior of interest direct perceived behavioral control.

The model does not tell what interventions are effective; yet it can provide guidelines how to develop and pretest behavioral interventions such as persuasive communication, face-to-face discussions, observational modeling, or what have you.<sup>13</sup> First is to conduct an elicitation study to determine the accessible beliefs of the population through a small sample. The second step is conducting a correlational study to 1) assess the contribution of behavioral attitude, norms, and perceived behavioral control on intention, 2) determine the effects of intention and perceived behavioral control on behavior; and 3) assess contribution of beliefs towards attitude, norms, and perceived behavioral control. The final step is to implement the intervention the investigators have decided to conduct.

Among studies using the Theory of Planned Behavior (TPB), an early formulation of the RAA, there is little attention given to elicitation studies.<sup>14</sup> Thus, this current study focuses on this first step and contributes to the body of literature on belief elicitation within the RAA framework. Aside from providing basis for intervention, the unearthed beliefs can also be used to create belief-based measures of behavioral attitude, injunctive and descriptive norms, and perceived behavioral control in order to quantitatively test the predictive validity of the RAA.<sup>15</sup>

This study was part of a larger project aiming to identify the incidence and determinants of a repeat VCT for HIV after three to six months among men who have sex with men. The larger project used the RAA model because 1) it has not been used to explain repeat VCT; and 2) it is a new formulation of the TPB; thus, this new model needs further testing. As reiterated previously, elicitation techniques have been given attention for studies using the TPB as framework; thus, this current study which serves as the exploratory part of the larger study.

This study intended to unearth important beliefs toward a repeat VCT three to six months following receipt of a non-reactive HIV screening test result using the RAA model. Specifically, it aimed to identify 1) the behavioral beliefs of MSM that capture attitude toward the behavior; 2) their normative beliefs which refer to the referents putting pressure to conduct a repeat VCT; and 3) their control beliefs to highlight factors that may facilitate or impede a repeat VCT.

## METHODOLOGY

### Study Design

This current research utilized a qualitative cross-sectional study design to address the objectives of the study. The RAA model served as a guide in what kind of beliefs should be extracted among the pool of participants, while Fishbein & Ajzen's recommendations on identifying these beliefs were followed.<sup>12</sup>

### Research participants

The study was conducted at a community-based HTC center in Mandaluyong City, Philippines. After communication of HIV test results and conduct of post-test counseling session, HIV/AIDS counselors informed their respective HIV non-reactive MSM client that a study on repeat HIV testing was being conducted at the study site. The counselors told their respective clients that if they are interested in participating, permit to disclose their HIV non-reactive result to the Principal Investigator (PI) of the research should be given to avoid breach of privacy. If permitted, the PI took over the counseling room to explain the succeeding steps of the study. An informed consent form was handed over to the client after expressing interest to participate; and screening proceeded once the agreement section of the consent form had been signed.

Godin & Kok (1996) on their review of the TPB recommended a sample size of 25 in order to elicit behavioral, normative and control beliefs.<sup>16</sup> However, for this study, it was increased to 30 to further enrich the data. Invitation and screening stopped once 30 eligible participants have already been interviewed. The following were the inclusion criteria: 1) biologically male who has sexual experience with other men, 2) aged 18 years or older, 3) studying, working, or residing in Metro Manila, 4) non-reactive to HIV antibodies, and 5) has engaged in any of the following for the past six

months: a) unprotected anal sexual intercourse, b) multiple anal sex partners, c) multiple oral sex partners, d) sex under the influence of alcohol, e) sex under the influence of drugs, or f) trading money for sex (i.e. bought or sold sex). Those who served as participants of another project requiring regular testing every three months were not eligible for the study since this research focused on client-initiated testing where conduct of a repeat test relies on intention.

### Data and Method

Questions made to elicit top-of-the-mind beliefs were based on Fishbein and Ajzen's question format.<sup>12</sup> The questions were adjusted to the behavior being studied by this research which was repeat VCT. In this study, repeat VCT was defined as client-initiated HIV testing and counseling within three to six months following receipt of a non-reactive test result, i.e., from the day of data gathering.

Clients were asked to enumerate their answers to the following questions — 1) "What do you think are the advantages and disadvantages of repeating the HIV test within the next three to six months?"; 2) "What would be the things that you would like/enjoy and dislike/hate about repeating the HIV test within the next three to six months?"; 3) Who are the persons who would approve/support or disapprove/not support you about repeating the HIV test within the next three to six months?"; 4) "Who are the persons who would repeat or conduct an HIV test/would not repeat or would not conduct an HIV test within the next three to six months?"; and 5) "What do you think are the factors that might facilitate/make it easy or hinder/make it difficult for you to repeat the HIV test within the next three to six months?." After enumeration of answers for each question, clients were asked to explain their answers to provide elaboration.

The first two questions elicited instrumental and experiential beliefs, respectively. The third and fourth questions asked about injunctive and descriptive normative beliefs, respectively. Finally, the last question inquired about control beliefs. The interviews were audio recorded to allow transcription of verbatim responses.

### Analysis of Data

Interviews were transcribed verbatim. Beliefs were sorted from most emitted to least; and those which cumulatively accounted for 75% (starting from most emitted to least) were considered as salient belief as recommended by Fishbein & Ajzen.<sup>12</sup> Many of the enumerated answers were direct; while a few were not. Thus, the PI initially did two rounds of analyses of data to compare if the same set of salient beliefs would appear. At third step, the program manager of the study site's HIV testing operations assisted in the analyses. At final step, two HIV/AIDS-trained volunteers also assisted in analyzing the data. All steps yielded the similar salient beliefs. Results were given to three individuals after the said four rounds of analyses. Two hold PhD degrees in

social science disciplines and one holds a PhD in an allied health discipline. No further comment was given by the evaluators and the beliefs emitted were accepted as is; thus, the analyses after the fourth round of analyses were retained.

### Ethical considerations

Prior to data gathering, ethics clearance was obtained from the University of the Philippines Manila Research Ethics Board (2018-021-01). The study adhered with the guidelines of the Data Privacy Act of 2012 (RA 10173) and the Philippine HIV and AIDS Policy Act (RA 1116).

The project was explained to all clients referred by the counselors. An informed consent form for their participation in the screening and interview processes was administered. Data gathering started after obtaining written informed consent from the client. All participants were assigned codes in encoding in the database of participants and during transcription. All forms of data were destroyed after publication of results and only the PI had previous access to these.

## RESULTS

Thirty-eight clients were screened for the elicitation study. The average age of the 30 eligible participants was 26 (SD = 5.58). Majority self-identified as a male (90.00%). Two clients self-identified as “bakla” or translated loosely, “gay” (6.67%). Majority of the participants were exclusively or more attracted to the same sex (66.67%). Table 1 presents the emitted behavioral beliefs of the participants.

### Behavioral Beliefs

Many of the responses from both type of behavioral beliefs overlapped. The following were perceived to be both advantages and things one would like when engaging in a repeat test after three to six months. Guided by the RAA, these beliefs form positive attitudes toward a repeat test.

*Peace of mind.* One of salient beliefs mentioned by the participants was having peace of mind. Participants reported that they were anxious or worried about their status that it might be reactive that is why when they receive a negative HIV test result on a repeat test, they would have a feeling of security.

*“I am always nervous whenever I get tested even if I do not engage in sex with others; thus, peace of mind. I have about three friends living with HIV. You’ll just be surprised that your friends have HIV.”*

*Knowing one’s status.* Participants also highlighted that one advantage of undergoing a retest is knowing one’s status.

*“Awareness and knowledge are very important. You being aware of yourself, of your condition, you would know how to fought [sic] on things; you know how to deal with this, so there. That’s the main reason why I would normally get (re)tested.”*

**Table 1.** Percentage distribution of behavioral beliefs

Behavioral Belief	Frequency	Percentage
<b>Instrumental Behavioral Beliefs</b>		
<b>Advantages (n = 64)</b>		
Peace of mind	13	20.31
Knowing one’s status	12	18.75
Confirming a negative status	10	15.63
Early detection and access to treatment	5	7.81
Monitoring/knowning health status	4	6.25
Practicing HIV prevention	4	6.25
Capacity to engage more in sex	4	6.25
Others (non-salient beliefs)	12	18.75
<b>Disadvantages (n = 32)</b>		
Investing time and travelling	7	21.88
Worry or anxiety about the result	6	18.75
Seeing familiar people	2	6.25
Getting a positive result	1	3.13
Pain brought by the needle	1	3.13
Perception that people judge you	1	3.13
(None)	14	43.75
<b>Experiential Behavioral Beliefs</b>		
<b>Likeable things (n = 47)</b>		
Peace of mind	13	27.66
Knowing one’s status	8	17.02
Meeting other people	5	10.64
Confirming a negative status	4	8.51
Engaging in counseling sessions	4	8.51
Monitoring/knowning health status	2	4.26
(None)	2	4.26
Others (non-salient beliefs)	10	19.15
<b>Unlikeable things (n = 38)</b>		
Pain brought by the needle	9	23.68
Worry or anxiety about the result	8	21.05
Investing time and travelling	6	15.79
Perception that people judge you	4	10.53
Getting a positive result	4	10.53
Others (non-salient beliefs)	7	18.42

*Confirming a negative status.* Participants also stated re-assurance of a non-reactive result as one advantage of conducting a retest.

*“Repeating the HIV test is for the assurance and accuracy of your previous test result. If you have sex again after your test result, the succeeding test result might not confirm the previous one.”*

*Monitoring and knowing health.* For others, engaging in a repeat HIV test was a means to monitor and secure one’s health. Absence of HIV for these individuals meant absence of HIV-related diseases or complications; and they can live healthy and longer.

*“If we repeat the test, it would be better because you can monitor your health. So, if you engage in sex many times, it is important that you do regular check-ups; thus, that would be an advantage.”*

The following were unique modal beliefs in terms of advantages of a repeat voluntary screening for HIV for the next three to six months after baseline screening.

*Early detection and access to treatment.* For the respondents, repeating the HIV test early means that there is a possibility of early detection of the virus and consequently, early access to medications.

*"If ever I would get positive in the repeat test, early detection would be better. The earlier that you know that you are HIV positive, the better because you can immediately start treating it."*

*Practicing HIV prevention.* Participants reported that HIV testing is a form of prevention. One said that if he became positive on a repeat test, he will be more cautious of his sexual behaviors. Another said that he would discontinue having sex if in the repeat test, he will be positive for HIV.

*"Of course, a repeat test would determine if I should still continue my habits. If ever I received a positive test result, definitely I should discontinue sex because, otherwise, I'm spreading HIV."*

*Capacity to engage more in sex if non-reactive.* Respondents mentioned that when they receive a negative HIV test result on their repeat test, it would enable them to have sex with others. This is especially true when potential sexual partners ask for HIV status.

*"I would have ease of having sex. In the circle where I belong, when you are not sure about your status, it would be hard for you to get someone for sex. Sometimes, they ask your status. In my case, I don't want to have sex when I'm not sure of my status."*

On the other hand, the following points are the unique experiential beliefs of the participants with regard to repeat HIV testing.

*Meeting other people.* Some respondents reported that one thing they would like for a repeat test is meeting other persons and such community testing center can be a venue for friendship building.

*"In this kind of community or organization, you meet people. We (MSM) are not accepted by society. So, we look for people like us. When you go to Manila, there are a lot of gay and bisexual men so it's an opportunity to meet them unlike in the province."*

*Engaging in counseling sessions.* Participants reported engaging in counseling as a likeable thing that they would experience when they will engage in a retest because they would be able to privately tell their intimate stories.

*"You could share your experiences privately or secretly during the one-on-one counseling. I could tell my biggest experience about sex."*

There were also responses that overlapped as both disadvantages and dislikable things for the participants. These beliefs form negative attitudes toward a repeat test.

*Worry or anxiety about the result.* Participants reported worry or anxiety as one consequence of repeating the HIV test. That is why when they receive a non-reactive result, they feel relieved as stated previously.

*"For me, disadvantage would be being nervous again about the result despite I know I am negative because I engage in blood donations."*

*Investing time and travelling.* Time and distance are common issues among the participants. One even said that travelling from an adjacent city would take him an hour while for some, it would take more than one hour especially for those who would be coming from the extreme northern and southern parts of NCR.

*"Time is important to me. So, most of the time, I am busy with work. I have a lot of things to do and if I go here, I need to spend the rest of the day to get my results."*

*Getting a positive result.* For some participants, this is a disadvantage and/or a thing that they would not like during a retest. Reasons vary why it is a disadvantage and unlikeable. One participant mentioned that you would take medications if you are HIV-positive. Another mentioned that you might contribute to its spread.

*"I would dislike getting a positive result. I know that I'm positive, and then definitely, that would affect my health. I'm not sure if in the future I would still be alive. I'm much worried also that I might spread HIV which I don't like. As much as possible, I should avoid spreading the disease."*

*Pain brought by the needle.* Many participants shared that when they repeated the test, they would again experience the pain brought by the needlestick during blood extraction.

*"I am afraid of the needle. I am afraid of the procedure."*

*Perception that people judge you.* Respondents perceived that they might get judged by the persons in the clinic for their sexual activities when they repeat the HIV test. They think that people would remember them having a test previously and that they might be sexually active for engaging a repeat test.

*"People might think that I am sexually active – that I always have sex with others."*

Many participants reported that there are no disadvantages in repeating HIV test for the next three to six months nor there are things they would dislike about it. However, a few reported that one disadvantage of a retest is having a possibility of seeing familiar people. One even said that when someone he knows see him getting tested, that person might ask why he would get tested for HIV. This belief was reported especially of those who have not disclosed their sexual orientation.

*"I am not out of the closet, especially to my work. So, someone might see me in this kind of facility where men who have sex with men usually visit."*

### Normative Beliefs

Table 2 presents the percentage distribution of the emitted normative referents of the clients.

No persons were believed to disapprove or the participants to repeat the test. Some participants also reported that no one supports or encourages them to repeat the test; thus, VCT is more likely self-initiated. For others, however, there are persons who would approve them to do so, namely the following.

*Close friends.* Participants emphasized that it is their close or best friends who would encourage them to repeat the test after three to six months. These are also the persons who also know the sexuality of the participant as well as his sexual activities.

*"I would count my close friends. They are the ones who know about my sexuality and sexual activities. They are also the ones who would support me to get tested."*

*HIV/AIDS counselors.* Another set of individuals that were reported to give support toward retesting was the counselors of the testing center.

*"My counselor said that my HIV test covers activities prior to March 21 so the succeeding ones were not covered. So, he told me to get a repeat test."*

*Romantic or sexual partners (including persons being dated).* Some participants were currently dating someone or were in a relationship during the conduct of the interview. Their

partners also play a role in building a supportive environment in having a repeat test. Others say that their sexual partners also encourage them to have a retest. In case of being in a relationship, one said that they do not engage in safe sex often and that his partner encourages him to engage in a retest.

*"My partner and I do not engage in safe sex. We rarely engage in protected sex. So, he tells me to get a retest."*

*Family members.* The family is also a recurring normative referent among the participants. For members who are out of their closet, their family or family members also play a vital role in having a retest for the next three to six months. One shared that his sister supports him to do so while another reported that it is his mother who plays that role. A first-time tester shared:

*"Actually, it's my first time to get tested. My family would tell me that if I receive a non-reactive result, then I should get another test after three to six months."*

In terms of descriptive normative beliefs, the participants cited that they do not know anyone who would not repeat the HIV test. Some participants also reported that they do not know anyone who would get a test soon. Similar to injunctive normative beliefs, other participants also reported that their friend/s and romantic or sexual partner/s would also get tested after the three to six-month period. In addition to these, colleagues were included as referents.

*Close friends.* Some friends was also believed to get tested soon. Thus, close friends can provide a normative pressure to the participants when it comes to repeat HIV testing. A participant shared that he has a friend who also engaged in risky sexual behaviors; thus, his friend would also get tested within three to six months.

*"I have a friend who might get tested by December or November because of engagement in unprotected sex. Moreover, my friend does not have peace of mind because of engaging in unsafe sex."*

*Romantic or sexual partners (including persons being dated).* The same is also true for romantic or sexual partners. These are also individuals supportive of the behavior and individuals who would also get a retest for HIV for the succeeding months. One participant shared that he and his partner do not use condom; thus, a repeat test would confirm their status.

*"My partner and I were talking about a repeat test because we engage in unprotected sex. We intend to repeat the test."*

*Colleagues* Participants described their workmates or colleagues as sexually active that is why these individuals would also get tested soon. One noted that his workmates engage in sex under the influence of drugs (i.e. "partee"). "Partee," "party and play", and "chemfun" are some of the terminologies used to refer to sexual activities involving drugs.

**Table 2.** Percentage distribution of normative beliefs

Normative Belief	Frequency	Percentage
<b>Injunctive normative beliefs</b>		
<b>Would support a test/retest (n = 47)</b>		
Close friend	17	36.17
Counselor	8	17.02
Romantic/Sexual partner	7	14.89
None	6	12.77
Family	6	12.77
Others (non-salient beliefs)	3	6.38
<b>Would not support a test/retest (n = 30)</b>		
None	28	93.33
Friend	1	3.33
Heterosexual peer	1	3.33
<b>Descriptive normative beliefs</b>		
<b>Would conduct a test/retest (n = 36)</b>		
Close friend	17	47.22
Romantic/Sexual partner	6	16.67
Colleague	4	11.11
(None)	6	16.67
Others (non-salient beliefs)	3	8.33
<b>Would not conduct a test/retest (n = 30)</b>		
None	24	80.00
Friend	6	20.00

*"I have sexually active workmates. My colleagues' activities are quite alarming because they engage in "partee."*

**Control Beliefs**

The following were the factors that would play as facilitators and barriers for a retest (Table 3).

*Time.* Participants reported that work schedule can enable or hinder one in repeating the HIV test.

*"Because of work, I tend to go home late. Then during weekends, I have lots of things to do. It is possible to have a repeat test despite my schedule, but I really work on it."*

*Accessibility.* For the participants, accessibility pertains to both availability and being near an HIV testing center. For availability, one participant mentioned about having mobile tests while a few mentioned about the availability of self-screening for HIV in the market. However, the latter is not yet available in the Philippine market.

*"If ever a self-screening kit be available, then a repeat test would be easier. It would be better if we could buy one or if some companies distribute such."*

*Exposure to sex.* Engagement in sex after receiving a negative HIV test result can enable or prevent one to get a retest according to the interviewed clients. If one has not engaged in sexual activities, the likelihood to get a repeat VCT is lower; while engaging in such engages one to take a retest.

*"There's no need to get a retest if there was no exposure to sex."*

On the other hand, the following are exclusively mentioned as enabling factors for a retest to be possible.

*Reminder to get tested.* Since individuals might forget to get tested again for HIV, others suggested that having a reminder for them to get a retest would enable them to do so. A participant thought that automated messages to remind

him to get tested again would facilitate his retest. Another participant mentioned about the role of advertisements.

*"If ever I would have a reminder, then a retest is more probable. For me, that would be effective, like advertisements, because you will not forget about it."*

*Company.* Aside from reminders, having someone to accompany the participant or being tested in group would enable them to have a test again. One participant said that it would be enjoyable if he will be accompanied by his friends.

*"A repeat test would be easier if I ever I would have friends who would go with me. The HIV test would be enjoyable if I have them with me."*

*Better HIV testing logistics.* Finally, the last enabling or preventive factor pertains to the operations of HIV testing centers. According to the participants, having longer clinic hours, quicker results, and lower client volume would make a repeat test more probable.

*"I would say it would be easier for me to be tested if the process is quicker. Right now, the queue takes about three hours. I would have incentive to stick to the three to six months schedule if testing is quicker."*

**DISCUSSION**

The present study aimed to identify the salient beliefs of MSM with regard to a repeat VCT three to six months after receiving a non-reactive HIV test result. Determining these beliefs provides an important step in understanding repeat testing since beliefs give foundation to attitudinal, normative, and control factors that shape behavioral intentions. It also paves the way in identifying potential interventions to increase routine VCT. To the knowledge of the author, this is the first study which elicited the beliefs of MSM toward a repeat testing for HIV.

First, in terms of behavioral beliefs, the findings revealed peace of mind as the most salient behavioral belief. This belief is related to other negative beliefs that repeating the test might be disadvantageous and unlikeable because of the worry and anxiety one may experience during the testing procedures. Others also presented that one negative consequence of repeating the test is the possibility of seroconversion. Clearly, these denote that individuals have strong emotional response to HIV infection. This implicates that HIV/AIDS counselors and information campaigns could encourage individuals at risk of acquiring the virus to opt for routine testing in order for them to have peace of mind. In fact, research has documented that heterosexual men of Mexican descent are more likely to seek testing if they foresee positive outcomes, including peace of mind.<sup>17</sup> Another study revealed that one HIV testing efforts conducted by pastors of an African American clergy is to encourage couples test for HIV for peace of mind.<sup>18</sup>

**Table 3.** Percentage distribution of control beliefs

Control Belief	Frequency	Percentage
<b>Facilitators (n = 46)</b>		
Accessibility	16	34.78
Time	7	15.22
Exposure to sex	5	10.87
Reminder to get tested	5	10.87
Company	4	8.70
Better HIV testing logistics	4	8.70
(None)	3	6.52
Others (non-salient beliefs)	2	4.35
<b>Barriers (n = 42)</b>		
Time	22	52.38
Accessibility	6	14.29
Exposure to sex	5	11.90
(None)	2	4.76
Others (non-salient beliefs)	7	16.67

Another positive consequence is having the opportunity to share experiences and meeting new people. Treatment centers provide individual counseling to clients in order for them to open up their sexual experiences which they could not disclose to other individuals because of stigma. These centers can also provide venues for friendship among MSM. Truly, people who are not getting timely testing because they experience judgmental or discriminatory responses from health care providers give an example of the impact of stigma against HIV testing.<sup>19</sup> This unearthed belief suggests that treatment hubs should provide a safe and secured space to further promote timely and regular testing to clients especially to the key populations; and anonymity and confidentiality should be strengthened. In fact, participants have also revealed that one potential consequence of repeating the test is that the health care staff might judge them for being sexually active for repeating the test. Others also reported that repeat tests might increase the possibility of being seen by known people who might question why they were in an HIV testing center.

Other salient behavioral beliefs include knowing one's status and assuring one's status since the previous test might have been done within the window period of HIV. Knowing one's status is a clear advantage of HIV testing. DOH Department Circular No. 2016-0171 (2016) stated that clients with reactive HIV screening test result shall be provided immediate referral to treatment hubs.<sup>20</sup> Their blood samples shall be sent to STD/AIDS Cooperative Central Laboratory of San Lázaro Hospital for confirmatory testing. The clinic or hub where the client was referred to shall conduct a repeat HIV test to the client. Reactive repeat test shall be the impetus for clinical assessments and CD4 count.

Others also said that through HIV testing, one can know and monitor their health. This is because they could feel secure about their health status in a way that they are comfortable being free from HIV-related co-morbidities. Prominent co-morbidities include tuberculosis, cryptococcal infection, Hepatitis B and C; and other sexually transmitted infections.<sup>21</sup> Messages that bring awareness about the co-morbidities of HIV could also be used by HIV/AIDS counselors and HIV/AIDS program administrators.

Negative consequences include having inconveniences, specifically investing in time and travelling to HIV testing centers. These were consistent with findings of our Filipino studies.<sup>6-8</sup> Time to wait for the result of the screening in the study site ranges from one and a half hour to two hours in the study site. Even being called to get inside the phlebotomy room to have one's blood extracted would also take time especially if the client load is high. Furthermore, post-test counseling would also take minutes depending on the skills of the counselor and whether there are further questions from the client. This implicates that more centers should be established; or at least, locations of various HIV testing centers and their operating hours should be communicated to the clients since they may not be familiar with other testing locations.

When it comes to normative beliefs, only a few referents were reported. The most salient one would be one's circle of friends. Sexual or romantic partners and colleagues also play as referents to the participants. The presence of workmates as a salient referent may be explained by the age of the participants since they are generally on the young working age cohort. When asked about the characteristics of their circle of friends and workmates, participants would state that they are sexually active. This indicates that the participants have a sexually active network, which verifies national studies about youth sexual behavior.<sup>22-24</sup>

Findings about the normative referents of the MSM suggests that friendship-based testing might increase VCT uptake. In fact, interviews of persons living with HIV suggested that encouraging friends and family to get HIV tested is beneficial.<sup>25</sup> A qualitative evaluation of a friendship-based intervention indicated that both male and female participants revealed multiple benefits of attending the intervention with their friends.<sup>26</sup> These include a feeling of being more comfortable, more ease in self-expression, and being able to talk about sensitive matters.

Finally, control beliefs comprise issues of time, accessibility, and better testing operations as circumstances that may affect a subsequent test. These were consistent with studies on Filipino uptake of HTC.<sup>5-7</sup> Establishment of accessible HIV testing centers and conduct of mass testing events should also remedy the problem of time and distance. Availability of self-screening kit in the market might aid the problem regarding time since it would take few minutes to determine the result of the kit. As the participants also report dislike against the pain brought by the needle, self-tests for HIV can provide a painless test because it is available through saliva test. One systematic review and meta-analysis provided evidence that self-test has the potential to increase HIV testing.<sup>27</sup> Some researchers have also documented preference to oral-based self-test than blood test.<sup>28,29</sup> However, self-screening is still not yet available in the Philippine market and studies about its feasibility and acceptability must be conducted.

This study has several limitations. One limitation is that the samples are MSM only. The results of the study may not be true to other key populations including injection drug users and sex workers since their experiences may be different. Interviews were conducted among MSM residing, working, or studying in NCR; thus, findings may not be generalizable to other MSM outside the region. These limitations suggest that beliefs of other key populations must be studied as well. Lastly, this study is only the first step towards providing intervention to increase routine and repeat VCT. It only elicited the top of the mind beliefs of participants towards repeat VCT and did not formally test the relative contribution of each belief to intention and behavior. Despite this, it outlines the cognitive foundation of attitudinal, normative, and control factors affecting retest intention among MSM.



## CONCLUSION

The results of the study shed light on beliefs toward repeat VCT among the hard to reach, marginalized, and stigmatized sector – the MSM. By understanding their characteristics and beliefs as well as the stigma they face, this study offered foundations in providing behavior change-targeted approach. As the RAA would suggest, health workers working in the field of HIV/AIDS can use the unearthed beliefs in their messages to promote routine VCT through persuasive messages and other interventions. The study suggests that messages that highlight peace of mind as benefit, talking with friends about HTC, testing in groups along with friends, and alleviating accessibility barriers would increase uptake of VCT and retest. However, these are not conclusive since a formal test through regression analyses or structural equations modeling would best determine which of the extracted beliefs significantly influence retest intention and behavior; and eventually identify which of these could be used for intervention.

## Statement of Authorship

The author conceptualized the research, conducted data collection, led the analysis, and approved the final version submitted.

## Author Disclosure

The author declared no conflicts of interest.

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