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Perceptions of HIV Testing Among African-Born Immigrants in Washington State

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Abstract

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BSN, Armstrong Atlantic State University, 2010

MSN, Walden University, 2014

Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
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Public Health

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Abstract

African born immigrants (ABIs) face challenges associated with HIV testing. As a result, many ABIs are not tested for HIV, and this population is among some of the most diagnosed at late stages of HIV/AIDS. The purpose of this qualitative phenomenological study was to explore and seek to understand the lived experiences of ABI adults ages 25 to 49 living in Washington State. I gathered data to gain their perceptions of HIV testing through in-depth interviews. The study was informed by the health belief model, which helped to understand the complex nature of healthcare-seeking behaviors among this population and how their experiences shape their decision making related to HIV testing. Thirty one ABIs completed the interviews. Data collected from interviews were analyzed and three themes emerged: (a) barriers to HIV testing and of the acceptability of HIV, (b) lived experiences of African immigrants impact their decision to take an HIV test, and (c) impact of perceptions, attitudes, and beliefs in HIV-related stigma. The current results provide new knowledge regarding ABIs' perceptions on HIV testing. The results indicate most ABIs embrace HIV testing; however, stigma and financial affordability of HIV-related care services remains a barrier for some ABIs. The findings of this study have potential implications for positive social change by providing an understanding of the impact of lived experiences of ABIS related to HIV testing. The consensus from the study was that there is potential for positive social change at all levels that can be achieved by implementing programs that would reduce bias, stigma, and barriers. The study may help public health programs implementers design programs that would be beneficial to ABIs through culture sensitive care.

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Dedication

I dedicate this dissertation to the memory of my mother, Florence Wanjiru Mugo, and to my children, Trevor, Brandon, and Samantha Kiarie. As I embarked on this journey, I did not think it would have been one of the most challenging and trying projects. Because of life challenges during the process, life had me so busy I could barely find time to accomplish my goals. There were many times I wanted to quit and many times I did quit and gave up, but there was always a fire in me that kept pushing me through the hard times. As my children have watched me tackle this journey one step at a time, my prayer is that I will inspire them to keep pushing in all they desire to do. May they never give up on their dreams.

Acknowledgments

First, giving honor to God, who is the maker, creator, and sustainer of all things, and through him and his guidance, I have been able to achieve the impossible. My mama died when I was 11 years old; as the second child and the oldest girl, I had to grow up fast and become a mother figure for my other four siblings. Growing up in a single-parent home, I learned at a young age that education is the key that will unlock any door. I also grew up in the ghettos of Nairobi, Kenya, and the ghetto was not forgiving. I yearned to make it better and achieve an education. This was the key to success and the one thing no one would be able to take away from me. In keeping with the teachings of my parents, grandparents, and family, I knew I was destined for success. If it had not been for them, I would not have made it this far. Time is not only a gift, but also an opportunity. Therefore, as I continue to stand on the shoulders of greatness, I must take the time to thank those individuals who have guided me along the way.

I would like to express my sincere appreciation and dedication to those who shared my dream of obtaining a doctorate of philosophy. I am truly grateful to have a loving and supportive family. This study is dedicated to my guardian angel, my mother, the late Mrs. Florence Mugo; my father, Charles Kiboi, who believed in me at an early stage and afforded me the building blocks that have enabled and inspired me to advance my education; my children, Trevor Mugo, Brandon Mbugua, and Samantha Wanjiku; my sisters and brothers, Justus, Cecilia, Mercy, and Robert, who have always been there for me; and the rest of my family who kept me motivated and supported me. Without you, this would not have been possible. To Heidi, my four-legged daughter, thank you for your protection, unconditional love, wet kisses, and your “barks” of approval and comfort. To the love of my life, Mr. Victor Musandu: We did it, Babe! Thank you for your love, support, inspiration, and encouraging words. To my dearest friend, Mrs. Gladys DeLeon, and her family, Gene and Lexi, thank you for your motivation, support, and constant reminders that hard work always pays off. You helped me to persevere. A special thanks to my close friends who continually had a listening ear and a shoulder to lean on when I wanted to give up. This has truly been a memorable and rewarding experience that I will cherish for the rest of my life. To every other person who has provided a kind word and a smile, thank you. Love always.

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Chapter 1: Introduction to the Study

Introduction

In recent years, the number of new human immunodeficiency virus (HIV) infections, which can lead to acquired immunodeficiency syndrome (AIDS), has remained stable in the United States, with approximately 50,000 people newly infected each year; however, rates of HIV diagnosis were higher in the African American community than in the general United States population (Centers for Disease Control and Prevention (CDC), 2015a). The current literature does not address challenges among African-born immigrants (ABIs) or give insight on HIV testing in ABI communities. Thus, it remains unclear if there is a low rate of those who are tested for HIV or if accurate data is not well reflected (Ojikuti et al., 2016). Most of the available data cluster ABIs with the African American population, creating a disparity in reporting and surveilling for this community (Kerani et al., 2008; Ojikuti et al., 2016). In this study, I looked at the challenges of the ABIs living in Washington state that contribute to low rates of HIV testing.

In Washington state, among foreign-born Black residents diagnosed with HIV between 2009 and 2013, 40% were late HIV diagnoses (King County, 2016). Local research on foreign-born Blacks in King County suggests there is an average of about 7 years between date of initial entry into the United States and date of HIV diagnosis, and about 5 years between last reported negative HIV test and first positive test (King County, 2016). Efforts to promote HIV testing as part of routine care have been limited, and identification of groups at high risk for late HIV diagnosis are needed (Golden, 2014). The focus on testing among ABIs has been low even though the rate of HIV infection is higher than among African Americans (81.4 compared to 78.9 per 100,000; Ojikutu et al., 2014).

The role of public health is to identify and propose strategies that directly address the health disparities and system of inequities to provide HIV-related services and other services associated with social determinants of health.

Background of the Study

The purpose of this study, driven by social constructivism and the advocacy worldview, was to explore the lived experiences of participants from Africa living in Washington state to gain an understanding of their perception and attitude toward HIV testing. The findings of the study may lead to a new understanding of the challenges this population faces. These findings could give healthcare providers insights on the population in question, their challenges, and how to better address their concerns. The methodology of the study was a phenomenological approach to set aside biases and preconceived assumptions about ABIs and their feelings and responses to their views of not testing for HIV.

Data were collected through responses from participants when they completed questionnaires that were mainly online; some were recorded via telephone or in-person interviews to accommodate participants. Demographic data were collected online to determine if participants qualified to participate in the study, and those who qualified completed the other questions during an interview. The recorded data were transcribed before being analyzed. The findings can improve the current social conditions of the ABI community by providing information to healthcare professionals who can improve or maintain the health of this population.

In reviewing the literature, I sought to understand HIV and social determinants of health behaviors associated with the rates of testing in ABIs in the United States and why testing is still a public health issue in the population. Kingori et al. (2016) examined relevant HIV prevention strategies that enhance HIV prevention among Somali immigrant/refugee young adults in the United States. Kingori et al. indicated there is a lack of aggregate data on HIV infection rates among ABIs, which is a gap in the literature. The study findings concluded a need for HIV prevention strategies by use of internal community resources and external platforms. To reduce new infections, there has been collaboration of different entities that has led to the formation of projects such as End AIDS Washington. This project is a collaboration of community-based organizations, government agencies, and education and research institutions that work together to reduce infections; the goal was to reduce infections by 50% by 2020.

Okoro and Whitson (2017) conducted a study based on social–cultural outlook with an effort to understand the strategies effective in limiting the spread of HIV infection and enhancing HIV care among ABIs. The data used in the study were from the Minnesota Department of Health HIV/AIDS surveillance report of 2015. Researchers focused on how HIV infections that disproportionately affect women (Okoro & Whitson, 2017). The findings indicate gender-specific sociocultural factors influence testing and treatment for HIV in ABIs (Okoro & Whitson, 2017); culture is an important aspect in the ABI community.

Worthington et al. (2013) conducted a study to explore community perceptions of HIV/AIDS to determine if gender influences these perceptions. The authors indicated that a breakdown in family resulting from cultural adjustment challenges can inhibit the success of HIV programs and indicate a need for a holistic approach for HIV prevention and services integrated with newcomer services.

CDC established recommendations on HIV testing in 2006 that everyone between ages 13 and 64 be tested at least once in their lifetime. Nonetheless, fewer than 40% of Americans have ever been tested. In the past year, nationally less than 30% of people most at risk were tested, and within rural areas most affected by HIV, about 26% of those recommended for annual testing were tested (whitehouse.gov/onap, 2014). The overall goal of this study was to understand the perceptions among ABIs in two counties in Washington state and their decision making on HIV testing and why most do not voluntarily seek HIV testing services, which can lead to late diagnosis of HIV. Even though ABIs have the highest number of those affected by HIV compared to other minority groups, there is still a huge knowledge gap in the perception of HIV risk. I sought to identify the factors influencing HIV risk perceptions among ABIs and how it is associated with the high prevalence rates in Washington state. No study has been conducted to examine what influences ABIs to voluntarily be tested for HIV.

Problem Statement

ABIs living in Washington state have been affected by HIV infections. Data indicate that 24% of all new documented cases between 2009 and 2011 were among foreign-born citizens, and from 2011 to 2015, that rate had increased to 35%. The care cascade demonstrates that about 56% of King County people living with HIV/AIDS are virologically suppressed, and although it is almost double the national average, there remains a gap in care continuum and a need to educate the community on the importance of HIV testing and treatment. ABIs are challenged by other factors, such as an inability to effectively communicate in the native language, feelings of confusion, helplessness, or poor knowledge about administrative or logistical requirements of the healthcare system, which are complicated by the fear of stigmatization from their peers, communities, or families (Tanser et al., 2015). HIV has been a serious public health issue complicated by inaccurate accountability among migrants; public health departments have no actionable knowledge of health requirements of migrants, and immigrants are more likely to enter into the healthcare system late and less likely to continue with care and be retained in successive stages of successive HIV cascades (Kerani et al., 2017). Due to most immigrants not having health insurance and experiencing a wide range of social, economic, political, sociocultural, environmental, and cultural norms, there is a risk that most immigrants are not being tested (Connor et al., 2016). The public health forum is aware of the increasing numbers of ABIs in Washington state, and more outreach is needed to reach these communities in the most effective culturally sensitive way. In 2004, there was funding in King County directed at HIV testing for ABIs, but there was a low testing volume; public health departments distributed testing kits to taxi drivers, but the effectiveness remains unclear; there is a need for strategies to better reach the ABI community, and efforts to promote HIV testing have been limited.

A gap exists in HIV testing especially in individual decisions regarding testing, and this is noted due to the high cases of late HIV detection in ABI communities (Connor et al., 2016). There is limited data documented health disparities for ABIs as they are mostly categorized as *African American,* and this makes it difficult to identify the needs of these communities. This lack of clear data limits the development and implementation of innovative care models to increase access to HIV prevention, care, and treatment services for ABIs. There is a need for public health leaders to identify and propose strategies directly related to providing HIV-related services to increase testing rates in the ABI communities. There is also a deficiency in HIV knowledge that limits screening, which creates a significant gap. This study will be dedicated to accessing perceptions, attitudes, and acceptability of HIV testing in the ABI community. The data will be used to understand the barriers to HIV screening and testing and create initiatives that can bridge the gap and create healthcare services that are sociocultural acceptable to the ABI community and also change the perceptions, attitudes, and acceptability of HIV testing and screening. This will be an effort to decrease health disparities associated with HIV and retain more people in successive stages of successive HIV cascades after diagnoses. Identifying the factors that affect and prevent HIV screening and testing among ABIs can lead to an increase in HIV prevention, diagnoses, care, and retention.

There is limited epidemiologic data on ABIs, leading to the underestimation of true numbers of those living with HIV. For example, when looking at data for Pierce County, nothing has been documented on how immigrants access healthcare services, and data on new HIV infections is divided between those born in the United States or its territories, those born outside the United States, and those whose birthplace unknown. This unclear data limits the understanding of HIV status among immigrants in the United States. Other data indicate that foreign-born residents of King County had an increase in HIV prevalence from 23–34% from 2006 to 2015; those from Africa lead at 34% of the total number, and 15% of the total of new diagnoses are foreign born (Kerani et al., 2017). Despite progress in understanding the virus since its identification, the HIV epidemic has continued to grow at an unprecedented scale. ABIs living in the United States have faced many challenges that come with acculturation: discrimination, lack of jobs, cultural differences, language barriers, and lack of proper documentation. This has created among this population a fear of seeking healthcare services, which has contributed to increasing health disparities, including HIV infections.

Purpose of the Study

The purpose of this dissertation was to investigate the perceptions, attitudes, and acceptability of HIV testing and how these contextual realities affect HIV spread among ABIs from sub-Saharan Africa living in Washington state, with an effort to strategize and formulate interventions to aid in reducing HIV infections, increasing linkage to care, and reducing health disparities (Okoro & Whitson, 2017). ABIs have health disparities similar to those that affect immigrants from other regions; culture, sociocultural beliefs, politics, and perceptions hinder continuum of care, preventive care, and screening and testing for health disparities, including HIV (Okoro & Whitson, 2017). Learning and understanding the factors that impact an individual’s decision to test or not test for HIV is vital in public health for strategizing and implementing interventions important to decrease health disparities (Connor et al., 2016). The purpose of the study was to determine perception and attitude of HIV testing in ABIs living in Pierce and King County, Washington. There is a gap in data and literature on immigrants' attitudes toward HIV testing, and little attention has been devoted to understanding the barriers to testing. The ABI community has also remained an invisible population in terms of HIV surveillance; however, King County, Washington, has started identifying HIV diagnoses per country of origin.

The study will be primarily qualitative; the quality of problem statements will be assessed through interviews. I sought to understand why HIV is a critical problem in this community even with the advancement of HIV treatment and improved knowledge of the virus. I collected data primarily via interviews to increase understanding of the issue from individuals in the ABI community. Primary data were collected through interviews. The interviews were semi structured personal interviews with open-ended questions.

Research Questions

RQ1: What are the barriers to HIV testing and the acceptability of HIV testing among ABIs in Washington state?

RQ2: How do the lived experiences of African immigrants impact their decisions to take an HIV test?

RQ3: What is the impact of perceptions, attitude, and beliefs in HIV-related stigma in African born immigrants' community on their healthcare-seeking behaviors?

Conceptual Framework

The health belief model (HBM) and structural–functional theory (SFT) were the conceptual frameworks used to explain and predict health behaviors in ABIs. HBM assumes optimal behavior change will be achieved with successful target on perceived barriers, benefits, self-efficacy, and threat (Jones et al., 2015). I focused on the beliefs and attitudes of the ABI community and used the six constructs of HBM to predict health behavior: (a) perceived risk susceptibility, (b) risk severity, (c) benefits to action, (d) barriers to action, (e) self-efficacy, and (f) cues to action (Jones et al., 2015). Individual, sociocultural, economic, educational, and political factors are functional units of society that influence individuals; messages will achieve optimal behavior change if they successfully target perceived barriers, benefits, self-efficacy, and threats (Jones et al., 2015). Behavior depends on the importance an individual places on an outcome and what the individual expects; sociocultural, economic, educational, and political factors are functional units of society that influence individuals.

HBM theory was vital to this study because theories are at the heart of practice, planning, and research in public health. Knowing the role of theory during the literature review process helped me gain more understanding on its application to the HIV epidemic (Glanz et al., 2008). According to Glanz and Bishop (2010), HBM aligned with the significance of this study in the following ways:

- Perceived risk: I can become infected with HIV.
- Perceived seriousness: HIV/AIDS has caused death and could shorten my life if I were infected.

- Perceived benefits: I will be aware of my HIV status if I am tested.
- Barriers to taking action: I can become seriously sick if I am not tested and am HIV positive.
- Cues to action: I will protect myself from infection if I am HIV negative, or I will seek medical services if I am HIV positive.
- Self-efficacy: I will protect myself from HIV infection.

SFT explains why society functions the way it does by emphasizing the relationships between various social institutions (Cole, 1966). SFT can be used to observe the dynamic equilibrium and examine the parts required to work together to promote health equity among ABIs by looking beyond the individual to social facts, such as laws, values, morals, customs, religious beliefs, rituals, and fashion, which all serve to govern social life (Cole, 1966). ABIs go through social changes after migration and are often conflicted by the new social norms they encounter and most often are different from their beliefs, and this creates dysfunction and discord. ABIs are also unaware of the healthcare services available and limited access to care can be a driver to late HIV testing and poor outcomes.

Nature of the Study

The nature of this study was a cross-sectional study using a phenomenological approach; the study objective was to understand lived experiences with HIV and if these experiences have an impact on HIV testing among ABIs in Washington state. The study findings will be useful in planning, monitoring, and evaluation regarding HIV among this population. Because the study does not derive a causal relationship, but rather, I sought to investigate how perceptions, attitudes, and beliefs affect choices to be tested or not, this was a feasible study design (Setia, 2016). A cross-sectional study can be used to collect data at a point in time from one sample selected to describe a specific larger population at that particular point in time (Setia, 2016). The data collection was mainly primary data collection through semi structured interviews in the local communities. Thematic analysis was conducted to evaluate HIV testing based on perceptions, attitudes, and beliefs and to develop an explanation of what works best empirically (Creswell, 2014).

Definitions of Terms

Acquired immune deficiency syndrome (AIDS): The most serious stage of HIV infection, AIDS occurs when the number of CD4 cells falls below 200. With a drop in CD4 cells, an individual is prone to one or more opportunistic infections, although this can happen regardless of their CD4 count.

African American: Americans of African descent with ancestry in North America; may also be referred to as *Black Americans* or *Afro Americans*. African Americans have a total or partial ancestry from any of the Black racial groups of Africa. African Americans are descendants of enslaved Black people from the United States. African Americans constitute the third largest ethnic group and the second largest racial group in the United States, after White Americans and Hispanic/Latino Americans.

African born immigrants (ABIs): Foreign-born individuals who reside in the United States and are of African descent. ABI refers to geographical or national origins rather than racial affiliation. An estimated 0.8 to 0.9 million Africans immigrated to the

United States since the Immigration and Nationality Act of 1965 and 2007; they account for 3.3% of all U.S. immigrants during this period.

Black: People having origins in any of the Black racial groups of Africa or Australian Aboriginal ancestry, including immigrants from the Caribbean, South America, and Latin America. Black is also often socially based system of racial classification to describe people who are perceived as dark-skinned compared to other populations.

HIV diagnosis: An individual who was exposed to the HIV virus and after testing has shown to be positive for HIV infection. The human body cannot remove HIV, and after a positive diagnosis, an individual has HIV for life.

Human immunodeficiency virus (HIV): A sexually transmitted infection (STI) occurring through body fluids. HIV attacks the body's immune system by attacking t-cells and decreasing CD4 cells. Without proper care, HIV can eventually destroy the t-cells and the body becomes unable to fight infections and diseases.

Assumptions

I assumed the research instruments used would be the most appropriate to collect data and answer the RQs. I assumed participants would share their HIV risk perceptions. I expected that participants would answer the interview questions honestly and provide information about their HIV risk perceptions before and after diagnosis. I assumed participants' identities would remain anonymous, and their responses would be private and confidentially preserved. I also believed the findings would support future research and preventive measures targeting the study population.

Scope and Delimitations

This study was limited to adults ages 20 to 49 years who resided in Washington state at the time of the study. This age range was selected because in 2020 this age group accounted for the majority of those ABIs living in Washington state. Participants were limited to two specific counties because most immigrants of African descent in Washington live in these two counties, which are in metropolitan areas of the state. The findings may not be generalized to other ABI adults in other U.S. states. A phenomenology framework was chosen for this qualitative study to answer the research questions and to help understand how the participants perceive the risk of HIV infection from their own personal lived experiences.

Limitations

There were a few limitations of the study. This study was limited to a phenomenological approach, and interviews were the primary data collection method. The use of interviews as the only mode of data collection was a challenge to the validity of data collection because the results depend on the honesty of the participants and the accuracy of the information shared during the interviews. The interviews were structured and were mainly individual and based on an online questionnaire.

Another limitation was that the data were self-reported. Self-reported data can have the potential for bias that can influence the results of the study. Data were recorded and kept on a secure computer. Participants were informed they had a choice to answer all questions or stop at any time. During the consent process, participants were advised that the interview process could take between 15 and 30 minutes. This information allowed them to plan their time accordingly before the initial interview.

Significance of the Study

The significance of the study is to identify barriers to HIV testing among ABIs and the issues that affect the ABI community. By reducing barriers and issues affecting ABIs, public health leaders can expand HIV testing and strategize interventions to improve access and timely entry into care to best address the social, economic, and cultural environment of this community. Public health leaders must identify and exploit the full potential of new options and strategies for health policy and action to develop effective population-based strategies vital in improving health outcomes for the community.

The findings of the study will be vital to the public health leaders in the Pacific Northwest to strategize and implement interventions and protocols geared toward the ABI community and to reduce barriers to testing through outreach and access to care. The findings can be used as a guide to develop strategies that address health needs, especially HIV testing for ABIs. The data may be used to assess meaningful gaps that exist in the implementation and recommendations to inform and improve healthcare services for the community.

Summary

In Chapter 1, I highlighted the gaps in HIV testing among ABIs and presented the nature of the study I conducted and used available data available to show gaps that exist regarding this population. Some complex influences and beliefs act as barriers to HIV testing among ABIs, which is also complicated by these communities living in a different country than their birth country, affecting various social factors and beliefs. Promoting HIV testing in ABI communities is an important component of public health strategies for HIV prevention and reducing undiagnosed HIV infections. Increasing HIV testing will ensure early access to treatment and limit further transmission.

Chapter 2: Literature Review

Introduction

The 21st century has changed how people in the world move around, with more open borders and advanced modes of transportation, which has led to an increase in globalization. Globalization has contributed to determinants of health both positive and negative. A positive and key dimension of globalization is immigration and movement of goods across borders with ease, cross-border flow, finance and trade, ideas, ideologies, culture, and communication (Czaika & Haas, 2014). A negative contribution of globalization is the spread of diseases across borders and continents. Migration has increased the spread of diseases and infections from one country to another and from continent to continent. The increase in disease spread has contributed to the rise in health disparities and is a challenge for public health especially in combating infectious diseases (Labonté et al., 2011). Globalization has led to a need for more surveillance and increasing awareness of healthcare gaps as an essential strategy in prevention and early detection of disease. Public health leaders need to close the gaps identified and promote polices appropriate for healthcare delivery among people of diverse racial, ethnic, and cultural heritages.

Health indicators are characteristics that describe the health of a population. Health indicators are essential in measuring the health and well-being of a community. Health indicators are a result of individual genetic predisposition to disease, behaviors, community, and environment, policies, and clinical care. Health indicators are based on health outcomes (mortality and morbidity) and health factors determined by communities. Communities strive to optimize health determinants with the aim of long, disease-free, and robust lives for citizens regardless of race, ethnicity, gender, or socioeconomic status.

The CDC's (2019) Healthy People 2020 objectives across 12 topics include access to health services, clinical preventive services, environmental quality, reproductive and social health, and social determinants. This study's primary goal is to investigate these characteristics and how they affect the ABI community and the impact of HIV testing. An individual's health and quality of life are determined by personal-level characteristics and social determinants that are physical, social, and environmental; health-related quality of life measures assess an individual's perceived health status and health outcomes (Jia et al., 2009). The characteristics are quantifiable and have statistical validity to make a statement about the health of a population.

Reproductive and sexual health are essential to overall health and an entry point for most immigrants into the medical care system. Reproductive health equity is essential to optimizing the quality of life of a community and addressing issues related to reproductive health, such as maternal and infant health, sexual relationships, STI prevention, and gender identification; the right information can help reduce unintended pregnancy, prevent disease, and ensure safe and nurturing sexual relationships (Northridge & Coupey, 2015). Most of these issues correlate and are involved in health disparities that can be associated with HIV.

In this literature review, I focused on an overview of previous research conducted on HIV. The goal of this review is to increase understanding of HIV and create awareness of the perceptions of ABIs on HIV by identifying personal, socioeconomic, and cultural factors unique to ABIs and may impede their acceptance of, access to, and use of HIV testing services. In this study, I gathered and analyzed data that can be used to influence decision making on whether to test or not to test for HIV and attitudes toward HIV and HIV testing.

In this chapter I focus on HIV/AIDS history and statistics and HIV in the United States. I focus on the epidemiology of HIV, elaborating on the statistical data of HIV globally, in the United States and the Pacific Northwest, attitudes toward HIV, transmission and prevention of HIV, and beliefs about HIV/AIDS among ABIs. There will be a section on HIV testing in which I elaborate on the awareness and usage of HIV testing resources available and attitudes toward HIV testing. Type of HIV testing was not a criterion in this study. Finally, I examine HBM and SFT to gain insight into the attitudes, social norms, and perceived behavioral control of ABIs related to HIV and HIV testing.

Literature Search Strategies

The keywords used in locating literature for this study included *HIV/AIDS*, *HIV in the United States*, *ABIs*, *health indicators*, *HIV testing*, *attitudes*, *HIV knowledge*, *social norm*, *perceived behavioral control*, *health belief model*, and *structural–functional theory*. The databases used to search for information included PsycINFO, MEDLINE, ProQuest, and CINAHL Plus. The research studies considered for inclusion in this study are those published between 2013 and 2022 in a peer-reviewed journal. Peer-reviewed journals and articles that did not cover topics related to ABIs, HIV, AIDS, and HIV testing were excluded. Search results were organized by recording details of each source in an Excel spreadsheet.

Theoretical Foundation

Health Belief Model

HBM is a social psychological theory researchers use to predict behavioral health characteristics within a population. HBM has been in use since its introduction in the 1950s. As a psychological behavior model, HBM is primarily used to investigate patterns of disease prevention within specific communities. In particular, HBM is ideal for researchers looking to predict the “failure of people to adopt disease prevention strategies or screening tests for the early detection of diseases” (LaMorte, 2019, para. 1). Nonetheless, the model can also be used to predict emotional reactions to medication and the psychological impacts of symptoms.

According to Zamboni et al. (2017), HBM’s fundamental assumption is that an individual’s views concerning a given disease, coupled with their views on the effectiveness of appropriate health actions, can be used to predict the probability of that individual implementing the desired behavioral changes. Using HBM, Jones et al. (2015) observed that an individual will make a decision regarding disease prevention if they feel vulnerable to a disease, if they believe the illness is highly severe, if they have access to an alternative strategy, or if they perceive barriers to the prevention of said illness. Thus, the HBM model can be subdivided into three components: individual perceptions about health; modifying factors (structural, demographic, sociopsychological); and the advantages of disease prevention (Tarkang & Zotor, 2015). Individual perceptions are one’s opinions regarding their vulnerability to illness and their expected severity of the disease.

In relation to the current study, examples of individual perceptions are whether ABIs feel they are at risk of HIV infection or whether the disease is a serious cause of concern in the community. Demographic, sociopsychological, and structural factors affect perceptions about HIV/AIDS. For instance, a highly educated ABI is more likely to practice condom use than an illiterate ABI is. The advantages of HIV prevention vary from person to person, depending on the existing modifying factors within a community. These assumptions have enabled researchers in the HIV prevention field to study the influence of behavioral factors in new infections, especially within vulnerable populations.

Jones et al. (2015) suggested the use of six constructs of HBM to predict health behavior: (a) perceived risk susceptibility, (b) risk severity, (c) benefits to action, (d) barriers to action, (e) self-efficacy, and (f) cues to action. These six constructs are widely used in contemporary research. LaMorte (2019) helped offer a deeper understanding of these components. Perceived susceptibility is used to describe personal awareness of the threat of a given illness to health status. Perceived susceptibility encompasses all the feelings and notions a person has regarding a specific disease. Perceived severity includes the notions a person possesses concerning the severity of a given disease, such as HIV/AIDS. The perceived susceptibility construct additionally comprises the perceived consequences of shunning medication or treatment for a disease.

A person may put the possibility of demise, disability, or strained social interactions into context.

On the other hand, the perceived benefits within HBM are the perceptions of the suitability of specific actions being carried out to contain the severity of a given disease. For instance, a possible perceived benefit of HIV testing for an African-born American immigrant would be the prevention of mother-to-child transmission. Perceived benefits boost the desirability of disease prevention or treatment, although they occur at the later stages of medical intervention (Jones et al., 2015). However, perceived barriers generated from expected future challenges of given health action can negatively affect medical interventions. In the current study, perceived barriers can be categorized as demographic, sociopsychological, or structural—consistent with LaMorte’s (2019) observations.

Jones et al. (2015) noted that perceived susceptibility, perceived severity, perceived benefits, and perceived barrier constructs influence a person’s impetus to make a medical decision concerning a recommended intervention (cue to action). Nevertheless, the authors acknowledged that the cue to action construct is reasonably underdeveloped (Jones et al., 2015). Initially, HBM only incorporated the first four constructs and the final two constructs were still under scientific review. Cues to action are either internal or external: Diminished immunity can be categorized as an internal cue to action, whereas a television advertisement for voluntary counseling and testing (VCT) services is an external cue to action.

The final construct of HBM, self-efficacy, is used to explain the intensity of an individual’s self-assurance they will execute a particular behavior. Research shows that self-efficacy positively correlates to the willingness of healthcare providers to tackle a perceived medical threat (Jones et al., 2015). The self-efficacy construct is an important aspect of HBM and is found in other behavioral models.

HBM is beneficial to the current research and will provide a deeper understanding of ABIs' behaviors in the United States. Through the six constructs, the focus was on the HIV testing trends within the African-born American immigrant community. Using this model will allow for recommendations to be made on HIV prevention strategies that can benefit ABIs. However, the HBM fails to justify the effects of individual presumptions or beliefs, health habits, financial factors, or environmental influences on health behaviors.

Structural–Functional Theory

The SFT, or structural functionalism, allows researchers to explain various social functions. Structural functionalism focuses on existing relationships between the social institutions that constitute society. Structural functionalism can be explained as a theoretical framework where society is an intricate and organized system and whose functions operate collectively to create stability and congruence within a system (Parsons, 2017). As it relates to the structural-functional approach, society can be compared to the human body where each organ carries out specific functions. No single organ can exist in isolation, as this would bring down the entire system. Similarly, each part of the social order has a purpose that adds to the preservation of society altogether. These social components are referred to like structures, and individual structures have varied functions. The SFT dictates that good health is imperative for social progress. Correspondingly, structural functionalist's campaign for a social order where an efficient healthcare system is provided for by the government and accessed by all citizens. The central assumption is that an unhealthy population would, in turn, bring suffering to social stability. In addition, social cohesion should be encouraged, social inequality eliminated, and interdependence is maintained. All these factors are paramount in the preservation of social equilibrium.

The SFT basically explains why society functions the way it does by emphasizing the relationships between the various social institutions that make up society (Cole, 1966). This theory will observe the dynamic equilibrium and look at the parts that are required to work together to promote health equity in the ABI by looking beyond the individual to social facts such as laws, values, morals, customs, religious beliefs, rituals, and fashion, which all serve to govern social life (Cole, 1966). ABIs go through social changes after migration and are often conflicted by the new social norms they encounter. These are often different from their beliefs and are seen to create dysfunction and discord. ABIs are also unaware of the healthcare services available, and limited access to care can be a driver to late HIV testing and poor outcomes.

In a study that integrated the SFT in an investigation of the interrelatedness and mutuality between people and social systems, and how these factors affected HIV transmission, it was found that “individual factors, socio-cultural factors, economic factors, educational factors, and political factors are functional units of society which function to influence the risk of HIV transmission within the social structure” (Karki & Gartoulla, 2015, p. 92). In particular, the scholars carried out an investigation at a time when social changes and transformations were unfolding and duly recorded the influences of factors like higher education, access to premium insurance, and government policy on health behaviors.

In the current context, the SFT will be used to help explain the perceptions of HIV testing in ABIs in the United States. Research has shown that ABIs in America are a vulnerable population and whose rates of new HIV infections are constantly on the rise. Consistent with the work carried out by Karki and Gartoulla (2015), the key areas of focus will be on the influence of individual factors, socio-cultural factors, economic factors, institutional factors, and political factors on the perceptions that lead to access of HIV testing and counseling. The structural-functional model will complement the health belief model of health behavior, and the results will facilitate policy formulation on access to HIV testing for ABIs within Pierce and King Counties.

Literature Review

HIV Knowledge

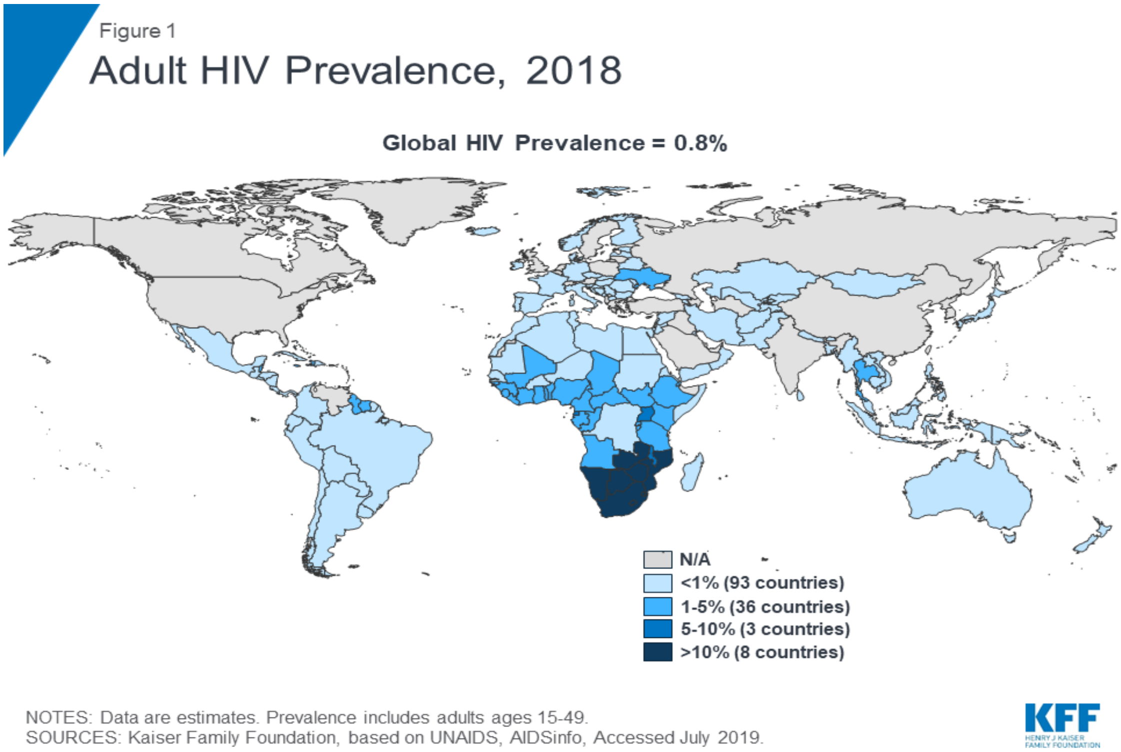
Researchers have conducted studies to investigate the level of knowledge and awareness of HIV and AIDS in the United States. The results have varied in ABI individuals, with some demonstrating a good understanding of HIV transmission. The gap in knowledge that was identified was on the available testing services, such as where to go if individuals needed to be tested, whom to contact for information on HIV, and testing (Valverde et al., 2017). Another gap in knowledge is on what testing involved, and the meaning of a positive result (Valverde et al., 2017). Lack of readily available information on HIV can contribute to people’s feeling that HIV is not an issue or the issue is not being dealt with (Valverde et al., 2017). There is not enough data on ABI awareness of HIV and how it does affect them.

HIV/AIDS Statistics

HIV/AIDS continues to be one of the most severe public health challenges and has led to a global commitment to stopping new HIV infections and ensuring that everyone has a means and access to testing and care. There are approximately 37.9 million people infected with HIV globally in 2018, with 36.2 million being adults, and 1.7 million were children. 79% of those living with HIV knew their status; about 8.1 million did not know they were living with HIV (HIV.gov, 2019).

Figure 1

Adult HIV Prevalence, 2018: HIV Prevalence Around the World



Note. From *The Global HIV/AIDS Epidemic*, by The Henry J. Kaiser Family Foundation, 2020. Copyright 2020 by Kaiser Family Foundation.

An estimated 74.9 million people have been diagnosed with HIV, and 32 million have died of AIDS-related illnesses since the epidemic started. In 2018, there were 770,000 deaths globally. The target for prevention was targeted for 2020, but with the rate of infection stalled, this goal is not achievable, and data indicates that there is a high number of individuals living with HIV who are not aware their status and a high percentage of those that tested positive for HIV who were not seeking treatment and thus still many people whose viral load was not suppressed (Carlson, 2019). In 2018 79% of those living with HIV knew their status, 78% were accessing treatment, and 86% were virally suppressed (Carlson, 2019). The goal now for public health is to end the HIV epidemic and AIDS by 2030.

HIV/AIDS in the United States

HIV is a mandatory reportable disease through local and State public health departments in all 50 states of the US, Washington, DC, and 6 US dependent areas, and HIV is reported from (cdc.gov, 2019). The term HIV/AIDS is used to refer to three categories of diagnoses collectively: the first one is a diagnosis of HIV infection (not AIDS); the second is a diagnosis of HIV infection and a later diagnosis of AIDS; and the third is a concurrent diagnoses of HIV infection and AIDS. (Healthypeople.gov, 2020). HIV testing is vital for both treatment and prevention efforts of public health, linking those diagnosed to care, promoting a continuum of care, and also identifying those at higher risk of infection to link them to care; fifteen percent of those infected with HIV are unaware they are infected and that accounts for one in every eight people of those infected. There are an estimated 1.2 million people in the United States are living with HIV, there are about 38,500 of new HIV infections, and there are about 51% of those infected who are virally suppressed (Kaiser Family Foundation, 2019). HIV remains a public health crisis in the United States and dependent areas; new HIV diagnoses yearly continue to be high regardless of the significant progress in Prevention and treatment strategies; in 2018, about 37,832 people were diagnosed with HIV. Although this number is high, there was a 9% decrease from 2010 to 2016 (cdc.gov, 2019). CDC National HIV Surveillance System (NHSS) is the body that is mainly responsible for monitoring HIV trends in the United States, and surveillance is ongoing with the data collected can be used to monitor critical outcomes of the national strategy (cdc.gov, 2019).

Figure 2

New HIV Diagnoses and U.S. Population by Race/Ethnicity, 2017

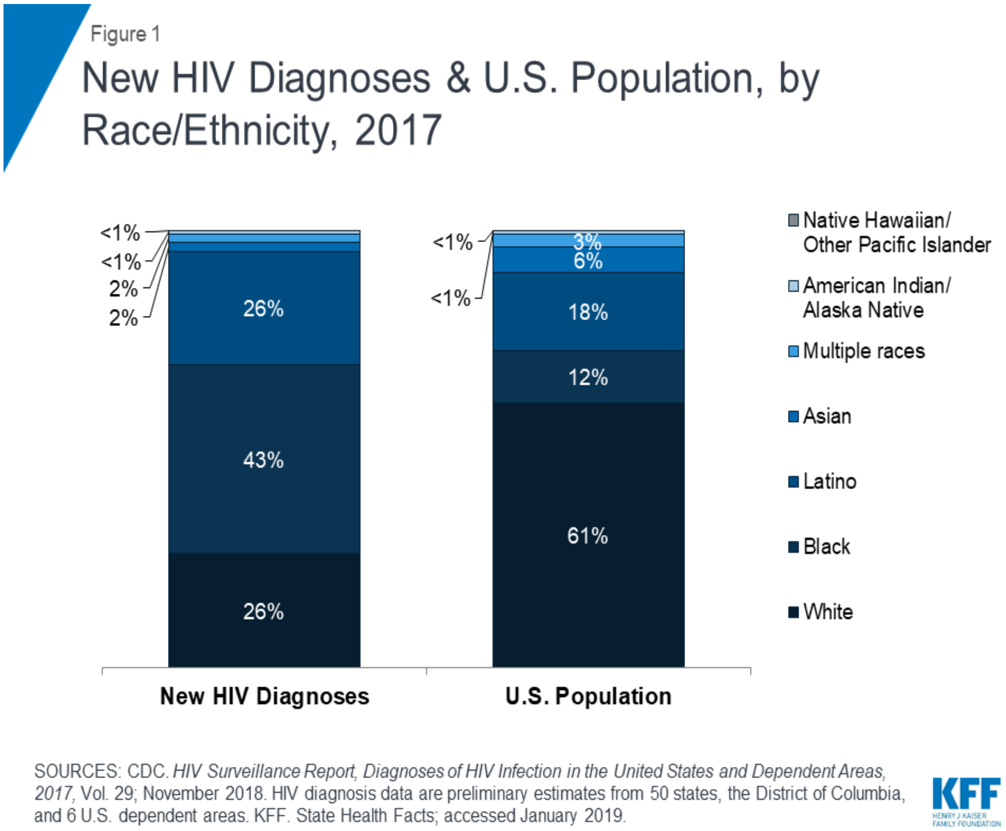


Figure 1

New HIV Diagnoses & U.S. Population, by Race/Ethnicity, 2017

SOURCES: CDC. *HIV Surveillance Report, Diagnoses of HIV Infection in the United States and Dependent Areas, 2017,* Vol. 29; November 2018. HIV diagnosis data are preliminary estimates from 50 states, the District of Columbia, and 6 U.S. dependent areas. KFF. State Health Facts; accessed January 2019.

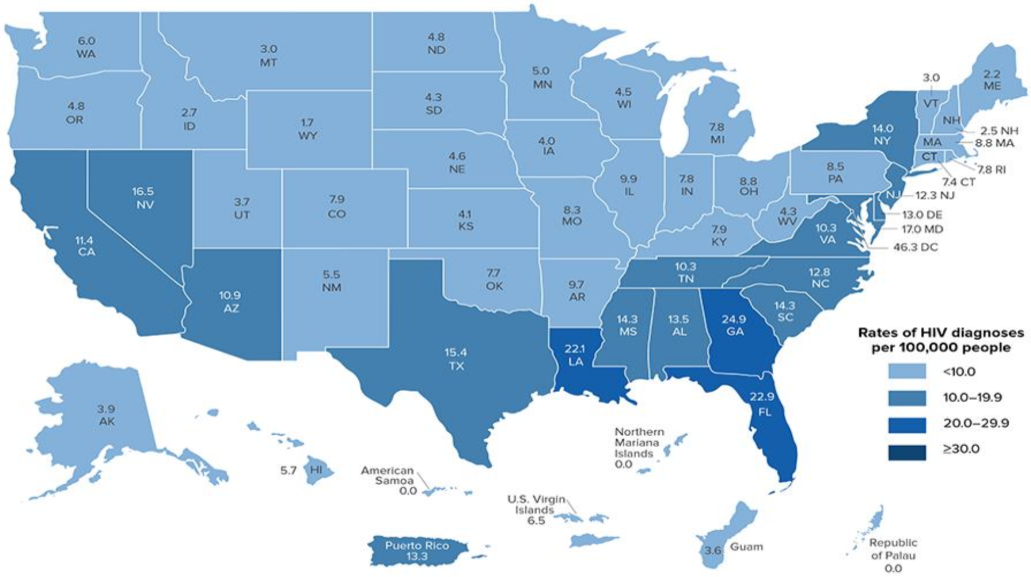
Note. From *The Global HIV/AIDS Epidemic*, by The Henry J. Kaiser Family Foundation, 2020. Copyright 2020 by Kaiser Family

Most individuals are diagnosed years after infection, and some are diagnosed at advanced stages of the disease process, which is a common occurrence in the United States; those diagnosed at later stages progress to AIDS within a year and the percentage of those diagnosed with AIDS within a year account for about 33% of those diagnosed with HIV with that undiagnosed, accounting for nearly 40% of these transmissions (Dailey et al., 2017; Davide et al., 2017). The impact of HIV differs across the country and continues to have a disparate impact on racial and ethnic minorities as well as gay and bisexual men; health inequities determine disparities in mortality and survival rates of persons depending on population, determinants of health, and communities in which individuals reside. These health disparities are more evident in individuals living in impoverished neighborhoods than in wealthy neighborhoods (Davide et al., 2017). Health inequities are a result of lack of access to healthcare, high rates of STIs, concurrent partnerships, lack of education, financial constraints, stigma, and fear of isolation by family, friends, and the community.

In the state of Washington, there are 12931 people living with HIV and one in 10 do not know they are infected; in 2017 there were 445 new diagnoses of HIV with gay and bisexual women and men being the most affected followed by heterosexuals and then people who inject drugs (Washington State Department of Health, 2018a). 93% of people living with HIV have been diagnosed, and 22% were new cases, but 19% of new diagnoses were concurrently diagnosed with AIDS; this is more common if foreign-born individuals in heterosexual relationships and were born outside the United States (Centers for Disease Control and Prevention, 2019; Washington State Department of Health, 2018a). The data indicates a need among the foreign-born community to pursue and focus more on testing and expanding testing opportunities and engaging the community in the efforts, strategies, implementation, and interventions of HIV testing.

Figure 3

Rates of HIV Diagnoses in the United States



Note. From the Centers for Disease Control and Prevention, 2018. In the public domain.

HIV/AIDS in Canada

As an immigrant-receiving nation, Canada is home to millions of African migrants. Comparable to the situation in the United States, immigrants originating from HIV-endemic countries to Canada have shown a high prevalence of HIV cases. Worthington et al. (2013) set out to investigate the effects of gender characteristics on HIV/AIDS perceptions by community members in African dwellings within the Calgary area. Calgary is a diversely populated area in the eastern part of the Alberta province. Since the introduction of migrant HIV screening in 2001, HIV testing numbers have increased in the country. The result has been an increase in research on the needs of HIV positive African immigrant populations. The research was beneficial as it influenced the expansion of social-structural policies engulfing housing, security, and healthcare issues

(Worthington et al., 2013). However, the researchers noted that widespread stigmatization of HIV positive African immigrants and differences in opinions regarding the roles of men and women within the African context continued to hamper policy implementation.

It is imperative to note that HIV knowledge levels vary based on ethnic and cultural backgrounds. In Canada, research shows that Canadian-born African immigrants are more conversant with HIV testing and counseling compared to their African-born colleagues. For instance, it was found that only 50% of ABIs understood the importance of condom use in the prevention of HIV, with a majority of the participants admitting that they thought the withdrawal method acted as a preventive measure (Tulloch et al, 2012). However, awareness of mother to child HIV infections was evenly grasped both in Canadian-born and ABI households. To understand the causes of these knowledge gaps in Canadian and other North American populations, an understanding of the perceptions and feelings towards HIV testing based on gender is paramount.

Worthington et al. (2013) attribute the knowledge gaps to gender biases and social stigma amongst African immigrant populations. African societies are made up of social hierarchies that limit women's roles to domestic duties. Some communities deny their women the right to seek knowledge in schools and institutions of higher learning (Ali et al., 2013). This is detrimental to women's progress as it restricts access to HIV/AIDS knowledge. Issues such as HIV testing, access to treatment, and safe sex, thus, become secondary issues of concern for women as most African cultures accord the utmost power and respect to men. Within familial settings, the man's decision is seldom questioned.

Most men have misplaced views of masculinity that render them more vulnerable to HIV infection (Worthington et al, 2013). The stigmatization of gay, lesbian, and bisexual men within the African context also has a negative influence on HIV perception as such individuals cannot amenably seek HIV testing and counseling.

Worthington et al. (2013) found that recently migrated ABIs in Canada became demoralized by the palpable respect afforded to Canadian women. This further limited the prospects of ABI men in Canada seeking HIV testing and treatment, as well as more knowledge on the AIDS epidemic. Although Canadian law criminalizes gender discrimination, feelings of disdain by ABI men towards their women are common, and sexual infidelity is a resultant phenomenon (Baidoobonso et al, 2013). Existing cultural beliefs among African immigrants may, in turn, diminish the importance of family and healthy intimate relationships between ABI sexual partners. Baidoobonso et al (2013) add that religion also plays a more profound role, as ABI women would instead rely on spiritual protection rather than practice safe sex.

In relation to the current research, there is a literature gap regarding the influence of gender on community perceptions of HIV/AIDS in the Washington state Counties of Pierce and King. Future research should be directed towards investigating whether there are existing influences of gender biases and social stigma on HIV testing perceptions in ABI populations residing in the two counties. The impacts of perception, attitude, and beliefs in HIV related stigma on healthcare-seeking behaviors by women also presents an additional area of focus for policymakers.

HIV in Sub-Saharan Africa

To understand the attitudes and perceptions of HIV testing by ABIs in Pierce and King Counties, an initial focus on the causal factors of unhealthy behavior within sub-Saharan African countries is essential. Orisakwe et al. (2012) set out to investigate existing associations between HIV awareness, opinions, perceptions, and the inclinations of patients in a KwaZulu-Natal, South Africa hospital. Attitudes and perceptions of HIV testing in the country were influenced by the ‘universal testing’ and ‘voluntary testing models.’ World Health Organization (WHO) recommends the use of three models for HIV testing in sub-Saharan Africa: mandatory, diagnostic, and voluntary. Mandatory HIV testing occurs as a prequalification for health insurance or job engagement contracts. Diagnostic and voluntary testing is carried out by clinicians before treatment and as part of VCT services, respectively. Although a 70% increase in home-based HIV testing in sub-Saharan Africa has been recorded, HIV status awareness in South Africa still lies below 10% (Sabapathy et al., 2012). With low employment rates and a stigmatized society still adversely affecting large sections of the population, the significance of HIV testing and counseling is still starved of the attention it deserves.

Orisakwe et al. (2012) carried out their study at Ngwelezana Hospital and sought to establish the reasons why the KwaZulu Natal population had systematically shunned HIV testing and treatment services. Research on the issue was insufficient at the time, and therefore they based their study on mirroring the lack of 100% HIV testing within the South African population. Over the years, the South African government, in conjunction with the World Health Organization (WHO), had invested in the procurement of testing facilities through initiatives such as VCT. Community campaigns had also enhanced the collective knowledge of HIV testing and treatment. However, these efforts had had negligible effects on the attitudes and beliefs of South Africans concerning HIV testing and treatment. In addition, divided opinions between healthcare providers, government officials, and civil societies in relation to the need for universal testing to collect HIV data on 100% of the populace had slowed down the progress created by the community campaigns.

Orisakwe et al. (2012) noted that although patients possessed different reasons for HIV testing, the most prevalent was the need to gain an understanding of HIV and to confirm HIV status. It was also noted that information on HIV testing and treatment was chiefly communicated through mass media and word of mouth. HIV clinics also acted as educational centers from which patients gained further insights on the treatment and containment best practices. However, 92.4% of the patients believed that HIV positive patients had brought the disease upon themselves due to irresponsible sexual behavior. In contrast, admitted to knowing that self-restraint, condom use, and faithfulness were ideal HIV preventive measures.

In carrying out their study, Orisakwe et al. (2012) fittingly observed the need for further research on the perceptions and attitudes that hinder HIV testing in South Africa, a sub-Saharan African country. Research shows that there are sufficient resources and goodwill on the government’s part to avail HIV testing tools and equipment. South African citizens are also aware of HIV preventive measures and the consequences of irresponsible sexual behavior.

There, however, exists a gap in the current literature. Although Orisakwe et al. (2012) were justified in studying the existing associations between HIV awareness, opinions, and perceptions and inclinations of patients in KwaZulu-Natal, their research was limited to Africans living in South Africa. Although the country has the highest HIV prevalence rates in Africa at 25%, further research should have been carried out on HIV perception and attitudes in countries like Kenya, Nigeria, Uganda, Mozambique, Zambia, Malawi, Tanzania, Zimbabwe, and Ethiopia (Kharsany & Karim, 2016). The authors also failed to investigate the barriers to HIV testing and of the acceptability of HIV testing, as well as the impact of perception, attitude, and beliefs in HIV related stigma on healthcare seeking behaviors

HIV/AIDS in African-Born Immigrants

HIV prevalence for ABI in the United States is underestimated since they are categorized under the black/African American category, and with recent increases in HIV prevalence among ABI, there is a need for accounting accurately (Koku et al., 2016). ABI is also disproportionately affected by HIV, has low testing rates, and the cases are different from US-born persons and thus do not need to be clustered in one group, and this poses a challenge in prevention measures in the ABI community. Washington has narrowed data to include foreign-born and further by area of origin, which is a positive effort towards understanding more on HIV effects on ABI living here. 29% of new HIV cases between 2012-2016 being from the foreign-born community, and 82% of all new cases are male, 17% women, and 1% transgender (Washington State Department of Health, 2018b). Washington has a high population of foreign-born blacks with HIV, and they have become a part of Washington's HIV epidemic, for there has been a trend of an increase in HIV infections in the community. The rates are higher in foreign-born blacks than those of US-born African Americans, and there are more women at 60% affected than men at 40%. Most of the foreign-born black individuals with HIV are thought to have been infected outside the United States, with almost 92% from the Sub-Saharan Africa (Washington State Department of Health, 2018b). In 2013, there were more than 700 foreign-born blacks living with HIV in Washington and 56% of the 700 were diagnosed with AIDS and most progress to AIDS with the first year of diagnosis, and it is estimated that HIV cases increase in the foreign-born blacks at about 7% (Washington State Department of Health, 2018b).

Table 1

Foreign-Born Black People Living With HIV Disease by Country of Birth, Washington State, 2013

Country of birth	Case county %	Country's primary language
Ethiopia	244 (34%)	Amharic
Kenya	95 (13%)	Swahili
Zambia	27 (4%)	Bemba
Eritrea	23 (3%)	Tigrinya/Arabic
Zimbabwe	23 (3%)	Shona/Ndebele
Somalia	23 (3%)	Somali
Sudan	20 (3%)	Arabic
Liberia	19 (3%)	English
Other (52)	242 (32%)	--------------

Risk for HIV Transmission in African-Born Immigrants

Compared with their nonminority peers, ABIs are at an increased risk for HIV infection and have higher rates of testing positive than non-immigrants, for they are disproportionately affected and differ epidemiologically from US-born persons (Valverde et al., 2017). Researchers have revealed that there was a more substantial proportion of women among foreign-born persons with diagnosed HIV than among US-born persons. Among foreign-born men, almost 21% of HIV diagnoses were attributed to heterosexual contact, compared with 12% among US-born men (Valverde et al., 2017). Research evidence indicates that most HIV transmission in ABI happens after the migration and the differences in HIV transmission patterns impact prevention services, thus creating a need to increase understanding of HIV transmission (Valverde et al., 2017). A few studies have explored HIV transmission networks among ABI.

HIV is transmitted in different ways; in Washington State, most HIV infections are through unprotected anal intercourse. Both anal and vaginal sex attribute to a higher risk than oral sex (doh.gov, 2018). HIV transmission risk through anal sex is more noted in US-born individuals, while most ABI HIV transmission is through vaginal sex.

HIV Risk and Barriers to Care for Women From African-Born Immigrants

Okoro and Whitson (2017) found that the probability of HIV contraction among African-born American immigrants is highest in women. In comparison to non-African-born American women, the rates of HIV diagnosis were 12 times more. Rates of new infections among African-born black Americans were also 36 times more than those observed in the U.S. born white women. The researchers noted that the findings contained similar characteristics to those made by the United Nations in sub-Saharan African countries. The high HIV prevalence rates among ABIs were attributed to domestic violence, same-sex sexual intercourse among men, social stigma based on HIV status, gender discrimination, and sexual health ignorance.

A methodical review of intimate partner violence (IPV) of African immigrant women indicates that abuse occurs both physically and psychologically. Emotional abuse of these women is also common, although studies indicate that a large section of the victims considers it normal (West, 2016). The fourth type of IPV prevalent in African immigrant households is sexual abuse, where husbands force themselves on their wives in the absence of consent (Akinsulure-Smith et al., 2013). In some instances, it was reported that husbands used American citizenship status to direct that their wives give in to their sexual demands. The effect of IPV on African immigrant women as relates to HIV is that it creates a fear of seeking medical care. Okoro and Whitson (2017) also noted that African immigrant women who had undergone IPV stated that the toxic marriages they were involved in "put them at greater risk of acquiring HIV because they were unable to demand faithfulness from their significant other or negotiate condom use for fear of being harmed or deserted."

In the case of same-sex sexual intercourse among African immigrant men as an HIV risk factor and barrier to care for ABI women, HIV positive men who have sex with men (MSM) rarely discussed with or opened up to their female partners about their HIV status. Okoro and Whitson (2017) again noted that MSM feared a backlash from other community members, thus opting to continue concealing their sexual preferences. The women, too, were not in a position to negotiate safe sexual intercourse with their MSM men. Therefore, these men ended up putting their women at risk of HIV infection. The result was that the ABI women at risk of infection could not seek HIV testing and counseling and that their existing knowledge of HIV/AIDS could not help salvage their situation due to fear of physical, sexual, or psychological retaliation from their partners.

Another barrier to HIV care for ABI women was limited knowledge on sexual health. Okoro and Whitson (2017) alluded that because reproductive health education was not openly taught in ABI households, female children principally missed out on this information and only acquired the urgency to explore issues such as HIV at the later stages of their lives. As a result, the HIV risk perception of ABI women was decreased. The authors additionally noted that even as mothers, these ABI women were still ignorant about the significance of HIV prevention and the need to practice safe sex. This absence of female empowerment from a young age had influenced their offspring as it put them at risk of mother to child HIV infections when births happened outside the healthcare system. Also, widespread ignorance on the importance of taking antiretroviral medication (ARVs) to curb HIV-related complications among South African women was connected to increased cases of HIV infections in unborn children (Gourlayet et al., 2013). Sexual health ignorance is an HIV care barrier that, therefore, needs to be addressed.

The investigation carried out by Okoro and Whitson (2017) was crucial to the current study as it focused on HIV risk and barriers to care for African-born American immigrants. Women are an integral aspect of African-born American immigrant households as they are both child-bearers and primary caregivers. Research also shows that the prevention of new infections among young women and teenage girls is key to the control of the HIV pandemic (Dellar et al., 2015). Cultural beliefs and customs should not limit ABI women’s access to HIV information and medical care. Future studies should focus on methods of overcoming HIV barriers to care for ABI women, especially in American cities that house large populations of ABIs.

HIV Prevention Strategies for African-Born Immigrants in the United States

American immigrants with an African origin are at a heightened risk of HIV infection. Kingori et al. (2016, p. 476) noted that “those of African descent have HIV transmission rates six times higher than any other minority groups in the United States.” Nevertheless, members of this demographic group were faced with systematic barriers to care, namely proximity to urban centers and a failure by the United States government to gather pertinent demographic data.

Kingori et al. (2016) focused their study on Somali-born refugees and immigrant communities residing in central Ohio. The aim of the study was to identify factors that assisted in raising awareness of the importance of HIV prevention in the target community. They found that strategies for HIV prevention could be divided into internal community resources and external platforms. Internal community resources were the utilization of community leaders, religious leaders, family members, and friends for sensitization drives. For instance, they found that by targeting mosques to pass messages of HIV testing and treatment, Somali-born refugees were more inclined to seek medical intervention.

On the other hand, external platforms were identified as community events, schools, healthcare providers, and communication media. HIV testing and treatment could be announced on television and in primary healthcare centers. Connor et al. (2016)

also introduced an HIV infection model targeting East-African-born male immigrants in the United States. The researchers had discovered that East-African-born American immigrants were at higher risk of reaching the later stages of HIV/AIDS as most had disregarded HIV testing and counseling. The East African HIV Prevention Model was thus introduced to help curb the effects of demographic influences, stigma, lack of disclosure, and illiteracy as risk factors for new HIV infections. The scholars recommended community campaigns that targeted male health needs and the introduction of ingenious incentives that would embolden East African men to seek early HIV testing and treatment.

In the current context, the recommendations made by both sets of researchers are applicable. The need to study the perceptions of HIV testing in ABIs arose from the increased numbers of new HIV infections among the population over the years. Although the study focuses on the views and opinions of ABIs, the results will allow timely interventions to curb the spread of HIV to be introduced and implemented within American urban areas. Policymakers can implement the East African HIV Prevention Model or utilize internal community resources and external platforms.

HIV Testing

HIV testing is an essential factor in HIV prevention, treatment, and care. HIV testing is vital to an individual for when one is aware of their HIV status and engages in a continuum of care; the individual is able to protect his or her health and the health of their partner/s and also decreases the risk of infecting and reduces the spread of disease (Arya et al., 2014). The most reliable way for an individual to determine their HIV status is by testing and research has indicated that most individuals who are aware of their condition are most likely to modify behavior and protect themselves to reduce risk factors and transmission of HIV (Johns, Bauermeister, & Zimmerman, 2010).

Awareness, Usage, and Attitudes Toward HIV Testing

Voluntary counseling and testing have been the cornerstone of public health efforts in HIV infection prevention. Public health leaders have believed that Serostatus knowledge has been known to motivate behavior changes and reduce infection rates among those that have been tested negative (St. Lawrence et al, 2015). Voluntary counseling and testing in the ABI community remain low despite all efforts in place and correlates with service awareness and utilization of these services (Paulin et al., 2015). This low rate of counseling and testing is complicated by unique barriers, including language, legal, cultural, and administrative, and inclusive of other barriers that affect individuals such as trust, healthcare providers, structural, healthcare usage, and community levels. HIV counseling and testing in ABI ranges from 21% to 73%, and it is higher for women than men due to women's acceptance and willingness to test than men and is also determined by the context in which testing is offered and who offers the test (Paulin et al., 2015). Data on HIV testing for ABI is minimal; it is challenging to aggregate data that is accurate on the knowledge of HIV testing, testing centers, and/or types of testing available. Most people do not seek information on HIV and HIV testing due to stigma in ABI, and healthcare providers do not adopt a community-based approach that raises awareness and increases promotion strategies for HIV testing.

HIV Testing and African-Born Immigrants

The HIV testing practices of ABIs have not been widely examined, encouraging ABI to get tested for HIV has been a challenge. In studies conducted by Kwakwa et al. (2017), efforts to engage ABI communities in HIV testing are essential, especially since the elimination of the HIV entry ban. As ABIs continue to migrate to the US from areas of higher prevalence, there is a need for public health to continue engaging in HIV testing and implement strategies that will encourage regular testing in ABIs. Foreign-born individuals who are newly diagnosed are less likely to report a previous test within 12 months.

Attitudes Toward HIV Testing Among African-Born Immigrants

HIV has disproportionately affected minority racial and ethnic populations, particularly in the ABI communities, and the attitude on testing varies in the communities, with most individuals afraid to test due to various reasons. Some of the reasons for not testing are some do not think that testing would help, concerned of family and loved ones leaving them if they tested positive for HIV, and other people would assume they are positive if they decided to test (Bova et al. 2016). Another concern for the community is trust towards the counselors and fear that healthcare providers would not keep their test results confidential and others preferring not to know their status (Bova et al, 2016).

Attitudes on HIV testing does affect the rate of HIV in ABI, and this group should be a priority target for HIV prevention/treatment. Healthcare providers should consider the cultural beliefs and practices, for they are a significant influence on health behaviors.

Lack of culturally and linguistically appropriate prevention strategies can be a hindrance for ABI to seek care, and it is crucial to ensure that messages/campaigns on prevention and treatment are appealing to the ABI.

Research has indicated there is a gap in the literature on the HIV epidemic in the foreign-born community. The increase in African immigration to the US and with data indicating that HIV in Sub Saharan Africa is of high prevalence is an indication that there is a need for more research to identify gaps in knowledge and priorities for service provision. Dynamics of HIV transmission in ABI are different from the general population of the US community, with most people in the ABI community affected by HIV are in heterosexual communities at 21% compared to 12% among US-born. Understanding transmission dynamics among the ABI community is essential for guidance for public health officials to strategize and put in place prevention goals that are appropriate for the ABI community (Eduardo et al., 2017). Knowledge about HIV transmission and discussing HIV in communities improves knowledge and increases the odds of testing.

HIV Testing Patterns, Awareness, and Stigma

Research shows that the HIV/AIDS pandemic affects black American residents more than any other demographic group within the United States. Although black people are a minority group in the country, they represent 44% of all new HIV infections (Ojikutu et al., 2013). Ongoing government interventions to curb the spread of HIV in the population have been focused on the detection of hurdles to the testing and treatment of

HIV. Key areas of focus have been on gay men, highly active heterosexual individuals, and users of banned substances.

The growth in the American population is attributed to an increase in foreign-born Black immigrants. According to Bialik (2018, par. 3), “immigrants are making up a growing number of the overall U.S. population – but the black immigrant population is growing twice as fast.” Between the years 1980 and 2016, there was a recorded 400% growth in the number of black immigrants residing in the United States. A high percentage of this upsurge in black immigrants has been driven by African migration into the United States. Although ABI numbers are a fraction of Caribbean-born black-Americans (who make up the majority of foreign-born black people in the country), there is a heightened interest in the socioeconomic needs of the former population.

A rise in non-native black American population figures can be observed in the state of Massachusetts. Ojikutu et al (2013) noted that upwards of 33% of urban-based black people were born outside the United States. Again, their research was indicative of the fact that HIV prevalence was higher in non–U.S. born black persons than in U.S.-born black persons. The researchers also noticed that the infection gaps were higher for non–U.S.-born black-American female residents than in the men, the key reason being the presence of deeply-rooted cultural, religious, and ethical beliefs. There was a correlation between HIV infection and testing patterns. HIV testing and counseling was lower in non–U.S.-born black persons than in U.S.-born black persons. More than 50% of the HIV tests had been carried out as mandatory prequalification before entry into the country, while less than half of the population had been voluntarily tested.

Ojikutu et al (2013) also identified stigma as a barrier to HIV testing in black American populations. The researchers observed that the fear of social stigma and the ensuing reluctance to disclose HIV status had a positive correlation to risky sexual behavior. An interrelationship between being HIV positive and a hesitation to seek medical care among U.S.-born blacks was also observed. There was, however, no research carried out on the same as relates to non-U.S.-born black Americans.

Consistent with the sub-Saharan African and Canadian studies on HIV testing patterns, awareness, opinions, perceptions, and inclinations, the inability by healthcare personnel to prevent new HIV infections was caused by insufficient knowledge on ways of virus transmission and difficulties in accessing treatment facilities among black populations in Massachusetts. Despite the CDC’s financing of public health campaigns to reduce the stigmatization of HIV patients, the improvement HIV knowledge drives, and health interventions in sub-Saharan African countries affected by the HIV/AIDS pandemic, 50% of non–U.S.-born black immigrants recorded poor scores on the HIV knowledge tests (Ojikutu, et al, 2013). Complications in knowledge transmission were due to cultural and language barriers. The research went a step farther to investigate the relationship between age and HIV testing. In both U.S.-born and non–U.S.-born black immigrant populations, it was found that older people had been more reluctant to undergo HIV testing. The government had also overlooked older generations in HIV public health campaigns. This is despite the fact that there was a considerable amount of new HIV infection cases in 2009, 15% of whom were among individuals above the age of 50 years (Centers for Disease Control and Prevention, 2009). The study carried out by Ojikutu et al. (2013) was limited by difficulties in tracing undocumented, ephemeral, and refugee immigrants.

The scholars also failed to focus their research on specific demographics, such as ABI populations in Massachusetts. However, their research provided a deeper understanding of HIV testing patterns, familiarity with, and effects of social stigma among Non–U.S.-Born Blacks and added to the existing knowledge on the relationship between age and HIV testing.

HIV Testing Services

HIV testing services focus on reaching individuals who may be living with HIV and are not aware of their status or those at high risk of acquiring HIV. Testing is the first step in the HIV treatment cascade (Avert). Traditionally HIV testing is performed in the hospital, public health, and clinic settings, and with technological advancement, new testing technologies have enabled public health officials to bring the tests to the community, including self-testing and out of health facilities. These new resources increase HIV testing, especially in communities such as the ABI community, for it provides privacy, and people can test without fear of the community of healthcare providers. Routine HIV testing in primary care settings still remains the most popular way most people get tested and provides an opportunity for earlier detection; according to the study by Arya et al., 2014, approximately 41% of primary care physicians were not aware that HIV testing should be routinely offered in primary care settings for adolescents, 45.6 % of physicians for adults. The study also indicated a high percentage of primary care providers who were not aware that teenage patients aged 13-17 years and adults aged 18-64 years should be routinely at 49.6% and 29.2%, respectively (Arya et al., 2014); however, there has been an increase in testing provided in non-traditional settings, including college campuses, in an attempt to provide access to testing. A member of an ABI community is less likely to seek care or HIV testing due to fear; a high number of undocumented immigrants are afraid of being discovered and deported. Most immigrants are (Krishen, 2019; Ojikutu et al., 2014). ABI communities have high numbers of individuals with no health insurance, social stigma within communities, structural barriers, mistrust of healthcare providers, and afraid that healthcare providers would not keep their test results confidential (Fakoya et al., 2017; Krishen, 2019).

Summary

Globalization has contributed greatly to the world's health perspective and challenges to population health. With the increase in human movement, there has also been an increase in transnational interactions that shape the health outcomes (Czaika, & Haas, 2014). Immigrants have been disproportionately affected by the HIV epidemic and have suffered greatly due to lack of awareness, opinions, perceptions, and inclinations. African born immigrants (ABIs) showed that the need to know one's HIV status was not the key driver, thus are not inclined to voluntarily test. Data showed that ABIs regard HIV as punishment for irresponsible sexual behavior, although they are aware of self-restraint, condom use, and faithfulness being ideal HIV preventive measures.

In Canada, HIV policy implementation within African immigrant communities was hindered by stigmatization and cultural differences of opinion. Canadian-born African immigrants are more aware of HIV testing, transmission, and prevention than

ABIs. These knowledge gaps are due to the victimization of women and social stigma accorded to African immigrant populations. The emergent literature gap was on the effects of gender on community perceptions of HIV/AIDS within the Washington state Counties of Pierce and King.

When it came to HIV testing patterns, awareness, and stigma differences between U.S.-Born and Non–U.S.-Born Blacks, it was found that HIV/AIDS affected black American residents more than any other demographic group within the United States. 44% of all new HIV infections were blacks. It was also found that rises in foreign-born Black American numbers were the key driver. Also, infection numbers were higher for female foreign-born black Americans due to cultural, religious, and ethnic beliefs. Also, the chief hindrances to HIV testing were the stigmatization of risky sexual behavior, inadequate knowledge regarding HIV transmission, and lack of access to HIV treatment for black minorities in Massachusetts. Despite these findings, research was limited by difficulties in tracing undocumented, ephemeral, and refugee immigrants.

The review of literature also covered HIV risk and barriers to care for ABI women. Research showed that female ABIs were at a higher risk of contracting HIV than non-African¬-born American women. The leading causes of this phenomenon were domestic violence, same-sex sexual intercourse among men, social stigma based on HIV status, gender discrimination, and sexual health ignorance.

In terms of HIV prevention strategies for ABIs within the United States, critical barriers to healthcare were proximities to urban centers and a failure by the United States government to gather pertinent demographic data. Research into Somali-born refugees showed the presence of internal community resources and external platforms as HIV preventive measures. The East African HIV Prevention Model was also proposed to tackle the effects of demographic influences, stigma, lack of disclosure, and illiteracy as risk factors for new HIV infections.

The Health Belief Model (HBM) and the Structural-Functional approach formed the bases of the theoretical framework. The Health Belief Model is a social psychological theory that researchers use to predict behavioral health characteristics within a population. On the other hand, the SFT, or structural functionalism, allows researchers to explain various social functions by focusing on existing relationships between the social institutions that constitute society.

Chapter 3: Research Method

Introduction

The purpose of this study was to explore and seek to understand the lived experiences of ABI adults ages 25 to 49 living in Washington state by gaining their perceptions of HIV testing through in-depth interviews. The study used the phenomenological method that is both a philosophical perspective and a qualitative research method to explore the structure of consciousness in an individual's experiences and help in exploring construct meaning (Creswell, 1998; Moustakas, 1994). The phenomenological study also can bring insights into HIV/AIDS testing. In previous research, the perceptions of ABIs on testing have not been investigated, thus a gap exists in the literature. Furthermore, no phenomenological studies had been conducted with this same target population to understand participants' perceptions and interpretations of their everyday experiences relevant to the phenomenon (Creswell, 2013). This study could be significant to the field of public health in providing a better understanding of the reasons behind individual decisions to test or not for HIV. This study is also significant for public health in relation to decision making, strategizing, outreach, and approach, creating culturally and linguistically appropriate programs, thus improving testing in the ABI community.

The purpose of Chapter 3 was to provide a detailed description of the research design and concept of the rationale for the research tradition. This chapter includes an explanation of my role as the researcher and the logic of the study methodology, including the sampling selection, recruitment, and data collection and analysis. In this chapter are also a description of the pilot study and its purpose and explanations of the instrumentation constructs, threats to validity, ethical procedures, and issues of trustworthiness that could have affected the study.

Research Design and Rationale

Research Questions

RQ1: What are the barriers to HIV testing and the acceptability of HIV testing among ABIs in Washington state?

RQ2: How do the lived experiences of African immigrants impact their decisions to take an HIV test?

RQ3: What is the impact of perceptions, attitude, and beliefs in HIV-related stigma in African born immigrants' community on their healthcare-seeking behaviors?

The methodology used for this study was qualitative. The qualitative methodology is essential in examining social phenomena and can lead a researcher to understand the complex nature of how respondents' experiences shape their decision making related to HIV testing (Dodgson, 2017; Neubauer et al., 2019; Teherani et al., 2015). I selected a phenomenological approach that allows the respondents to provide an intricate description of their HIV testing perceptions. A qualitative approach was used to gather information about the participants' individual experiences and life situations: their beliefs, opinions, and emotions; their decision making on HIV testing; and how their decisions affect the relationships with their partners, family members, and healthcare providers. Researchers use phenomenological methods to understand perceptions of life events and situations (Neubauer et al., 2019).

I used a phenomenological design to obtain the perceptions of ABIs living in Washington state on voluntary HIV testing, to conduct in-depth interviews, to describe respondents’ perceptions of their life experiences, and to identify emerging themes. Phenomenological reflection is retrospective and gives insight to the researcher on respondents’ lived experiences and describes how individuals experienced the phenomenon to provide a depth and richness of the underlying lived experiences (Neubauer et al., 2019). This study can help increase insight for public health leaders on why most ABIs choose not to be tested for HIV voluntarily and can improve strategies designed toward increasing HIV testing in the ABI community and decreasing health disparities associated with HIV/AIDS.

Role of the Researcher

For this qualitative study, I was the interviewer, data collector, and data analyst. My role was to attempt to access respondents’ thoughts and feelings by conducting thorough reviews of literature, examining documents relevant to the study, and collecting data relevant to the study (Sutton & Austin, 2015). As the researcher, I approached the problem being investigated with an open mind and without preconceived perceptions because I wanted to focus on understanding the perceptions of the individuals who volunteered for the study.

For qualitative research, the sample size should be large enough to describe the phenomenon and address the research questions sufficiently. According to Malterud et al. (2016), qualitative researchers must determine the most appropriate sample size based on the purpose of the study, objectives of the study, analysis strategy, and the research questions. The estimated sample size was between 25 and 30 individuals. The goal of interviews was to follow a step-by-step procedure to minimize researcher bias. Another goal was to maintain the respondents' privacy by following the ethical guidelines instituted by the Walden University Institutional Review Board (IRB) for safe storage of data collected.

Methodology

Participant Selection Logic

According to Vasileiou et al. (2018), the target populations is the population or group a researcher is interested in researching and analyzing. It comprises individuals with common characteristics that allow them to fit the criteria established by a researcher. This study's population was ABI adults ages 25 to 49 who lived in the Pacific Northwest, in Washington state. In 2020, most ABI communities were concentrated in two counties in Washington state, thus I focused on this area. Members of the target population were chosen because they experience the phenomenon and fit the study criteria and population specificity (Asiamah et al., 2017; Vasileiou et al., 2018).

Sampling

The expected sample size was 25–30 participants based on the appropriateness of the study and considering the composition and size needed for trustworthiness and quality data (Vasileiou et al., 2018). For this study, I used purposive sampling to obtain study participants to provide information most relevant to the study's phenomenon. Purposive sampling in this qualitative study included identifying and selecting individuals who had some knowledge of HIV. Purposeful sampling depends on information-rich individuals who are knowledgeable enough to speak to the study's central issue (Sutton & Austin, 2015; Vasileiou et al., 2018). According to Sutton and Austin (2015), the sample should meet the study criteria and gain insight into respondents' feelings and thoughts.

In this study, the sample was based solely on purpose versus statistical sampling. I included a combination of homogeneous and heterogeneous sampling. Homogeneous sampling involved individuals with similar subcultures who allow for an in-depth exploration of similar characteristics among participants mainly identified in those recruited from the same communities (Cheng et al., 2015). Using posters and fliers in common areas frequented by ABIs allowed for heterogeneous sampling. This allowed for diverse exploration by using the community to recruit online media, and referrals highlighted different perspectives while having similarities in experiences, behaviors, and/or perceptions (Cheng et al., 2015).

Per U.S. Census Bureau data from 2014-2018, the population of immigrants in Washington state was estimated at 14.7% of 7,614,893, 1,066,085 people. ABIs comprise about 6.5% of that, or approximately 71,879 people, the majority from Eastern Africa accounting for about 50,362 (U.S. Census Bureau, 2018). The purpose of having a sample for the study is to consider a sufficient number of people assumed to have knowledge related to the phenomenon under study. The data collection was mainly conducted online via Zoom, Google, or Facebook meetings. Special arrangements were made to meet face to face with those willing to participate who did not have internet. All interviews were recorded. The goal for respondents was 25–30 participants. In this qualitative study, I used purposive sampling, and the sample size was determined by the feasible number to meet and serve the study's purpose.

To collect the sample for the study, I sent online requests to different communities and individuals from the ABI community and targeted people ages 25–49 who live in certain areas of Washington state. I targeted organizations that work with ABI communities and other local community group leaders who work in these community organizations. I introduced my study to the leaders of these organizations and obtained written consent to use their resources to reach my target sample population. I sent letters to two African churches to seek permission to recruit from the congregation and presented an overview of the study. During the presentation, I discussed the interview questions, informed consent, and how participants' privacy would be maintained. I also displayed posters at an organization that provides a safe space and support for community members of African descent. The posters included the nature and purpose of the study, how to participate, and my contact information to allow interested individuals to contact me for additional details. I asked those who responded to the flier to refer friends or colleagues.

Reaching data saturation impacts the quality of a research study, and the aim of a study helps determine when saturation is achieved. Data saturation is reached when there is enough information and further coding is not feasible (Fusch & Ness, 2015; Saunders et al., 2018). When saturation occurs, a researcher no longer recruits more participants and determines that will be no new data collected. Any additional information collected would be redundant and would not influence the study’s analysis and results (Saunders et al, 2018).

Research Instruments

I was the primary research instrument for this study. The data were collected by distributing questionnaires online and by conducting interviews with the participants—all of whom met the inclusion criteria and signed the informed consent form. The main aim of data collection was to verify similarities and differences in all categories to ensure that the data were accurately represented (Sutton & Austin, 2015).

The data collection and analysis were done concurrently to allow for saturation and for me to recognize when saturation was reached. Data saturation was when no new relevant information was emerging, and there was no need for more data collection (Sutton & Austin, 2015; Vasileiou et al., 2018). The relationship between saturation and sample size was meaningful in this study due to a lack of data saturation that may negatively affect the data analysis process (Sutton & Austin, 2015; Vasileiou et al., 2018). During data collection, I captured important information about respondents’ HIV risk perceptions, attitudes, demographics, and beliefs on HIV testing. After completion of data analysis, I developed recommendations regarding the theory guiding this study, public health practice and policies, and future research based on the findings revealed through the data collection, data analysis, and discussion.

Most questions were open-ended during the individual and private interview sessions online through Zoom, Facebook, or Google meeting forums to allow participants to share details about their HIV risk perceptions and personal lived experiences. The interviews were private to ensure privacy related to the sensitive topic and to ensure individuals felt free to answer questions without feeling scrutinized or judged by others. The participants were free to answer questions without any influence or pressure from me. Each of the interviews was expected to last approximately 15 to 40 minutes.

These are open-ended questions and prompts that were presented to the participants of the study to answer my RQs:

1. What is your age group?
2. What is your Gender?
3. What is your sexual identity?
4. What is your Zip Code?
5. What is your status in the US?
6. How many years you have lived in the US?
7. What is your highest Education level?
8. Have you ever been tested for HIV?
9. How do you feel about testing for HIV?
10. Are there any barriers to accessing HIV related testing care services?
11. Do you think you are at risk for contracting HIV?
12. What is your knowledge of HIV resources and support programs in your community?
13. How comfortable are you in discussing about HIV with your family/friends?
14. How does knowing your HIV status affect you, your family, or community?

Recruitment of Participants

Participants were recruited from the ABI communities in Pierce and King Counties, and no agency or entity was utilized because the study targeted participants in the ABI community and thus not necessarily engaged in any care for HIV. After potential participants who met the inclusion criteria were identified, and they expressed an interest in joining the study, they were directed to schedule for the interview and the consent information provided. The consent form was attached to the questionnaire and by the participant proceeding with the interview, was an indication that they gave permission to participate in the study. Each participant was notified that they could withdraw from the study at any time. For an individual to be included in the study they had to meet the following inclusion criteria: the participant was born in Africa, migrated to America as an adult, and had basic knowledge of HIV and HIV testing. Exclusion Criteria: they were of African descent or parents are of African descent but were born in America, they migrated to the United States as children, and they were below 25 or above 49 years of age. The consent letter was written in plain language; described the purpose of the study and the nature of their involvement. The letter of consent included the participants rights and benefits and any risks that might be associated with participation. Participants were informed through the letter of consent that each participant was required to read and understand the consent form prior to participating in the interview, and thus opening the way to conduct the interviews.

Data Collection

A phenomenological approach was used to collect data, for it allowed the participants to describe their lived experiences in depth and descriptions of their experiences to include emotions, feelings, memories, thoughts, and reactions (Creswell, 2013; Sun-Kyung, & Keun, 2016). For data collection, in-depth interviews with open-ended questions and the interview were semi-structured, and due to the COVID-19 pandemic, the interviews were carried out remotely by computer chatting programs or face to face for those without internet access. The interviews were conducted one-on-one basis due to the topic's sensitivity, and participants were informed that they could choose the venue of the interview that was convenient for them and provided privacy for them.

The estimated time for each interview was approximately 20 to 30 minutes. The information to be captured about the participants' was on demographics, beliefs, and perceptions of HIV testing, and perceptions/attitudes toward HIV/AIDS. The open-ended questions allowed the participants to share their lived experiences and perceptions of HIV risk of infection without implied answers (Creswell, 2013). Interviewees responses were recorded for transcription and analysis purposes, and the participants were made aware of the interview being recorded.

Debriefing Procedures

The purpose of the study was to understand how one's lived experiences influenced decision making for the participants when deciding to get tested for HIV. The participants in qualitative researchers were selected because they were capable of providing rich information that answered the RQs and provided a better understanding of the phenomena under investigation (Creswell, 2013). The debriefing procedure ensured that study participants received truthful and accurate information without withholding the study’s nature or purpose (Krogh, Bearman, & Nestel, 2016; Simoni et al., 2019). The debriefing procedure in this study included a description of the study’s purpose and nature and how data would be collected. The goal of the debriefing was to ensure that the participants understand the research procedure, explain the role of deception in research, the process of answering the participants’ questions, ask the participants for suggestions to improve the study, thank them for participating, and provided contact information they could use if they had future questions or concerns, and for sharing the results with interested participants (McMahon, & Winch, 2018).

Data Analysis and Plan

The researcher’s goal was to collect data and conduct the analysis simultaneously, and the data would be appropriately coded to ensure an accurate analysis of the data. According to Linneberg & Korsgaard (2019), coding is a repetitive process that links the data to the RQ that is utilized in qualitative research. The codes usually capture the main elements of the data to develop patterns and categories based on the analysis. The codes also determine themes and breakdown the text into smaller units and reorganize them into relatable stories (Elliott, 2018; Linneberg, & Korsgaard, 2019).

Coding was important for the study to turn text from the open-ended questions into quantifiable, applicable information. I utilized thematic coding throughout the data analysis to look for the core variables and themes in the data. I also used memos to consider and explain the meanings of the codes that was used in the research study and record reflective notes detailing observations from the data (Razaghi, Abdolrahimi, & Salsali, 2015). I wrote memos noting ideas and insights, clarifying, arranging, and developing ideas that identified relationships between codes and hypotheses (Razaghi, Abdolrahimi, & Salsali, 2015). The memos were also used as additional data to be analyzed and, thus, stayed true to the data's validity and reliability. The recorded data was transcribed, organized, reviewed using Health Belief Model as a theoretical basis. Sub-themes were created from coded data, and significant themes developed.

Since the data collection was through interviews, there was a need to use data analysis software to analyze the data and for storage. The notes from the interviews and memos were entered into NVivo 12 software, and this software was necessary for organizing and extracting relevant data and defining the data collected from interview responses to form central themes (QSR International, 2020). I also used thematic analysis software to determine themes in the data. I used narrative descriptions and tables to display the themes, thematic categories, and codes. Emerging themes were identified by the use of textural comparison based on the assigned identification number for each participant and the interview questions.

Issues of Trustworthiness

In qualitative research, trustworthiness is essential in ensuring the degree of confidence in data, interpretation, and methods in the study's truth, thus increasing the credibility of the study. Trustworthiness establishes credibility, transferability, confirmability, and dependability. Credibility ensures that there is confidence in the research study findings and that triangulation shows that the findings are credible.

Transferability refers to how much findings are applicable or how they can be generalized from the original study to other contexts or groups (Connelly, 2016; Leung, 2015). Confirmability is the degree of neutrality in the study and ensures that the findings are based on the participants' responses. Dependability indicates that others could repeat the study and remain consistent (Connelly, 2016; Leung, 2015). The validity of the study measures the study's trustworthiness; validity aims to measure the truthfulness of a study and assess the accuracy and credibility of the data (Korstjens, & Moser, 2018).

Internal and External Validity

The research study must be credible; Internal validity ensures that there is dependability (research design, measuring of variables) and is threatened by inflexible knowledge related to the theoretical framework, and subjectivity is a significant threat to internal validity (Leung, 2015). External validity ensures dependability in the study and can be threatened if participants, places, or times are poorly chosen (Leung, 2015). Validity in the research study ensured that tools, processes, and data utilized were appropriate for producing the study's desired outcome. The methodology was appropriate for answering the research questions, and the design of the study was valid for the methodology (Leung, 2015). Validity also ensured that sampling and data analysis was appropriate, and the results and conclusions were valid for the sample and context (Leung, 2015). Validity and reliability increased transparency and decreased researcher bias. To ensure the study's validity, participants checking was conducted, and the participants were allowed to review the information they had provided immediately after the interview so they could verify that the information they provided was accurate. My interpretations of their responses' meanings were also accurate and added credibility to the study (Korstjens, & Moser, 2018). Internal and external validity included the standards used to judge the quality of qualitative research.

There is a need to ensure the trustworthiness of this study and reduce bias. For the study to retain its trustworthiness, I ensured that my personal views, feelings, or thoughts were set aside while I was collecting and interpreting the data. I used purposive sampling to get the small sample that was a fit for the study and fitted the demography of ABIs in the Pacific Northwest (Pierce and King Counties) of Washington State, and therefore the findings were not generalized to other populations outside of the State of Washington.

Confirmability

Confirmability ensures that there is neutrality in the study and I used conformability to verify that my interpretation of the data was accurate and representative of the information that the participants provided (Korstjens, & Moser, 2018). The interpretation of the data will not be based on my preferences and viewpoints, but the viewpoints of the participants and an audit trail will be maintained by ensuring that all notes on decisions made during the research process will be provided to enable transparency (Korstjens, & Moser, 2018). The views or perceptions of the researcher will not be included in the findings.

Ethical Procedures

Participants voluntarily joined the study and were recruited from the African born immigrants (ABI) community. All participants were provided with a copy of the informed consent and read out to the participants and were assured of their privacy and that no identifying information was to be used, and their identity was protected (Creswell, 2013; Roth, & Von Unger, 2018). The participants were briefed on the nature of the study and the importance of their contribution to the study. Participants were also allowed to withdraw and informed that they could withdraw at any time of the interview. Walden University IRB guided the ethical procedures for this study (Approval # is 07-21-21-0385910).

Recruitment is crucial in successfully collecting data that is appropriate for the study, and that supports the hypothesis. I used the IRB approval documentation to negotiate access to the recruitment site. I also ensured respect and self-awareness as the recruiter by ensuring that I maintained respect, compassion, responsibility, and cultural sensitivity (Gyure et al., 2014). The participants recruited were adults between the ages of 25-49 who live in Pierce and King counties of the Pacific Northwest in Washington State. The participants were recruited from the community and through a local organization of ABIs origin, such as Washington State Coalition of African Leaders (WASCAL), a local organization formed by ABI communities. I provided the chairman of WASCAL with the IRB documentation for review and ensured that potential participants' rights and welfare would be protected. The leadership at WASCAL helped to connect with members of the organization and identify appropriate locations for the recruitment flyer, which provided valuable information about the study. All potential candidates were provided with a consent form. reading the consent form and agreeing to participate indicated that the individuals had been informed about the study and were willing to volunteer to be in the study.

Data collection focused on interviews and narratives to produce a description of the experiences of the participants. In the study, I, as the researcher, I am the instrument of data collection and have to ensure no harm can become of the participants. Data collection is achieved by ensuring confidentiality is maintained at all times in the data collection process (Fleming & Zegwaard, 2018; Sanjri et al., 2014). the purpose of the informed consent in data collection is to ensure transparency and respect for the study participants by maintaining an open and honest communication process. To ensure that there was transparency, the consent form that I prepared was one that is readable and easy for the participant to understand (Fleming, & Zegwaard, 2018) The participants were picked out from a pool of individuals who respond to the flyer and met the needed criteria for the study. The individuals who were willing to participate in the study were briefed on the nature of the study, understood the risks and/or benefits they may be faced by participating, and the importance of their contribution to the study. No individual was coerced to participate, and all of them were advised that they had the right to withdraw from participating in the study at any time without any negative consequences. No clinical trials were carried out on the participants.

Treatment of Data

The individuals chosen to participate in the study are those that fit the inclusion criteria. The participants were required to read the informed consent in its entirety and allowed to ask any questions. The concerns brought forth were addressed, and the participants were required to sign the consent forms before engaging in the interviews. The participants were identified with letters to ensure privacy (Creswell, 2013). No identifiable information such as name or date of birth was used in the findings. Participants were asked of their ages and gender to identify the static analysis of those who participated. Interviews were conducted through questionnaires online for the demographics and interviews, and individuals were asked not to write their names or other personal information, and only the year of birth was used to identify age. Data was also collected by interviewing the participants and was done on an individual basis with no one else present, and all interviews were recorded, and notes were taken. All data was stored in a password-protected computer, notes taken were transcribed to the computer, and the handwritten notes stored in a locked cabinet. All data will be stored for five years then destroyed as per university requirements.

Summary

Chapter 3 describes the methodology in-depth, the credibility of the study, and the importance of addressing ethical concerns in recruitment and data collection. The chapter also highlighted what measures were in place to ensure confidentiality and participants protection. Chapter 4 will highlight the findings of data analysis.

Chapter 4: Results

Introduction

The purpose of this qualitative study was to explore and understand the lived experiences of ABI adults ages 25 to 49 living in Washington state and how those experiences influence their decision making on being tested for HIV. I chose a qualitative study design to explain and predict health behaviors of the ABI community through an expansive survey of experiences using a phenomenological method, and I collected data regarding individuals’ perceptions of HIV testing through in-depth interviews. The phenomenological method approach provided information on participants’ perceptions and how those perceptions influence their decisions on healthcare services.

The study targeted a sample between 25 to 30 individual ABIs. There were 39 potential participants; however, seven did not meet the inclusion criteria and one did not complete the survey. Of the potential participants, 31 people met the inclusion criteria for the study, surpassing the targeted sample. Patton (2002) posited that, in qualitative research, there are no set rules guiding sample size; sample size purely depends on the depth and richness of information obtained to meet what the researcher intends to investigate.

In this chapter, I expound on the questionnaire results participants completed. I also describe the research setting, demographics, data collection, data analysis, and evidence of trustworthiness including credibility, transferability, dependability, and confirmability. I present the study results and a summary of study findings.

Research Questions

The study’s objectives were to understand how lived experiences influence perceptions regarding HIV testing among ABI people living in two counties in Washington state. The research questions for this study were:

(RQ) 1: What are the barriers to HIV testing and of the acceptability of HIV testing among African-born immigrants (ABI) in Washington State?

(RQ) 2: How does the lived experiences of African-born immigrants (ABI) impact their decision to take an HIV test?

(RQ) 3: What is the impact of perception, attitude, and beliefs in HIV related stigma in African born immigrants’ community on their healthcare seeking behaviors.

Setting

In the study, I employed primary data collection tools using a phenomenology framework to answer the research questions. The goal was to understand how the participants perceive the risk of HIV infection from their own personal lived experiences. The research was targeted toward adults ages 25 to 49 who resided in Washington state at the time of the study. The data collection process was conducted by administering questionnaires to the target group. To participate in the study, inclusion criteria were required to be met: born in Africa, migrated to the United States as an adult, has basic knowledge of HIV and HIV testing, and has met the inclusion criteria and signed the informed consent form. The majority of the interview questions were open-ended. I distributed the link to interested individuals by advertising on social media (Facebook, WhatsApp, Telegram) and placing fliers with a detachable link at a local ABI organization. Due to the sensitivity of the study’s focus, using this mode to transmit the information ensured privacy and participant comfort and maintained anonymity. Approximately 20 to 30 minutes were spent completing the survey.

Demographics

According to Paton (2002), participant demographics refers to the background information that identifies participant characteristics and help locate them in relation to others. The inclusion criteria for this study required participants to have been born in Africa, migrated to America as an adult, have basic knowledge of HIV and HIV testing, be between 25 and 49 years of age, and live in Washington state at the time of the study. To uphold the inclusion criteria, participants were asked to provide their demographic information, such as age, gender, sexuality, ZIP code, citizenship status, number of years they have lived in the United States, and highest level of education.

Demographic information is important because it provides data regarding research participants and is necessary for determining whether the individuals in a particular study are a representative sample of the target population for generalization purposes. For this study, the target group was ABIs, ages 25 to 49 living in Washington state, specifically those living in two counties because most immigrants of African descent in Washington state lived in these counties, which were metropolitan areas.

A total of 39 participants chose to participate in the study, 38 completed the survey questionnaire that was used to determine if they met inclusion criteria, and one participant withdrew and did not complete the questionnaire. After review of the those who completed or answered most of the questions, seven participants were noted as over the age of 50 and did not meet the inclusion criterion regarding age. In the sample, the participants were grouped by age, education level, years in the United States, gender, sexual identity, and status in the United States. To meet the criteria, participants were asked to provide their demographic information.

The main age groups of those who participated were between ages 40 and 49 (61.3%), which is a good representation of the median age of those born in Africa who migrated to the United States as adults. In the sample, nine participants lived in the United States for 1–5 years, four for 6–10 years, and eighteen participants for over 10 years. Twelve participants had their status changed to U.S. citizens (38.7%), 14 (45.2%) were permanent residents, and five (16.1%) had other types of temporary visas. Twenty-nine participants identified as heterosexual, one participant identified as transgender, and one chose not to self-identify. There were 25 female participants and six male participants. Most of the participants had an undergraduate degree or higher: 16 held undergraduate degrees, nine held postgraduate degrees, six held certificates and/or diplomas, two had completed Year 12 or equivalent, and one was a high school graduate. Table 1 provides a summary of participant demographic information. Tables 2–6 provide percentage information of participant demographics.

Table 1

Summary of Participant Demographic Information (N = 31)

	Age	Gender	Identity	U.S. status	Years in U.S.	Education
1	40–44	Female	Heterosexual	Permanent resident	1–5	Undergraduate degree
2	35–39	Female	Heterosexual	Temporary visa	1–5	Undergraduate degree
3	30–34	Female	Heterosexual	Permanent resident	>10	Postgraduate degree or higher
4	45–49	Female	Heterosexual	Temporary visa	>10	Undergraduate degree
5	40–44	Male	Heterosexual	Citizen	>10	Postgraduate degree or higher
6	45–49	Female	Heterosexual	Citizen	>10	Postgraduate degree or higher
7	40–44	Female	Heterosexual	Citizen	>10	Postgraduate degree or higher
8	30–34	Female	Heterosexual	Permanent resident	>10	Postgraduate degree or higher
9	45–49	Female	Heterosexual	Citizen	>10	Postgraduate degree or higher
10	40–44	Male	Heterosexual	Citizen	>10	Certificate/diploma
11	35–39	Male	Heterosexual	Citizen	>10	Undergraduate degree
12	40–44	Female	Heterosexual	Citizen	>10	Postgraduate degree or higher
13	45–49	Female	Heterosexual	Permanent resident	1–5	Undergraduate degree
14	45–49	Male	Heterosexual	Permanent resident	>10	Undergraduate degree
15	35–39	Female	Heterosexual	Temporary visa	1–5	Postgraduate degree or higher
16	40–44	Male	Heterosexual	Permanent resident	6–10	Certificate/diploma
17	45–49	Female	Heterosexual	Citizen	6–10	Undergraduate degree
18	40–44	Female	Transgender	Permanent resident	1–5	Certificate/diploma
19	30–34	Female	Heterosexual	Permanent resident	1–5	Undergraduate degree
20	40–44	Female	Heterosexual	Permanent resident	>10	Undergraduate degree
21	25–29	Female	Heterosexual	Citizen	>10	Year 12 or equivalent
22	40–44	Female	—	Permanent resident	1–5	Postgraduate degree or higher
23	30–34	Female	Heterosexual	Permanent resident	6–10	Undergraduate degree
24	45–49	Female	Heterosexual	Citizen	6–10	Year 12 or equivalent
25	35–39	Female	Heterosexual	Temporary visa	1–5	Undergraduate degree
26	35–39	Female	Heterosexual	Permanent resident	1–5	Undergraduate degree
27	45–49	Male	Heterosexual	Citizen	>10	Undergraduate degree
28	25–29	Female	Heterosexual	Citizen	>10	Undergraduate degree
29	45–49	Female	Heterosexual	Temporary visa	>10	Certificate/diploma
30	40–44	Female	Heterosexual	Permanent resident	>10	Undergraduate degree
31	30–34	Female	Heterosexual	Permanent resident	>10	Undergraduate degree

Table 2

Participants' Age

	N	%
25–29	2	6.5%
30–34	5	16.1%
35–39	5	16.1%
40–44	10	32.3%
45–49	9	29.0%

Table 3

Participants' Gender

	N	%
Female	25	80.6%
Male	6	19.4%

Table 4

Participants' Identity

	N	%
No response	1	3.2%
Heterosexual	29	93.5%
Transgender	1	3.2%

Table 5

Participants' Years in the United States

Years	N	%
> 10 years	18	58.1%
1–5 years	9	29.0%
6–10 years	4	12.9%

Table 6

Participants' U.S. Citizenship Status

	N	%
Citizen	12	38.7%
Other temporary visa	5	16.1%
Permanent resident	14	45.2%

ABIs have health disparities similar to those that affect immigrants from other communities. The similarities are in culture, sociocultural, beliefs, politics, and perceptions that hinder continuum of care, preventative care, and screening and testing for health disparities. The study population comprised individuals who knew about HIV, and most had previously tested for HIV. However, those who had not tested for HIV had similar subcultures allowing an in-depth exploration of similar characteristics among participants. The participants were recruited from the same diverse exploration using the community to recruit highlighted different perspectives while having the similarities of the individual experiences, behavior, and perception.

Data Collection

During the data collection process, the researcher gathered and measured information on variables of interest by using an established systematic fashion that enabled one to answer stated research questions, test hypotheses, and evaluate outcomes (Kabir, 2016). To obtain the appropriate data from the target group, The researcher employed a phenomenology approach to collect data, which constituted of in-depth semi-structured interviews with open-ended questions. However, due to the COVID-19 pandemic, the interviews were carried out remotely by computer chatting programs, mainly Zoom, Google meetings, Facebook, and face-to-face for those without internet access. The researcher conducted interviews one-on-one due to the topic's sensitive nature. The researcher also allowed the participants to choose the interview venue that was comfortable for them in terms of convenience and privacy. The criteria to collect samples for the study was by sending online requests to different communities and individuals from the ABI community and targeting people ages 25-49 who live in the Pierce and King Counties areas. The researcher targeted community leaders working with African Born Immigrants (ABI) communities to send out invitations for the survey. The communities targeted were Mother Africa, Center for Multicultural Affairs, Washington State Coalition of African Leaders (WASCAL), and other local community group leaders that work in the different community organizations within one month on each type of data.

During data collection, the researcher captured important information about the respondents' HIV risk perceptions, attitudes, demographics, and beliefs on HIV testing from the ABIs. The sample size used in this study to collect data was 39 respondents from the ABIs, and each participant spent between 20 to 30 minutes.

The participants' responses were recorded in a google document with the participants' permission during the data collection period. The data was later organized, reviewed using Health Belief Model as a theoretical basis, sub-themes created from coded data, and significant themes developed. Later, the responses were recorded in an appropriate format (excel workbook) for analysis purposes to ensure that the data was clean and any inconsistencies that would present difficulties while interpreting the results were eliminated.

Notably, there were variations in the planned number of participants and time taken per interview session. The plan was to have between 25 to 30 participants compared to the 31 that participated. Notably, the individual time estimated an individual would spend on the questionnaire lasted longer than the scheduled time of between 15 to 40 minutes, whereas the sessions mostly lasted between 20 to 30 minutes.

Data Analysis

The inductive approach is evident in several qualitative data analyses, grounded theories (Strauss & Corbin, 1990). According to David R. Thomas (2003), the inductive approach was mainly used to allow research findings to emerge from the frequent, significant, or dominant themes in the raw data without the restraints imposed by structured methodologies (Bingham & Witkowsky, 2022). The inductive approach helps identify themes that are often obscured, left invisible, or obscured due to the preconceptions in data collection and data analysis procedures assessed by deductive data analysis, such as those used in experimental and hypothesis-testing research (Bingham, & Witkowsky, 2022). The inductive approach was used to condense extensive and varied raw text data into a brief, summary format. It was also used to establish clear links between the research objectives and the summary findings from the raw data to ensure these links are both transparent and defensible in a justifiable way, given the research objectives (Bingham & Witkowsky, 2022). This approach also develops a theory about the underlying structure of experiences or processes evident in the text (raw data).

Understanding the themes present in the data is key to producing findings to answer the research questions.

To use the information collected from the surveys, the researcher transcribed the individual research survey answers and formatted the raw data files in a standard format for further analysis using the NVivo program. A systematic and rigorous reading and coding of the transcripts allowed significant themes to emerge. Segments of survey text were coded, enabling an analysis of interview segments on a particular theme, the documentation of relationships between themes, and identifying themes important to participants.

The data was imported into NVivo 12 plus version of Computer Assisted Qualitative Data Analysis Software, the software aided in building of codes and themes for ease of analysis. Coding was done to reduce the data into themes. The codes were condensed, interpreted and the presented discussions (Creswell, 2003). The NVivo program auto-coded the responses and resulted in 20 later reduced to 8 categories. Some of the smaller categories were merged with similar allied categories since they were very closely related.

Evidence of Trustworthiness

Credibility

To enhance credibility, the researcher did recruit participants, and other stakeholders with specific interests in the research were allowed to comment and assess the research findings, interpretation, and conclusions

Transferability

To enhance the transferability of the study, the researcher gave participants a chance to comment on whether the categories and outcomes described in the findings related to their personal experiences. The findings must be applied or generalized to other contexts or groups from the original study.

Dependability

The study findings were compared with findings of other studies to make sure the results were consistent with findings of other studies. These findings ensured that other researchers could repeat the study and remain consistent. Comparisons were made with previous evaluations on the same topic.

Confirmability

The data interpretation was not based on the researcher’s preferences and viewpoints. Still, the views of the participants and an audit trail were maintained by ensuring that all notes on decisions made during the research process were provided to enable transparency (Korstjens & Moser, 2018). The views or perceptions of the researcher are not included in the study findings.

Results

The transcribed data was imported into NVivo 12 and analyzed through thematic process and coded to relate to the research questions. Through thematic analysis and coding I was able to generated three main themes: That is barriers to HIV testing and of the acceptability of HIV, lived experiences of African immigrants impact their decision to take an HIV test and impact of perception, attitude, and beliefs in HIV related stigma.

The coding process through NVivo was rigorous and conversely, it became difficult to fit some text units neatly into only one of these categories. A total of 20 codes were generated and included; behavior, checks, community, death sentence, disease, drugs, fluids, health, life, methods, partners, physical, relationship, risk, sexual partner, status, testing, and treatment. However, only eight codes could fit the research questions. The codes used during the analysis were: treatment and testing for the question ‘how do you feel about testing for HIV. A death sentence for the question ‘Are there barriers to accessing HIV-related services. Risks and fluids for the questions ‘do you think you are at risk for contracting HIV. Health check, method, and status for the question ‘what is your knowledge of HIV resources and support programs in your community. The coded categories were broken down further into subcategories that helped describe the underlying factors per each theme.

The emerging themes were developed by studying the patterns in the raw data and considering possible meanings. How they fitted with developing themes to answer the research questions, that were: the barriers to HIV testing and of the acceptability of HIV testing among ABIs in the two counties in Washington State; How the lived experiences of African immigrants impact their decision to take an HIV test; and what was the impact of perception, attitude, and beliefs in HIV related stigma in African born immigrants’ community on their healthcare-seeking behaviors. Around these questions, codes, categories, and themes emerging from the interview responses were built to help in developing patterns around the transcripts to answer the research questions. From the transcripts, a robust and systematic reading and coding of the responses permitted significant categories and themes to emerge, enabling analysis of interview sections on specific themes, identification of relationships between themes related to the perceptions of HIV testing in ABI in Pierce and King Counties.

Theme 1: Barriers to HIV Testing and of the Acceptability of HIV

This theme described the barriers to HIV testing and of the acceptability of HIV among the African Born Immigrants (ABI) living in Pierce and King Counties at the time of the study. The theme was developed to support RQ1 and was intended to identify any barriers to HIV testing among the ABI community. There were different questions that were used to gather this data and gave the participants an opportunity to describe their challenges/barriers to HIV testing. The participants described what challenges they face when accessing HIV testing and how these are barriers to HIV testing and acceptability of HIV.

Most of the participants did indicate that they did not experience any barriers. However, it was found that the location of the testing centers, the stigma associated with the disease, and the affordability of the related care services impeded some ABIs' access to the related care services. Combing through the responses and particularly participant 1 gave the response: "Promote awareness and easy accessibility to testing centers" under the question, "How do you feel about HIV testing?"

This response was considered to comprise three different meaning elements and consequently was counted as three distinct elements and was assigned two different code numbers related to three different themes. The first segment, "Awareness promotion," fitted into the theme "Health." The second segment of meaning "easy accessibility" this text fit in the “Accessibility” code, and “testing centers” was deemed fitting in the “testing” theme. From this text element, it can be seen that participant 1’s feelings about HIV testing are that testing promoted awareness. Participant 1’s thoughts are that easy accessibility to HIV testing in testing centers promotes positive health outcomes.

Participants 3; “It is expensive, not readily available in the USA like they do in most African countries.”

This response consisted of two elements, which are “Expensive” and “not readily available,” fitting into the barriers theme. This response implies that some of the impediments to HIV testing among the ABIs were the cost of testing and availability of the testing services, among other barriers. This response also indicated that there was a lack of knowledge for the participant on the availability of free clinics and how to access the clinics. The participant was deterred from seeking HIV testing due to the notion of the testing is expensive and not available.

Participant 4 attributed the barrier to having no insurance and thus would limit access to HIV testing. “*Lack of medical insurance that will help you get the test without payment*”

From the above participant, it was revealed that lack of medical insurance poses a challenge to HIV testing since the service is not offered for free in testing centers.

Participant 5 stated, “It is expensive, not readily available in the USA like they do in most African countries.”

From above statement, it can be inductively deduced that cost of testing is a major constraint/barrier to testing for HIV among the ABIs. However, it was noteworthy that the location of the testing centers, and related care services impeded some ABIs' from seeking HIV testing. Combing through the responses and particularly participant 11 responded, "*Stigma associated with the disease and testing*." From this response, two categories emerged, revealing that stigma remains an issue as far as testing of HIV is concerned. Nonetheless, some ABIs have embraced testing to be socially responsible and protect the community from contracting the disease.

The participant 11 was also concerned about how others including the family and community would react if they were aware of the participant being tested for HIV. This is an indication that stigma around HIV remains a major issue among the larger ABIs population and most individuals are afraid of their community thinking they have HIV or are promiscuous and that is why they got test and that does make a lot of people to shy away from voluntary testing, and thus are not willing to be tested for HIV. This sentiment expressed the fear of being marginalized by your own community, and thus make a choice not to get tested. Nonetheless, some ABIs have embraced testing to be socially responsible and protect the community from contracting the disease.

Some respondents felt testing for HIV was a death sentence to them, and therefore a pre-testing therapy was crucial to encourage the ABIs to know their HIV statuses. Participant 13 gave the respond, "*It can be a traumatizing process, and pre-testing therapy should be the key*." From this response, the researcher concluded that although much HIV testing may effectively control the spread of HIV among the ABIs, some community sects felt the process was traumatizing. Pre-testing therapy was necessary as this could be an essential support tool.

The study findings showed that with increased awareness, ABIs continue to become comfortable discussing topics around HIV with fellow community members and their families. The transcript responses indicate how comfortable the ABIs discussed HIV with their family/friends.

"Comfortable discussing with adult family and friends," from this response text, the researcher inductively generated two categories that are "comfortable discussing" and "adult family and friends."

The texts units meaning the ABIs were comfortable discussing HIV, especially with family/friends. This response is noted in the response of participant 5, among other responses, answered. Notably, there are social and cultural barriers such as HIV is a taboo, and therefore discussing issues around the disease are not permitted. The study revealed that the ABIs who felt they were at risk of contracting HIV due to exposure to the risk groups and the nature of their jobs were more likely to get tested. Participant 18 gave the response, "*It is very important to get tested so that you can know your status*," thus, from this response, themes were noted "very important" and "you can know your status." This response revealed the perceptions on HIV testing among the ABIs that they recognized how necessary the testing was since they would get to know their HIV status out of it.

Theme 2: African-Born Immigrants' Lived Experiences

In this study lived experience is understood from a lifeworld approach originating from the writing of Husser (Dahlberg, Dahlberg, & Nyström, 2008). In the lifeworld, the experiences must be regarded in the light of the body and the lifeworld of a person. The participants were able to narrate why they get tested, and the study investigated how the lived experiences of African immigrants impact their decision to take an HIV test.

According to participant 18; “It is necessary considering the high infection rate and increase in infidelity in society”.

This participant has noted that personal choices and how the community choose to live does affect their sexual healing and has been attributed to the high numbers of HIV in the community, and due to this chooses to decide that HIV testing is a necessity and would attribute to lower HIV cases if the community members choose to get tested. The lived experience of the African born immigrants (ABI) has an impact on their decisions to get tested of the HIV, from the response above, the ABIs’ acknowledge that, considering the high infection rates and degradation in societal morals leading to high fidelity, it therefore considered imperative that taking the test is imperative, since in such a state, knowing ones HIV status in very important.

For participant 10; “To have a clean bill of health.”

To some it comes as a turning point especially on sexual behavior, sex being one of the ways HIV is acquired.

Participant 10: “Learn on how to manage and live with the status of it turns out positive”

As for the reasons as to why one should get tested, the text above shows that, the African Born Immigrants (ABI) living in Pierce and King Counties at the time of the study got tested know their health status, to change sexual behavior that is risky and also how they can manage and live when they turn positive for HIV. Knowing one’s HIV status remains at the core preventing and effective treatment of the disease. The study findings showed that knowing the status allowed the ABIs communities to seek early treatment, become sexually responsible, and improve community health by maintaining individual and partner's and creating awareness in the community. The study underpins the essence that knowing HIV status affects ABIs, their family, or community. The study findings established that the status of the ABIs greatly affected the ABIs themselves, family and the community at large.

According to participant 25: "Creating awareness, prevent infecting our partners, seeking treatment"

The units of the text implied that knowing status made the ABIs create awareness about HIV, thus socially responsible by making partners aware of their status and seeking treatment.

Theme 3: Impact of Perceptions, Attitudes, and Beliefs on Healthcare-Seeking Behaviors

Literature shows that perceptions, attitude and beliefs about a phenomenon has a major influence on behavior. This study sought to understand the impact of perception, attitude, and beliefs in HIV related stigma in African born immigrants' community on their healthcare seeking behaviors. This theme describes how the African Born Immigrants perception, attitude and beliefs in HIV related stigma impact their healthcare seeking behaviors. The participants discussed as shown in the responses below;
According to participant F:

“I feel grateful to those who struggled to remove the stigma, to force governments to address the epidemic, I feel hopeful and wish everyone not to be afraid but rather to prevent, test, address any issues timely”. (Participant 6)

Stigma remains an issue to tackling HIV and the participant appreciates the efforts made in dealing with the Stigma related to HIV and especially in making the government to act. This in turn has influenced their healthcare seeking behavior by seeking timely HIV tests. Participant 11 also shared that:

(Participant11): “Taking more precautions to not spread and deal with the stereotypes against HIV positive people.”

ABIs knowing their HIV status affect them, their family, or community as well. The participants become more cautious not to spread the disease hence improved health outcomes and also deal with the stereotyping associated with HIV. ABIs felt at risk of contracting HIV due to exposure to the risk groups and the nature of their jobs that they engaged in daily. From the themes generated, some respondents felt testing for HIV was a death sentence to them, and therefore a pre-testing therapy was crucial to encourage the ABIs to know their HIV statuses. Participant 13 gave the respond: “It can be a traumatizing process, and pre-testing therapy should be the key.”

From this response, the researcher concluded that although much HIV testing may effectively control the spread of HIV among the ABIs, some community sects felt the process was traumatizing. Pre-testing therapy was necessary as this could be an essential support tool. Participant R gave the response, Participant 18: “It is very important to get tested so that you can know your status,” thus, from this response, themes were noted “very important” and “you can know your status.”

This response revealed the perceptions on HIV testing among the ABIs that they recognized how necessary the testing was since they would get to know their HIV status out of it. The above themes were aligned to the theoretical and conceptual framework of this study in order to answer each research questions.

To further address the issues faced by African-born immigrants (ABIs) the following questions were noted in the survey and were also used to support the research questions and below are the results inducted from the questions:

Feeling About Testing for HIV

The study revealed that the ABIs felt at risk of contracting HIV due to exposure to the risk groups and the nature of their jobs that they engaged in daily. From the themes generated, some respondents felt testing for HIV was a death sentence to them, and therefore a pre-testing therapy was crucial to encourage the ABIs to know their HIV statuses. Participant 30 gave the response, “It can be a traumatizing process, and pre-testing therapy should be the key.” From this response, the researcher concluded that although much HIV testing may effectively control the spread of HIV among the ABIs, some community some felt the process was traumatizing. Pre-testing therapy was necessary as this could be an essential support tool. Participant 18 gave the response, “It is very important to get tested so that you can know your status,” thus, from this response, themes were noted “very important” and “you can know your status.” This response revealed the perceptions on HIV testing among the ABIs that they recognized how necessary the testing was since they would get to know their HIV status out of it.

Barriers to Essential Care Services

The study revealed that most of the ABIs did not experience any barriers. However, it was found that the location of the testing centers, the stigma associated with the disease, and the affordability of the related care services impeded some ABIs' access to the related care services. Combing through the responses and particularly participant 1 responded, "Stigma associated with the disease and testing." From this response, two categories emerged, revealing that stigma remains an issue as far as testing of HIV is concerned. Nonetheless, some ABIs have embraced testing to be socially responsible and protect the community from contracting the disease.

HIV Risk

The findings revealed that the ABIs were at risk of contracting HIV due to behavior patterns among the community, including sexual and risk behavior, exposing them to the danger of contracting the disease. However, the study shows that with the HIV information they had acquired, they felt knowledgeable enough about issues surrounding the disease that they no longer felt at risk of exposure. On whether the ABIs thought they were at risk of contracting HIV, participant 12 gave the response, "Yes, have worked with HIV patients and have had unprotected sex with few people during dating." From these text segments, it can be seen that the ABIs are at risk of contracting HIV. Some of the risks identified were: exposure to various risks ranging from working with risk groups, that is, working with HIV patients, engaging in risky sexual behaviors such as having unprotected sex during dating, among other risks as evident from the transcript responses.

Knowledge of Community Resources and Support Programs

The findings showed that the community had a fair knowledge of the HIV resources and support programs in their respective communities. The resources and support programs including; free testing kits, home testing kits, testing centers, disease-preventing methods, that is to say, preventive methods, primary methods and safe methods, and routine testing. However, it was noted that some ABI had very little knowledge about HIV resources and support programs. From the transcripted responses, the researcher noted patterns in the data in response to this question, from participant 13 gave responses, "Free HIV testing and also preventive methods are put in place" from this response, two categories were inductively generated that is free testing and preventive methods. However, the study also revealed that some ABIs had no knowledge of the HIV resources and support programs in their community. From the responses of participant 24, "There is not much that I see or hear about," it can be seen that there existed participants who had zero knowledge of the HIV resources and support programs in their communities.

Comfort in Discussing HIV With Family/Friends

The stigma around HIV remains an issue among the larger ABIs populace; however, with continued United States government support, the stigma around the disease continues to fade away. The study findings showed that ABIs continue to become comfortable discussing topics around HIV with fellow adults. Notably, some ABIs populace still cannot discuss issues around HIV freely due to culture-related reason; for example, some ABIs communities consider HIV a taboo, and therefore discussing issues around the disease are not permitted. The transcript responses indicate how comfortable the ABIs discussed HIV with their family/friends. This response is noted in the response of participant 5, among other responses, answered “Comfortable discussing with adult family and friends,” from this response text, the researcher inductively generated two categories that are “comfortable discussing” and “adult family and friends.” The texts units meaning the ABIs were comfortable discussing HIV, especially with family/friends.

HIV Status Knowledge

Knowing one’s HIV status remains at the core preventing and effective treatment of the disease. The study findings showed that knowing the status allowed the ABIs communities to seek early treatment, become sexually responsible, and improve community health by maintaining individual and partner’s and creating awareness in the community. The study underpins the essence that knowing HIV status affects ABIs, their family, or community. The study findings established that the status of the ABIs greatly affected the ABIs themselves, family and the community at large. Participant 25 answered, “Creating awareness, preventing our partners, seeking treatment” the units of the text implied that knowing status made the ABIs create awareness about HIV, thus socially responsible by making partners aware of their status and seeking treatment.

Summary

The study sought to establish the perception of African born immigrants (ABIs) in Pierce and King Counties, Washington. It investigated the barriers to HIV testing and the acceptability of HIV testing among ABIs. It was found that some barriers exist, including the stigma associated with the disease, cost, unavailability of testing kits, and distance to the testing centers. Moreover, on how the lived experiences of ABIs impact their decision to take HIV tests, the findings showed that HIV remains an issue due to limited knowledge among some ABI quarters about HIV. Cultures of the ABI present a challenge since the disease is considered taboo and, therefore, a death sentence making some ABIs live in denial. In addition, perception, attitude, and beliefs in HIV-related stigma in ABIs' communities hugely impact their healthcare-seeking behaviors. The study findings established that the ABIs' healthcare-seeking behaviors are crucial to improving the health and wellness of their community. Health behaviors such as seeking early treatment, becoming sexually responsible, improving community health by maintaining individual and partner's healthy lifestyle, and creating awareness in the community are often influenced by perception, attitude, and beliefs in HIV-related stigma. Chapter five will highlight the discussion, conclusions, and recommendations from these research findings based on the study findings.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose for this study was to investigate the lived experiences of members of the ABI community living in Washington state regarding their perceptions, attitudes, and acceptability of HIV testing and how these contextual realities affect HIV spread among ABIs. The study findings may help strategize and formulate interventions that will increase voluntary testing, reduce HIV infection rates, increase linkage to care, and reduce health disparities by acquiring a comprehension of the perceptions toward HIV testing among this population. The study findings may also help develop a new understanding of difficulties in seeking healthcare services as experienced by the ABI community. These findings may help healthcare providers better understand the challenges ABIs experience and develop better strategies to address ABIs' concerns.

The research was guided by the following research questions:

RQ1: What are the barriers to HIV testing and the acceptability of HIV testing among ABIs in Washington State?

RQ2: How do the lived experiences of African immigrants impact their decision to take an HIV test?

RQ3: What is the impact of perception, attitude, and beliefs in HIV-related stigma in African born immigrants' community on their healthcare-seeking behaviors?

The target group under study was ABI adults between ages 25 and 49 living in two specific counties that are metropolitan areas in Washington state.

Interpretation of Findings

For this study, I used the HBM for the conceptual framework. The HBM was the appropriate model and conceptual framework that helped meet the goals of the study and the findings did support the conceptual framework of the HBM that is concerned with health decision making by perceived barriers, benefits, self-efficacy and threat. The participants did identify all these determinants: the perceived barriers were identified as cost of the test and this was magnified by lack of insurance, availability of HIV testing centers and distance from the areas where ABIs generally live. Most participants identified the benefits of getting tested and most of those who participated have previously been tested. this was able to determine that assimilation of culture and beliefs have enabled there to be an increase in testing and acceptance of HIV testing. With more people choosing to get tested voluntarily, there was an increase in self-efficacy and empowering people to proactive and seeking HIV testing services. There is still threat to HIV testing in the ABI community that is still fueled by stigma, fear, taboo, culture, and social norms that limits some people from voluntary testing.

The study investigated the barriers to HIV testing and the acceptability of HIV testing among ABIs. The results of the study did confirm that lived experiences had an impact on how African immigrants seek for health care services and there has been an increase in the numbers of those who seek to test for HIV. The majority of ABIs in this study (95%) had undertaken HIV testing; 5% of participants had not. These results imply that HIV testing has significantly been embraced among ABIs. Innovative HIV testing approaches put in place by public health authorities have rendered testing more acceptable and readily accessible. HIV testing is crucial for achieving testing and treatment saturation among ABIs. This finding result may also be attributed to the implementation of HIV testing in community settings outside the clinical environment, which acts as a buffer to the stigma associated with HIV. According to Ojikutu et al. (2012), prior to 2010, HIV testing was offered as a component of a medical screening examination according to U.S. immigration law for those seeking long-term residency in the United States. The removal of this law may serve as a barrier to HIV testing, especially in communities that have not embraced individuals living with HIV and HIV testing; leading to late diagnosis for recent immigrants. Some of the ABIs still live in communities where HIV is still looked down on and revered to as a taboo to discuss any issues related to HIV.

The findings in this study establish that barriers to HIV testing are more predominant among recent immigrants. According to Ojikutu et al. (2015), immigrants face numerous barriers to healthcare access, ranging from lack of health insurance, provider linguistic discordance, and fear of deportation; the vast majority of immigrants are members of an ethnic or racial minority group, and perceived and anticipated discrimination has been identified as a bulwark to accessing health services.

In this study, Participant 1 identified a barrier as, “Stigma associated with the disease and testing.” From this response, two categories emerged: fear of knowing HIV status and fear of testing related to perception from the community or family. Stigma remains an issue in regard to HIV testing. Nonetheless, some ABIs embrace testing as socially responsible and a means to protect the community from disease. This implies that few barriers exist to HIV testing and its acceptability among ABIs living in metropolitan areas in Washington state. Some ABIs' still face barriers, ranging from the location of the testing centers, stigma associated with the disease, and affordability of related care services.

Okoro and Whitson (2017) found that reproductive health education is not openly taught in ABI households. In most cases, children are not provided this information and only explore issues such as HIV later in their lives due to stigma, leading to poor sexual health. According to Zamboni et al. (2017), an individual's views concerning a given disease, coupled with their opinions on the effectiveness of appropriate health actions, can predict the probability of that individual implementing the desired behavioral changes. Moreover, Kingori et al. (2016) noted that "those of African descent have HIV transmission rates six times higher than any other minority groups in the United States" (p. 476). Members of this demographic group face systematic barriers to care—namely, proximity to testing centers.

I examined how the lived experiences of ABIs impact their decisions regarding HIV testing; these lived experiences include ABIs' choices and knowledge and preferences regarding HIV. The findings establish that ABIs in this study believe knowing their status helps them create awareness, not spread the disease to partners, and seek treatment. Knowing their status makes ABIs socially responsible and allows them to make their partners aware of their status and seek treatment if necessary. The findings also show that the ABIs in this study sought HIV testing for various reasons. For most it was to know their health status, but other reasons included fear of exposure to at-risk groups and risky behaviors. Consequently, the majority of the participants had taken the HIV test. The study also revealed that the majority the ABI populace living in Washington State were not at a high risk of contracting HIV since they did not engage in risky sexual behaviors. Moreover, the stigma around HIV remains an issue among the larger ABI populace; however, with continued United States government support, the stigma around the disease continues to fade away.

The study established that ABIs continue to become comfortable discussing topics around HIV with fellow adults. Notably, some ABIs populace still cannot discuss issues around HIV freely due to culture-related reasons. For example, some ABIs communities consider HIV a taboo, so discussing issues around the disease is not permitted.

The findings further revealed that the community had a fair knowledge of the HIV resources and support programs in their respective communities. The resources and support programs include: free testing kits, home testing kits, testing centers, disease-preventing methods, that is to say, preventive methods, primary methods and safe methods, and routine testing. However, it was noted that some ABIs had very little knowledge about HIV resources and support programs. This finding is also noted and confirms the findings of Ojikutu et al. (2013), who found that despite the CDC’s financing of public health campaigns to reduce the stigmatization of HIV patients, and improve HIV knowledge in immigrants. The findings are consistent with other studies like Tulloch et al. (2012), who found that HIV knowledge levels vary based on racial and cultural backgrounds. In Canada, research shows that Canadian-born African immigrants are more conversant with HIV testing and counseling compared to their African-born colleagues.

The study also established that perception, attitude, and beliefs in HIV-related stigma in African born immigrants' community have a significant impact on the healthcare-seeking behaviors of the ABIs'. Noting from the response of participant 30, who gave the response, "*It is very important to get tested so that you can know your status*," thus from this response, themes were noted "very important" and "you can know your status." This response revealed the perceptions on HIV testing among the ABIs that they recognized how necessary the testing was since they would get to know their HIV status out of it. The findings of the study confirm the findings of a study done by Orisakwe et al. (2012), who investigated the existing associations between HIV awareness, opinions, perceptions, and the inclinations of patients in a KwaZulu-Natal, South Africa hospital, established patients possessed different reasons for HIV testing, the most prevalent were the need to gain an understanding of HIV and to confirm HIV status. The study further found that ABIs communities could seek early treatment, become sexually responsible, and improve community health by knowing their status, as was found by Orisakwe et al. (2012). He also established that although patients possessed different reasons for HIV testing, the most prevalent was the need to understand and confirm their HIV status. Beliefs that come with stigma related to HIV still pose a challenge in controlling its spread. The study established that beliefs powerfully influenced the ABIs' health-seeking behaviors. Case in point, participant 3 gave the response, "*The stigma associated with it and the fact that in African culture it is not* *discussed*." From this response, the study established that the stigma associated with HIV does not allow the ABIs' to hold discussions about the disease. This highlights poor health-seeking behaviors whereby there will be no people seeking testing or treatment related to HIV. According to Paulin et al. (2015), HIV counseling and testing in ABIs ranges from 21% to 73%, and it is higher for women than men due to women's acceptance and willingness to test than men. It is also determined by the context of testing and who offers the test.

The study investigated the ABIs' attitudes towards HIV testing; it was established that most ABIs felt the testing was essential considering the high infection rate and increase in infidelity in society. However, some people thought the HIV testing process was a traumatizing process and that pre-testing psychological counseling. should be the key to increasing voluntary testing. This was evident in a study by Bova, et al. (2016), who found that HIV has disproportionately affected minority racial and ethnic populations, particularly in the ABI communities, and the attitude on testing varies in the communities, with most individuals afraid to test due to various reasons. Some of the reasons being some do not think that testing would help, are concerned about family and loved ones leaving them if they tested positive for HIV, and other people would assume they are positive if they decided to test. Moreover, the study established that some ABIs were not comfortable with the testing due to trust-related issues, supporting the findings of Bova, et al. (2016) that trust towards the counselors and fear that healthcare providers would not keep their test results confidential and others preferring not to know their status.

Limitations of the Study

This study has several limitations. Firstly, this study was limited to a phenomenological approach, and interviews were the primary data collection method. The use of interviews as the only mode of data collection was a challenge to the validity of the data collected. The results were dependent on the honesty of the participants and the accuracy of the information shared during the interviews. The interviews were mainly individual-based and answered by the respondents during the individual meetings with the researcher. The initial demographic questionnaire was conducted using a questionnaire online to determine the if the people interested met the inclusion criteria.

Secondly, the study was constrained by budget, the cost of the internet during data collection, the expansiveness of the area under study, and the longer than expected time for the individual interviews.

Lastly, the data was self-reported, which could present a potential for bias that can influence the study results. Data was recorded online on a secure computer. Participants were informed that they had a choice to answer all questions or stop at any time. Participants were advised that the interview process could take between 15 and 30 minutes during the consent process. This information allowed them to plan their time accordingly before the initial interview.

Recommendations

The recommendations presented in this study for further research are grounded in the strengths and limitations of this study and the literature reviewed from other studies and are within the current study’s boundaries.

The study only investigated lived experience, perception, attitude, beliefs in HIV-related stigma, and barriers to HIV testing. For this reason, the study recommends further research on how social-economic factors that contribute to the lack of race/ethnicity data in HIV reports could strengthen the knowledge base of HIV perception in ABIs and how the study could contribute to current knowledge about issues that influence individuals to participate in HIV testing. Moreover, it is imperative to study further the association between ABIs' characteristics and barriers to HIV testing and acceptability in relation to improved health outcomes.

Culture, lifestyles, background, and habits that characterize a particular society are critical determinants of people's healthcare-seeking behavior because they are the main determinants of a society's way of life. This study was focused on finding out the impact of perception, attitude, and beliefs in HIV testing among ABIs without looking at various aspects of culture. It is imperative to note that an individual's health and quality of life are determined by personal-level characteristics, lived experiences/perception, and social determinants that are physical, social, and environmental to measure an individual's perceived health status and health outcomes. Since the ABIs come from different cultures, this could not allow the findings of this study to be replicated in other environments/cultures. For this reason, the study recommends that more inclusive aspects of the ABIs should be investigated; lived experience of a given person and the knowledge gained plays a significant role in the health outcomes of a society.

This study only focused on identifying barriers to HIV testing in ABIs; however, research shows that HIV knowledge levels vary based on ethnic and cultural backgrounds. For example, a study conducted in Canada by Tulloch et al. (2012) established that Canadian-born African immigrants were more conversant with HIV testing and counseling compared to their African-born colleagues. For instance, it was found that only 50% of ABIs understood the importance of condom use in the prevention of HIV, with a majority of the participants admitting that they thought the withdrawal method acted as a preventive measure. For this reason, the study recommends further investigation on how lived experiences of ABIs impact their decision to take an HIV test in Washington state, which could provide a basis for comparison and evidence-based policy direction.

The current study was limited to adult ABIs aged between 20 to 49 years who resided in Washington state. For future research, the study recommends an expanded age group and a larger sample size as this will provide better results by giving more accurate mean values, a smaller margin of error, and identifying outliers that could skew data in a smaller sample size since the current study had a sample size of 31 ABI respondents.

Recommendations for Practice

The current study sought to address the barriers to HIV testing and seek to understand how these barriers affect HIV testing in the ABI communities. It is imperative for health care providers and public health leaders to strategize on interventions to improve access and timely entry into care and to best address the social, economic, and cultural environment and exploit the full potential of new options and strategies for health policy and action to develop an effective population-based plan that will be vital in improving the health outcomes of the communities. For further investigation, the study recommends a study on how improved health outcomes are affected by the lived experiences of ABIs living in Washington state.

According to Winston SE. (2011), a change in immigration policy that required mandatory testing for immigrants may serve as a barrier to HIV testing leading to late diagnosis for new immigrants. Prior to 2010, testing was offered as a component of the medical screening examination required for the majority of the immigrants. With this policy change, understanding barriers to HIV testing and acceptability among ABIs and developing appropriate interventions is necessary to ensure that the ABIs are tested. Therefore, the study recommends further research on how this change in policy as a barrier to HIV testing and acceptability influence the perception, attitude, and beliefs in HIV-related Stigma in African born immigrants’ community on their healthcare-seeking behaviors. This would offer more insights since the current study only focused on barriers to HIV testing and the acceptability of HIV testing among ABIs in the two counties in Washington State without considering the change of immigration policy on HIV testing.

The study participants comprised of those who had lived in the United States for more than ten years, being the majority representing 60 percent of the study sample. In light of this, the study recommends that researchers consider how lived experiences of the most recent immigrants as this will help develop policies regarding HIV testing and acceptability in the most extreme cases whereby culture shock predominates. A study by Lebrun (2012) that focused on the effect of length of stay and language proficiency on healthcare experiences among immigrants in Canada and the United States established that in both countries, immigrants with shorter length of stay (less than ten years) and limited language proficiency had lower rates of access or use of healthcare access and utilization compared to those with a more extended stay (ten years and above).

Moreover, the study investigated the risk exposure of the ABIs contracting HIV by examining their perceptions towards the risks. In light of this study, it would be necessary to carry out further study on how the specific risks affect the health outcomes of ABIs. The current study is limited to the opinions of the ABS on risks. It does not pinpoint the types of risks and offers appropriate policy recommendations.

In addition to the above recommendations, the study employed a phenomenological research design, which inherently has its shortcomings, including difficulties with analysis and interpretation of the data coupled with lower levels of validity and reliability limiting the study. There is a possibility that the participants who chose to participate in the study experienced diverse barriers creating bias in the study estimates of the lived experiences of the ABIs. Notably, all measures were self-reported with a potential of recall bias. Therefore, the researcher recommends further using a different research design to confirm the findings of this study.

Implications

Social Change

The research done in the past has shown that ABIs are disproportionately affected by HIV and do not voluntary test leading to late diagnosis and AIDS diagnosis shortly thereafter, and increased mortality rate. The HBM was appropriate for the study for it helped focus on the lived experiences of the ABI and how these experiences determine decision-making and provide the potential for positive social change at personal, family, organizational and societal levels within the study boundaries. Increasing awareness of the importance of HIV testing and focusing of reducing, stigma, bias, and social/culture barriers will be imperative to increasing voluntary HIV testing. According to Arya et al. (2014), HIV testing is imperative to an individual since when one is aware of their HIV status and engages in a continuum of care, they can protect their health and the health of their partner/s. It also decreases the risk of infection and reduces the spread of disease. Therefore, social change must continue to be the main focus and priority.

The HBM was helpful and suitable conceptual framework for it helped outline the perceptions and attitudes that influence the risk of HIV transmission within the social structure. Testing is the first step in the HIV treatment cascade; with technological advancement, new testing technologies, including out of health facilities and self-testing, have eliminated some of the barriers of geographical challenges, enabling public health officials to bring the tests closer to the communities, including the African born immigrants, for these testing technologies provide privacy and cushion against the stigma associated with the disease. Increased HIV testing and its acceptability among the ABIs in Washington state has brought a social change in this community, as evidenced in the study results.

At individual levels, the ABIs acknowledge that one begins self-healthcare management with testing, which shapes their sexual behaviors. Testing acceptability will increase the numbers of those testing across all genders and ages. New HIV testing technologies have revolutionized HIV testing as individuals can now test themselves privately. The perception of HIV as a death sentence among individuals will change the dwindling stigma. Individuals who know their HIV statuses will practice caution while getting into new relationships, avoid transmitting and seek treatment accordingly hence improved healthcare outcomes. With more knowledge about HIV, there will be a deepened understanding of transmission and non-transmission ways which will help decrease discrimination against HIV.

Fatalism constitutes a significant barrier to participation in positive health behavior and influences health outcomes. This significantly influences immigrants who have received substandard medical care in their home countries, thus holding a more fatalistic perspective towards HIV. However, with increased testing and information, the individual ABIs will be in a position to benefit from increased access to healthcare and experience reduced fatalistic belief over time.

As the smallest unit of society, the family has not been spared either. Sharing of information about HIV and increased testing among the African born immigrants at family has come with changes on how the ABI families interact, with a significant influence on perception, attitude, and beliefs in HIV related Stigma in African born immigrants' community on their healthcare-seeking behaviors. Individuals will now appreciate knowing their status at the family level, especially if a member has been infected. Therefore, knowing one's status will consider an act of social responsibility. It will make everyone feel comfortable and secure in the family and community and make it easy to talk about issues surrounding HIV. Families will now feel safe living with infected ABIs without prejudice or stereotyping since it will become a social responsibility to improve community health.

The knowledge gained from this study can also be used to assist educators, policy makers, public health leaders, community organizations, and researchers to develop programs that would be beneficial to ABIs. Implementing culture and language sensitive programs may promote more holistic care and distribution of information may be more understood and improve ABI health outcomes. Strategizing with the health sector in setting up voluntary counseling and testing consulting points that are more accessible for ABIs and training health care providers to improve the quality of their services to increase utilization of HIV support programs may also be essential in health promotion and HIV testing.

The study's methodology was a phenomenological approach that promoted the researcher to set aside biases and preconceived assumptions about ABI, feelings, and responses to their views of not testing for HIV. This approach involved finding out how individuals perceived the meaning of an event beyond people's perceptions. Moreover, this study was anchored on the HBM as a social psychological theory that researchers use to predict behavioral health characteristics within a population. The HBM was beneficial to the current research as it provided a deeper understanding of ABIs behaviors in the United States. Through the six constructs (Perceived risk (I can get infected with HIV), Perceived seriousness (HIV/AIDS has caused death, and it could shorten my life if I got infected), Perceived benefits (I will be aware of my status if I get tested), Barriers to taking action (I can get seriously sick if I do not get tested and I am HIV positive), Cues to action (I will protect myself if negative or seek medical services if positive) and Self-efficacy (I will protect myself from HIV infection)), the study focused on the HIV testing trends within the African-born American immigrant community. The model also allowed the researcher to make recommendations on ideal HIV prevention.

Implications for Professional Practice

Based on the findings of this research, this study can provide knowledge on practice of HIV testing that may increase the health and well-being of the ABI communities across the United States. Future research can focus on HIV resources and support programs for ABIs to ensure the availability of the necessary information concerning HIV testing. With improved HIV testing knowledge, there will increase testing and hence acceptability, leading to improved health outcomes. Resources like free testing kits and pre-testing counseling should be provided for those seeking testing services. This will help in removing the barriers associated with testing.

Another implication for practice would be to implement initiatives that enforce privacy protections that inhibit discrimination, promote the rights of ABIs and create an environment where disclosure of HIV status is much easier. The health policies should be focused on reproductive and sexual health since they are essential to the overall health and considered the entry point for most immigrants into the medical care system in the United States. Reproductive health equity is vital in optimizing the quality of life of a community and addressing issues related to reproductive health such as maternal and infant health, sexual relationships, sexually transmitted infections (STIs) prevention, and gender identification because, with the correct information, it can help prevent sexually transmitted disease and safeguard safe and nurturing sexual relationships. Moreover, the inclusion of additional services and resources for ABIs related to HIV testing, and use of

HBM model in behavior change research to encourage voluntary testing and provision of necessary HIV information to the ABIs to tackle stigmatization and stereotyping may promote more voluntary testing.

Conclusions

This study sought to examine the perceptions, attitudes, and acceptability of HIV testing and how these contextual realities affect HIV spread among ABIS from Sub-Saharan Africa living in Washington state and driven by both social constructivism as well as the advocacy worldview, was to explore the lived experiences of participants from Africa living in Washington state to gain an understanding of their perception and attitude towards HIV testing. The study found that perceptions of the ABIs about HIV play a significant role as far as testing and acceptability of HIV testing is concerned, which influences the communities' health behavior change towards improved community healthcare outcomes. With increased testing, the individual members of the community will be more socially responsible not to engage in risky behaviors that could expose them and their partners to contracting the disease. Sexual health is essential to overall health. Health equity is essential in optimizing the quality of life of a community and addressing issues related to reproductive health such as maternal and infant health, sexual relationships, sexually transmitted infections (STIs) prevention, and gender identification.

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Appendix A: Informed Consent

You are invited to participate in a research study. The reason for the study is to find out how people who were born in Africa and now live in Washington State feel about HIV testing and if they are able to get the test when they need it. Anyone can participate and be a part of the study and it is voluntary to participate. For a person to participate please make sure

- You were born in Africa. You come from one of the countries listed here: Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo (Brazzaville), Congo DRC (Zaire), Cote d'Ivoire (Ivory Coast), Djibouti, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Reunion, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, Somalia, South Africa, South Sudan, Sudan, Swaziland, Tanzania, Togo, Uganda, Zambia, Zimbabwe.
- You are able to read, write, and understand English.
- You are between the ages of 25-49 years old.
- Live in any part of Washington State.

Phoebe K. Mugo is the researcher of the study and she is a PhD student at Walden University and her teacher supervising the study is Dr. Wen Hung Kuo. Phoebe K Mugo's her contact information is listed at below. The researcher can be contacted at any time in the survey if you have any questions.

Please read every section of this form and ask questions if you do not understand any part of the form before starting the survey.

Background Information:

This study is being conducted to understand what problems people who have migrated from Africa and now live in America face when trying to get HIV testing. The study also wants to understand if the cultures, beliefs, and feelings affects a person when deciding to look for help. HIV is a very serious problem that affects a lot people in the United States regardless of where the come from. A lot of people from. Africa are affected by HIV and most of them do not know they are sick and sometime do not have this information until they are very sick. There is more information about HIV testing CDC website at: https://www.cdc.gov/hiv/testing/index.html or at: hivtest.org. These websites provide National HIV and STD testing resources available in your neighborhood and the best way to find the nearest testing center closest to you is to enter your ZIPCODE and a list of resources near you will be listed. This information is also available at the State and

Counties public health websites. The information collected in this study may be used to start programs that can be of help to immigrants from Africa.

Procedures:

I will need about 25 people to participate in the study and please make sure that you meet the requirement stated above and complete a research survey online. The instructions for completing the questions will be provided at the top of the survey form. When you complete the survey, you will submit your responses by clicking the done button. If you have any questions, you can call the researcher (Phoebe K. Mugo) at any time. The contacts for the researcher are provided to you at the end of this form. This survey will take approximately 20-40 minutes.

Voluntary Nature of the Study:

Your participation in this study is completely voluntary. There are no foreseeable risks associated with this project. However, if you feel uncomfortable answering any questions, you can withdraw from the survey at any point. You will not be treated differently if you decide not to be in the study. If you decide to join the study now, you can still change your mind during the study or later. Your survey responses will be strictly confidential and data from this research will be reported only in the aggregate. Your information will be coded and will remain confidential. If you have questions at any time about the survey or the procedures, please contact the researcher.

Risks and Benefits of Participating in the Study:

Being part of this study will not have any health risks to you. You may experience some discomfort with answering some of the questions but since you will complete the survey privately, you should be honest with your answers. If you are affected by the participation in this study please seek help at any Sea Mar Clinic (www.seamar.org) or Navos (www.navos.org; 206- 248-8226) and at these websites will you will be able to find more information for a clinic near you and. How to contact them. There are no direct benefits to your participation in the study but the information collected could be used to start programs that will benefit your community. The major benefit of your participation will be that; the results will help people working in healthcare to learn more about your community and what is the best way to provide services to your community and how to provide HIV testing and benefit from treatment services.

Compensation:

At the end of the survey, the researcher will donate $5.00 to a charity of your choice as a thank you for participating. The instructions are provided at the end of the survey. You will be asked to enter the name of the charity of choice and any additional information that will help the researcher to locate your charity. All charities must be legal, non-profit, and involved in community development efforts. Participation in researcher donation to a charity of your choice is optional. If you don't feel like providing a name, you can leave box blank or enter OTHER, and the researcher will randomly donate to any charity selected from among those provided by other participants. Only one entry per participant will be allowed.

Confidentiality:

Any information you provide will be kept confidential. Your information will not be used for any purposes outside of this research study and please do not include your name in the survey. All information will be saved and locked in a safe place only accessible by the researcher. Electronic data will be kept secure into a computer and hard drive that is protected by a password only known by the researcher. The information will be stored for 5 years before it is destroyed per guidelines from the university.

Contacts and Questions:

Phoebe K. Mugo

Phone: 253-353-1178

Email: phoebe.mugo@waldenu.edu.

If you want to talk privately about your rights as a participant, you can call a Walden university representative who can discuss this with you at 612-312-1210. Walden University's approval number for this study is 07-21-21-0385910 and it expires on July 20, 2022.

If you understand well the study enough to participate and wish to volunteer please go to the next section below to start the survey.

Thank you very much for your time and support.

Appendix B: Demographic Survey and HIV Testing Knowledge Questionnaire

What is your opinion on HIV testing?

Every day we face challenges in our lives. The goal of this survey is to serve as a tool that will guide what and how we may best address the issues being experienced by our youth. Please answer honestly because your input is crucial and highly appreciated.

THIS SURVEY IS ANONYMOUS

Please Answer ALL Questions

1. What is your age group?
   - ☐ 18 – 24
   - ☐ 25 -29
   - ☐ 30 -34
   - ☐ 40 44
   - ☐ 45 -49
   - ☐ 50
2. What is your Gender?
   - ☐ Male
   - ☐ Female
   - ☐ Other
3. What is your sexual identity?
   - ☐ Heterosexual
   - ☐ Gay
   - ☐ Lesbian

☐ Bisexual

☐ Transgender

☐ Other

4. What is your zip code?

____

5. What is your status in the US?

☐ Citizen

☐ Permanent Resident

☐ Student Visa

☐ Other Temporary Visa

6. How many years you have lived in the US?

☐ < 1 year

☐ 1-5 years

☐ 6-10 years

☐ >10 years

7. What is highest education level you have achieved?

☐ Elementary school

☐ High school

☐ Year 12 or equivalent

☐ Certificate/Diploma

☐ University, Post Graduate or Higher

8. Have you ever been tested for HIV?

☐ Yes

☐ No

9. How do you feel about testing for HIV?

____

10. Are there any barriers to accessing HIV related testing care services?

____

11. Do you think you are at risk for contracting HIV?

____

12. What is your knowledge of HIV resources and support programs in your community?

____

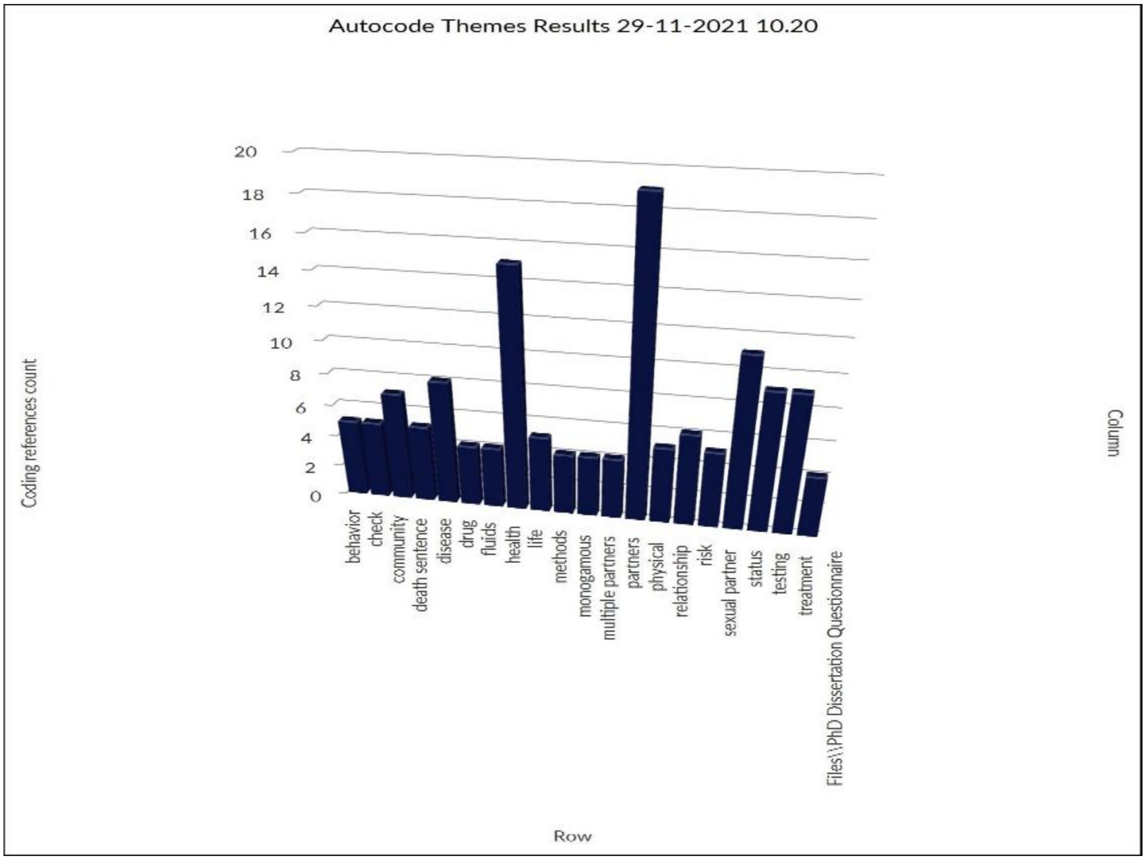
13. How comfortable are you in discussing about HIV with your family/friends?

____

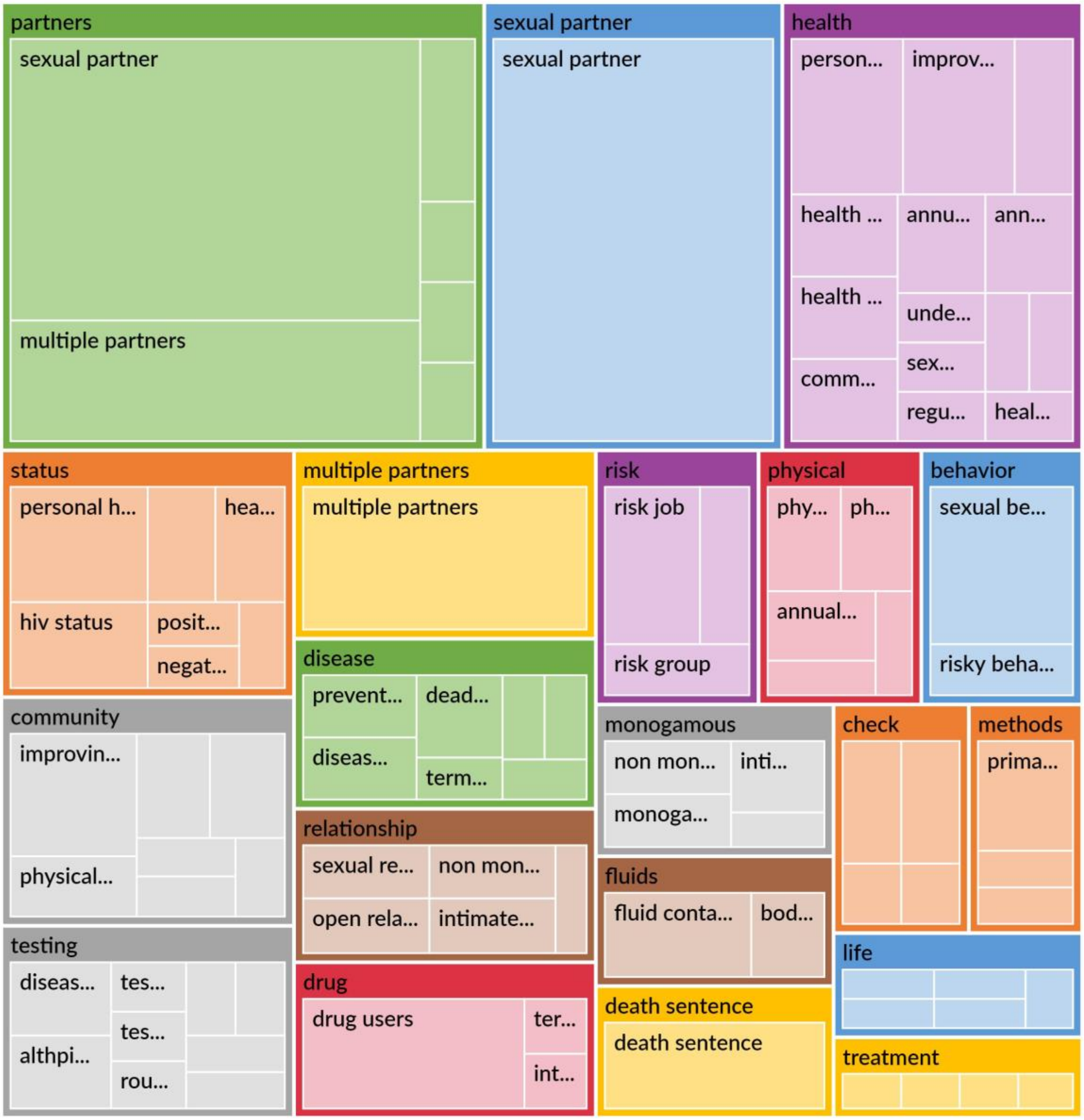
14. How does knowing your HIV status affect you, your family, or community?

____

Appendix C: Autocode Themes Results



Appendix D: Compared by Numbers of Coding References



Appendix E: Nodes/Coded Themes

Name	Description	Sources	References
Behaviour		1	5
risky behavior		1	2
sexual behavior		1	3
Check		1	5
annual health check		1	1
pregnancy routine check		1	1
weekly check		1	1
yearly check		1	2
Community		1	7
community centers		1	1
community clinics		1	1
community health		1	1
community resources		1	1
community support		1	1
improving community health		1	1
physical community		1	1
death sentence		1	5
death sentence		1	5
Disease		1	8

Name	Description	Sources	References
chronic disease		1	1
curable disease		1	1
deadly disease		1	2
diseases tests		1	1
heart diseases		1	1
preventable disease		1	1
terminal disease		1	1
Drug		1	4
drug users		1	2
intravenous drugs		1	1
term drug		1	1
Fluids		1	4
body fluids		1	2
fluid contamination		1	2
Health		1	15
annual health check		1	1
annual health physical		1	1
community health		1	1
health decline		1	1
health district		1	2

Name	Description	Sources	References
health status		1	1
improving community health		1	1
multicultural health		1	1
personal health		1	1
personal health status		1	1
physical health		1	1
regular health screening		1	1
sexual health screening		1	1
underlying health issues		1	1
Life		1	5
full life		1	1
life expectancy		1	1
life span		1	1
obtaining life insurance		1	1
sexual life		1	1
Methods		1	4
preventive methods		1	1
primary methods		1	2
safe methods		1	1
Monogamous		1	4

Name	Description	Sources	References
intimate non monogamous relationship		1	1
monogamous marriage		1	1
monogamous status definition		1	1
non monogamous relationship		1	1
multiple partners		1	4
multiple partners		1	4
Partners		1	19
active partners		1	1
different partners		1	1
faithful partner		1	1
multiple partners		1	4
partners sake		1	1
sexual partner		1	11
Physical		1	5
annual health physical		1	1
physical community		1	1
physical demands		1	1
physical exam		1	1
physical health		1	1
Relationship		1	6

Name	Description	Sources	References
1 person relationships		1	1
intimate non monogamous relationship		1	1
non monogamous relationship		1	1
open relationship		1	1
sexual relationship		1	2
Risk		1	5
risk group		1	2
risk job		1	2
support groups		1	1
sexual partner		1	11
sexual partner		1	11
Status		1	9
current status		1	1
health status		1	1
HIV status		1	3
monogamous status definition		1	1
negative status		1	1
personal health status		1	1
positive status		1	1
Testing		1	9

Name	Description	Sources	References
althpigh testing		1	1
annual exam test result		1	1
diseases tests		1	1
free testing kits		1	1
HIV testing		1	1
home test kits		1	1
routine testing		1	1
testing centers		1	1
testing locations		1	1
Treatment		1	4
immediate treatment		1	1
seeking treatment		1	1
treatment asap		1	1
treatment regime		1	1

Appendix F: Nodes/PhD Dissertation Questionnaire

Name	Description	Sources	References
Are there any barriers you encounter when trying to access HIV related testing care services in your community What are the barriers		1	38
Do you think you are at risk for contracting HIV Why		1	38
HIV testing is one of the primary methods of prevention for HIV. What are your thoughts on HIVAIDS testing		1	38
How comfortable are you in discussing about HIV with your family friends		1	38
How do you feel about HIV testing		1	38
How does knowing your HIV status affect you, your family, or community		1	38
How often do you think that a person gets tested		1	38
If you have been tested, what were your reasons for being tested		1	38
What are some of the reasons you think a person should get tested		1	38
What do you think of when you hear the word HIVAIDS		1	38
What is your knowledge of HIV resources and support programs in your community		1	38

Appendix G: Doctoral Student Researcher Basic Course

CITI PROGRAM

Completion Date	20-Nov-2019
Expiration Date	N/A
Record ID	34289683

This is to certify that:

Phoebe Mugo

Has completed the following CITI Program course:

Not valid for renewal of certification through CME.

Student's
(Curriculum Group)
Doctoral Student Researchers
(Course Learner Group)
1 - Basic Course
(Stage)

Under requirements set by:

Walden University

CITI
Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?wf51744e9-323b-4dbf-8579-83a9391f8a81-34289683

Appendix H: CITI Report

COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COMPLETION REPORT - PART 1 OF 2
COURSEWORK REQUIREMENTS*

* NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details. See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

• **Name:**	Phoebe Mugo (ID: 8673291)
• **Institution Affiliation:**	Walden University (ID: 2906)
• **Institution Email:**	phoebe.mugo@waldenu.edu
• **Phone:**	2533531178
• **Curriculum Group:**	Student's
• **Course Learner Group:**	Doctoral Student Researchers
• **Stage:**	Stage 1 - Basic Course
• **Record ID:**	34289683
• **Completion Date:**	20-Nov-2019
• **Expiration Date:**	N/A
• **Minimum Passing:**	60
• **Reported Score*:**	91

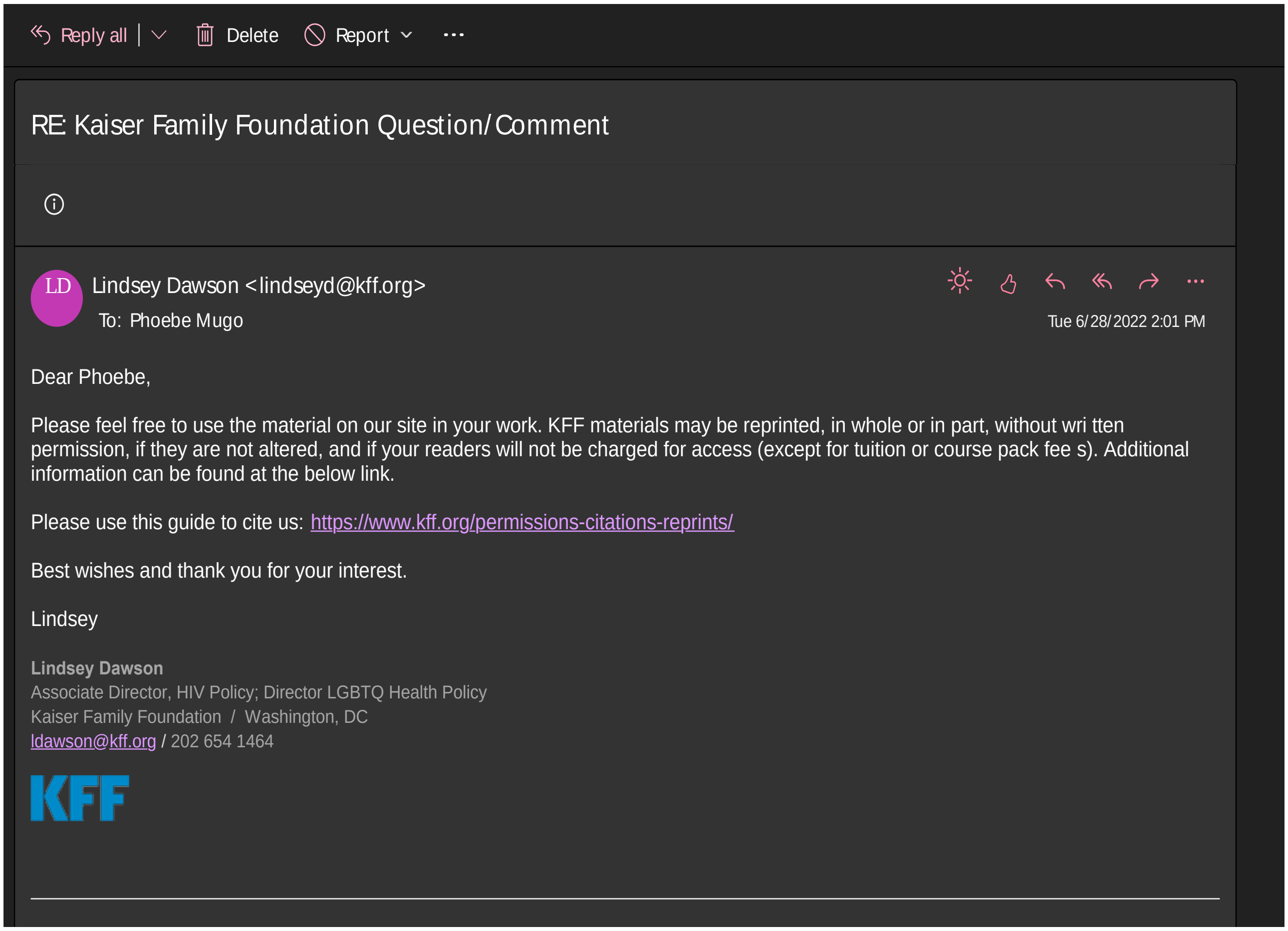
REQUIRED AND ELECTIVE MODULES ONLY	DATE COMPLETED	SCORE
History and Ethical Principles - SBE (ID: 490)	20-Nov-2019	4/5 (80%)
Assessing Risk - SBE (ID: 503)	20-Nov-2019	5/5 (100%)
Informed Consent - SBE (ID: 504)	20-Nov-2019	5/5 (100%)
Privacy and Confidentiality - SBE (ID: 505)	20-Nov-2019	5/5 (100%)
Unanticipated Problems and Reporting Requirements in Social and Behavioral Research (ID: 14928)	20-Nov-2019	4/5 (80%)
Students in Research (ID: 1321)	20-Nov-2019	4/5 (80%)
Cultural Competence in Research (ID: 15166)	20-Nov-2019	5/5 (100%)

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

Verify at: www.citiprogram.org/verify/?kf2092f75-4936-4ecf-800f-ee48e93cef9b-34289683

Collaborative Institutional Training Initiative (CITI Program)
Email: support@citiprogram.org
Phone: 888-529-5929
Web: https://www.citiprogram.org

Appendix I: Letter from Kaiser Foundation



RE: Kaiser Family Foundation Question/Comment

Lindsey Dawson <lindseyd@kff.org>
To: Phoebe Mugo
Tue 6/28/2022 2:01 PM

Dear Phoebe,

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Best wishes and thank you for your interest.

Lindsey

Lindsey Dawson
Associate Director, HIV Policy; Director LGBTQ Health Policy
Kaiser Family Foundation / Washington, DC
ldawson@kff.org / 202 654 1464

KFF