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ORIGINAL ARTICLE

Concepts of risk among young Swedes tested negative for HIV in primary care

Focus-group interviews

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Abstract

Objective. To explore why young adults test for HIV, how they construct the HIV risk, and what implications testing has for them. *Design*. Six tape-recorded focus-group interviews were transcribed verbatim and analysed according to a grounded theory approach. *Subjects and setting.* Women and men between 18 and 24 years of age were recruited from a youth clinic in northern Sweden in 2004–05 after being tested and found to be HIV negative. *Results.* A core category – *reconsidering risk* and four categories – *HIV: a distant threat*; *the risk zone*; *responsibility: a gendered issue*; *a green card* – emerged. HIV was described as being far away. Stereotypical images of risk actors emerged but were perceived to be clichés. "Ordinary" people including themselves were also considered at risk. Many had event-driven reasons for testing for HIV, multiple partners being one. One closer risk zone was "the bar"; a dating milieu that often was expected to include "one-night stands" for both women and men. Responsibility for testing was a gendered issue: it was "natural" for women, while men rather "escaped from responsibility". A resistance towards testing was revealed among young men. Receiving a negative HIV test result was "a green card", confirming healthiness and providing relief. Most informants felt "clean" and discussed how to restart with renewed ambitions. *Conclusions*. As participating in focus-group interviews was apparently an "eye-opener" for many, a counselling conversation reconsidering risk following an HIV test might be a good idea. Liberal HIV testing among young men and women could evoke insights and maturation and start a process of reflections concerning their sexual risk-taking behaviour.

Key Words: *Family practice, focus-group interviews, gender, HIV test, sexual risk-taking, youth*

Early diagnosis of HIV has public health benefits [1] and to provide HIV testing for those at risk is essential [2]. In Sweden, voluntary, free, and anonymous HIV testing is available for everyone, and there are national screening programmes for pregnant women and blood donors [3]. The work of general practitioners (GPs) is an important link in prevention of sexually transmitted infections (STIs). For some healthcare services testing for HIV is a routine matter, but many GPs and other healthcare professionals may hesitate to raise the issue of testing [4]. HIV testing in primary care is therefore mostly the result of a voluntary request from patients. A survey study on sexual behaviour and HIV in Europe revealed that voluntary HIV testing is low, especially among heterosexual respondents under the age of

The informants had personal grounds for testing: unprotected sex, many partners, experimenting with drugs, sex abroad, infidelity, needle-stick injuries, and hypochondria.

- Testing was a gendered issue: it is "natural" for women, while young men need to overcome different barriers against testing.
- Receiving a negative HIV test was a relief and confirmed healthiness. They felt "clean" and could restart.
- Reconsidering risk in a counselling conversation following an HIV test could be a good idea for GPs.

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24 years, despite histories of risky behaviour [1]. There are barriers against testing among young people, arising from cost, shame, or fear of judgemental behaviour [5], and healthcare services are not always designed to reach youths and their specific needs [6]. Sweden, however, has a growing body of youth clinics, run by midwives, physicians, social workers, and psychologists [7]. Here young people are offered contraceptive counselling and are encouraged to check for STIs.

The aim of this study is to explore why young adults choose to test themselves for HIV, how they construct the HIV risk, and what implication testing has for them.

Material and methods

The findings in this study are drawn from analysis of six focus-group interviews (FGIs).

Informants between 18 and 24 years of age were recruited in 2004–05 after being tested and found to be HIV negative by the staff at a youth clinic in Umeå, a university town in northern Sweden. Fourteen women and nine men were recruited and sorted into six groups; three for women, two for men, and one mixed. Three women and one man initially agreed to participate but did not keep their appointments and refused to participate in another group. Another 14 women and 15 men refused from the start for various reasons.

The interviews followed focus-group research principles [8]. The moderator (MC) invited and encouraged everyone in the group to share their experiences of HIV testing and sexual risk-taking. An observer (EEJ) took notes during the sessions. Afterwards each informant completed a questionnaire regarding background data.

The tape-recorded conversations lasted 90 minutes, were transcribed verbatim and analysed according to a grounded theory approach [9,10]. After each FGI the researchers had a debriefing discussion and a preliminary analysis was started, where emergent ideas were checked in the following FGI. Memos were written. The researchers independently read the transcriptions and coded the text (open coding). These labels described events and experiences concerning HIV testing and risk-taking. The interviews were reread in detail and the codes were reorganized and grouped to build subcategories. In the axial coding, subcategories related to categories, context, causes, and consequences were integrated. The authors then together evaluated the categorization to achieve consent. By constant comparison between categories, interview text, and memos, i.e. a higher and more abstract phase of analysis, the final categories and a core category crystallized. From this analysis the storyline materialized that is presented in this paper. Data on impressions from post-test counselling have been saved for further analysis.

Ethical considerations

The participants were informed about the study in writing and verbally and that participation was voluntary. They were assured of confidentiality, i.e. information gathered would be carefully protected and that the unit of analysis was the group, not the individual. Furthermore, they were informed about the obligation to respect the privacy of the other members by not disclosing any personal information that they shared during the FGIs. The Medical Ethical Research Committee at Umeå University approved the study in 2002.

Findings

Some characteristics of the informants are given in Table I. Each subheading corresponds to concepts emanating from the coding of the material. The emerging core category, *reconsidering risk*, relates to each subheading, starting with the informants' perceptions of HIV, followed by intimate relationships, gender roles, and testing, and ending with a negative test result.

HIV – a distant threat

In most groups HIV was discussed as a distant threat, present in Africa, Asia, and big cities but not part of their social world. Many concluded that since few were actually HIV+ in Sweden, people did not worry about contracting the disease.

> *It's not like it's directly around the corner. (Man)*

> *I think that many people think like that; it won't happen to me, instead it's the Africans' problem. (Man)*

During the discussions they recognized that there were "people at risk", for example, immigrants, prostitutes, homosexuals, drug addicts – and there were those who were not, such as the straights or the average Swede. This clichéd thinking, dividing people into "them" and "us", was seen as hazardous but was perceived as common among people. Those who were strangers, older, young, and dumb, who were "fuck-arounders", "sick-in-the-head", sloppy, and "blue-eyed" were other examples of stereotypical images they connected with risk. Tattoos or intimate piercing could also be warning signs. Moreover, risk calculations were often based on conventional

Table I. Some characteristics of the informants (n = 23)

Characteristics	Women (n = 14)	Men (n = 9)
Age		
Median years (range)	22 (21–23)	23 (18–24)
Ethnicity		
Born in Sweden	12	7
Born in Sweden (parents mixed ethnicity)	2	0
Born in the Middle East	0	2
Education		
University	7	6
Secondary high school	11	9
High school	3	0
Present occupation		
Student	7	7
Employed	3	1
Unemployed	3	1
Sick-leave	1	0
Sexual orientation		
Heterosexual	13	7
Homosexual	0	2
Bisexual	1	0
Number of HIV tests		
Median (range)	1 (1–3)	1 (1–7)
Sexual debut		
Median years (range)	15 (14–18)	17 (15–18)[1]
Number of sexual partners		
Median (range)	14 (7–30)[2]	8 (0–33)[1,2]
Drug use		
Tobacco regular use	5	0
Tobacco on occasion	2	4
A mixture of tobacco and nicotine – snuff inserted under the lips	10	3[3]
Alcohol	13	7
Other drugs occasionally	5	0
None	0	1
Present contraceptive use		
Oral contraceptives	7	
Condom use	1	4
Both condom and oral contraceptives	2	2
None	4	2[2]

[1]One virgin; [2]one did not answer; [3]on occasion.

feminine and masculine appearances such as blonde flirty bimbos, prince charming, or players. As the discussions continued, any nice, good-looking woman, and in fact any man, came to be seen as an eventual risk. "You can never trust men", one man claimed. They realized that even "ordinary" people like themselves could catch HIV, because of "bad luck".

> *I sometimes think like HIV is extremely far away, but then it hits me that those who have HIV it's not those who have been sleeping around and fucked a prostitute, instead it's people who are unlucky, and that tells me that it can happen to me. (Woman)*

The risk zone

The informants described what they regarded as risk zones. One recurring example mentioned was charter travel, i.e. "losing your head abroad". Closer risk zones were "bars", places where people mingled and drank alcohol. Many women discussed the "silent rules" of expected behaviour when interacting with men in bars; going home with a new partner often ended in sex. They wanted to know the partner first, but had problems handling this situation:

> *There are boys who say that they can sleep on the sofa, and you are on the same wavelength and then nothing happens except that you drink tea and talk. (Woman)*

> *That's the way I hope it will be. . . . But then you get home and you notice; oh no, he didn't want to drink tea . . . mostly it is about sex anyway . . . (Woman)*

Some men also described situations where they sometimes regretted one-night stands, but they blamed it on "instinct":

> *Yeah well, but you're not more than a mammal in some ways . . . so it makes you want to go and mate. . . (Man)*

Their motives for testing varied: "wake-up calls"; soap-operas about HIV, friends getting tested, worries, or suggestions from healthcare bodies. They described personal grounds for testing such as unprotected sex, many partners (see Table I), experimenting with drugs, sex abroad, condoms breaking, infidelity, recently single, initiating relations, needle injuries, or hypochondria. Another reason was fear of transmitting STIs to partners, mostly expressed among the women;

> *I couldn't live with the thought. (Woman)*

Responsibility – a gendered issue

Both female and male informants talked about "irresponsible" men. In trying to understand why

men seldom take tests, while women do, some women saw this as only natural:

I have many male friends and some of them have not even thought about testing themselves . . . for almost all my female friends, it's natural. (Woman)

I think it is more natural for girls to do it. . . (Women)

In explaining "natural", the informants referred to upbringing. Girls were brought up to be caring, and boys were not. The irresponsibility of boys could be considered normal or even masculine. Some thought that men rather "escaped from responsibility". They discussed how deeply rooted these attitudes were in society. For instance, the teaching of sex education in school consisted for girls of teaching them "mostly about risks and less about pleasure", while for boys it was "acceptable to sleep around". They thought that girls worried about contamination, while boys never considered themselves as transmitters.

All informants highlighted the view that men generally resisted testing due to shame and fright, fear of painful examinations, or deformity concerning their genitals, and worries about STIs. They suggested that information on testing, easier testing procedures, and involving men could increase their willingness to be tested.

A green card

Few men and women worried about HIV. They tested "just in case", to ensure that they were healthy and "clean", "up to 110%". Quotations such as "Now that I'm clean I don't want to get dirty again" indicated a wish to change their behaviour. Most informants said that the test result allowed them to start again with renewed ambitions. They had received a "certificate" – a "green card" or a "licence" to "drive" – to show a potential partner.

A negative HIV test proved that it "could not happen to me". For one man the green card meant "new, vicious circles" of unprotected sex. However, visits into the risk zone were seen by many as transitions that would end when people matured or found stable partners. For most of them a reflective process started:

Nope, I don't think it has changed me . . . instead I think that the older I get the safer I feel. So I think that in ten years I won't have sex if the person hasn't been checked. . . that's what I think.

Well . . . like you said; I felt so clean. That was nice . . . I think that I'm more cautious now, but I don't think that this has anything to do with the test. It's more that I try to think . . . sometimes. (Women in mixed group)

Discussion

On method

There are practical and theoretical challenges linked to the method [11], for example recruitment. Of 52 HIV tested who were invited to participate, more than half refused (n = 29), perhaps due to the sensitive topic in combination with low motivation among busy, healthy young people to participate in research. It was also more difficult to recruit men. This could reflect resistance towards sharing intimate experiences with others. In this study we got talented young people who were willing to attend and this produced decent discussions. Choosing this design, there is a risk that opinions come from the most verbal and confident, but individuals' willingness to participate in FGIs is crucial. Having few informants in each group might have contributed to the open climate, providing rich data [12,13]. The theoretical basis for FGIs – a cautious moderator, combined with a transcript-based analysis, including field notes and written summaries of all interviews – ensures that conclusions may be regarded as credible [8].We cannot state that our informants represent all young people in Sweden, but they are voices from consumers in primary healthcare with various experiences and backgrounds.

Reconsidering risk

The informants described HIV as a distant threat. This is quite realistic in Sweden, with below 50 HIV-infected people of their age [14]. Conversely, according to Lupton, focusing on risk as "otherness" brings with it a tendency for certain social groups to be defined as marginalized and to become the "risky other" [15]. In the study groups, stereotypical images of risk actors emerged but most informants perceived these to be clichés, and thought that "ordinary" people with "bad luck", including themselves, could be at risk. Many had event-driven and rational reasons for testing for HIV, multiple partners being one. The women and men had had a median of 14 and 8 sexual partners respectively, which is more partners than average in their age group. In the latest population-based study on sexuality in Sweden from 1997 it was found that people between 21 and 25 years of age had a median of 5.4 lifetime sexual partners [16]. Nowadays, the increasing incidence of Chlamydia among Swedish youth indicates relaxed attitudes towards unsafe sex [17].

The risk zone was experienced not only as distant but also as nearby, i.e. in "the bar". Socially, bars are studied as venues for sexual initiation [18]. Here social norms promote increased alcohol consumption and sexual networking. Bars can also be arenas where gender is reproduced, i.e. where conventional dichotomized social/cultural roles for expected feminine and masculine behaviour are displayed [19]. For instance, women in our study perceived that bar dating implied sex afterwards, while they preferred small talk. The men could not say no to sex either when they got the chance. However, not all informants felt "trapped" in these "given" roles, which might be labelled "natural"; instead they argued their right to say no or yes to sex, but all of them discussed the gendered sexual arrangements in bars. Such interactions at "bars" could, according to West & Zimmerman, be seen as continuous processes of the social doings, i.e. doing gender [19].

"Naturalness" was referred to when discussing responsibility for testing. For females it was "natural" to get tested. Structurally this also seems evident. There are national programmes for screening pregnant women and blood donors [3], but not for screening potential fathers. Girls worried about infecting partners, while boys seldom considered themselves as transmitters. This is also expressed in a study on Chlamydia [20]. Statements such as "men rather escaped from responsibility" might mirror a resistance to testing, shame, fear of painful examinations or of deformity, and also that STIs are linked to maliciousness for men. One way to increase testing among men could be to offer testing over "the Net" [21], but this innovative approach does not include HIV testing.

Research has shown that "testers" are not necessarily severe risk-takers, but also that risk-takers might not ask for HIV tests [22]. As mentioned before, there are both personal and structural barriers against testing [5]. So, what can GPs do to encourage testing? Simply asking all sexually active female *and* male patients if they want an HIV test can promote testing [4]. In our study the various reasons for testing showed that risk-taking was one, and receiving confirmation of healthiness was another. All informants mentioned that receiving a negative HIV test was a relief. By receiving "a green card" they felt "clean" and restarted with renewed ambitions, including reconsidering risk.

Conclusion

Participating in an FGI was an "eye-opener" for many, therefore reconsidering risk in a counselling conversation following an HIV test could be a good idea. Liberal HIV testing among young men and women could evoke insights and maturation, and start a process of reflection concerning their sexual risk-taking behaviour.

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