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African American Females and Herpes Simplex Virus 2: A Basic Interpretive Qualitative Study

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Abstract

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Dissertation Submitted in Fulfillment
of the Requirements for the Degree of
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Abstract

According to recent studies, African American females are most susceptible to HSV-2 and are often asymptomatically diagnosed. Yet, the perceived benefit of discussing sexual health as well as recognizing a need to discuss HSV-2 with a healthcare provider was an identified gap in the existing research and current study findings. The purpose of this qualitative interpretive study was to understand the experiences of African American females who received an asymptomatic HSV-2 diagnosis. The health belief model constructs guided this study. Outlined through semi-structured interviews were the experiences of seven African American females diagnosed with HSV-2 in Fulton County, GA, as well as examined barriers and challenges discussing HSV-2 with healthcare providers. The data were coded and analyzed and indicated how the participants described a lack of primary prevention knowledge pre-diagnosis, and how they evolved from the initial hurt and shame post-diagnosis. Furthermore, literature and participants emphasized that routine STD or STI testing does not automatically include HSV-2 screening nor discussion about it. Additionally highlighted, a decrease in condom use arises when emotional commitment is established, and a lower perception of severity occurs when controlling symptoms with medication is understood and communicated. Results from the study also highlighted that not all participants preferred African American healthcare providers, and participants were pleased that sexual partners were supportive of their diagnosis disclosures. African American females and their corresponding providers could benefit from health education initiatives that address this information as well as the results from this study, thus creating positive social change.

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Acknowledgments

In August of 2019, my dad passed from a five-year battle with pancreatic cancer, and I had no idea where the strength was about to emerge for me to finish this degree. Persevering, I was granted IRB approval for data collection in February of 2020. Weeks later, the pandemic forced many restrictions, including accessing the required population for my data collection process. A few months after powering through, one of my closest aunts passed from health complications. At this point, far too much kept happening personally and systemically to stay optimistic. I confided in my Chair, Dr. Rojas, who was highly supportive and continued working with me to provide timely feedback about my manuscript and my well-being.

The hardest thing I have ever done is staying motivated to graduate during a pandemic while filled with anxiety, uncertainty, and grief. Talks with my closest friends and loved ones alleviated feelings of self-doubt, while daily inspiration from my incredible mother balanced me out. I also appreciate all of the reframed insight provided by my committee member, Dr. Brown, Editor Dr. Gold, and University Reviewer Dr. Long-White. I would be remiss if I failed to mention that the most critical cornerstone in completing my degree was through God’s care and every moment of spiritual reassurance received. By nourishing my spirituality, I found the strength to finish my degree while also comprehending that my dad has missed nothing and is still cheering with me today. Recognizing all of the compiled efforts, I share this moment with you all. Thank you.

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Chapter 1: Introduction to the Study

This study explored the experiences of African American females with an asymptomatic diagnosis of Herpes Simplex Virus type 2 (HSV-2), living in, or diagnosed in, Fulton County, Georgia. Herpes simplex virus, type 1 or type 2, is an infection spread from lesions, mucus, genital fluids, and oral fluids of an infected partner, often without symptoms (Centers for Disease Control and Prevention [CDC], 2017a). According to the CDC (2016a; 2017a; 2017b), HSV-2 affects millions worldwide, primarily African American females, with no state-by-state data to highlight geographical infection rates (CDC, n.d.). Additionally, HSV-2 is often asymptomatic in diagnosis (CDC, 2015a; CDC, 2017a). There is currently no protocol for routine HSV-1 or HSV-2 testing (CDC, 2017a; CDC, n.d.) and HSV-2 is not included in the standard panel for STD and STI testing and the widely available tests for HSV-2 are known to give false positives (Luthi, 2019). This study has the potential for positive social change by encouraging the creation of health education programs that target educating patients on the necessity for engaging in prevention measures against transmission or contraction of HSV-2. This study also has the potential to start a conversation regarding the health needs of African American females by assessing the population directly about their misconceptions, perceptions, and barriers to prevention.

This chapter begins with the background of the topic, outlining the necessity of state-by-state statistics for all STDs and STIs, the current national statistics for HSV-2, and the likely comorbidity of HSV-2 and HIV for African American females, alongside information about chlamydia, gonorrhea, syphilis, human papilloma virus (HPV), and hepatitis b (HBV) infections and comorbidity. Next, this chapter introduces the problem statement, highlighting the role mistrust supplies between African Americans and the healthcare field, alongside the problem with lack of awareness of HSV-2 for this demographic. Thereafter, the purpose of studying African American females with an HSV-2 asymptomatic diagnosis is explained, with the inclusion of research questions. The theoretical framework is then introduced as the use of the health belief model (HBM) to understand the overall issue. Facilitating a basic interpretive qualitative study is then mentioned under the nature of the study, concluding with definitions, assumptions, scope and delimitations, limitations, and significance of this overall study.

Background

The most recent sexually transmitted infections (STIs) and diseases (STDs) surveillance data from the CDC (2017b) estimated a total number of over 110 million new and existing STIs or STDs in the United States. Further mentioned, an HSV infection does not require national reporting; thus, the reported total number of new and existing STIs is missing numerous asymptomatic HSV-2 infections. The CDC data continued to outline that over 87% of people, ages 14-49, seropositive for HSV-2, reported never being told by a healthcare professional about the diagnosis. According to the CDC (2017b), African American females are the most affected. Further examined, over the past 10 years, the overall HSV-2 prevalence for African American females decreased from 55% to 50%, and that percentage for African American females has remained stable. The percentage of those infected is often age-adjusted between the range of 14-49 years old; therefore, estimating the overall infection rate for African American females at 34.6% (CDC, 2017a; McQuillan et al., 2018). By the time an African American female reaches the age of 35, there is likelihood of an 80% prevalence of HSV-2 (Patel et al., 2016) and the highest HSV-2 seroprevalence among ages 40-49 (CDC, 2017b).

Looker et al. (2017) researched that the presence of HSV-2 increases the likelihood of contracting HIV, and increases the possibility of transmitting HIV from individuals co-infected with HSV-2 and HIV, may increase genital shedding of HIV or HSV-2, in addition to producing a faster disease progression (Looker et al., 2015). The CDC (2016b) outlined that 47% of women who die from HIV are African American. By the end of 2016, over 258,000 females were documented to have HIV, representing 19% of the nearly 39,000 new HIV cases in the US; additionally, outlining nearly 3,900 deaths from HIV were also involving women (CDC, 2019b). In 2019, nearly 50,000 people in Georgia reported their diagnosis of HIV, with 62% represented as women (AIDSVu, 2019a), and data was present for over 50,000 Georgians diagnoses of syphilis, gonorrhea, and chlamydia (Georgia Department of Public Health [DPH], 2019), but no data was provided on HSV-2, regardless of co-infection severity and common occurrence. In addition to the possibility of HSV-2 seroprevalence for African-American females, and the likelihood of comorbidity with HIV, Operario et al. (2015) researched that African American females are more likely to report more occurrences of gonorrhea, chlamydia, and any other STI in a lifetime than any other racial group.

According to the United States Census (2019a) over 327 million people reside in the United States, with about 13 percent, or 42 million, who are African American. The

2010 Census reported that 55% of African Americans live in southern states. The South displayed the highest regional percentage of over 20%, or over 23 million, of its entire population as African American (United States Census, 2011). The United States Census (2019b) reported Georgia was ranked as the eighth most populated state in the United States, with over 10.5 million residents, in which 32%, or roughly 3.3 million, reported as African American. The most recent DPH (2019) surveillance information from 2018 reflected that Fulton County, GA reported 9,066 cases for chlamydia in which 2,435 were from African American females, 3,649 reported cases for gonorrhea in which 577 were from African American females, and 460 reported cases of primary and secondary syphilis in which 28 were from African American females. DPH also highlighted that in 2018 Fulton County, GA alone represented 230,408 cases of all 1,338,055 Georgia-related reported STD cases, and according to AIDSVu (2019b), 1,578 HIV cases were reported in 2016 as the most recent calculation for Fulton County, representing the county with the largest number of reported HIV cases in Georgia.

The reported cases of gonorrhea for African Americans is eight times higher in comparison to Whites, over four times higher for syphilis when compared to Whites, and African American females represent a reported chlamydia rate five times higher than White females (CDC, 2017b). According to the Georgia Department of Public Health (DPH; 2019), the total number of STD cases reported in 2018 for the state of Georgia was 89,975, in which African Americans represented 46,099 cases, and African American females represented 23,946 cases. The same 2019 DPH data outlined that the total number of STD cases reported during the time span of 1998-2018 has yielded over

1,338,055 cases, in which over 690,000 were reported for African Americans and over 407,000 were reported for African American females. The infection rates for Georgia support the disproportionate STD rates among African Americans geographically placed in the South and support the findings (Henderson, 2015) that the clustering of diseases occur in specific geographical regions.

Recognizing the susceptibility of African Americans to all STDs and STIs is higher than other demographics (CDC, 2016b), alongside acknowledgment of the likely comorbidity for HSV-2 and other STDs and STIs that present high susceptibility (Operario et al., 2015; CDC, 2017a), there are no publicly provided formal suggestions from the CDC for HSV-2 testing, only situations to consider are provided when implementing testing (CDC, 2015b). Additionally, there is not any mention of the seroprevalence severity for HSV-2 (CDC, 2017a). Routinized HSV-2 serological testing is not even recommended by the United States Preventive Services Task Force (2016), with emphasis that HSV-2 screening tests approved by the United States Food and Drug Administration result in such high false-positives, lack of available confirmatory tests, and low specificity, that the tests are concluded as ill-equipped for testing the population on a wide scale. Additionally, and strongly advised, the harm accompanying routinized testing was found to outweigh the benefits to individuals tested, even for those who are pregnant. According to the findings of Prince, Batterman, and Schwab (2019), the HerpeSelect (HSLT) HSV-2 IgG enzyme immunoassay is the most commonly used screening test that may yield more false positives than a Western blot assay and emerge most with low index values between 1.10 and 3.50. Further stated, the CDC recommends that anyone with these low index values receive a confirmatory test to determine being truly positive for HSV-2 (Prince et al., 2019). Utilizing a modified version of the most common HSV-2 test, the findings from Prince et al. (2019) yielded several false positives and indeterminate results within their study participants who had reactive results within the low index range and would be considered a true positive following CDC guidelines. Diagnosing a person with HSV-2 within the low index range of results that have been found to yield false positives and indeterminate results leads to misdiagnosis and unnecessary psychological stress, antiviral medication, and negative impact on partners and relationships (Prince et al., 2019).

Though there are no recommendations for routinized HSV-2 screening, nor of anyone asymptomatic, the US Preventive Services Task Force acknowledged that many people are diagnosed asymptomatically, mainly because the widely available screening test for HSV-2 is of little use for an accurate reading when the diagnosis is asymptomatic. People below the age of 25 should receive chlamydia and gonorrhea testing every year, in addition to recommendations for syphilis, HIV, and hepatitis B testing for pregnant females (CDC, 2017c). Also recommended, people between the ages of 13-64 should be tested at least once in their lifetime for HIV (CDC, 2017c). Further advisement from the same CDC data indicated that HSV-1 and HSV-2 are not health conditions that require national reporting. The CDC is only receiving surveys about HSV-2 incidence or seroprevalence from those who self-report it on a national level rather than receiving or publishing state-by-state data (CDC, n.d.). The lack of localized HSV-2 data could be hindering accurate seroprevalence and incidence knowledge, as well as prevention methods that affect this target population.

The CDC (2017b) has advised that healthcare providers choose STD tests based upon sexual behaviors of the person being tested, as well as common infections in the geographical location of the person being tested. The same CDC information outlined that honest discussions are important because STD tests are based upon the infections with serious outcomes if untreated. Further highlighted (CDC, 2015b), there is no evidence that diagnosing genital herpes with a blood test for asymptomatic individuals would change sexual behaviors to stop the virus; therefore, creating uncertainty that testing everyone would stop the spread. The CDC (2017a) recognized that people infected with HSV-2 have an increased risk for HIV even when there are no symptoms for HSV-2; yet, the CDC outlined uncertainty in testing asymptomatic individuals. Testing the blood rather than lesions from an outbreak creates the possibility of false positives which is why the CDC does not recommend routinized testing (CDC, 2017a).

This study was conducted to understand the overall perspectives African American females have about HSV-2, their understanding of an asymptomatic diagnosis of HSV-2, and their perceptions of susceptibility to complications and comorbid infections directly associated with a diagnosis of HSV-2. Additionally, I sought to provide insights regarding the experiences that females have encountered discussing sexual health with healthcare providers and how they describe these experiences.

Problem Statement

The CDC (2017b) reported a nearly 50% HSV-2 seroprevalence among African American females: The highest infection rate for HSV-2 in the nation. The reported rate affects various ages in African American females, but the range most affected is between 40 and 49 years of age (CDC, 2016a; CDC, 2017b). African American females are highly susceptible to HSV-2 and have likely comorbidity with other STDs (Kelly et al., 2016). The CDC (2017a) recommends that patients should start open conversations with their healthcare providers about their sexual history; however, the hindrance of those discussions are often due to a historical mistrust of healthcare providers (Bronson & Nuriddin, 2014) and a discomfort initiating conversations with healthcare providers (Fray & Caldwell, 2017; Hagiwara et al., 2017; Shen et al., 2018).

Although research has identified a significant disparity regarding the seroprevalence of HSV-2 within African American females (Operario et al., 2015; CDC, 2017a; CDC, 2017b), a vast majority focused on HSV-2 comorbidity with gonorrhea, chlamydia, and HIV (Operario et al., 2015; McQuillan et al., 2018; DPH, 2019) with limited focus on HSV-2 lived experiences (N’Diaye, 2014; Hendry, 2017). Though research has addressed that condoms can reduce the risk of STDs and STIs (Bobrow, 2016; Painter et al., 2014; Workowski & Bolan, 2015), condoms are rarely used or negotiated when females want to establish trust in relationships (Andrasik et al., 2014; Caldwell & Mathews, 2015; Ewing & Bryan, 2015). Literature outlined African Americans lack necessary knowledge for effective decision making (Hoffman et al., 2016), but not a lot of researchers have focused on the perceived benefit of discussing sexual health with sexual partners, nor the need to discuss HSV-2 with a healthcare provider (Royer et al., 2013; Fray & Caldwell, 2017).

This basic interpretive qualitative study examined the lack of awareness of the susceptibility of HSV-2, alongside the lack of sexual health conversations between patients and healthcare providers, which welcome the already-escalated prevalence and incidence of HSV-2 and negatively impact social change. Exploring the experiences of African American females living in, or diagnosed in, Fulton County, GA, asymptomatically diagnosed with HSV-2, could assist healthcare providers in understanding how lack of awareness for susceptibility and inaction towards the severity contributes to the HSV-2 incidence and prevalence within the African American community.

Purpose of the Study

This basic interpretive qualitative study sought to understand the experiences of African American females, ages18-49, living in, or diagnosed in, Fulton County, GA and their asymptomatic diagnosis of HSV-2, in addition to exploring factors that impact prevention of HSV-2. The purpose of this study was to explore the attitudes and beliefs of the susceptibility and severity of African American females to HSV-2. The experiences of African American females participating in this study were examined using the HBM, addressing the six constructs of perceived susceptibility and perceived severity that create the perceived threat, perceived barriers and perceived benefits, perceived self-efficacy, and cues to action. Also, this study explored any barriers experienced regarding discussing HSV-2 with healthcare providers. Understanding the barriers when discussing

HSV-2 with healthcare providers can result in the creation of health education programs that may improve the awareness and prevention African American females have pertaining to HSV-2.

Research Questions and Hypotheses

1. RQ1. What is the experience of herpes simplex virus 2 (HSV-2) for African American females, ages 18-49, living in, or diagnosed in, Fulton County, GA, who were asymptomatic prior to being diagnosed?

   Sub-question: How do African American females, ages 18-49, living in, or diagnosed in, Fulton County, GA, perceive their susceptibility to HSV-2?
   Sub-question: How likely are African American females, ages 18 to 49, to protect themselves against HSV-2?
2. RQ2. What barriers and challenges do African American females, ages 18-49, living in, or diagnosed in, Fulton County, GA experience during conversations with healthcare providers about HSV-2?

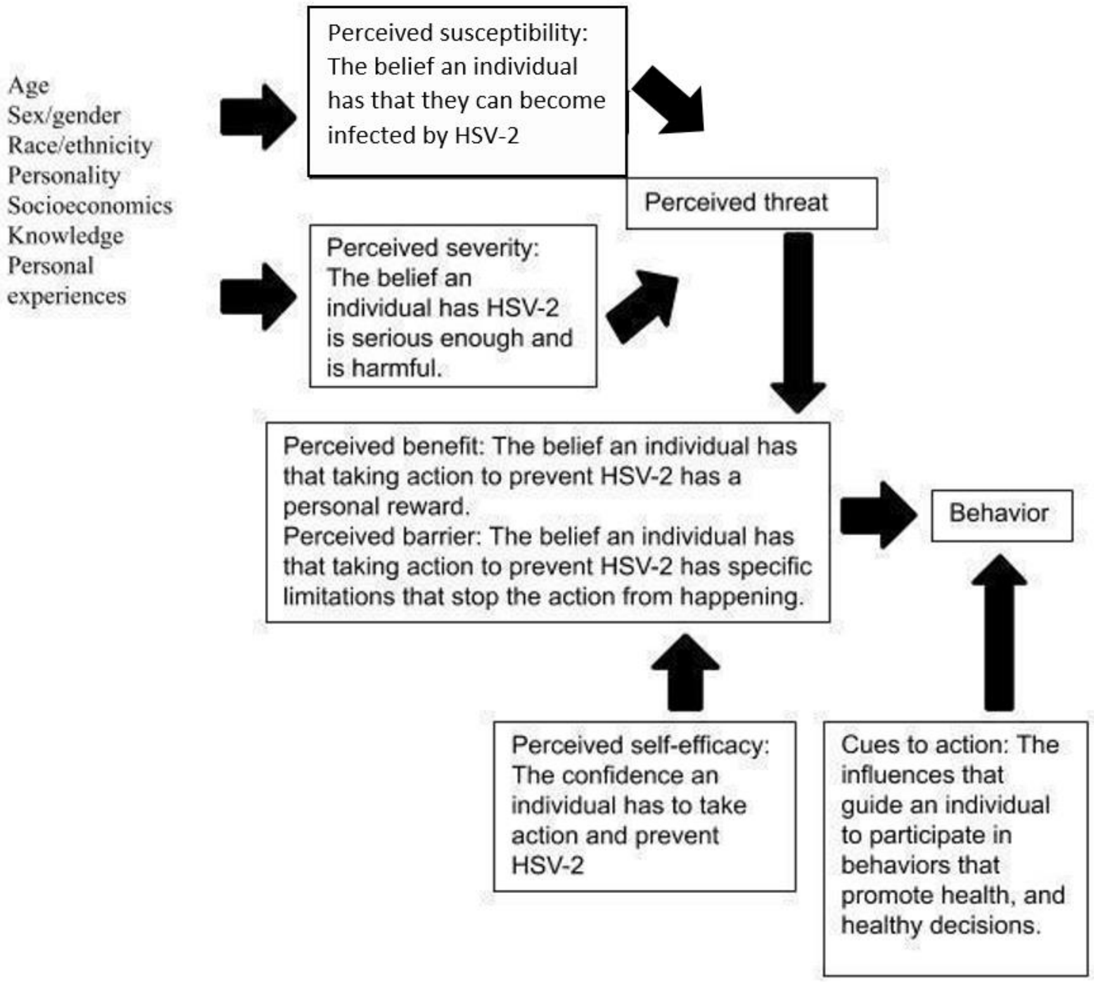
Theoretical Framework

The theoretical framework for this study is the HBM. The HBM originated in the 1950s by Godfrey Hochbaum as a value-expectancy model to evaluate information about what an individual values and what is expected (Boslaugh, 2019). The overall use of the HBM is to understand that if an individual believes an illness can be harmful enough to place the individual at-risk, then the likelihood of taking action to prevent it is high. An individual is more likely to take action with more benefits and less barriers, especially if an individual believes there will be success with prevention.

The application of this framework addresses the beliefs and attitudes within African American females that serve as possible barriers to more desired sexual health behaviors or outcomes. Figure 1 displays how characteristics (i.e. age, gender, personal experiences, and so forth) guide how susceptible people feel they are to illness or how severe certain illnesses can affect them, based upon their characteristics. The perceived threat shown in Figure 1 originated from the severity and susceptibility perceived, contributing to the benefits or barriers that people believe are connected to doing something about feeling threatened. As outlined in Figure 1, whatever a person does to act against the threat introduces a behavior; however, the level of confidence to take action at all also determines what might be believed as a barrier or benefit to do something about feeling threatened. The more severe the perception, alongside the belief to be at-risk, paired with the overall confidence in having a successful result, the more likely an African American female will be to take action to reduce the risk of infection or spread of HSV-2, which could be perceived as a positive result or benefit.

Figure 1

Constructs of the Health Belief Model (HBM) Applied to HSV-2



In order to engage African American females in prevention, the demographic may need to recognize that HSV-2 can happen to anyone represented, or self-reporting, as the demographic. The threat of HSV-2 disproportionately impacts African American females and highlights the individual health differences that affect self-efficacy within this demographic. Recognizing that racial groups have their own lived experiences (Concha, Villar, & Azevedo, 2014; Berry, Fleming-Rife, & Dayo, 2015), the HBM constructs in this current study were adapted for research questions addressing the experiences of African Americans. The study research questions addressed the African American female perceptions of susceptibility to HSV-2 and the likelihood to protect against it, alongside exploring the barriers of African American females discussing HSV-2 with a health professional.

Nature of the Study

Qualitative studies add researcher awareness alongside identifying and describing the problem (Creswell & Creswell, 2018). Qualitative research contributes to descriptions of phenomenon, focusing on ways to repeat the findings in future research while avoiding an overall approach to simply generalize findings (Wu et al., 2016). In evaluating the best fit for the nature of this study, a basic interpretive qualitative study was chosen.

According to Merriam and Grenier (2019), qualitative researchers aim to understand how individuals make sense of their lives and how that meaning is constructed. Basic, interpretive studies, much like phenomenological studies, are used to uncover and interpret those meanings through interviews, observations, and documentation, all while implementing the researcher as the instrument. The nature of this current study did not seek to reveal the essence of lived experiences regarding asymptomatic HSV-2, which would align it with a phenomenological study; instead, it provided an overall simplification of the lived experiences regarding asymptomatic HSV-2. In recognition of the research, the nature of this study was a basic, interpretive qualitative study to explore and understand the experiences of African American females who were diagnosed with HSV-2, asymptomatically.

One of the key methods of evaluating experiences and gaining insight for this study was captured through interviews. In previous qualitative studies, interviews have helped researchers explore the lived experiences of African American females with HSV-2 (Ion et al., 2013; N’Diaye, 2014). Interviews help to reveal conversations that may not traditionally happen with self-reporting surveys or observations; thus, interviewing provides a variety of engagement for recording, reviewing, and allowing for an accurate report (Alshenqeeti, 2014). Further elaborated, qualitative data collected through interviews connects actions to beliefs while exploring the nature of people’s experiences and comprehension of their behaviors. Additional information supported that interviews provide an in-depth investigation into the perceptions of others in a natural setting, narrating their own thoughts, and expressing with their own voice.

The inclusion criteria for females already tested for HSV-2 was African American, biological sex as a female, ages 18-49, living in, or diagnosed in, Fulton County, GA, and have received the results of the HSV-2 test. The exclusion criteria for females already tested for HSV-2 was testing outside of the Fulton County, GA area. The experience of females who have already tested for HSV-2 can help highlight the possible asymptomatic dangers, lack of healthcare provider education or healthcare provider conversations prior to diagnosis, and the cues to actions for protecting against HSV-2 after knowing a diagnosis. The source of data collection for this study included individual, semi-structured interviews. The participants were recruited from local community-based organizations (CBOs).

The study implemented purposive sampling of females previously tested for HSV-2. Upon purposive selection, alongside methodological details that are so richly and extensively described to help others replicate the study, transferability is accomplished (Anney, 2014). Replication to the overall population is harder with smaller sample sizes, often insufficiently powered with large intervals of prediction; therefore, being less informative while limiting the ability for replication (Patil et al., 2016). This study did not focus on saturation where new data no longer provides insight (Vasileiou, 2018); instead, the current study focused on information power (Malterud et al., 2016) with a sample size of seven semi-structured interviews. The interviews were analyzed using manual coding by hand alongside member checking to increase reliability (Birt et al., 2016).

Definitions

Asymptomatic: An infection or disease that has no visible or noticeable symptoms, externally or internally (CDC, 2017a).

Cues to action: The influences that guide an individual to participate in behaviors that promote health and healthy decisions (Skinner, Tiro, & Champion, 2015).

Healthcare Provider: Any person determined by the secretary of state capable of conducting healthcare services (Cornell Law School, n.d.).

Health Literacy: The ability to comprehend health information and make informed decisions pertaining to personal well-being (Mantwill, Monestel-Umana, & Schulz, 2015).

Herpes Simplex Virus: An infection spread from lesions, mucus, genital fluids, and oral fluids of an infected partner, often without symptoms (CDC, 2017b).

Human Immunodeficiency Virus (HIV): A virus, passed through specific bodily fluids, that makes it difficult for the body to fight off infection, and can eventually destroy the cells that prevent infections and disease (CDC, 2019a).

Incidence: The measure of new cases of a health condition occurring during a specified timeframe (CDC, 2016c).

Perceived barrier: The belief an individual has that preventing a disease has specific limitations that stop the action from happening (Skinner et al., 2015).

Perceived benefit: The belief an individual has that preventing a disease has a personal reward (Skinner et al., 2015).

Perceived severity: The belief an individual has that a specific disease is serious enough and is harmful (Skinner et al., 2015).

Perceived susceptibility: The belief an individual has that they can become infected by a disease (Skinner et al., 2015).

Perceived self-efficacy: The confidence an individual has to take action and prevent a disease (Skinner et al., 2015).

Perceived threat: The combination of perceived susceptibility and perceived severity, or an individualized susceptibility to a serious health condition (Skinner et al., 2015).

Prevalence: The amount of a population that has a specific health condition during a specific period of time (CDC, 2016c).

Seroprevalence: The occurrence that a population has a specific health condition, determined by blood samples, during a certain period of time (AIDSinfo, 2019).

Sexual Objectification: An experience where there is a feeling of body parts primarily being valued for its use to others (Watson et al., 2015).

Sexually Transmitted Diseases or Infections (STDs or STIs): A disease or infection received through sexual activity that includes a vagina, an anus, or a mouth, plus the infected fluids that secrete from the membranes in the vagina, the anus, or the mouth (CDC, 2016d).

Assumptions

In conducting this qualitative study, I assumed that participants would answer truthfully. Qualitative research has a key philosophical assumption that when individuals interact with their social worlds, they develop a perception of reality (Merriam & Tisdale, 2016). Assumptions are beyond my control, but the absence of assumptions would display my study as unconnected (Leedy & Ormrod, 2019).

Scope and Delimitations

The sample population was delimitated to sexually active, African American females, ages 18-49, asymptomatically diagnosed with HSV-2, residing in, or diagnosed in Fulton County, GA. The participants were either in a committed relationship or single, providing written consent to participate in a semi-structured interview after receiving details of the study and what was expected. This specific focus was chosen because current research acknowledges that an asymptomatic diagnosis of HSV-2 is occurring, assisted by the absence of protocol requiring healthcare providers to test, screen, report, or discuss HSV-2 (CDC, 2017c). In the absence of healthcare provider protocols for routine HSV-2 testing, screening, reporting, or discussions, African American females are still expected to understand their susceptibility to HSV-2. Low health literacy is considered a barrier to comprehension (Hovick et al., 2015; Weekes, 2012), often dismissed in Westernized culture (Cooper, 2015), and was examined in connection with poor communication between patients and healthcare providers (Davis et al., 2019; Mantwill et al., 2015). Additionally, without healthcare providers explaining HSV-2 or other STDs and STIs, African American females are held responsible for initiating conversations with healthcare providers, amidst research (Hagiwara et al., 2017; Penner et al., 2017; Shen et al., 2018) outlining that Black patients have been found with discomfort initiating conversations with healthcare providers.

The findings from this qualitative study were analyzed using the HBM constructs as applied to African American females, ages 18-49, asymptomatically diagnosed with HSV-2, residing in, or diagnosed in, Fulton County, GA. The study might be replicated with similar conditions; however, as a researcher, I was unable to provide evidence for ensured applicability; I could only provide the platform for the possibility. The ability to transfer the results to additional contexts with separate participants is what constitutes transferability and is seen as an overall goal for successful research (Anney, 2014).

Limitations

This study consisted of a purposive sample, and participants were specifically chosen based upon designated criteria. Examining the process for how data are collected and analyzed was important to confirm the accuracy of the findings. The study lacked generalizability due to the choice in specific research criteria that challenged replication, but through purposive sampling and thick language, transferability was strengthened (Anney, 2014). Further explained by Anney (2014), thick language comes from the details in the methodology that has extensive clarity in the descriptive data which encourages the possibility for comparison in other contexts. Recognizing trustworthiness in concise and potentially repeatable findings was important, thus, dependability was needed. The following methods to assist with dependability derived from Anney (2014): An audit trail, code-recode strategy, and peer examination. The potential weaknesses to this research study are included in the limitations, as follows:

- The participants were selected by race, age, and geographical location, and other variables not chosen could affect the overall outcome for this study.
- Data on participants’ previous STD and STI results were not collected, which may limit understanding any comorbidity association.
- Self-reporting an asymptomatic HSV-2 diagnosis may yield incorrect reporting and potentially interfere with accurate prevalence and incidence data.

- African American females were assessed without inclusion of African American males. The results will not yield an overall outcome for the racial group, only the target population. Additionally, no other racial or ethnic groups were included; thus, no comparisons were made.

Significance

African Americans are more affected by HSV-2 than any other racial group, with researched recognition that HSV-2 significantly impacts African American females more than African American males (CDC, 2016b; CDC, 2017a). The overall objective of this research study was to increase awareness of, and prevention for, the infection rate within this demographic as well as understand the self-efficacy of African American females to engage in more conversations with healthcare providers to help create effective cues to action. Most individuals who are tested for STDs and STIs assume that they are automatically screened for HSV-1 or HSV-2 (Royer et al., 2012). African American females are highly susceptible (Kelly et al., 2016) and need awareness of susceptibility, even if they are reluctant to speak with healthcare providers (Bronson & Nuriddin, 2014). Healthcare providers are not required to routinely screen for HSV-2 (CDC, n.d.) because it is not protocol (CDC, 2017c).

The results of this study highlighted barriers to prevention of HSV-2 which could exhibit necessity for public agendas addressing the high infection rate within this demographic and support the presence of routinized discussions with healthcare providers about HSV-2, including advertised fallacies and stigma. This study has the potential to encourage more community understanding on the impact that lack of awareness perpetuates, which may result in better educational discussions between healthcare providers and patients. The implications of this study could increase cultural sensitivity and cultural awareness when engaging with African American females to understand the personal perceptions and challenges unique to the population. The implications of this study may also emphasize the necessity for health messaging to highlight the susceptibility of African Americans to comorbidity of HSV-2 and other STDs or STIs. The conclusions that can be drawn from this study could promote conversations about the current CDC recommendations that lack the inclusion of routinized HSV-2 testing. The indicated goals for this study are to increase awareness that African Americans are more susceptible to all STDs and STIs in comparison to Whites, but are not tested for every STD.

This study has the potential for positive social change by encouraging the creation of health education programs that target educating healthcare providers on the importance of HSV-2 conversations between healthcare providers and patients as well as educating patients on the necessity for engaging in prevention measures against transmission or contraction of HSV-2. This study also has the potential to start a conversation regarding the health needs of African American females from assessing the population directly about their misconceptions, perceptions, and barriers to prevention.

Summary

This chapter began with an introduction of HSV-2 and outlining the demographic most affected, as well as which geographical area was best used and most effective for a research study. I outlined national statistics and highlighted why state-by-state information is vital for a more localized assessment of prevalence and incidence data. Comorbidity of HSV-2 and HIV were evaluated, as well as the lack of awareness for HSV-2 affecting numerous African American females, thus leading to widespread and asymptomatic diagnosis. The HBM was then introduced as a means to understand the overall concern of perceptions for the severity and the susceptibility, with recognition that, overall, African Americans do not trust the healthcare field, hindering prevention or conversations with healthcare providers.

In Chapter 2, the literature explores the phenomenon of African American females with an asymptomatic HSV-2 diagnosis. The HBM highlights challenges of conversations with patients and healthcare providers. The origin and diagnosis of HSV-1 and HSV-2 is explained, alongside the complications of both viruses. Statistics highlight the susceptibility of HSV-2 and the comorbidity possibility with HIV, challenges with vaccination, and barriers experienced by females self-reporting test results will be introduced. The sexual history of African Americans is explained, justifying the needed improvement of sexual health literacy for better sexual health decisions.

Chapter 2: Literature Review

Introduction

The highest seroprevalence for HSV-2 in the nation affects African American females (CDC, 2016b), alongside researched susceptibility to comorbidity with other STDs (Kelly et al., 2016). Black patients have been researched as uncomfortable initiating conversations with healthcare providers (Hagiwara et al., 2017; Penner et al., 2017; Shen et al., 2018). Though there is limited research on sexual health literacy or the overall health literacy of African Americans, Weekes (2012) advised that African Americans are only 2% proficient in their overall comprehension of health, compared to a 14% proficiency for Whites, contributing to the potential for misinformed sexual health knowledge. Slavery has transitioned African Americans into individuals who mistrust healthcare providers and who thus seek methods of self-healing with self-obtained knowledge (Bronson & Nuriddin, 2014). The most recent literature highlighted that when sexual health conversations occur with healthcare providers, specific recommendations are made for chlamydia, gonorrhea, syphilis, and HIV (CDC, 2015b) but rarely about HSV-1 or HSV-2 (Royer et al., 2013; U.S. Preventive Services Task Force, 2016). There are considerations for type-specific HSV testing for women who present for STD testing and have multiple partners, especially if already diagnosed with HIV (CDC, 2015b). Further considerations advised it might be beneficial to use type-specific HSV testing for knowing if pregnant women are at-risk for either type of HSV. CDC (2015b) emphasized that all guidelines for herpes are not recommendations, only considerations. Many education programs that pertain to sexual health encompasses chlamydia, gonorrhea, syphilis, and HIV but rarely about HSV-1 or HSV-2 (CDC, 2017c).

The lack of awareness of the susceptibility of HSV-2, alongside the lack of sexual health conversations between healthcare providers and patients, welcome the already-escalated prevalence and incidence of HSV-2 to continue increasing and are equal contributions to negatively impacting social change. Exploring the experiences of African American females living in, or diagnosed in, Fulton County, GA, asymptomatically-diagnosed with HSV-2, could assist healthcare providers in understanding how lack of awareness for susceptibility contributes to the HSV-2 incidence and prevalence within the African American community. The perceptions about HSV-2 for African American females with HSV-2 were examined within this current study. The purpose of this basic, interpretive qualitative study was to explore the attitudes and beliefs of the susceptibility and severity of African American females to HSV-2. The experiences of African American females participating in this basic, interpretive qualitative study were examined using the HBM, addressing the six constructs of perceived susceptibility and perceived severity that create the perceived threat, perceived barriers and perceived benefits, perceived self-efficacy, and cues to action (Skinner et al., 2015).

This chapter discusses the HBM, relating the major constructs of the model to the phenomenon of asymptomatic HSV-2 diagnosis in African American females. I also outline the origin of HSV-1 and HSV-2, issues with proper diagnosis, complications of both viruses, the national prevalence and incidence trends for both viruses, susceptibility of comorbidity with HIV, and strategies for vaccination and prevention. I conclude discussing the health beliefs of African American females and their capacity for health literacy, as well as the role of conversations with healthcare providers for the chosen demographic and the challenges with HSV-2 testing.

Literature Search Strategy

Search strategies most effective for this literature review consisted of various databases to locate scholarly journals. A literature search concluded at the Walden University library. Academic Search Complete, EBSCO Research Database, ProQuest, and Google Scholar are all databases that were used to complete the search.

A variety of key phrases, both independently and in combination, produced efficient information for this literature review. Some of the keywords used are as follows: Herpes Simplex Virus, Herpes Simplex Virus and African American females, African American and females and sex OR sexual behaviors, African American or females and sex OR sexual behaviors, African American OR females and STDs OR STIs, HSV and Black OR African American and females, HSV OR STDs OR STIs and African Americans OR Blacks and diagnosing OR diagnosis, HSV and females, HSV and African Americans OR Blacks, HIV and HSV and African American females, Health Belief Model OR HBM and African American females, health beliefs and African Americans, health beliefs and African American females, objectification theory, phenomenological studies, systematic review, African American females and HSV. Based on the results of the search, a total of 225 articles and 12 dissertations were reviewed.

Health Belief Model

The theoretical framework for this study is the HBM, originated in the 1950s by Godfrey Hochbaum (Tarkang & Zotor, 2015). Tarkang and Zotor (2015) explained that Hochbaum examined factors associated with participation in tuberculosis (TB) screenings and was astonished that people were not taking advantage of TB screenings when it was a public health program. Further explained, Hochbaum decided to collaborate with colleagues Irwin Rosenstock and Stephen Kegels to analyze the relationship of diseases, decisions, data, and subjective worldview, which resulted in the development of the HBM. The HBM uses information about what an individual values and expects (Boslaugh, 2019). This balance of value-expectancy is outlined by Boslaugh (2019) as a means to assess why some individuals adjust behaviors to improve their health and other individuals reject adjustment, as well as why some individuals take advantage of health programs and others find no benefit.

The overall use of the HBM is to understand that if a person believes an illness is serious and that he or she is at-risk, the likelihood of taking action to prevent it is high (Boslaugh, 2019). Further outlined by Boslaugh (2019), the higher the benefits, the more likely someone is to take action, and the higher the barriers, a person is less likely to take action. Additionally suggested by Boslaugh, if a person has an overall belief that he or she can be successful in prevention, then the level of self-efficacy will result in an individual’s decision to take action. Preventive actions are taken to avoid transmission or receipt of a disease when individuals understand they are vulnerable and acknowledge the seriousness, recognize the rewards and pitfalls to preventing the disease, and can initiate strategies to protect against it (Tarkang & Zotor, 2015).

There are four major components of the HBM: perceived seriousness of being affected, perceived susceptibility of being at-risk, perceived benefits in level of efficiency in reducing the perceived problem, and perceived barriers that create challenges to reducing the perceived problem (Skinner et al., 2015). Additionally outlined, perceived threat is developed by perceived seriousness and perceived susceptibility, and cues to action, alongside self-efficacy, are major components (Boslaugh, 2019). Further, perceived threat consists of perceived susceptibility, which is the belief of being at-risk of becoming ill, and perceived severity, which is the belief of how serious an illness can develop or what harm can happen if not treated (Boslaugh, 2019). Perceived benefits derive from believing there is a positive reward for taking action, and individuals are convinced not to take action when they perceive barriers are present (Boslaugh, 2019). The belief that an individual can successfully perform a behavior refers to the confidence level, or as Boslaugh (2019) relayed it from Albert Bandura, self-efficacy. All components are also outlined by Skinner et al. (2015) as large contributors to health-related behaviors; but the inclusion of self-efficacy is an important belief in the self to change, alongside cues to action that encourage steps towards change.

Demographics and socioeconomics are not modified through health education (Abraham & Sheeran, 2015), but racial groups have their own lived experiences (Concha et al., 2014; Berry et al., 2015). African Americans differ in historical and structural experiences than other racial groups, and race, ethnicity and gender are intertwined with social-structural experiences (Hoffman et al., 2016). Certain perceived threats may vary by race, ethnicity, and gender, including sexual consequences, STDs, or STIs (Hoffman et al., 2016). Though there is limited research on the application of the HBM constructs to African American females (Concha, et al., 2014; Berry et al., 2015) with an HSV-2 diagnosis (N’Diaye, 2014), specifically asymptomatic, previous research (Magaret et al., 2016) evaluated that the decision to use condoms can reduce the transmission of HSV-2.

HBM Application with African American Females and HSV-2

African Americans often perceive that there are minimal treatments and cures, often mistrust the healthcare field, lack necessary knowledge for adequate decisions pertaining to health, and overall do not understand the level of risk that necessitates health screenings and interventions (Hoffman et al., 2016). The application of this model addressed the beliefs and attitudes within African American females that serve as possible barriers to more desired sexual health behaviors or outcomes. The framework was outlined to reflect the literature that a perceived threat of HSV-2 for African American females consists of both the perceived susceptibility and the perceived severity of the infection. The literature highlighted that African American females were more likely to implement self-care, decrease feelings of shame, and feel an increase in forgiveness and self-love after participating in personalized interventions targeting post-diagnosis physiological well-being, physical well-being, and spiritual connection (N’Diaye, 2014). The same findings also informed that not only is awareness of threat essential, but how an African American female perceives herself reflects what will happen with the information received. Self-efficacy has been researched as meaningful to the perceived barriers because in order to overcome the obstacle and conquer a behavior change, there has to be confidence in the ability to follow-through (Cottrell et al., 2015). Applying this framework to ground the study highlighted the threats and expectations towards cues to action.

The components of HBM are explained as the perceived seriousness and perceived susceptibility that both encompass the perceived threat, alongside the perceived benefits, perceived barriers, cues to action, and self-efficacy (Skinner et al., 2015; Boslaugh, 2019). These components have an extensive contribution to health-related behaviors.

Perceived Threat

A perceived threat means a person believes there is a chance to become ill from something harmful, especially if left untreated (Boslaugh, 2019). Skinner et al. (2015) outlined that perceived threat is the combination of perceived susceptibility and perceived severity, or an individualized susceptibility to a serious health condition. Perceived susceptibility is a weak predictor of engagement without a strong sense of perceived severity. Further, if health messaging is shaped with assumptions that the public is already aware of a perceived threat it may fail to alter self-efficacy and instead showcase perceived barriers. However, if the perceived barriers are low, there might be less necessity of a high perceived threat. The same research concluded that when the perceived threat and the perceived benefits are high while the perceived barriers are low, the cues to action will be stronger. Perceived threat is a significant mediator of changed behavior, especially for individuals with high self-efficacy; thus, the higher the self-efficacy, the better chance healthcare providers have to target a perceived threat (Jones et al., 2015).

Perceived Susceptibility

Perceived susceptibility is the belief an individual has that he or she can become infected by a disease (Skinner et al., 2015). CDC (2017b) advised that HSV-2 is not a health condition that requires national reporting to tally the occurrence nor a health condition that requires partner notification; thus, numerous people will not know that they are infected. CDC (2017c) highlighted that HSV-2 testing will not been completed during a screening for STDs and STIs without direct request or physician discretion, further contributing to why numerous people will not know that they are infected. By the time an African American female reaches the age of 35, there is likelihood of an 80% seroprevalence for HSV-2 (Patel et al., 2016). Many females post-diagnosis advised that prior to diagnosis they felt invincible to HSV-2 due to perceiving such a low risk (Bobrow, 2016). African American females are not only highly susceptible to HSV-2 (McQuillan et al., 2018) and have likely comorbidity with other STDs (Kelly et al., 2016), but are more likely to report more occurrences of gonorrhea, chlamydia, and any other STIs in a lifetime than any other racial group (Operario et al., 2015). CDC (2017b) highlighted that over 87% of all races and genders that self-reported as having HSV-2 advised that they were seropositive before ever receiving formal diagnosis from a healthcare provider.

Researchers highlighted that African Americans are likely to receive an HSV-2 diagnosis by a certain age and have comorbidity with other STDs and STIs (Kelly et al., 2016; Patel et al., 2016). Research also showcased that African American females lack protective behaviors to preserve sexual relationships (Andrasik et al., 2014). There is a lack of condom use when females want to establish trust in relationships (Caldwell & Mathews, 2015). African Americans advised that Black culture influences casual sex without condoms (Wilson et al., 2014).

Perceived Severity

Perceived severity is the belief an individual has that a specific disease is severe enough and is harmful (Skinner et al., 2015) but has limited power to predict preventive health behaviors (Jones et al., 2015; Skinner et al., 2015). Skinner et al. (2015) proclaimed that perceived severity has the potential to moderate other variables, but an increased level of perceived severity is necessary before perceived susceptibility can predict behavior. Perceived susceptibility works best when personalized to the risk behaviors of the population at-risk and consistent with an individual’s definite risk. In contrast, perceived severity is a specification of the dangers. Jones et al. (2015) discussed that perceived severity applies to the belief that actions might have serious consequences, not the reality of what is taking place to cause serious effects. Perceived severity determines the perceptions of and responses to a health threat and can evaluate the enormity of the cue to action (Skinner et al., 2015). Oseso et al. (2016) evaluated 470 females and found that the perceived severity of HSV-2 was ranked higher than being robbed, being fired from a job, or ending a relationship. Though HSV-2 affects a large number of people (CDC, 2017b), the findings from Bobrow (2016) advised that only 10% of females in the study claimed to know a person with HSV-2. Bobrow suggested that the negative stigma about HSV-2 correlates with how many people choose to disclose, which ultimately affects the conversations that could help others understand the severity of diagnosis occurrences.

Perceived Barriers

Perceived barriers are the beliefs an individual has that preventing disease has specific limitations that stop the action from happening (Skinner et al., 2015). Females believed that discussing an HSV-2 diagnosis would violate trust in a relationship and negatively impact a relationship's longevity (Bobrow, 2016; Royer et al., 2013). Further findings outlined that, after a positive HSV-2 diagnosis, females often stayed in relationships, or avoided future relationships, due to fear of disclosing the results, believing that the diagnosis would ruin sexual encounters (Bobrow, 2016; Royer et al., 2013). Females perceived partners ridiculing the diagnosis; thus, deciding against open discussions (N'Diaye, 2014). Additionally, African American females often felt their sexual identity was affected post-diagnosis, accompanied by feeling undesirable with a deep sense of shame for what society might think (N'Diaye, 2014). The perceived barriers of negative social stigma are attached to revealing an HSV-2 diagnosis, followed by feelings of depression, embarrassment, and anxiety that prohibit open discussions (Bobrow, 2016; Royer et al., 2013).

Emotional connection, especially in committed relationships, might decrease the perceived risk or willingness for African American females to use condoms. If involved in physically abusive relationships, may not be able to negotiate condoms (Caldwell & Mathews, 2015). Emphasizing that males are often facilitators of preventive behaviors, females perceive condom use as a barrier to building trust in relationships (Andrasik et al., 2014; Caldwell & Mathews, 2015; Ewing & Bryan, 2015). African American females are less likely to use condoms when perceived to be in a committed relationship, but the idea of not using condoms with sexual partners having additional sexual partners was of less concern for older African American females (Caldwell & Mathews, 2015).

Though many females with an HSV-2 diagnosis are asymptomatic, a diagnosis without symptoms leads to mental health and sexual worth concerns (Ion et al., 2013). Further outlined, many females avoid disclosing their diagnosis or engaging in sexual encounters post-diagnosis due to negative self-perception and a perceived barrier of consistent outbreaks. Research suggested that the mere perception of symptoms typically leads to the cessation of sex rather than safer sex (CDC, n.d.; Royer et al., 2013). Medication can control symptoms (Bobrow, 2016; Royer et al., 2013); however, the barrier with HSV-2 symptomology is there is no cure (Oseso et al., 2016). Females typically rely on the presence of HSV-2 symptoms to initiate discussions with healthcare providers (Royer et al., 2013). Females face difficulty in discussing STD testing with healthcare providers (Bobrow, 2016). For African American females who mistrust the healthcare field, this barrier intensifies (Bronson & Nuriddin, 2014; Hoffman et al., 2016).

Perceived Self-Efficacy

Perceived self-efficacy is the confidence an individual has to take action and prevent disease (Skinner et al., 2015). Self-efficacy helps people build coping mechanisms to avoid handling at-risk situations previously unhealthy or ineffective

(Skinner et al., 2015). Regardless of comfort with providers, females reported a lack of confidence in discussing STDs (Bobrow, 2016). Females reported no concerns having male healthcare professionals for gynecological exams while preferring a female for nursing and other health professions (Willis et al., 2017). There is limited research discussing how the perceived self-efficacy of African American females is affected by conversations with healthcare providers.

When a female internalizes the expectations and false representations of external sources, the result is feeling powerless to change a situation and possibly avoiding prevention while questioning the ability to protect the self and believing the consequences are deserved (N'Diaye, 2014). After an HSV-2 diagnosis, African American females often feel negative sexual perceptions of their female identity, self-consciousness, and isolation, alongside feelings of rejection, vulnerability, inferiority, and full responsibility for exposure (N'Diaye, 2014). Findings support that females rely on male sexual partners to lead STD prevention discussions (Bobrow, 2016). Results also support females often feel discomfort discussing past partners, multiple partners, condom negotiation, discomfort or pain during or about sexual activities, as well as discomfort initiating sexual activity (Quinn-Nilas et al., 2016). Though there is limited research on the self-efficacy of both partners, sexual communication self-efficacy is an approach found to increase a couple's level of confidence to discuss prevention together (Quinn-Nilas et al., 2016). Unis, Johansson, and Sallstrom (2015) found that females gain self-esteem through feelings of competency and appreciation, further supporting that discussing prevention together could increase overall self-efficacy within a relationship.

Perceived Benefits

An individual’s belief that preventing disease has a personal reward is defined as a perceived benefit (Skinner et al., 2015). Perceived benefits to seeking treatment for HSV-2 include African American females encountering a more profound desire for self-worth and self-care after an HSV-2 diagnosis, as well as an enriched yearning to grow their spiritual connection (N’Diaye, 2014). Self-reports of African American females with guided healing post-diagnosis outlined nurtured spiritual growth, self-love, continuity of self-care, skills to manage stress, ability to foster forgiveness, appreciation for the facilitators of guided healing, and feelings of support from females in the African American community (N’Diaye, 2014). Additionally, African American females perceived a benefit in engaging in intimate relationships with decreased feelings of shame. A more substantial commitment in the current relationship after sharing an HSV-2 diagnosis was an additional perceived benefit reported, reducing the perceived feelings of being damaged (N’Diaye, 2014).

Sexual self-worth is possible with an HSV-2 diagnosis. Understanding the asymptomatic nature and medicated control of symptomology might increase informed sexual decisions and comprehension of health education (Royer et al., 2013). Individuals often want an HSV-2 cure and, if treatments were at an advanced stage with a short timeline on the market, individuals would find a personal benefit in treatment participation (Oseso et al., 2016). Females expressed frustration from the lack of medical field resources available about coping with the stigma and handling the emotional aspect of the diagnosis (Bobrow, 2016). Further mentioned, after females sought HSV-2 treatment, they chose to decrease the stigma by educating romantic partners on the likelihood of transmission and were surprised by the positive reaction of those partners. The same findings highlighted that if public health strategies provided more empowerment on handling the negative stigma of HSV-2, then the potential for more disclosure conversations and partner prevention discussions might occur.

Cues to Action

Cues to action are the influences that guide an individual to participate in behaviors that promote health and healthy decisions (Skinner et al., 2015). Females who rely on symptoms to engage in STD testing delay a cue to act towards prevention and testing (Nwankwo & Sadiq, 2014; Royer et al., 2013). The lack of routinized HSV-2 screening is an opportunity for healthcare providers to at least advocate for HSV-2 testing of at-risk individuals (Bobrow, 2016). Diagnosis alone is not a significant motivator of safer sex practices (Royer et al., 2013; Nwankwo & Sadiq, 2014; Hendry, 2017); however, the perception of risk is the most common barrier to receiving health services (Hoffman et al., 2016).

When females perceive themselves in a relationship, there is a lack of condom use to secure a monogamous commitment (Caldwell & Mathews, 2015), fearing accusal of infidelity when justifying the lack of condom use to their sexual partners (Parks, 2013). The presentation of condoms in a trusting relationship interferes with individual perceptions of a pleasurable experience and equates to feelings of mistrust (Caldwell & Mathews, 2015). Publicizing the necessity of condoms (Bobrow, 2016) is supported by research showing condoms reduced HSV-2 transmission by 96% (Magaret et al., 2016).

Even after asserting that well-informed females make better sexual decisions (Parks, 2013; Wilson et al. 2014), the findings from Wilson et al. highlighted that self-efficacy correlates to feelings of mistrust with sexual partners and interfered with cues to action for condom utilization (Wilson et al., 2014). African Americans recognize the risk of STD infection, yet hesitation for condom use is apparent with a fear of losing partners or having less sexual pleasure (Wilson et al., 2014).

Overview of the Herpes Simplex Virus

According to Chattopadhyay et al. (2018) and the Virus Pathogen Database and Analysis Resource ([ViPR], n.d.), Human Herpesviridae (HHV) consists of 8 strains most common in humans. These strains result in sexually transmitted lesions and sores (HHV-1 and HHV-2), chickenpox (HHV-3), various cancers (HHV-4), HIV or human immunodeficiency virus (HHV-4), cancer in HIV patients (HHV-8), nerve damage to babies or weak immune systems (HHV-5), multiple sclerosis (HHV-6A and 6B), and influenza-like illness (HHV-7). Herpes Simplex Virus (HSV) 1 and 2, or HHV-1 and HHV-2, are known to cause oral and genital lesions and are the only HHV to be sexually transmitted (Bobrow, 2016). HHV-3 causes chickenpox in children, which can reactivate into shingles for adults (Irizarry-De La Cruz, 2015; CDC, 2018). Shingles, HSV-1, and HSV-2 originate from Varicella-Zoster Virus (VZV), the same virus that causes chickenpox; however, shingles originate from a different strain of VZV resulting in Herpes Zoster not sexually transmitted like Herpes Simplex (CDC, 2018).

A problem with HSV-1 and HSV-2, much like all viruses in the Herpesviridae family, is the ability to lie dormant and reactivate at any time during a lifespan (Bobrow, 2016; Irizarry-De La Cruz, 2015) and are incurable (Looker, 2015), which makes both types a global health issue (Francis et al., 2018). Many people usually contract HSV-1 as a child through non-sexual contact with saliva (CDC, 2017a), while sexual contact primarily spreads HSV-2 (CDC, 2015a). An asymptomatic diagnosis of HSV-1 is more common than with HSV-2 (CDC, 2017a), but individuals with HSV-2 often pass the virus without symptoms, which is why it is so common (CDC, 2015a; CDC, 2017a). HSV-1 and HSV-2 can create cold sores, sores on the corneas, buttocks, and anus, around the penis, and around or inside the vagina (CDC, 2017a). Symptoms from HSV-2 are typically more severe in frequency and intensity than HSV-1 (CDC, 2015a) and create higher susceptibility for STD/STI comorbidity (CDC, 2017b). Additionally, symptoms can last for several weeks, accompanied by a sore throat, fever, swollen glands, itching, burning, and achiness (CDC, 2017b).

Challenges of Testing

Both HSV-1 and HSV-2 can cause genital herpes, transmitted through mucus and lesions, and lying dormant in the dorsal root ganglia as a lifetime latent infection (Thellman et al., 2017). The virus is released back into the genitals for seroconversion reactivation as either symptomatic with oral lesions, genital lesions from oral-genital sex or passed asymptomatic with no symptoms (Dhillon & Smith, 2018). Over 80% of all HSV-2 diagnoses are asymptomatic, with a 10% chance the person will know about the infection (Gilbert et al., 2017).

The CDC (2017a) advises that testing the blood rather than lesions from an outbreak creates the possibility of false positives, which is why the CDC does not recommend routinized testing. The CDC only recommends HSV-2 testing as an at-risk preventive measure if there are genital ulcers if someone is HIV-positive or males with sex with males (Kelly et al., 2016). The Kalon HSV-2 ELISA test screens for HSV-2; however, the manufacturer cut-off value to qualify a positive result might indirectly exaggerate prevalence (Hallfors et al., 2015). Those who test positive for HSV-2 with a low antibody index (0.9 - 3.5) may not indeed be positive for HSV (CDC, 2017a). The CDC (2017a) further asserts that modern HSV-2 tests screen for antibodies from having previous exposure to HSV-2, but exposure does not necessarily equate to actual infection, with no tests available to the population that can accurately decipher latent infection from last exposure. Testing for HSV-2 presents an ongoing challenge when HSV-2 antibodies can produce false positives through serological testing (CDC, 2017a). In contrast, Western Blot testing, restricted to population access, could reduce the likelihood of testing errors by examining copies of HSV DNA (Hallfors et al., 2015). Females who tested positive for HSV-2 represent about 88%, while only 17% received a prior diagnosis, and 83% received HSV-2 through asymptomatic transmission without knowing (Kelly et al., 2016).

Vaccination

Currently, there are no vaccinations for HSV-2 because this virus is not typically a target for prevention (Vanyukov et al., 2018), but efforts to develop one are underway (Looker et al., 2015). Eradication depends on a high level of vaccine uptake and comes from quantifying the global burden (Looker et al., 2015). Researchers even recognize that antiretroviral intervention reduces HIV incidence, but vaccination will extend protection if done with significant uptake of primary prevention to begin to lower the incidence and close the prevention gap (Bekker & Gray, 2017). HSV-2 causes more morbidity through genital disease than HSV-1 and is more of a risk factor for HIV (Gilbert et al., 2017). The combination of treatment and condoms for protection lowers the risk of infection for HSV-2 and the comorbidity with other STDs or STIs, outlining vaccination as a possible solution.

HSV-2 and HIV

The last estimated global burden of HSV-2 was in 2003, but a more in-depth understanding of the association between HSV-2 and HIV has restored the attention on HSV-2 (Looker, 2015). The African American population is disproportionately affected by, and infected with, HSV-2, especially those within the demographic who are positive for HIV (Patel et al., 2016). African American females are 46 times more likely to test positive for HIV than females in other racial groups and more likely to test positive for HSV-2 (Operario et al., 2015). Additionally, African American females are more likely to report more gonorrhea, chlamydia, and any other STI in a lifetime than any other racial group. The presence of HSV-2 increases the likelihood of contracting HIV and increases the possibility of transmitting HIV from individuals co-infected with HSV-2 and HIV (Looker et al., 2015). Individuals co-infected with HIV and HSV-2 may experience increased genital shedding and transmissibility of HIV or HSV-2, in addition to faster disease progression (Looker et al., 2015).

African American, heterosexual females, contributed 43% of new HIV infections in the United States in 2017 (CDC, 2019c), and are more likely to test for HIV in a lifespan than any other racial group (Operario et al., 2015). It is essential to consider African American females when examining racial/ethnic disparities of HSV-2 rates of infection, especially given the rate of possible co-infection (Looker et al., 2015; Operario et al., 2015; CDC, 2017a).

Sexual History of African American Females

Appearance and sexual functioning often define the value of a female. The media has constructed sexualized perspectives through the standards of males, becoming the template for how women view and view their worth (Baraj, 2015). Sexualizing women tolerates females as victims and trains males that females are sex objects, generating sexual violence (Baraj, 2015).

African American sexual socialization is complex, resulting from adaptive coping strategies in response to slavery, racism, and poverty (Sanchez et al., 2017). African American females are more frequent targets of sexual objectification than White counterparts, in addition to encountering more racially driven sexual stereotypes, fear of physical safety, fear of rape, fear of crime, and an overall higher level of psychological distress (Watson et al., 2015). African American females have centuries of tolerating their non-existent sexual boundaries in a male-dominated social structure, having been observed as, and compared to, animals since slavery (Baraj, 2015; Cooper, 2015). The impact of slavery, combined with the patriarchal social structure, heightens sexual objectification, minimizes females to their bodies, and degrades it solely for sexual functioning (Baraj, 2015; Cooper, 2015). Sexual exploitation has since resulted in generations of unresolved sexual trauma, heightened by the era of the Middle Passage

(Cooper, 2015). Further mentioned, this era left many females stripped of their right to wear clothing, forcefully branded and repeatedly raped, only to receive continued treatment during slavery where violation determined sexual operation, after that auctioned to assess capacity in the workforce. Initial sexual encounters were typically rape, perpetuating a worldview of embarrassment, inferiority, violence, and shame for African Americans (Cooper, 2015).

Before slavery, the occurrence of African girls exposing their bodies, or having sex and children out of wedlock, was not tolerated; therefore, the objectification of African females has affected the lineage that followed (Cooper, 2015). African Americans still express the effects of post-slavery while Westernized culture has provided advisement to move beyond it; the perceived insensitivity has, over time, generated the belief that the dominant culture is in agreement with the oppressor (Cooper, 2015). Furthermore, generational and historical damage from unresolved sexual trauma for females of African heritage and lineage can cause feelings of shame and inferiority and an acceptance of violence as a worldview. Whether directly or indirectly, marketed or targeted, the perpetuation of historical damage for African American females is a barrier to higher self-esteem, which is a direct association to mental health concerns, substance use disorders, sexual consequences, and sexual decision-making (Alexander et al., 2014; Kelly et al., 2016; Vanyukov et al., 2018). When a female has higher self-esteem, there will be personal empowerment to make better sexual decisions (Alexander et al., 2014).

Improving Sexual Decisions through Sexual Health Literacy

Sexual activity starts for African Americans before any other racial group (Hoskins & Simons, 2015). African Americans often lack specific health information about themselves due to family members enabling closed-ended conversations about health concerns that fail to enlighten or increase literacy (Hovick et al., 2015). Parental communication could minimize adolescents from engaging in high-risk sexual behaviors (Kajula et al., 2016). Parents welcome opportunities to have better sexual health conversations. African American mothers have shown directness and honesty when discussing protection from sexual infections and pregnancy with their children in full detail (Murray et al., 2014). Though females were more likely to undergo an STD screening without a parent present, nearly 23% of all individuals between the ages of 15-17 chose not to seek sexual healthcare for fear of their parents finding out (Leichliter et al., 2017).

Though females are more likely to get tested, according to Naidoo and Taylor (2015), there is a higher likelihood for both males and females engaging in condom-protected sexual activity to receive STD counseling. Additional findings supported that intervention programs tend to focus on primary prevention but may not recognize that females who desire pregnancy are prone to sexual decisions that do not include condoms. Findings suggest that 25% of African American females reported that their last sexual encounter involved no contraception, further outlining that African American females are the demographic with the highest rate of risky sexual activity (Hoskins & Simons, 2015). Condoms reduce HSV-2 (Magaret et al., 2016); however, talking about condoms disrupts the mood and raises suspicion with partners (Caldwell & Mathews, 2015; Wilson et al., 2014). African American females were more likely to wear condoms after a post-diagnosis disclosure (Bobrow, 2016).

Not only do African American females have sex at a younger age than other racial groups, but they also have far more sexual partners and no proper understanding of sexual health (Hoskins & Simons, 2015). There are differences between what qualifies as sexual encounters, and women typically assign more activities like kissing or unwanted advances as sexual encounters (Schmitt, 2017). There is a need for developmentally specific interventions to highlight challenges with certain ages (Alexander et al., 2014) because early misinformed sexual decisions produce ill-informed adult decisions (Hoskins & Simons, 2015).

Literacy in health education means having the ability to understand and relate how the health information can help with better lifestyle choices (Mantwill et al., 2015). Lower health literacy connects with poor communication between patients and healthcare providers (Davis et al., 2019). Findings suggest that healthcare providers who promote shared decision-making (SDM) encourage patient conversations (Jolles et al., 2019). Jolles et al. (2019) further mentioned that encouraging patient conversations could guide patients to make informed treatment decisions in understanding available treatment while also collaborating with the healthcare provider to recognize the role of circumstances, preferences, values, and efficacy in the decision-making process. When African American patients have healthcare providers who are not African American, patients are often suspicious of the behaviors and words of those healthcare providers alongside strong disbeliefs that non-Black healthcare providers will support their worldviews (Penner et al., 2017). Slavery created African Americans into individuals who mistrust the healthcare field (Bronson & Nuriddin, 2014), and this mistrust is due to generational damage of being used as experimental test subjects for diseases with minimal treatments or cures (Ferrera et al., 2016). The historical mistrust not only limits health education interactions between patients and healthcare providers that increase sexual health literacy but hinders overall health literacy (Bronson & Nuriddin, 2014).

Qualitative Studies on Emotional Aspects that Guide Female Sexual Decisions

This section examines the use of a qualitative design approach from previous studies that explore sexual decisions of females and how interventions for the sexual health of females need to consider these aspects. This information helps evaluate past qualitative studies assessing sexual health beliefs from African American females. For example, the findings from Ion et al. (2013) highlighted that assigned social roles of motherhood, caregiving, and purity in the sexual image are all affected by the stigma of HSV-2 infection. Researchers (Ion et al., 2013; N’Diaye, 2014) highlighted results from interviews addressing the quality of life with an HSV-2 diagnosis and displayed that HSV-2 affected daily physical and social functioning, intimacy, and relationships. Ion et al. (2013) recommended that public health providers could use a framework for social determinants of women’s health to better connect gender with lived experiences and socio-cultural contexts that females identify with, such as relationships and emotions, directly affected by an HSV-2 diagnosis. The use of a qualitative design provided researchers with female perceptions that an image of purity is affected by HSV-2 and caregiving in intimate relationships and motherhood. Additionally mentioned, the researchers advised that HSV-2 can affect emotions and the choices of personal relationships that follow; therefore, sexual health programs need to consider frameworks that enlighten about lived experiences.

According to the World Health Organization (WHO; 2017), sexual health promotion often neglects to mention the social and emotional aspects involved and often places these aspects with reproductive health rather than an overall view of sexual health. The WHO (2017) further explained that definitions of safer sex need to advise that this means feelings of safety; therefore, the description needs to outline that violence, coercion, and discrimination limit individuals from engaging in sex that feels safe. The findings from Schmitt (2017) emphasized that women qualify interactions like kissing or unwanted advances as sexual encounters in ways that are different than male definitions, fully aligning with the suggestions from the WHO regarding more precise definitions. An Australian study (Helmer et al., 2015) highlighted findings that feeling safe with a sexual partner was more concerning than STDs and STIs. The researchers concluded by suggesting that individual choices for less than safer sex are not necessarily an individual’s disregard for risk or a result of lacking awareness, but that risks are adjusted to fit personalized situations that align with relationships and emotions. Using a qualitative approach allowed all researchers to examine the rationalization of sexual decisions, finding that promoting safer sexual practices needs to align with emotional aspects that females rely upon to guide sexual choices.

Another researched example (Andrasik et al., 2014) suggested a link between sexual decisions that yield higher risks for negative sexual consequences and the perceived limited dating options that perpetuate a more inferior quality in sexual choices for African American females. According to Andrasik et al. (2014), African American females often engage in more sexual risks than any other racial counterparts, assuming they outnumber African American males, creating limited dating choices and frequently risky sexual decisions. The researchers further highlighted that in the various geographical locations where African American males outnumber African American females, the male incarceration rate is in high enough numbers that ultimately limit the dating choices, validating African American female dating assumptions. Findings concluded that sexual decisions directly affected by limited dating options often result in an increased risk for STDs and STIs. Through this qualitative design, the researchers were able to identify that African American females engage in sexual decisions based upon perceptions of quality choices for intimate relationships. Andrasik et al. (2014) specifically outlined that African American females intentionally attempt to preserve established sexual relationships, even if of more inferior quality or possible negative sexual consequences, directly perceiving a lower grade in viable relationship options. Conducting a qualitative approach allotted the researchers to support female sexual decisions guided by emotional functioning preserve established relationships, influenced by historical and collective complex traumas that result in consistent relationship dissatisfaction led by dysfunction and impaired communication.

Fray and Caldwell (2017) reflected that having prevention knowledge does not equate to better sexual health discussions with sexual partners or healthcare providers.

Females often believe that initiating conversations with partners would damage relationships (Andrasik et al., 2014), aligning with the findings that the preservation of established sexual relationships, even with negative sexual consequences, is perceived as more critical than STD or STI prevention (Helmer et al., 2015). Wilson et al. (2014) found that African Americans expect unprotected sex among the Black culture. Findings from Gakumo et al. (2014) outlined that African American females have lower condom negotiation skills and experience more sexual pressure than White females, regardless of having higher self-esteem than other racial counterparts.

The results of Andrasik et al. (2014), Wilson et al. (2014), Caldwell and Mathews, (2015), and Mantwill et al. (2015) support the purpose of the current study to build comfort in discussing sexual health to reflect more informed sexual decisions. The aforementioned qualitative studies in addition to research on sexual health education (Gakumo et al., 2014; Helmer et al., 2015; WHO, 2017) are all critical to the purpose of this current study highlighting factors that increase the likelihood of an HSV-2 diagnosis, including the perceived sexual influences to African Americans.

The aforementioned qualitative studies have provided insight into how emotional well-being impacts sexual decisions. The designing and planning of interventions for sexual health promotion could consider findings (Ion et al., 2013) that the sexual image of purity and motherhood socially assigned to females is affected directly by HSV-2. A framework that directly addresses the lived experiences of females could better connect how females associate their relationships and emotions post-diagnosis (Ion et al., 2013). Emphasizing that social and intimate functioning are included in the social determinants of female health (Ion et al., 2013; N’Diaye, 2014) and often neglected in sexual health promotion (WHO, 2017). Females qualify sexual encounters differently than males (Schmitt, 2017); therefore, revising definitions to include that safer sex is feeling physically secure and free of violent acts and intolerance is needed (WHO, 2017). Additionally, important is recognizing that safety is of more importance to females than disease prevention because these feelings are individually customized to align directly with emotional needs (Helmer et al., 2015).

Sexual health promotion interventions need to consider that African American females participate in more sexually risky behaviors than any other racial group and engage in unhealthy sexual relationships from a shortage of dating options (Andrasik et al., 2014). Considering that unprotected sex is a norm within the Black culture (Wilson et al., 2014) and African American females maintain lower condom negotiation than White females (Gakumo et al., 2014), sexual health promotion interventions could understand this to reduce STDs and STIs among African Americans. Approaches such as Acceptance Commitment Therapy (ACT), self-compassion-focused therapy, and mindfulness help stigmatized populations specifically targeting HSV (Hodgson, 2015).

Summary and Conclusions

Through literature search strategies, I discovered literature to help explore the phenomenon of African American females with an asymptomatic HSV-2 diagnosis. The HBM related significant constructs of the model to the phenomenon, highlighting how health beliefs and health literacy interfere with initiating conversations with healthcare providers or prevention decisions for protection against HSV-2 or any other STD and

STI. The origin of HSV-1 and HSV-2 was explained, alongside issues with proper diagnosis of either infection. Additionally, the complications of both viruses, paired with statistics about the national prevalence and incidence trends for both viruses, emphasized the susceptibility of HSV-2 and the comorbidity possibility with HIV. The challenges with vaccination were outlined, in addition to the barriers experienced by females self-reporting test results and having adequate resources for prevention. I concluded by outlining the necessity for improving sexual health decisions through sexual health literacy and understanding the sexual history of African Americans while including qualitative examples to strengthen the purpose of the current study. In chapter 3, the choice for a basic interpretive qualitative study will be explained to connect the gaps found during the literature search strategy and to address the research questions.

Chapter 3: Research Method

Introduction

This basic interpretive qualitative study aimed to understand the experiences of African American females, ages 18-49, living in, or diagnosed in Fulton County, GA and their asymptomatic diagnosis of HSV-2, in addition to exploring factors that impact prevention of HSV-2. There was an identified gap of the perceived benefit discussing sexual health as well as recognizing a need to discuss HSV-2 with a healthcare provider (Fray & Caldwell, 2017; Hagiwara et al., 2017; Royer et al., 2012; Shen et al., 2018). The purpose of this research study was to explore the attitudes and beliefs of the susceptibility and severity of African American females to HSV-2. The experiences of African American females participating in this study were examined using the HBM, addressing the six constructs of perceived susceptibility and perceived severity that create the perceived threat, perceived barriers and perceived benefits, perceived self-efficacy, and cues to action. The choice for a basic qualitative research design is discussed in this chapter, as well as the methodological details for this study. A description of the research design and rationale is first described, alongside the population, setting, sample, and sampling procedures for this study. Next, I explain the process of semi-structured interviews and the benefit of examining this demographic through interviews. I display the method of data collection and how the data were analyzed. Lastly, I am providing ethical detail for studying human participants involved in this research study.

Research Design and Rationale

The research tradition used for this study was a basic interpretive qualitative study. A purely phenomenological approach was not appropriate for this study because this study aimed to explore the experiences of African American females, including beliefs and attitudes about HSV-2. When the researcher targets the opinions, experiences, and reflections of the participants, more than the inner structure and processing of those experiences for the participants, then the sole focus of a phenomenological approach is not appropriate (Merriam & Grenier, 2019). Qualitative research pertains to understanding certain scenarios, people, and moments, which is different from quantitative research that focuses on discovering averages and how intentional changes affect specific outcomes (Burkholder et al., 2020). Identifying and describing the problem is done through qualitative studies, while allowing researchers to gain awareness of the described problem (Creswell & Creswell, 2018). As such, a basic interpretive qualitative study was the best approach.

According to Merriam and Grenier (2019), all qualitative researchers aim to understand how individuals make sense of their lives and how that meaning is constructed. Basic interpretive studies, much like phenomenological studies, are used to uncover and interpret those meanings through interviews, observations, and documentation, all while implementing the researcher as the instrument (Merriam & Grenier, 2019). The data received in basic, interpretive studies, much like phenomenological studies, are inductively analyzed to recognize themes and patterns, then the findings are presented in a descriptive way that reference the literature responsible for shaping the study. Though phenomenology focuses on how complex meanings are formulated from direct experiences, many researchers assume all qualitative research is phenomenological and must be implemented this way. Though that assumption acknowledged that all qualitative research has aspects of phenomenology, further elaboration suggests that the best topics for phenomenology include those of inner feelings or that are emotion-centered. Merriam and Grenier (2019) highlighted that most qualitative research is basic in design but researchers often desire to categorize studies as such, leading to an inappropriate match of a phenomenological study. The nature of this current study did not seek to reveal the essence of lived experiences regarding asymptomatic HSV-2, which would align it with a phenomenological study; instead, it provided an overall simplification of the experiences regarding asymptomatic HSV-2. In recognition of the research, the nature of this study was a basic interpretive qualitative study that explored to understand the experiences of African American females who were diagnosed with HSV-2, asymptomatically.

The qualitative studies (Andrasik et al., 2014; N'Diaye, 2014; Bobrow, 2016) outlined in Chapter 2 highlight how qualitative research has previously evaluated HSV-2 and African American females diagnosed with HSV-2. Phenomenology explores perceptions of how individuals think events happened rather than how they actually happened (N'Diaye, 2014). If quantitative research were chosen for this topic, the focus would be, as Burkholder et al. (2020) described, discovering averages to predict outcomes. A basic interpretive qualitative study was appropriate for this study because the focus was on individualized experiences, as N'Diaye (2014) emphasized. For the outcome of this study, I did not aim to develop theories grounded within the study, nor study participants over a period of time within a specific setting, which Teherani et al. (2015) would describe as grounded theory and ethnography, respectively. Though ethnography involves an in-depth look at either the culture of participants or something those participants within a culture experience, the overall view for ethnography displayed by Teherani et al. pertains to the culture itself.

This basic interpretive qualitative study examined the lack of awareness of the susceptibility of HSV-2, alongside the lack of sexual health conversations between patients and healthcare providers, which encourage the already-escalated prevalence and incidence of HSV-2 and negatively impact social change. Exploring the experiences of African American females living in or diagnosed in Fulton County, GA, asymptomatically diagnosed with HSV-2, could assist healthcare providers in understanding how lack of awareness for susceptibility and inaction towards the severity contributes to the HSV-2 incidence and prevalence within the African American community. Research questions to explore the experiences for this current study were used to coincide with the advisement of Saldana (2016) that research questions address the overall feeling of being, having, or living.

1. RQ1. What is the experience of HSV-2 for African American females, ages 18-49, living in, or diagnosed in, Fulton County, GA, who were asymptomatic prior to being diagnosed?

   Sub-question: How do African American females, ages 18-49, living in, or diagnosed in, Fulton County, GA, perceive their susceptibility to HSV-2?

Sub-question: How likely are African American females, ages 18 to 49, to protect themselves against HSV-2?

2. RQ2. What barriers and challenges do African American females, ages 18-49, living in, or diagnosed in, Fulton County, GA experience during conversations with healthcare providers about HSV-2?

One of the key methods for evaluating experiences and gaining insight for this study was captured through interviews. Interviews help to reveal conversations that may not traditionally happen with self-reporting surveys or observations (Alshenqeeti, 2014). Considering that African American females have a historical mistrust of the healthcare field, which hinders health education interactions between healthcare providers and patients (Bronson & Nuriddin, 2014), this study was led by an African American female. The facilitation of this study by an African American female researcher, certified as a health education specialist and licensed as a therapist, can help build emotional rapport, offer evidence-based discussions with study participants, and address any discomfort felt from African American participants. The implementation of a basic, interpretive qualitative approach helped to discover personal and direct discussions of private health information that might not occur with any other research approach, especially for African American females conversing about HSV-2 and experiences with the healthcare field. The discovery of any barriers when discussing HSV-2 with a health professional can inform on the necessity for improving awareness and prevention through health education programs that target educating healthcare providers on conversation importance with patients. Demographics and socioeconomics are not modifiable in health education but create different quality of life outcomes from experiences (Concha et al., 2014; Abraham & Sheeran, 2015). Recognizing experiences contribute to various health-related behaviors, this will also help inform the discipline of health education on the importance of conversations between patients and healthcare providers.

Role of the Researcher

As a researcher facilitating semi-structured interviews, I operated from an emic point of view by gaining insight on participant worldviews from an objective stance (Ravitch & Carl, 2016). The professional relationship to maintain was specific to research, ensuring authority over the interview process, but no personal, supervisory, or instructor relationships involving positions of power facilitated. Acknowledging that researchers are the main instrument throughout the research process, my positionality, identity, and subjectivity shaped the data and the findings (Ravitch & Carl, 2016).

Though I am an African American female conducting research on African American females, I still needed to be mindful of what Ravitch and Carl (2016) define as deficit orientation which assumes individuals are inferior to me and lack certain knowledge or skills. To be mindful of deficit orientation in this current study, I considered the health literacy of African American females, but I was cautious of judgement and ensuing a power dynamic. I ensured that terminology and procedures outlined in all paperwork and all interviews were explained to all participants upfront, to show that explanations of health information are more for policy rather than potentially shaming participants for a lack of knowledge. African American females do not initiate conversations, including asking for clarification, nor is literacy strong enough to facilitate sexual health discussion (Bobrow, 2016; Mantwill et al., 2015). In recognition of research, my advisement of a required thorough explanation throughout the entire process for all participants acknowledged potential barriers to comprehension but did not target anyone specific based upon any potential assumptions of participants not understanding information.

I did not conduct research within my work environment that could originate conflicts of interest. This research study was incentivized, with advisement of a $10 gift cards at the completion of the interview as acknowledgment and appreciation of time and effort in participating. The socioeconomic status of all participants was evaluated at the time of receiving informed consent. Regardless of socioeconomic status, participants did not receive the gift card as a bribe for completing the interview, nor received varying totals of gift card value. In order to safeguard any potential concerns regarding Institutional Review Board (IRB) approval, Form A, provided through the Research Ethics Review Process with Walden University (n.d.c.), was completed to receive tailored guidance about the incentive option from the IRB to ensure IRB approval. Participants were also informed about helping to advance the awareness of asymptomatic diagnosis to fellow individuals that represent the participation population.

Methodology

Alshenqeeti (2014) advised that the semi-structured interview allows the interviewer to probe the interviewee’s responses in a more flexible way than a structured interview. The in-depth expansion still permits the interviewer to maintain the parameters of the interview, upheld by the research question(s), alongside a checklist to stay on-topic. Considering the nature of the research questions, this current study included semi-structured interviews. The interviews were captured with the use of Voice Memos, an electronic recording software to help with transcription. The collected data from Voice Memos were analyzed manually with Google Sheets, a Google version of Microsoft Excel. During this manual coding, I assessed relationships from group-shared ideas but through individual, semi-structured interviews. The collected data from the semi-structured interviews were coded with labels that identified themes that categorized and grouped similar responses. Characteristics were sought that served as individualized responses that might represent identified limitations of the study. Birt et al. (2016) suggested that more than one researcher check the same data to verify reliability of researcher interpretations; therefore, this occurred in this current study.

Participant Selection Logic

The population chosen for this current research study was African American females, ages 18-49, with an asymptomatic diagnosis of HSV-2, living in, or diagnosed in, Fulton County, GA. The inclusion criteria for females already tested for HSV-2 needed to be African American, biological sex as a female, ages 18-49, living in, or diagnosed in, Fulton County, GA, and have received the results of the HSV-2 test. The exclusion criteria for females already tested for HSV-2 was testing outside of the Fulton County, GA area. The females were recruited through local community-based organizations (CBOs) provided via flyer (Appendix A) distributed by the institution to conceal identity. These organizations were contacted through email and phone with a request to briefly discuss the purpose of the study and the necessity for recruitment through a local CBO. Once permission was received, advisement was provided that the CBO was prohibited from assistance with recruiting or interviewing for the study. If permission was not received, the CBO was thanked for their time in discussing consideration. The selection was chosen through purposive sampling of females previously tested for HSV-2. Purposive sampling with detailed methodology allows for transferability (Anney et al., 2014), though replication is harder in smaller populations (Patil et al., 2016).

An exact amount of a sample size for a qualitative research study has been debated but advised as large enough to permit a rich understanding and small enough an in-depth analysis is not prevented (Vasileiou, 2018). Additional findings support that reaching a sufficient sample size is when there is a data saturation and no longer provides fresh insight nor highlights new information of the theories researched. Information power suggests that if more power is in the information from the sample, then a smaller sample size is sufficient. Vasileiou (2018) emphasized that a previous study included 60 interviews but reached saturation by interview number twelve, another had 20-40 interviews to reach saturation in multi-site research, and another study reached saturation by interview number seventeen. The researcher revealed that code saturation, or the point where no new problems surface, was achieved after interview number nine. The findings also suggested that meaning saturation, or the point where no new discoveries to the problem emerged, was reached after 16-24 interviews. Additional results from Vasileiou (2018) outlined that if the study is grounded in theory, 20-30 interviews are sufficient, while 15-30 interviews are efficient for single-case projects. In recognition of all literature, this current study used a sample size of seven participants.

In qualitative studies, researchers often rely on saturation because, unlike quantitative research, a calculation for an effective sample size does not exist; thus, researchers choose to exhaust resources until no new information is found (Malterud et al., 2016). Further explained, this process of exhaustion serves as a measurement that achieving enough information has occurred to consider the aim of the study thoroughly researched. Malterud et al. (2016) outlined that qualitative researchers lead with the idea that using a large sample size achieves the study's bottom line. Contrastingly advised, the concept of saturation often lacks the justification for the large number of people who participate in a study and concentrates more on how many people participate rather than the quality of the information received (Malterud et al., 2016). Malterud et al. explained that the mere act of exhausting multiple resources does not supply an adequate level of measurement for having achieved the most effective content to answer the research questions.

Information power is introduced by Malterud et al. (2016) as a contrast to saturation to achieve adequate sampling, quality in the data, and various related events for the phenomenon studied. Further rationalized, the use of information power allows for reviewing fewer people because the content received from the few participants evaluated is strong enough to help identify enough new knowledge to achieve the point of the study. Additionally suggested, the use of information power works best if the aim of the study is narrow with specificity yet described, has a specific theory that guides the analysis, and when the interview dialogue is robust from exploring narratives on an in-depth level. Recognizing the benefit of information power and my alignment with it, I did not need to use saturation for this study. Instead, I used information power, as it was more helpful to my study. The use of information power enabled the sample size of seven participants; therefore, seven participants became the sample size for this study.

Instrumentation

Semi-structured interview protocols organize and guide the interview, with specific questions to ask all participants, but the order and the wording depend on the individual (Ravitch & Carl, 2016). Additionally mentioned, specific follow-up questions can help with probing during the interview, if necessary. Ravitch and Carl (2016) suggest looking for similar responses or confusion to questions that need clarity and assessing concerns to the flow of the questions, including evaluation of an adequate number of questions and examining new themes that emerge within responses.

I developed an interview guide (Appendix B) to maintain focus on the research questions. The interview guide must be valid; thus, several experts comprised of African American women and sexual health needed to review the guide. On July 10, 2019, I asked three experts to provide feedback to the Expert Reviewer Acknowledgement form (Appendix C) to advise of the guide’s overall readability and supply any changes needed advisable. On July 14, 2019, Certified Health Education Specialist Tonya O’Bryan returned the form (Appendix D) advising of no changes because the research questions aligned with the interview guide; contrastingly, Dr. Diakima Thomas and Dr. Zenobia Bryant felt that changes were necessary. Dr. Thomas, with published research about condom use among the African American population, provided feedback (Appendix E) and signed (Appendix F) acknowledgment of her input on July 21, 2019. Dr. Bryant, with published research about unintended teen pregnancy, provided feedback (Appendix G) and signed (Appendix H) acknowledgment of her input on July 22, 2019. Both researchers included grammatical corrections to the introduction; additionally, Dr. Thomas suggested changing the wording explaining the study purpose. Dr. Bryant offered language on who will access the audio recordings and assure anonymity. Both Dr. Thomas and Dr. Bryant advised corrections to question 1, with Dr. Bryant providing grammatical fluidity and Dr. Thomas highlighting the need for more open-ended inquiries. Dr. Bryant for question 4 supplied an additional grammatical adjustment, while Dr. Thomas advised that question 6 would probe better with a “why or why not” added. I included all feedback in the revised version of the interview guide (Appendix B). Table 1 displays the alignment of the research questions with the interview questions.

Table 1

Alignment of Research Questions with Interview Questions

Research Questions	Interview Questions
RQ1 - What is the experience of Herpes Simplex Virus 2 (HSV-2) for African-American females, ages 18-49, living in, or diagnosed in, Fulton County, GA, who were asymptomatic prior to being diagnosed?	Perceived Severity Knowledge What do you know about Herpes Simplex Virus-2? What are the symptoms and signs of HSV-2? What possible sexual health complications are you aware of that accompany HSV-2? Are you aware that HSV-2 can be transmitted and contracted without showing or having any signs or symptoms? Please explain. Experience Have you ever negotiated condoms with your partner? Describe your experience. How likely are you to discuss HSV-2 with a partner even when no signs or symptoms are present? Have you told any partners after your diagnosis about the diagnosis before engaging in sexual activity, even if no signs or symptoms were present?
Sub-question: How do African-American females, ages 18-49, living in, or diagnosed in, Fulton County, GA, perceive their susceptibility to HSV-2?	Perceived Susceptibility Prior to diagnosis, did you feel you would ever become infected with HSV-2? Why or Why not? After diagnosis, do you believe you can become infected with another STD or STI? Why or why not? What sexually transmitted diseases (STDs) and infections (STIs) affect African-Americans? Do you believe females are more infected with HSV-2? Why or why not? Do you believe financial stability has anything to do with receiving or passing HSV-2? Why or why not? Do you believe religion has anything to do with receiving or passing HSV-2? Why or why not? Is a current or previous STD or STI a factor in whether an African-American has an STD or STI?
Sub-question: How likely are African-American females, ages 18 to 49, to protect themselves against HSV-2?	Perceived Self-Efficacy Do you believe you and your sexual partner(s) have a responsibility in protecting yourselves against STI's and STD's? Why or why not? Perceived Threat How important is it to be tested annually for STDs and STIs?

Table 1 (continued)

Research Questions	Interview Questions
RQ2 – What barriers and challenges do African-American females, ages 18-49, living in, or diagnosed in, Fulton County, GA experience during conversations with Healthcare providers about HSV-2?	Perceived Cues to Action Have you ever asked your healthcare provider to be tested for HSV-2, even if you did not have any symptoms? If so, describe your experience. Have you ever been offered an HSV-2 test by your healthcare provider, even if you did not have any symptoms?
	Perceived Barriers and Benefits What might be the consequences or outcomes of speaking with a healthcare provider if you have concerns or questions about HSV-2?
	Perceived Self-Efficacy Do you feel comfortable or comforted speaking with a healthcare provider who is not African-American regarding HSV-2 and other STDs and STIs? Why or why not?

Procedures for Recruitment, Participation, and Data Collection

I contacted the lead community outreach liaisons for Atlanta-Metro community-based organizations (CBOs) via phone call requesting an email address to send more information. The emails were addressed directly to the lead for community outreach or the Program Director if needed. The emails requested assistance with the recruitment of African American females who have ever been diagnosed with HSV-2. A recruitment flyer (Appendix A) with the IRB approval number of 02-13-20-0387264 was included, with instructions that the CBO is not to recruit directly, or conduct the study, only to display the flyer within the organization. Per IRB guidance, I did not need a Cooperation Letter. I ensured that there was biological sex of females upon consideration for inclusion criteria, in addition to having been diagnosed or currently living in the Fulton County, GA area. Contact information, including my name, telephone number, and email address, were all included on the recruitment flyer, as well as the projected interview dates and incentive information.

Once participants contacted me with interest in the study, I provided the platform for participants to ask any questions about the study. Interested participants scheduled a meeting to discuss informed consent virtually so that the terms and conditions of participation were thoroughly explained, including disseminating the results. Once the potential participant agreed to participate in the study, I conducted the interview. I provided a sociodemographic questionnaire (Appendix I) at the time of receiving informed consent to describe participants better, adding to the thick description while providing transferability and clear, descriptive data for the results section.

Using semi-structured interviews, I focused on the perceptions of how participants interpret their experiences in their worldviews, or as Burkholder et al. (2020) define it, a naturalistic approach. Qualitative interviewing interconnects descriptions from separate participants to create an understanding of events that researchers may not experience (Alshenqeeti, 2014; Burkholder et al., 2020). Confirming I understood all descriptions of participant experiences, member-checking occurred during the interview. Member-checking is a process that helps to validate findings and check interpretations of internal thinking, in addition to clarifying emergent ideas (Saldana, 2016). A majority of the data derived from recording the participants via audio software allowed for review of the data collected; thus, aligned with validating findings after the interview.

Ravitch and Carl (2016) outlined that before the interview, not only should a quiet setting be chosen, but a clear explanation of the purpose for interviewing, including the format, structure, and process of the interview, should be provided. Continued description highlighted that consent to record the interview should be received, and a review of the consent form with the participant should occur. After the interview ended, the next steps were advised, alongside ensuring that the participant is comfortable physically and emotionally while also checking for any remaining questions. During the interview, it is essential to engage participants, establish trust, and provide clear information about the process and duration of the interview (Ravitch & Carl, 2016). Additional suggestions outlined to listen actively, asking participants to explain their comprehension of key concepts so that the participant's language emerges in the contextualized responses. The authors further mentioned checking the emotional level of the participants to ease or understand distress. Once the interview concludes, Ravitch and Carl (2016) suggest writing notes on the instrument with demographic information and the date to add clarity to follow-up questions and any observations made during the interview that I may not have unobtrusively noted. Additional suggestions highlighted that thanking the participant is vital to reflect an appreciation for the time spent and the responses.

The interviews intended to occur on-site at community-based organizations that helped recruit participants or a local community center happened virtually. In compliance with the social-distancing requirements of COVID-19, I facilitated the interviews through a telehealth platform for video conferencing called Doxy.me. This platform is HIPAA-compliant, requiring the researcher to sign in and provide a unique link sent to each participant before the interview. Upon clicking the link, the participant joined a virtual waiting room only visible to the researcher. To ensure privacy in all settings, the researcher secured a safe place to discuss sensitive information, free from onlookers and those who might overhear information. The interview began with brief pleasantries to greet the participant while building rapport, followed by short words of gratitude for voluntary participation. I explained an approximate time frame of 45-60 minutes to complete the interview. I gave a reminder that all information is confidential, and should any question during the interview elicit discomfort, the interview can cease at any time. I informed the participants that all data obtained would be transcribed, and I requested consent for recording the interview via audio software. Throughout the interview process, I clarified and validated statements to confirm I captured their responses accurately. After each interview, participants received a gift card for $10. I advised participants that the gift card was not to influence their responses but was grateful for participation in the study. I informed participants that I would digitally disseminate the final study results to the emails provided during providing informed consent.

Though Phase One of data collection focused on receiving ten interviews, I achieved information power with seven interviews. Phase One involved the initial interviews starting in March of 2020 and ceased in August of 2020. This phase also included an analysis process of transcribing the interviews, beginning the coding process, and comparing themes. Phase Two was slated for August of 2020 through September of 2020 if more interviews were needed to reach information power. I achieved information power in Phase One; thus, September of 2020 was when I transcribed all of the interviews.

Data Analysis Plan

The research approach and research questions influence the coding process and data reduction (Ravitch & Carl, 2016). Further mentioned, the data reduction process for the analytical focus undergoes the removal of repeated responses and all things irrelevant to a study leading to coding and grouping data into themes. Additionally highlighted, data analysis should focus on the content and context of what participants say and how they express ideas. Researchers are further encouraged to avoid the impulse to assume meanings because the fidelity is to what the participants experience, understanding that authenticity produces validity and ethical research.

The data analysis for this study was iterative and recursive to see the layers of authenticity about ideas and ground the findings. An iterative and recursive study is where each process informs another, nothing is linear, and data directly connects to the research questions, instrumentation, and what is sought and found (Ravitch & Carl, 2016). Beginning in Phase One, I kept a journal for field notes and all audio software. I wrote in the margins all of the codes that emerged as I synthesized my thoughts. I reviewed transcripts and began coding at a low level, paying close attention to themes with no patterns. After the interviews, a formative analysis helped refine the methods and instrumentation to help teach from the data and ultimately fine-tune the research questions (Ravitch & Carl, 2016); thus, this current research study was also formative.

Issues of Trustworthiness

Credibility

Measuring what is intended for measurement is the cornerstone of internal validity and taking in challenges that arise by structuring a study that tends to complexities is vital to credibility (Ravitch & Carl, 2016). Further advised, member-checking helps verify or nullify inferences and provides feedback that encourages credibility and helps the participants sustain their voices in the study. A method known as interpersonal process recall (IPR) helps review the audio-recorded interactions with the participant. Previous approaches to utilizing IPR emphasize that recorded playback results in more vital retrieval than free recall (Jones et al., 2016). Additionally mentioned, IPR allows participants to understand and reflect upon their responses as the researcher plays back the recorded conversations (Macaskie et al., 2015). The idea is that the researcher represents a dominant stance that can present an imbalance in power, which can often result in the participant engaging with passivity; thus, IPR guides participants to challenge researcher blind spots and interpretations (Macaskie et al., 2015). I initiated IPR at the end of every interview to review the transcriptions and audio, which helped clarify discrepancies in research interpretation and served as an added tool for member-checking. After I facilitated IPR, if I was uncertain about a response, the participants conducted the member checks with me by adding any missing information or clarifying any unclear information. Researchers who incorporate rigorous reflexivity into their practice ensure that their pet theories, prejudices, and wishes do not show up in their findings (Macaskie et al., 2015). This process could take anywhere between a few seconds to a few minutes. Once participants agreed with the structure and interpretations of the researcher, Ravitch and Carl (2016) advised that the research is considered credible.

Transferability

Transferability occurs when the methodological details in a purposive sample are so extensively described that it helps others repeat the study in future research with a new set of participants (Anney, 2014). Further explained, a thick description is an extensive level of detailing about the research process of data collection, conditions of the study, and the finalized report. To provide a thick description in this current study, I first needed to collect descriptive data that allowed for comparison and then offer insight into whether the context could intertwine with other possible contexts. Qualitative research aims to develop context-specific appropriate responses to broader contexts, not to generate factual statements that have been generalized to different contexts (Ravitch & Carl, 2016). Though the current study lacks generalization, due to the research criteria chosen and the small sample size, Anney (2014) outlined that thick language with extensive clarity in the details of the descriptive data allows stronger transferability, encouraging the possibility for comparison in other contexts.

Dependability

Data is dependable when consistent over time (Ravitch & Carl, 2016) and denotes the trustworthiness in concise and potentially repeatable findings (Anney, 2014). According to Anney, several approaches achieve dependability, such as an audit trail, code-recode strategy, and peer examination. My dissertation committee conducted an audit trail to validate the data collection, analysis methods, and recordings. Additionally suggested (Ravitch & Carl, 2016), researchers can perform external audits by assessing a sample of data and evaluating whether the data supports personal interpretations; therefore, addressing how interpretations can come from biases. Researchers account for all activity on how data collection occurred, how data was recorded and evaluated, in addition to keeping all raw data, all interview notes, and all documents collected (Anney, 2014). The code-recode strategy consisted of coding the same information eight times with a few weeks between each coding to allow for a code agreement. Face validity was conducted through peer examination with colleagues neutral to the research and the research process by discussing my topic and receiving feedback without biases. These colleagues were Tonya O'Bryan (Appendix D), Dr. Thomas (Appendix E), and Dr. Bryant (Appendix G).

Confirmability

Ravitch and Carl (2016) outlined that qualitative researchers should not claim to be objective; instead, they should inform that they have confirmable data with flexibility and unacknowledged biases that are inevitable. Further mentioned, the goal of confirmability is to acknowledge our biases and seek out how they shape data interpretations throughout the entire research process. As Ravitch and Carl (2016) outline, reflexivity is the researcher's positionality, identity, and subjective stance. Understanding that the researcher is the primary instrument, disciplining reflexivity is essential to the research process. Anney (2014) suggests using a reflexive journal for interpreting, planning, and reflecting on data collection. Additionally advised, a reflexive journal should contain personal reflections from events in the field to evaluate how the researcher’s background, perspectives, and interests influence the research process. In recognition of Anney (2014) enlightenment, I kept a reflexive journal (Appendix J) during all data collection.

Ethical Procedures

Before I could begin engaging and recruiting participants for this study, I required that the IRB approve my study for data collection (Walden University, n.d.c). The IRB provided me with IRB approval number 02-13-20-0387264. The IRB is essentially responsible for ensuring that a research study of interest protects the privacy and confidentiality of the participants (Ravitch & Carl, 2016). Protecting the privacy of the CBOs and the participants, the data collected was not linked to any information about the personal identities or entities used for data collection. The IRB required that this research study inform all participants of all aspects of the research, with an overall objective to create no harm (Ravitch & Carl, 2016). The potential burden of psychosocial detriment is a risk when considering this research design; yet, according to Hodgson (2015), these effects, if at all, are not longstanding. Seeking treatment after awareness was positively associated with the confidence displayed in self-care alongside discussions of the diagnosis (N’Diaye, 2014), and the perceived severity of HSV-2 decreased post-diagnosis. The risk of harm that this study may provide was reasonable to the level of knowledge proposed; however, the overall goal for this research study was to be free from damage for all involved.

Research that is free of harm means no language pressures involvement, especially from people in positions of institutional power over the participants, or misleading participants about the point of research and how the data will be used (Ravitch & Carl, 2016). Suppose participants discuss personal concerns that leave them vulnerable for feeling judged or shamed. In that case, the IRB is required early in the dissertation process for consulting about ethical considerations (Walden University, n.d.c.). I contacted the IRB during the proposal stage to safeguard ethical concerns. The university stated that choosing race as an inclusionary factor requires early ethics consultation. I needed permission to select participants to be studied because it has the potential for feelings of ostracizing, especially with personal health information included. The IRB required that my study benefit the participants studied while being fair, respectful and ensure no coerced gain or malicious intent from studying African American females, ages 18-49, with HSV-2, living in or diagnosed in Fulton County, GA. I coordinated the recruitment in a manner that was non-coercive because there were no existing relationships with the participants. I provided no lavish compensation, and the recruitment did not occur in a group, a school, or work setting, nor were the service providers involved in the recruitment process. I prevented coercion by sympathizing with racial and gender oppression, emphasizing that an African American female led the current study. I also advised that I am certified as a health education specialist and licensed as a therapist.

I further mentioned it could help build emotional rapport while offering evidence-based discussions with study participants and address any discomfort felt from African

American participants. My reactions to responses should not judge the participants (Ravitch & Carl, 2016). Roller and Lavrakas (2015) suggested that all in-depth interviews are affected by the influence of the interviewer, whether directly or indirectly, and might be unknown to the interviewer. As previously mentioned, probing and follow-up questions encourage elaboration and can ultimately increase the clarity of participants (Ravitch & Carl, 2016). Probing is encouraged as long as there is no desire to seek a line of questioning to receive a specific response (Roller & Lavrakas, 2015). A reflexive journal can help gain a particular awareness about personal prejudice (Anney, 2014; Roller & Lavrakas, 2015). Ravitch and Carl also advise that I should not reflect dishonesty about the time it takes to finish the study; thus, I informed the estimated timeframe before presenting any documentation to the participant.

The researcher’s ability to protect the participants’ privacy with confidentiality is essential with an established plan to ensure that data management is capable of protecting privacy (Ravitch & Carl, 2016). All data collected is kept in a password-protected device and held for five years. Further outlined, I did not share data that breached a participant’s confidentiality, and I avoided an apathetic approach to informed consent. The language should be clear about the voluntary process of participation and all of the expectations, including confidentiality of the data (Ravitch & Carl, 2016). I explained all written content for consent before voluntary participation and that participants had the right to cease study participation at any time. In assessing specific individuals as individual units of analysis, Morse and Coulehan (2014) advised individually providing informed written consent with no breaches of confidentiality and no harm done from disseminating involuntarily declared information. Even in reporting data, I ensured that I changed the demographics to the group's data and only the information that is important to the topic. Morse and Coulehan (2014) additionally mentioned that identifying participants should only be used for the process of analysis but, once used, should be removed to ensure protected privacy. The CBOs used for recruitment were not named in the study, nor were the identities of participants.

Summary

I discussed the choice for a basic interpretive qualitative research design and the methodological details for this study in this chapter. Additionally, I discussed the rationale for the research design and population and the elements of the research design. I explained the benefit of examining this population through semi-structured interviews. Furthermore, I provided a display of the analysis of the data collection plan and details of the data collection procedures. The chapter concluded with ethical points for studying human participants involved in this research study. The next chapter will summarize the collected data that best answered the research questions.

Chapter 4: Results

Introduction

The purpose of this study was to explore the attitudes and beliefs of the susceptibility and severity of African American females to HSV-2. The participants in this study engaged in online interviews with me, which were audio-recorded and confidential. All interviews addressed the following research questions:

RQ1. What is the experience of HSV-2 for African American females, ages 18-49, living in, or diagnosed in, Fulton County, GA, who were asymptomatic prior to being diagnosed?

Sub-question: How do African American females, ages 18-49, living in, or diagnosed in, Fulton County, GA, perceive their susceptibility to HSV-2?

Sub-question: How likely are African American females, ages 18 to 49, to protect themselves against HSV-2?

RQ2. What barriers and challenges do African American females, ages 18-49, living in, or diagnosed in, Fulton County, GA experience during conversations with healthcare providers about HSV-2?

The results of this study may help improve the awareness and prevention African American females have pertaining to HSV-2. The results of this research study could encourage the necessity in public health messaging addressing the high infection rate within this demographic, as well as the susceptibility of African Americans to comorbidity of HSV-2 and other STDs or STIs. Additionally, this study has the potential to inspire more community awareness which may result in better educational discussions between healthcare providers and patients. This chapter provides the results of this study and is organized in relation to the research questions. The conditions of the study, including the recruitment of participants and the collection of the data for the interviews, are included in this chapter. Additionally, the emergent themes of the collected data, including the coding and analysis, are included. To present the data and the themes in a concise manner, tables are used.

Setting

Various CBO locations throughout the Fulton County, GA area agreed to display my recruitment flyer that highlighted purposive sampling criteria. The recruitment of participants followed strict IRB guidelines. Due to the restrictions of COVID-19, the IRB approved the facilitation of online interviews, and this setting for data collection was consistent throughout the entire process. The interviews were conducted through an online HIPAA-compliant platform, Doxy.me. The interviews focused on the lived experiences of asymptomatic HSV-2 for the participants, as well as any difficulties communicating with healthcare providers about the diagnosis.

Participant Demographics

The participants were selected if they identified as an African American who was biologically born as a female, and were between the ages of 18-49 at the time of an asymptomatic diagnosis of HSV-2, while living in, or diagnosed in, Fulton County, GA. I obtained sociodemographic data pertaining to biological sex, age, and racial group, highest level of schooling completed, marital and employment status, as well as annual income. All participants identified as biologically born a female with no racial or ethnic identifiers other than African American. Two participants (29%) were between the ages of 30 and 39, four participants were between the ages of 40 and 49, and one participant (14%) was 51 years of age. One participant (14%) completed some college, five participants completed a master’s degree, and one participant (14%) completed a doctoral degree. All participants were employed. Five participants (71%) reported an annual income of $50,000 - $64,999 and two participants (29%) reported an annual income of $65,000 - $75,000. Three participants (43%) reported a marital status of dating, one reported a marital status of divorced, and three participants (43%) reported a marital status of single. Table 2 displays the sociodemographic data of all females who participated in this study.

Table 2

Sociodemographic Data of Participants

Participant	Age	Biological sex	Race / ethnicity	Level of school	Marital status	Employment	Annual income
P1	34	Female	African American	Master's degree	Single	Full-time	$55,000
P2	51	Female	African American	Master's degree	Divorced	Full-time	$60,000
P3	44	Female	African American	Master's degree	Single	Full-time	$60,000
P4	33	Female	African American	Master's degree	Single	Full-time	$50,000
P5	43	Female	African American	Master's degree	Dating	Full-time	$60,000
P6	45	Female	African American	Some college	Dating	Full-time	$68,000
P7	41	Female	African American	Doctoral degree	Dating	Full-time	$75,000

Data Collection

The process of collecting data occurred March 16, 2020 through August 29, 2020. I conducted a total of seven interviews. The social distancing requirements experienced during the pandemic of COVID-19 presented limitations to obtain additional interviews. This study still presented information power to the research questions with the seven participants. I recruited participants from my displayed flyer throughout CBOs that specialize in STDs and STIs. Once the participants contacted me, I coordinated available dates for the interview. I requested an email address from each participant to distribute and collect informed consent. Once the participants signed their copy, I signed the form, and a copy was sent to the participant. The interviews did not occur without first receiving the signed and dated informed consent document from both the participant and the researcher.

Once the informed consent document was received, and an interview time was scheduled, the participants were asked to go to a personalized link through www.doxy.me to begin the virtual interview. At the beginning of every interview, participants were greeted to build rapport and given the opportunity to ask any questions. Thereafter, the signed informed consent document was reviewed for further clarity, and the participants were asked their sociodemographic data found in Appendix I. Once the participants expressed written and verbal consent with complete understanding of the research study, the participants were asked if they were ready to begin. I advised that all interviews would be audio-recorded as I simultaneously transcribed, and all participants agreed to this condition. Once participants advised readiness, the interview commenced addressing the research questions as outlined on the Interview Guide in Appendix B.

Throughout the interview, I sought clarity of each response and reframed or elaborated on certain questions that seemed unclear. I provided evidence-based rationale for any interview questions that needed elaboration and performed member-checking to verify the responses received. Additionally, I assessed the emotional and mental wellness of all participants during their responses to sensitive content. I provided follow-up questions for participants who mentioned content that was not directly asked in the Interview Guide. Once the semi-structured interview was completed, all participants were asked if they had additional input, in which two participants provided additional data. All participants were informed that a $10 e-gift card would be emailed shortly after the interview.

The online interviews were slated for completion between 45 and 60 minutes, but all interviews lasted 60 minutes. All participants provided punctuality and warmth throughout all interviews. My decision to attempt partial transcription during the interviews served as an immense advantage at the completion of all interviews and did not distract myself or the client from the authenticity of the conversation. I completed the first interview on March 16, 2020, the second was on May 18, 2020, and June 04, 2020 was the date of the third interview. The next three interviews were completed July 6, 2020, July 24, 2020, and July 25, 2020, respectively. The final interview transpired on August 29, 2020. The spacious timeline of the interviews was not ideal. The immediate concerns of individuals during the pandemic timeframe were less centralized around sexual health and more about survival, financial security, and environmental safety; thus, I obliged.

Serving as the sole instrument for collecting data, I was mindful of effective rapport building and the comfortability of the interview setting. I observed the nonverbal communication of all participants to assess any discomfort during moments of engagement. I was mindful to follow the questions on the Interview Guide without bias while performing a body scan to examine any tension in my facial expressions, word choices, and tone. I became more relaxed with each interview and more concise with my attentive listening responses as to keep the conversation on-track. This communication delivery allowed for honest conversations that had a natural flow where participants reported a sense of ease discussing sensitive content so freely. As added reassurance of the confidential information discussed, I reminded the participants that unique identifiers for all participants (P1, P2, etc.) would be used and that the study would consist solely of these identifiers to maintain anonymity. I also advised that I would not include organization names where my flyer was displayed.

Data Analysis

I implemented the purposive sampling plan for recruitment outlined in Chapter 3. All interviews were approved for virtual facilitation due to COVID-19 restrictions. I audio-recorded all interviews. I conducted member-checking during the interviews which served as an alternative to safeguard any possible health risks and time delays that mailing transcripts may have presented. I reviewed the content of all interviews multiples times to guarantee accuracy. I transcribed all interviews into separate Google Docs, a Google version of Microsoft Word, and manually coded all interviews into Google Sheets, a Google version of Microsoft Excel. Information power was achieved with seven interviews.

I generated 284 codes that I condensed into 37 themes. Then I condensed the 37 themes into six emergent themes, after reviewing themes within the themes, and condensed the 284 codes into 42 codes. The most frequent theme was increased health risk. The other emergent themes were feelings related to stigma, condom use, shared responsibility and ownership, frustrations with testing, and fear of judgment. After the coding and analysis of all seven interviews produced six emergent themes, information power was reached. The alignment of the emergent themes and corresponding codes with the research questions are outlined in Table 3 below.

Table 3

Alignment of Research Questions with Emergent Themes and HBM Constructs

Research questions	Emergent themes	HBM constructs
RQ1 - What is the experience of HSV-2 for African American females, ages 18-49, living in, or diagnosed in, Fulton County, GA, who were asymptomatic prior to being diagnosed?	Increased health risks Feelings related to stigma	Perceived severity
Sub-question: How do African-American females, ages 18-49, living in Fulton County, GA, perceive their susceptibility to HSV-2?	Feelings related to stigma Increased health risks	Perceived susceptibility
Sub-question: How likely are African American females, ages 18 to 49, to protect themselves against HSV-2?	Shared responsibility and ownership Condom use	Perceived self-Efficacy Perceived threat
RQ2 - What barriers and challenges do African American females, ages 18-49, living in, or diagnosed in, Fulton County, GA experience during conversations with Healthcare providers about HSV-2?	Frustrations with testing Fear of judgment	Perceived cues to action Perceived barriers and benefits
	Fear of judgment	Perceived self-efficacy

Evidence of Trustworthiness

Acknowledging our potential biases while establishing reliable data with succinct and repeatable findings helps set the foundation for trustworthiness. This study integrated credibility, transferability, dependability, and confirmability. I also embodied ethical considerations to provide trustworthiness.

To authenticate credibility, I used member checking to help verify the inferences of all participants to provide reliability for this study. Throughout the interview, I implemented reflective listening to clarify researcher comprehension. To ensure that I clarified the responses correctly, at the end of all interviews, I performed interpersonal process recall (IPR) by reviewing the transcribed responses with the participants to illuminate any discrepancies with researcher interpretation. IPR was implemented by first asking the interview questions and then reviewing the responses received with the participant. I reframed participant responses back to them after those responses to ensure that my interpretations were correct and to remain aligned with what statements and intention. The coding and analysis of all transcriptions did not occur without first performing an IPR. The social distancing requirements of COVID-19 did not allow mail transcripts after the interviews for additional member checking, as previously projected.

Verifying transferability was approached carefully in this study, considering the utilization of thick language and vast transparency within the details of the descriptive data. Recognizing that the sample size and research criteria created a lack of generalizability for this study, a rich level of detail about the study's data collection process and conditions were included to strengthen the thickness for comparisons in other contexts. The dependability of the data was achieved through an audit trail outlining examples of the code-recode process facilitated after the completion of all interviews. Face validity was conducted through peer examination by Tonya O'Bryan (Appendix D), Dr. Thomas (Appendix E), and Dr. Bryant (Appendix G). Peer examination for dependability confirmed that the interview guide was free of bias when collecting sensitive information from the interview questions throughout each interview. Comprehending the possibility for unacknowledged biases, considering that I was the instrument for data collection, I thoroughly examined confirmability. I kept a reflexive journal (Appendix J) to note my subjective stance and reflect on my interpretations. I observed that my racial background, biological sex as female, and my research position often encouraged empathy for participant responses. My reflexivity often advocated for informing participant inferences with evidence-based reframing; thus, I consistently evaluated that the interpretations formed from the participants' lived experiences and not my own.

Results

The purpose of this qualitative study was to explore the attitudes and beliefs of the susceptibility and severity of African American females to HSV-2. After analyzing the constructed codes derived from the complete transcriptions of each participant's response, I found emergent themes. I presented the results in alignment with the research questions. Table 4 outlines a summary of the main findings.

Table 4

Summary of Main Findings

Research Question	Main Findings
What is the experience of Herpes Simplex Virus 2 (HSV-2) for African American females, ages 18-49, living in, or diagnosed in, Fulton County, GA, who were asymptomatic prior to being diagnosed?	All unaware of HSV-2 prevention prior to diagnosis All agreed on the necessity in protecting against HSV-2 86% were diagnosed in their twenties All participants evolved beyond initial hurt and shame All participants received emotional support from partners 71% were aware of their source 86% felt they could contract another STD/STI All participants felt African Americans experience more STDs/STIs Five out of seven participants felt HSV-2 is connected to religion 86% felt sexual preference is connected to HSV-2 71% felt finances are connected to HSV-2 Six out of seven participants reported not knowing HSV-2 existed All reported outbreaks and itching All reported HSV-2 testing and sharing results is important All reported the importance of condoms All reported no condoms with commitment All reported someone who they discuss their diagnosis All reported that HSV-2 disclosure is important
What barriers and challenges do African American females, ages 18-49, living in, or diagnosed in, Fulton County, GA experience during conversations with healthcare providers about HSV-2?	All reported never asking for an HSV-2 test pre-diagnosis All participants were never offered an HSV-2 test pre-diagnosis All reported discomfort discussing HSV-2 with healthcare provider 43% reported discomfort with non-African American healthcare providers

RQ1

The first RQ asked about the experience of HSV-2 for African American females, ages 18-49, living in, or diagnosed in, Fulton County, GA, who were asymptomatic prior to being diagnosed. The asymptomatic nature of an HSV-2 diagnosis was experienced by all African American female participants in this research study. The epidemiology highlighted within the literature outlined the possibility that Fulton County, GA, might have an increased number of those at-risk. All seven participants experienced diagnosis within this area of Georgia, and 86% of participants experienced diagnosis within their twenties or younger; P6 was diagnosed in her thirties. I asked all seven participants about their lived experiences regarding diagnosis, how they perceived their susceptibility and their likelihood of protection against HSV-2. Every participant illuminated an absence of primary prevention information before diagnosis and highlighted the need for protecting against HSV-2 and all other STDs and STIs. Inquiring about participant knowledge, the emergent theme of increased health risks connected to this research question addressed the knowledge base. Table 5 shows the emergent themes from the first research question.

Table 5

Emergent Themes from Research Question 1

Research Question	Codes	Emergent Themes
What is the experience of Herpes Simplex Virus 2 (HSV-2) for African American females, ages 18-49, living in, or diagnosed in, Fulton County, GA, who were asymptomatic prior to being diagnosed?	Ashamed	Feelings Related to Stigma
	Confusion	
	Depression	
	Disappointed	
	Disbelief	
	Guilt	
	Judgment	
	Mistrust	
	Not Promiscuous	
	Regret	
	Religious Punishment	
	Self-Care	
	Affects Pregnancy	Increased Health Risks
	All Demographics	
	Vulnerable	
	Anatomical Discomfort	
	Asymptomatic	
	Dormancy	
	Family Dynamics	
	Global Stressors	
	Incurable	
	Modality Matters	
	Not Inevitable	
	Partner Unsafe	
	Partners Share Results	
	Prevention Methods	
	Self-Education Misleading	
	STD/STI Susceptibility	
	Onset Warning	
	Out of Sight Out of Mind	
	Outbreaks	
	Young Diagnosis Age	
	Enjoyment Unprotected	Condom Use
	Latex Allergy	
	Negotiation	Shared Responsibility and Ownership
	Not Taught Benefits	
	Not with Commitment	
	Reciprocated Responsibility	
	Uncomfortable Discussions	

Emergent Theme: Feelings Related to Stigma

All seven participants advised that they have all evolved beyond the initial feelings of being diagnosed. P5, P6 and P7 reported assumptions that future partners would shun them but have all received supportive responses that people still wanted to engage in romantic and sexual relationships.

P1 advised,

> That was in 2009 so I've been living with it and focusing on things that can be controlled. I'm continuing my education. Relationships? I desire them but am not pursuing them. Because of having to have that conversation with someone who may not really be a safe place to have that, so I have avoided that.

P2 reported that her diagnosis was 27 years ago and led to divorcing her husband. She added,

> There are times when I still struggle. I have accepted it for me. I am very thankful I met a man I could tell and he was accepting of it. I have girlfriends that have it. They date people and don't tell. I don't agree with that. It wasn't my choice to get it, so we should give others the option to say no. A lot of rejection comes from it which deepened that depression. Which is why most women do not share. The right thing to do is share. Something was put on me that I did not ask for. I am in a better place. It's a part of me now in terms of medical history. There's still a certain level of shame.

P3 reported that the partner who is the source of her diagnosis passed away years ago. P4 stated that she was 21 years old at the time and does not currently think about it. P6 mirrored P4, advising she does not think about it daily and is currently in a relationship. P4 added, “My thing is, I do not want to expose him at all. I did tell him from the beginning and made it his choice to go forward. I’m okay. I guess because I am in a relationship.” P5 mentioned,

> My apprehension and fear was that my partners would be distraught, but I happened to have very understanding partners. I believe that [God] Spirit knew I needed this diagnosis to have more empathy and understanding in my field because I’m not so sure I would have been open to positive partners if I were negative.

P7 explained,

> It definitely can be triggering when with a new partner. It makes oral sex complicated in a lesbian relationship. It’s always interesting. I have almost 95% of the time gotten a positive response that it’s not a baby and it’s not AIDS. Talking about it is always uncomfortable.

Though all seven participants reported feeling acceptance at this time, after the diagnosis there were expressed feelings of hurt, regret, and shame. P2 and P6 both reported being pregnant at the time. P2 mentioned that she was married and P4 stated she received it after a one-time encounter. Both P5 and P7 advised that they do not recall the source, and P1 stated she received the diagnosis during sexual assault. Except for P4, all participants felt they could contract another STD or STI after receiving an HSV-2 diagnosis. P4 explained her confidence, “I knew that I was going to be extra safe.” P2, P5, and P7 advised of additional STD diagnoses after HSV-2 diagnosis. P2 explained, "Two more things came my way" when addressing additional diagnoses. When asked if P2 was having healthcare provider conversations she replied, "I didn't know I could." P6 advised that she now requests to see the test results of a partner, stating, "In the relationship I am in now, we see the sheets."

P6 proclaimed, "There is a stigma that it only happens to loose people who are promiscuous." Defending this point, P1 and P7 both advised that their first encounter with sexual activity was through rape not an act of consent. Both P1 and P7 emphasized that sexual education focuses on the symptomology of STDs and STIs. Further clarified by P7, "They were trying to scare kids with those terrible pictures...made me feel ashamed. 'My body don't look like that.' But if I tell people [I have HSV-2], that's what they are going to think my body looks like."

Apart from P3 and P6, all other participants felt religion is connected to an HSV-2 diagnosis. P1 stated,

> For me, that has impacted how I pursue sex. The dark cloud hangs over you that says don't do it before marriage, it's a sin and you're going to burn in hell. For a long time, I thought that my diagnosis was a repercussion of not keeping my temple. A lot of mental anguish around that just because things that come from people in the ministry, or your own interpretation of the scripture.

Additional sentiments from P2 outlined, "I was having sex with a man at 23 and felt guilty that we were not married." P7 stated, "Masturbation is a sin. Fornication is a sin. Just talking about it or having an option" is considered punishment. P7 further elaborated, “The thing that shifted for me in college was God as punishing and God as wrathful [with vengeance]…I had to shed a wrathful, vengeful God to a loving, nurturing God.”

Both P2 and P3 felt sexual orientation and preference are not connected to the diagnosis of HSV-2, and P6 was unsure. P3 stated, “There is a previous belief that only gay people receive STDs…Everyone is vulnerable.” P6 also felt religion is not connected to the diagnosis, and P3 shared this same belief. P4 reported, “[With] my religious background, we never talked about sexual health education. Me not having that safe space, or feeling shameful, I did sex how I wanted without proper information.” Likeminded, P5 advised, “There is a certain level of shame attached to it, especially with women. When you add lack of open and honest sexual health conversations that increases any STD.” P7 concurred that religion perpetuates a negative stigma, and stated that with religion, “there is something inherently wrong with any kind of sexuality. I think that pervades our society.”

Emergent Theme: Increased Health Risks

The perceptions of susceptibility elicited participants evaluating the diagnosis of previous STDs, unfaithful partners, sexual education classes focusing solely on symptomology, and that diagnosis was never considered as a possibility. Except for P4, all participants reported never considering the existence of HSV-2 prior to diagnosis. P4 responded that she knew she had a higher chance because of the commonality on her college campus and her previous STD history. P2, P3, and P5 reported that they were in monogamous relationships at the time of diagnosis and experienced infidelity. P6 stated that it can happen “when you’re not fully educated on what your partner has.” When asked if a previous STD determines receiving another, P2 responded, “Just because you encounter one thing does not mean you will catch anything else.” P3 also spoke against inevitability and advocated, “I hope it would help someone think twice about sexual health.”

P1 called the diagnosis “the quiet one,” with similar emphasis by P3, P5, P6, and P7 advising of its asymptomatic nature and dormancy. P4, P6, and P7 described the modalities for transmission as oral, vaginal, and anal sex, with P2 and P3 reporting that during pregnancy, “You can pass it to your baby.” When I directly asked about the signs and symptoms of HSV-2, all seven participants reported outbreaks and itching. P3 indicated, “low-grade fever and back pain” coupled with instances reported by P7 of “pain in the lower back,” alongside “pain while urinating, pain in the legs” and typically warning signs of the impending onset. Still incurring the knowledge participants have regarding susceptibility, I proceeded to ask about possible sexual health complications. P2, P4, P6, and P7 advised of not being aware of any complications. The likelihood of additional STDs in the future was mentioned by P4, and the possibility to pass it through childbirth was advised by P3 and P5. The theme of risk reduction was introduced with this question once P1 and P2 reported abstinence during outbreaks, and P2 additionally mentioned the facilitation of medication as treatment.

P7 advised that annual testing is important, “the younger you are and the more partners you have.” P4 reported, “The body goes through changes as we get older. In a year, you may have only had a few partners, but if those partners have partners, the risks go up.” P2 relayed that if she was not pregnant at the time, she would not have known her diagnosis. P1 emphasized that annual testing applies to those who are less sexually active but everyone else should test every 3 to 6 months. P6 stated that annual HSV-2 testing is not necessary but did mention, alongside all other participants, the importance of testing for other STDs and STIs, annually. P7 detailed, “I get tested when I go to my doctor, I have them run everything.” P4 adds, “We need to follow up with a PCP.” P3 also mentioned, “Annually, women get that” when discussing testing by a healthcare provider and added, “men don’t do that unless that’s a part of their yearly check-up.” P5 enforced, “Even in a monogamous relationship the only person you know what’s happening with is yourself. It’s not necessarily something to do with trust. You can’t depend on someone else to take care of you. Their results are not your results.”

All seven participants stated that African Americans are disproportionately affected by all STDs and STIs. P4 claimed, “The heavier hit STDs are HSV, HIV, and chlamydia.” P2 advised that not only are African Americans at-risk, but without the use of condoms, every racial group and ethnicity can experience being affected by all STDs and STIs. When asked about beliefs regarding financial stability as a connection to HSV-2, both P2 and P7 believed this to be true. P2 stated, “if you’re in a lower income level, especially now that people are out of work, women and men, when you need money, you need money. Which means that you may do whatever you can to get it.” P7 emphasized there are “disparities around income and the access to income. Females that do not go to the doctor put people at greater risk. Young adults are at greater risk from lack of resources, information, and prevention.” Though the financial viewpoint of P7 inclined that there are disparities around income and the access to it, P1 believed, finances are not a big factor in how you pursue sexual relationships. P5 advised, “I don’t believe how much money you make determines whether or not you would receive the infection. However, those with privilege may feel nothing will happen to them, sexually.”

P5 added that the modality or type of sexual activity places people at-risk and “not necessarily the sexual preference.” P5 further informed about the types of sexual activity, stating “biological women who only have sex with other biological women are less likely than any other group to pass HSV-2 to each other based upon the mode of transmission.” P7 reported, “I was about 26 or 27 when I actively started dating women,” and defended that there is “a stereotype that lesbians do not have sexual risk.” P1 also stated that, “probably through heterosexual sex” is where higher risk is integrated into receiving or transmitting HSV-2. P4 elaborated on this point of vulnerability, stating “Most of us in my social circle, we have partners without relationships. The dating scene is set up to where people have multiple partners and often without condoms.” P2 and P6 expressed that a previous or existing STD or STI is not connected to experiencing another one. P1 advised of its inevitability, even in relationships. P7 proclaimed that HSV-2 lesions are direct sites for infection which creates higher susceptibility and P4 stated that the immune system is affected. P5 added that “it increases your chances because, more often than not, STDs do not have signs and symptoms that people can see. If you already have one and do not know that leaves you more open to something else, just based upon the nature of STDs.”

Emergent Theme: Condom Use

Remaining intentional about the alignment with perceived severity, and wanting to also understand the lived experiences, I asked the participants about condom negotiation. The common codes that displayed negotiation outlined that it often happens in the beginning of a sexual relationship, and if the partner seems unsafe. Codes that emphasized that negotiation would not take place was if commitment is established, if there is discomfort in having the discussion, if unprotected sex is enjoyed, and if the participant is not taught how to negotiate. Both P1 and P4 advocated that both men and women need forms of protection. P4 stated, “Women should carry [male] condoms, and men should check on women using birth control” as P1 aligned, “we both need to have our own.” P2 and P5 reported that they negotiate condoms, and both reported that it is a challenge but it is necessary. In practice of condom negotiation, P6 reported she uses condoms “in the beginning” but not once a commitment is established. P1 advised that her first encounter with removing a condom resulted in contracting HSV-2 and she has since become celibate.

Continuing the evaluation of condom negotiation, more codes emerged. The codes examined for this theme included, young diagnosis age, family dynamics, unknown partner results, latex allergy, and only sex with men. P7 reported that she only negotiates condoms with men and P3 reported a male condom latex allergy and often does not use condoms. P7 also mentioned that she will negotiate condoms if she cares about the person and will advise of the potential risks of unprotected sex. P2 narrated that “Growing up, sex was something that happened to a woman and [she was] not responsible for it. It was something done to the woman not something she negotiated. My family members did not enjoy sex because they didn’t know they could.”

Emergent Theme: Shared Responsibility and Ownership

Ownership, as summarized by the participants, is comprehension that, the use of contraceptives, the implementation of known sexual health prevention, and facilitating uncomfortable sexual health discussions is the independent responsibility of all parties sexually involved. Shared responsibility, also summarized, includes negotiating with sexual partners about the use of contraceptives, and facilitating sexual health conversations with all parties sexually involved, as well as with healthcare providers. Additionally outlined, shared responsibility also included the ability to discuss sexual outcomes with others within a trusted circle. All participants identified someone within their trusted circle they have all told about their diagnosis, including partners, friends, roommates, relatives, pastors, and therapists. In response to addressing the likelihood for disclosure, P5 proclaimed, “both of us are obligated to take responsibility.” P2 and P4 reported that unless sexual activity is happening, disclosures are withheld. P5 and P6 reported that disclosure only occurs with an exclusive commitment. P4 reported “there is a 50% chance that I will tell” but advised that this step only happens if feeling emotionally safe and not feeling judged.

In response to notifying partners about the diagnosis prior to sexual activity, even without signs and symptoms, P7 reported “I have other health conditions;” thus, stated she discloses for reciprocated emotional wellness. P3 also indicated that she always opts for disclosure even without signs and symptoms. Sharing annual results was reported as important for P2 and that she likes to give advance notice of any outbreaks. In response to addressing the likelihood for disclosure, P1 advised “I want you to be sure” when elaborating that she wants anyone romantically and sexually interested in her to have the choice to choose a sexual relationship. P7 also professed, “I don’t want to be responsible for you catching it;” thus, professed that she chooses to always disclose. P7 additionally advised, “I don’t need to discuss often” due to a regimen that suppresses outbreaks. In addressing the likelihood for diagnosis disclosure, even without signs and symptoms, P1 reported that she chooses to remain celibate to avoid consistent explanations. P5 advised that disclosure is unlikely without commitment and P6 reported “never” when asked.

All seven participants believed there is a shared responsibility among them and their partners in protecting against STIs and STDs. “P1 advised, “I have a lot more education around these things now” and P3 proclaimed, “It changes the weight of your impact on the world.” Further mentioned by P3, “If you’re letting someone know, you are making sure others are healthy with you.” P2, P5, and P6 all advocated against having their partners feel the negative emotion they personally felt after diagnosis. P5 reported, “It’s important to me because I want to take care of myself and be in my best health, but also I don’t want to give something to my partner whether they are okay with it or not.” P2 stated “It is not my business what other people don’t do. I am responsible for what I do. I remember the pain, suffering, and shame I experienced, and I wouldn’t wish that on anyone.” P6 advised, “I never want for anyone to go through what I have gone through. It is important for me to tell my partners. I don’t want to put anybody in the position that I was in.” P4 professed, “You have to be accountable for you first, then others.” P5 explained, “I think that my sexual health is mine and my responsibility is mine. It is no one else’s responsibility to take care of my health for me, and this is the same for anyone else.” Sharing similar views of other participants, P7 affirmed,

> The price is really high for willful ignorance. We need to take care of our bodies and have challenging conversations that we can feel healthy about, [and] lighthearted about, versus avoiding discomfort and then having a higher price to pay down the line or more turmoil.

RQ2

The second RQ asked about the barriers and challenges African American females, ages 18-49, living in, or diagnosed in, Fulton County, GA experience during conversations with healthcare providers about HSV-2. All seven participants reported that they have never asked a healthcare provider for an HSV-2 test and that they were diagnosed without any signs or symptoms. There were also varying responses regarding the comfort level of discussing HSV-2 and other STDs and STIs with a healthcare provider who is not African American. The emergent themes that surfaced with this research question were frustrations with testing and fear of judgment. Table 6 shows emergent themes from the second research question.

Table 6

Emergent Themes from Research Question 2

Research Question	Codes	Emergent Themes
What barriers and challenges do African American females, ages 18-49, living in, or diagnosed in, Fulton County, GA experience during conversations with healthcare providers about HSV-2?	Reciprocity Self-preservation Support System Comfortability	Frustrations with Testing Fear of Judgment

Emergent Theme: Frustrations with Testing

All participants expressed frustration receiving an asymptomatic diagnosis. Further clarity in the responses outlined that the absence of symptomology and adequate prevention knowledge often placed the barriers between them and early detection, alongside requests for a retest post-diagnosis. Except for P5, all other participants have never been offered an HSV-2 test. P5 explained, “once” when asked during the qualitative interview and added, “I received an entire panel.” Counter to the other participants, P5 and P7 stated that they were retested post-diagnosis. P5 advised, “I wanted to see what my titer for HSV-2 was. When I asked for it originally, they asked ‘why?’ I told them I felt I was exposed. Then they went ahead and tested me.” She expressed frustration in mentioning, “I have done STD testing for 26 years” and highlighted only being offered HSV-2 testing one time in nearly three decades. P5 further emphasized, “It doesn’t matter if I came to you months ago asking to be tested. Do this again. Don’t be lookin’ at me like I just came in. Do what I asked. Don’t judge me. I don’t care what you have to say, I’m paying money.” P7 reported,

> I have asked them to test for it and do visuals. I don’t remember my diagnosis. I don’t remember if it was a blood test, visual examining, or skin samples. I have asked before particularly with active outbreaks and they are reluctant to do any more than just look. Mine are so mild that it is not always visible to the eye. I can feel it and I can see it, because I know what the rest of my body looks like. I think

> I was in grad school the last time I got tested for everything at a public health clinic. I was shaping what communication and disclosure would look like.

Emergent Theme: Fear of Judgment

Participants often perceived judgment when discussing with healthcare providers in the past, which often determined their level of engagement and discussion facilitation, in addition to their comfort level and perception of support received. In responding to possible outcomes or consequences when discussing HSV-2 with a healthcare provider, P1, P4, P5, and P7 expressed varying levels of discomfort. P7 spoke to feelings of judgment

> I feel like speaking with the doctor is always a real concern. Moving through the world and presenting to the world as young, Black, unmarried and you don’t wear your degrees on your shirt. I’ve been treated like I’m a little crazy. Some of it is the lack of patient compassion and care. Particularly in Black and Brown communities. The absence of that is hard...interacting with doctors about sexual health. I have one primary doctor during my pregnancy that made me feel easy and light about it and everyone else was pretty critical.

P4 affirmed, “I don’t think there would be any direct issues. There is an uncomfortable question of why I need the test. It goes back to judgment.” P2 provided alignment with P4, mentioning, “Most physicians would look at you puzzled and ask more probing questions about why you need it. Most of this is due to stigma.” P3 stated that she was not aware of any outcomes or consequences speaking with a healthcare provider regarding questions about HSV-2, whereas P6 stated “you just get more educated.” P1 advised, “If you’re not strong or confident, your mental health could suffer, just feeling that you have no outlet. I don’t know any doctor right now that I would feel comfortable having the conversation with. It feels like a don’t ask, don’t tell situation.” P4 reported that, post-diagnosis, she decreased its priority to cope with the incurability, stating, “If I didn’t feel I wasn’t showing any symptoms, I didn’t ask, I would not want it to be a priority. It’s easier to stomach something you can manage rather than something you cannot get rid of.” P3 also spoke to the discomfort and replied that she only mentions the diagnosis in the medical questionnaire on the intake form. P2 verified, “I was never tested again. I didn’t think I could ask [them] to test me again.” P6 also stated, “I did not know 13 years ago” that she could make that request.

All participants were asked about their comfort level discussing HSV-2 and other STDs and STIs with a healthcare professional who is not African American. P5 reported, “I do it because I have to but not because I am comfortable with it. And this is just my experience. I have been to doctors and had conversations with them about it. I have felt judged.” P6 similarly shared discomfort and mentioned, “My gynecologist is African American. Most times, it is whomever is available, but my preference is African American.” P7 also verified discomfort, stating “I don’t but I’ll do it anyway.”

Though some participants expressed preference for African American healthcare providers, others were in opposition. P4 reported, “I felt comfortable with my White experiences. There was no connection, so I did not care what they thought. When someone is Black it makes me feel like my aunt or my grandmother is talking to me, and I feel judged and shamed.” P7 expressed preference for someone African American but also stated, “Black women, we have our own stuff. They weren’t mean, they were just real clinical. They were ‘doctory’ and about business.” She added, “I had to go to an internist who was an old White man specifically about HSV during pregnancy, and I was like, ‘Really?’ He was super-duper clinical and research-based in his approach. I appreciate expertise but this is all very personal, too.” P3 admitted, “I have had an African American male and an Indian woman, but no White person just yet. I wouldn’t have any issue.” P1 expressed uncertainty about her comfort level, mentioning “I haven’t broached the subject. My therapist is Caucasian, and I felt comfortable that things would not leave the room, but I don’t have that same feeling with a medical provider.” P2 exclaimed, “The best gynecologist I ever had was a White woman” which was similar to P7 stating, “The one that made me feel comfortable was White, a White woman.” P2 further mentioned, “I received a lot of knowledge about what I need to do, and she taught me how to ask more questions. I have mostly gone to Black women for gynecological services and my most recent experience was not good.” P1 echoed those frustrations,

> The place that I was going to for my primary care, primarily employs Africans and Caribbeans. There is an attitude of Americans and how we compare about things; that we complain about everything that matters. We are all considered Black when you look at us, but there is a clear distinction.

Summary

The findings of this study support the assertion that a lack of sexual health conversations between healthcare providers and patients and those with their partners affects the incidence, prevalence, and prevention of HSV-2 among African American females. I documented various barriers that discourage or eliminate sexual health conversations. The data accumulated from this study can assist healthcare providers in understanding how a lack of awareness for HSV-2 susceptibility, coupled with a passivity towards the severity, both contribute to the HSV-2 incidence and prevalence within the African American community. Comprehending these barriers can lead to the creation of health education programs that highlight HSV-2 awareness and prevention for African American females.

The participants supplied their knowledge and experiences of their diagnosis, alongside perceived susceptibility, their likelihood for protecting themselves against HSV-2, as well as barriers and challenges discussing HSV-2 with others. The perceived barriers, perceived benefits, and perceived cues to action were connected to various frustrations with the HSV-2 testing process, concurrently with a fear of judgment. I also found this same fear of judgment with the perceived self-efficacy. Additional findings with the perceived self-efficacy emphasized that protection against HSV-2 was a shared responsibility, which included condom use, and were both also found in the perceived threat of HSV-2. In addition to the increased health risks and feelings related to the stigma, both emerged, assessing each participant’s perceived severity and perceived susceptibility. The absence of adequate intervention will perpetuate these experiences among more African American females.

This research study highlighted that HSV-2 is a significant concern for African American females diagnosed in Fulton County, GA. I also displayed the barriers to HSV-2 discussions and knowledge in the findings. Chapter 5 will outline the alignment of the health belief model constructs to research questions and the emergent themes, in addition to an overview of the potential impact of positive social change deriving from this research study.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

This basic interpretive study was conducted in Fulton County, GA and met all purposive sampling criteria. The data collected for this study occurred through virtual interviews with seven African American biological sex females who consented to participate. Through applying the HBM constructs to African American females diagnosed with HSV-2, I sought to explore factors that impact the prevention of HSV-2 as well as gain an understanding of barriers experienced when discussing HSV-2.

This research study was deliberate in evaluating how the HBM constructs of perceived threat (perceived severity and perceived susceptibility), perceived barriers and benefits, perceived self-efficacy, and perceived cues to action could help me understand the experiences of African American females with HSV-2 with protecting themselves against the diagnosis and any barriers to communicating about the diagnosis. This study sought to answer the two research questions, and any corresponding sub-questions, utilizing the HBM as a theoretical framework. Table 7 displays the alignment of all emergent themes and the analytic categories with the research questions. These categories guide the emergent themes based on the HBM constructs.

Table 7

Alignment of Research Questions with Emergent Themes and Analytic Categories

Research questions	Emergent themes	Analytic categories
RQ1 - What is the experience of HSV-2 for African American females, ages 18-49, living in, or diagnosed in, Fulton County, GA, who were asymptomatic prior to being diagnosed?	Increased health risks Feelings related to stigma	Perceived severity
Sub-question: How do African-American females, ages 18-49, living in Fulton County, GA, perceive their susceptibility to HSV-2?	Feelings related to stigma Increased health risks	Perceived susceptibility
Sub-question: How likely are African American females, ages 18 to 49, to protect themselves against HSV-2?	Shared responsibility and ownership Condom use	Perceived self-efficacy Perceived threat
RQ2 - What barriers and challenges do African American females, ages 18-49, living in, or diagnosed in, Fulton County, GA experience during conversations with Healthcare providers about HSV-2?	Frustrations with testing Fear of judgment Fear of judgment	Perceived cues to action Perceived barriers and benefits Perceived self-efficacy

Interpretation of Findings

An iterative and recursive process for data analysis began with coding the data where numerous codes and corresponding themes were generated. A thematic analysis was implemented to ensure that my themes aligned with the research questions. All themes were then condensed to six emergent themes that all aligned with the research questions. The emergent themes were increased health risks, feelings related to stigma, condom use, shared responsibility and ownership, frustrations with testing, and fear of judgment. Table 8 also summarizes the key findings aligned with the analytic categories, grounded on the HBM constructs. Aligning the key findings with previous research is vital and has been outlined in Table 8 below.

Table 8

Alignment of Key Findings with Previous Research

Key findings	Previous research
Perceived threat: Perceived relationship commitment decreases condom use	Jones et al. (2015): Perceived threat negotiates changed behavior. Hoffman et al. (2016): Changed behavior varies by race, ethnicity, and gender. Caldwell and Mathews (2015): Committed relationships decrease condom use.
Perceived susceptibility: Low perceived susceptibility, even with previous STDs and STIs High perceived susceptibility after HSV-2 diagnosis All diagnosed before age 30 Emotional connection with sexual partner decreases condom use	Kelly et al. (2016): African American females are highly susceptible to HSV-2. Patel et al. (2016): By age 35, African Americans have 80% seroprevalence likelihood. CDC (2017a): Likely comorbidity for HSV-2 with other STDs and STIs. Ewing and Bryan (2015): Relationships decrease condoms
Perceived severity: Factors associated with high perceived severity included: Stigma with disclosing Factors associated with low perceived severity: Understanding symptomology controlled with medication; all participants diagnosed while asymptomatic	Bobrow (2016): Negative stigma determines disclosure Royer et al. (2013): Symptoms determine cues to action. Oseso et al. (2016): HSV-2 perceived as more severe than robbery, break-ups, and being fired.
Perceived barriers and benefits: Discomfort discussing diagnosis Assumptions that HSV testing is automatic All participants have some form of college Differing racial preferences for providers	Bobrow (2016): HSV-2 discussions affect longevity. Royer et al. (2013): Stay in or avoid relationships due to fear of disclosing. Helmer et al. (2015): Females valued emotional safety higher than disease prevention. Bronson and Nuriddin (2014): African Americans mistrust healthcare Fray and Caldwell (2017): African Americans do not initiate healthcare conversations. Weekes (2012): African Americans have lower health literacy Penner et al. (2017): Suspicion with Non-Black providers.
Perceived self-efficacy: Participants reported no judgment disclosing diagnosis to partners Participants reported judgment discussing diagnosis with providers	Alexander et al. (2014): Higher esteem leads to healthier sexual decisions
Perceived cues to action: Pre-diagnosis, participants reported no knowledge of HSV-2 for prevention	Fray and Caldwell (2017): Prevention knowledge not automatic change agent.

Table 8 (continued)

Key findings	Previous research
Post-diagnosis, participants gained knowledge for prevention All participants lead HSV-2 discussions with partners for awareness and prevention All participants diagnosed by asymptomatic blood test; some reported cues to act come from symptomology	U.S. Prevention Services Task Force (2016): Sexual health conversations with providers exclude HSV-2 suggestions. CDC (2015b): No evidence that diagnosing asymptomatic HSV-2 through blood test will stop virus

Analytic Category 1: Perceived Threat

The perceived threat that a person feels is comprised of their perceived susceptibility and perceived severity (Skinner et al., 2015) or perceived susceptibility and perceived seriousness (Boslaugh, 2019). Feeling at-risk of becoming ill, how serious illness can develop, and what harm can occur if an illness is not treated, are all factors in a perceived threat (Boslaugh, 2019). Perceived threat was researched as a significant negotiator of changed behavior (Jones et al., 2015), and can vary based upon race, ethnicity, and gender (Hoffman et al., 2016). The literature emphasized that if African American females participate in post-diagnosis interventions that focus on spiritual connectedness, as well as physical and physiological well-being, there is a higher likelihood of increasing feelings of self-love and forgiveness, facilitating self-care, and decreasing feelings of shame (N'Diaye, 2014). Findings from P1, P4, and P7 support these previous conclusions from the research. P1 reported feeling healthier post-diagnosis working on her spiritual and mental development. Additionally, P7 stated that releasing the stigma helped her strengthen her spirituality while P4 stated that her spirituality helps her stress less.

The perceptions that an African American female has about herself is paramount to her actions after she is made aware of a threat (N'Diaye, 2014). The main threats to perpetuating HSV-2 examined within this study were condom use, and shared responsibility and ownership. African American females were researched as less likely to use condoms when perceived to be in a committed relationship (Caldwell & Mathews, 2015) which was supported by all participants reporting they remove condoms when in a perceived monogamous commitment. Additionally, Caldwell and Mathews (2015) outlined that older African American females are less concerned with using condoms if their sexual partners have additional sexual partners. P4 mentioned that the majority of her social circle has partners without relationships and the dating scene encourages multiple partners without condoms. Contrastingly, P4 stated that even with a few partners, once those partners have partners, the risk goes up, especially when the body ages.

Analytic Category 2: Perceived Susceptibility

African Americans have a higher susceptibility to STDs and STIs than any other demographic (CDC, 2016b), and African American females are highly susceptible to HSV-2 (Kelly et al., 2016), with the 80% likelihood for seroprevalence of HSV-2 by the age of 35 (Patel et al., 2016). Except for P4, all other participants reported never considering HSV-2 as a possible diagnosis until it happened. P4 stated her friendship circles were frequently diagnosed with STDs and STIs and that she felt she would inevitably be diagnosed with HSV-2. Researched findings highlight there is a likely comorbidity for HSV-2 and other STDs and STIs (Operario et al., 2015; CDC, 2017a).

Various statistics for the state of Georgia have been provided by the Georgia Department of Public Health (2019) regarding syphilis, gonorrhea, and chlamydia, concurrently HIV statistics have been provided by AIDSVu (2019a), but neither site reported data on HSV-2 nor the possibility for comorbidity. Participants reported experiencing other STDs and STIs prior to an HSV-2 diagnosis and also thereafter. P5 emphasized that comorbidity is possible with an HSV-2 diagnosis due to the nature of outbreaks and viral shedding. P4 aligned by mentioning there is a higher likelihood for HIV based upon the open wounds.

The participants also linked their perceptions of commitment with their partners to their STD and STI history. All participants expressed frustration in their decision to assume monogamy would alleviate the possibility of any STD or STI. All participants also reported diligent condom use before the diagnosis and that condoms are often removed once a commitment is established. Researched findings support that condoms are rarely negotiated when females are seeking to build trust in relationships (Andrasik et al., 2014; Caldwell & Mathews, 2015; Ewing & Bryan, 2015) and an emotional connection could decrease the willingness for African American females to use condoms, especially in physically violent relationships where condoms may not be possible for negotiation (Caldwell & Mathews, 2015). Additional research highlighted that unprotected sex is considered a Black culture norm (Wilson et al., 2014), with lower condom negotiation than White counterparts (Gakumo et al., 2014). The findings from the research aligned with the current study participants reporting that emotional connection usually leads to a decrease in condom negotiation due to perceived trust and assumed-negative test results.

Analytic Category 3: Perceived Severity

Symptoms from HSV-2 are typically more severe in frequency and intensity than HSV-1 (CDC, 2015a) and create higher susceptibility for STD/STI comorbidity (CDC, 2017b). Researched findings outlined that females perceived HSV-2 severity higher than being robbed, fired, or experiencing a break-up (Oseso et al., 2016). These prior findings align with the current study participants who perceived HSV-2 severity higher after diagnosis and learning there was no cure, but learned symptomology could be controlled with medication, therefore decreasing their perceptions of severity and stigma. A barrier of understanding symptomology prevention is often that there is no cure (Oseso et al., 2016) and many females do not understand that symptomology can be controlled with medication (Bobrow, 2016; Royer et al., 2013). All seven participants were aware of controlling their symptoms with medication and that HSV-2 is incurable. All participants also understood its nature for dormancy but were clear that being asymptomatic did not omit the risk or severity. All seven participants also reported a history of outbreaks and itching and recognized that prior to an HSV-2 diagnosis they were never aware of its severity. The perceived severity of passing it through childbirth was identified for several participants; though, no participant reported passing HSV-2 to their children. P1 and P7 exclaimed that sexual health education classes were misleading in advising that all STDs and STIs have symptomology.

All participants reported that pre-diagnosis, their perceived severity decreased with a perceived-monogamous commitment. Post-diagnosis, some participants reported abstinence or celibacy, other participants reported engaging in unprotected sex once another commitment was established. Research suggested that the mere perception of symptoms typically leads to cessation of sex, rather than safer sex (CDC, n.d; Royer et al., 2013); yet, diagnosis alone is not automatically correlated to practicing safer sex (Royer et al., 2013). However, all participants did report that during outbreaks, sexual activity does not occur.

Analytic Category 4: Perceived Barriers and Benefits

According to the HBM constructs, individuals are often persuaded not to take action when barriers are perceived to exist (Boslaugh, 2019) and prevent them from taking action to prevent a disease (Skinner et al., 2015). The researched findings highlight that African Americans often perceive possible ridicule with open discussions (N'Diaye, 2014). All participants in this study expressed fear of judgment when discussing HSV-2 with a partner. For example, all participants felt sexual health discussions were meaningful, but all participants expressed discomfort in discussing the onset of outbreaks, even within an established commitment. These findings are similar to previous studies where females believed that discussing an HSV-2 diagnosis would violate trust and discourage longevity (Bobrow, 2016; Royer et al., 2013).

Further mentioned, females often stay in or avoid future relationships due to the fear of disclosing their diagnosis or ruining sexual encounters by choosing to have the conversation (Bobrow, 2016; Royer et al., 2013). Additional research highlighted that females valued feeling emotional safety with a partner as more important than disease prevention (Helmer et al., 2015). Females often rely on male sexual partners to facilitate discussions regarding STD prevention (Bobrow, 2016).

In pre-diagnosis, all participants in this current research advised valuing their perceived monogamy more than the idea that preventing disease was necessary. In post-diagnosis, all participants reported facilitating sexual health discussions as a part of their emotional safety. Females typically rely on the presence of HSV-2 symptoms to initiate talks with healthcare providers, but the reliance on symptomology delays cues toward action (Royer et al., 2013). P4 reported that without showing any symptoms, discussions about HSV-2 with her healthcare providers do not occur. In contrast, P5 advised she chose to have a conversation with her healthcare provider about testing again while asymptomatic but was met with suspicion and reported feeling judged for her inquiry.

Another barrier expressed by all participants was apprehension discussing HSV-2 with healthcare providers. The research outlined a connection with poor communication between patients and healthcare providers with lower levels of health literacy (Mantwill et al., 2015). Poor communication is perpetuated by African American family dynamics encouraging closed-ended conversations about health information and often increases sexual health illiteracy (Hovick et al., 2015). Participant responses aligned with engaging in closed-ended discussions about sexual health with trusted family members and spiritual leaders due to experiencing stigma and judgment. The CDC (2017b) advised that honest talks with healthcare providers are needed because healthcare providers designate STD tests based upon the sexual behaviors of the individual. The CDC (2017a) also recommended that patients begin these discussions. Previous findings highlighted that African Americans often do not initiate these conversations with healthcare providers due to their mistrust in the healthcare field (Bronson & Nuriddin, 2014), constantly feeling discomfort with starting sexual health discussions with healthcare providers (Fray & Caldwell, 2017; Hagiwara et al., 2017; Shen et al., 2018). Before diagnosis, all participants in this current study reported that conversations about HSV-2 never came up during annual exams, regardless of risk or any of the demographics highlighting the risk potential. All participants reported finding out with an asymptomatic diagnosis and a diagnosis age much younger than when interviewed. Previous research from Hoskins and Simons (2015) found that African Americans have sex at younger ages, and with far more partners, than any other racial group, with no formal understanding of sexual health, which then produces ill-informed adult sexual decisions. All participants reported feeling ill-informed and misinformed about the asymptomatic nature possible for any STD or STI and would have preferred adequate knowledge for prevention against HSV-2. All participants reported that before an HSV-2 diagnosis, testing for it was never personally requested and that they were unaware of the exhaustive list of STDs and STIs to request personally. In probing further, participants expressed that before an HSV-2 diagnosis, they were unaware that all STDs are not automatically screened and often assumed that an annual exam was unnecessary within a relationship or established sexual commitment.

Statistics emphasized that African Americans are less aware of their health literacy (Weekes, 2012) even to comprehend what to ask. The participants' responses varied more based on experiences and perceived barriers than differences in knowledge or education. All participants reported an association with a college education. One participant advised of completing some college, five participants announced the completion of a master's degree, and one participant advised to complete a Doctoral degree. P7 emphasized that being Black and unmarried with HSV-2 often has healthcare providers judge that she is uneducated, and often leads to discomfort in building rapport, which hinders open communication. Studies have found that limitations in health literacy are first experienced within family dynamics (Hovick et al., 2015) then perpetuated with effects of post-slavery often dismissed in Westernized culture (Cooper, 2015). P2 highlighted that she learned from the women in her family that sex happens to a woman. Until receiving HSV-2 from her husband, P2 was unaware that sexual health discussions with anyone were possible. The findings from this current study outline that the lack of prevention knowledge or health literacy is not in automatic association with a lack of general knowledge or formal education.

Literature outlined that when African Americans have healthcare providers who are not African American, this can result in suspicion of the behaviors and words of those healthcare providers, resulting in solid disbelief that those healthcare providers will support their worldviews (Penner et al., 2017). Most participants desired an African American healthcare provider but often accepted who was available. Other participants preferred someone of a different race or culture because there was perceived to be less shame. One participant reported shame speaking with African American healthcare providers because it feels like an aunt or a grandmother. Three participants reported that they prefer someone African American, yet often supplied with whoever is available. Though most participants expressed a preference for African American healthcare providers, the other participants were open to different experiences, which have already yielded more discretion, empathy, professionalism, and connection.

The perceived barriers outlined by all participants often outweighed the perceived benefits reported in this current study. Perceived benefits originate from the belief that there is a positive reward for taking action to prevent a disease (Boslaugh, 2019). All participants were able to identify a perceived benefit of post-diagnosis discussions. Among the researched benefits, N'Diaye (2014) highlighted that after receiving an HSV-2 diagnosis, more substantial commitments in current relationships emerged, and engagement in intimate relationships with less shame or feelings of being damaged occurred. One participant from the current study chose to limit future discussions by becoming celibate after her diagnosis. In contrast, all other participants have engaged in some intimate relationship where disclosure was deemed necessary. Findings from Bobrow (2016) support that only 10% of females claimed to know someone with HSV-2 and suggested that the negative stigma often determines disclosure. All participants in the current study expressed apprehension explaining the diagnosis to others, even though all participants could identify someone with whom they have shared their diagnosis. Some participants explained they know others with the diagnosis. Of the six participants who chose to have a sexual health discussion with new partners post-diagnosis, all participants reported feeling empowered to disclose, and four of those participants expressed feeling pleasantly surprised with the support received. Researched findings (Boslaugh, 2019) also highlighted that females received a pleasant reaction discussing the possibility of transmission with partners. If more public health strategies supplied guidance and inspiration on navigating the negative stigma of HSV-2, more disclosure conversations might occur.

N’Diaye (2014) also assessed African American females after an HSV-2 diagnosis self-reporting an increase in spiritual growth, self-love, self-care, stress management, forgiveness, and an increased appreciation for guided healing. Two participants reported participating in mental health interventions post-diagnosis, three participants reported growing spiritual wellness in which one participant stated managing her stress by strengthening her spirituality. Additional research emphasized that post-diagnosis, building sexual self-worth after an HSV-2 diagnosis is possible. Suppose adequate education on symptomology and prevention align. In that case, the result could be more confidence to act towards prevention, an increase in informed sexual decisions, and a better comprehension of sexual health (Royer et al., 2013).

Analytic Category 5: Perceived Self-Efficacy

Reported by all participants was the decision to build self-care and understand the diagnosis to make informed and confident sexual decisions. Similarly, as N’Diaye (2014) stated, building awareness and seeking treatment were associated with self-care and confidence in discussing an HSV-2 diagnosis. The level of confidence to take action and prevent disease is the cornerstone of self-efficacy (Skinner et al., 2015). Females increase levels of self-esteem when feeling competent and appreciated (Unis et al., 2015). One participant explained that she lives in a house full of women who exude a positive sense of self, keeping her aware of her self-esteem. Additional participants expressed that in the absence of judgment discussing the diagnosis, they are likely to maintain a positive sense of self discussing it in the future. When females have higher self-esteem, personal empowerment connects to healthier sexual decisions (Alexander et al., 2014). Though all participants expressed feeling more empowered post-diagnosis to lead sexual health discussions with partners, all participants expressed less confidence in discussing sexual health with healthcare providers because of perceived judgment. Findings emphasize that a higher self-efficacy or confidence level of an individual increases the possibility for healthcare providers to target a perceived threat (Jones et al., 2015); yet, there is still a lack of confidence for many females to initiate discussing STDs with a healthcare provider (Bobrow, 2016).

Analytic Category 6: Perceived Cues to Action

Having prevention knowledge is not an automatic correlation with better sexual decisions (Fray & Caldwell, 2017), but it can steer the conversation into awareness. Pre-diagnosis, some participants reported previous diagnoses of other STDs and STIs and after an HSV-2 diagnosis. All participants, regardless of STD or STI history, reported awareness of condoms and that condoms prevent the spread of HSV-2. All participants also reported that decisions not to use condoms occur with established commitment. Helmer et al. (2015) researched female feelings that preserving established relationships were more critical than STD and STI prevention. Condoms use is rare when females seek to develop trust in relationships (Caldwell & Mathews, 2015); thus, if self-efficacy correlates to wanting partners to trust them, the cue to act towards condom utilization is disrupted (Wilson et al., 2014). Previous research also advised that utilizing condoms is a method of risk reduction for the transmission of HSV-2 (Magaret et al., 2016). Regarding other prevention methods, no evidence exists that diagnosing genital herpes with a blood test for asymptomatic individuals would change sexual behaviors to stop the virus;

therefore, creating uncertainty that testing everyone would prevent the spread (CDC, 2015b). However, prevention knowledge can help African Americans address the discomfort of initiating conversations with healthcare providers (Hagiwara et al., 2017; Penner et al., 2017; Shen et al., 2018).

Literature emphasized that conversations with healthcare providers about sexual health often exclude suggestions about HSV-2 (U.S. Preventive Services Task Force, 2016) and do not address the historical mistrust and discomfort that African Americans often feel for healthcare providers (Bronson & Nuriddin, 2014; Fray & Caldwell, 2017; Hagiwara et al., 2017; Shen et al., 2018) that prevent cues to action. Reliance solely on symptomology delays this cue to act (Nwankwo & Sadiq, 2014; Royer et al., 2013). All participants expressed that before receiving a diagnosis while asymptomatic, there was no urgency to understand HSV-2 prevention. Researched findings suggest that the sense of seriousness about a disease can affect the cue to act towards prevention (Skinner et al., 2015). Actions to prevent and protect against a disease happen when individuals understand the severity, comprehend their vulnerability, acknowledge barriers and benefits, and facilitate the techniques and resources to protect against it (Tarkang & Zotor, 2015). Diagnosis is not a significant motivator of practicing safer sex (Royer et al., 2013), but it is an opportunity for healthcare providers to advocate for HSV-2 testing of at-risk individuals.

Limitations of the Study

This study had limitations that may have impacted the findings. Though I reached information power with seven participants, the study consisted of a purposive sample with inclusion criteria that lacks generalizability. The thick and descriptive language strengthened transferability to compare in other contexts; however, the variables outside of race, age, and geographical location could affect the overall outcome. The results of this study helped to provide a voice to the experiences of the African American females who participated in this study; however, this inclusion criteria presents a challenge for replicating this study. Though participants established rapport to respond openly to the interview questions, the data collection process began during the start of COVID-19, which mandated virtual interviews and might have decreased the reliability of various responses.

Recommendations

HSV-2 among African American females is spotlighted with a high infection rate through STD and STI research, and not just specific to a diagnosis in Fulton County, GA. This centralized focus for this study emphasized the awareness needed for both African American females and their providers and the healthcare community interested in African American wellness. The facilitation of qualitative research helped illuminate that diagnosis experiences occurring at an early age did not prevent these females from choosing self-education through analysis in areas they felt unknowledgeable. The data presented identified barriers to sexual health discussions with healthcare providers as well as partners. Acknowledging that sexual activity without condom use is likely for African American females who establish a perceived commitment, strategies to increase desirability and pleasure with continued condom use is critical in future research to impact social change. It is vital to address that the findings from previous studies and this current study both identified that females are more likely to cease or avoid condom use with a trusted partner, even without knowing test results, making couples testing a possible benefit. Future qualitative studies that shed light with a basic interpretive approach and phenomenological approach will gain more lived experiences from African Americans with HSV-2. This type of research might guide health educators in formulating strategies and techniques that can decrease the stigma connected to discussing an HSV-2 diagnosis.

The examination of the HBM constructs may help identify areas of focus for health education initiatives. The result could be increased awareness highlighting the importance of conversations with healthcare providers and partners and clarity for common barriers with prevention through fear of initiation or a lack of perceived urgency for long-term effects. Table 9 displays examples of possible topics to cover.

Table 9

Topics of Health Education in Alignment with HBM Constructs

Health Education Topic	HBM Construct
Awareness of HSV-2: How serious is it and for whom?	Perceived Threat
Race, gender, and a lack of condoms: HSV-2 barriers	Perceived Barriers
Stigmatized and Silent: Should you have the talk?	Perceived Benefits
The confidence to prevent	Perceived Self-Efficacy
Relying on symptomology, unknowingly asymptomatic	Perceived Cues to Action

Qualitative research that explores the connection between healthcare professionals and patients when discussing STDs and STIs with individuals can increase healthier sexual decisions. Additionally, quantitative baseline survey studies that focus on examining the prevalence and incidence of STDs and STIs could benefit health education programs that spotlight social determinants of health that impact HSV-2 infection rates.

Social Implications

This study focused on exploring attitudes and beliefs that African American females hold of their susceptibility and severity to HSV-2 and the family, policy, societal, and organizational factors regarding the diagnosis. The implications of this study can increase cultural sensitivity and cultural awareness when engaging with African American females. Those implications can provide comprehension for healthcare professionals about the unique obstacles for African American females and emphasize the higher susceptibility to every STD and STI but the absence of being tested for every STD and STI. This study could underline the necessity for health messaging that speaks to the susceptibility of African Americans and the likelihood of comorbidity of HSV-2 and other STDs or STIs. This study can also help improve the awareness and prevention that African American females have about HSV-2.

The data accumulated from this study can assist healthcare providers in understanding how a lack of awareness for HSV-2 susceptibility, adjacent to a passivity towards the severity, both contribute to the HSV-2 incidence and prevalence within the African American community. Furthermore, the findings can inspire more community awareness which could encourage more informed educational discussions between healthcare providers and patients. The positive change that may emerge from this study can promote health education programs that target educating patients on the necessity for engaging in prevention measures against transmission or contraction of HSV-2. This study also can start a conversation regarding the health needs of African American females by assessing the population directly about their misconceptions, perceptions, and barriers to prevention. Deterrents that decrease the occurrence of sexual health conversations were highlighted in this study. The comprehension of such obstacles may provide an overall understanding of methods to build rapport and teach African American females how to improve sexual health conversations. The findings of this study support that a lack of sexual health conversations between healthcare providers and patients, and those patients with their partners, affect the incidence, prevalence, and prevention of HSV-2 among African American females. The conclusions drawn from this study could promote conversations about the current CDC recommendations that lack the inclusion of routinized HSV-2 testing.

Conclusions

My research study outlined the benefit for African Americans to understand and discuss their sexual health, especially with partners and healthcare providers. The experiences of African American females who received an asymptomatic HSV-2 diagnosis were examined and found relevant based upon previous research and the research questions of this current study. The study highlighted that all participants were diagnosed while asymptomatic, and participants reported satisfaction knowing that disclosing their diagnosis still allowed for relationships and sexual engagement. Additionally, not all participants expressed a preference for African American healthcare providers, a point not considered initially. Though the CDC does not suggest routinized HSV-2 testing, and asymptomatic HSV-2 testing could yield false positives, the results of this study still encourage HSV-2 awareness conversations between African American females and their sexual partners, as well as corresponding healthcare providers.

References

Abraham, C. & Sheeran, P. (2005). The health belief model. In M. Conner & P. Norman (Eds.), *Predicting health behaviour: Research and practice with social cognition models* (2nd ed., pp. 30-69). Open University Press.

AIDSinfo. (2019). *HIV/AIDS glossary: Seroprevalence.* https://aidsinfo.nih.gov/understanding-hiv-aids/glossary/650/seroprevalence

AIDSVu. (2019a). *Local data: Atlanta.* https://aidsvu.org/state/georgia/atlanta/

AIDSVu. (2019b). *Local data: Georgia.* https://aidsvu.org/local-data/united-states/south/georgia/

Alexander, K., Jemmott, L., Teitelman, A., & D'Antonio, P. (2014). Addressing sexual health behaviour during emerging adulthood: A critical review of the literature. *Journal of Clinical Nursing, 24,* 4-18. https://doi.org/10.1111/jocn.12640

Alshenqeeti, H. (2014). Interviewing as a data collection method: A critical review. *English Linguistics Research, 3*(1), 39-45. https://doi.org/10.5430/elr.v3n1p39

Andrasik, M., Nguyen, H., George, W., & Kajumulo, K. (2014). Sexual decision making in the absence of choice: The African American female dating experience. *Journal of Health Disparities Research & Practice, 7*(2), 66-86. https://pubmed.ncbi.nlm.nih.gov/27182463/

Anney, V. (2014). Ensuring the quality of the findings of qualitative research: Looking at the trustworthiness criteria. *Journal of Emerging Trends in Educational Research and Policy Studies, 5*(2), 272-281. https://www.jeteraps.scholarlinkresearch.org

Baraj, B. (2015). Understanding objectification theory. *International Journal on Studies in English language and literature, 3*(11), 70-74.

Bekker, L. & Gray, G. (2017). Hope for HIV control in Southern Africa: The continued quest for a vaccine. *PLOS Medicine, 14*(2), 1-3. https://doi.org/10.1371/journal.pmed.1002241

Berry, V., Fleming-Rife, A., & Dayo, A. (Eds.). (2015). Black culture & experience: Contemporary issues. Peter Lang Publishing, Inc.

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: A tool to enhance trustworthiness or merely a nod to validation? *Qualitative Health Research, 26*(13), 1802-1811. https://doi.org/10.1177/1049732316654870

Bobrow, M. (2016). Full disclosure: Herpes stigma and communication practices among HSV+ individuals (Doctoral dissertation). https://commons.clarku.edu/idce_masters_papers/85

Boslaugh, S. (2019). Health belief model. Salem Press Encyclopedia.

Bronson, J. & Nuriddin, T. (2014). “I don’t believe in doctors much”: The social control of healthcare, mistrust, and folk remedies in the African American slave narrative. *Journal of Alternative Perspectives in the Social Sciences 5*(4), 706-732. https://www.japss.org/

Burkholder, G., Cox, K., Crawford, L., Hitchcock, J. (2020). *Research design and methods: An applied guide for the scholar-practitioner.* Sage Publications, Inc.

Caldwell, K. & Mathews, A. (2015). The role of relationship type, risk perception, and condom use in middle socioeconomic status Black women’s HIV-prevention strategies. *Journal of Black Sexuality and Relationships, 2*(2), 91-120. https://doi.org/10.1353/bsr.2016.0002

Centers for Disease Control and Prevention (CDC). (2013). *Estimates of sexually transmitted infections in the United States, 2008* [PDF file]. https://www.cdc.gov/std/stats/STI-Estimates-Fact-Sheet-Feb-2013.pdf

Centers for Disease Control and Prevention (CDC). (2015a). *2015 Sexually transmitted diseases treatment guidelines: Genital HSV infections.* https://www.cdc.gov/std/tg2015/herpes.htm

Centers for Disease Control and Prevention (CDC). (2015b). *Screening recommendations and considerations referenced in treatment guidelines and original sources.* https://www.cdc.gov/std/tg2015/screening-recommendations.htm

Centers for Disease Control and Prevention (CDC). (2016a). *Figure 51. Herpes Simplex Virus (HSV) type 2 – seroprevalence among non-Hispanic Whites and non-Hispanic Blacks by Sex and age group, national health and nutrition examination survey, 1988-1994, 1999-2002, 2003-2006, and 2007-2010.* https://www.cdc.gov/std/stats15/figures/51.htm

Centers for Disease Control and Prevention (CDC). (2016b). *Health disparities in HIV/AIDS, viral hepatitis, STDs, and TB.* https://www.cdc.gov/nchhstp/healthdisparities/africanamericans.html

Centers for Disease Control and Prevention (CDC). (2016c). *Terms, definitions, and calculations used in CDC HIV surveillance publications*. https://www.cdc.gov/hiv/statistics/surveillance/terms.html

Centers for Disease Control and Prevention (CDC). (2016d). *What are STDs?* https://www.cdc.gov/std/general/default.htm

Centers for Disease Control and Prevention (CDC). (2017a). *Genital herpes – CDC fact sheet (detailed).* https://www.cdc.gov/std/herpes/stdfact-herpes-detailed.htm

Centers for Disease Control and Prevention (CDC). (2017b). *Sexually Transmitted Disease Surveillance 2016* [PDF]. https://www.cdc.gov/std/stats16/CDC_2016_STDS_Report-for508WebSep21_2017_1644.pdf

Centers for Disease Control and Prevention. (2017c). *STD and HIV screening recommendations.* https://www.cdc.gov/std/prevention/screeningreccs.htm

Centers for Disease Control and Prevention (2018). *Shingles (herpes zoster).* https://www.cdc.gov/shingles/about/overview.html

Centers for Disease Control and Prevention (2019a). *About HIV/AIDS.* https://www.cdc.gov/hiv/basics/whatishiv.html

Centers for Disease Control and Prevention (2019b). *HIV among women.* https://www.cdc.gov/hiv/group/gender/women/index.html

Centers for Disease Control and Prevention (2019c). *HIV and African Americans.* https://www.cdc.gov/hiv/group/racialethnic/africanamericans/index.html

Centers for Disease Control and Prevention (n.d.). *Genital herpes: Screening FAQ.* https://www.cdc.gov/std/herpes/screening.htm

Chattopadhyay, D., Mukhopadhyay, A., Ojha, D., Sadhukhan, P., & Dutta, S. (2018). Immuno-metabolic changes in herpes virus infection. *Cytokine*, *112*, 52-62. https://doi.org/10.1016/j.cyto.2018.06.028

Concha, M., Villar, M., & Azevado, L. (2014). Health attitudes and beliefs tool kit. http://cfs.cbcs.usf.edu/projects-research/_docs/HealthBeliefsToolkit.pdf

Cooper, I. (2015). Commodification of the Black body, sexual objectification and social hierarchies during slavery. *The Earlham Historical Journal*, *7*(2), 21-43. https://earlham.edu/media/2544043/ehj-spring%202015.pdf#page=27

Cornell Law School. (n.d.). *29 CFR 825.125 – Definition of healthcare provider.* https://www.law.cornell.edu/cfr/text/29/825.125

Cottrell, R., Girvan, J., McKenzie, J., & Seabert, D. (2015). *Health promotion and education* (6th ed.). Pearson Education, Inc.

Creswell, J & Creswell J. (2018). *Research design: Qualitative, quantitative, and mixed methods approaches* (5th ed.). Sage.

Davis, S., Wischhusen, J., Sutton, S., Christy, S., Chavarria, E., Sutter, M.,…Gwede, C. (2019). Demographic and psychosocial factors associated with limited health literacy in community-based sample of older Black Americans. *Patient Education and Counseling.* https://doi.org/10.1016/j.pec.2019.08.026

Dhillon, R. & Smith, P. (2018). Diskogenic reactivation of herpes zoster. *World Neurosurgery, 109*, 138-139. https://doi.org/10.1016/j.wneu.2017.09.132

Ewing, S. & Bryan, A. (2015). A question of love and trust? The role of relationship factors in adolescent sexual decision-making. *Journal of Developmental &*

Behavioral Pediatrics, 36(8), 628-634. https://doi.org/10.1097/dbp.0000000000000190

Ferrera, M., Feinstein, R., Walker, W., & Gehlert, S. (2016). Embedded mistrust then and now: Findings of a focus group study on African America perspectives on breast cancer and its treatment. *Critical Public Health, 26*(4), 455-465. https://doi.org/10.1080/09581596.2015.1117576

Francis, A. Oksana, D., Timmy, D., Richard, A., & Mohammed, S. (2018). Co-infection prevalence of herpes simplex virus types 1 and 2 with human papillomavirus and associated risk factors among asymptomatic women in Ghana. *International Journal of Infectious Diseases and Therapy, 3*(3), 45-51. https://doi.org/10.11648/j.ijidt.20180303.11

Fray, N. & Caldwell, K. (2017). Communication between middle SES Black women and healthcare providers about HIV testing. *Journal of National Medical Association, 109*(2), 115-125. https://doi.org/10.1016/j.jnma.2016.11.005

Gakumo, C., Enah, C., & Azuero, A. (2014). A comparison of sexual health and sexual pressure among young African American and Caucasian women. *Journal of Health Disparities Research and Practice, 7*(2), 107-117. https://digitalscholarship.unlv.edu/jhdrp/

Georgia Department of Public Health (DPH). (2019). *OASIS.* https://oasis.state.ga.us/trendingtool/index.html?redirectto=STD

Gilbert, P., Excler, J., Tomaras, G., Carpp, L., Haynes, B., Liao, H., Montefiori, D., Rerks-Ngarm, S., Pitisuttithum, P., Nitayaphan, S., Kaewkungwai, J., Kijak, G., Tovanabutra, S., & Kim, J. (2017). Antibody to HSV gD peptide induced by vaccination does not protect against HSV-2 infection in HSV-2 seronegative women. *PLOS One, 12*(5), 1-15. https://doi.org/10.1371/journal.pone.0176428

Hagiwara, N., Slatcher, R., Eggly, S., & Penner, L. (2017). Physician racial bias and word use during racially discordant medical interactions. *Health Communications, 32*(4), 401-408. https://doi.org/10.1080/10410236.2016.1138389

Hallfors, D., Cho, H., Mbai, I., Millimo, B., Atieno, C., Okumu, D., Luseno, W., Hartman, S., Halpern, C., & Hobbs, M. (2015). Disclosure of HSV-2 serological test results in the context of an adolescent HIV prevention trial in Kenya. *Sexually Transmitted Infections, 91*(6), 395-400. https://doi.org/10.1136/sextrans-2015-052025

Helmer, J., Senior, K., Davison, B., & Vodic, A. (2015). Improving sexual health for young people: Making sexuality education a priority. *Sex Education*, *15*(2), 158-171. https://doi.org/10.1080/14681811.2014.989201

Henderson, L. (2015). Racial isolation and chlamydia rates in US counties. *Race and Social Problems,* 7(2), 111-122.https://doi.org/10.1007/s12552-015-9143-8

Hendry, K. (2017). Oral sex and HSV-1 knowledge among college freshmen females. *Doctor of Nursing Practice Projects*. https://scholarworks.umass.edu/cgi/viewcontent.cgi?article=1095&context=nursing_dnp_capstone

Hodgson, J. (2015). *Integrating acceptance and commitment therapy with self-compassion focused therapy: An intervention for people struggling with a Herpes* *simplex virus diagnosis* (Doctoral dissertation). Widener University, Chester, Pennsylvania.

Hoffman, R., Bryant, B., Allen, S., Lee, M., Aarons, C., & Kelz, R. (2016). Using community outreach to explore health-related beliefs and improve surgeon-patient engagement. *Journal of Surgical Research, 206,* 411-416. https://doi.org/10.1016/j.jss.2016.08.058

Hoskins, D. & Simons, L. (2015). Predicting the risk of pregnancy among African American youth: Testing a social contextual model. *Journal of Child & Family Studies, 24,* 1163-1174.

Hovick, S., Yamasaki, J., Burton-Chase, A., & Peterson, S. (2015). Patterns of family history communication among older African American adults. *Journal of Health Communication, 20,* 80-87.

Ion, A., Greene, S., MacMillan, H., & Smieja, M. (2013). HSV-2/HIV co-infection, health-related quality of life and identity in women. *Canadian Journal of Human Sexuality*, *22*(3), 123-133. https://doi.org/10.3138/cjhs.2131

Irizarry-De La Cruz, M. (2015). *Herpes virus infections, inflammatory markers and risk of developing T2DM and CVD: An analysis of NHANES with adults, aged 20-49, 1999-2010* [Doctoral dissertation, Walden University]. ScholarWorks. https://scholarworks.waldenu.edu/cgi/viewcontent.cgi?article=2382&context=dissertations

Jolles, M. P., Richmond, J., & Thomas, K. (2019). Minority patient preferences, barriers, and facilitators for shared decision-making with health care providers in the USA:

A systematic review. *Patient Education and Counseling, 102*(7), 1251-1262. https://doi.org/10.1016/j.pec.2019.02.003

Jones, C., Jensen, J., Scherr, C., Brown, N., Christy, K., & Weaver, J. (2015). The health belief model as an explanatory framework in communication research: Exploring parallel, serial, and moderated mediation. *Health Communication, 30*(6), 566-576.

Jones, S. A., Latchford, G., & Tober, G. (2016). Client experiences of motivational interviewing: An interpersonal process recall study. *Psychology and Psychotherapy: Theory, Research and Practice, 89*, 97-114. https://doi.org/10.1111/papt.12061

Kajula, L., Darling, N., Kaaya, S., & De Vries, H. (2016). Parenting practices and styles associated with adolescent sexual health in Dar es Salaam, Tanzania. *AIDS Care, 28*(11), 1467-1472. https://doi.org/10.1080/09540121.2016.1191598

Kelly, J., Cohen, J., Grimes, B., Philip, S., Weiser, S., & Riley, E. (2016). High rates of herpes simplex virus type 2 infection in homeless women: Informing public health strategies. *Journal of Women's Health, 25*(8), 840-845. https://doi.org/10.1089/jwh.2015.5579

Leedy, P., & Ormrod, J. (2019). *Practical research: planning and design,* (12th ed.). Pearson Education, Inc.

Leichliter, J., Copen, C., & Dittus, P. (2017). Confidentiality issues and use of sexually transmitted disease services among sexually experienced persons aged 15-25 years – United States, 2013-2015. *Morbidity and Mortality Weekly Report, 66*(9), 237-241.

Looker, K., Magaret, A., Turner, K., Vickerman, P., Gottlieb, S., & Newman, L. (2015). Global estimates of prevalent and incident herpes simplex virus type 2 infections in 2012. *PLOS One, 10*(1), 1-23. https://doi.org/10.1371/journal.pone.0114989

Looker, K., Elmes, J., Gottlieb, S., Schiffer, J., Vickermna, P., Turner, K., & Boily, M. (2017). Effect of HSV-2 infection on subsequent HIV acquisition: An updated systematic review and meta-analysis. *Infectious Diseases, 17*(12), 1303-1316. https://doi.org/10.1016/S1473-3099(17)30405-X

Luthi, S. (2019). Lack of knowledge, unreliable testing feed the stigma of herpes. *Modern Healthcare, 49*(14). 16. https://www.modernhealthcare.com/providers/lack-knowledge-unreliable-testing-feed-stigma-herpes

Macaskie, J., Lees, J., & Freshwater, D. (2015). Talking about talking: Interpersonal process recall as an intersubjective approach to research. *Psychodynamic Practice, 21*(3), 226-240. http://dx.doi.org/10.1080/14753634.2015.1042517

Magaret, A., Mujugira, A., Hughes, J., Lingappa, J., Bukusi, E., DeBruyn, G., Delany-Moretlwe, S., Fife, K., Gray, G., Kapiga, S., Karita, E., Mugo, N., Rees, H., Ronald, A., Vwalika, B., Were, E., Celum, C., & Wald, A. (2016). Effect of condom use on per-act HSV-2 transmission risk in HIV-1, HSV-2-discordant couples. *Clinical Infectious Diseases, 62*(4), 456-461. https://doi.org/10.1093/cid/civ908

Malterud, K., Siersma, V., & Guassora, A. (2016). Sample size in qualitative interview studies: Guided by information power. *Qualitative Health Research, 26*(13), 1753-1760. https://doi.org/10.1177/1049732315617444

Mantwill, S., Monestel-Umana, S., & Schulz, P. (2015). The relationship between health literacy and health disparities: A systematic review. *PLOS One, 10*(12), https://doi.org/10.1371/journal.pone.0145455

McQuillan, G., Kruszon-Moran, D., Flagg, E., & Paulose-Ram, R. (2018). Prevalence of herpes simplex virus type 1 and type 2 in persons aged 14-49: United States, 2015-2016. *National Center for Health Statistics Data Brief,* 304. https://www.cdc.gov/nchs/products/databriefs/db304.htm

Merriam, S. & Grenier, R. (2019). *Qualitative research in practice: Examples for discussion and analysis* (2nd ed.). Jossey-Bass

Merriam, S. & Tisdale, E. (2016). *Qualitative research: A guide to design implementation* (4th ed.). Jossey-Bass.

Morse, J. & Coulehan, J. (2014). Maintaining confidentiality in qualitative publications. *Qualitative Health Research, 25*(2), 151-152. https://doi.org/10.1177/1049732314563489

Murray, A., Ellis, M., Castellanos, T., Gaul, Z., Sutton, M., & Sneed, C. (2014). Sexual health discussions between African American mothers and mothers of Latino descent and their children. *Sex Education, 14*(5), 597-608. https://doi.org/10.1080/14681811.2014.908767

N'Diaye, S. (2014). *A sister's voice: Imagery and the lived experiences of African American women with HSV-2* (Unpublished doctoral dissertation). Saybrook University, Oakland, California.

Naidoo, S. & Taylor, M. (2015). HIV health literacy, sexual behaviour and self-reports of having tested for HIV among students. *African Journal of AIDS Research, 14*(2), 107-115.

Nwankwo, E. & Sadiq, M. (2014). Prevalence of chlamydia trachomatis infection among patients attending infertility and sexually transmitted diseases clinic (STD) in Kano, North Western Nigeria. *African Health Sciences, 14*(3), 672-678.

Operario, D., Lee, J., Kuo, C., & Zaller, N. (2015). Racial and ethnic disparities in HIV and STIs in the United States – national health and nutrition examination survey 1999-2012. *AIDS Patient Care and STDs, 29*(12), 635-638. https://doi.org/10.1089/apc.2015.0169

Oseso, L., Magaret, A., Jerome, K., Fox, J., & Wald, A. (2016). Attitudes and willingness to assume risk of experimental therapy to eradicate genital herpes simplex virus infection. *Sexually Transmitted Diseases, 43*(9), 566-571. https://doi.org/10.1097/OLQ.0000000000000493

Painter, T., Herbst, J., Diallo, D., White, L. (2014). Community-based program to prevent HIV/STD infection among heterosexual Black women. *Morbidity and Mortality Report, 63*(01), 15-20. https://www.cdc.gov/mmwr/preview/mmwrhtml/su6301a4.htm

Parks, R. Q. (2013). *The health belief model and safe sex among African American adolescent females* (Doctoral dissertation). Dissertations & Theses @ Walden University. (Accession No. 1362252135).

Patel, E., Laeyendecker, O., Hsieh, Y., Rothman, R., Kelen, G., & Quinn, T. (2016). Parallel declines in HIV and hepatitis c virus prevalence, but not in herpes simplex virus type 2 infection: A 10-year, serial cross-sectional study in an inner-city emergency department. *Journal of Clinical Virology, 80*, 93-97. https://doi.org/10.1016/j.jcv.2016.05.003

Patil, P., Peng, R., & Leek, J. (2016). What should we expect when we replicate? A statistical view of replicability in psychological science. *Perspectives on Psychological Science, 11*(4), 539-544. https://doi.org/10.1177/1745691616646366

Penner, L., Harper, F., Dovido, J., Albrecht, T., Hamel, L., Senft, N., & Eggly, S. (2017). The impact of Black cancer patients' race-related beliefs and attitudes on racially-discordant oncology interactions: A field study. *Social Science & Medicine, 191*, 99-108. https://doi.org/10.1016/j.socscimed.2017.08.034

Prince, H., Batterman, H. & Schwab, D. (2019) Herpes simplex virus type 2 (HSV-2) IgG index values in two immunoassays in relation to HSV-2 IgG inhibition assay results. *A diagnostic microbiology & Infectious Disease 95*(3), 1-4. https://doi.org/10.1016/j.diagmicrobio.2019.07.002

Quinn-Nilas, C., Milhausen, R., Breuer, R., Bailey, J., Pavlov, M., DiClemente, R., & Wingood, G. (2016). Validation of the sexual communication self-efficacy scale. *Health Education & Behavior, 43*(2), 165-171. https://doi.org/10.1177/1090198115598986

Ravitch, S. & Carl, N. (2016). Qualitative research: Bridging the conceptual, theoretical, and methodological. Sage Publications.

Roller, M. & Lavrakas, P. (2015). *Applied qualitative research design: A total quality framework approach.* The Guilford Press.

Royer, H., Falk, E., & Heidrich, S. (2012). Sexually transmitted disease testing misconceptions threaten the validity of self-reported testing history. *Public Health Nursing, 30*(2), 117-127. https://doi.org/ 10.1111/phn.12013

Royer, H., Falk, E., & Heidrich, S. (2013). Genital herpes beliefs: Implications for sexual health. *Journal of Pediatric and Adolescent Gynecology, 26*(2), 109-116. https://doi.org/10.1016/j.jpag.2012.11.007

Saldana, J. (2016). *The coding manual for qualitative researchers* (3rd ed.). Sage.

Sanchez, D., Flannigan, A., Guevara, C., Arango, S., & Hamilton, E. (2017). Links among familial gender ideology, media portrayal of women, dating, and sexual behaviors in African American, and Mexican American adolescent young women: A qualitative study. *Sex Roles, 77*, 453-470. https://doi.org/10.1007/s11199-017-0739-x

Schmitt, D. (2017, July 11). Can we trust what men and women reveal on sex surveys? [forum post]. https://www.psychologytoday.com/us/blog/sexual-personalities/201707/can-we-trust-what-men-and-women-reveal-sex-surveys

Shen, M., Peterson, E., Costas-Muniz, R., Hernandez, M., Jewell, S., Matsoukas, K., & Bylund, C. (2018). The effects of race and racial concordance on patient-physician communication: A systematic review of the literature. *Journal of Racial and Ethnic Disparities*, *5*(1), 117-140. https://doi.org/10.1007/s40615-017-0350-4

Skinner, C. S., Tiro, J., & Champion, V. L. (2015). The health belief model. Background on the health belief model. In Glanz, K., Rimer, B., & Viswanath, K. (Eds.), *Health behavior: Theory, research, and practice* (75-94). Jossey-Bass.

Tarkang, E. & Zotor, F. (2015). Application of the health belief model (HBM) in HIV prevention: A literature review. *Central African Journal of Public Health*, *1*(1), 1-8. https://doi.org/10.11648/j.cajph.20150101.11

Teherani, A., Martimianakis, T., Stenfors-Hayes, T., Wadhwa, A., & Varpio, L. (2015). Choosing a qualitative research approach. *Journal of Graduate Medical Education*, *7*(4), 669-670. https://doi.org/10.4300/JGME-D-15-00414.1

Thellman, N., Botting, C., Madaj, Z., & Triezenberg, S. (2017). An immortalized human dorsal root ganglion cell line provides a novel context to study herpes simplex virus 1 latency and reactivation. *Journal of Virology*, *91*(12), 1-18. https://doi.org/10.1128/JVI.00080-17

United States Census Bureau. (2011). *The Black population: 2010* [PDF file]. https://www.census.gov/prod/cen2010/briefs/c2010br-06.pdf

United States Census Bureau. (2019a). *QuickFacts: United States.* https://www.census.gov/quickfacts/fact/table/US/PST045218

United States Census Bureau. (2019b). *U.S. Population and World Clock.* https://www.census.gov/popclock/?intcmp=w_200x402

Unis, B., Johansson, I., & Sallstrom, C. (2015). Rural high school students’ sexual behavior and self-esteem. *Open Journal of Nursing, 5,* 24-35. https://doi.org/10.4236/ojn.2015.51004

US Preventive Services Task Force. (2016). Serologic screening for genital herpes infection: US Preventive Services Task Force recommendation statement. *JAMA, 316*(23), 2525-2530. https://doi.org/10.1001/jama.2016.16776

Vanyukov, M., Nimgaonkar, V., Kirisci, L., Kirillova, G., Reynolds, M., Prasad, Tarter, R. & Yolken, R. (2018). Association of cognitive function and liability to addiction with childhood herpesvirus infections: A prospective cohort study. *Development and Psychopathology; 30*(1), 143-152. https://doi.org/10.1017/S0954579417000529

Vasileiou, K., Barnett, J., Thorpe, S., & Young, T. (2018). Characterising and justifying sample size sufficiency in interview-based studies: Systematic analysis of qualitative health research over a 15-year period. *BMC Medical Research Methodology, 18,* 1-18. https://doi.org/10.1186/s12874-018-0594-7

Virus Pathogen Database and Analysis Resource (ViPR). (n.d.). *About the herpesviridae family.* https://www.viprbrc.org/brc/aboutPathogen.spg?decorator=herpes#X

Walden University. (n.d.a.). *Research ethics & compliance: Guides & FAQs.* https://academicguides.waldenu.edu/researchcenter/orec/guides

Walden University. (n.d.b.). *Research ethics & compliance: Application & general materials.* https://academicguides.waldenu.edu/researchcenter/orec/application

Walden University. (n.d.c.). *Research ethics & compliance: Research ethics review process.* https://academicguides.waldenu.edu/researchcenter/orec/application

Watson, L., Marszalek, J., Dispenza, F., & Davids, C. (2015). Understanding the relationships among White and African American women's sexual objectification experiences, physical safety anxiety, and psychological distress. *Sex Roles, 72*, 91-104. https://doi.org/10.1007/s11199-014-0444-y

Weekes, C. (2012). African Americans and health literacy: A systematic review. *ABNF Journal, 23*(4), 76-80.

Willis, E., King, D., Dwyer, J., Wainer, J., & Owada, K. (2017). Women and gynecological cancer: Gender and the doctor-patient relationship. *Topoi, 36*(3), 509-519. https://doi.org/10.1007/s11245-015-9349-9

Wilson, J., Burlew, A., Montgomery, L., Peteet, B., Johnson, C., & Hatch-Mailette, M. (2014). Do masculinity and perceived condom barriers predict heterosexual HIV risk behaviors among Black substance abusing men? *Journal of Health Disparities Research and Practice*, *7*(6), 54-71. https://digitalscholarship.unlv.edu/cgi/viewcontent.cgi?article=1217&context=jhdrp

Workowski, K. & Bolan, G. (2015). Sexually transmitted diseases treatment guidelines, 2015. *Morbidity and Mortality Weekly Reports Recommendations and Reports, 64*(RR3), 1-137. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5885289/

World Health Organization. (2017). *Sexual health and its linkages to reproductive health: An operational approach* [PDF file]. https://apps.who.int/iris/bitstream/handle/10665/258738/9789241512886-eng.pdf

Wu, Y., Thompson, D., Aroian, K., McQuaid, E., & Deatrick, J. (2016). Commentary: Writing and evaluating qualitative research reports. *41*(5): 493-505. https://doi.org/10.1093/jpepsy/jsw032

Appendix A: Recruitment Flyer

Interested?

Cherlisa Jackson
Cherlisa.Jackson@waldenu.edu

Cherlisa Jackson
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Cherlisa Jackson
Cherlisa.Jackson@waldenu.edu

Cherlisa Jackson
Cherlisa.Jackson@waldenu.edu

Dissertation research study will be conducted by Walden University student, Cherlisa Jackson.

Program Details

Who: African-American females, ages 18-49

What: A study of African-American females, diagnosed with HSV-2, but no signs or symptoms before diagnosis.

Time Required: Less than one hour of your time.

Where: The interviews will be conducted at this location.

Description: You will be asked questions regarding your lived experiences of HSV-2 and about HSV-2, overall.

$10
GIFT CARD PROVIDED!

HSV-2 & U

African- American
Females
and Herpes Simplex Virus-2

Participants needed!

Appendix B: Interview Guide

Interview Protocol for a Phenomenological Study on African American Females and an Asymptomatic HSV-2 Diagnosis

Date:
Time:
Interview #:
Setting of Interview:

Parts of the Interview	Interview Questions
Introduction	Hello, my name is Cherlisa Jackson. I am a doctoral candidate at Walden University and I am conducting a research study on African American females with an asymptomatic HSV-2 diagnosis. Thank you for helping me with this interview, which should last between 45-60 minutes. The purpose of this study is to understand your experiences, beliefs, and thoughts on living with an HSV-2. diagnosis. I will audio record your responses and only myself and the University will have access to the recordings. You will remain anonymous and only be identified as a participant in all documentation. After the interview, I will provide you with a $10 gift card as appreciation for your time. I will also examine your responses through data analysis and provide you with a copy of what I find. You can choose to stop the interview at any time, or take any needed breaks during the interview. Do you have any questions about the study before signing the informed consent to participate? (Review Informed Consent Form and Sociodemographic Questionnaire with participant. Define all terms in both documents, including informed consent and sociodemographic. Receive completed documents before proceeding.)

	Are you ready to begin?
Question 1:	1. What do you know about Herpes Simplex Virus-2 (HSV-2)? Follow-up Question(s) What are the symptoms and signs of HSV-2? What possible sexual health complications are you aware of that accompany HSV-2? Are you aware that HSV-2 can be transmitted and contracted without showing any signs or having any symptoms? Please explain.
Question 2:	2. After receiving the diagnosis, how were you feeling? Follow-up Question(s) How do you feel now? How has your sexual life been affected? How has your overall well-being been affected?
Question 3:	3. Who have you communicated with about your diagnosis? Follow-up Question(s) How likely are you to discuss HSV-2 with a partner, even when no signs or symptoms are present? Have you told any partners about your diagnosis before engaging in

	sexual activity, even if no signs or symptoms were present?
Question 4:	4. Have you ever negotiated condoms with your partner? Follow-up Question(s) Describe your experience.
Question 5:	5. Prior to diagnosis, did you feel you would ever become infected with HSV-2? Why or why not? Follow-up Question(s) After diagnosis, do you believe you can become infected with another STD or STI? Why or why not?
Question 6:	6. What sexually transmitted diseases (STDs) and infections (STIs) affect African Americans? Follow-up Question(s) Do you believe females are more infected with HSV-2? Why or why not? Do you believe sexuality has anything to do with receiving or passing HSV-2? Do you believe financial stability has anything to do with receiving or passing HSV-2? Does religion have anything to do with receiving or passing HSV-2 Is a current or previous STD or STI a factor in whether an African American has an STD or STI?

Question 7:	7. Do you believe you and your sexual partner(s) have a responsibility in protecting yourselves against STIs and STDs? Follow-up Question(s) Why or why not?
Question 8:	8. How important is it to be tested annually for STDs and STIs?
Question 9:	9. Have you ever asked your healthcare provider to be tested for HSV-2, even if you did not have any symptoms? Follow-up Question(s) If so, describe your experience.
Question 10:	10. Have you ever been offered an HSV-2 test by your healthcare provider, even if you did not have any symptoms? Follow-up Question(s) If so, describe your experience.
Question 11:	11. What might be the consequences or outcomes of speaking with a healthcare provider if you have concerns or questions about HSV-2?
Question 12:	12. Do you feel comfortable or comforted speaking with a healthcare provider who is not African American regarding HSV-2 and other STDs and STIs? Follow-up Question(s) If so, describe your experience.
Conclusion	Thank you for participating in this interview. Here is your $10 gift card as gratitude for your time and responses today. I will review your audio recording and transcribe your responses exactly. You will receive a copy of what I transcribe and have an opportunity to confirm and clarify my understanding of your responses.

	(Conduct IPR with participant and review responses to confirm receipt of clear responses). Do you have anything additional to share? Do you have any questions for me today? You can reach me at (censored). Thank you again and have a great day.

Appendix C: Expert Reviewer Acknowledgement

Date:
Name:
Credentials:
Field of Study:
List Any of Your Publications:

I, ____, do hereby confirm that I have thoroughly read the Interview Guide provided by doctoral candidate, Cherlisa Jackson. I understand that the expert reviewer process is not complete without sending back the signed acknowledgement for receipt of review to Miss Jackson. I understand that this process is completed via email for my convenience.

_______________There are no necessary changes to the Interview Guide provided.
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_______________There are changes needed and I have provided edits.
Initial Here

Printed Name: ____

Signature: ____

Date: ____

Appendix D: Expert Reviewer Acknowledgement from Tonya O’Bryan

Date: 7/14/19
Name: Tonya O’Bryan
Credentials: MS in Health Promotion; CHES
Field of Study: Reproductive Health & Advocacy
List Any of Your Publications:

I, Tonya O’Bryan__, do hereby confirm that I have thoroughly read the Interview Guide provided by doctoral candidate, Cherlisa Jackson. I understand that the expert reviewer process is not complete without sending back the signed acknowledgement for receipt of review to Miss Jackson. I understand that this process is completed via email for my convenience.

___TO_________There are no necessary changes to the Interview Guide provided.
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________________There are changes needed and I have provided edits.
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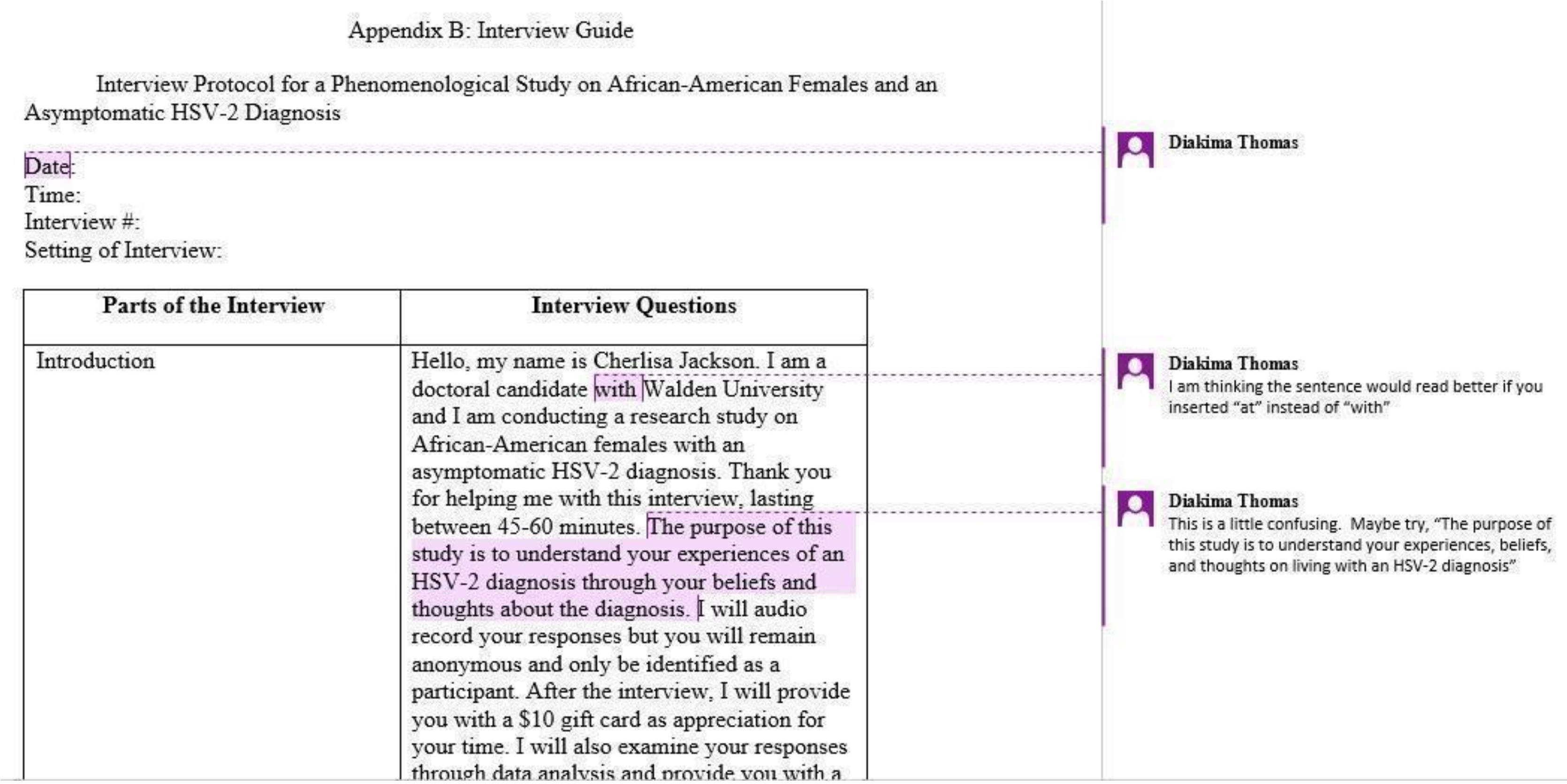
Printed Name: __Tonya O’Bryan____

Signature: __Tonya O’Bryan____

Date: _____7/14/19____

Appendix E: Interview Guide Feedback from Diakima Thomas



Appendix B: Interview Guide

Interview Protocol for a Phenomenological Study on African-American Females and an Asymptomatic HSV-2 Diagnosis

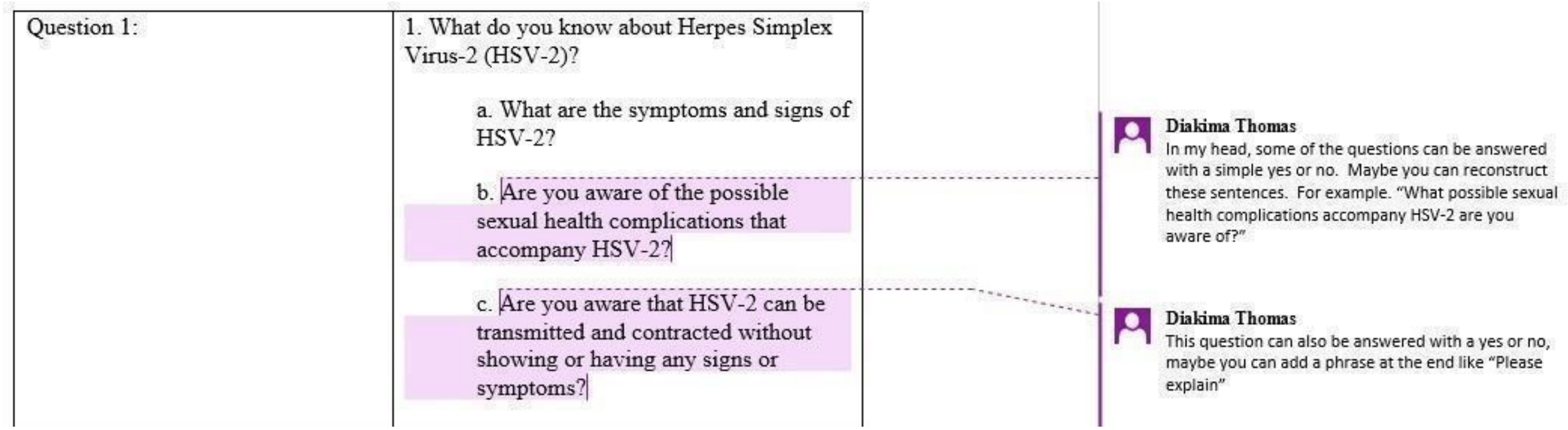
Date:
Time:
Interview #:
Setting of Interview:

Parts of the Interview	Interview Questions
Introduction	Hello, my name is Cherlisa Jackson. I am a doctoral candidate with Walden University and I am conducting a research study on African-American females with an asymptomatic HSV-2 diagnosis. Thank you for helping me with this interview, lasting between 45-60 minutes. The purpose of this study is to understand your experiences of an HSV-2 diagnosis through your beliefs and thoughts about the diagnosis. I will audio record your responses but you will remain anonymous and only be identified as a participant. After the interview, I will provide you with a $10 gift card as appreciation for your time. I will also examine your responses through data analysis and provide you with a

Diakima Thomas

Diakima Thomas
I am thinking the sentence would read better if you inserted "at" instead of "with"

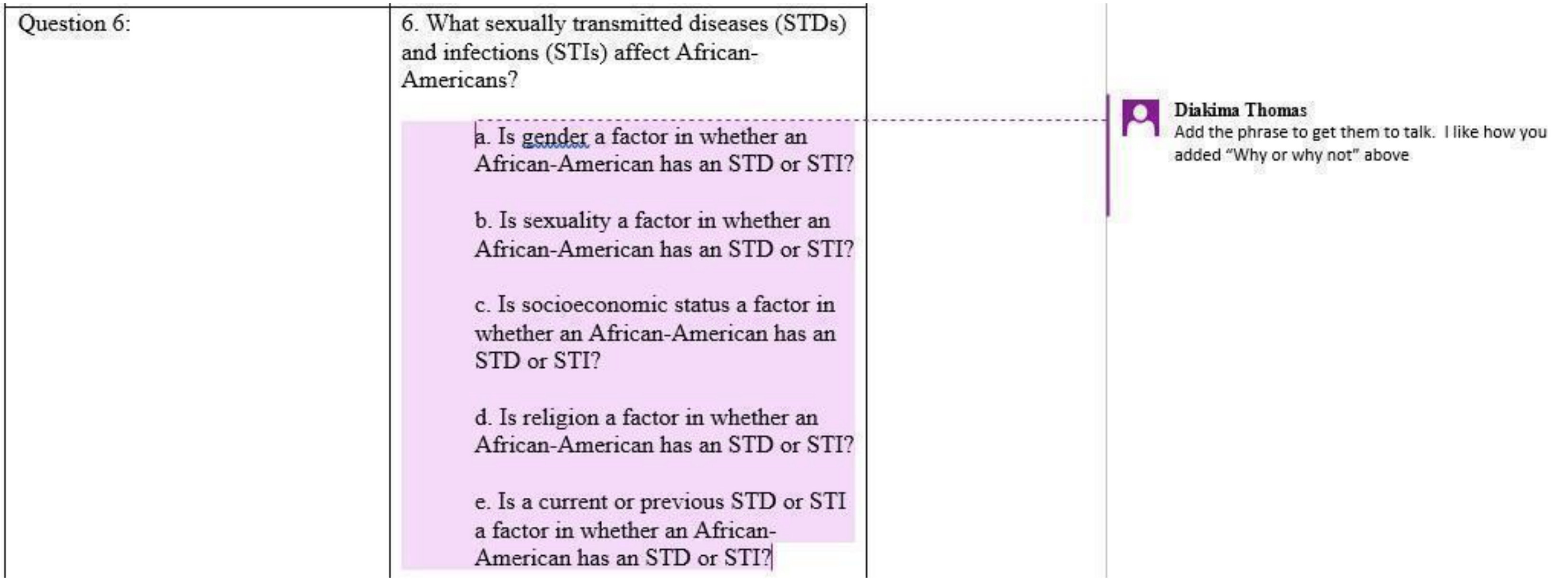
Diakima Thomas
This is a little confusing. Maybe try, "The purpose of this study is to understand your experiences, beliefs, and thoughts on living with an HSV-2 diagnosis"



Question 1:	1. What do you know about Herpes Simplex Virus-2 (HSV-2)? a. What are the symptoms and signs of HSV-2? b. Are you aware of the possible sexual health complications that accompany HSV-2? c. Are you aware that HSV-2 can be transmitted and contracted without showing or having any signs or symptoms?

Diakima Thomas
In my head, some of the questions can be answered with a simple yes or no. Maybe you can reconstruct these sentences. For example. "What possible sexual health complications accompany HSV-2 are you aware of?"

Diakima Thomas
This question can also be answered with a yes or no, maybe you can add a phrase at the end like "Please explain"



Question 6:	6. What sexually transmitted diseases (STDs) and infections (STIs) affect African-Americans? a. Is gender a factor in whether an African-American has an STD or STI? b. Is sexuality a factor in whether an African-American has an STD or STI? c. Is socioeconomic status a factor in whether an African-American has an STD or STI? d. Is religion a factor in whether an African-American has an STD or STI? e. Is a current or previous STD or STI a factor in whether an African-American has an STD or STI?

Diakima Thomas
Add the phrase to get them to talk. I like how you added "Why or why not" above

Appendix F: Expert Reviewer Acknowledgement from Diakima Thomas

Date: July 21, 2019
Name: Diakima Y. Thomas
Credentials: PhD, MPH
Field of Study: Public Health (e.g. HIV, STD/STI, condom use among the African American population)
List Any of Your Publications: The Relationship Between Limited Partner Availability, Masculine Ideologies, and Condom Use

I, ______Diakima Y Thomas, PhD, MPH____________________________________, do hereby confirm that I have thoroughly read the Interview Guide provided by doctoral candidate, Cherlisa Jackson. I understand that the expert reviewer process is not complete without sending back the signed acknowledgement for receipt of review to Miss Jackson. I understand that this process is completed via email for my convenience.

________________There are no necessary changes to the Interview Guide provided.
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____DT___________There are changes needed and I have provided edits.
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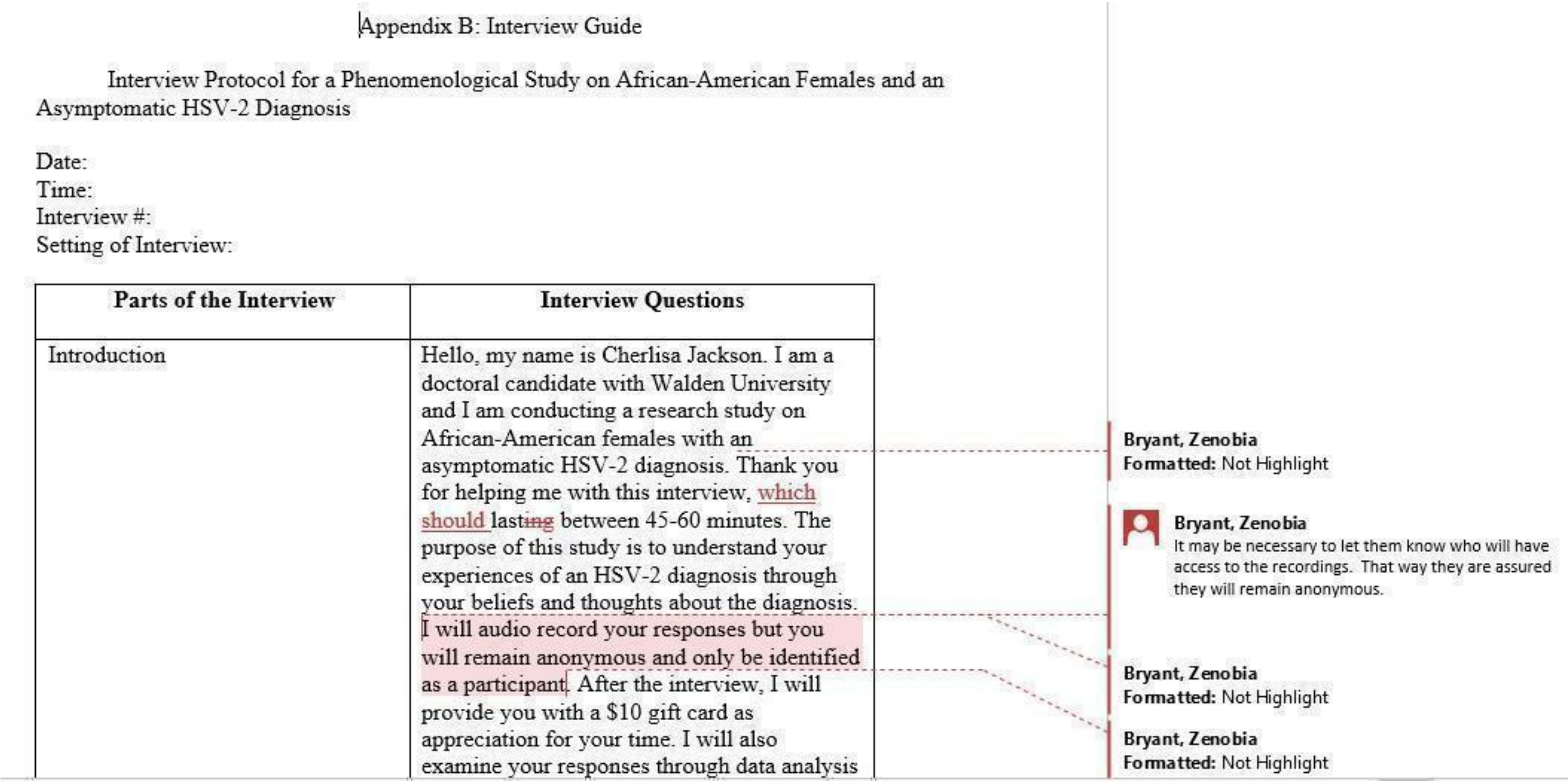
Printed Name: _____Diakima Y. Thomas____
Signature: ____Diakima Y. Thomas, PhD, MPH___________________________________

Date: ______July 21, 2019____

Appendix G: Interview Guide Feedback from Zenobia Bryant



Appendix B: Interview Guide

Interview Protocol for a Phenomenological Study on African-American Females and an Asymptomatic HSV-2 Diagnosis

Date:
Time:
Interview #:
Setting of Interview:

Parts of the Interview	Interview Questions
Introduction	Hello, my name is Cherlisa Jackson. I am a doctoral candidate with Walden University and I am conducting a research study on African-American females with an asymptomatic HSV-2 diagnosis. Thank you for helping me with this interview, which should last~~ing~~ between 45-60 minutes. The purpose of this study is to understand your experiences of an HSV-2 diagnosis through your beliefs and thoughts about the diagnosis. I will audio record your responses but you will remain anonymous and only be identified as a participant. After the interview, I will provide you with a $10 gift card as appreciation for your time. I will also examine your responses through data analysis

Bryant, Zenobia
Formatted: Not Highlight

Bryant, Zenobia
It may be necessary to let them know who will have access to the recordings. That way they are assured they will remain anonymous.

Bryant, Zenobia
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Bryant, Zenobia
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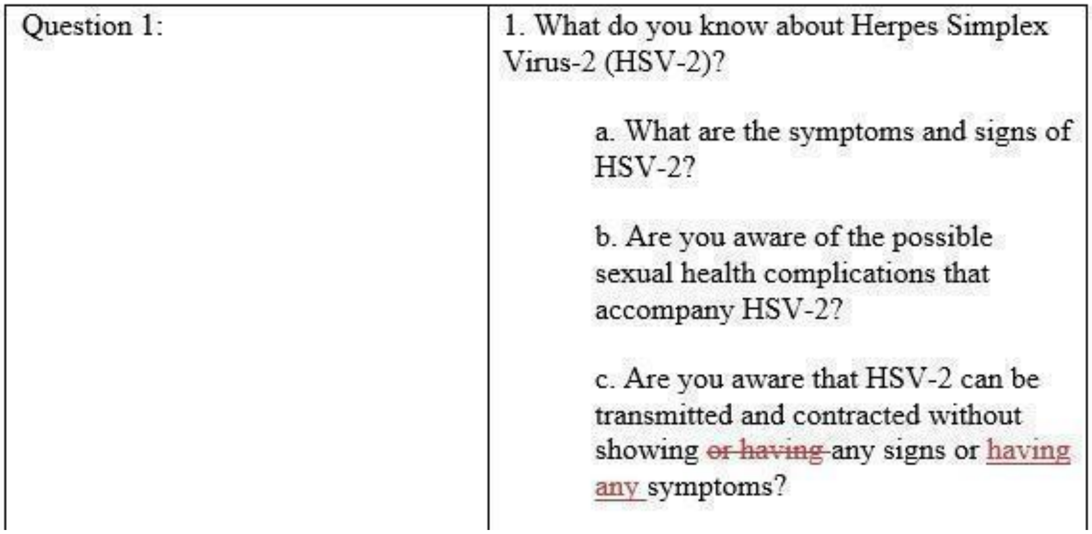

Question 1:	1. What do you know about Herpes Simplex Virus-2 (HSV-2)? a. What are the symptoms and signs of HSV-2? b. Are you aware of the possible sexual health complications that accompany HSV-2? c. Are you aware that HSV-2 can be transmitted and contracted without showing ~~or having~~ any signs or having any symptoms?

Appendix H: Expert Reviewer Acknowledgement from Zenobia Bryant

Date: July 22, 2019
Name: Zenobia Bryant
Credentials: Doctor of Philosophy
Field of Study: Public Health with a concentration in Epidemiology
List Any of Your Publications: Danawi, H., Bryant, Z., & Hasbini, T. (2016). Targeting unintended teen pregnancy in the US. International Journal of Childbirth Education, 31(1).

I, Zenobia Bryant do hereby confirm that I have thoroughly read the Interview Guide provided by doctoral candidate, Cherlisa Jackson. I understand that the expert reviewer process is not complete without sending back the signed acknowledgement for receipt of review to Miss Jackson. I understand that this process is completed via email for my convenience.

________________There are no necessary changes to the Interview Guide provided.
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_______ZB____There are changes needed and I have provided edits.
Initial Here

Printed Name: Zenobia Bryant, PhD

Signature: Zenobia Bryant, PhD

Date: ________________________July 22, 2019_________________________________

Appendix I: Sociodemographic Questionnaire

Please fill in or circle the most appropriate response. Thank you for your responses.

1. Were you biologically born a female?

   Yes No

2. What is your age?________

3. Is your racial group more than just African American or Black?

   If Yes, specify ___________________________ No

4. What is the highest degree or level of school you have completed?

   Some high school, no diploma

   High school graduate, diploma or the equivalent (for example: GED)

   Some college credit, no degree

   Trade/technical/vocational training

   Associate degree Bachelor’s degree Master’s degree

   Doctoral degree

5. What is your marital status?

   Single Dating Married Widowed Divorced Separated

6. What is your employment status?

   Employed Looking for work Not looking for work Homemaker

   Student Military Retired Disability

7. What is your (approximate) annual income? ______________

Appendix J: Reflexive Journal

March 16, 2020 - Interview 1

Did I ask the right questions? I hope that I made enough sense to the follow-up questions I asked. Would this interview have gone differently had it not been online? I thought that transcribing during the interview would be helpful. It feels like it has saved me time in completing the full transcription later.

May 18, 2020 - Interview 2

This participant brought up a different point I have never considered. Does Autism have any connection with a mother having HSV-2 during pregnancy? This might be something to consider later. I may have needed more interview questions that consider pregnancy and time of diagnosis.

June 4, 2020 – Interview 3

This process is getting easier. I noticed a different level of eye contact this time. I am starting to identify a bit better with these questions. Let me continue to remain objective. It is important to ask the questions as is, but your feedback to the responses is okay.

July 6, 2020 – Interview 4

This interview was the easiest, thus far. I believe this may have been due to her energy and research knowledge. I took notes differently and believe that my note-taking may have been stronger. The rapport seems stronger. I am getting familiar with this process and am noticing that reading things verbatim is no longer necessary.

July 24, 2020 – Interview 5

It was challenging not to paraphrase thoughts. I found myself trying to interpret what participants meant rather than writing statements as objectively as possible. Being an African American female but not advocating at all times is challenging, which is often what led to me filling in the blanks of what was being stated. I identified with this interview and various others which posed an added obstacle of keeping my responses research-driven.

July 25, 2020 – Interview 6

This interview was the first where I was able to inform a bit more. Other participants have had experience with their healthcare experiences including the research involved; however, this interview placed me in a position towards health education and promotion. I had to tread lightly in my responses; yet this participant experience also kept me on-topic the most.

August 29, 2020 – Interview 7

The level of knowledge in this interview helped me check my own researched information and resulted in me responding less with statistics. I trusted the reliability in the participant's responses. Are 7 interviews enough? Many of these answers have sounded the same. Her reflections were a bit more extensive than other participants; yet, highlighted many similarities.

Reflection

It was often hard to transcribe completely during the interview. I often found myself trying to translate during transcriptions and paraphrasing. I had to go back and make sure when I transcribed it was fully the participant in the responses and not my interpretation. Though I verified the responses, I still may have indirectly contributed to my own biases in the coding of those responses. I personally know what the person may have implied versus stated because I remember the tones and non-verbal communication of the interviews which often resulted in coding that was interpreted. This resulted in re-coding to ensure I aligned the responses and codes with the research questions versus the evidence based-research.