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The Self-Perceived Cultural Competency of HIV Interventionists

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College of Health Sciences

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Tonya Herring

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Walden University
2019

Abstract

The Self-Perceived Cultural Competency of HIV Interventionists

by

Tonya Herring

MA, Strayer University, 2010

BS, Liberty University, 1999

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health

Walden University

May 2019

Abstract

Despite significant research and inroads with the human immunodeficiency virus (HIV), disparities in HIV infection continue to widen for African American (AA) men who have sex with men (MSM). In recent times, cultural competence has been receiving increased attention as a possible factor to enhance the quality of health messaging and lessening HIV disparities. However, there is a dearth of research specifically dedicated to AA MSM and culturally competent HIV health messages. To address this gap, this qualitative research was designed to investigate the self-perceived cultural competency among HIV counselors. The theoretical framework for the project was the PEN-3 cultural model. The interview participants for the study were 10 HIV interventionists employed with health institutions that partially or entirely specialize in HIV prevention in the Richmond, Virginia, area. The analysis of the data was aided by a phenomenology analytical approach. The results revealed that cultural competence training can be one effective means to enhance the quality of health messages targeting AA MSM. This investigation has social change implications, especially in the context of developing sustainable HIV prevention interventions focused on integrating culture, thereby reducing HIV disparities in the Richmond metropolitan area. The findings may also lend insight into the various ways that health establishments can engage in culturally relevant prevention and position themselves to be leaders in informing the development of culturally competent HIV prevention messages that will aid in the acceleration of changing longstanding, ineffective prevention approaches targeting AA MSM.

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Dedication

I believe education without values can be futile. I dedicate this study to my God, for in him do I live, move, and have my being. I hope He uses this work to highlight the fact that though all humans are of the same type and species, we may be different culturally. But with that said, it only takes a bit of effort to understand one another, a bit of compassion to appreciate one another, and a bit of love to restore one another.

I would like to also dedicate this project to my uncle, Warren Miller. He was a kind and intelligent man who succumbed to HIV complications in 2011. Before his death, he informed me that he was diagnosed with HIV in 1986, when he was just 18 years old. I can't imagine the fear he must have experienced as he watched his community be overrun by this merciless disease.

Acknowledgments

This journey has not been without challenges and vexations. On those rare occasions, when I thought the pressure would derail my goals, I was reminded of a personal decree I made at the start of the process, "I will not falter." Of course a mere aphorism alone did not cause me to persevere, but thanks be to God who gave me the strength through Christ Jesus.

I would like to acknowledge my dissertation Chair, Dr. Fraser, for her dedication to enhancing my project, and guiding me throughout this process. I thank her immensely for her consistent promptness, expertise, and support. I also acknowledge my committee members, Dr. Kennedy and my University Research Reviewer, Dr. Palmer. Thank you both for your expertise and support. I would like to also acknowledge, Dr. Rea, who was an essential piece in facilitating the completion of this project and helping me realize my goal, thank you very much.

I would like to thank my family and friends for their support, and regarding this journey as a shared accomplishment. I fully subscribe to the notion that change in one area can cause reverberating effects for generations to come, so my success is your success. Thank you all for your prayers, encouragement, and simply listening to me when I needed to externalize the pressure that was building up in me.

I would like to thank all of the participants in my study for their time and sharing their knowledge on the subject of HIV prevention in relation to AA MSM. Finally, I would be remiss if I did not give a special thank you to Susan Tellier for her commitment to ensuring the success of this project.

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Chapter 1: Introduction to the Study

Introduction

Despite significant research and inroads with the human immunodeficiency virus (HIV), disparities in HIV infection continue to widen for African American (AA) men who have sex with men (MSM; Centers for Disease Control and Prevention [CDC], 2016a). AAs represent practically half of all new HIV diagnoses and account for 40% of all persons living with HIV in America (CDC, 2016b). Since 2000, AA MSM have outdistanced their White counterparts in HIV diagnoses, although the entire racial group represents 12% of America's population (CDC, n.d.). If HIV trends continue, 50% of AA MSM will be infected at some point in their lifespan (CDC, 2016c).

Racial disparities in HIV diagnoses signify uneven quality in prevention programs (Betancourt, Corbett, & Bondaryk, 2014). Although the causes of these disparities are diverse, Betancourt et al. (2014) proposed that evidence-based approaches exist to confront this gap, one being enhancing cultural competence in prevention messaging. Improving cultural competence with health professional organizations and HIV counselors may prove to reduce racial disparities in HIV (Saha et al., 2013). According to Betancourt et al. (2014), prevention programs and messages are usually developed by individuals from the majority culture and without thoughtfulness of cultural relevance. In an area where behavioral aspects prominently factor into infection, prevention, and intervention, cultural awareness is vital to delivering effective counseling/education (Betancourt et al., 2014). A lack of appreciation for cultural relatedness and the social constructs that increase the risk of HIV including poverty, marginal education, and

unemployment can compromise the effectiveness of prevention programming targeting AA MSM. Weakened prevention efforts do little to alter behaviors that could reduce HIV transmission rates among AA MSM (Betancourt et al., 2014).

In addition to HIV, AA MSM bring multifarious issues to the therapeutic setting; it is crucial for HIV counselors to have more than a baseline awareness of their culture to optimize the outcome of the client-counselor encounter and prevention messaging (Wyatt, 2009). Risk for infection can be heightened consequent to the lack of understanding of how the culture of AA MSM influences behavior (Wyatt, 2009). With regard to the social implications, my research may impel HIV counselors to assess their levels of proficiency with the target population's culture and the ways in which this may affect HIV prevention messages. This may lead to the development and delivery of more culturally competent prevention messages (Wyatt, 2009). Cultural competence is vital for HIV counselors for several reasons including assuring an effective exchange between counselor and client, providing adequate analysis of the information gleaned from interactions, and ensuring appropriate engagement in prevention objectives (Wyatt, 2009).

In the remainder of this chapter, I address the background of the study and the need for this specific project. Also, I discuss the problem statement, the purpose of the study, and the research questions. I then present the theoretical framework for the project, the PEN-3 cultural model. Last in this chapter, I cover the nature of the study, definitions, assumptions, scope and delimitations, limitations, and significance.

Background

Since the genesis of HIV, the CDC and the broader public health community sought to isolate factors that increase HIV infection for those who are at greater risk (Wyatt, Williams, Gupta, & Malebranche, 2012). According to the CDC (2017), AAs represent 40% of those living with HIV and in 2015 AA MSM represented 58% of all new HIV diagnoses. These numbers indicate that pinpointing solely risk behaviors and failing to wholly contextualize the unique individual and environmental contributors of this group may cause HIV messages to be deficient (Wyatt et al., 2012). Iwelunmor, Newsomeb, and Airhihenbuwac (2014) asserted that HIV counselors may be viewed as dismissive if they fail to explore the significance of culture on health. One critical element that has not received adequate consideration has been cultural factors related to sexual decisions; this could enhance HIV prevention messages (Wyatt et al., 2012). Culturally-based behaviors are essential to acknowledge because they frequently provide meaning to an individual or group's identity and define certain aspects of their lives (Wyatt et al., 2012). According to Iwelunmor et al. (2014), considering the cultural dynamics are crucial for health messages to be effective and justifiable. Each culture has specific beliefs about health which can be instructive or protective, but if culture is ignored, this can produce unintended risky sexual behaviors (Wyatt et al., 2012). HIV risks are increased when particular groups fail to receive the needed skills that will be reasonable and consistent with their culture (Wyatt et al., 2012).

Six objectives were formulated for ameliorating health promotion services detailed in the Institute of Medicine's (IOM) report, "Crossing the Quality Chasm"

(Alper, 2016). One objective is to provide health interventions that are equitable; this means interventions/health messages do not differ in quality because of attributes such as race and ethnicity (Alper, 2016). Bernard Rosof, the chief executive officer of the Quality in Healthcare Advisory Group, suggested that effectuating messaging and decreasing disparities involve aligning the health system complexities with the clinician's capabilities, and this alignment entails incorporating cultural competency (Alper, 2016).

That culture is important in health messages for a multicultural and diverse population is not a novel contention (Lucasa, Lakey, Arnetz, & Arnetz, 2010). Research indicated that clinician communication/messaging is in relationship to client satisfaction, compliance with recommendations, and health outcomes (Wyatt et al., 2012). Therefore, adverse health outcomes could result when sociocultural factors are not reconciled by the HIV counselor/clinician (Wyatt et al., 2012). Lucasa et al. (2010) advised that HIV counselors must endeavor to become more culturally competent and integrating this enhancement into health interventions/messages would be beneficial for disenfranchised populations. To realize this goal, it is not necessary for HIV counselors to be adept on every culture and racial group in the United States, but they should be cognizant of their target group and be capable of employing techniques to overcome cultural divisions (Lucasa, et al., 2010). Counselors must be culturally responsive in addressing the needs of clients (Wyatt et al., 2013). Lucasa et al. was passionate about the exercise of incorporating culture into prevention, expressing that it is imperative that HIV counselors understand the importance of cultural competence to health outcomes. Culture affects countless aspects of peoples' lives, to include how people function in society, function

with and within their families, and how they practice religion (Lucasa et al., 2010). Therefore, HIV counselors need to appreciate the associated components of the culture and how it influences the target population's views on health. It would also be prudent for HIV counselors to keep up with the cultural composition of their target population. By knowing their population of interest, HIV counselors will be able to determine the specific culturally concomitant needs of the population, such as the extent of health literacy, their level of education, and other health-related issues (Lucasa et al., 2010).

It would be compelling if HIV counselors enlisted cultural brokers with a similar racial makeup as the population of interest to assist in the creation of health messages (Wyatt, 2009). Leaders in the community and organizations affiliated with the population of interest can be brokers (Wyatt, 2009). Working together with leaders from organizations and the community who are familiar with the target group can be a good means of acquiring valuable information to create effective health messages (Wyatt, 2009). It is Wyatt's contention that race has little to do with cultural competence, therefore, HIV counselors should acquire cultural competence skills irrespective of their race or ethnic makeup (Wyatt et al., 2012).

The gap in knowledge with public health research dedicated to AA MSM in the area of culturally competent HIV health messages is vast given the dearth of studies on this topic (Saha et al., 2013). This research is dedicated to examining the self-perceived cultural competency among HIV counselors who deliver prevention services to AA MSM. Saha et al. (2013) advised that self-assessment is crucial to ensuring that HIV

messages are as effective as they can be. For that reason, HIV counselors should persistently appraise and evaluate their proficiency in cultural competence.

The need for this study is indisputable—it serves to probe an area that is under-researched with important health implications for a marginalized group (Saha et al., 2013). If infection rates hold, it is projected that 5% of AA men and 50% of AA MSM will contract HIV at some point in their lives (CDC, 2016). The statistical implications of this projection can be devastating to an ethnic minority group that only makes up 12% of the U.S. population (Andrasik et al., 2014). In recent times, cultural competence has been receiving increased attention as a possible factor to enhance the quality of health messaging and eradicating HIV disparities (Andrasik et al., 2014).

Problem Statement

Cultural competence can expand an HIV counselor's understanding of the target population's cultural behaviors and environment, thereby ameliorating health communication/messaging on HIV epidemiology and prevention (Michalopoulou, Falzarano, Arfken, & Rosenberg, 2010). A lack of cultural competence can cause HIV prevention messages and activities for AA MSM to be ineffectual (Saha et al., 2013). Cultural competence is largely considered part of the infrastructure for eliminating health disparities through diversity informed health messages (Michalopoulou et al., 2010).

AA MSM continue to be the most HIV-vulnerable group in the United States (CDC, 2016a). Currently, AA MSM have the highest diagnoses of HIV of any racial group in the United States (CDC, 2017). According to the CDC (2017), risk factors exist

for all MSM but there are circumstances specific to AA MSM. These circumstances include the following:

- Socioeconomic factors. Inadequate quality health care, low level of education attainment, lower earnings, and higher joblessness and imprisonment position AA MSM for risk of infection.
- Smaller sexual networks. AA MSM is a small community representative of a larger group, and their sexual partners are commonly of the AA race. Due to the size of the AA MSM community and the epidemical impact of HIV in that community, AA MSM are at increased risk of infection.
- Unaware they are HIV positive. Compared to other races of MSM, AA MSM have a higher percentage of the virus being undiagnosed. Those who are not aware of their status are not participating in HIV care and could unintentionally infect their sex partners.
- Heterosexism, bigotry, and HIV-related stigma. These attitudes heighten the susceptibility of mental health issues and put AA MSM at greater risk of not seeking therapeutic and prevention services.

To address the HIV epidemic in the AA MSM community, the CDC allocated $11 million to local health departments for a 5-year term in 2011 (CDC, 2017a). The CDC has recommitted HIV prevention funds directed toward AA MSM for 2017 (CDC, 2017a). Understanding that funds alone will not be sufficient, the CDC has partnered with other HIV prevention agencies targeting AA MSM (CDC, 2017b). Via its Act Against AIDS movement, the CDC has expressed a commitment to developing culturally

competent prevention messages targeting AA MSM (CDC, 2017b). Some of the campaigns include the following:

- Start Talking. Stop HIV. This campaign aids AA MSM in talking openly about safe sex practices, HIV testing, and other related areas.
- Doing It. This campaign focuses on HIV testing and prevention. It prompts AA MSM to find out about their HIV status and encourages them to make testing a routine to protect themselves.
- HIV Treatment Works. This campaign demonstrates a formula on how to live healthily post HIV diagnosis.
- Partnering and Communicating Together (PACT). The CDC extended a 5-year commitment to partner with HIV organizations that target AA MSM to raise awareness concerning testing, prevention, and provide resources about self-care and health care.

Saha et al. (2013) has challenged public health organizations to enhance their cultural competence based on their study of medical professionals' cultural competence linked with quality HIV messaging/services. They proposed that quality HIV messaging/services are an offshoot of the providers' confidence and sensitivity of their personal cultural competence. Their conclusions indicated that incorporating cultural competent interventions into the clinical setting will cause a decrease in quality care disparities and subsequent health outcomes.

In recent times, there has been an increase in the acceptance of the essential role of culture in relation to health and health behaviors; furthermore, culture can be seen as a

possible method towards enhancing the effectiveness of HIV messages (Wyatt et al., 2013). Wyatt et al. (2013) performed an exhaustive literature review to ascertain which HIV interventions/ messages integrated facets of cultural beliefs. They systematically examined the extent to which HIV interventions/messages adequately focused on cultural beliefs and behaviors of the population at risk for HIV. Wyatt et al. (2013) located 166 interventions and 132 or 66% failed to integrate culture or show evidence of what the research team self-described as having an understanding of approaching HIV in different ways. The conclusions showed that priority should be given to HIV interventions/messages when integrated with aspects of ethnicity and cultural beliefs (Wyatt et al., 2013).

There is a dearth of research that is specifically dedicated to AA MSM and culturally competent HIV health messages (Wyatt et al., 2013). Assessing the role of culture in health messages will be delayed because there does not appear to be enough commitment to exploring this component (Wyatt et al., 2013). According to Wyatt et al., to strengthen health messages, HIV researchers need to include important components related to their target population such as, culture, ethnicity, and sexual orientation.

Purpose of the Study

I have used qualitative research methods, specifically phenomenology, to assess (a) the self-perceived cultural competency among Richmond, Virginia, HIV counselors; (b) how their self-perceived cultural competency affects the development of HIV prevention messages; and (c) how their self-perceived cultural competency affects the

delivery of prevention messages. The phenomenon of interest is HIV counselors' self-perceived cultural competence in relation to AA MSM in prevention efforts.

Research Questions

1. What is the self- perceived cultural competency of HIV counselors delivering HIV prevention services to AA MSM in Richmond, Virginia, and surrounding counties?
2. How do HIV counselors' perceptions of cultural competency affect (a) the development of HIV prevention messages, and (b) their delivery of prevention messages?

Theoretical Framework for the Study

The theoretical framework for the project was the PEN-3 cultural model. This model was first advanced by Airhihenbuwa in 1989 to emphasize the necessity of culture in health interventions and education (Iwelunmora et al., 2014). At the core of this theory is the idea that culture dictates and shapes a person's perception of health and health behaviors (Iwelunmora et al., 2014). I selected this model because of the three dimensions featured in the model: cultural identity, relationships and expectations, and cultural empowerment (Iwelunmora et al., 2014). These dimensions are essential for having an understanding of the development of culturally sound interventions/health messages for AA MSM (Iwelunmora et al., 2014). Also, the PEN-3 model was valuable because it was used to consider the counselors' awareness of culture during the intervention/message development stage (Iwelunmora et al., 2014). The model also helped to centralize culture in the development of interview questions presented to

participants. In terms of the analysis phase, it aided in defining emerging themes from the transcripts. Once interviews were completed, I reviewed the results and scrutinized them further.

Nature of the Study

The study was a qualitative research inquiry. Qualitative research is any type of research that arrives at conclusions without statistical assistance (Cypress, 2015). Investigators conduct this type of research in a context-specific manner to expose an individual's experience with the identified problem (Cypress, 2015). A qualitative approach aided in exploring, exposing, describing, and investigating the problem. An in-depth understanding of the problem is difficult to obtain without a qualitative approach; a quantitative approach cannot provide a deeper understanding (Cypress, 2015). A qualitative approach was apposite for the exploratory research which provided understanding of the self-perceived cultural competency among HIV counselors.

Phenomenology methodology was used for this research. The nature of a phenomenology approach is to relate a lived experience of the problem (Willis, Sullivan-Bolyai, Knafl, & Cohen, 2016). A phenomenological approach proved effective in revealing the opinions of HIV counselors relative to their self-perceived cultural competence in the development and delivery of prevention messages to diverse populations. Data collection can occur in several ways such as, written or oral accounts, art, and more (Willis et al., 2014). However, for this project, I conducted semi-structured interviews. Also, I used thematic analysis to abstract themes from the data.

Definitions

In this section, I have defined and highlighted key terms to reduce the possibility for confusion.

Table 1
Definitions

Source	Definition
CDC (2015)	Cultural competence: A group of consistent behaviors, perceptions, and approaches that work together in an organization or among service workers that creates effectiveness in diverse populations.
SAMHSA (2016)	Cultural competence: A professional's ability to interface with clients of diverse cultures effectively. With individuals as well as agencies, culture should be given attention in every phase of prevention.
Elminowski (2015)	Cultural awareness: The intentional self-examination of personal biases, prejudgments, and suppositions we might have concerning people who are dissimilar from us.

Note. CDC, Centers for Disease Control and Prevention; SAMHSA, Substance Abuse and Mental Health Services Administration.

Assumptions

One assumption that I had for this research was that HIV counselors would be concerned about their cultural competence if they are serving diverse communities. I also assumed that if HIV counselors participated in the study, they would be forthcoming and honest. I hoped to gain their trust to disclose truthfully by ensuring confidentiality. As a screening criterion, each participant would have worked with the target population of AA MSM community in the capacity of an interventionist or as a behavioral counselor.

Scope and Delimitations

In this study, I was focused on the self-perceived cultural competence of HIV counselors who target AA MSM with prevention efforts. The targeted participants were HIV counselors associated with health departments and organizations with an HIV prevention component in the Richmond, Virginia, area. This study only included public health personnel who oversee or are responsible for developing and/or delivering HIV prevention messages. Participants were not excluded based on race.

In terms of delimitation, the study was only focused on HIV counselors in Richmond, Virginia, and surrounding counties and did not include persons outside of this metropolis. Since the study was only concerned with the HIV counselors' cultural competence of AA MSM, competence related to other cultures was not considered. I gave significant effort toward conducting a thorough study; describing the study context and findings comprehensively as to strengthen the possibility of transferability.

Limitations

There was a foreseeable limitation for the research that may weaken the study. I utilized interviews and relied upon HIV counselors' trustworthiness. Self-reporting can be considered limiting in that it is impossible to verify answers involving perception and judgment (Creswell, 2013). Researcher bias could also undermine the study. I have developed opinions about the subject given my exposure to AA MSM. I have provided significant efforts to monitor my bias. I did this by journaling my thoughts to ensure that I was aware of how I was feeling during the data collection and data analyzation phases. Again, I made significant efforts in conducting a thorough study

and describing the study context and findings comprehensively as to strengthen the possibility of transferability. In addition, Creswell (2013) suggested that researchers use a purposeful sample with a phenomenology approach to make certain that study units have similar experiences.

Significance

Cultural competence must be incorporated into prevention messages if they are to be effective for AA MSM. To a significant degree, marginalized communities experience suboptimal prevention services from counselors who have minimal awareness of their culture (Betancourt et al., 2014). HIV counselors often deliver prevention messages from their own socio-cultural perspective which can be contrary to that of the targeted population's culture; it would be advisable to deliver prevention messages that are sensitive to the population's socio-cultural identity to ward against less efficacious prevention messages (Betancourt et al., 2014). This study was distinct in that it served to probe an area that is under-researched with important health implications for a marginalized group.

The social change implications of the study were that HIV counselors would be able to identify their self-perceived cultural competence and the ways in which this affected HIV prevention messages. This may lead to the development and delivery of more culturally competent prevention messages.

Summary

AA MSM are disproportionately affected by HIV. Since 2000, AA MSM have outdistanced their White counterparts in HIV diagnoses, although the entire racial group

only represents 12% of America's population (CDC, n.d.). If HIV trends continue, 50% of AA MSM will be infected at some point in their lifespan (CDC, 2016c). Given the effect cultural competency can have on prevention messages among the AA MSM population, I have explored the self-perceived cultural competency among HIV counselors, and their perceptions concerning the extent to which their competency affects the development and delivery of prevention messages to AA MSM living in Richmond, Virginia.

The following chapter will cover prior research on HIV and cultural competence in relation to AA MSM. I conducted a literature review and ideas were undergirded with prior and current studies. I critically reviewed the literature and further validated and established the need for the study and the chosen theoretical framework.

Chapter 2: Literature Review

Introduction

A lack of cultural competence can cause HIV prevention messages and activities for AA MSM to be ineffectual (Saha et al., 2013). Cultural competence can ameliorate health communication/messaging in HIV epidemiology and prevention and expand a counselor's understanding of the target population's cultural behaviors and environment (Michalopoulou et al., 2010). My purpose in this inquiry was to study and describe the self-perceived cultural competence of HIV counselors in Richmond, Virginia; how their self-perceived cultural competency affects the development of HIV prevention messages; and how their self-perceived cultural competency affects the delivery of prevention messages.

Although in recent years antiretroviral drugs have become more effective, prevention continues to be an indispensable component for combating HIV (Rowniak & Selix, 2016). Broad consensus exists among public health practitioners, medical professionals, and researchers about the vitalness of cultural competence in HIV prevention (Rowniak & Selix, 2016). However, if behavior modification strategies are to be successful, culturally-specific HIV prevention messages should be relevant to AA MSM's sexual health (Freeman, 2010). Because culture affects how AA MSM view their sexuality and health, HIV counselors' ability to deliver culturally competent prevention services could have significant prevention messaging implications (Freeman, 2010).

Race is socially composed and is considerably shaped by cultural and socioeconomic factors including destitution, racism, and underemployment; high risk behaviors can be an attendant of these issues (Vinh-Thomas, Bunch, & Card, 2003). Considering this, prevention messages must be developed and delivered with cultural sensitivity, concentrating on a variety of conditions that impact the risk for infection, giving significant consideration to sociocultural factors (Wyatt et al., 2012). It is crucial to acknowledge the interplay of culture and behavior in view of the fact that several practitioners have endorsed an association amongst cultural competence in prevention messages and services and better health outcomes (Wyatt et al., 2012). Therefore, understanding HIV counselors' self-perceived cultural competence was paramount in my study.

In the remainder of Chapter 2, I will cover additional information on cultural competence in relation to HIV prevention messages and services. Also, I include the literature search strategy and theoretical foundation. Moreover, I will discuss the literature review related to cultural competence, HIV counselors, AA MSM, and prevention messages. Last, I summarize themes in the literature and demonstrate how the study will address a gap in the literature.

I conducted the literature review to pursue information concerning HIV counselors' self-perceived cultural competence in relation to AA MSM and to ascertain whether a gap in the literature exists. I conducted the literature review by accessing Walden University's Library. I performed the iterative search via multiple databases, including CINAHL, MEDLINE, ProQuest, and BioMedCentral. I used Google Scholar

to obtain information from government sources. Web search queries included the following key words: *HIV, African American, MSM, Black, cultural competence, prevention, intervention, HIV counselors, nurses, and sexual health.* I conducted a *CINAHL* and *MEDLINE* simultaneous search; first using *cultural competence, African American* or *Black,* and *HIV*. This specific search produced 54 returns. This initial search failed to yield sufficient returns; therefore, I withdrew *African American* or *Black* and there was a substantial increase in returns. The search terms for ProQuest included *HIV, African American* or *Black,* and *cultural competence* and this query produced several results. BioMedCentral produced numerous results with the same terms inputted. I emphasized keeping the information current; accordingly, most of the articles explored were published within the last 7 years. Those included in the study that fell outside of the timeframe I used in spite of, because they offered value in expanding the understanding of the topic. Moreover, publications older than 7 years I included because of the dearth of research on this subject. I perused and examined many articles on cultural competence and HIV. The queries returned limited information on cultural competence in HIV prevention services for AA MSM. Nevertheless, I was able to locate information from studies that focused on other minority groups to expand on cultural competence in prevention messages/services. I included publications older than 10 years given the limited availability of research designed for AA MSM exploring the cultural competence of HIV prevention efforts. The publication dates of articles used in the literature review generally fell between 2009 and 2018, with most published after 2009.

Theoretical Foundation

PEN-3 Cultural Model

The PEN-3 model has been used to investigate the influence of culture on health for HIV prevention workers (Iwelunmor, Idris, Adelakun, & Airhihenbuwa, 2010). Implementing efficacious culturally competent interventions/messages to advance HIV prevention among AA MSM is vital to eliminating disparities (Iwelunmor et al., 2010). This model positions culture as the most prominent component in the development and implementation of prevention messaging (Iwelunmor et al., 2014a). The PEN-3 model's utility in this study was three fold; I used it to explain the importance of cultural competence in the development and implementation of HIV messages/interventions, it aided in formulating interview questions, and it directed the analysis of responses and interpretation of emerging themes (Iwelunmor et al., 2014a). The PEN-3 model appeared to be the best fit to explore the role of cultural competence in HIV prevention in this study.

Airhihenbuwa first introduced the PEN-3 model in 1989 (Sharma, Branscum, & Atri, 2014). It was originally intended to inform on children's health in Africa. In its early use it was employed to study HIV and healthy eating and exercise in the AA community (Iwelunmor et al., 2014b). Airhihenbuwa developed the PEN-3 as a response to other health behavior theories and models failing to include culture as a factor in health outcomes (Iwelunmor et al., 2014a). The PEN-3 model was designed to concentrate more on culture than behavior to realize lasting positive health outcomes, and also in

developing effective interventions/solutions for marginalized groups (Sharma et al., 2014).

After its debut in 1989, on a broader scale, the model has been used to develop cancer education outreach programs for Hispanics, diabetes intervention initiatives for AA, domestic violence awareness programs geared toward Chinese immigrants, and HIV stigma investigations in South Africa (Iwelunmor et al., 2014b). The PEN-3 can be applied to assist in contextualizing targeted health behaviors (Iwelunmor et al., 2014b). This is carried out by pinpointing pertinent health factors that affect the group of interest, and spotlighting these factors when developing culturally competent health prevention initiatives (Iwelunmor et al., 2014b).

There are three dimensions to the PEN-3 model, and they are all interrelated (Sharma et al., 2014). These dimensions include cultural identity, cultural empowerment, and relationship and expectations (Iwelunmor et al., 2014a). PEN derives from the first letter of each element in the three dimensions as shown in Figure 1 (Sharma et al., 2014).

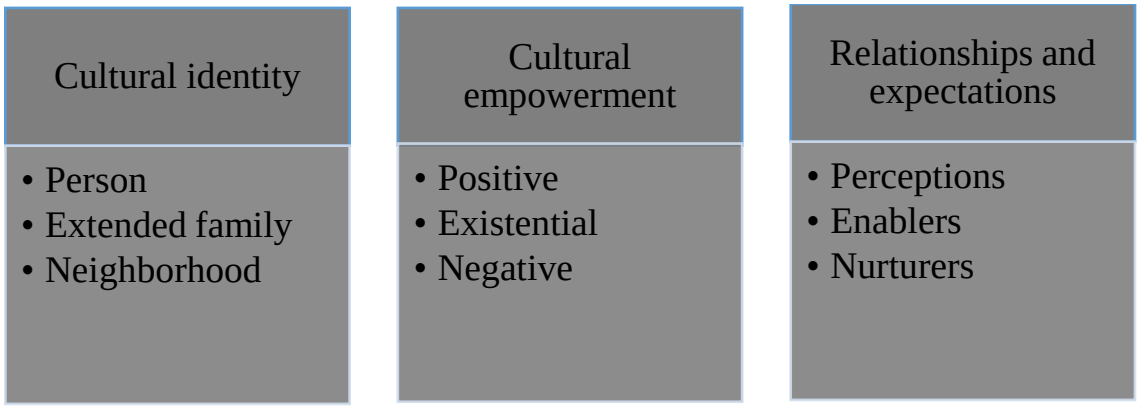

Figure 1. Dimensions of the PEN-3 model.

Cultural identity is the first dimension in the model (Iwelunmor et al., 2014a). The first letter in the acronym, *P*, represents the person, which signifies that the health interventions/prevention should ameliorate the health of each individual and should empower everyone to make informed decisions according to their personal situations. The second letter in the acronym, *E*, represents the extended family, which signifies that even though interventions/prevention may focus on the person, the family should be taken into account as part of the person's context. Last, the *N* represents the neighborhood, which signifies that interventions should consider communities and recognize the value in collaborating with community leaders to make sure that prevention messages are culturally relevant. These dimensions would benefit HIV counselors in helping with defining their audience, AA MSM, their families, and their communities (Iwelunmor et al., 2014a).

Culture empowerment is the second dimension in the model (Sharma et al., 2014). This dimension is important to the development of culturally applicable prevention strategies targeting AA MSM (Sharma et al., 2014). The first letter in the acronym, *P*, represents positive, which signifies that HIV counselors should determine the positive features of the individual, the family, and the neighborhood that will lead to engagement in prevention strategies (Sharma et al., 2014). The second letter in the acronym, *E*, represents existential, which signifies that practices that have no destructive consequences will be incorporated into HIV prevention efforts (Sharma et al., 2014). Last, the *N* represents negative, which involves health beliefs that are detrimental for a person's health (Sharma et al., 2014). Before the development of interventions by HIV

counselors, they should contextualize what is preventing AA MSM from engaging in prevention strategies and what is driving them to engage in destructive health behaviors (Sharma et al., 2014).

Relationships and expectations is the third dimension in the model (Sharma et al., 2014). This dimension is concerned with learning what influencers affect people's behavior (Iwelunmor et al., 2014a). With this dimension, the first letter *P* represents perceptions, this signifies the cultural components that can help or hinder compliance with health prevention recommendations (Iwelunmor et al., 2014a). Also, perceptions indicate the understanding and attitudes that may lead to problems with engagement in HIV prevention strategies (Iwelunmor et al., 2014a). The *E* represents enablers, which signifies the availability of resources on many levels that can either facilitate or impede behavior change (Iwelunmor et al., 2014a). The *N* represents nurturers; these are the people who are within the social system of the individual targeted for prevention efforts who will cultivate or support positive health seeking behavior (Iwelunmor et al., 2014a).

As aforementioned, the PEN-3 model's utility in this study was three fold. First, it was used to explain the importance of cultural competence in the development and implementation of HIV messages/interventions, it aided in formulating interview questions, and it was used as an organizational tool with text in order to separate, define, and delineate emerging themes (Iwelunmor et al., 2014a).

Phenomenology

The main tenet of a qualitative phenomenology inquiry is the subjective human experience (Yan, Song, Liu, Hong, 2017). This methodology can be used to better

understand the structures of consciousness of HIV counselors working with AA MSM. It is a method of describing cultural competence in the first person, investigating just how a person experienced the phenomenon (Tuohy, Cooney, Dowling, Murphy, & Sixmith, 2013). Phenomenology proceeds from the Greek word, *phainomenon*, interpreted as "appearance." Thus, it is an exploration in appearances. In the 18th century, Lambert first presented this concept; however, in 1901, Husserl launched phenomenology into prominence with the manuscript, Logical Investigations (Yan et al., 2017). Today, to engage phenomenology methodology, researchers may use descriptive or interpretive (hermeneutic) methods (Tuohy et al. 2013). I will be using interpretive phenomenology for this inquiry (Tuohy et al., 2013). This path allowed me to describe, decode, and understand the HIV counselors' experiences. With interpretive phenomenology, it is essential for investigators to understand that participants' realities are influenced by their social and cultural frame of reference.

Previous Applications of the PEN-3 Model

Effective health messaging has been well-researched (Oster, Dorell, Mena, Thomas, & Toledo, 2011). However, few studies have been dedicated to examining health messages pertaining to AA MSM (Oster et al., 2011). Arnold et al. (2015) posited that AA MSM are at significant risk of being diagnosed with HIV; however, limited prevention efforts are directed toward their unique health needs. I accessed the CINAHL & MEDLINE database to conduct a search of studies that applied the PEN-3 model and HIV prevention efforts for AA MSM. The search from this database produced 32 peer-reviewed articles. Results specifically focused on HIV when applying the PEN-3 model

were limited. The ProQuest search yielded 20 peer-reviewed results, with none of the studies pertaining directly to AA MSM. For this reason, I conducted a researched-based analysis of the application of the PEN-3 model in the development of prevention and intervention messaging/strategies associated with minorities on a variety of health issues. I mapped each article to ensure that it featured prevention/intervention messaging/strategies and applied the PEN-3 model (Iwelunmor et al., 2010). The literature that informed the analysis of the theory was not perfectly aligned with my research focus, but there was consonance between the PEN-3 cultural model application, minorities, and prevention efforts; following are the articles that I used to demonstrate the theory and prevention research.

Iwelunmor et al. (2010) conducted a systematic review of health studies that applied the PEN-3 model as the theoretical framework in prevention strategies. They collected 45 articles for inclusion in the review. The authors sought to broaden the current research on how culture affects health and examined how the PEN-3 model has been applied to deal with health problems. Although the health problems varied, it was common for the researchers of each study to employ the PEN-3 model to make culture prominent in the development of prevention strategies. Saha et al. (2013) would concur with this premise; the researchers emphasized a need for enhancing cultural competence in HIV prevention efforts targeting AA MSM. As a result of the literature review, Iwelunmor et al. (2010) noted that there was evidence of the PEN-3 model's facility toward providing a way for investigators to explore health behavior and culture from a positive angle. HIV prevention workers/interventionists have experienced a paradigm

shift away from concentrating on negative behaviors to relying on the positive aspects of behavior and culture. This produces a positive leaning toward understanding the manner in which people endure in conditions and environments of hardship and adversity (Iwelunmor et al., 2010). There has been compelling evidence of the advantages of concentrating on the more favorable aspects of behavior and culture. Investigators have come to recognize that focusing on symptomatology and negative traits for prevention strategies was inefficacious toward preventing the spread of disease. Iwelunmor et al. (2010) explained that HIV counselors are permitted to construct culturally relevant prevention strategies when their focus is on positive traits of the target audience's culture and behavior; this is in conjunction with reframing those aspects of their culture that were traditionally considered to be adverse and disadvantageous.

Erwin et al. (2010) applied the PEN-3 model to construct prevention messages and program materials for a cancer intervention initiative targeting Latino women. The researchers conducted 13 separate focus groups that were composed of 112 Latino women from the states of New York and Arkansas (Erwin et al., 2010). In this study, the researchers sought to interpret the diverse perceptions and understanding of Latino women about breast cancer examinations. Erwin et al (2010) advised that the divergent culture of Latino women from the dominant culture in the United States is often disregarded in cancer intervention strategies, and the employment of the PEN-3 model in qualitative research can uncover inequitable practices and cultural variation to ameliorate intervention approaches. The researchers applied the dimensions of the PEN-3 model to

categorize the participants' answers and to construct an effective culturally applicable cancer prevention intervention.

Hiratsuka, Trinidad, and Avey (2016) sought to describe sociocultural factors associated with smoking and cessation. They used the PEN-3 model to construct the research question for the study and to guide the assessment of participants' interviews in understanding the needs related to user participation in discontinuing cigarette smoking with pharmacogenetics treatment. The research participants comprised of three groups: 20 smokers, 12 health care workers (doctors, nurses, and educators), and nine tribal leaders. Through use of the PEN-3, the researchers discovered that smoking by American Indians/Alaska Natives (AI/AN) was attributed to family and tribal expectations, more likely in a positive, enabling fashion. The role of family and community in AI/AN discontinuance of smoking emphasizes the significance of understanding how family contributes to decisions associated with health (Hiratsuka et al., 2016). The PEN-3 model was valuable in underscoring the need to take into account the positive and negative perceptions of health behavior, enablers, and nurturers that could support counselors in developing smoking cessation messaging that is congruent with AI/AN smokers. Also, under the guidance of the PEN-3 model, former AI/AN smokers who were integrated into the cessation treatment program helped to change the community's skeptical perceptions of the health promotion program.

Matthews, Sánchez-Johnsen, and King (2009) conducted a pilot study to explore how the PEN-3 model was applied to an AA smoking cessation program in Chicago. The participants included 8 AA smokers who met the conditions of: Ethnicity, smoking at

least one cigarette a day, engaging in smoking for a minimum of 12 months, education exceeding 9th grade, understanding spoken and written English, and a non-homeless status (Matthews et al., 2009). In this study, the PEN-3 model was used to obtain a better understanding of participants and factors that influenced smoking habits. The investigators focused on the first phase of the model, person, extended family, and neighborhood. The researchers targeted neighborhoods in Chicago that were comprised of AAs with low-socioeconomic status. The second module of the PEN-3 was incorporated by conducting a literature search on how perceptions, enablers, and nurturers affected barriers to cessation treatment. These variables were incorporated in educational packaging, as well as infusing language relevant to the target group within the curriculum. The results suggested that incorporating the modules of the PEN-3 model into the smoking intervention study is effective in ameliorating smoking termination outcomes for AA smokers (Matthews et al., 2009).

Han, Perumalswami, Kleinman, and Jandorf (2013) conducted a study to assess the impact the PEN-3 model had on follow-up appointments subsequent to viral hepatitis diagnoses. As an antecedent to liver cancer, the researchers sought to reduce the burden of viral hepatitis by exploring the barriers and enablers to follow-up treatment by conducting semi structured participant interviews with 20 primary care doctors who treated people from migrant communities. The PEN-3 model was incorporated as part of the theoretical framework to assist the researchers in understanding perceptions about factors that affected follow-up, enablers that contributed to the beliefs or practice of follow-up, and nurturers that strengthened these convictions. With the use of the PEN-3

model, the researchers were able to identify several barriers to follow-up treatment. These barriers were used to inform the development of culturally targeted interventions to increase participation and treatment.

Each of the aforementioned studies utilized the PEN-3 cultural model as the theoretical framework. Iwelunmor et al. (2010) suggested that consideration of culture-specific factors could enhance prevention messages. The model derives from the premise that culture is a forceful variable affecting decision making and how people interpret health communication (Erwin et al., 2010). Accordingly, each of the studies found the model useful in identifying cultural factors that contributed to a group's health vulnerability.

Previous Applications of Phenomenology

A study was conducted to investigate microaggressions of counselors being trained to address mental health issues (Smith, Chang, & Orr, 2017). The study included 24 trainees who were all in a master's degree program at Southeastern University. Phenomenology was used to explore the significance of microaggressions and their first-hand experience with this attitude/behavior. Journals comprising written and photographic expressions from the trainees were used to reveal opinions and feelings concerning the phenomenon. Grounding the investigation in phenomenology allowed for a deeper reflection, and subsequently richer data of what the participants experienced (Smith et al., 2017). The overarching themes of the subjects' journals were denial, panic, recognition, and action.

Tillman, Creel, and Pryor (2016) conducted a study using interpretive phenomenology to explore the attitudes of 30 students enrolled in a nursing program who provided health services to members of the LGBT community at a health fair. Students completed semi structured interviews to communicate their perceptions and opinions about the health fair in relation to their preparedness in caring for this population. The participants described their feelings as empathic given the sociopolitical challenges that the LGBT community has to endure. However, the results showed that the ambiguity of gender was extremely confounding and anxiety provoking for the students/participants. The subjects reported that prior to the day of the fair exposure to the LGBT community in a health forum was minimum. The themes that emerged from the quantitative-phenomenology methodology were: blurring of gender roles, acceptance, and love of school (Tillman, Creel, & Pryor, 2016).

A phenomenological study was conducted to explore the impetuses and experiences of being a Hassidic Jewish foster parent of children provided by a secular human services program (Huss & Englesman, 2017). The participants were interviewed to obtain information on how ultra-orthodox religious parents experienced fostering children who shared their religious beliefs after being placed in their home by a secularized foster program. There were 20 female subjects, aged 20 to 40 years, who usually had 6 to 12 year old children within their care, and had more than 2 years of fostering experience. After the data were thematically analyzed, the result showed that there was an altruistic quality to fostering children outside of their religious group. The themes revealed the customary challenges when taking in a foster child such as sibling

rivalry and trouble with biological parents. The study results also showed that fostering special needs children can impact the chances of their foster siblings marrying due to the stigma (Huss & Englesman, 2017).

Rationale for Theory

The PEN-3 model was first used in Africa to provide a theoretical framework to develop health programs directed at children's safety (Iwelunmor et al., 2010). Despite the country or the health problem, the PEN-3 model is typically employed to guide researchers in centralizing culture while seeking to understand health behaviors and to incorporate culturally appropriate elements in the development of effective health prevention messages (Iwelunmor et al., 2010). According to Freeman (2010), effective HIV prevention messages need to be guided by a model that considers AA MSM and their complex relationships. Further, Freeman (2010) determined that conceptual frameworks that neglect to utilize cultural contexts of AA MSM undermine the researchers' facility towards developing effective HIV prevention strategies. The PEN-3 model provides a path to assist researchers in understanding the complexity of health problems by integrating cultural beliefs that influence behavior through championing, accepting, and/or discouraging health behavior (Hiratsuka et al., 2016).

The PEN-3 model helped with understanding the self-perceptions of HIV counselors' cultural competence, and interviews informed on persons they consider central to affecting health decisions for AA MSM, the role of family in AA MSM health decisions, and the context of the neighborhood that influence decision-making in health behavior (Hiratsuka et al., 2016). Also, with investigating the self-perceptions of HIV

counselors' cultural competence, domain 2 aided with identifying the factors they feel hinder or promote health behavior, the community aspects that affect health behavior, and those community influencers that strengthen behavior (Hiratsuka et al., 2016). Further, domain 3 helped in identifying the factors adjudged to promote engagement in specific health behaviors, negative aspects that prevent engagement in health behavior, and characteristics unique to the culture that should be integrated in prevention messages.

The PEN-3 model related to the current study by providing a framework that addressed the purpose and questions of the research; it gave insight into the self-perceived cultural competence of HIV counselors in Richmond, Virginia, how their self-perceived cultural competency affects the development of HIV prevention messages, and how their self-perceived cultural competency affects the delivery of prevention messages. The model was used to centralize the culture of AA MSM health behaviors in relation to HIV and bring forth culturally relevant components (Iwelunmor et al., 2014b). The PEN-3 model was also used to organize themes during data analysis.

A phenomenological approach was effective in revealing the opinions of HIV counselors relative to their self-perceived cultural competence in the development and delivery of prevention messages to diverse populations. Interpretive phenomenology allowed a path that gave meaning to participants' experiences. The implications of this provided a phenomenological lens into how decision making and behavior are influenced (Meyer, 2017). The investigative value of the phenomenology approach was found in the insight it provided into HIV counselors/prevention workers subjective experiences with their own cultural competence related to providing education for AA MSM (Ivey, 2013).

HIV Prevention and Key Concepts

The key concepts included in the literature review were cultural competence, culturally competent education, cultural awareness, and HIV prevention with AA MSM. The lethality of HIV impacts gay and bisexual men of all racial groups, but with an extraordinarily devastating assault on AA MSM (Rausch, Dieffenbach, Cheever, & Fenton, 2011). This group accounts for 9% of men in America who engage in sex with men; however, they represent 38% of new HIV diagnoses (Andrasik et al., 2014). According to the CDC (2016c), if trends persist, 50% of AA MSM will be infected with HIV at some point in their lifespan. According to Wyatt et al. (2014), HIV prevention efforts would prove more effectual if they went beyond factors such as gender, drug use, and sexual preferences, and integrated cultural beliefs in the development of prevention messages. Colón and Malow (2010) supported opportunities for constructing HIV prevention services that are culturally competent for HIV prevention workers who are tasked with the development and delivery of prevention messages/communication. HIV prevention counselors/organizations should be aware that adapting culturally competent evidence based services/messaging will provide optimal benefit to AA MSM (Colón & Malow, 2010). Many HIV prevention workers are acquainted with their target audience's culture; nevertheless, Colón and Malow (2010) suggested they fall short of being well-informed as to how their target population's cultural background affects HIV risk behavior.

Cultural Competence

As aforementioned, AA MSM carry the severest burden of HIV in the United States (Arnold et al., 2015). Arnold et al. suggested there may be dissonance in prevention communication with the AA MSM community as many AA MSM reject long-established HIV prevention efforts, which they feel are not specifically customized for their unique needs. Williams, Ramamurthi, Manago, and Harawa (2009) advised that more HIV prevention initiatives should have explicit cultural components targeting AA MSM given the disease burden on this group.

Arnold et al. (2015) conducted focus groups to try out their culturally tailored prevention strategy with 61 AA MSM. The study, The Bruthas Project, involved a research team consisting of HIV prevention workers associated with universities with extensive experience in counseling and health education of the AA community. The results were based on the 36 remaining participants after 25 dropped out of the study. Upon completion, the findings showed a substantial decrease in unprotected sex and a reduction in sex when in an altered state of mind by drugs or alcohol. Additionally, the participants reported an increase in social support and feelings of self-worth and diminished loneliness (Arnold et al., 2015). The investigators discovered that integrating cultural elements into prevention work causes the tone and intention to resonate with AA MSM.

Saha et al. (2013) contended that health organizations have long endorsed increasing cultural competence with health practitioners to ensure effective prevention and intervention work. The researchers surveyed participants from four HIV medical

centers, which included 45 health providers and 437 patients to assess the relationship of cultural competence and quality prevention/intervention. The Enhancing Communication and HIV Outcomes Study was carried out to examine the association of provider cultural competence in relation to effective HIV interventions. The results revealed that enhancing cultural competency in HIV prevention/intervention work could improve strategies to shrink HIV disparities.

Benefits of cultural competence. Gatson (2013) conducted research that was unique in that it assessed cultural competence from the patients' perspective rather than the providers/intervention workers' perspective. The researcher employed a cross sectional, descriptive approach in which the association between AA opinions of HIV interventionists' cultural competence and the participants' adherence to prescribed recommendations and treatments was investigated. There were 202 AA patients in the sample who completed a survey during medical visits. The results showed more participants would like their providers to incorporate their culture into HIV therapeutic modalities; they believed this would result in an increase in their adherence to medical instructions. The findings specified the need for enhanced focus on centralizing cultural competence in HIV intervention. In the opinion of Gatson, considering participants' perceptions of cultural competence has great possibilities in ameliorating HIV intervention adherence and HIV outcomes.

Wyatt (2009) presented an approach for designing HIV prevention messages that was somewhat compatible with the dimensions of the PEN-3 model. She suggested that innovative HIV prevention messages would increase in effectiveness if they were aligned

with AA HIV risk reduction methods and cultural factors. Adjusting and customizing long-established HIV interventions for AA MSM would be beneficial for the person, family, and communities. Integral to effective HIV prevention for AA MSM is the cultural competence of the interventionist. Culturally competent HIV counselors have a crucial skill set that would increase the prospect of integrating cultural components into traditional HIV strategies (Wyatt, 2009). Their understanding of the culture of AA MSM determines how well they construct strategies and the impact of the intervention.

Colón and Malow (2010) supported opportunities for constructing HIV prevention services that are culturally competent for HIV prevention workers who are tasked with the development and delivery of prevention messages/communication. HIV prevention counselors/organizations should be aware that adapting culturally competent evidence based services/messaging will provide optimal benefit to the target audience (Colón & Malow, 2010). Many HIV prevention workers are acquainted with their target audience's culture; nevertheless, they fall short of being well-informed as to how their target population's cultural background affects HIV risk behavior (Colón & Malow, 2010).

Cultural Competence Training

Though there is no real consensus on the causes of health disparities, social station, economic conditions, insurance status, and provider expertise could possibly be determinants (Alizadeh & Chavan, 2016). The cultural competence of those working on the front lines to forestall disease has been advanced as a viable solution for health disparities and poor health outcomes. Yet, after decades of making an effort at

integrating cultural competence into the health services context, there is dispute about operationalizing this construct (Alizadeh & Chavan, 2016). Whether referred to as cultural diversity training or cultural competence training, the concept was first introduced in 1988 to address the mental health needs of Hispanic and AA children (McCalman, Jongen, & Bainbridge, 2017). Since its initial application, cultural competence training has been making gains in its use among health practitioners to improve their health services to disenfranchised communities. Widening health disparities in the 1990s prompted a sweeping acknowledgment of the essential role of culture as a significant element contributing to health and health behaviors, and feasibly the factor that is able to enhance the effectiveness of HIV prevention messages and interventions (Wyatt et al., 2012).

Based on their comprehensive literature review, Wyatt et al. (2012) comprised an 11 step process for incorporating cultural facets into HIV prevention intervention: (1) HIV counselors must be culturally aware of norms and behaviors of the communities they serve. Cultural competence involves having a proficiency towards communicating with and formulating health strategies for targeted diverse groups. Also, HIV counselors should be adept at incorporating cultural elements into HIV messages to increase their efficaciousness; (2) HIV counselors should target specific communities with an understanding of the role culture plays in race and those populations on the periphery of society such as the LGBT community; (3) researchers should carry out studies with a sufficient sample size to broaden the range of conclusions; (4) HIV counselors need to work collaboratively with community leaders to construct culturally congruent

prevention messages; (5) research should focus on those issues related to life experiences and circumstances applicable to the targeted population. This included identifying those factors that serve as mediators or moderators to healthier sex practices; (6) HIV prevention messages should be culturally congruent and based on positive aspects of the population's culture; (7) HIV counselors should integrate the target population's history and socialization that help form health behaviors into health messages; (8) consideration should be given to deciphering how the target population's cultural values impact knowledge and behavior; (9) culture should be considered an evolving construct. Cultural identity can be impacted by age, economic status, social circumstances, and religion; (10) it is important to give attention to marginalized persons' lack of access to health information and other identified barriers that impede change; (11) among diverse populations, the most fitting strategy is to incorporate linguistic preference and specific cultural vulnerabilities into health messages.

Cultural competence training can be one effective means to enhance the quality of health messages for AA MSM (Malat, 2013). Such trainings can expose HIV counselors to the obstacles their target population faces and can lend itself to a context in which they can adequately address those barriers within their health communications. Research produced minimal HIV prevention cultural competence curricula that are widely recognized when working with AA MSM. However, AA MSM style trainings that are present appear to be comparable in structure and content, emphasizing components: (1) historical and social elements of the target group and dialect of the target group; (2) differences among gender expression and sexual orientation; (3) clinical approach to

addressing distinctive health care needs of AA MSM, including ways to affirm and maintain the dignity of the representatives of the marginalized population (Orgel, 2017).

The Office of Minority Health (OMH, 2017) advised that if practitioners tailor services to a population's culture, they can experience positive health outcomes. Therefore, in 2000 the OMG developed guidelines, the culturally and linguistically appropriate services (CLAS); it was refined in 2013 (Office of Minority Health, 2017). CLAS is responsive to the health needs of racial and ethnic minorities; these procedures or guidelines inform culturally sensitive practices (Office of Minority Health, 2016). The framework includes standards, governance and leadership, communication, and engagement, and continuous improvement. In terms of standards, it is recommended that health services become responsive to diverse groups by providing equitable and respectful intervention/prevention activities in accordance to the health belief of that population. Governance and leadership address the adoption of health equity policy, recruitment of diverse leadership and personnel, and the education of personnel in culturally competent practices. With regard to communication, health information is developed and disseminated after first understanding the needs of the population. It is also recommended that health material is in easy to understand diction. Lastly, engagement and continuous improvement introduces culturally competent goals throughout the health services process. It also involves partnering with the target population and assets of the community to increase the possibility of developing culturally appropriate interventions (Office of Minority Health, 2016).

To create positive change with AA MSM and the HIV epidemic, prevention messengers should know the cultural context of the population (SAMHSA, 2016). Likewise, HIV prevention counselors must have the desire and capability to develop prevention strategies within the cultural context of their target population. This means relying on community-based principles and collaborating with those from the community that are close to the issue of interest. There are actionable steps that HIV counselors can take to ensure prevention messages are culturally competent (Delphin-Rittmon, Andres-Hyman, Flanagan, & Davidson, 2013). Below, in Figure 2, are the actionable steps (Delphin-Rittmon et al., 2013).

Actionable steps to cultural competence	Course of action
Ensure accountability	Align oneself with policy; Adhere to culturally competent standards of the organization
Collaborate with key community leaders and foster beneficial partnerships	Encourage participation in an advisory capacity from stakeholders; and cultivate community relationships
Participate in cultural competence evaluations	Carry out service satisfaction evaluations
Develop linguistic competence	Utilize linguistic services assistance
Create strategies for the target population's grievances	Develop a structured process for formally documenting and addressing issues

Figure 2. *Actionable steps to cultural competence*.

Cultural Awareness

Cultural awareness refers to the intentional self–examination of personal biases, prejudgments, and suppositions people might have concerning others who are dissimilar (Elminowski, 2015). The investigator conducted a study to explore cultural awareness and to assess the effectiveness of a cultural education seminar; the effectiveness of the

seminar on the participants was gauged by a pre and post-test. The goal of the investigation was to improve cultural knowledge amongst participants. The conference topics consisted of familiarizing the participants with the following terminology: ways to become culturally competent, centralizing culture when developing interventions, health beliefs, technique for improved patient compliance, and barriers to effective communication. The findings indicated that diversity training is an effective method to increase cross-cultural learning (Elminowski, 2015). The scores of the post-test increased considerably from that of the pre-test; this signified that there was improved cultural awareness and an openness to diversity subsequent to the forum. Based on the findings, Elminowski proposed that culturally competent services/ health messages increased the chances of cooperation, dialogue amongst professionals and clients, and improved compliance.

The U.S. Census Bureau reported there will not be a majority ethnic group by 2044 (Conway-Klaassen & Maness, 2017). With demographics changing, Conway-Klaassen and Maness (2017) believe it is crucial for HIV counselors/interventionists to adjust their approach to the target group's culture. The target audience's culture can influence its approach to health, illness, treatment, and the manner in which healthcare and health information is navigated. Education in cultural awareness can enable changes in attitude and actions when interacting with those of diverse cultures. It is essential to understand that culture can impact the manner in which people follow through with health recommendations and interact with health practitioners. Culture can influence their opinion about health, cause of disease and their level of trust in health practitioners.

Culture can dramatically affect a client's view on healing from diseases and their level of trust in the recommendations given by health interventionist for wellness (Conway-Klaassen & Maness, 2017). Making use of cultural elements from the target group can stimulate cooperation, increase adherence, and enhance prevention work/messages (Conway-Klaassen & Maness, 2017). Based on the literature, cultural awareness in conjunction with self-examination of biasness can enhance cultural competency and improve health outcomes.

Natesan, Webb-Hasan, Carter, and Walter (2011) referred to cultural awareness as the extent to which actions are informed by the target group's culture. Pesquera, Yoder, and Lynk (2008) asserted that self-awareness is one of the most crucial factors to ameliorating cultural competency skills when interacting cross culturally in the health environment. Findings showed that different cultures view health care differently and this can impact their perceptions of health workers and their intentions to comply with intervention strategies. Findings also showed that stereotypic practices toward disadvantaged communities along with bias experienced inside and outside of health environments can impact perceptions as well. Health service workers may feel that AAs are more apt to shun treatment and are more inclined to display health risk behaviors than Whites. According to Pesquera et al. (2008), AAs historically do not hold the health care system in America in high regard; customarily, after a diagnosis they rely on family for support and their religion for restorative powers. Therefore, interventionists with the most cultural knowledge of their target audience will have a significant advantage when it comes to developing and delivering prevention plans (Pesquera et al., 2008).

HIV Prevention with AA MSM

Perry-Mitchell and Davis-Maye (2017) conducted a review of HIV prevention strategies that were evidenced-based and centralized AA culture when designing interventions. The literature was surveyed by the researchers and HIV prevention strategies targeting AAs and centralizing culture were identified (Perry-Mitchell & Davis-Maye, 2017). Based on the review, they found that the most affected population, the AA community, could benefit from prevention programming/messaging when they are well thought out and founded on AA centered evidence-based frameworks. According to Perry-Mitchell and Davis-Maye (2017), AA MSM who feel disenfranchised, reside in chaotic neighborhoods, have low socioeconomic status, and are largely discriminated against by the broader society; they require programming/prevention messaging that promote cultural avenues of nurturance and encouragement. Based on the findings, it would be beneficial for HIV workers commissioned to aid those at risk of being infected with HIV to be thoughtful about AA MSM's experiences while ensuring that values, cultural aspects, and 400 years of marginalization be addressed (Perry-Mitchell & Davis-Maye, 2017).

Williams et al. (2009) developed an intervention, Men of AA Legacy Empowering Self (MAALES); it is a culturally centered HIV intervention focused on AA MSM. The MAALES intervention was structured based on the critical thinking and cultural affirmation model (CTCA) (Perry-Mitchell & Davis-May, 2017). The CTCA model integrates enablement and cultural affirmation to confront historically based discrimination and how it may affect a person's perception of HIV counselors and the

adoption of HIV prevention/intervention strategies (Perry-Mitchell & Davis-May, 2017). The MAALES consist of multiple sessions; the themes include safe spaces, observing the past, self-esteem, perseverance, love and self-control, and prudence. With every session, the researchers integrated culturally centered aspects into activities including music and affirmations groups. These groups were in part designed to impart cultural pride, minimize HIV risk behaviors, promote health, and increase protections relative to health (Perry-Mitchell & Davis-May, 2017). The study was held in public health organizations between the years of 2007-2011 with 381 participants (Perry-Mitchell & Davis-May, 2017). The findings indicated that culturally centered prevention initiatives are an essential step to developing efficacious HIV prevention messages/strategies targeting AA MSM. The results of the study showed a decrease in condomless sex with AA MSM.

Wyatt et al. (2012) posited that in order for HIV prevention messages to reach AA MSM, they must integrate culture. For this reason, they conducted a review of the literature to investigate prevention initiatives that incorporated cultural concepts. There were 166 HIV prevention initiatives identified of which 34 incorporated culture into their HIV prevention and reduction messages. The selected articles met the criteria: peer reviewed articles, HIV prevention as it relates to the United States, and reported intervention findings. Subsequent to their investigation, the researchers concluded that the development of guidelines for incorporating culture into HIV risk reduction messages should be given priority to fortify the prevention initiative. Although some critics argue that the focus on cultural beliefs in a general sense reinforces stereotypes, Wyatt et al. found that it is difficult to wholly evaluate because culture is not adequately studied.

Culture has a significant role in determining the health of people (Saha et al., 2013). This is quite relevant in the context of minorities, using archetypical prevention messages without infusing a more culturally-specific focus that incorporates important influencers of the culture, for example, life experiences and cultural beliefs could compromise HIV prevention efforts (Saha et al., 2013). Being culturally competent in HIV prevention requires familiarizing counselors with new ways of functioning and effectively employing them in the targeted settings (CDC, 2015b). In order for HIV prevention to be successful, the unique needs of AA MSM—marginalized due to race, educational and socioeconomic levels, and sexual identity must be addressed thoughtfully (CDC, 2015b).

PrEP is a relatively modern biomedical strategy for HIV prevention (Eaton et al., 2017b). Using PrEP or any other antiretroviral therapy is immensely effective for AA MSM who are HIV negative. When factoring in the culture of AA MSM, conspiracy beliefs may impact the implementation of PrEP. These conspiracy beliefs derive from a historically based pattern of malfeasances by health establishments (Eaton et al., 2017b). The study conducted by Fields et al. (2017) supported this notion. A large portion of the participants expressed suspicions concerning PrEP, and reported feeling that it was a self-serving medical trap for AA MSM. At the other end of the spectrum, and another sociocultural issue, is the commentary surrounding PrEP. Those who use the drug were labeled as “Truvada Whores” and were said to be simply accommodating their promiscuity (Eaton et al., 2017b). A study conducted by Fields et al. (2017) corroborated this notion. The researcher found that many of the participants associated promiscuity

with those who use the drug (Filed et al., 2017). This could be a potential barrier to PrEP adherence.

Although social support and family ties are not necessarily unique to AA culture, the bedrock of Black culture has been the family. Increased adherence to HIV prevention recommendations among AA MSM is associated with social support (Scott et al., 2014). Scott et al. conducted a study to explore the relationship between social support and HIV testing among AA MSM. The results demonstrated that social support contributed to more HIV testing and even acted as a buffer for experiences of homophobia for AA MSM. This finding buttressed other studies that reported a relationship with social support and better health outcomes, for instance, lower incidences of unprotected sex. One such study conducted by LeGrand, Muessig, Pike, Baltierra, and Hightow-Weidman (2014) also found a correlation with social support and a reduction in sexual risky behaviors. Therefore, LeGrand et al. (2014) suggested integrating these features into HIV prevention messages/services targeting AA MSM.

Many AA MSM are economically disadvantaged and reside in urban poverty areas (CDC, 2017a). Studies show that a delay in HIV testing is associated with food insecurity and housing instability (Aidala et al., 2016). A systematic review of 152 studies was conducted and found that targeted housing assistance can be a significant component to increased retention in HIV services. The results linked poor housing status with poorer outcomes. Aidala et al. (2016) found that housing instability was a major hindrance to consistent engagement with HIV prevention interventions. The U. S. Department of Housing and Urban Development (HUD) agrees with the emerging

evidence that associates housing assistance with better HIV health outcomes (HOPWA, 2013). It is HUD's position that health systems, in order to be effective, must take into consideration the determinants of health. Further, integrating them into HIV interventions and establishing strategic collaborations would promote full engagement into care (HOPWA, 2013).

Race is socially composed and is considerably shaped by cultural and socioeconomic factors including destitution, racism, and underemployment (Vinh-Thomas et al., 2003). Food security as a significant factor in HIV prevention is increasing in momentum. Anema, Vogenthaler, Frongillo, Kadiyala, and Weiser (2009) introduced evidence that food insecurity is associated with HIV prevention engagement. Anema (2009) uncovered evidence that food insecurity significantly impacts HIV behavior risks, is linked to poor clinical outcomes, and is associated with hindering access to HIV prevention services.

Statistics in Virginia. Approximately 39,393 people were diagnosed with HIV in the United States in 2015, but the numbers could be greater than estimated as 1 in 7 are unaware of their infected status (CDC, 2017c). Among the 50 states, Virginia placed 12th in HIV diagnoses in 2015 (CDC, 2017c). Approximately 67.6% of the new diagnoses in 2015 were among MSM of which 43% were AA MSM (VDH, 2016). Overall, MSM are more likely to be diagnosed with the disease. Statistics show an increase in MSM HIV cases from 2004-2014, estimating that 54% of MSM in the United States were diagnosed with HIV during this time. In Virginia, men who identify as MSM or engage in sexual contact with men are estimated at 6.2% of the population; 6.7% are

White, 5.2% are AA, and 6.4% are Hispanic (VDH, 2016). In 2017, Virginia's population was 8,470,020. The demographical breakdown was 19.8% AA, 70% White, 9.1% Hispanic, and 6.6% Asian (United States Census Bureau, 2017). Virginia is considered a medium size state, containing 38 cities and 95 counties (VDH, 2016).

Local health departments in VA. The commonwealth of Virginia consists of five health regions and 35 districts (VDH, 2016). Within these regions and districts are several LHDs. Virginia's LHDs are essential for HIV prevention due to their accessibility to those severely burdened by the disease (Smith et al., 2016). These LHDs provide a range of prevention and care services for those residing in their district. Their relationship with those populations most impacted by the HIV epidemic has demonstrated their criticalness to the execution of effective prevention messages/interventions. According to Smith et al. (2016), the original work of LHDs entailed providing support for those living with the disease and advocacy for care and HIV research. As a result of research providing evidential support towards effective intervention pathways, local health departments now include testing, educational resources, and group and individual counseling (Smith et al., 2016).

Summary and Conclusions

In summary, cultural competence can ameliorate health communication/messaging on HIV epidemiology and prevention and expand a counselor's understanding of the target population's cultural behaviors and environment (Michalopoulou et al., 2010). There is a dearth of research related to AA MSM and practitioners' cultural competence. Therefore, the search for relevant, congruent

literature was sparse. Culture has a significant role in determining the health of people (Iwelunmora et al., 2014). Understanding the self-perceived cultural competency of HIV counselors is essential because it is associated with effective health messaging, compliance, and health outcomes (Wyatt et al., 2012). The information from this investigation could be a step toward addressing the gaps for HIV prevention messages and AA MSM and provide recommendations for enhancing the cultural competence of HIV counselors. In chapter 2, I introduced cultural competence and conducted a literature review that concentrated on furthering the understanding of the concept and elaborated upon how cultural competence elevates prevention messages/services and may possibly impact health outcomes. Despite understanding the need for increase cultural competence in health interventions, the review of the literature revealed an enormous research gap associated with a dearth of studies dedicated to the subject. This investigation aimed to build upon previous research on cultural competence and HIV prevention for AA MSM. In the upcoming chapter, details on the research design, role of the researcher, methodology, issues of trustworthiness, and the summary are provided.

Chapter 3: Research Method

Introduction

I designed this investigation to examine the self-perceived cultural competency of HIV counselors delivering HIV prevention services to the AA MSM population. Chapter 3 is composed of the research design and rationale, the role of the researcher, and the methodology.

I conducted this study to increase understanding of HIV counselors' perceptions of their cultural competence and effectiveness in delivering prevention services to AA MSM. Although presently HIV among the AA MSM community is considered an epidemic, there is a paucity of studies focused on AA MSM and HIV culturally competent prevention services (Wilson et al., 2016). A qualitative approach will yield in-depth information on the self-perceived cultural competence of HIV interventionists who serve AA MSM (Wilson et al., 2016).

I conducted a qualitative study using an interpretive phenomenological framework, which permitted me to concentrate on what the participants experience and how they interpret events (Shen, 2015). As mentioned in Chapter 1, the main tenet of a qualitative phenomenology inquiry is the subjective human experience (Yan et al., 2017). I used this methodology to better understand the structures of consciousness, meaning, the perceptions and mental processes of HIV counselors working with AA MSM. Exploring human phenomena qualitatively was first established in the social sciences (Cypress, 2015). This methodology lends itself to an interpretational approach because it involves features of ideology, culture, and human relationships, which are not delineated

using quantitative methodology. As opposed to quantitative studies that pursue causality, projection, and generalization of results, qualitative studies allow for a systematic process to examine, understand, and describe the intricacies inherent in the phenomena (Campbell, 2014). I used a phenomenological approach to examine the following research questions:

1. What is the self- perceived cultural competency of HIV counselors delivering HIV prevention services to AA MSM in Richmond, Virginia, and surrounding counties?
2. How do HIV counselors' perceptions of cultural competency affect (a) the development of HIV prevention messages, and (b) their delivery of prevention messages?

A phenomenological approach was the most suitable methodology for examining the research questions: It is exclusively involved with the examination of the experience; it examines the meaning participants give their experience without justifications; and the entire focus is on the experience as opposed to the single parts. Among all the qualitative methods, phenomenology is much more inductive than the others (ethnography, grounded theory, narrative, and case study) (Cypress, 2015). Phenomenological research is concerned with the subjectively lived experiences of subjects and their perceptions of the experience. The aim of phenomenology is to elucidate the sentiments of participants who share an experience with a specified phenomenon. My aim in this study was to uncover the perceptions of HIV counselors about their cultural competence when serving AA MSM. Creswell (2013) suggested that investigators use phenomenology when

attempting to understand participants' viewpoints and essential themes related to a shared experience. After the results are determined, those working in HIV prevention could use the insight to inform the development of culturally competent HIV prevention messages and activities targeting AA MSM communities.

Role of the Researcher

In qualitative studies, the researcher is a human instrument. An essential duty of the researcher is to allow aspects of the participants' experiences to emerge as they are perceived by the participants as opposed to the investigator's perspective (Cypress, 2015). In this study, I was the instrument for collecting data regarding the self-perceived cultural competency of HIV counselors who provide HIV prevention services to AA MSM. Xu and Storr (2012) suggested that there should be significant reflection in qualitative research, prior to and throughout the project, as a means for ensuring context and understanding for the audience. Sutton and Austin (2015) advised that researchers should refrain from ignoring their personal biases; rather, reflexivity requires investigators to give thought to and plainly notate their viewpoints and subjectivities. With this in mind, bias and subjectivity should not be viewed as negative. To some extent bias is unavoidable, and the investigator would be right-minded to display transparency in communicating this and showing efforts to decrease its influence by addressing it in the analysis/discussion section (Sutton & Austin, 2015). According to Creswell (2013), investigators should feel compelled to acknowledge how their research could be affected by their personal perspectives. Nam (2017) suggested that, to circumvent biases, it would be beneficial for investigators to closely track their

subjectivity from the beginning of the project until completion as opposed to after gathering data. I heeded this recommendation as I gathered and analyzed the data to ensure that my personal perceptions of cultural competence and AA MSM did not affect the results (Nam, 2017). I was cognizant that my exposure of the topic could be useful for me at the data gathering and analysis stages. However, I was careful to monitor my personal position as to not affect the investigative process. I have not made the acquaintance of any of the participants. Therefore, there are no personal or professional relationship dynamics to report. If I became aware that a participant was a former colleague or associate, I would have inquired about their level of comfort with my role as the investigator for the research.

Monitoring subjectivity and bias. Nam (2017) provided a means to monitor subjectivity. The author argues that when subjectivity presents, it should be immediately tracked. Subjectivity entails emotions, impulse, personal objectives, levels of awareness, and other factors. It is not an aspect that should be repressed with an attempt to eliminate it from research procedures; instead, researchers ought to acknowledge their biases and monitor them to increase the trustworthiness of the study. Nam proposed that one way investigators can become fully conscious of their subjectivity is by reflection, which can be carried out by journaling as a method of providing insight into one's subjectivity. I applied this idea throughout the investigation but particularly during the data collection activities. I journaled my thoughts and feelings about the interviews/responses to the questions. Throughout the process I monitored my subjectivity, I emphasized one question: At any time did I advance my position and feelings (Nam, 2017).

Methodology

Participant Recruitment Logic

Creswell (2013) advised that phenomenological studies should compose only participants who are familiar with the phenomenon by way of experience. The participants were appropriate for the phenomena of interest. The participants of the study were employed in the area of HIV prevention/counselor with the duties that include developing prevention messaging/activities for AA MSM, and each were performing in their role at the time of the interview. If the employees were beyond the introductory period with new employee training and were carrying out their job responsibilities in HIV prevention, they were included in the study. Those who were employed in the area of HIV prevention and employed with VDH, The Health Brigade, Nationz, and the Minority Health Consortium (MHC) were participants in this research study. These practitioners are charged with innovatively protecting all communities from this disease, with considerable attention on those communities who are disproportionately affected by the epidemic (CDC, 2015a). Each potential participant responded to the invitation email to verify that they met criteria.

A current and common debate in social science research is the size a sample should be to be considered trustworthy and dependable (Rijnsoever, 2017). The sampling process was purposive; according to Rijnsoever (2017), the objective is to acquire the needed breadth and depth of information, and subjects who are appropriate for the investigation to support the question under study. A sufficient sample size is one that adequately addresses the question under study (O'Reilly & Parker, 2013). With this in

mind, generalizability is not pursued by the investigator and the emphasis becomes more about sample adequacy rather than size. According to O'Reilly and Parker (2013), the researcher will be aware that the sampling is adequate when saturation has been demonstrated; this means that no new data are being generated to expand categories (Nelson, 2017). For interpretive phenomenology, small sample sizes are customarily used (Roberts, 2013). As the research method has evolved throughout the years, sample sizes have continuously become smaller to ensure that individual experiences are centralized. Roberts (2013) suggested that a small sample size is most suitable to meet the interpretive phenomenology requirements, whereas a sizable sample could inundate the investigator with data. Creswell (2013) went as far as to provide investigators with concrete numbers of sample sizes for each qualitative approach; phenomenology, Creswell suggested, should have a sample size of three to 10 cases. For this study, the sample size was a minimum of 10 volunteers. In a qualitative study, identifying volunteers should not follow the same approach as quantitative sampling since the goal is not to calculate the number of respondents but to assess the variety of opinions in relationship to the issue under study (O'Reilly & Parker, 2013). Also, I confined the investigation to a small geographical location, Richmond, Virginia, and its surrounding counties. I focused on central Virginia's five health regions and 35 districts. There was a directory to contact possible participants for the study via the Virginia Department of Health's website. This directory included the names, job titles, and contact information of their employees (VDH, 2018). However, one of the parameters for inclusion will be the specific job duties involving HIV prevention messaging and activities/counseling.

Also, I solicited participation from the MHC, The Health Brigade, and Nationz. I contacted the director of MHC for a list of employees appropriate for the study. MHC was founded in 1987. One of its goals is to serve minorities who are at high risk for HIV infection. The HIV/AIDS prevention programs began in 2000 and it is located in the Richmond, Virginia, and Petersburg, Virginia, areas. In terms of the Health Brigade and Nationz, I identified employees from their websites.

Researcher Developed Instrumentation

Ingham-Broomfield (2015) advised that investigators should use a structured interview guide as opposed to impromptu questions to ensure the interview remains focused on the research questions. I used an interview guide method to develop questions to directly answer the research questions (see Appendix A) (Brayda & Boyce, 2015). This approach did not allow the interviewer to explore issues that are not being addressed in the research. However, it provided a framework for probes and themes that are within the purview of the research to be explored. Before creating the interview questions, I familiarized myself with guidelines on developing effective interviews (Harvard, n.d.). The instructional aid to developing interview questions illuminated several points: probes should be made simple and not complex; the most effective questions will elicit the most in-depth responses from the participants; refrain from questions that only take one word to adequately answer; refrain from questions that make the interviewee responsible for the researcher's analysis; and I should refrain from asking questions that require the respondents to answer for a group of people (Harvard, n.d.). In addition, the instructions provided details about effective ways to construct interview

questions: I should use wording that motivates the interviewee to want to respond earnestly to the questions; I should start the interview with a question that will facilitate rapport as to put the respondents at ease; I should consider the logical flow of the interview sessions and arrange questions accordingly; and potentially uncomfortable probes should be held off towards the end of the interview, at such time rapport would have likely been created (Harvard, n.d.).

One essential aspect of effective interviewing is posing appropriate questions. Brayda and Boyce (2015) advised that interview questions should align with the overarching research questions. They suggested that there are six categories of questions that an investigator can pose. These categories can be found in the table below:

Table 2

Types of Interview Questions

Types of question	Focus
Experiential and behavioral	What has a person done
Opinion and value	Thoughts about the phenomenon
Feelings	Emotions connected to thoughts
Knowledge	Facts and understanding
Sensory	What has a person seen, heard, and so on
Demographic	Age, job title, & education

Brayda and Boyce (2015) recommended that investigators ask questions concerning opinions and feelings first while exploring their interpretation of respondents' experiences. Then, investigators may probe the areas of knowledge about the

phenomenon and experience with the phenomenon as a follow-up to opinion and feeling questions. The authors mentioned limiting background and demographic questions because they are quite routine and unexciting. Also, Braya and Boyce (2015) advised that with ensuring validity, the researcher should be certain to ask appropriate questions that will provide adequate information to answer the research questions.

Pilot Study

Pilot studies are essential for preliminary planning in preparation for the actual study (Abbott, 2014). They are developed to assess the performance properties of the study design, processes, and the recruitment specifications that are being considered for implementation in the larger study. Pilot studies aid in locating revisions that are necessary for the subsequent study. I invited each health department in Central Virginia to participate in the study, as well as MHC employees. I interviewed two volunteers for the pilot study. I interviewed one individual from VDH and the other from MHC. The pilot study was conducted with the first person from each organization who volunteered. I accessed the website for the Virginia Department of Health and contacted the director of MHC to acquire names and contact information to forward invitations to participate in the study (see Appendix B). The invitation included the criteria for the study. The invitations also contained my contact information including my telephone number and email address. Subsequent to scheduling interviews, I first verified that potential participants met all inclusion criteria (pilot and the larger study). I requested that participants sign the consent forms at the time of the interview. The participants were

informed that each interview will take no more than an hour, and their information would be anonymized.

Procedures for Recruitment, Participation, and Data Collection

I contacted the Virginia Department of Health to ascertain their policies for staff participation in research, and then I accessed their websites to acquire names and contact information to forward invitations for participation in the study to employees who met the criterion of working in HIV prevention. I contacted the director of the MHC as well for policy related to research participation and names of employees tasked with HIV prevention. The invitation included all of the criteria for the study to allow potential participants to assess their suitability. The email invitation included the option for potential participants to inquire further of the study if they felt more information was needed to help with their decision. In addition, I made myself available to answer any questions for those interested in participating in the study. Once again, the participants were informed that each interview will take no more than an hour, and their information would be anonymized. Creswell (2013) recommended that investigators understand the significance of creating a comfortable interviewing environment. The interviews were conducted face to face. The interviews took place at the local library; a private room was reserved for privacy and comfort. However, on those rare occasions where a participant requested a different setting, the interview was carried out at their private offices. Given that transcribing is reliant on quality equipment, the data will be recorded with a high quality interview recorder. I practiced reflective listening during the data collection process to ensure the data gathered was an accurate representation of the perceptions of

the HIV counselors. Creswell (2013) advised that following up by practicing reflective listening with participants during the interview process helps to demonstrate validity of the analysis. Subsequent to the interviewing process, I thanked each of the volunteers for their participation and informed them that I will be forwarding each an executive summary of the results.

Data Analysis Plan

Creswell (2013) informed that the data analysis phase is very intricate and should be approached with skillful organization. Qualitative investigators should expect to become intimate with their data. This relationship with the data must start with reviewing transcripts numerous times to recognize emerging themes and classifications (Yates & Legget, 2016). Usually investigators start the data analysis inductively; this allows for creating a code protocol. Then, the investigator can proceed in a deductive fashion, utilizing the codes to pinpoint and classify statements in the transcripts. The process of interpreting the data is the investigator's method of developing meaning from the themes and classifications (Yates & Legget, 2016). I used NVivo to aid in the data analysis process. I transferred the voice recording into written text and entered the text into the program. Also, I used interpretive phenomenology for this inquiry; interpretive phenomenology is used interchangeably with hermeneutics (Tuohy, Cooney, Dowling, Murphy, & Sixsmith, 2013). This path allowed me to decode the HIV counselors' experiences. In Table 2, I listed a summary of what I replicated from Jeong and Othman (2016), the table is a phenomenology analytical process for the data analysis phase. Smith, Flowers, and Larkin (2009) were the originators of the process.

Table 3

Analytical Process for an Interpretive Phenomenology Study

Steps	Actions	Data analysis process
1	Reading and re-reading	Getting familiar with the original data
2	Initial noting	Discovering new information.
3	Developing emergent themes	Identifying emergent themes—informed by the study questions.
4	Connecting emergent themes	Grouping superordinate and subordinate themes.
5	Moving to the next case	Repeating the first four steps with a different participant.
6	Looking for patterns across cases	Identifying shared themes across participant interviews.

Issues of Trustworthiness

Evidence of validity is needed in one's research. According to Amankwaa (2016), it is essential that qualitative investigations have veracity and applicability to be judged valuable. To ensure a rigorous study, specific criteria have to be met: Credibility, transferability, dependability, and confirmability (Amankwaa, 2016). Credibility is related to the accuracy of the data and the participants' responses and the interpretation of their answers by the investigator (Cope, 2014). Credibility will be demonstrated by my engagement and auditing practices (Cope, 2014). I employed member checking by sharing the transcripts, and I will be sharing the data findings with all of the respondents for their feedback as well (Varpio, Ajjawi, Monrouxe, O'Brien, & Rees, 2017). These activities will enhance the credibility of the findings. Varpio et al. (2017) proposed that

researchers carry out member checking in two phases of the investigation. Firstly, researchers should allow respondents to examine the transcripts to verify what they were attempting to convey has been accurately captured. Secondly, researchers should permit respondents to examine the data findings to endorse the investigator's interpretations.

Transferability refers to the evidence of applicability in other settings (Amankwaa, 2016). The investigator has fulfilled this criterion if the findings are applicable to other groups not included in the research and the audience can relate the results to other settings (Cope, 2014). I can achieved this by providing ample information on the participants and the study context so that others can determine if the results have the ability to be transferred.

Dependability ensures that the findings of the research are repeatable. One effective method of establishing dependability is to invite an unassociated, seasoned investigator to audit my research (Amankwaa, 2016). In addition, meticulous and systematic examination of the data assisted with dependable coding.

Confirmability refers to the neutrality of the researcher; it refers to the voice of the respondents shaping the research as opposed to the investigator (Amankwaa, 2016). I demonstrated confirmability by comprehensively reporting how interpretations and findings were conclusively obtained from the responses (Copoe, 2014). I was certain to offer adequate information on the participants and the study context in order to aid the audience in evaluating the results and its ability to be transferred (Cope, 2014). I assured confirmability by including discrepant cases and non-confirming information in the results sections.

Ethical Procedures

I received approval from the Institutional Review Board (IRB), my approval number was 08-08-18-0254801. Before I made contact with the potential participants, I communicated with the different institutions to ascertain their policies for staff participation in research. Recruitment materials were developed based on the research policy participation for employees. I informed potential volunteers that their participation was not mandatory and they would be permitted to exit the study at their own discretion. There was no monetary compensation to the volunteers for their participation in the study. Names of the participants are confidential; they were referenced by place of employment, job title/duties, and identified by code (such as participant 1, participant 2, participant 3, etc.). In terms of power differential, I was sure to practice professionalism at all times and resist the potential to establish a dual relationship (creating friendships with participants) during the research process. Also, I secured all research information in a password secured file on a password secured computer only accessible to the researcher. Per Walden University's policy, I will retain the research data for 5 years.

Summary

A phenomenological design was used for this qualitative research. I utilized interviews to explore the self- perceived cultural competency of HIV counselors. HIV prevention counselors/workers in Richmond, Virginia, and surrounding counties were invited to participate in the research. Their responses were transcribed and entered into NVivo, which aided in analyzing the data. Finally, trustworthiness was demonstrated by

enhancing credibility, transferability, dependability, and confirmability. Next, chapter 4 will address the data from the pilot study and the larger study. Chapter 4 will feature data collection, data analysis, evidence of trustworthiness, and the results.

Chapter 4: Results

Introduction

Purpose of the Study

AA MSM are affected more significantly by HIV than any other group in the United States (CDC, 2017b). The epidemiological surveillance data indicate that the infection rate amongst AA MSM underscore the necessity to increase evidenced based, culturally competent HIV prevention strategies. However, to assimilate cultural competence and apply this concept into HIV prevention interventions involves a consideration for social and cultural influences on AA gay and bisexual men's health beliefs (Gatson, 2013). AA MSM bring numerous issues to the therapeutic setting; therefore, it is crucial for HIV counselors to have more than a baseline awareness of their culture to optimize the outcome of the client-counselor encounter (Wyatt, 2009). The gap in knowledge in public health research dedicated to AA MSM in the area of culturally competent HIV health messages is vast given the dearth of studies on this topic (Saha et al., 2013). My purpose in this research was to examine the self-perceived cultural competency among HIV prevention counselors who provide services to AA MSM aimed at reducing the spread of HIV.

Research Questions

The research questions were as follows:

- What is the self- perceived cultural competency of HIV counselors delivering HIV prevention services to AA MSM in Richmond, Virginia, and surrounding counties?

- How do HIV counselors' perceptions of cultural competency affect (a) the development of HIV prevention messages, and (b) their delivery of prevention messages?

The remainder of this chapter will include information pertaining to demographics, data collection and analysis, evidence of trustworthiness, and a discussion of the results.

Pilot Study

A pilot study is a small-scale investigation conducted to gauge feasibility, time, or inauspicious events prior to the employment of the main study. The pilot study allows the researcher to perform precursory analysis on the feasibility of different aspects of the full-scale study to include the interview questions (Abbott, 2014). The interview questions were developed from the three domains of the PEN-3 cultural model. The domains include cultural identity, cultural empowerment, and relationship and expectations. For pilot studies, Henson and Jeffrey (2016) asserted that it is conceivable to conduct a pilot investigation with just a single participant. For my study, I recruited two volunteers using an email invitation (Appendix B) and conducted the interviews using an interview instrument (Appendix A). The participants for the pilot study were HIV counselors employed with the Minority Health Consortium and Virginia Department of Health.

My purpose in conducting this pilot study was to determine whether there were any unnecessary or repetitive aspects in the interview instrument. Subsequent to the pilot investigation, I found no adjustments to the questions necessary. The initial pilot study

interview was approximately 30 minutes, whereas the second interview did not exceed 20 minutes.

The pilot study was pursued independent of the full-scale study and the results were not reported in the overall research findings. I tested the interview instrument and considered it effective toward collecting data for this research study. As a result of the pilot study, it was confirmed that the instrument properly answered the two research questions. The pilot study provided the means to measure the comprehensibility and applicability of the interview questions, and also if they were clear to the participants. There were no issues pertaining to the interview instrument to report. There were no concerns relative to the participants' ability to comprehend wording or arrangement of questions, and length of the interview.

Study Setting

Data collection for this research study occurred between the months of August, 2018 and October, 2018. The participants of the study were employed with health institutions that partially or entirely specialize in HIV prevention in the Richmond, Virginia, area. The study volunteers were coded with labels of Participant 1 through Participant 10 for confidentiality purposes. Once consent forms were signed and interviews were scheduled, no one withdrew from the study. However, one participant rescheduled due to a scheduling conflict. I conducted the interviews face to face at libraries or participants' private offices. I determined that no organizational or personal conditions influenced the participants at the time of the interview. The settings selected were conducive to ensuring privacy with little distraction. At the time of each interview,

I reiterated the purpose of the interview and noted that all identifying information would be omitted from any published findings, and I described the format of the interview, the approximate time to completion, and how participants could contact me later with questions or concerns. There was no monetary compensation for participation in this study.

Participants' Demographics

I constructed a working definition for *HIV prevention counselors/workers* from amalgamating job descriptions received from the Virginia Department of Health, the Health Brigade, and VCU/MCV. The synthesized job description is as follows: practitioners charged with furnishing HIV prevention education/services to people diagnosed with the disease and those who are considered at high risk for contracting the disease. There were 10 participants in the study (Table 4).

Table 4

Characteristics and Demographics

Code	Age	Race	Gender	Years of experience
Participant 1	30-39	AA	Male	20
Participant 2	40-49	Caucasian	Female	17 ½
Participant 3	40-49	AA	Female	17
Participant 4	> 59	AA	Male	22
Participant 5	50-59	Caucasian	Female	28
Participant 6	40-49	AA & Indian	Female	20
Participant 7	30-39	AA	Female	20

Participant 8	20-29	Black Hispanic	Female	2
Participant 9	> 59	AA	Female	18
Participant 10	> 59	Caucasian	Male	25

Data Collection

The participants in this study were 10 HIV prevention counselors/workers from the VDH, the MHC, The Health Brigade, and Nationz. Several invitations were sent to HIV prevention workers with VCU/MCV but invitations were left unanswered. At the time of the study, all of the participants were employed with these institutions. I conducted the interviews face to face at libraries or participants' private offices. The interviews generally lasted 20 minutes. Prior to each interview there was a brief introduction, description of the study, review of the informed consent specifics, and each participant received clarification of the term *cultural competence*. I was guided by the instrument in Appendix A, and recorded each of the interviews using a voice recording device. I protected the identity of the participants by the assignment of an alpha-numeric code (the word "participant" and the order/number in which they came in the interviewing process). The interviews were saved in a password locked document on a password locked computer. I did not deviate from the plan described in Chapter 3, and there were no unusual circumstances during the data collection process to report. I used NVivo as a tool to store, organize, classify, and analyze the data.

Data Analysis

I used a qualitative approach to understand participants' beliefs, experiences, and actions (Dorman & Kelly, 2017). For this study, volunteers agreed to participate to further build on prior knowledge of cultural competence in HIV prevention targeting AA MSM. There were a set of assigned interview questions capable of answering both research questions. Interview Questions 1-3 addressed the first overarching research question. While Research Question 2, could be answered by Interview Questions 4-12. I recorded the interviews using an audio recorder and transcribed interviews verbatim. After transcribing, I imported the information into the NVivo database. I used NVivo and hand coding techniques to analyze the data from the 10 interviews. The purpose of the thematic exploration was to identify a pattern of thought that would lead to a description of how HIV counselors' perceptions of cultural competency affected the development and delivery of HIV prevention messages.

The Analytical Process

The analysis of the data replicated the approach detailed by Smith et al. (2009), the phenomenology analytical process. The steps within this process include reading and re-reading the transcripts, initial noting, developing emergent themes, connecting emergent themes, moving to the next case to repeat the steps, and looking for patterns across cases. This inductive analytical approach was aimed at identifying patterns and resemblances from the data collected. I moved the raw data from interview form to codes and themes. I reviewed each transcript multiple times to get a thorough understanding of the information prior to inputting the data into NVivo. The coding methodology aided in

organizing central ideas or segments of the respondents' transcripts into codes and themes to capture the perceptions and experiences of HIV counselors/workers. I created nodes using sections of the data excerpted from the transcripts. I performed a content analysis by extracting sections or central ideas of the interview transcripts and housed them in the nodes. With NVivo, nodes refer to the naming of analytic ideas or insights from the participants that are stored in a specific place. I created descriptive notations in the transcripts so as to elucidate central ideas and nodes. This step was crucial in facilitating the clarification of concepts and allowing for exploration of the relationships between central ideas and nodes. Creating nodes based on similar ideas and closely connected references aided in the development of codes. A code is labeling that captures facets of the data or the significance of a word (Clark & Vealé, 2018). This collection of ideas helped with identifying and establishing themes. The frequency of word or phrase usage underscored the importance of ideas. Central ideas are dominant impressions, such as any communication relative to the interview questions and informative words and phrases. There were 34 central ideas and from these, 11 codes developed to demarcate parts of the text. These codes were operationalized to summarize portions of the participants' responses with succinct phrasing. After deciphering the meaning of specific portions of the data, it was condensed and labeled; this allowed for context, emergence of themes, and distinguishability amongst the codes. All vague and insignificant data were discarded, as they were not informative nor instructive towards increasing understanding of the phenomenon being examined.

Connecting Central Ideas, Codes, and Themes

Coding is mostly subjective and interpretive, not exactly science. The coding process was iterative. I revisited the transcripts several times (re-read), adjusted codes, and adapted emergent themes. This was done according to the prescribed approach specified in chapter three. Firstly, nodes were created to describe central ideas. Once more, nodes are the naming of analytic ideas or insights taken from transcripts. There were 34 central ideas identified. After this, codes were assigned to capture the salient points. The summarization came in two phases. The first phase ranged from coding a word to complete sentences to multiple sentences. The second phase involved coding some of the same units previously coded, longer text excerpts, and ultimately reconfiguring some of the already coded data (Saldana, 2016). Next, the coding process involved a pattern coding method. This entailed an approach that identified text that were similarly coded. This approach also helped to organize data into units and aided in more meaningful organization. Pattern coding created a path to examine causes, associations, and explanations (Saldana, 2016). These actions lead to the development of codes then the emergence of themes. The final phase of coding is establishing themes; it is the result of considerable analytical consideration (Clark & Vealé, 2018).

Again, ultimately, 34 central ideas were documented, which lead to 11 codes, and the emergence of three themes. In pursuit of ascertaining a connection, I invested several sessions to reviewing the code/theme relationship. This process allowed for a broader narrative to be revealed and a discovery of connectivity across codes. Table 2 displays the development of themes; CC refers to cultural competence.

Table 5

Development of Themes

Central ideas	Codes	Themes
Self-assessment	Values CC	Theme 1: Cultural knowledge
CC benefits		
Participating in CC trainings		
Attitude about CC		
Knowledge of AA MSM community		
Acceptance of AA MSM		
Idea systems	Exposure to AA MSM Community	
Behavioral practices		
Historical malfeasances	Knowledge of AA history	
Duel discrimination		
Suspicious of gov.	Cultural sensitivity	
Empathy for AA MSM		
Distrust		

Central ideas	Codes	Themes
PrEP as the only prevention approach	PrEP	Theme 2: Culture-specific strategies
Misuse of PrEP		
Self-stigma	Stigma	

Stigma & the family		
Stigma & public health		
Messaging targeting the family		
Messages targeting the community	Religious institutions	
Mobilizing the church		
Condemnation from the church		
Lack of education	Lack of education	
Denial		
	Tailored messages	
Myths about the disease		
Detrimental health beliefs		
Dual discrimination		

Central Ideas	Codes	Themes
Supportive family	Support network	Theme 3: Relationships and resources
Supportive friends		
LGBTQ organizations		
	Community resources/ organizations	
Health agencies		
Economic & social disadvantages		

Food pantries

Homelessness
prevention services

Documentation of Themes

I scrutinized and analyzed all of the transcribed data from the 10 interviews to identify overarching themes. Hillman, Wentzel, and Anderson (2018) advised that researchers should be careful to permit ideas and patterns to organically emerge, instead of them proceeding from preconceived notions of the investigator. Accordingly, I reviewed the transcripts several times and fastidiously examined each category. After that, supportive passages were carefully chosen to illustrate the three themes. The themes that emerged were cultural knowledge, culture-specific strategies, and relationships and resources.

Themes

Theme 1: Cultural Knowledge

The first theme that emerged was cultural knowledge. This theme suggested a demonstrated cognizance and appreciation for the variables that could possibly manifest itself between clinicians and the AA MSM community. Some of the factors associated with this theme were exposure to the AA MSM community, knowledge of AA history, and values cultural competence. A recurring theme from the participants was the historical malfeasance committed against the AA community by public health officials. Many of the respondents verbalized an understanding of the distrust experienced by AA MSM consequent of past maltreatment. They all acknowledged that race discrimination can shape the experience of AA MSM and cause harmful effects on health, and according

to respondents, this awareness was an indication of at least a base level of cultural competence. Although some of the participants may have been more impassioned about the historical context that shapes the culture and socialization of AA MSM, they all acknowledged its significance.

This theme also included the HIV counselors' self-assessment of their cultural competency. Only one participant reported receiving cultural competence training at some point during their professional career, but all of the participants assessed themselves to be culturally competent.

Theme 2: Culture-Specific Strategies

This theme related to factors that could possibly address the heightened risk of HIV transmission with AA MSM. It also revealed the components that are considered when developing effective culturally competent HIV prevention messages. The factors related to this theme included PrEP, stigma, lack of education, and religious institutions. According to the respondents, many of these elements may help to forecast compliance, adherence, and positive health-seeking behaviors, and can be helpful in stemming the progress of HIV, if appropriately addressed when developing prevention messages targeting AA MSM.

Theme 3: Relationships and Resources

The third theme to emerge was relationships and resources. Support systems were discussed at great length by participants in relation to this theme. Many of the participants advised that their aim was to use the protective role of support systems in the delivery of prevention messages/services. Religious institutions, families, and

community organizations were advanced as positive social supports. This theme was also associated with food insecurity and housing instability. As reported by the respondents, oftentimes prevention work was in conjunction with assessing the needs of the service area and linking them to the necessary resources.

Discrepant Cases

There was only one discrepant point identified during the data collection and analysis phase in response to the question, "Please give an example of an occurrence when you felt the need to make an adjustment in your prevention/counseling messages on behalf of the AA MSM community/or member?" While 9 out of the 10 participants expressed that in the past they had made adjustments to HIV prevention messages on behalf of AA MSM, participant 8 expressed that she does not alter her prevention messages. She advised that "I pretty much keep my messages general. Per case, if the person talks about sex with a particular term, I will use that term. I do not change my message for AA MSM versus someone of a different race." With this discrepancy being discovered at the data collection and analysis phase, it allowed for further exploration by inquiring with the participant to elaborate upon her approach. Participant 8 believed that her HIV prevention messages should be universal, although, she would practice mirroring the language of her AA MSM clients during counseling.

Evidence of Trustworthiness

Credibility

Credibility was established by adhering to the data collection procedures delineated in chapter three. I received approval from each participant for recording and

transcribing of the interviews. Deviation from the interview guide (Appendix A) did not occur except in the case of clarification or follow-up questions that would prompt elaboration. To ensure credibility, Varpio et al. (2017) advised researchers to employ a transcript review by sharing the transcripts with the participants. I talked briefly with each of the participants to clarify any indistinct responses. Each of the respondents concurred with the content and advised that editing was not needed.

Transferability

Transferability has been achieved if the findings are applicable to different groups not included in the research, and those researchers invested in the topic can relate the results to other settings (Cope, 2014). Within this study, I carefully described the participants and the study context in detail so that investigators may apply the findings to other marginalized groups to determine the self-perceived cultural competency of HIV prevention workers within their target population. Participants consented to being interviewed with open-ended questions so as to share their opinions and experiences about AA MSM and culturally competent HIV prevention services. Other researchers may determine the findings relevant and applicable to other groups and settings.

Dependability

As a way to establish dependability of my study, I was careful to make certain that the raw data were consistent with my conclusions. I received consent from each of the participants to record interviews, which allowed for exact transcribing of the opinions and experiences of HIV prevention workers. Moreover, meticulous and systematic examination of the data assisted with dependable coding. To ensure dependability,

researchers must be disposed to capture changes that present after the proposal; however, no such changes appeared in my study. As a result, there are no changes to report with the study design of this research.

Confirmability

As Amankwaa suggested (2016), confirmability requires neutrality from the researcher. This refers to the voice of the respondents shaping the research as opposed to the investigator. Also, it can be established by providing a thorough description of the processes as to allow other investigators to repeat or continue with the research. To assure confirmability with this study, the data analysis process conformed to Jeong and Othman's (2016) data analysis approach. Again, the process involved reading and re-reading the transcripts, initial noting, developing emergent themes, connecting emergent themes, repeating the first four steps, and looking for patterns across cases.

Results

Research Question 1

The first research question was, what is the self- perceived cultural competency of HIV counselors delivering HIV prevention services to AA MSM in Richmond, Virginia, and surrounding counties? Theme one, cultural knowledge, addressed results related to RQ1. This theme encapsulated the data that largely pertained to knowledge of AA history and exposure to AA MSM. All of the participants considered themselves knowledgeable about AA MSM culture and each believed that exposure was the pivotal construct that fuels the energy and desire to integrate culture into HIV prevention interventions.

Self- Perceived Cultural Competency

The first theme to emerge from the data was cultural knowledge. The factors that allowed this theme to emerge included values cultural competence, exposure to the AA MSM population, and knowledge of AA history. All of the participants perceived themselves to have cultural competency knowledge and were confident in their ability to deliver culturally competent HIV prevention services to AA MSM. The need for awareness and cultural capacity in prevention was echoed with each participant. Being conversant with the AA MSM population was important to all of the respondents. With only one reporting having experienced cultural competence training, many felt that exposure to the target community was equivalent to and just as valuable as formal cultural competence education. P1 advised, "Yes, I'm culturally competent. I am a part of the LGBTQ+ community, so of course I'm culturally competent to perform duties pertaining to HIV prevention with AA MSM." P10 stated, "The ability to understand the culture from an informed outsider's viewpoint. Meaning, you've had contact with that culture." P2 stated, "A combination of experience, education, and a willingness to be open to other cultures." P8 expressed, "Knowing the norms of the AA MSM community—by interacting formally and informally."

After receiving feedback on how HIV prevention workers perceived their personal cultural competence and cultural competence in general, they were asked about the importance of understanding AA history. Knowledge of the unique components that contribute to the trust and distrust with the public health system presented with great frequency. Understanding how trust and distrust affects health-seeking behaviors could

explain prevention workers' approach to the development of HIV prevention strategies. It may also illustrate how HIV prevention professionals conduct themselves in the counseling environment with AA MSM. Most of the participants introduced examples of the contributing factors that lead to trust and distrust with the public health system. The subsequent quotes are representative of HIV interventionists' perceptions of factors that contribute to the distrust by AA MSM. P4 advised, "Racism is alive, you can see it in police brutality and this is systematic, even in health." In like manner, P5 advised, "…Understanding Tuskegee is important and understanding how people may have a distrust of the government." P8 expressed, "…My mental state plays a part in how I deal in life. My history factors into how I approach my health, our suspicions even." In terms of those factors that create trust and facilitate health-seeking behaviors, P5 advised, "You should be sending a message that you accept them where they are, and you're ready to serve them even if it is not HIV related." Participant 10 advised, "Show acceptance of them and understanding of the prejudice that they might have experienced."

Most of the respondents expressed that having an awareness of AA history was essential to their work. While some appeared impassioned about the benefits of being exposed to AA history, others had a more moderate viewpoint of the topic. P1 was one of the participants that had a lackluster response concerning the importance of having exposure to AA history. He stated, "I think the history is important, but I don't think it would change outcomes." I then asked him a follow-up question, "Do you think it would help to understand the target audience's history when developing health promotions?" To that he answered, "History is history; teaching people about AA history won't change

people." Another moderate response came from P8 who stated, "I guess, well, having that background does assist with suppressing subconscious bias a worker might have." P2 and P4 made their convictions known about the need for having a general awareness of AA history. P2 stated, "Actually it is very important." P4 expressed, "Everyone who is addressing HIV should have to go through a module in understanding the population."

Research Question 2

The second research question was, how do HIV counselors' perceptions of cultural competency affect (a) the development of HIV prevention messages, and (b) their delivery of prevention messages? There were a series of interview questions that sought to uncover the factors that affect the development and delivery of prevention messages based on the self-reported perceptions of the interventionists. Themes two and three were culture-specific strategies and relationships and resources. Both of these themes pertained to those elements that aid in the development and delivery of culturally applicable prevention strategies. Most of the respondents advised that effectively working in the cultural context of AA MSM is important to the success of HIV prevention in the Richmond area. Given this, most of the participants reported conscientiously integrating/addressing the forthcoming cultural factors that contributed to these themes to ensure the development and delivery of culturally sound interventions.

Development of HIV Prevention Messages

Culture-specific strategies emerged as the second theme. The factors that allowed this theme to emerge included PrEP, stigma, lack of education, and religious institutions. Many felt that addressing these elements in the development of HIV prevention

messaging targeting AA MSM could ensure effective culturally competent interventions. The respondents assessed these features to have a cultural significance with AA MSM.

PrEP appeared to present a unique challenge for the respondents. As reported by the participants, for AA MSM to have been prescribed the anti-HIV medication, they had to have accessed prevention services at some point in the past. However, some AA MSM fail to adhere to the recommendations for taking PrEP responsibly, such as taking it in accordance with the prescribed instructions and combining it with other prevention methods (condoms and reduced sexual partners), which is a sexual health imperative. It was commonly reported that with the advancements in HIV related medications, some high-risk HIV-negative AA MSM do not have a sense of trepidation about the disease like when it first made its appearance. Some of the respondents indicated that PrEP is the only prevention method used by many AA MSM; they may view it as a complete cure-all. Most of the respondents advised giving significant attention to addressing AA MSM's sole reliance on PrEP as prevention. According to P1, "PrEP is for you to protect yourself, but it can also promote promiscuity. On dating apps, MSM mention PrEP as a secret code word to invite unprotected sex." P3 stated, "AA MSM feel it's just a pill; it's not that serious anymore." P8 advised, "PrEP is not an absolute remedy—they are not very strong in the prevention aspect if someone is not using them correctly."

Many of the respondents felt that HIV-related stigma and heterosexism was a long-standing cultural phenomenon within the Black community. Many of the participants recognized stigma as a significant barrier to prevention, and they felt they had to have a robust response to stigma and discrimination during counseling sessions.

Some of the respondents expressed that as an intervention strategy, they invited family members into the counseling setting to educate them about HIV and the impact of stigma and/or engage in some variation of talk therapy. P2 advised, "Homosexuality is frowned upon in Black homes. The stigma leads to shame and trying to live how their family wants them to live." Many reported that it can also be a barrier to testing, prevention, and pursuing treatment. P1 advised, "…because of stigma, HIV is used to slander people. You feel shame about walking into a clinic, and by the time you properly address it, you are dying."

Many of the participants shared that a lack of education is a determinant for heightened risk and contracting the disease. The participants found it alarming to think that there is an HIV knowledge deficit in the United States given the concentration of information targeting at risk populations, specifically MSM. None of the respondents could conclusively provide a rationale for the insufficient knowledge about HIV. Poverty and lack of access to accurate health information were presented as possible cultural components that drive this knowledge deficit. Many of the interventionists advised that they allocate numerous hours to educating and encouraging AA MSM to evaluate and adjust their risk behaviors to ensure they remain negative. Responses associated with knowledge deficits were advanced multiple times. P6 stated, "…Lack of education—people mention Magic Johnson all the time. We have to explain that he is undetectable…" P7 advised, "Lack of education…the focus is usually on Caucasian MSM." P8 advised, "It is about becoming more educated."

In terms of incorporating positive cultural influencers, many participants cited the church/religious institutions. Many recognized that the church, historically, has had a prominent place in advocacy and political activity with respect to the Black family. In recent times the church has become a viable collaborator in disease prevention and health promotion activities. P1 advised, "The church could play a significant role in decreasing stigma; I've reached out to pastors before..." P2 advised, "The Black church, in times past, has been the loudest voice in condemnation; they could take the mantle and lead in showing true love and care." P10 stated, "The church has a great opportunity to participate in prevention efforts and emotional healing."

Delivery of Prevention Messages

With the second research question in mind, behavior changes can be realized based on the delivery of culturally relevant HIV prevention messages/services. Relationships and resources emerged as the third theme. Factors associated with the emergence of this theme were social support and available resources. Many of the study participants felt that understanding the strengths of AA MSM and incorporating their positive cultural features in prevention services has significant potential to be effective. Although social support and family ties are not necessarily unique to AA culture, the bedrock of Black culture has been the family. Social support was advanced several times as a necessary prevention element and having cultural significance. Most of the respondents reported inviting family members/friends into the counseling process as an intervention strategy. P1 stated, "…It depends on the family and friends that you surround yourself with. If they are positive and helpful, this can be very beneficial to the

process." P8 advised, "…Women, if the mothers in their lives are supportive of health and getting tested then the men will follow. I generally welcome mothers." P7 advised, "Involving the family in the counseling process can be impactful. Support and love is needed in this process." P10 stated, "The importance of the relationship between the mother and son—this enhances prevention messaging."

To increase the effectiveness of HIV prevention messages in the delivery phase, cultural relatedness was discussed under this theme, as well as social constructs, such as challenges associated with poverty and underemployment. Many of the respondents posited that addressing non-HIV needs (housing instability and food insecurity) lead to increased engagement in HIV services, which could affect health outcomes. To ensure consistency, many reported that counseling activities were geared towards promptly assessing the needs of their clients and making necessary referrals. Available resources and access to those resources can have a significant effect on behavior change. Many of the interventionists made reference to linking their clients to those organizations that confront poverty and hunger. P3 stated, "…Agencies that help with food, housing, etc. have helped with engagement. They can focus on their health when other issues are resolved." P2 advised, "There are programs designed to help people with homelessness. Having a stable home usually increases the likelihood of remaining in counseling/treatment." P4 advised, "…I evaluate my clients' needs early and refer them to health outreach fairs, food pantries, and homeless prevention agencies have helped with the treatment process."

Summary

The aim of this qualitative research was to examine the cultural competency of HIV counselors in Richmond, Virginia. The research results demonstrated the significant challenge faced by HIV interventionists given the monumental task of evaluating the effectiveness of HIV prevention strategies targeting AA MSM are intrinsically difficult. There were two overarching research questions for this study. The first of the main questions focused on the self-perceived cultural competency of HIV counselors delivering prevention services to AA MSM. The theme that emerged from the series of interview questions was cultural knowledge. There were several common strands of data that supported this theme including, HIV interventionists' self-assessment, exposure to AA MSM community, knowledge of AA history, and understanding the historical distrust of public health. Each of the participants were resolute concerning the need for cultural competence in HIV prevention and health promotion in general. Although each participant perceived themselves to be culturally competent, only one participant reported receiving cultural competence training at some point during their career.

The second research question was, how do HIV counselors' perceptions of cultural competency affect (a) the development of HIV prevention messages, and (b) their delivery of prevention messages? The two themes that emerged from the series of interview questions were culture-specific strategies and relationships and resources. The common strands that supported these themes were PrEP, stigma, and knowledge deficits as well as social support systems and non-HIV related resources respectively.

In this chapter, I discussed the pilot study, data collection method, data analysis, evidence of trustworthiness, and the results. The upcoming chapter will focus on the interpretation of the findings, limitations of the study and the implications of the study.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

My purpose in this investigation was to explore HIV counselors' self-perceived cultural competence in relation to AA MSM in HIV prevention efforts. The research uncovered valuable information about how HIV counselors' perceptions of cultural competency affect the development of prevention messages and their delivery of prevention messages. Saha et al. (2013) suggested that improving cultural competence with people in health organizations may reduce racial disparities in HIV.

AAs represent 40% of those living with HIV, and in 2015 AA MSM represented 58% of all new HIV diagnoses (CDC, 2017). These numbers indicate that pinpointing solely risk behaviors and failing to wholly contextualize the unique individual and environmental contributors of this group may cause HIV messages to be deficient (Wyatt et al., 2012). According to Iwelunmor et al. (2014), taking the cultural dynamics into account is crucial for health messages to be effective. Research indicates that clinician communication/messaging is in relationship to client satisfaction, compliance with recommendations, and health outcomes (Wyatt et al., 2012).

Summary of Key Findings

Although only one study participant reported receiving formal cultural competence training at some point during their career, all 10 of the respondents perceived themselves to be culturally competent. Wyatt (2009) supported cultural competence training; she advised that risk for infection can be heightened consequent to the lack of understanding of how the culture of AA MSM influences behavior (Wyatt, 2009).

Wyatt (2012) also advised that HIV counselors should acquire cultural competence skills irrespective of their race or ethnic makeup. Belonging to the same ethnic group as your target population or being a member of the LGBTQ+ community is not tantamount to cultural competence. According to the CDC (2015b), providing quality, culturally appropriate HIV prevention services cannot be predicated on being a member of the LGBTQ+ community. Cultural competence is demonstrated by valuing clients' cultural beliefs, facilitating an exchange among providers and the targeted communities, collaborating with the community and other agencies to define needs, and professionalizing personnel (CDC, 2015b). The research findings indicated that each of the HIV interventionists demonstrated an appreciation for the associated components of the culture of AA MSM and how these components influence their views on health. The research findings also indicated that incorporating culture into HIV prevention work targeting AA MSM is a monumental task because AA MSM bring numerous issues to the therapeutic setting. Culture affects countless aspects of our lives, to include how people function in society, function with and within our families, and how we practice our religion (Lucasa et al., 2010).

Interpretation of Findings

Although there was a dearth of research in the area of cultural competence and AA MSM in HIV prevention, the historical context of cultural competence relative to other ethnic minorities guided the research. The participants in the study were 10 HIV prevention counselors/workers from the VDH, the MHC, The Health Brigade, and Nationz. Each agreed to be interviewed; the interviews were guided by the instrument in

Appendix A. Following the data analysis process, 34 central ideas were documented, which lead to 11 codes, and the emergence of three themes. After the themes were established, I referred back to the literature review to check for concurrence or dissidence with the established evidence. In the following section, I will compare the findings against the literature.

Literature Review and the Findings

The literature uncovered the importance of cultural competence for those working on the front lines of prevention; it has been advanced as a viable solution for health disparities and poor health outcomes. Colón and Malow (2010) supported adopting culturally competent evidence based services/messaging; they felt it would provide optimal benefit to AA MSM. It is widely accepted that cultural competence is an iterative pursuit (Saha et al., 2013). Cultural competence, as defined by SAMHSA (2016), is a practitioner's ability to interface with clients of diverse cultures effectively. The HIV prevention practitioners involved in this study assessed themselves to be culturally competent. To put cultural competence into practice one must have a certain degree of cultural awareness. This term refers to the intentional self–examination of personal biases, prejudgments, and suppositions people might have concerning those who are dissimilar to them (Elminowski, 2015). Most of the respondents assumed that ingrained prejudices and insensitivity could impact the success of prevention work. In addition, many were able to describe the complexities of working with AA MSM and the various needs they bring to the health setting. There was consensus among all of the participants as it pertains to cultural competence; each practitioner believed it could lead

to effective messaging/services, increased compliance, and, ultimately, better health outcomes.

Research Question 1

The first research question was: What is the self- perceived cultural competency of HIV counselors delivering HIV prevention services to AA MSM in Richmond, Virginia, and surrounding counties? The theme that was associated with this research question was cultural knowledge. As aforementioned, each of the participants perceived themselves to be culturally competent, although only one reported receiving cultural competence training at some point during their career.

To create positive change with AA MSM and the HIV epidemic, prevention messengers should know the cultural context of the population (SAMHSA, 2016). Most of the participants advised that they had extensive exposure to AA MSM and deemed themselves culturally sensitive. The respondents also considered cultural competence as an indispensable component in HIV prevention messaging. According to Malat (2013), cultural competence training is just one effective means to enhance the quality of health messages for AA MSM. Having an appreciation for the historical and social elements of the service area and dialect of the target population, having an understanding for the differences among gender expression and sexual orientation, and identifying ways to affirm and maintain the dignity of the representatives of the marginalized population are all approaches that enhance cultural competence (Orgel, 2017). Although some of the participants displayed more passion about the historical context that shapes the culture and socialization of AA MSM, they all acknowledged its significance.

Participants displayed an understanding of how distrust affects health-seeking behaviors. Mistrust of the public health system could be attributed to antipathy associated with the historical unethical practices perpetrated against Black Americans (Gatson, 2013). Perceived and real acts of discrimination lend credence to conspiracy theories related to public health (Gatson, 2013). According to Perry-Mitchell and Davis-Maye (2017), AA MSM who feel disenfranchised, reside in chaotic neighborhoods, have low socioeconomic status, or are largely discriminated against by the broader society, require programming/prevention messaging that promote cultural avenues of nurturance and encouragement. HIV interventionists should also be cognizant of the fact that poverty and the social conditions in which some AA MSM live could engender significant HIV risk. (CDC, 2017a). The literature confirmed that it would be beneficial for HIV workers commissioned to aid those at risk of being infected with HIV to be thoughtful about AA MSM's experiences while values and cultural aspects are respected (Perry-Mitchell & Davis-Maye, 2017). The Substance Abuse and Mental Health Services Administration (2012) advised that HIV prevention counselors must have a desire to develop prevention strategies within the cultural context of their target population. Conway-Klaassen and Maness (2017) concluded that culture can dramatically affect clients' views on healing from diseases and their level of trust in the recommendations given by interventionists. With HIV counselors reporting an awareness of this distrust, they must have measures in place to counteract this destructive philosophy of AA MSM.

Research Question 2

The second research question was: How do HIV counselors' perceptions of cultural competency affect: (a) the development of HIV prevention messages, and (b) their delivery of prevention messages? Culture-specific strategies was the second theme to emerge from the data. There were a few factors that allowed this theme to emerge including PrEP, stigma, and lack of education. Religious institutions were considered positive. According to the respondents, these negative components contribute to HIV risk with AA MSM, and should be accounted for when developing prevention messaging/services. The findings show that, with stigma and lack of education, initiating and adhering to HIV prevention services may be impeded. However, PrEP presents as a unique challenge in that at some level services have been accessed by the client, but the findings demonstrate that some AA MSM may view the medication as a cure-all and as a result abandon condoms and other preventative methods. Promiscuity was cited as an unanticipated phenomenon that may be associated with PrEP (Field et al., 2018).

Based on the evidence from the literature review, adjusting and customizing established HIV interventions, such as PrEP, for AA MSM could be beneficial for the person, family, and community. The respondents shared that they provided intense counseling concerning adherence and combining the drug with condoms and other prevention techniques to counterbalance the actions inimical to health and prevention. PrEP as a modern, innovative prevention method holds enormous promise with 99% efficacy in decreasing the probability of transmission of HIV (Eaton et al., 2017a). However, many of the participants were concerned that PrEP was fitting into a sort of

self-serving, sexually risky lifestyle. The study conducted by Fields et al. (2018) supported this notion. They found that the commentary surrounding PrEP is largely negative in the AA MSM community. The researchers concluded that many of the participants associated promiscuity with those who reported using the drug. In like manner, Eaton et al. (2017b) conducted a study that revealed that those who used the antiretroviral were derogatorily labeled by the participants as being "Truvada Whores" and are said to be simply accommodating debauchery (Truvada is a PrEP drug).

The literature review appeared to corroborate many of the participants' opinion that a lack of education is a determinant for heightening risks and contracting the disease. The CDC (2018b) cites people's lack of knowledge about prevention as a risk for contracting the disease. According to Wyatt et al. (2012), consideration should be given to deciphering how the target population's cultural values affect knowledge and behavior. They believe it is important to give attention to marginalized persons' lack of access to health information and other identified barriers that impede change. Even more, the researchers suggest that HIV risks are increased when particular groups fail to receive the needed skills that are reasonable and consistent with their culture (Wyatt et al., 2012). It is important to note that the lack of knowledge about HIV and HIV prevention services can at times be attributed to an intentional response by AA MSM; they are more likely to shun treatment than their White counterparts (Pesquera et al. (2008). Race is shaped by cultural and socioeconomic factors; low level of education attainment is a prominent factor. With this in mind, it is also recommended that HIV health materials are presented in easy to understand diction (Office of Minority Health, 2016).

The CDC (2017) cites heterosexism, bigotry, and HIV-related stigma as risk factors that should be understood when developing AA MSM prevention activities. HIV stigma is biased opinions and unfavorable beliefs about people diagnosed with HIV. This type of prejudice condemns a particular group and labels them socially unacceptable (CDC, 2018a). The findings from this study demonstrated that stigma was a significant force that HIV interventionists contend with when addressing HIV related issues. This is consistent with the contention of Conway-Klaassen and Maness (2017), who advised that addressing stigma in the AA MSM community and making use of cultural elements from the target group can stimulate cooperation, increase adherence, and enhance prevention work/messages. Malat (2013) asserted that HIV counselors should have knowledge of the obstacles their target population face to include stigma, because this can lend itself to a context in which they can adequately address those barriers within their health communications. That culture plays a significant role in determining the health of people is quite relevant in the context of minorities. Using archetypical prevention messages without infusing a more culturally-specific focus that incorporates important influencers of the culture, for example, stigma and other life experiences, could compromise efficacy (Saha et al., 2013).

The findings appear to line up with those of Wyatt et al. (2012) who advised that HIV prevention messages should be culturally congruent and based on positive aspects of the population's culture. In terms of positive influencers, AA religious institutions have historically been instrumental in influencing health behaviors. Pesquera et al. (2008) stated AAs historically do not hold the health care system in American in high regard.

Customarily, after being diagnosed, they rely on family for support and their religion for restorative powers. Therefore, collaborating with religious institutions would be beneficial when developing HIV prevention interventions. Culturally competent HIV counselors have a crucial skill set that would increase the prospect of integrating cultural components into traditional HIV strategies (Wyatt, 2009). Their understanding of the culture of AA MSM determines how well they construct strategies and the effects of the intervention. The literature confirms that identifying those cultural factors that serve as mediators or moderators in conjunction with long standing interventions could prove successful towards healthier sex practices.

Relationships and resources was the third theme to emerge from the data. Factors associated with the emergence of this theme were social support and available resources. This theme appears to be confirmed by the literature. According to LeGrand et al. (2014), having a robust social support can operate as a buffer to shield AA MSM from the structural barriers that may obstruct positive health behavior, and could assist with some of the uncertainty experienced about HIV prevention interventions they find themselves having to be involved in. It is well documented that the delivery of HIV prevention messaging/services should incorporate elements that leverage a strong social support (LeGrand et al., 2014).

Increased adherence to HIV prevention recommendations among AA MSM is associated with social support (Scott et al., 2014). LeGrand et al. (2014) conducted a study to explore the relationship between social support and HIV testing among AA MSM. The results demonstrated that social support contributed to more HIV testing.

Although social support and family ties are not necessarily unique to AA culture, the bedrock of Black culture has been the family. Having the support of family when maneuvering the public health system and managing a potentially life altering situation, can be crucial in ensuring AA MSM remain engaged in HIV prevention interventions (LeGrand et al., 2014).

An important aspect of cultural competence is being able to properly assess the needs of the service area and link them to the necessary resources. Many AA MSM are economically disadvantaged and reside in urban poverty areas (CDC, 2017a). The respondents acknowledged that food insecurity and housing instability heightens vulnerabilities. According to the participants, incorporating nutritional and housing support into HIV messaging/services is essential to improve engagement. This approach was supported by the literature. Anema (2009) uncovered evidence that food insecurity significantly impacts HIV behavior risks, is linked to poor clinical outcomes, and is associated with hindering access to HIV prevention services. Anema (2009) conducted a systematic review of 152 studies. It was found that targeted housing assistance can be a significant component to increased retention in HIV services. HUD determined that health systems, in order to be effective, must take into consideration the determinants of health (Housing Opportunities for Person with AIDS, 2013).

Conceptual Framework

The theoretical framework for this project was the PEN-3 cultural model. At the core of this theory is the idea that culture dictates and shapes a person's perception of health and health behaviors (Iwelunmora et al., 2014). The key dimensions of the PEN-3

central to the study are cultural identity, cultural empowerment, and relationships and expectations (Iwelunmora et al., 2014). Associated with the domain of cultural identity are the sub-categories of person, extended family, and neighborhood. The sub-categories for relationships and expectations are positive, existential, and negative. Last, the cultural empowerment domain is supported by perceptions, enablers, and nurturers (Iwelunmora et al., 2014). The PEN-3 model was valuable because it was used to consider the HIV prevention counselors' awareness of culture. HIV prevention counselors are charged with furnishing HIV prevention education/services to people diagnosed with the disease and those who are considered at high risk for contracting HIV.

Cultural Identity

Again, person, extended family, and neighborhood are the sub-categories for the cultural identity domain (Iwelunmora et al., 2014a). This domain helps HIV interventionists to focus on the most effective entry points. This involves knowledge about the person, family, and community. Relative to this domain, the health message/interventions should target each individual and should empower AA MSM to make informed decisions according to their personal situations. The interventionist should also take the family into account as part of the person's context. Finally, in developing prevention messages/interventions, the interventionist should consider the community and recognize the value in collaborating with community leaders to make certain that prevention messages are culturally relevant (Iwelunmora et al., 2014a).

Iwelunmora et al. (2014a) posit that the forest will provide more information than a single tree. This is to suggest that illness is a shared responsibility. The PEN-3 model

highlights the contribution of the collective in establishing how AA MSM approach their health, and it emphasizes the seriousness of guiding health-related decision making (Saha et al., 2013). For example, among Latino women, Erwin et al. (2010) found that the divergent culture of Latino women from the dominant culture in the United States is often disregarded in cancer intervention strategies. Similarly, with American Indians/Alaska Natives, Hiratsuka et al. (2016) found that smoking was greatly attributed to family and tribal expectations, more likely in a positive, enabling fashion.

The findings of this study demonstrated an awareness of the influence that sociocultural factors have on AA MSM and HIV prevention workers. The findings also demonstrated an acceptance of the interventionists' obligation to exploit the cultural elements of health in their service area including the entry points of person, family, and neighborhood. The findings also showed knowledge concerning the diverse issues that AA MSM bring to the clinical setting.

Person. Health messages/interventions should empower AA MSM to make informed decisions about their health. Each of the participants considered historical and cultural factors concerning AA MSM valuable towards developing HIV prevention messages/interventions. Culturally relevant and compelling interventions for behavior modifications involve knowledge of factors pertaining to the individual–level coupled with influences from cultural norms (Iwelunmora et al., 2014a). The findings demonstrated that HIV prevention workers carried this out by pinpointing pertinent health factors that impact a person from the group of interest or the whole group and spotlighting these factors when developing culturally competent health prevention

initiatives.

Family. Understanding the influence of the family on health is an important concept when developing effective prevention interventions for AA MSM. The PEN-3 model is operationalized to position the family as a significant contributor of an individual's health (Sharma et al., 2014). The collective is viewed as sharing the responsibility of disease and illness. The family is emphasized when determining the health experiences of AA MSM and is prioritized when considering health-related decisions.

The findings demonstrated that, although messaging/interventions may focus on the person, the family and even predecessors should be taken into account as part of the person's context. This allows for isolating particular cultural values regarded as central to AA MSM culture that could possibly play a role in HIV prevention messaging/interventions. For example, the participants noted that the adoption of their predecessors and family's distrust of health establishments may be one of the key AA MSM values strongly recalled when facing health challenges. Erwin et al. (2010) discovered that the family's cynical perspective of the health system in the United States may take precedence when AA MSM are attempting to identify ways to address their health challenges. Per the findings, HIV interventionists appear to have an understanding about the factors that impede AA MSM from adhering to HIV prevention interventions. Culture can influence opinions about health and AA MSM's level of trust in health practitioners. Culture can also dramatically affect a client's view on healing from

diseases and their level of trust in the recommendations given by health interventionists (Conway-Klaassen & Maness, 2017).

Community. There are underlying causes of HIV that are considered preventable; the factors that increase AA MSM's risk include engaging in unprotected sex, having multiple sex partners, and having a high-risk companion. Wyatt et al. (2012) believe that HIV risks are increased when particular groups fail to receive the needed skills that will be reasonable and consistent with their culture. HIV counselors often deliver prevention messages from their own socio-cultural perspective which can be contrary to that of the targeted population's culture; Betancourt et al. (2014) advised that the delivery of prevention messages that are sensitive to the population's socio-cultural identity are more effective prevention messages.

The findings demonstrated that HIV counselors at times enlisted community organizations to assist in the creation of health messages. Leaders in the community and organizations affiliated with the population of interest can be brokers. This means relying on community-based principles and collaborating with those from the community that are close to the issue of interest. Working together with leaders from organizations and the community who are familiar with the target group can be a good means of acquiring valuable information to create effective health messages/interventions (Wyatt, 2009).

Cultural Empowerment

With this domain, the positive, existential, and negative characteristics of the targeted behavior are examined (Iwelunmora et al., 2014a). This dimension is important

to the development of culturally applicable prevention strategies targeting AA MSM (Sharma et al., 2014). The positive aspects involve factors relating to principals and relationships, existential involves behaviors that are unique to AA MSM and should not be defined as destructive. The negative aspects are adverse behaviors or views that should be modified (Sharma et al., 2014).

Positive. Based on this construct of the PEN-3, discerning and promoting positive health behaviors of AA MSM should be central to prevention messaging and interventions. In the literature Sharma et al. (2014) discussed compelling evidence of the benefits that comes with focusing on positive features of the culture and behaviors of AA MSM. Conway-Klaassen and Maness (2017) determined that concentrating on symptomatology and negative aspects for prevention messaging has not been successful. Iwelunmor et al. (2010) support the construction of HIV messages based on the positive traits of AA MSM, while shrinking particular features of their culture that were traditionally interpreted as negative and disadvantageous.

In view of the cultural empowerment domain, the findings showed positive practices correlative to the development of prevention messages/interventions in an effort to impact health seeking behaviors of AA MSM (existential) and confront destructive beliefs (negative) that served to impede HIV prevention efforts. These positive practices of HIV prevention workers included a willingness to collaborate with community organizations to address AA MSM's various issues in a holistic manner, as well as their ability to incorporate cultural factors relevant to AA MSM that will increase engagement. The findings also demonstrated that the participants had an understanding that identifying

and incorporating positive features of the culture of AA MSM could encourage positive decision making such as testing, condom use, and adherence.

Existential. This construct includes behaviors or beliefs that are unique to AA MSM and should not be defined as destructive. These behaviors and beliefs should be incorporated into health messaging to inform the development of culturally sensitive interventions. The findings demonstrated that the centrality of the church's role in the life of AA MSM could be considered existential. AA MSM have had a complicated history with the Black church given their stigma reinforcing messages. However, traditionally, AAs have relied heavily upon the church for moral and spiritual leadership. The findings also demonstrated knowledge concerning the types of prevention strategies/treatment available to and targeted at AA MSM such as, inclusion of supportive family members and partners into the clinical environment.

Negative. This construct includes destructive beliefs and behaviors by AA MSM. Before the development of messaging/interventions, HIV counselors should contextualize what is preventing AA MSM from engaging in prevention strategies and what is driving them to engage in destructive health behaviors (Sharma et al., 2014). The findings demonstrated that stigma can promote shame and fear of disclosure. It can also be a barrier to testing and prevention. The findings also demonstrated that a lack of knowledge about the disease can comprise their response to prevention strategies and adherence. Understanding this, AA MSM targeted messaging/interventions should include support for positive values and modifying negative ones.

Relationships and Expectations

In this domain, perceptions of AA MSM concerning HIV and HIV-related risk behaviors, availability and access to resources, and the impact of a social network in making decisions related to health are examined (Sharma et al., 2014). This dimension is concerned with learning what influencers affect people's behavior (Iwelunmor et al., 2014a). With this dimension, the first letter P represents perceptions, The E represents enablers, and the N represents nurturers.

Perceptions. This construct allows practitioners to explore the knowledge and values of AA MSM needed for behavior change. It accounts for the family and community as well. Positive perceptions are the knowledge and values of AA MSM that influence decision making in a positive manner (Iwelunmor et al., 2014a). For instance, having an understanding about factors that are responsible for and are consequent of HIV risk behaviors are considered positive perceptions. From the responses of the HIV interventionists, it was quite clear that they had an understanding of AA MSM's perceptions.

Enablers. This construct signifies the availability of resources and referrals that can either facilitate or impede behavior change (Iwelunmor et al., 2014a). Positive enablers pertain to resources and organizational support that are helpful and encourage AA MSM in positive health decision making to prevent further risk, for example, accessibility to HIV prevention workers or homelessness prevention programs. The participants of this study are considered positive enablers. They are all employed with public health agencies or HIV prevention agencies and they respond and work to ensure

the well-being of the AA MSM population. HIV prevention workers' duties are not limited to direct HIV prevention work; some of their work involves indirect prevention activities including making referrals to address food insecurity, housing instability, and mental health needs. Again, food insecurity is associated with HIV prevention engagement (Anema, 2009). Negative enablers are considered discouraging structures for AA MSM that may heighten risky sexual behaviors, such as unsupportive health clinics.

Nurturers. This construct includes the people who are within the social system targeted for prevention efforts who will cultivate or support positive health seeking behavior (Iwelunmor et al., 2014a). The social system is central to this construct in that beliefs and behaviors of AA MSM are influenced by family and friends. Nurturing is considered positive when family and friends show support that lends itself to healthy sexual decision making. The findings showed that the role of the social system, as perceived by the respondents, was to support issues regarding healthy sexual decision making such as HIV testing, PrEP adherence, condom use, and so on. Increased adherence to HIV prevention recommendations among AA MSM is associated with social support (Scott et al., 2014). Negative nurturers are seen as discouraging family members and even health workers who adversely impact healthy sexual decision making. The essential people who were found to have a meaningful negative impact on AA MSM were parents.

Limitations of the Study

There were limitations associated with this investigation; therefore, the reader should consider the study in the context of the limitations. First, the 10 interviews were conducted with professionals who work in HIV prevention from several public health organizations in the Richmond, Virginia, area. The data were the responses of the participants and could be susceptible to bias or exaggeration. The bias may have influenced responses as the interview questions are subject to the interpretation of the participants, which could affect codes/themes. Additionally, in chapter one, I shared my concerns that researcher bias could undermine the study. I have done due diligence to ensure this did not occur. Throughout the data collection and analysis phases, I journaled my thoughts and was sure to avoid projecting my opinions, which allowed the respondents' perspectives to be authentically shared.

Recommendations

Remarkable advances have been made in the area of HIV prevention. Nevertheless, the limited literature dedicated to AA MSM and culturally competent HIV prevention messaging shows that there is a need for further exploration for the utility of cultural competence in prevention efforts targeting AA MSM. In this study, all but one participant reported receiving formal cultural competence training at some point during their career. The HIV interventionists considered the concept of cultural competence in the context of their prevention work and viewed it as complicated, multi-layered, and commonly accompanying respect, which demonstrates itself by the actions and behaviors of the practitioners. Levy et al. (2014) found that AA MSM's experiences with HIV

prevention services are inadequate and fail to offer culturally appropriate strategies that will lead to behavior changes. HIV prevention counselor populations would have greater success if they structured interventions around enhancing MSM cultural competency (Jin et al., 2014).

Creating theory-based, culturally appropriate HIV prevention messages to promote sound strategies for AA MSM is vital to eliminate HIV disparities (Govere & Govere, 2016). Cultural competence training can be one effective means to enhance the quality of health messages targeting AA MSM (Malat, 2013). Such trainings can expose HIV counselors to the obstacles their target population encounter and can lend itself to a context in which they can adequately address those barriers within their health communications. Based on their systematic review, Govere and Govere (2016) found that cultural competence training enhances this skill with health practitioners.

The findings indicated a significant level of exposure to AA MSM, there, however, is a severe deficit in formal training on the concept of cultural competence. I would recommend cultural education focused on AA MSM emphasizing the components of: (1) historical and social elements of the target group and dialect of the target group; (2) differences among gender expression and sexual orientation; (3) clinical approach to addressing distinctive health care needs of AA MSM, including ways to affirm and maintain the dignity of the representatives of the marginalized population (Orgel, 2017).

Social Change Implications

Public health research is critical for organizations seeking to engage AA MSM. The social change implications can be monumental. Although change can be difficult,

communicating and sharing new approaches in HIV prevention messaging/services can effect changes in the structure and function of prevention organizations as a whole (Sablonnière, 2017). Without applicable research, health establishments focused on change may be built on speculative problem identification and conjectured community needs. The findings of the study reinforced that cultural competence is vital for HIV counselors in Richmond, Virginia, for several reasons including assuring an effective exchange between counselor and client, providing adequate analysis of the information gleaned from interactions, framing solutions, and ensuring appropriate engagement in prevention objectives (Wyatt, 2009).

This investigation has social change implications, especially in the context of developing sustainable HIV prevention interventions focused on integrating culture, thereby reducing HIV disparities in the Richmond, Virginia, area. The findings showed that culturally-based behaviors are essential to acknowledge because they frequently provide meaning to an individual or group's identity and define certain aspects of their lives (Wyatt et al., 2012). I will share my results with the participants and their agencies. The findings may cause HIV prevention workers in Richmond, Virginia, to become more cognizant of their target group and employ techniques to overcome cultural divisions (Lucasa, et al., 2010). Additionally, the findings may cause HIV interventionists in Richmond, Virginia, to become more culturally responsive in addressing the needs of their service area. Opportunities may exist to share the study/findings with HIV prevention counselors in the Richmond, Virginia, as well as practitioners in other localities through peer reviewed journals.

Based on the findings of the study, I have identified a way that HIV interventionists in Richmond, Virginia, may seize upon a unique opportunity of buttressing associations that have a historical and cultural legacy of eluding involvement in HIV prevention targeting AA MSM. Meaning, AA church leaders and AA family members have failed to respond to the HIV epidemic that has devastated the Black community in a way commensurate with the impact of the disease. This would be an opportunity to make further inroads into religious institutions for the purposes of guiding and promoting prevention messaging that could correlate with better health outcomes. HIV counselors may create strategies that incorporate the family and collaborate with Black churches, for instance, this could involve health fairs for families and family therapy sessions that occur once a month, and HIV prevention seminars at Richmond churches. In terms of family members, their support, which comes from a position of importance, could help promote self-actualization and better health outcomes for AA MSM. In this way, these groups that were once a source of condemnation and ostracism could be made into an ally for HIV prevention.

A constructive contribution of the findings from this investigation include HIV prevention workers in the Richmond, Virginia area understanding of the effect that heritage and acculturation have on the behaviors and beliefs of AA MSM and integrating such in the development of prevention messages/strategies. This integration may coincide with Black History Month, AA Heritage Day or any other culturally significant day recognized and revered by AAs. It is vitally important that interventionists allow the findings of this investigation to inform their work to ensure an optimally effective clinical

experience for their target population. It is also paramount that this approach is internalized so much so that it will be consistently applied to their prevention messages/work for their service area in Richmond, Virginia.

Theoretical Implications

The PEN-3 model was utilized to examine the targeted health behavior in this study. Other researchers may be able to apply all or some of the three domains to investigate the influence culture has on beliefs and behaviors with other marginalized groups, and also on how the family's role is key in determining health behaviors. Regardless of the malady or the minority group of interest, the PEN-3 model affords the researcher the opportunity to investigate cultural values that are advantageous to constructive health behaviors, identify unique customs that are not averse to health, and isolate negative beliefs that may have a destructive influence on health. Iwelunmora et al. (2014a) advised that health may be partly entrenched in relationships guided by their culture; the PEN-3 could aid in capturing the influence of the collective on health behaviors.

Conclusion

The results of the study revealed that HIV prevention workers perceived themselves to be culturally competent, although only one had received cultural education. The data also showed that cultural competence training can be one effective means to enhance the quality of health messages targeting AA MSM (Malat, 2013). Most of the HIV interventionists in this study appeared to be cognizant of some important

components underpinning effective HIV prevention messages/services, such as a recognition of AA history and the cultural dynamics of AA MSM.

After the data analysis process, I determined that HIV prevention workers in Richmond, Virginia, have at least a baseline understanding of the cultural constructs specific to AA MSM, and how to operationalize cultural competence in HIV strategies. Acknowledging that barriers to access HIV prevention services and a lack of adherence to recommendations may be rooted in the lack of cultural relevance in prevention messages/strategies for the service area, can be transformational for the AA MSM in Richmond, Virginia.

The theoretical framework for this project was the PEN-3 cultural model. The key dimensions of the PEN-3 are cultural identity, cultural empowerment, and relationships and expectations (Sharma et al., 2014). The PEN-3 model's utility in this study was three fold; it was used to explain the importance of cultural competence in the development and implementation of HIV messages/interventions, it aided in formulating interview questions, and it helped in directing the interpretation of emerging themes.

Research indicated that clinician communication/messaging is in relationship to client satisfaction, compliance with recommendations, and health outcomes (Wyatt et al., 2012). The themes that emerged from the study demonstrated that HIV counselors may be aware of the aforementioned factors that are a result of effective, culturally appropriate messages. The three themes that emerged were cultural knowledge, culture-specific strategies, and relationships and resources. The first theme, cultural knowledge, suggested a demonstrated cognizance and appreciation for the variables that manifest

itself between the clinician and the AA MSM community. This is indicative of HIV counselors operating with cultural awareness during clinical decision making, and it also lends itself to an understanding of its prospective effect on service provision. The second theme, culture-specific strategies, related to factors that could possibly address the heighten risk of HIV transmission with AA MSM. The factors associated with this theme included PrEP, stigma, lack of education, and religious institutions. The factors associated with the third theme, relationships and resources, were social support and available resources.

This study has important social change implications to public health. It serves to probe an area that is under-researched with important health implications for a marginalized group. The findings of the study may expand HIV interventionists' perspective on cultural competence and show that cultural education and the internalization of that education could lead to consistent application of those learned principles in AA MSM targeted HIV prevention messages. The findings may also give insight into the various ways health establishments can engage in culturally relevant prevention, and position themselves to be leaders in informing the development of culturally competent HIV prevention messages that will aid in the acceleration of changing longstanding, ineffective prevention approaches targeting AA MSM.

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Appendix A: Researcher Developed Instrumentation—The Self-Perceived Cultural Competency Tool—Interview Guide

I appreciate your willingness to participate in the study, (name). My name is Tonya Herring and I am a Walden University student pursuing a doctorate degree in Public Health. This interview will be a part of my dissertation research. Do I have your permission to record this interview?

The informed consent form indicated that your involvement is optional, and you may elect to stop the interview at your discretion or ask questions as you wish. The information obtained from you and the other participants will give greater insight into the role that cultural competence plays in HIV prevention targeting AA MSM. Your identity will be confidential and your responses will be aggregated with the responses of all the other participants. There are no wrong answers to these questions.

The interview questions are as follow:

Q1: In your opinion, what type of factors would make one culturally competent in HIV prevention efforts targeting AA MSM? How would you describe your cultural competence with AA MSM?

Q2: How many times have you received cultural competence training in the area of AA MSM and HIV prevention? Do you consider yourself culturally competent, why?

Q3: As an HIV prevention specialist, describe the importance of having education in African American history or other marginalized groups?

Q4: How can the family be taken into account when developing prevention messages/activities for AA MSM?

Q5: How can the community be taken into account when developing prevention messages/activities for AA MSM?

Q6: Do you have any thoughts about what factors could contribute to the high HIV rates among AA MSM?

Q7: Please give an example of an occurrence when you felt the need to make an adjustment in your prevention/counseling messages on behalf of the AA MSM community/or member?

Q8: Do you have any thoughts about what factors could possibly slow HIV rates among AA MSM?

Q9: Describe detrimental health beliefs of AA MSM?

Q10: Describe the positive features of AA MSM, the family, and the neighborhood that can be incorporated into HIV prevention messages that will lead to engagement.

Q11: What are the available resources that can facilitate behavior change?

Q12: Identify the people who are within the social system of AA MSM who could cultivate or support positive health seeking behavior.

Q13: Is there anything else you would like to add on the subject of cultural competence and your work with AA MSM?

Demographical questions:

Q1: What is your race?

Q2: Which gender best describes you?

Q3: Does your age fall between 20-29, 30-39, 40-49, 50-59, beyond 60?

Q4: How long have you worked in HIV prevention?

Appendix B: Email Invitation to Potential Participants

Dear (HIV Worker),

I am conducting interviews as part of a research study to gain an understanding of cultural competence with those who work with African American men who have sex with men (MSM) in the prevention of HIV. As a prevention worker, you are an ideal candidate to discuss your personal perspectives on this topic. Each interview will take approximately 30 minutes and will be very informal. My aim is to simply capture your perspective on being culturally competent as an HIV worker who serves African American MSM. Your personal information will be confidential, as such, you will be assigned a case number/code to help ensure this; your actual name will not be used in study documents. There is no compensation for the study. However, your participation will assuredly help in increasing the understanding of cultural competence in HIV prevention. If you are willing to participate in this research, please confirm your availability for further discussions when responding to this email. If you have any questions, please feel free to ask.

Thank you,

Tonya Herring