

FOR US, BY US:
SOCIOCULTURAL TARGETING
OF HIV PREVENTION MESSAGES
TO BLACK MSM

A Thesis
presented to
the Faculty of the Graduate School
at the University of Missouri-Columbia

In Partial Fulfillment
of the Requirements for the Degree
Master of Arts

by
MATHEW DAVIS
Dr. Jeannette H. Porter, Thesis Supervisor

MAY 2020

© Copyright by Mathew Davis 2020

All Rights Reserved

The undersigned, appointed by the dean of the Graduate School, have examined the thesis entitled

FOR US, BY US:
SOCIOCULTURAL TARGETING
OF HIV PREVENTION MESSAGES
TO BLACK MSM

presented by Mathew Davis,

a candidate for the degree of master of arts,

and hereby certify that, in their opinion, it is worthy of acceptance.

Professor Jeannette H. Porter

Professor Cynthia Frisby

Professor Monique Luisi

Professor Michelle Teti

ACKNOWLEDGEMENTS

I would like to express deep and sincere gratitude to my thesis chair, Dr. Jeannette H. Porter for agreeing to lend her time and expertise as my research supervisor. I am extremely grateful for the constant support, encouragement and motivation that she offered me during my research. I would also like to thank her for the empathy and flexibility she provided, not only my research supervisor, but also as someone who has undergone the process to receive both her graduate and doctoral degrees as well. Her contributions as thesis chair have been truly invaluable.

I would also like to extend heartfelt thanks to the other members of my thesis committee: Dr. Cynthia Frisby, Dr. Monique Luisi and Dr. Michelle Teti. When assembling my committee, it was paramount to not only select professors with similar interest areas whose proficiency could guide my research, but also women of color, if possible. It was a great privilege and honor to have these outstanding women on my committee and I am eternally grateful for their role in helping me complete this thesis successfully.

Finally, I would like to thank my mother, Melanie Jefferson, for her love, prayers, caring and sacrifices for educating and preparing me for my future. Without her this research – and, by larger extent, both my undergraduate and graduate degrees – would not have been possible.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	ii
LIST OF TABLES	iv
ABSTRACT	v
Chapter	
1. INTRODUCTION	1
Goals of the Study	4
2. LITERATURE REVIEW.....	10
3. METHODS	27
Research Design.....	27
Participant Observation Plan.....	28
Interviews Plan	30
Data Analysis	32
4. FINDINGS	34
5. DISCUSSION	55
Significance.....	56
Limitations	59
Directions for Future Research.....	60
6. CONCLUSION	62
REFERENCES	63
APPENDIX.....	69

LIST OF TABLES

Figure	Page
1. Table 1. Common Message Elements	34
2. Table 2. List of Barriers	49

FOR US, BY US: SOCIOCULTURAL TARGETING
OF HIV PREVENTION MESSAGES TO BLACK MSM

Mathew Davis

Dr. Jeannette H. Porter, Thesis Supervisor

ABSTRACT

When compared to other racial and ethnic demographics of men who have sex with men (MSM), Black MSM contract HIV at disparately high rates. To combat these high HIV infection rates, scholarly research suggests HIV interventions, confirmed by meta-analyses to be successful in decreasing HIV risk behaviors, such as unprotected sex. However, the continued disparity in HIV infection rates among Black MSM suggests that these interventions do not effectively meet the demographic's needs.

Given this continuation of HIV risk behavior among Black MSM, who bear the most inequitable burden of HIV infection, the development of HIV intervention campaigns that target the population with relevant sociocultural messaging designed to decrease said risk behavior is critical.

This pilot, or pre-study, examines the potential inclusion of Health Belief Model-based, sociocultural targeting into HIV intervention campaigns. Through in-depth interviews with 11 Black MSM, this research studies how HIV intervention campaigns, operationalized with the (1) common message elements, (2) barriers to HIV prevention behaviors and (3) normalization of HIV prevention behaviors – all identified by Black MSM – might influence HIV risk behavior of the demographic.

Chapter 1: Introduction

The year was 1992. The Cold War officially ended; Whitney Houston's cover of "I Will Always Love You" was released and the cost of a daily newspaper was 25 cents. The year 1992 also saw the birth of the New-York based, urban fashion brand FUBU, launched by Daymond John and three childhood friends turned business partners ("About Us," 2020).

The brand name, an acronym for "For Us, By Us," communicated John's desire to create a clothing line designed both for and by African Americans in a world of non-Black owned clothiers targeting Black consumers (Robin, 1999). Designed to make a positive statement about Black empowerment, the brand quickly rocketed to success, adorning countless taste-making Black music artists and celebrities, such as LL Cool J who famously wore FUBU in a Gap commercial, rapping the acronym in a 30-second freestyle and exposing the brand to millions of consumers (Banks, 2015).

John's goal to make a positive statement about Black empowerment targeted directly to Black consumers was a success. In 1998, at the brand's height, its sales were over \$350 million USD (Banks, 2015). The message to be taken away from this example? The impact direct targeting can make in reaching a desired demographic.

Research Problem

Since the beginning of the epidemic almost three decades ago, the human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) have arguably become the most frightening health threats of our time. HIV attacks the body's immune system, making it difficult for the body to fight off infection. If left untreated,

HIV eradicates the body's defenses, allowing infection or infection-related cancers to take advantage of the weakened immune system, signaling the development of AIDS. HIV remains incurable; however, it can be controlled and managed with appropriate medical care.

Although HIV/AIDS poses significant risk to the general population, particular subgroups, such as men who have sex with men (MSM), continue to remain disproportionately affected by the virus. Despite only representing 2% of the U.S. population, MSM are at the highest risk for HIV infection (DiNenno et al., 2017), accounting for 70% of all HIV diagnoses in 2015 (Singh, Mitsch, & Baohua, 2017).

The prognosis is even bleaker for minority MSM, particularly Black MSM. According to Basu, Dillon and Romero-Daza, "among the estimated 31,896 HIV infections attributed to male-to-male sexual contact in 2011, approximately 62% occurred in African American (38.2%) and Latino (23.5%) MSM" (2016, p. 1367). This trend has shown no signs of slowing. According to the Centers for Disease Control and Prevention (CDC), in 2018 Black Americans counted for 42% of the new HIV diagnoses in the United States – despite only representing 13% of the U.S. population – and 80% of those diagnoses were from male-to-male sexual contact ("HIV and African Americans," 2020).

Despite awareness of the risks involved, MSM, and especially Black MSM, continue to engage in risk behavior increasing the likelihood of HIV infection (J. D. Fisher, Fisher, Misovich, Kimble, & Malloy, 1996; W. A. Fisher, Fisher, & Rye, 1995; Oster et al., 2011). Given this continuation of HIV risk behavior in the Black MSM community, the development of HIV intervention campaigns and the promotion of HIV risk behavior change among Black MSM, who bear the most inequitable burden of HIV

infection, are absolutely critical. Because changing the behavior of those most at risk “has been recognized as the only possible way to stop the spread of this disease and hopefully to contain it,” (Melkote, Moore, & Velu, 2014, p. 85) a substantial responsibility has been placed on HIV intervention campaigns, which play an integral role in circulating prevention messaging that may influence HIV risk behavior.

According to Basu et al., approaches to reduce HIV infections typically rely on “educational interventions that promote condom use, HIV-status disclosure among sexual partners, and developing interpersonal communication skills related to condom navigation and serostatus disclosure,” (2016, p. 1367). *Serostatus*, according to the U.S. Department of Health and Human Services’ AIDSinfo website, refers to “the state of either having or not having detectable antibodies against a specific antigen, as measured by a blood test (serologic test)” (“HIV/AIDS Glossary,” 2019). For example, an individual with detectable HIV antibodies would be considered HIV seropositive, while an individual with no detectable HIV antibodies would be considered HIV seronegative. HIV positive individuals that reach seronegative HIV status, otherwise known as an “undetectable” HIV status, engage in another HIV intervention strategy known as treatment as prevention (TasP), which “refers to taking HIV medication to prevent the sexual transmission of HIV” (“HIV Treatment as Prevention,” 2020).

According to Basu et al., meta-analyses confirm that HIV interventions “are consistently successful in increasing condom use and reducing unprotected anal sex” (2016, p. 1367). However, despite these documented successes, Basu et al. argue that the continued disparity in HIV infection rates among Black MSM suggests that these interventions “do not meet the needs of MSM of color because they fail to address how

cultural, social and contextual factors may influence HIV/AIDS risk” (as cited in Basu et al., 2016, p. 1367). In other words, current HIV interventions are not as successful among Black MSM because they do not effectively target the population with relevant sociocultural messaging designed to decrease HIV risk behavior.

Goals of the Study

The purpose of this research is to examine the effect that theory-based, socioculturally targeted HIV intervention campaigns could have on HIV risk behavior among Black MSM.

To maximize the chance of success, campaigns designed to alter HIV risk behavior should be grounded in proven behavioral theory, as growing evidence indicates that interventions “based on social and behavioral science theories are more effective than those lacking a theoretical base” (Glanz & Bishop, 2010, p. 399). Numerous theories and models, such as the Health Belief Model (HBM), have been developed by researchers “to explore the relationship between knowledge, attitudes, beliefs, perception of risk, outcome expectancies, self-efficacy, peer support, risky behavior and other pertinent factors” (Melkote et al., 2014, p. 86). An understanding of the HBM, discussed at length in the literature review below, provides the basis for more targeted messaging to Black MSM.

The argument for targeted HIV intervention campaign materials for Black MSM is “based upon principles of ‘market segmentation,’ which aim to find a specific group of consumers for a particular product or service” (Kreuter, Strecher, & Glassman, 1999, p. 277). Although generic communication materials – defined as communication materials not targeted to any one demographic in particular – possess strength in their ability to

cover general information quite broadly, that characteristic is also their most distinct shortcoming (Kreuter et al., 1999). Targeted campaign messaging addresses issues in greater detail than does generic campaign messaging, and, according to Kreuter et al., “such materials can contribute to individual behavior change” (Kreuter et al., 1999, p. 277).

Stroman (2005) provides further justification for the creation of relevant sociocultural health messaging targeting African Americans:

One rationale for developing culturally appropriate health communications for African Americans is research finding that African Americans possess distinct communication styles and distinct ways of interpreting messages. Shade, for example, argues that African Americans, in contrast to European Americans, “seem to prefer intuitive rather than deductive or inductive reasoning, prefer to attend to people stimuli rather than non-social or object stimuli, and tend to rely on nonverbal as well as verbal communication.” These factors, coupled with the emphasis that African Americans place on oral tradition, have numerous implications for the design and dissemination of HIV/AIDS messages to African Americans. (p. 25)

Explication of Concepts

Before investigating how socioculturally targeted HIV intervention campaigns could affect HIV risk behavior among Black MSM, the following terms must be explicated: *intervention*, *campaign*, *intervention campaign*, *sociocultural* and *risk behavior*.

According to the World Health Organization’s International Classification of Health Interventions (ICHI), an *intervention* “is an act performed for, with or on behalf of a person or population whose purpose is to assess, improve, maintain, promote or modify health, functioning or health conditions” (“International Classification of Health Interventions (ICHI),” n.d.). This research will only concern itself with interventions related to HIV research, education and prevention.

In accordance with the National Institutes of Health (NIH), this study defines intervention as “a manipulation of the subject or subject’s environment for the purpose of modifying one or more health-related biomedical or behavioral processes and/or endpoints” (“Frequently asked questions,” 2017). The NIH lists examples of intervention categories such as health-related behavior change, treatment, prevention, diagnostic, and delivery systems, like telemedicine. Because this research is exclusively concerned with interventions addressing HIV, we look to another source to narrow further the way this study defines intervention.

In a 2008 study, Sweat examined “how the field of HIV behavioral prevention science has described and categorized interventions historically” (p. 6). According to Sweat, “most interventions are complex sets of interrelated activities” (2008, p. 5). Sweat defined the term broadly because “the scientific literature showed that there is little consistency in how interventions are described and defined” (2008, p. 9).

Despite lacking evidence for a standard definition, Sweat acknowledged and explained the common approaches existing in the literature to categorize interventions based on the characteristics emphasized. These characteristics include:

- **Activity.** Sweat (2008) defines this as specific activities carried out by project staff, including counseling, testing, education, training and policy enactment.
- **Mode of delivery.** This encompasses the specific channel through which the content is delivered and includes mass media, peer education, faith-based intervention and community-based intervention.

- **Target population.** This definition focuses solely on the targeted behavioral risk group, such as men who have sex with men, injecting drug users or sex workers.
- **Setting.** Sweat (2008) defines this as based on the location of intervention delivery, such as the workplace or schools.
- **Commodity.** This describes a product that is provided. Examples include “condom social marketing, needle exchange, microcredit and condom distribution” (Sweat, 2008, p. 9).
- **Outcome or goal.** This intervention type is described by its intended goal, such as abstinence or empowerment.
- **Theory.** This definition reflects the intervention’s theoretical basis. Examples include structural interventions and policy interventions.

This research will focus on two characteristics: the activity and the mode of delivery. The term intervention will be used to emphasize an activity, or specific methods undertaken, such as education, whereas the phrase *intervention campaign* will be used to emphasize the mode of delivery, or the specific channels of content delivery.

When organized into a concentrated effort, modes of delivery are referred to as a *campaign*. Noar and Kennedy define campaigns as “efforts to generate specific outcomes or effects in a relatively large number of individuals, usually within a specified period of time, and through an organized set of communication activities” (2009, p. 980). These can occur at the national, regional or local level, “either as stand-alone efforts or as part of multicomponent programs” (Noar & Kennedy, 2009, p. 980). Campaigns typically use either a single medium or multiple media, including broadcast (radio, television, etc.),

publishing (newspaper, magazine, posters, banners, etc.) and the Internet (websites, email, social media, etc.). Although Noar and Kennedy report that three-quarters of campaigns use multiple media channels, involving multiple campaign strategies, to disseminate their messages, this study will concern itself only with public service announcements (PSAs), “an essential element of campaign efforts” (2009, p. 980).

Next, the *sociocultural* targeting of the intervention must be defined. According to the Cambridge dictionary (2019), sociocultural refers “to the different groups of people in society and their habits, traditions and beliefs.” Drake defines sociocultural by shared characteristics, including the “use of a common language, adherence to a common religion (or at least to shared cultural features that have a religious basis), and ... values, customs, organizations and institutions” (1989, p. 64). Additionally, Poyer describes “agency; power; the relative role of social structures and individual action in culture change; the intersections of ethnicity, class and gender; and the historical shaping of modern institutions and cultural representations” (2001, pp. 2893-2894).

Using a combination of these definitions, this study acknowledges that sociocultural encompasses a multitude of concepts including, but not limited to, ethnicity, class, gender, language, religion, values, customs, and organizations and institutions. This research posits that interventions and intervention campaigns operationalized to include relevant sociocultural factors will be more successful at reducing HIV risk behavior among Black MSM, as suggested by previous research (Basu et al., 2016; Kandula, Khurana, Makoul, Glass, & Baker, 2012; Li, Lei, Wang, He, & Williams, 2016).

Finally, and most simply, this research defines *risk behavior* as any behavior that puts a subject at greater risk for HIV infection. Basu et al. describes circumstances for increased susceptibility to HIV infection such as “having sex with more than four partners, using drugs or alcohol before having sex, and engaging in unprotected intercourse” (2016, p. 1367).

With the explication of relevant terms complete, this research will go on to discuss theory and prior literature as well as the research methods used.

Chapter 2: Literature Review

Introduction of Theory

As previously mentioned, the purpose of this research is to determine the effect that theory-based, socioculturally targeted HIV intervention campaigns could have on HIV risk behavior among Black MSM. Intervention campaigns designed to alter HIV risk behavior should be based on proven behavioral theory. The Health Belief Model (HBM) provides an established foundation upon which to ground this study.

The model was created in the 1950s by a group of U.S. Public Health Service social psychologists “in an attempt to understand the widespread failure of people to accept disease preventives or screening tests for the early detection of asymptomatic disease [and] it was later applied to patients’ responses to symptoms, and to compliance with prescribed medical regimens” (Janz & Becker, 1984, p. 2).

Janz and Becker (1984) explain that the HBM’s components are the result of a body of psychological and behavioral theory whose models hypothesize that behavior is dependent upon two key variables:

(1) The value placed by an individual on a particular goal; and (2) the individual’s estimate of the likelihood that a given action will achieve that goal. When these variables were conceptualized in the context of health-related behavior, the correspondences were: (1) the desire to avoid illness (or if ill, to get well); and (2) the belief that a specific health action will prevent (or ameliorate) illness (i.e., the individual’s estimate of the threat of illness, and of the likelihood of being able, through personal action, to reduce that threat). (p. 2)

Theoretical Components. The model contains four basic components: perception of “(1) vulnerability to the negative event, (2) severity of the negative event, (3) benefits of specific preventative actions, and (4) barriers to performing preventative actions”

(Gerrard, Gibbons, & Bushman, 1996, p. 390). This research expounds on the model's components below:

1. **Perceived Susceptibility.** Perceived susceptibility (or perceived vulnerability) refers to the belief about the chances of contracting a condition or disease. For instance, a Black MSM must believe there is possible risk of becoming infected with HIV before he will be interested in altering his HIV risk behaviors or engaging in HIV prevention behaviors, such as increased utilization of condoms or preventative antiretroviral drug regimens, like pre-exposure prophylaxis (PrEP).
2. **Perceived Severity.** This component of the HBM refers to feelings of how serious a condition or illness is, or how serious the consequences of leaving a condition or illness untreated, such as pain, disability and death, are. Additionally, possible social consequences are considered within this component, such as potential effects to family, work and social relations. For the sake of brevity, “the combination of susceptibility and severity has been labeled as perceived *threat*” (Champion & Skinner, 2008, p. 47).
3. **Perceived Benefits.** Even if an individual recognizes the perceived threat of an illness or condition as significant, the individual is not expected to accept recommended health action, such as reducing HIV risk behaviors, unless he also perceives the benefits of the various available actions, like regular condom usage, HIV testing, etc., for reducing the disease. Champion and Skinner acknowledge that “other non-health-related perceptions, such as the financial savings related to quitting smoking or

pleasing a family member by having a mammogram, may also influence behavioral decisions” (2008, p. 47).

4. **Perceived Barriers.** This component encompasses the negative aspects of a particular health action, such as reducing HIV risk behaviors. According to Champion and Skinner, an unconscious “cost-benefit analysis occurs wherein individuals weigh the action’s expected benefits with perceived barriers – ‘It could help me, but it may be expensive, have negative side effects, be unpleasant, inconvenient, or time-consuming’” (2008, pp. 47-49). In this way, the perceived threat provides the catalyst for an individual to take action and the perception of benefits, minus the perceived barriers, provides the individual a preferred path of action (Rosenstock, 1974).

As research about the model evolved, two additional constructs were added (Champion & Skinner, 2008):

5. **Cues to action.** This includes stimuli to trigger the preventative behavior, such as conscious perception of HIV intervention campaigns offering HIV prevention strategies.
6. **Self-efficacy.** According to Bandura (1997), self-efficacy is defined as “the conviction that one can successfully execute the behavior required to produce outcomes” (as cited in Champion & Skinner, 2008, p. 49). For behavior change to successfully occur, an individual must feel competent to overcome the perceived barriers to take action.

Champion and Skinner (2008) also acknowledge a multitude of other variables that play a role in the efficacy of the HBM:

7. **Other variables.** Diverse factors such as demographic, sociocultural, and structural variables may influence perceptions and, thus, indirectly influence health-related behavior. These variables, such as age, ethnicity, socioeconomic status, etc., serve as modifying factors that affect the perception of threat (susceptibility and severity), benefits, barriers and self-efficacy (Champion & Skinner, 2008). Cues to action also affect these perceptions. The combination of modifying factors and perceptions compose individuals' beliefs, which in turn lead to their behavior.

Furthermore, although not widely recognized in the literature, according to Peterson, the model was modified in 1989 by Guydish and Ekstrand to include “peer and social norms, which may be perceived as supporting or discouraging preventative behavior” (1992, p. 41). This study acknowledges such an inclusion.

The Health Belief Model and HIV Interactions. The HBM can help create a theoretical background for HIV interventions. The HBM suggests that HIV prevention behaviors are a function of the perceived threat of HIV infection and the perceptions of benefits and barriers specific to HIV prevention behaviors. According to Mantell, Divittis and Auerbach, the HBM is “the most commonly used model to predict and explain individual health behaviors” (as cited in Toro-Alfonso, Varas-Diaz, & Andujar-Bello, 2002, p. 448). The model has been used to understand the uptake of health services, making it particularly relevant and useful for understanding HIV-testing

practices (Schnall, Rojas & Travers, 2015, p. 3). Melkote et al. (2014) provides the following example of the HBM's use in HIV interventions:

According to this theory, if a person believes that AIDS is a dreadful disease and that using a condom will prevent the transmission of HIV, then that individual will be more likely to use a condom (provided there are no serious obstacles to using it) than someone with dissimilar beliefs. (p. 86)

Given this information, the HBM's application to this research is evident, albeit imperfect.

Theoretical Limitations. A marked limitation of HBM includes failing to account for the “serious obstacles” mentioned by Melkote et al., such as people who wish to protect themselves from HIV but cannot for other “social, psychological, cultural or financial reasons” (2014, p. 86). According to Melkote et al., factors such as these present more urgency than the likelihood of infection (2014, p. 86). Unfortunately, these factors are of greater consequence to Black Americans because of historic, systemic racial inequity and discrimination, which has affected Blacks socially (Williams & Jackson, 2005), psychologically (Sellers, Copeland-Linder, Martin, & Lewis, 2006) and financially (Robb & Fairlie, 2007).

An especially insidious way that this inequity manifests is in less and lower quality health care for Blacks (Snowden, 2012). In fact, at the request of Congress, the Institute of Medicine (IOM) assessed the health disparities between Black and White Americans as an overall societal problem and “concluded that health care disparities were genuine and problematic” (Snowden, 2012, p. 525). However, the IOM could not ascertain a solitary cause, stating:

The sources of these disparities are complex, are rooted in historic and contemporary inequities, and involve many participants at several levels, including health systems, their administrative and bureaucratic processes,

utilization managers, healthcare professionals, and patients. (Smedley, Stith, & Nelson, 2003, p. 1)

According to a 2019 Pew Research Center study, “a majority [of adults] (56%) sees being Black as a disadvantage, with 25% saying it hurts people’s ability to get ahead a lot” (Horowitz, Brown & Cox, 2019a). Additionally, over three-quarters of Blacks (76%) express that they have experienced discrimination or have been treated unfairly because of their race or ethnicity at least from time to time (Horowitz, Brown & Cox, 2019b).

The historic discrimination faced by Black Americans has resulted in lower socioeconomic status, which Mueller and Parcel defined as “the relative position of a family or individual on a hierarchical social structure, based on their access to or control over wealth, prestige and power” (Shavers, 2007, p. 1013). Whether measured by income, education or occupational status, socioeconomic status is “among the most robust determinants of variations of health outcomes in virtually every society throughout the world” (Williams, Priest & Anderson, 2016, p. 1). Therefore, the lower an individual’s socioeconomic status, the lower his or her health outcomes are likely to be, which coincides with the previously mentioned disparate nature of HIV infection rates between Black MSM and other populations. This inequity of HIV infection among Black MSM supports Basu et al.’s aforementioned argument that current interventions – many of which use the HBM as a basis – “do not meet the needs of MSM of color because they fail to address how cultural, social and contextual factors may influence HIV/AIDS risk” (as cited in Basu et al., 2016, p. 1367).

Based on this assertion, the use of sociocultural targeting could make HBM-based HIV intervention campaigns more effective. The ability for generic communication

materials to cover general information broadly remains their most pronounced weakness (Kreuter et al., 1999). However, targeted communication materials, which address issues in greater detail, can “contribute to individual behavior change” (Kreuter et al., 1999, p. 277).

Further argument for socioculturally targeted health messages comes from Basu et al., who assert that “the health communication discipline has long been dominated by top-down, expert-driven research/intervention approaches that are often out of touch with the lived experiences of those affected by health inequities” (2016, p. 1368). This is evidenced in the results of Kandula et al.’s 2012 research on the best ways to target cardiovascular health promotion messages to South Asian immigrants. The study found that:

A community and culture-centered approach to developing cardiovascular health promotion messages revealed tensions between the researcher’s vantage point of “cultural targeting” and the community’s perceptions and reactions to these messages. Engaging communities in every phase of message design, incorporating their explanatory models (EMs), recognizing community heterogeneity, and addressing economic and structural barriers, are critical steps to ensuring that health promotion messages reach their intended audience and achieve true cultural appropriateness. (p. 1308)

With this understanding, this study acknowledges that health interventions should heavily incorporate the feedback of the respective groups to which they are targeted to ensure sociocultural competency and, ultimately, increased efficacy in the achievement of desired results.

Prior Research. Many research studies have identified a relationship between HBM components and HIV prevention behaviors. Despite a variation in results, “support for significant relationships between perceived [threat], perceived benefits and barriers, and perceived self-efficacy are apparent” (Champion & Skinner, 2008, p. 59). These

HBM components – perceived threat, benefits and barriers, and self-efficacy – have been used in HIV interventions developed to decrease HIV risk behaviors and are reviewed next.

Perception of Threat. The HBM suggests that individuals exhibiting HIV risk behaviors require the perception of *threat* – a combination of the HBM components severity and susceptibility – before commitment to changing these risky behaviors occurs. The results of several studies found that “HIV knowledge and perception of prevalence contributed to perceived susceptibility” (Li et al., 2016, p. 69). In other words, increased knowledge increases the perception of threat of HIV infection necessary to change behavior, according to the HBM.

Research also found that the knowledge of the causes and symptoms of HIV/AIDS accurately predicted HIV risk reduction behaviors. According to J. D. Fisher et al., “information that is directly relevant to AIDS transmission and AIDS prevention is an initial prerequisite of risk behavior change” (1996, p. 114). As a result, accurate and credible information related to HIV/AIDS and HIV risk behaviors can play an integral role in a reduction of HIV risk behaviors (Melkote et al., 2014; Li et al., 2016).

In fact, in their study of condom use among Chinese MSM, Li et al. (2016) discovered that erroneous HIV information was the primary cause of low HIV risk perception. Participants in the researchers’ 17 in-depth, semi-structured interviews were uninformed on how HIV was transmitted during sexual intercourse, with a third of the participants unaware that the virus was present in seminal fluid (Li et al., 2016).

This potential for HIV misinformation can also be found among young Black MSM. In a study examining the health information-seeking practices of young (18-21)

Black MSM, Rose, Friedman, Spencer, Annang, and Lindley discovered that the health information-seeking practices were not entirely sound. Study participants reported accessing health information through both interpersonal sources, like peers and doctors, and media sources, like the Internet. Despite some study participants' receiving their health information from reliable sources like a health care provider, "peers were the most frequently mentioned interpersonal source of health information," (Rose et al., 2016, p. 351) calling into question the integrity of the information received. One study participant acknowledged this lack of credibility, admitting, "You can't always get [the] right information from your friends" (Rose et al., 2016, p. 352).

Rose et al. also found that the Internet was the overall most utilized source of health information among the study participants due to its availability, compounding the risk for misinformation among young, Black MSM. In spite of their high utilization of the Internet for health information seeking, many of the study's participants acknowledged the shortcomings of using it as a source. One participant went so far as to assert, "You can't always trust what you see online because that stuff ain't always right" while another mused, "Hopefully you can find some credible sources on there" (Rose et al., 2016, p. 353).

PSAs, made available on the Internet via websites, ads, and streaming platforms such as YouTube – which this study seeks to investigate – can possibly offer a solution. Noar and Kennedy (2009) point to evidence from several studies (Noar, Palmgreen, Chabot, Dobransky, & Zimmerman, 2009; Zimmerman et al., 2007; Snyder et al., 2004; Vidanapathirana, Abramson, Forbes, & Fairley, 2005) that PSAs, as part of larger media

campaigns, can reduce HIV risk behavior, like unprotected sex, and increase HIV prevention behaviors, such as HIV testing.

However, Noar and Kennedy (2009) acknowledge that these HIV prevention behaviors are typically short term and recommend that future studies apply more rigorous designs tailored to evaluate the outcomes of these campaigns, such as the addition of a control, or comparison, condition, “answering the question of what would have happened in the absence of a campaign” (Noar, Palmgreen and Zimmerman, 2009, p. 107).

Additionally, Noar et al. (2009) suggest dividing national campaigns into components that can be rolled out individually or rolling out campaigns one city, or region, at a time so that “more rigorous quasi-experimental pretest-posttest control group designs could be considered while still having significant public health impact” (2009, p. 110).

Questionable health information-seeking practices notwithstanding, young Black MSM seem to understand the severity of HIV, recognizing it as “the most significant health problem” of their population (Rose et al., 2016, p. 353). In addition, members of the demographic understand their susceptibility to the disease, considering “themselves to be a greater risk for contracting HIV/AIDS because of their lifestyle and high-risk behaviors” (Rose et al., 2016, p. 354). However, this understanding of the threat posed by HIV does not appear to have altered the HIV risk behaviors of Black MSM, indicated by the disparity between HIV infection rates between Black MSM and the general population.

This continued inequity suggests that, although perception of threat is a key factor in the HBM’s use to predict health-related behaviors (Li et al., 2016), the perception of the threat of HIV alone is not enough to alter HIV risk behaviors among Black MSM.

The findings of Basu et al.'s study of minority MSM supports this theory, noting “a contradiction between high levels of HIV/AIDS knowledge and a simultaneous lack of vigilance to enact this knowledge in ways that lesson HIV risk at the individual and community level” (2016, p. 1372). This is perhaps explained by Gerrard et al.'s (1996) assertion that while perceived personal threat is a necessary motivator of precautionary behavior, it is not solely responsible for said behavior. Therefore, while HIV intervention campaigns targeted toward Black MSM should incorporate the perception of threat, additional components of the HBM should be assessed for their ability to alter HIV risk behaviors. This study will also test this theory utilizing PSAs featuring this HBM component.

Perceived Barriers as Benefits. Albarracín et al. suggests that HIV intervention campaigns “are likely to increase protection behaviors when they can successfully induce perceived desirability of the behavior (i.e., positive attitudes and expectancies about the behavior) and normative pressure to engage in the behavior (i.e., social norms)” (2003, p. 166). Plainly stated, HIV intervention campaigns should use messaging that frames HIV prevention behaviors, like consistent condom use and antiretrovirals as PrEP, as benefits, not barriers.

Prior studies recommend erotizing HIV prevention behavior (Seal et al., 2000; Toro-Alfonso et al., 2002), like consistent condom use or a monogamous relationship with a single sexual partner, as an effective strategy to reframe barriers as benefits. Albarracín et al. (2001) asserts that an individual is more likely to adopt a positive attitude about condom use if he or she believes that it will lead to a positive outcome, like making sex more fun, and prevent negative outcomes, such as preventing STDs like HIV.

Toro-Alfonso et al. created an intervention comprised of four, three-hour workshops, one of which specifically incorporated “the benefits of increasing safer sex and reducing risk behaviors by being able to eroticize safer sex” (2002, pp. 448-449), for approximately five to eight Puerto Rican MSM. The researchers distributed pretests and posttests assessing sexual activity risk at both the initial and final meetings of the intervention, and results “showed reduction in high- and moderate-risk sexual practices and a significant increase in safer sex behaviors” (Toro-Alfonso et al., 2002, p. 453).

Although participants of Toro-Alfonso et al.’s study “were residents of various areas in the island including metropolitan areas such as San Juan, Ponce and Mayaguez and rural towns such as Arecibo” (2002, p. 450), research indicates that eroticizing HIV prevention behaviors may be just as effective on African American MSM. In Seal et al.’s 2000 study, 72 MSM, aged 16 to 25, completed individual interviews “to identify necessary components of HIV prevention” (p. 5). The participants, which included a sample of 32% Black/African American, acknowledged the need for condom use to be eroticized. One participant noted that “gay sex is supposed to be erotic, but introducing safe sex makes it less of a fantasy. We need to find ways to make it more enjoyable. More intense” (Seal et al., 2000, p. 12).

This study will build upon prior research to test the viability of reframing HIV prevention behaviors as a benefits, and not barriers, on the HIV risk behaviors of Black MSM.

Perception of Social Norms. As previously mentioned, Guydish and Ekstrand modified the HBM in 1989 to include “peer and social norms, which may be perceived as supporting or discouraging preventative behavior” (1992, p. 41). This modified version of

the HBM suggests that social norms regarding a specific behavior play a role in an individual's likelihood to perform said behavior.

HIV intervention campaigns should acknowledge the role social norms play in shaping individual belief – and ultimately potentially affecting behavioral change – and seek to make HIV prevention behavior more normative. When behavior or change of behavior has “wide social endorsement, then even if it causes initial personal hardship, the behavior will be adhered to if a person believes that his/her action has the approval of significant others” (Melkote et al., 2014, p. 87).

The importance of social influence in shaping intention explains, in part, why community-level HIV interventions, designed to alter communitywide norms and practices in an effort to support individual community member's efforts to change, are so successful (Wolitski et al., 1999). In their research, Wolitski et al. describe The AIDS Community Demonstration Projects, “an innovative 5-city trial to evaluate the effects of a community-level intervention for underserved populations at risk for HIV infection” (1999, p. 336). Researchers trained local residents, including Black MSM, to discuss HIV prevention behaviors with their peers and to endorse behavior changes. Post-intervention, “unprotected sexual intercourse decreased and condom use for anal intercourse increased” (Wolitski et al., 1999, p. 336).

The results of The AIDS Community Demonstration Projects are especially notable due to other research also confirming interpersonal communication as an effective means of disseminating HIV prevention behavior strategies. In the focus group and face-to-face interviews conducted by Rose et al. (2016), “word-of-mouth was the most commonly recommended channel of health information” (p. 356) and “peers were

the most frequently mentioned interpersonal source of health information” among young, Black MSM (p. 351).

Moreover, in the qualitative, in-depth interviews conducted by Seal et al., “respondents believed that young MSM should be recruited to help develop and administer HIV prevention programs” (2000, p. 15). The research goes on to suggest that said peer support programs could lead to normative changes within social groups (Seal et al., 2000).

Sociocultural Variables as Modifying Factors. In their research, Basu et al. recognize that “despite the centrality of communication in both perpetuating and working to eliminate health disparities...there is minimal health communication scholarship focusing on HIV/AIDS within African American and Latino MSM populations” (2016, p. 1368). In the available research, sociocultural variables, applicable to underserved populations such as MSM of color, although not exclusively Black MSM, did appear as barriers to effective HIV interventions.

A general trend of marginalization was present across the research, especially from within the various “cultural communities” of the respondents (Basu et al., 2016, p. 1370). In multiple studies, MSM participants of varied cultural backgrounds reported discrimination from within their own cultural communities (Basu et al., 2016; Seal et al., 2000). Root causes of homophobia within the communities of MSM of color ranged from ingrained cultural associations with religion, especially Christianity, to cultural norms and meanings – like *machismo*, or high priority of masculinity, in Latino culture – that affected opinions on male-to-male sexual contact (Basu et al., 2016). Additionally, Basu et al. (2016) noted that these discriminatory encounters, and their accompanying shame,

influenced many study participants' willingness to participate in HIV risk behaviors and reticence to discuss HIV/AIDS-related issues publicly. For Latino men, especially, *machismo* influenced HIV risk behaviors, such as unprotected sex, because, in the words of one participant, "real men don't wear condoms" (Basu et al., 2016, p. 1371). Although data was not disaggregated based on race, Basu et al. note the aforementioned willingness to participate in HIV risk behaviors in "both African American and Latino" men (2016, p. 1371).

Additionally, socioeconomic factors affected HIV prevention behavior. In Basu et al.'s (2016) research, study participants suggested that their attempts to manage the threat of HIV infection were linked to their lack of access to material resources. "They spoke, in particular, of difficulties finding consistent work amid the discrimination they experienced as [MSM of color]," which made it difficult "to secure basic necessities (e.g., food, housing, etc.) and/or access health resources to help them prevent...HIV/AIDS" (Basu et al., 2016, p. 1371). Further research indicates that HIV prevention behavior is negatively affected when fundamental needs are not met (Dutta-Bergman, 2005; Melkote et al., 2014).

Because these sociocultural factors specific to MSM of color – such as socioeconomic status and ingrained homophobia due to religious or cultural belief – appear with frequency in the limited research done on the demographic, PSAs shown to Black MSM participants in this study will include sociocultural components to gauge their efficacy in influencing HIV prevention behaviors.

Research Questions. As the research indicated, HIV interventions based upon the HBM can attempt to increase perception of threat through the dissemination of

HIV/AIDS information, shape belief by reframing barriers as benefits and normalize HIV prevention behaviors. Further, research posits that the disparate rates of HIV infection between MSM and Black MSM merit the addition of sociocultural modifying factors to increase the efficacy of HIV intervention campaigns among Black MSM.

Examination of existing studies suggests the following research questions as a good starting point to conduct research related to HIV intervention campaigns and Black MSM:

RQ 1. What common message elements do Black MSM identify as being most socioculturally relevant?

This question is important as it sets a benchmark for the sociocultural modifying factors to be included in future HIV intervention campaigns to make them more culturally competent, and thus, more effective in changing HIV risk behaviors among Black MSM.

RQ 2. How can socioculturally targeted HIV intervention campaigns address and reframe as benefits circumstances that Black MSM name as barriers to HIV prevention behaviors, such as not enjoying sex with condoms or sticking to the daily regimen of taking antiretrovirals as PrEP?

According to prior research (Albarracín et al., 2003; Seal et al., 2000; Toro-Alfonso et al., 2002), if barriers to successful HIV prevention behaviors are addressed and reshaped as benefits, or eroticized, individuals may be more likely to increase their utilization of HIV prevention behaviors. Black MSM should define these barriers so that future studies may address them.

RQ 3. How can socioculturally targeted HIV intervention campaigns normalize HIV prevention behaviors to increase buy-in among Black MSM?

Prior research (Guydish and Ekstrand, 1992; Melkote et al., 2014) suggests that normalizing behavior among an individual's social group will increase the likelihood of the individual subscribing to said behavior. This theory should be studied among Black MSM, as it has the potential to help refine current HIV intervention campaigns and increase their efficacy among the demographic.

Chapter 3: Methods

Research Design

According to Brennen, qualitative methods should be used “to understand concepts based on people’s experiences” (2017, p. 4). Qualitative research is exploratory and not limited to a single objective answer, but rather “a variety of meanings and truths” extrapolated from the socially constructed realities of those they study (2017, p. 4). Additionally, qualitative research is used to do a deeper dive into a research area and gain a more in-depth understanding than numbers or statistics alone can supply.

For these reasons, a qualitative approach is appropriate for this study, which seeks to gain information about the motivations, thought processes and attitudes of Black MSM as it relates to HIV intervention campaigns with specific sociocultural targeting for their demographic.

Qualitative Interviews. Qualitative interviews are the primary research method for this study. According to Brennen (2017), in-depth interviews are not centered around data collection, but instead are concerned with understanding the meanings and context of the information, opinions and interests mentioned by respondents. Face-to-face, in-depth interviews allow the researcher an opportunity to probe the respondents’ hidden beliefs and gain a deeper understanding of their “deeply nuanced inner worlds” (Brennen, 2017, p. 29).

For this research, the ability to do the aforementioned is critical to developing effective HIV intervention campaigns for Black MSM in future. Sociocultural factors, such as socioeconomic status, religion, language, etc., must be accounted for to

reconfigure current HIV intervention campaigns designed to change and reduce risk behaviors among Black MSM. This research acknowledges Basu et al.'s perspective that the best way to change the behavior of a given demographic is by "engaging the voices" of its members (2016, p. 1368), such as through in-depth interviews. The in-depth interviews conducted in this pilot study provide insight into the thoughts and experiences of Black MSM and can help shape future HIV intervention campaign research among the demographic.

In-depth interviews also allow for unexpected discoveries based on the perspectives of the respondents. Berger asserts that "the more people talk, the more they reveal (give away) about themselves" (1999, p. 57), which uncover unconscious biases, attitudes or beliefs in the respondents useful to this research.

Furthermore, depending on their structure, in-depth interviews provide the freedom to adapt to situations as they change (Berger, 1999). Because the in-depth interviews conducted for this study were essentially a conversation between researcher and respondent, they allowed the flexibility to pivot to alternate points of interest, requesting either more specificity or generality as needed.

Participant Observation Plan

Purposive and convenience sampling were implemented to collect data from participants: (1) aged 25 to 34 years, (2) self-identified as Black or African American, (3) self-identified as cisgender, (4) self-identified as MSM and (5) residing in the Kansas City region within the greater Kansas City metropolitan area.

The high risk of HIV infection associated with Black MSM aged 25 to 34 years warranted the focus of this study. According to CDC data, Black MSM in this age group

experienced a 42% increase in new HIV diagnoses; by comparison, new HIV diagnoses among differently aged populations of Black MSM either decreased or remained stable (“HIV and African Americans,” 2020).

According to the Mid-America Regional Council (MARC), a nonprofit association of city and county governments and the metropolitan planning organization for the bistate Kansas City region, the greater Kansas City metropolitan area is comprised of 14 counties across the border between Missouri and Kansas (“Statistical Areas,” 2020). This research focused exclusively on the seven-county Kansas City region within the greater Kansas City metropolitan area, as defined by the Missouri Department of Health and Senior Services in their 2017 epidemiologic profile of Missouri (“Kansas City HIV Care Region,” 2017). In 2017, Blacks/African Americans accounted for 40.4% of total cases of HIV disease, defined as the sum of HIV cases and stage 3 (AIDS) cases, in the Kansas City region (“Kansas City HIV Care Region,” 2017). The defined demographic of this study – Black MSM aged 25 to 34 – in this particular region drew this study’s focus due to Black/African American males comprising 35.9% of cases of HIV disease among males in the region (“Kansas City HIV Care Region,” 2017).

Individuals known to meet the study’s inclusion criteria were recruited through email, text or direct message via social media sites such as Instagram and Snapchat (see Appendix A). Because Basu et al. note the “well-documented difficulties recruiting MSM of color to take part in research studies” (2016, p. 1368), previously established relationships with local HIV/AIDS prevention groups were leveraged to help identify potential participants for the study. These groups included the HMM Project, a community-based initiative focused on HIV education, prevention, and treatment

among MSM, and Blaq Out, “a united community of individual advocates, community activists and healthcare professionals who work to address the psychosocial and environmental challenges faced by Black MSM in the greater Kansas City area” (“What We Do,” n.d.).

After the recruitment of the initial sample, additional participants were identified using the “snowball sampling technique,” identified by Basu et al., in which participants provide “contact information to others who [meet] the inclusion criteria and [are] interested in taking part in the study” (2016, p. 1368). The minimum goal of the sample was 10-12 participants meeting all the criteria for study inclusion. Ultimately, 11 participants meeting the criteria for study inclusion were interviewed.

Interviews Plan

In-depth, qualitative interviews were held face-to-face with each participant. Audio of each interview was recorded using multiple digital recording devices. Before participating, participants were asked to give both written and oral informed consent in accordance with Institutional Review Board (IRB) standards (see Appendix B). To protect the confidentiality of participant identities, pseudonyms were assigned to each individual and no identifying information was collected.

Interviews were conducted using a semi-structured format. Semi-structured interviews differ from structured interviews in that they allow the flexibility to vary the order of the interview questions and to incorporate follow-up questions “to delve more deeply into some of the topics or issues addressed, or to clarify answers given by the respondent” as needed (Brennen, 2017, p. 29).

First, participants were asked about their personal experience with HIV prevention behaviors and aspects of HIV intervention campaigns, with particular focus paid to PSAs, through a list of pre-established questions (see Appendix C).

Next, participants were asked to watch two short PSAs produced by the Centers for Disease Control and Prevention (CDC) for its Act Against AIDS initiative (see Appendix C). In 2009, the CDC launched Act Against AIDS “to raise awareness about HIV and AIDS among all Americans and to reduce the risk of HIV infection among the hardest-hit populations – gay and bisexual men, African Americans, Latinos, and other communities at increased risk” (“Gateway to Health Communication,” 2016). Act Against AIDS comprises multiple campaigns targeted at both the general public and health care providers. This study featured two PSAs from the “Doing It” campaign, a national campaign urging adults to test for HIV and be aware of their HIV status. The first PSA displayed racially, ethnically and sexually diverse people sharing the message that HIV testing is important and the second displayed a homogenous mix of Black MSM expressing the same message.

Finally, after watching the PSAs, participants were asked to comment on the perceived effectiveness of the PSAs through another series of pre-established questions (see Appendix C).

Interviews were conducted at the convenience of participants, at times and in locations of their own selection, including, but not limited to, public venues with access to private rooms, such as local libraries, and private residences. No financial compensation was provided.

Research Materials

The study exclusively concerned itself with cisgender Black men who have sex with men, regardless of their sexual identity – that includes men who identify as straight, bisexual, pansexual, curious, etc.

To maintain the credibility of the research, both research logs and audio recordings were used in the study. According to Berger, research logs are an effective way “to think about things and to maintain an ‘internal dialogue’” (1999, p. 15) about the study’s progress – both successes and failures. Keeping logs of the research process, and frequently revisiting them, ensured the study’s overall aim was not lost and that the study’s credibility was maintained. Additionally, audio recordings of the study’s interviews provided a tangible solution to keep the data connected to the realities of the subjects, which also maintained the credibility of the research.

Data Analysis

The data analysis process of this study was informed by Basu et al.’s 2016 study, which examined “how cultural and contextual nuances, (in)access to structural resources, and participants’ ... capacity to act upon available knowledge/resources influences the ways they manage (the threat of) HIV/AIDS” (p. 1367). In their study, Basu et al. (2016) used Morse’s (1994) analysis procedure, which consists of four steps: comprehending, synthesizing, theorizing and recontextualizing.

During the first stage, comprehension involved accurate transcription of the data and the generating of initial codes to assess emerging themes. The data were then synthesized “in order to isolate discrete concepts that can be easily labeled and sorted” (Basu et al., 2016, p. 1369). The established codes were grouped into conceptual

categories allowing for easier thematic identification in advance of the theorizing process. Theorizing is described by Morse (1994) as “the constant development and manipulation of malleable theoretical schemes until the ‘best’ theoretical scheme is developed” (as cited in Basu et al., 2016, p. 1369). Once clear theory was established, the final process of recontextualizing began. During this process, ways in which the theoretical explanations could prove beneficial within and beyond the study context were identified (Basu et al., 2016).

Chapter 4: Findings

The main findings of the research are presented in accordance with the study’s research questions, restated here for reading convenience:

- RQ 1. What common message elements do Black MSM identify as being most socioculturally relevant?
- RQ 2. How can socioculturally targeted HIV intervention campaigns address and reframe as benefits circumstances that Black MSM name as barriers to HIV prevention behaviors, such as not enjoying sex with condoms or sticking to the daily regimen of taking antiretrovirals as PrEP?
- RQ 3. How can socioculturally targeted HIV intervention campaigns normalize HIV prevention behaviors to increase buy-in among Black MSM?

Common Message Elements

Table 1. Common Message Elements (N = 11)

Common Message Elements	N (%)
Sociocultural Factors	2 (18)
Diversity	4 (36)
Everyone is Susceptible	6 (55)
Underrepresented Black MSM	5 (45)
Messenger(s) Supersede Message	
Pre-PSA Exposure	8 (73)
Post-PSA Exposure	7 (64)
Message Supersedes Messenger(s)	
Pre-PSA Exposure	3 (27)
Post-PSA Exposure	4 (36)
PSA Tone and Point of View	4 (36)
More than Testing	6 (55)
Localization	3 (27)
Statistics	1 (<10)
Mode of Message Delivery	
Social Media	8 (73)
Television/Streaming Services	3 (27)

First, this research sought to isolate common message elements that Black MSM identified as being most socioculturally relevant and impactful and, therefore, most influential in their ability to alter HIV risk behavior.

Sociocultural Factors. Previous research indicated that sociocultural factors specific to MSM of color – such as socioeconomic status and ingrained homophobia due to religious or cultural belief – could negatively impact HIV prevention behaviors (Basu et al., 2016; Dutta-Bergman, 2005; Melkote et al., 2014; Seal et al., 2000). However, only two research participants (18%) mentioned such sociocultural factors in their interviews. The first research participants focused on the socioeconomic factor of the cost of preventative antiretroviral medication, quoted to him as potentially \$1800 per month, which he described as “not accessible,” not only for him, but also for “a lot of other people.” When he was asked to design an HIV intervention campaign PSA that would be most influential to himself, he said:

I just need to know the key takeaway of ok, this is what it is, this is what’s going on in my community, it’s going to cost me potentially nothing – you don’t gotta tell me the \$1800, because that’s going to scare me way – but let me know, hey, you don’t have to come out of pocket for it anyway so you might as well do it, which, honestly, is part of the reason I started. I don’t have to pay for anything? It’s going to help me prevent HIV? What’s the point? Come on. Sign me up.

The other participant illustrated the notion that HIV prevention behavior is negatively affected when fundamental needs are not met (Dutta-Bergman, 2005; Melkote et al., 2014). After mentioning “not being in the right frame of mind to engage in sex,” the participant was asked to elaborate:

It’s very vague. I didn’t even want to say. But, um, I guess thinking about, you know, if I were not feeling, like, not really good about myself, like having a – if I had, for instance, a really long day – I had a really long day at work today – if I

were to have had a day like this and maybe, you know, financial issues or, um, facing eviction, or, like, um, some – like owed somebody some money or something and they were about to, like, threaten me with violence or some – none of these issues are real issues for me right now, but, um, things like that where that I wasn't in a really good space or a frame of mind, I may be more susceptible to making poor decisions about my own health... If that means that in order for me to feel better I arrange a group sex session with some people that I'm, like, yelling at on the Troost Max line as they're getting off the bus outside of my window, and I'm assuming that they're gonna to be, you know, gay-friendly, and they come up to my apartment and they rob and kill and maim me and gangrape me or something, then that could be a situation that would potentially change my serostatus and/or, you know, my living status. You know, there's a lot of opportunity for crazy to go on when you're not in the right frame of mind, so that's kinda where I was going with that.

While no other research participants specifically mentioned sociocultural factors such as these in their interviews, the common message elements identified below demonstrate the present deficiency in cultural competency in current HIV interventions.

Diversity. Several research participants noted the importance of diversity within an HIV intervention campaign. When asked to recall the most impactful message communicated by any component of an HIV intervention campaign, one research participant highlighted the diverse nature of people in the campaign, not only in terms of race and ethnicity, but also in terms of gender. He explained:

Thinking back on it, I think one of the things that really struck me about it was, like, the diversity in the commercial. Because there was someone that I assumed to be a trans woman, there was a Black man, I think there was a White woman, there was a White man, there was a White, male, gay couple, there was a heterosexual couple – and it just kind of spoke to the idea or the notion that it can happen to anyone. You can be – whatever you identify as, the disease doesn't care. It's gonna get you if it wants to. You know, if you come in contact with it. It doesn't matter if you're a man or a woman, gay or straight or trans or any of the above. And that was one of the things that I think really stood out to me in the commercial.

The notion that the increased diversity of people shown within HIV intervention campaigns better communicated that HIV's impact was not limited to any one particular

demographic was also expressed by another participant when he was asked to design an HIV intervention campaign PSA that would be most influential to himself:

It would have to be diverse. I don't want to just see Black; I don't want to just see White. It has to be like a diverse group on the stage. Because I feel like when you target certain groups, you're making it seem like that's the only group that gets it, whereas, in fact, anybody can get it.

However, not all research participants felt that diversity was important to communicate this message. After watching the two PSAs from the CDC's "Doing It" campaign, and being asked how either PSA would convince him to protect himself from HIV exposure, one participant described the amount of diversity shown in the first PSA as "distracting":

There were some distractions for me in the first one. Like, I know the CDC is trying to encompass a big population or appeal to a larger population of people with that first video, and I got it, but there was a lot of distraction and a lot of different messages. Even though, you know, HIV – it was clear that HIV affects everybody. Like, that was their initial stance and it was threaded throughout the campaign, but you have Blacks, Asians, Hispanics, couple White guys, there's trans, there's straight – all in this. And, so – dogs were in the video; they're eating ice cream – it's just kind of distracting and the message gets convoluted in what's being displayed to me.

Everyone Is Susceptible. While only two of the research participants (18%) expressed the idea that diverse representation mattered to better illustrate every person's inherent susceptibility to HIV, the sentiment that HIV could happen to anyone was echoed by six research participants (55%). When asked to design an HIV intervention campaign PSA that would be most influential to himself, one research participant chose to focus on this concept specifically and acknowledged his own susceptibility to HIV as the impetus for beginning a PrEP regimen:

I think it would focus on the fact that everyone is an option, that no one is precluded from this disease. That even though you may have gone years, and however many sexual partners, and been, for all intents and purposes, fine, that

not only is it possible for you to contract the virus, but it is also probable. And I think that is probably the – that would be, and was for me, what made me decide to get on PrEP. Because it was like, this is something that is happening, it has not yet happened to you, but – it’s almost like I felt like it will, instead of it could. I think that for me that was the difference in what made me actually seek out preventative measures.

As this example suggests, Black MSM seem to understand their high susceptibility to HIV, mirroring Rose et al.’s aforementioned findings. However, despite expressing this understanding early in their interviews, after watching the sample PSAs several of the research participants noted relating to the thought process that “HIV can’t happen to me” expressed by one of the PSAs characters, due to the lack of disease susceptibility discussed in their childhood households. As one research participant mentioned, “We didn’t talk about it. It wasn’t a thing. I didn’t think it could happen to me.” Another participant explained:

There were several characters that they just happened to say things that I also mentioned earlier in the interview about how it’s – how I also grew up in a home that it wasn’t really discussed, how it can happen to anyone and it can be your first time or your thousandth time. These are ideas that also resonate with, notions that also resonate with me. And, specifically when he said, “Oh, it doesn’t happen to me. It happens to other people.” I think that’s one thing that has prevented me from doing something like getting on PrEP or getting on like a PrEP alternative. Because I’ve always just had this mindset that like, “Oh, it’s not going to happen to me! It happens to other people. You know, it happens to people who aren’t safe. People who sleep around a lot. People who do this, that or the other. Not me. I’m fine. I’m great.”

Participants suggested that a lack of discussion about HIV susceptibility was “normal” in the childhood households of Black MSM and that HIV intervention campaigns should highlight their understood notion that every person is susceptible to the disease.

Another respondent suggested that to better demonstrate everyone’s susceptibility to the disease, HIV intervention campaigns should widen their lens to include Black

MSM not typically represented so as not to communicate the idea that only one “type” of person gets the disease:

I just think that when you do stuff like that, then that goes into people’s heads that only that type of gay gets it. Not like, “Oh, well he’s just this one” or “He just bottoms so he’s going to [get it] – I can’t get it.” So you have to mix it up so it can go out to everybody and not just a single group.

The suggestion that alternate types of people within the Black MSM demographic should be shown in HIV intervention campaigns was present in several other research participants’ responses and will be discussed at length in the next section.

Underrepresented Black MSM. When asked what was missing in the sample PSAs shown during their interviews, several research participants (45%) expressed a noticeable lack of diverse representation in the different kinds of Black MSM shown.

Black MSM with culturally stereotypical masculine gender expression and “corporate”

Black men were specific callouts named by participants:

I feel like there’s a population of Black men that are not in public spaces, or even considered on platforms like this. Like, people who look like this – in a shirt and tie, for the most part – or you never get that down low brother who needs to be saying something about his particular lifestyle. Those things are challenges within the Black community, I think. Just a couple examples of some of the challenges and so to really see myself in there would have to be somebody sitting in pretty much a suit, talking about their experience in corporate America or on the streets or whatever the case may be, um, to really just hit home for me.

Some respondents explained that although they possessed an appreciation for all Black MSM, regardless of gender expression, that they would have liked to see more varied types of Black MSM represented in the PSAs:

I just feel like when they get groups of Black gay men together on PSAs, or TV period, it always seems like more of the feminine gays. So, kind of like you clump in all one group. There’s all types of gays. Like, every gay is not like that. So that’s why I feel like when everyone says, “Oh, you’re gay?” that’s what they think of. That group of men right there is what they think of. You got fake hair in your head, you’re putting your makeup, getting all that done, but there – it’s all

types of gay men out there. That's the only thing I didn't like about that. They could have pulled gays from all over the place. They may be a group of friends, and that's who they hang around, but if that's the case, then you should have had that group and then you should have had a few other like sprinkled in. Like, he's also a Black gay male, but he doesn't have weave in his hair and he doesn't do this and he – just a little, mix it up a little bit.

However, another participant expressed absolute distaste in viewing any gender expression not conforming to the stereotypical masculine norm, noting that effeminate Black MSM were unlikely to influence him in any way because that is not what he “relates to”:

I don't typically want to listen to people that seem feminine because that's not what I'm attracted to and that's not me. And I think – and I know that I'm not the only one. For people like me it's off putting. We don't want to deal with it. We don't see ourself on the same level. We don't associate with that.

While these participants discussed interest in differing types of Black MSM being present in HIV intervention campaigns, for numerous reasons, they all agreed that having Black MSM represented at all was critical.

Messenger(s) Supersede Message. One of the least surprising findings from the research was that, at some point in their interview, the overwhelming majority of research participants (73%) expressed that racial and ethnic homogeneity – in other words, other Black MSM who “looked like them” – would be most impactful to them in HIV intervention campaigns. One participant explained, “If it's targeted towards me – Millennial, young, African American male – then that's kind of what you want to see replicated.”

For the majority of the research participants the messenger(s) often superseded the message itself. They identified an increased likelihood to consume the HIV

intervention campaign content if they saw “the right person,” which, in turn, increased the influence of the HIV intervention campaign on their HIV risk behavior:

If I’m listening to the messengers and I can relate to the messengers and I, therefore, trust the messengers a little bit more than I would somebody else, so I, therefore, trust the message and can maybe understand, synthesize, relate to and be impacted by the message, I think more than I would if it weren’t from those individuals or those messengers.

When asked if one of the sample PSAs would have been as influential in changing his HIV risk behavior if the messengers had been his antithesis, White women, another research participant responded:

It definitely would not have been as impactful, no. Because of that example, I guess my answer is going to be that I think the most impactful part of it was the fact that they looked like me, not that I could identify myself in the examples. Because I think that’s the mark that’s being missed, is that representation is what makes you feel like it’s possible. So, the same way that you could always say, or that someone could always say, that anyone could be president and then it’s only ever been White men – so for a Black man to see a Black man become president, that brings it closer to him because it still feels distant in that it was a White man, so maybe he was a male, but he was not you; he was a White male. If you even had White men primarily speaking in those ads I would still feel like that was something that was largely affecting the community of White males, of which I am not. So, having Black males speak to their experiences was most impactful over me seeing myself in the examples.

However, not all participants shared the perspective that the messengers delivering the message were more important than the message itself. For example, one participant asserted that the messengers were merely a starting point to grab his attention, but that the ultimate influence of the message rested on its content:

It’s like an ongoing challenge, I think, for people to get the message right, as well as, you know, what they’re displaying. I mean, you can grab my attention all day long with imagery, but then if I never pay attention to what you’re saying because I don’t like the tone of the voice that comes across, it gets lost. And I mean, that’s just going to be an ongoing challenge with everything.

As the participant suggested, balancing the importance placed on the message or the messenger remains a challenge for HIV intervention campaigns designed to influence HIV risk behavior among Black MSM. Another challenge presented in the research findings was the shifting importance participants themselves attributed to each.

Message Supersedes Messenger(s). Of the findings present in this research, the most surprising was that the opinions of research participants pre-exposed to HIV intervention messaging were not always reliable guides to opinions post-exposure. For example, after watching the sample PSAs from the “Doing It” campaign, the same participant who originally felt that messengers superseded message content acknowledged that the message, especially when one of shared experience, could be just as influential as a messenger who looked like him:

I identify, ironically, with the girl who was heterosexual, who was also female, so I guess I don't really need them to look exactly like me. I just need their stories to probably hit on something that can make me think about it a little bit more, and about how it functions for me. So, yeah, maybe they don't need to be the spitting image of myself, but, you know, what they have to say, content wise ... I think, helps, big time.

Another research participant also experienced this same shift in perspective after watching the sample PSAs. The participant initially theorized that HIV intervention campaigns would be more influential if the messenger(s) looked like him, but, post-PSA exposure, acknowledged that as long as people in HIV intervention campaigns shared “similar experiences, thoughts and notions,” the campaign would resonate with him:

Before seeing that I thought that it would have made more of a difference if they looked like me, but after seeing that, I don't think that it makes a difference to me whether or not they are a person who looks like me.

However, the participant then noted the importance “to at least have gay men in the commercial,” highlighting that an HIV intervention campaign consisting of

exclusively heterosexual couples would be written off. Yet, when questioned further about the influence of non-Black MSM messengers delivering a message to which he could relate, the participant admitted, “I would find it less effective, but I think that it would still – influential yes, but not as much so as when I also see people of color.”

While the research participants’ perspective shifts seemed to place increased importance on the message, instead of messenger, one participant experienced a shift that was exactly opposite. Pre-exposure to the sample PSAs, the participant stressed that “even a woman” could be influential in altering his HIV risk behavior, as long as he was able to relate to her experience. However, post-exposure the same participant said, “And now I understand, like, the importance of actually being able to relate to somebody, so it is probably more important that I’d thought when I was saying before, like, what would affect me.”

PSA Tone and Point of View. Several research participants (36%) noted that the tone of HIV intervention campaigns needed to be changed in order to either communicate the severity of the disease itself or to attract and hold their attention to influence their HIV risk behavior.

One respondent discussed the straightforward and predictable nature of current HIV intervention campaigns, expressing a desire for an unexpected plot twist and to be “surprised at the presentation” of the message:

I feel like when I see most things, it’s like straight in your face. It’s like, “This is about protecting yourself from HIV” and not that that’s a bad thing, but I just feel like it’s almost so common that people – I am desensitized to it. And so I’m like, “Oh yeah, another HIV commercial. It’s not going to happen to me, so, fine.”

Other research participants mentioned needing the message of the PSA to be “jarring” so that it exposed how close a person could be to the virus at any given time.

One participant explained, “If possible, I think that it would be jarring, but it would be jarring in a way that did not feel – that was not meant to really incite fear, but more, just make someone aware of where they actually are in proximity to the virus.”

When asked to design an HIV intervention campaign PSA that would be most influential to himself, another participant echoed the sentiment that showing a person’s proximity to the virus would be jarring enough to make him feel “disgusted” and would render the campaign more impactful:

I would have to see somebody, like in a commercial, that, like, had a negative symbol above their head, walking around, like in a club, and everybody has their positive or negative symbols above their head, and then I would have to see how that person interacts with everybody. And then also see him, like, reject condoms and see how exposed to him – to HIV he is, and then see just how many people around him have it and then also see maybe a positive over somebody’s head that says – and they verbally tell him, “Oh, I’m negative.” You know, that type of stuff I would – just seeing it, and I would probably be disgusted.

All of the aforementioned participants referenced a desire to see the “dangers of actually having” HIV presented in a “real” way in order to make HIV intervention campaigns more influential. When asked to design an HIV intervention campaign PSA that would be most influential to himself, one participant suggested testimonials from Black MSM who had contracted HIV:

Maybe even young, Black men that have actually contracted the virus and maybe giving testimonials and being able to speak on how it happened for them. Specifically for me, it’d be most impactful to see people that always just thought they were going to be fine, right, and never really considered it heavily or seriously, but still, unfortunately, contracted the virus.

Overall, participants who mentioned changing the tone of HIV intervention campaigns explained that the tone should be less “jovial” and “light,” even at the risk of making them less easy “to swallow or easy to receive for kind of any audience.” Instead, the tone should be “more passionate” and “more grounded” in nature to convey the

severity of the disease. One participant suggested running multiple different PSAs with varying tones:

I think [an] alternative PSA that could run alongside that would be one with kind of a more serious tone, one that kind of discusses the risks of “if you don’t do this, this could happen.” Because the reality is that, you know, not every moment in the fight against AIDS, or the fight against HIV, is going to be a happy-go-lucky one. So I think a more serious one could also be good to have.

Additionally, research participants suggested differing, and conflicting, points of view be used in HIV intervention campaigns to increase their efficacy in influencing HIV risk behavior. For example, one participant thought speaking directly to PSA viewers was most effective:

I would switch the point of view from people watching people talk about their experiences to the people talking about their experiences speaking directly to the consumers of the ad and speaking to them in, like, in a “you” voice, right? So a person in the ad saying, “You need to do this” not “I did this and this was great” but saying, “You need to do this as well, whoever you are, consuming the ad.” Just making it more focused and direct and not just an idea of what people who look like you are doing. But there’s something that needs to be – I don’t know what this would be – but something needs to, in my opinion, make a stronger connection between what people who look like you are doing and what you yourself need to be doing specifically.

However, another participant expressed opposition to this message strategy, favoring an “outside looking in” approach so as not to make PSA viewers feel judged:

I think when you talk at people, you feel a little judged, or I guess the person that’s, I guess, receiving the message might feel a little bit judged or they might feel as if, you know, you’re looking down, or they won’t really take everything in. But if I’m able to just sit back, listen, kind of not say anything and I can still gain all the same information, um, it becomes an effective message to me.

While these participants did not agree on the specific point of view that an HIV intervention should take, they, and several others, did agree that HIV intervention campaigns as a whole are more influential when they focus on more than testing.

More Than Testing. Both of the PSAs shown from the “Doing It” campaign focused exclusively on getting tested and knowing one’s HIV status as prevention.

However, the majority of research participants (55%) did not feel that this was enough:

I think that there should have been a bigger focus on after [testing] – like, for example, I think one of the guys in the video said, “There’s no better feeling than walking out of there knowing that you’re ok and you’re HIV negative” and it’s like, “Ok, now that I’ve walked out of there knowing that I’m HIV negative, what is going to encourage me to remain HIV negative moving forward? Like, what is going to help me be able to do that?” I don’t think that, that was really touched on.

Another participant explained that a singular focus on testing could mistakenly lead a person to believe that they are safe from HIV, despite their HIV risk behavior. He suggested that a larger focus should have been placed on antiretroviral medication, such as PrEP or TasP:

If being on preventative medication is something that the community and/or the industry wants to move towards, I think that, that is something that they should try to emphasize more in PSAs, if that is what they’re trying to move towards. I don’t recall that really being mentioned, being on any sort of preventative medication. Getting tested? Yes, and I do that. So, again, I just feel like that would be disarming for me if I saw that because I’d be like, like I said, “Oh yeah, I do that! So I’m good.”

Testing became a source of contention for another participant who expressed frustration in the PSAs not “talking about other HIV prevention” methods in which he was interested:

HIV prevention is not just testing. Like, we talk about testing all the time and we have what we call “testing fatigue.” People try to test us at events when we ain’t tryna hear about testing. They try to talk to us about testing when they should just be giving us Magnum XL condoms or Bare Skyn condoms. Like, they try to talk about testing when we should be getting on PrEP. Like, we don’t care about testing. We know we negative. We know he positive. We know we don’t know what they status is, but this is what we want right now.

Localization. Interviews with research participants exposed another unexpected finding that could potentially be impactful in influencing the HIV risk behavior of Black MSM. Three participants (27%) identified having local imagery or resources present in HIV intervention campaign components, specifically PSAs, as more relatable and, therefore, more effective in altering HIV risk behaviors:

If I felt like they were like taping in Kansas City and I recognized, like, the little horse the man sits on in Liberty Memorial or I could see Union Station in the background or our downtown skyline, you know? That's more relatable for me, so the real localized component.

Despite research participants seeming to come to a consensus on the inclusion of local elements to make HIV intervention campaigns more relatable and influential, such an agreement was unable to be reached on the inclusion of statistics in HIV intervention campaigns.

Statistics. Although the factual and concrete nature of statistics typically lends credibility, only one research participant (<10%) thought that HIV intervention campaigns could benefit from their inclusion:

I want to see actual studies and numbers. That's what gets me. Like you can't just say, "Oh, don't do this because you'll get HIV" or – like, well why not? How would I get it? Why am I getting it? Who's getting it? I need to see statistics and all of that stuff.

In fact, two other research participants (18%) explained that they needed more than statistics and numbers to be influenced, with one going to far as to say that statistics are the "opposite way" to influence him:

I think, for me, to hear, like, number-wise this problem means this, means less than, like, these are the feelings that are going to come along with, you know, um, just any situation, whether it's fear about getting tested, whether it's fear of a partner not communicating with you – like I think all of those things make a bigger impact with me than just like numbers. So, I would have to understand

how it would emotionally impact me, I think, for it to reach me in the way that I think people would want it to.

Mode of Message Delivery. After describing the design of the HIV intervention campaign PSA that would be most influential to themselves, the research participants were asked which medium would be used to broadcast the PSA to increase the likelihood of them seeing and being influenced by it. Eight participants (73%) named some form of social media, such as Facebook, Instagram and dating apps that cater to MSM, like Jack'd and Grindr, as their medium of choice:

Now, in this day and age, I would say it has to be some kind of social media platform – Instagram or Facebook, because everybody is mainly on there. Nobody really watches TV anymore and so I would say somewhere on – I would say some kind of social media platform.

However, despite the aforementioned participant's dismissal of television as a viable dissemination tool for HIV intervention campaigns, several other research participants (27%) thought otherwise, naming both TV and streaming services, such as Hulu, as options to potentially influence their HIV risk behaviors:

Probably the TV ads. I think it adds a sense of credibility to a very disenfranchised community. So, speaking of, like, Black gay men in particular, we're kind of like the existing body of people, like, you see us everywhere, but people fail to recognize us, I think a lot. So, to see us visible and just like promulgated, I think, all through prime time television – you may see an ad for Biktarvy, Truvada for PrEP or something. I know when POSE was coming on there were so many different commercials going for pre-exposure prophylaxis and they featured folks that looked like me or that I knew shared a lifestyle similar to mine and that was really validating for me to see that type of exposure and very influential and impactful I think for myself, but also other community members.

Reframing Barriers as Benefits

Table 2. Barriers to HIV Prevention Behavior (N = 11)

Barriers	N (%)
No Barriers	3 (27)
Condoms	1 (<10)
Distrust in Preventative Medication	3 (27)
Alcohol and Other Substances	2 (18)
Access	3 (27)
Spontaneity and Trust	2 (18)
Themselves	1 (<10)

Secondly, this research sought to answer how socioculturally targeted HIV intervention campaigns could address and reframe as benefits circumstances that Black MSM name as barriers to HIV prevention behaviors. In doing so, these barriers can be addressed and reshaped, or eroticized, by future HIV intervention campaigns in an attempt to influence and increase HIV prevention behaviors among the demographic.

Three research participants (27%) cited no circumstances or barriers preventing them from protecting themselves from HIV. However, the remaining eight participants listed the following barriers to their personal HIV prevention behavior.

Condoms. One participant acknowledged being “very susceptible” to HIV infection because of his refusal to wear condoms when engaging in sexual intercourse, despite an admission of having sex with other MSM and “prostitutes”:

Condoms are terrible. They take away 97% of the pleasure that I get. I cannot maintain an erection putting it on. It takes away from the intimacy of the experience as well. I just, I think they’re terrible. I think I wish there wasn’t even a need for them, you know?

To mitigate his risk of HIV infection, the research participant listed prayer, serostatus sorting, substituting anal sex for lower risk oral sex and building rapport with potential sexual partners before engaging in intercourse.

Distrust in Preventative Medication. Three research participants (27%), including the same research participant that classified condoms as a barrier, listed distrust of, and general lack of information about, preventative antiretroviral medication, like PrEP:

I have thought about PrEP, but I've felt like it's a little too soon for my comfort. I would like it to be out and, you know, be around for several more years before I start doing that because as I assumed they have, you know, the commercials "If you or a loved one was hurt or died from taking PrEP then call this number." And that always scares me and it seems like it always happens with new drugs. Um, and everybody got on it and my doctor said, you know, get on it and I was going to do it, but I just wanna wait, you know? I don't have as much sex, period, as I used to and I think that is partly because I realized how really I guess just lucky I was to not have contracted any uncurable disease by now with my risky behavior. Um, so I just kind of try to abstain when I can. But, you know, PrEP, I don't think it's for me right now.

Even after the interview concluded and the research participant was informed that Truvada for PrEP had been FDA approved since 2012 and that the safety risk of the preventative antiretroviral medication was minimal, the participant continued to express hesitancy in pursuing the medication further.

Alcohol and Other Substances. Two research participants (18%) named alcohol or other mind-altering substances as barriers to practicing HIV prevention behaviors:

Well, I guess just being drunk, or – I can't really say high because I don't get high – but being drunk in a situation where I've reached my peak [of intoxication] and I'm not making the right decision at the time period.

Access. Three participants (27%) named access issues as potential barriers to practicing HIV prevention behaviors. The participants listed access to condoms and testing sites as barriers. Another participant expounded further, saying, "Definitely access to PrEP. Access to pertinent information about my partner. Access to information about my labs, about my own level of protection – real or realized levels of protection."

Spontaneity and Trust. Interestingly, only one research participant (<10%) named spontaneity as a barrier impacting his HIV risk behavior. However, the participant also explained the way that he attempts to mitigate such spontaneous thoughts and actions:

I try to keep, not necessarily a routine of sexual partners, but, know who my sexual partners are and have some type of understanding and really track record with them so at least that relationship is established, so if anything were to occur we can have the conversation. But, again, once you start putting in new bodies you have to establish that rapport all over again.

For this participant, establishing a level of trust with sexual partners made him feel more secure in not practicing HIV prevention behaviors.

Trust also played a role in another participant not protecting himself from HIV. Due to role in a “mostly monogamous” relationship, he felt comfortable not practicing HIV prevention behavior. When asked what circumstances prevented him from taking active measures to prevent HIV infection, he answered, “Trusting the person that I’m with, which I don’t know if that’s really a good answer, but I mean, that’s the truth. Like, you know, if I was single I think I would definitely be more careful with protecting myself against that.

Themselves. One respondent actually listed himself and his own naivety as the main barrier to actively protecting himself from HIV infection.

I don’t know that there are any actual circumstances besides me being – I don’t know if “lazy” is the word that I want to use – almost naïve and not doing [it]. There’s no reason I couldn’t do it, I suppose. There’s no reason I couldn’t go to my doctor and say, “Hey I’m interested in getting on PrEP” or something like that. I wouldn’t really say that there are any actual circumstances in my life that are preventing it besides myself not going and doing it.

This participant went on to acknowledge his not being “a super preventative person, so much as a reactive person” in most instances related to his health, which, by his own admission, was “a very dangerous way to live.”

Normalizing HIV Prevention Behaviors

Finally, this research sought to ascertain how socioculturally targeting HIV intervention campaigns could normalize HIV prevention behaviors to increase buy-in among Black MSM. Prior research indicated that normalizing HIV prevention behavior among Black MSM and their social group(s) could increase the likelihood of Black MSM subscribing to said behavior. This study’s findings suggest accuracy in that assertion.

When asked how their stated social group(s) taking active measures to prevent HIV exposure, such as through condom use, PrEP and regular testing, the vast majority of research participants (73%) answered that their social group(s) taking such active measures would influence their likelihood to do the same:

Honestly, the people I keep around me, I have very close relationships with so, therefore, the things they do, their recommendations, the things they say are probably ten times more valuable than a stranger. And, honestly, I typically know most of my friends are going to tell me things, or my social group tell me things, based upon what they’ve gone through. So I give a lot more credit to those who are telling me from first-hand experience versus those who are just reading things in a book. That’s probably the easiest way to say it.

Additionally, three participants (27%) noted that they, themselves, began a form of HIV prevention, PrEP, due to a friend modeling the same behavior:

Once they told me about PrEP, they had already made their way through it so that helped me, like, kind of know exactly how to navigate through it to understand: What do I need to do to get on it? How do I work my way through the bloodwork? Who do I need to call? Um, you know, then call your insurance to work out the full kinks of it. Um, because honestly if I had to do it myself, I probably would not have seen it to fruition.

Further, another participant noted his friend's ability to explain the benefits of preventative antiretroviral medication in a way that made sense as being influential in assuming the HIV prevention behavior. When asked what made his friend's influence encourage the participant to be more preventative, the participant answered, "His knowledge and him knowing who I am and knowing how to explain it to me in a very black and white manner that to me – like the only answer that made sense to 'Will you try PrEP?' was a yes."

When asked how the influence of their social group(s) might be best expressed to them, each of the participants indicated some form of direct conversation, either in-person, by phone or in a group chat via text message:

Most of it is just going to be just through plain conversation – just sitting around having conversation. Um, every now and then you know – well I guess that would be considered conversation too, if we're just kind of talking back and forth through group messages. But just sitting down having candid conversations about, just about life and, you know, we decide to talk about certain topics and once we get on those topics, you know, we kind of all say, you know, this is how it affects me or this is what's going on me, or it might be going on with somebody else and somebody else might have already been through it. Um, and that just kind of influences everybody even if you aren't, even if you aren't responding back, but I'm definitely taking it in and then I'm able to decipher and decode and then process it and then and then I'm able to kind of work my way through it to say, "Ok, great, I've heard all of them talking about PrEP. Let me figure out how I should get on."

Although a majority of respondents expressed belief that the behavior of their social group(s) would be influence their HIV risk behavior, three research participants (27%) stressed that the HIV prevention behavior of their social group(s) would have no effect on their own:

I don't know that them doing it would influence me to do it. They have plenty of other things in their lives that they do that I'm very well aware that they do, and it has nothing to do with this, but it's just things that they do that I don't do, and that they have done for a very long time, but I just don't see the interest in doing it.

And I think that this, though a very different topic, would be right along with that. If they decided to do it, I would still probably just be like, “Oh, good for you! I’m happy that you’re doing that. I probably won’t, but tell me how that goes.”

While recognizing that the influence of his social group does cause him to devote more thought to his HIV risk behavior, another participant still affirmed that his social group’s HIV prevention behavior did not affect his:

I don’t think that it influences me at all honestly. Because, if it did, I would be using condoms or just not having sex. It does make me, you know, think twice sometimes before I go and, you know, have sex with a random guy unprotected. But, for the most part, they preach to me about condoms all the time and I just don’t hear it, you know?

Chapter 5: Discussion

Having already explained the potential benefits of socioculturally targeted health messages (Basu et al., 2016; Kreuter et al., 1999) and incorporating the feedback of the group(s) to which said health messages are targeted (Basu et al., 2016; Kandula et al., 2012), this study concerned itself with three main points of research.

First, this study sought to isolate common message elements of HIV prevention campaigns identified by Black MSM as being socioculturally relevant. In response to research question one, the study discovered the following as common message elements central to the Black MSM research participants interviewed:

- Sociocultural factors, such as socioeconomic status and a lack of fundamental needs
- Diversity, including, but not limited to, Black MSM
- The inherent susceptibility of all people to HIV
- Underrepresented Black MSM, like the “corporate” or stereotypically masculine
- The messenger(s) superseding the message
- The message superseding the messenger(s)
- Tone and point of view used
- An emphasis on more HIV prevention behaviors than testing, like PrEP or TasP
- Increased localization, such as the featuring of prominent local landmarks
- The inclusion of statistics; and

- The mode of message delivery, like social media or television or streaming services

Secondly, this study found value in isolating potential barriers to HIV prevention identified by Black MSM. In response to research question two, research participants listed dislike of condoms, distrust in preventative medication, alcohol and other substances, spontaneous thoughts and actions based upon trust in sexual partner(s), and themselves as barriers negatively impacting their HIV prevention behavior.

Finally, ways to most effectively normalize HIV prevention behaviors to increase buy-in among Black MSM were examined. In response to research question three, this study's findings suggest that direct, in-group communication is likely to reduce HIV risk behavior among Black MSM.

Significance

The first significant finding of this study, with obvious implication for future research, is the isolation of various common message elements identified by Black MSM.

Surprisingly, while categorizing common message elements that Black MSM found relevant, sociocultural factors identified in previous scholarship were not as abundantly present in this study's findings. However, socioeconomic factors, such as the high cost of preventative antiretroviral medication, and decreased HIV prevention behavior in the absence of basic necessities, were present. Future studies should focus on these sociocultural findings, as well as the other common message elements that follow, which, in being identified by Black MSM, demonstrate deficiency in cultural competency in current HIV interventions.

One of the most surprising findings present in this study seemed to be that the opinions of research participants pre-exposed to HIV intervention messaging were not always reliable guides to opinions post-exposure. Over the course of their interviews, several research participants changed perspective on where the focus should lie in HIV intervention campaign PSAs: message or messenger. An important implication of this finding is that future studies should test the weight attributed to each element to determine which should take precedence.

The findings of this study show a need for balance between a number of common message elements identified by Black MSM in order to make HIV intervention campaign components, particularly PSAs, more effective among the demographic. While some research participants valued PSAs with a large amount of racial, ethnic and sexual diversity other participants seemed to prefer a more homogenous mix of Black MSM.

Additionally, this study's findings suggest the necessity for equilibrium between the display of underrepresented, corporate and stereotypically masculine Black MSM and, seemingly, overrepresented, effeminate Black MSM. If achieved, this balance could potentially communicate that no one person or type of person is precluded from HIV exposure and contraction, broadening Black MSM's understanding of HIV susceptibility and increasing HIV prevention behaviors.

This study's findings suggested no socioeconomic differential between the two masculine types of MSM identified by research participants ("corporate" and "DL/stereotypically masculine). However, one research participant's interview suggested a sociocultural differential between effeminate Black MSM and traditionally masculine Black MSM. This research was unable to conclude if the participant's rejection of HIV

intervention campaign components, specifically PSAs, featuring effeminate Black MSM stemmed from sociocultural values – similar to the aforementioned high priority of masculinity, or *machismo*, present in Latino culture – however, future studies should examine this possibility to increase the influential nature of HIV intervention campaigns among Black MSM.

Differing message tones and points of view should also be examined by future studies to determine what tone (jarring, jovial, somber, etc.) or point of view (neutral or direct) Black MSM find most influential in influencing their HIV risk behaviors.

Based on the findings of this study, future studies should consider examining the influence of physical visual markers of community (localization), the inclusion of different HIV prevention methods, such as PrEP and TasP, and statistics.

Another significant finding of this research is the identification of direct barriers to HIV prevention behavior listed by Black MSM. Again, these barriers included:

- Dislike of condoms
- Distrust in preventative antiretroviral medication
- Alcohol and other substances
- Access (or in-access) to preventative measures, such as condoms, PrEP or testing sites
- The relationship between spontaneity and trust; and
- Themselves

This research's documentation of these barriers to HIV prevention behaviors is significant because it affords the opportunity for future studies to examine and address

barriers expressly named by Black MSM in an attempt to improve the efficacy of HIV intervention communications targeting the demographic.

The final significant finding of this study is the seeming confirmation of prior research (Guydish and Ekstrand, 1992; Melkote et al., 2014), which suggests a correlation between normalizing HIV prevention behavior among an individual's social group and buy-in to said behavior by the individual. While there was a small, but significant, group of participants who were unresponsive to their social group's impact on their HIV prevention behavior, the overwhelming majority of Black MSM indicated that their social group taking active measures to prevent HIV infection would influence them to do the same. Research participants in this study also stated that this influence would be most successfully expressed to them through direct communication (in-person, by phone or in a text group chat). Future studies should examine how best to apply these findings to HIV intervention campaign components designed to influence HIV risk behavior of Black MSM.

Limitations

It is important to acknowledge this study's limitations. First, this study was composed of Black MSM living within the greater Kansas City metropolitan area, possibly limited by regional norms. Secondly, this study only expressly examined one component of HIV intervention campaigns, public service announcements (PSAs), despite knowledge indicating that the majority of health campaigns use multiple media channels to disseminate their messages. Thirdly, the pool of research participants was small, at eleven people. Finally, due to its qualitative nature, the study's findings and conclusions were based upon the researcher's own interpretation of participant accounts,

meaning a risk of reflecting “participants’ stories in ways they did not intend” (Basu et al., 2016, p. 1373) exists.

Directions for Future Research

This study’s findings exemplify the necessity for increased market segmentation in health communications, a requirement long accepted by other forms of marketing (Kreuter et al., 1999). This research asserts that future health communications targeting Black MSM must not only realistically appeal to their experience as MSM, but also their experience as Black and the intersectionality of the two. No longer can health communicators expect the simple inclusion of Black or brown faces in health communication materials to be enough to move the needle towards more equitable health outcomes. Future health communications should feel genuine to Black MSM by integrating aspects of their varied experiences if increased efficacy and altered population behavior are the desired results.

As previously mentioned, future research should work to expand upon and incorporate the common message elements identified in this research by Black MSM. The inclusion of these sociocultural modifying factors in future health communications, supported by the theoretical base of the Health Belief Model, can promote an increased understanding of person susceptibility, disease severity and prevention benefits. Additionally, future research should acknowledge the specific barriers recognized by Black MSM in this research as negatively impacting their HIV risk behaviors. In the acknowledgement of these barriers, future research should try to normalize HIV prevention behaviors, using examples of direct communication from the social groups of Black MSM as the cues to action to mitigate the aforementioned barriers, potentially

leading to an increase in self-efficaciousness in HIV prevention behaviors and, eventually, more equitable health outcomes among the demographic.

The direct feedback provided by Black MSM in this pilot study can potentially also help to refine future health messaging campaigns, not only for Black MSM, but also for other demographics. Future studies should quantitatively test the findings of this study on a larger scale to discern if they may be applied to further studies examining the effects of health messaging campaigns on other cultural subgroups.

Chapter 6: Conclusion

Due to the disparate rates of HIV infection among Black men who have sex with men (MSM) as well as the relatively minimal research focusing on HIV among the demographic, this study examined the potential inclusion of theory-based, sociocultural targeting into HIV intervention campaigns and the effects that such an inclusion would have on the HIV risk behavior of Black MSM. As indicated by the research, the Health Belief Model (HBM) operationalized with sociocultural variables as modifying factors served as an appropriate basis for the study.

This study holds value as a pilot, or pre-study, whose findings have the potential to better inform the design of future HIV intervention campaigns targeted toward Black MSM. Additionally, the findings of this study may offer significant contributions to future studies examining the efficacy of sociocultural targeting on health intervention campaigns among other cultural subgroups.

References

- About Us. (2020). Retrieved from <https://fubu.com/pages/history>
- Albarracín, D., Johnson, B. T., Fishbein, M., & Muellerleile, P. A. (2001). Theories of reasoned action and planned behavior as models of condom use: A meta-analysis. *Psychological Bulletin*, *127*(1), 142-161. doi:10.1037/0033-2909.127.1.142
- Albarracín, D., McNatt, P. S., Klein, C. F., Ho, R. M., Mitchell, A. L., & Kumkale, G. T. (2003). Persuasive communications to change actions: An analysis of behavioral and cognitive impact in HIV prevention. *Health Psychology*, *22*(2), 166-177. doi:10.1037/0278-6133.22.2.166
- Bandura, A. (1997). *Self-efficacy: The exercise of control*. New York: W. H. Freeman.
- Banks, A. (2015, June 30). *The rise and fall of FUBU: A lesson in business and branding*. The Hundreds. <https://thehundreds.com/blogs/content/the-rise-and-fall-of-fubu>
- Basu, A., Dillon, P. J., & Romero-Daza, N. (2016). Understanding culture and its influence on HIV/AIDS-related communication among minority men who have sex with men. *Health Communication*, *31*(11), 1367-1374. doi:10.1080/10410236.2015.1072884
- Berger, A. A. (1999). *Media research techniques*. Thousand Oaks, CA: SAGE.
- Brennen, B. (2017). *Qualitative research methods for media studies*. New York: Routledge.
- Cambridge University Press. (2019). *Sociocultural*. Retrieved from <https://dictionary.cambridge.org/us/dictionary/english/sociocultural>
- Champion, V. L., & Skinner, C. S. (2008). The health belief model. In Glanz, K., Rimer, B. K., Viswanath, K., & Orleans, C. T. (Eds.), *Health behavior and health education: Theory, research and practice* (pp. 45-65). San Francisco: Jossey-Bass.
- DiNenno, E., Prejean, J., Irwin, K., Delaney, K., Bowles, K., Martin, T., Taylor, A., Dumitru, G., Mullins, M., Hutchinson, A., & Lansky, A. (2017). Recommendations for HIV screening of gay, bisexual, and other men who have sex with men — United States, 2017. *Morbidity and Mortality Weekly Report*, *66*(31), 830-832. <http://dx.doi.org/10.15585/mmwr.mm6631a3>

- Drake, C. (1989). The Sociocultural Dimension. In *National Integration in Indonesia: Patterns and Policies* (pp. 64-100). Honolulu: University of Hawai'i Press. doi:10.2307/j.ctv9zcnv.9
- Dutta-Bergman, M. J. (2005). Theory and practice in health communication campaigns: A critical interrogation. *Health Communication, 18*(2), 103-122. doi:10.1207/s15327027hc1802_1
- Fisher, J. D., Fisher, W. A., Misovich, S. J., Kimble, D. L., & Malloy, T. E. (1996). Changing AIDS risk behavior: Effects of an intervention emphasizing AIDS risk reduction information, motivation, and behavioral skills in a college student population. *Health Psychology, 15*(2), 114-123. doi:10.1037/0278-6133.15.2.114
- Fisher, W. A., Fisher, J. D., & Rye, B. J. (1995). Understanding and promoting AIDS-preventive behavior: Insights from the theory of reasoned action. *Health Psychology, 14*(3), 255-264. doi:10.1037/0278-6133.14.3.255
- Frequently asked questions. (2017, September 8). Retrieved from https://grants.nih.gov/grants/policy/faq_clinical_trial_definition.htm#5224
- Gateway to health communication & social marketing practice. (2016). Retrieved from <https://www.cdc.gov/healthcommunication/campaigns/index.html>
- Givhan, R. (1999, August). FUBU sportswear build a bridge between hip-hop and the mainstream. *The Washington Post*, C1.
- Glanz, K., & Bishop, D. B. (2010). The role of behavioral science theory in development and implementation of public health interventions. *Annual Review of Public Health, 31*, 399-418. <https://doi-org.proxy.mul.missouri.edu/10.1146/annurev.publhealth.012809.103604>
- HIV/AIDS glossary. (2019, July 15). Retrieved from <https://aidsinfo.nih.gov/understanding-hiv-aids/glossary/1632/serostatus>
- HIV and African Americans. (2020, January 30). Retrieved from <https://www.cdc.gov/hiv/group/raciaethnic/africanamericans/index.html>
- HIV treatment as prevention. (2020, February 24). Retrieved from <https://www.hiv.gov/tasp>
- Horowitz, J. M., Anna, B., & Cox, K. (2019, April 9a). Views of racial inequality. *Race in America 2019*. Retrieved from <https://www.pewsocialtrends.org/2019/04/09/views-of-racial-inequality/>
- Horowitz, J. M., Anna, B., & Cox, K. (2019, April 9b). The role of race and ethnicity in Americans' personal lives. *Race in America 2019*. Retrieved from

<https://www.pewsocialtrends.org/2019/04/09/the-role-of-race-and-ethnicity-in-americans-personal-lives/>

- International Classification of Health Interventions (ICHI). (n.d.). Retrieved from <https://www.who.int/classifications/ichi/en/>
- Janz, N. K., & Becker, M. H. (1984). The health belief model: A decade later. *Health Education Quarterly*, *11*(1), 1–47. <https://doi-org.proxy.mul.missouri.edu/10.1177/109019818401100101>
- Kandula, N. R., Khurana, N. R., Makoul, G., Glass, S., & Baker, D. W. (2012). A community and culture-centered approach to developing effective cardiovascular health messages. *Journal of General Internal Medicine*, *27*(10), 1308–1316. <https://doi.org/10.1007/s11606-012-2102-9>
- Kansas City HIV care region. (2017). Retrieved from <https://health.mo.gov/data/hivstdaids/pdf/KCHIVSTD2017.pdf>
- Kreuter, M. W., Strecher, V. J., & Glassman, B. (1999). One size does not fit all: The case for tailoring print materials. *Annals of Behavioral Medicine*, *21*(4), 276–283. doi:10.1007/BF02895958
- Li, X., Lei, Y., Wang, H., He, G., & Williams, A. B. (2016). The health belief model: A qualitative study to understand high-risk sexual behavior in Chinese men who have sex with men. *JANAC: Journal of the Association of Nurses in AIDS Care*, *27*(1), 66–76. doi:10.1016/j.jana.2015.10.005
- Melkote, S. R., Moore, D., & Sanjanthi, V. (2014). What makes an effective HIV/AIDS prevention communication campaign? Insights from theory and practice. *Journal of Creative Communications*, *9*(1), 85–92. doi:10.1177/0973258613517441
- Statistical areas. (2020). Retrieved from <https://www.marc.org/Data-Economy/Metrodataline/General-Information/Statistical-Areas>
- Morse, J. M. (1994). “Emerging from the data:” The cognitive processes of analysis in qualitative inquiry. In J. M. Morse (Ed.), *Critical issues in qualitative research methods* (pp. 23–43). Thousand Oaks, CA: Sage.
- Noar, S. M., & Kennedy, M. G. (2009). HIV/AIDS prevention messages. *The Virtual Mentor*, *11*(12), 980–987. <https://doi.org/10.1001/virtualmentor.2009.11.12.msoc1-0912>
- Noar, S. M., Palmgreen, P., Chabot, M., Dobransky, N., & Zimmerman, R. S. (2009). A 10-year systematic review of HIV/AIDS mass communication campaigns: Have we made progress? *Journal of Health Communication*, *14*(1), 15–42. <https://doi.org/10.1080/10810730802592239>

- Noar, S. M., Palmgreen, P., & Zimmerman, R. (2009). Reflections on evaluating health communication campaigns. *Communication Methods & Measures*, 3(1/2), 105-114. <https://doi-org.proxy.mul.missouri.edu/10.1080/19312450902809730>
- Oster, A. M., Wiegand, R. E., Sionean, C., Miles, I. J., Thomas, P. E., Melendez-Morales, L., Binh, C. L., & Millett, G. A. (2011). Understanding disparities in HIV infection between Black and White MSM in the United States. *AIDS*, 25(8), 1103–1112. <https://doi-org.proxy.mul.missouri.edu/10.1097/QAD.0b013e3283471efa>
- Poyer, L. (2001). Sociocultural Anthropology. In *Encyclopedia of Sociology* (2nd Ed., Vol. 4, pp. 2888-2894). New York, NY: Macmillan Reference USA. Retrieved from <http://link.galegroup.com/apps/doc/CX3404400368/GVRL?u=morenetuomcolumn&sid=GVRL&xid=d8e1d61a>
- Robb, A. M., & Fairlie, R. W. (2007). Access to financial capital among U.S. businesses: The case of African American firms. *The ANNALS of the American Academy of Political and Social Science*, 613(1), 47–72. <https://doi.org/10.1177/0002716207303578>
- Rose, I. D., Friedman, D. B., Spencer, S. M., Annang, L., & Lindley, L. L. (2016). Health information-seeking practices of African American young men who have sex with men: A qualitative study. *Youth & Society*, 48(3), 344-365. doi:10.1177/0044118X13491769
- Rosenstock, I. M. (1974). The health belief model and preventive health behavior. *Health Education Monographs*, 2(4), 354–386.
- Schnall, R., Rojas, M., & Travers, J. (2015). Understanding HIV testing behaviors of minority adolescents: A Health Behavior Model analysis. *The Journal of the Association of Nurses in AIDS Care: JANAC*, 26(3), 246–258. doi:10.1016/j.jana.2014.08.005
- Seal, D. W., Kelly, J. A., Bloom, F. R., Stevenson, L. Y., Coley, B. I., & Broyles, L. A. (2000). HIV prevention with young men who have sex with men: What young men themselves say is needed. *AIDS Care*, 12(1), 5-26. doi:10.1080/09540120047431
- Sellers, R. M., Copeland-Linder, N., Martin, P. P. & Lewis, R. L. (2006). Racial identity matters: The relationship between racial discrimination and psychological functioning in African American adolescents. *Journal of Research on Adolescence*, 16(2), 187-216. doi:10.1111/j.1532-7795.2006.00128.x

- Shavers V. L. (2007). Measurement of socioeconomic status in health disparities research. *Journal of the National Medical Association*, 99(9), 1013–1023.
- Singh, S., Mitsch, A., & Baohua, W. (2017). HIV care outcomes among men who have sex with men with diagnosed HIV infection — United States, 2015. *Morbidity and Mortality Weekly Report*, 66(33), 969–674.
<http://dx.doi.org/10.15585/mmwr.mm6637a2>
- Smedley, B. D., Stith, A. Y., & Nelson, A. R. (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. (B. D. Smedley, A. Y. Stith, & A. R. Nelson, Eds.). Washington, DC: National Academies Press. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&AuthType=ip,cookie,url,uid&db=psyh&AN=2003-02632-000&site=ehost-live&scope=site>
- Snowden, L. R. (2012). Health and mental health policies' role in better understanding and closing African American–White American disparities in treatment access and quality of care. *American Psychologist*, 67(7), 524–531.
<https://doi.org/10.1037/a0030054>
- Snyder, L. B., Hamilton, M. A., Mitchell, E. W., Kiwanuka-Tondo, J., Fleming-Milici, F., & Proctor, D. (2004). A meta-analysis of the effect of mediated health communication campaigns on behavior change in the United States. *Journal of Health Communication*, 9(Suppl1), 71–96.
<https://doi.org/10.1080/10810730490271548>
- Stroman, C. A. (2005). Disseminating HIV/AIDS information to African Americans. *Journal of Health Care for the Poor and Underserved*, 16(4), 24–37.
<https://doi-org.proxy.mul.missouri.edu/10.1353/hpu.2005.0118>
- Sweat, M. (2008). A framework for classifying HIV-prevention interventions. *Geneva: UNAIDS*.
- Toro-Alfonso, J., Varas-Díaz, N., & Andújar-Bello, I. (2002). Evaluation of an HIV/AIDS prevention intervention targeting Latino gay men and men who have sex with men in Puerto Rico. *AIDS Education and Prevention*, 14(6), 445–456.
 doi:10.1521/aeap.14.8.445.24110
- Vidanapathirana, J., Abramson, M. J., Forbes, A., & Fairley, C. (2005). Mass media interventions for promoting HIV testing. *Cochrane Database of Systematic Reviews*, N.PAG. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&AuthType=ip,cookie,url,uid&db=cin20&AN=105838354&site=ehost-live&scope=site>
- What we do. (n.d.) Retrieved from <http://www.blaqout.org/>

Williams, D. R. & Jackson, P. B. (2005). Social sources of racial disparities in health. *Health Affairs*, 24(2), 325-334

Williams, D. R., Priest, N., & Anderson, N. B. (2016). Understanding associations among race, socioeconomic status, and health: Patterns and prospects. *Health psychology: Official Journal of the Division of Health Psychology, American Psychological Association*, 35(4), 407-411. doi:10.1037/hea0000242

Wolitski, R. J., Fishbein, M., Higgins, D. L., Rietmeijer, C., Guenther-Grey, C. A., & Johnson, W. D. (1999). Community-level HIV intervention in 5 cities: Final outcome data from the CDC AIDS community demonstration projects. *American Journal of Public Health*, 89(3), 336-345.

Zimmerman, R. S., Palmgreen, P. M., Noar, S. M., Lustria, M. L. A., Lu, H.-Y., & Horosewski, M. L. (2007). Effects of a televised two-city safer sex mass media campaign targeting high-sensation-seeking and impulsive-decision-making young adults. *Health Education & Behavior*, 34(5), 810–826. <https://doi.org/10.1177/1090198107299700>

Appendix A

Sample Recruitment Script

Good morning/afternoon,

My name is Mathew Davis and I am a graduate student from the School of Journalism at the University of Missouri-Columbia. I am recruiting individuals to participate in my research study about the influence of sociocultural targeting in HIV campaigns on the HIV risk behaviors of black men who have sex with men (MSM). The purpose of this study is to examine if sociocultural targeting of HIV campaign messaging, particularly PSAs, toward black MSM affects their HIV risk behaviors.

If you decide to participate in this study, you will be interviewed at the location of your choice for approximately one hour. The interview will be audio recorded; however, no identifying information will be collected.

Inclusion in this study is completely voluntary. You can choose to be in the study or not. If you would like to participate or have any questions about the study, please contact me at mrd7b2@mail.missouri.edu.

Thank you for your consideration.

Appendix B

Informed Consent Script

Study Title: Sociocultural Targeting of Black MSM in HIV Intervention Campaigns

Name(s) Of Researcher(s): Mathew Davis

Project IRB #2016559 MU

Please take as much time as you need to read this consent form. If there is anything you do not understand, please ask me to explain. You can then decide if you want to take part in the study.

What Is The Purpose Of This Study?

The purpose of this study is to examine HIV campaigns use of sociocultural targeting and its influence on HIV risk behavior among black men who have sex with men (MSM).

Why Am I Being Asked To Participate?

I invite you to take part in this research study because you comprise the demographic being studied. This consent form tells you why I am doing the study and what will happen if you join the study.

Do I Have To Participate?

Research studies help us to answer questions that may improve our understanding of human behavior, attitudes, beliefs, and interactions. Taking part in this study is voluntary. You are free to say yes or no. I will only include you in this study if you give me your permission first. Even if you join this study, you do not have to stay in it. You may stop at any time without giving a reason.

What Is Expected Of Me During This Study?

If you decide to participate, you will complete a one-time, audio-recorded interview lasting approximately one (1) hour. You will be asked to answer a series of interview questions. Next you will watch two (2) PSAs from the “Doing It” campaign, a national Centers for Disease Control and Prevention (CDC) campaign urging adults to test for HIV and be aware of their HIV status. Finally, you will be asked to answer another series of interview questions.

Are There Any Benefits To Taking Part In This Study?

There will be no direct benefit to you from taking part in this study. However, the information I learn from you during this study may help me better understand how sociocultural targeting of HIV campaigns can influence HIV risk behavior among black MSM.

Are There Any Risks To Taking Part In This Study?

Some interview questions ask about HIV prevention measures. The problems that some

people have experienced in studies like this one are discomfort or awkwardness over some of the items asked during the interview. You may also feel that some of the questions I ask are stressful or upsetting. If you do not wish to answer a question, you may skip it and go to the next question, or you may stop immediately.

Another risk may be loss of confidentiality. Audio recordings and transcripts of your interview will be stored on my personal computer, to which only I have access. Every effort will be made to keep your research records confidential, but I cannot guarantee it. Depending on the kind of information being collected, if your research information were accidentally seen, it might be used in a way that could embarrass you. If you have questions, you can talk to me about whether this could apply to you.

After the removal of your identifiable, private information, the information collected as part of this research could be used for future research studies or distributed to another investigator for future research studies without additional informed consent.

Will I Be Paid For Taking Part In This Study?

There will be no financial compensation given for taking part in this study.

Who Can I Call If I Have Questions, Concerns, Or Complaints?

If you have more questions about this study at any time, you can call Mathew Davis at (816) 679-6997 or Dr. Jeannette Porter at (573) 882-8834.

You may contact the University of Missouri Institutional Review Board (IRB) if you have any questions about your rights as a study participant. The IRB is a group of people who review research studies to make sure the rights of participants are protected. Their phone number is (573) 882-3181.

If you want to talk privately about your rights or any issues related to your participation in this study, you can contact University of Missouri Research Participant Advocacy by calling (888) 280-5002 (a free call), or emailing MUResearchRPA@missouri.edu. I will give you a copy of this consent form.

Name (signed)

Date

Appendix C

Interview Schedule

An initial interview will take place, including the following list of pre-established questions:

- What are the biggest challenges in your life right now?
- What are your health priorities?
- How do you define sociocultural? What does the term mean to you?
- How severe do you think HIV infection is?
- How susceptible/vulnerable do you think you are to HIV infection?
- How do you protect yourself from HIV?
- What prevents you from protecting yourself from HIV?
- How do you define community and/or your social group?
- What does your social group think about HIV prevention?
- What does your social group do to protect themselves?
- How might your social group taking active measures to prevent HIV exposure influence your likelihood to do the same? How would that influence be successfully expressed to you?
- Have you ever seen HIV intervention campaigns before? Through which media?
- What is the most impactful message you ever received about HIV prevention from an intervention campaign?
- What made it impactful?
- When/where/how did you receive it?

- What was the worst/the stupidest/the least useful message you ever received about HIV prevention from an intervention campaign?
- If you were going to design a PSA about HIV prevention to reach yourself, what would it look like? What would it say? When/where would it air?

Next, participants will watch two short PSAs from the “Doing It” campaign, part of the Centers for Disease Control and Prevention (CDC) Act Against AIDS initiative.

- “Doing It” PSA 1 – <https://youtu.be/IghlfCW-SpE>
- “Doing It” PSA 2 – <https://youtu.be/NKmSLGi4eew>

After watching the PSAs, participants will be asked to comment on the perceived effectiveness of the PSAs through a series of pre-established questions including:

- How would the PSAs you just watched convince you to protect yourself from HIV exposure? What was missing?
- How could you see yourself in any of the PSAs you just watched? What was missing?
- How would you improve the PSAs you just watched?
- How are the PSAs you just watched realistic to your experience? What was missing?