

¿Qué te parece?: Pre-testing an HIV Testing Enablers Diagnostic Tool among Hispanic/Latino Immigrant Women

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Abstract:

This article describes the procedures used to determine the conceptual adequacy and cultural appropriateness of a newly developed HIV Testing Enablers Assessment (H-TEA) instrument to be used with underserved Hispanic/Latino immigrant women. The aim was to create an appropriate format for women with similar language proficiencies and ethnic backgrounds. We discuss the feedback we received from the women in terms of cultural nuances we must pay attention to when creating items and organizing them into an assessment instrument. Women reported on the understandability, com-fort level, likelihood of truthfulness, and cultural relevancy of questions and response options for the instrument. These are key factors in developing an instrument that is relevant, reliable, and culturally appropriate for our target population.

Este artículo describe los procedimientos que se usaron para determinar si los conceptos utilizados en un instrumento recientemente desarrollado HIV Testing Enablers Assessment (H-TEA) para evaluar factores sociales y culturales facilitan que mujeres latinas inmigrantes se hagan la prueba del VIH y para determinar si los elementos de dicha evaluación son adecuados y apropiados dentro del contexto cultural que se examinó. El objetivo del proyecto fue crear un instrumento cuyo formato pudiera ser utilizado con mujeres latinas con niveles lingüísticos y antecedentes étnicos similares. Se discuten las recomendaciones provistas por las mujeres que participaron para que se adapte el instrumento toman-do en consideración los antecedentes culturales que se deben tomar en consideración para desarrollar un instrumento apropiado. Las mujeres entrevistadas proveyeron comentarios en torno a la claridad del instrumento, cuan cómodas se siente con el lenguaje utilizado en el instrumento y la validez y relevancia de las preguntas y respuestas provistas en el instrumento. Éstos son elementos centrales en el proceso de desarrollar un instrumento que sea válido, relevante, confiable y que pueda ser aplicado al contexto de la población de interés.

Keywords: HIV testing | Enablers | assessment instrument | Hispanic/Latino | immigrant women

Article:

HIV counseling and testing services (CTS) is a key strategy “integral to HIV prevention, treatment, and care efforts” (Kaiser Family Foundation, 2006, p. 1). Despite the higher HIV risk and need for testing, about 53% of the members of the Hispanic/Latino community reported not having been tested for HIV (Kaiser Family Foundation, 2013). Although Hispanics/Latinos currently comprise about 16% of the U.S. population, they constitute about 20% of AIDS cases, and they have the second highest rate of HIV diagnoses with most infections occurring after entry into the United States. Therefore, programs that promote timely testing for HIV among diverse at-risk groups are a priority.

The importance of timely testing in stemming the spread of the HIV infection has been underscored by the Centers for Disease Control and Prevention (CDC, 2006, 2012) recommendations to include HIV testing as part of routine primary care for all groups but especially among higher risk groups including Hispanics/Latinos. Hispanics/Latinos are considered a higher risk group for HIV/AIDS for several reasons, including that a greater proportion of them are foreign-born and rates of diagnoses and patterns of higher risk behaviors vary by place of birth and length of residence in the United States (Espinoza, Hall, & Hu, 2012). HIV risk behaviors in the Hispanic/Latino population include higher proportions of men having sex with men, low condom use, higher injection drug use for men and higher proportions of women having sex with men who have these risky behaviors for heterosexual women. Although Hispanics/Latinos comprise many sub-cultures and ethnicities, some broad cultural similarities are associated with HIV risk, including gender roles such as *machismo* for men that entails proving masculinity through power and dominance (including unprotected sex and multiple sex partners), *simpatía* (including silence on sexual matters, female unwillingness to negotiate condom use because of fear of male violence), *familismo* (familial solidarity), and *respeto* (respect), which reduce the ability to discuss issues of same-sex behavior (Harawa, McCuller, Chavers, & Janson, 2013; Herbst et al., 2007). However, testing rates among the Hispanic/Latino population outside the context of prenatal care are still low (Herbst et al., 2007). North Carolina still has a significant percentage of late testers who are Hispanic/Latino (North Carolina Department of Health and Human Services, 2012). Late testers are diagnosed later in the disease by which time they already have HIV-associated complications, poorer prognoses, and limited benefit from therapy, leading to lower survival rates (Chen, Erbelding, Yeh, & Page, 2010; del Rio, 2011; Dennis, Napravnik, Seña, & Eron, 2011). Late testers also present a major risk for further transmission (Dennis et al., 2011; Marks, Crepaz, & Janssen, 2006). This underscores the need for increased HIV testing among underserved and at-risk populations.

In response to this lack of testing and to the 2006 CDC recommendations, North Carolina offers HIV testing free of charge in local health departments and several community-based organizations. The state has expanded outreach of free HIV and sexually transmitted infection testing through development of nontraditional testing sites (NTS). NTS range from community-based organizations, community planning groups, local health departments, and AIDS care organizations to homeless shelters, public parks, street corners, nightclubs, and col-leges (North

Carolina Department of Health and Human, 2012). Persons found infected with HIV are linked to appropriate services through a network of county-level AIDS service organizations (ASOs).

To improve HIV testing services to underserved groups such as Hispanics/Latinos, studies advocate a holistic, culturally customized approach (Brown, Taylor, Mulatu, & Scott, 2007; Chen et al., 2010). Duran et al. (2010) recommend that because the Hispanic/Latino population is heterogeneous, HIV-related interventions need to be customized to be “risk specific and culturally relevant,” and CTS should be encouraged in high-risk settings and locations (p. S157). Studies of testing indicate that Hispanic/Latino women are less likely to be tested than men and are more likely to be tested only in the context of prenatal screening because they report needing their partner’s assent to be tested otherwise. Furthermore, because most women do not at any given time need prenatal care and many Hispanic/Latino women lack health insurance and have limited access to health care, there are gaps in their access to CTS (Chen et al., 2010). Therefore, additional efforts to strengthen CTS by customizing services to lower income Hispanic/Latino women are needed.

Researchers who have studied HIV testing have generally adopted measures and domains from so-called knowledge, attitudes, practices, and behaviors studies. Most of these approaches rely on a model of identifying barriers to testing. Few have examined strengths or factors that enable or support women to take up testing (CDC, 2006; Royce et al., 2001). Our effort to develop an assessment instrument to identify factors enabling Hispanic/Latino women to take an HIV test is an effort to fill this gap.

This article reports on the pretesting phase of a data collection strategy within a larger federally funded study to identify and characterize social and environmental factors in HIV testing decisions and behaviors. That larger study used participatory, qualitative research methods to interview 31 Hispanic/Latino women and 11 community health service workers. The key purpose is to develop an assessment instrument that can be administered to Hispanic/Latino women who seek health care for any reason, to identify women who feel more ready to take an HIV test, versus those who need more outreach and support. Health care providers and outreach workers can then focus on the latter to provide them additional encouragement to take an HIV test.

In this article, we describe the process of pretesting this culturally customized instrument, the HIV Testing Enablers Assessment (H-TEA) tool, with a smaller group of five Hispanic/Latino women. The goals of this pre-test process were to assess appropriateness of wording choice, understandability of the instrument, and identify problem areas in its comprehension and administration among members of the target population. We synthesize feedback received and discuss lessons learned during the pretesting phase. This pretesting process wherein we solicit and incorporate feedback from a group of women whose characteristics reflect our target population of interest aligns with our overall participatory research approach. In this article, we use the term *Hispanic/Latino women* to refer to the population of women who are the target participants in our larger study.

Guiding Framework

Development of the HIV-TEA tool was guided by the PEN-3 model (Airhihenbuwa, 1989, 2010; Airhihenbuwa et al., 2009), a framework used in health education, which considers the role of culture in disease prevention and health promotion. The model comprises three interrelated cultural domains, each having three components. The first domain, cultural identity, focuses on whether *Persons*, *Extended family*, or *Neighborhoods* should be targets for health promotion. The second examines how cultural relationships and expectations influence audience's *Perceptions of health* and the *Enablers* and *Nurturers* of health behaviors. The third, cultural empowerment encompasses the *Positive*, *Existential*, and *Negative* aspects of health behaviors. This study focused on developing an instrument to assess the *Enablers* component of the model, that is, family and peer systems, social groups, networks, community organizations, and other environmental systems and structures that influence health behaviors.

The H-TEA tool contains six main questions with response items arranged as statements representing *Enablers*. These Enablers were derived through qualitative interviews with 31 Hispanic/Latino women in the larger overall study. For example, the instrument contained the question *why would you get tested for HIV*, which has multiple responses. Respondents are told to "select all that apply" from a list of statements such as "Concerned about my health" and "I want to be able to care for my family/children." The six questions and response options are presented in the form of an 8.5 in. by 11 in. two-sided pamphlet. Each response item will be scored as a 1 or 0 to indicate presence or absence of the Enabler and summed to provide a total Enablers score. In future research and development, we will investigate appropriate segmentation of the score into "high," "moderate," and "low" designations to signify Enabler status. This will allow HIV service providers to better profile Hispanic/Latino clients' needs and target resources appropriately to meeting these needs.

Cognitive Interviewing

To provide culturally relevant interventions to reduce HIV disparities, culturally customized measures and instruments are important (Stern et al., 2012). Instead of using direct translations of existing measures, culturally *Women* appropriate measures must be developed and implemented. This can be accomplished by using a theoretically grounded, "bottom up" process based on recommendations elicited directly from the population of interest and validated using mixed methods (Betancourt, Flynn, Riggs, & Garberoglio, 2010). This bottom up process where feedback is elicited from participants is in contrast to "top down" processes that are designed solely with input from researchers. Direct use of measures normed for this population without additional steps of pretests, field tests, and analyses might yield misleading and invalid findings (Morales, 2001).

A key technique used in preliminary testing and validation of a measure with a target population is cognitive interviewing (Nápoles-Springer, Santoyo, O'Brien, & Stewart, 2006; Willis, 2005). This technique, drawing from cognitive psychology and information processing perspectives, examines the culturally shaped covert cognitive processes of survey respondents as they interpret and answer questions, such as question comprehension, information retrieval, judgment formation, and response editing. The purpose of this technique is to reduce the errors that can arise when participants do not interpret questions in the manner intended by the interviewer. Thus, when survey questions are being developed, the questions are "pretested" or field tested on

a small number of participants, and respondents are encouraged to “think aloud” the thought processes and feelings leading to the answers, whereas researchers use verbal probes to explore their interpretation and solicit alternative wording if needed (Rosal, Carbone, & Goins, 2003). This technique identifies inadvertent difficulties in the questions that were not intended by the researchers and helps develop optimum question wording. The approach helps determine not only which items work but also which items present problems or do not work. Cognitive interviewing is thus a key step in assessing the conceptual adequacy of new self-report measures and examining whether measures work in diverse groups’ cultural contexts and lifestyles.

Methods

Participants

The process described in this article is part of a larger overall study, which uses participatory and qualitative research methods to identify factors that support or “enable” Hispanic/Latino women to voluntarily take an HIV test. The larger overall study gathered information from 31 Hispanic/Latino women through qualitative techniques such as “free listing” factors they thought would enable women to take an HIV test. Based on the information gathered, the most frequently mentioned HIV test Enablers were identified. These were drafted into a tool to be administered to women of the target population to ascertain if these factors are present in their lives. This article is another step in the process of validating the tool and improving its design with feedback from women from the target community.

The draft tool was administered to five women whose characteristics reflect those of the target population in a cognitive interviewing process. For cognitive interviewing, reliable and valid information can be gained with smaller sample sizes. Because the purpose is not statistical evaluation, important information can be gained from even one interview and a judicious selection of subjects can balance the need for larger numbers (Willis, 2005). Zuckerberg, Von Thurn, and Moore (n.d.) show that the information gained from analyzing a smaller number of participants does not differ significantly from that gained with a larger number. This is especially true of the exploratory phases of a study, which can use a minimum of five participants, as does our study (Shafer & Lohse, n.d.).

The pretest was conducted with five women who provided feedback on the instrument and its administration. The women were recruited through solicitation by community contacts of one of the bilingual and bicultural members of the research team and were invited to participate in the interview held at a location of their choosing. The women were acquainted with one another because they shopped at the same stores. Three women were from Mexico, one was from the Dominican Republic, and one from El Salvador. The women’s ages ranged from 29 to 40 years, and all but one had children younger than age 18 years. All but one of the women had education until at least the sixth grade, and all had been educated in their countries of origin. One woman was not literate and would need the questionnaire read to her. These demographic characteristics and varying literacy levels reflects those among the target population and are thus appropriate characteristics for the pretest study population. Three research team members, two bilingual/bicultural women of Mexican American descent and one European American woman with moderate Spanish skills, conducted the pre-test sessions.

Procedures

Rapport building was critical to the success of this process. We implemented several steps to ensure that the women were offered a welcoming and friendly environment. First, all research assistants were trained in principles and practices of rapport building during qualitative interviewing with both cross-cultural and ethnically matched groups (Seidman, 2013). Second, we asked the women invited to participate to suggest a day, time, and location convenient to them for the interviews. All indicated an interest in coming to the university campus and visiting the surrounding area. They expressed curiosity as to the university structure and about processes that would be relevant to their children's future education. Upon arrival at the campus, women and their accompanying children and family members were given a tour of the campus and its facilities. This created ongoing dialogue with the bicultural bilingual research team members about their own journey into higher education.

At the interview site, the women, children, and family were offered refreshments. The research assistants shared about their cultural backgrounds and family features, and many aspects resembled those of the women. Then, the accompanying family members watched the children while the women went to an adjacent room to participate in the cognitive interview process. Prior to administering the draft tool, women were encouraged to share any concerns they had. This allowed the participating women to share their opinions and feedback candidly. These strategies, along with the personal connections among the participants and research team members, facilitated a friendly and nonthreatening environment.

The objectives of the pretest of the draft tool were to (a) assess whether the women understood the instrument itself, (b) determine the optimal response categories that were to be used for ratings and reports related to HIV testing, and (c) identify problem areas in comprehension (e.g., language, cultural relevance, reading level, content, and the response tasks). In particular, four categories of feedback regarding the questions were explored: understanding the question wording, comfort with the question content and choice of words, likelihood of truthful responses given the potentially sensitive subject matter, and relevance of the concepts in the target cultural population. The institutional review board of the University of North Carolina at Greensboro reviewed and approved the study.

During the sessions, the researchers described the project and informed consent procedures to the women. They orally verified that the women were consenting to participate in the research. The women were first asked to fill out the H-TEA tool. This process took about 10 min, with one woman having the instrument orally administered to her in Spanish. The women were then invited to provide feedback on the instrument for appropriate language, ease of understanding, logical flow of the questions, comfort in answering them, cultural appropriateness of the questions, and likelihood of truthful responses to the questions. This was done through a semistructured cognitive interview conducted in Spanish. The questioning for the cognitive interview occurred under four categories: understanding, comfort, likelihood of truthful responses, and relevance. These interviews took about 45 min to an hour. The women also provided written feedback on copies of the assessment instrument. Because these interviews were not audio-recorded as per participant preference, the researchers took extensive notes,

carefully documenting observations, and the perceptions and suggestions shared by each woman. The women were served refreshments while participating and were offered a \$10.00 grocery store gift card, to a store that members of this community frequented, as a token of appreciation for their participation.

To promote rigor in the data collection process, recommended cognitive interview techniques, such as concurrent interviewing, where participants think aloud and share their thoughts in the course of the interview were followed (Almond et al., 2009). Other recommended techniques, which we followed, included several members of the research team being present and taking detailed notes, which are subsequently triangulated with each other.

Analytic Methods

Feedback was given in both English and Spanish. All Spanish language materials were translated into English by the bilingual/bicultural research team members. First, the handwritten notes the women made on the draft tool and the field notes made by the research assistants were compiled, and a content analysis performed with attention to items that were similar in nature. The research team compiled a list of all items that represented suggestions made by the women and placed them under categories that fit the four domains of questioning used in the cognitive interviews, namely, whether the questions were understandable to the women, whether they were comfortable answering them, would the questions likely elicit truthful responses, and were the questions culturally appropriate. The process was an iterative one with the researchers being open and flexible to discovering commonly recurring items that represented suggestions about the instrument's content, format, and administration. The researchers discussed each suggested item, checking for any misunderstandings and coming to consensus on areas where they appeared to be discrepancy. Consensus was reached when all the research team members agreed on the categories and items (i.e., the suggestions) that fit within the categories. This contributed to reliability and consistency in the process (Bernard & Ryan, 2010).

Results

The goal of the cognitive interview process was to ascertain whether the draft assessment instrument was considered acceptable to the women, along four domains, described as follows. The women were asked whether the questions were understandable to them as administered; were they comfortable with answering them; would the questions, in their opinion, elicit truthful responses when administered to other women in the community; and were the questions culturally appropriate and relevant. In addition to asking the women, the researchers also noted the women's reactions, conversations, and responses, which provided additional information on these four domains.

Understanding the Questions

When the pretest began, one of the women notified the researchers that she was not literate and that she would need the pretest read aloud to her. One woman also asked about the logistics of selecting her answer choices to the questions, asking if she should choose only one answer or mark all answers that applied to her. The pretest instrument already included directions to mark

all answer choices that apply, and we assume that she clarified for being absolutely sure that she was completing the instrument properly.

To the question “How did you hear about the HIV test?” one woman asked if this was limited to a certain time, that is, was she allowed to include all ways she had heard about the HIV test over the course of her life, or should she only include all ways she had heard about it during the past 12 months.

Three women would have liked to see more answer options to the question, “When I think about myself and HIV testing, I” There were 14 options given in the draft version of the instrument that included factors that might make a woman feel comfortable getting tested, for example, “. . . have someone who can go with me for the test,” “. . . feel comfortable with the site where the HIV testing takes place,” “. . . know my husband/partner wants me to get tested,” “. . . have transportation to get there,” “. . . know that the staff serves Hispanic/Latinos at the site.” There was also an option labeled *other* _____ where women could write in their thoughts. Some other answer choice suggestions were “I want to be tested for my personal health” and “I want to get tested to get more information.” All participants noted that two questions contained two answer options that were too similar, one regarding having someone to accompany them for the test (“. . . have some-one who can go with me” and “. . . someone went with me”) and one which mentioned access to transportation to a testing facility (“. . . have transportation to get tested” and “. . . have transportation to get there”). They suggested using only one of the options in each case.

Two women began a discussion among themselves that the Spanish translation for friend/companion in some of the answer choices (*amiga/compañera*) could be unclear in the context of an HIV survey, perhaps referring to roman-tic partner. However, after discussion, they recommended leaving the word choice as it was because the information about intent of the instrument and the instructions for completing it made the meaning clear. They suggested making adjustments to wording to clarify the time and to abate confusion. Overall, the participants felt that most questions were clear and that the instrument was easy to complete; one woman remarked on its “simple and concise” nature. They also thought that the flow of the instrument was appropriate.

The pretest process highlighted some potential difficulties with a self-administered instrument. Although most women were able to read through and respond to the questions on the instrument, one woman indicated she was unable to read in either Spanish or English. She requested an oral administration by one of the researchers. This situation mirrors a common one that has challenged health providers working with individuals of limited literacy. In this case, questions were read to the woman and options carefully explained when clarifications were needed.

Comfort With Questions

All women reported being comfortable with the content of the questions and were eager to discuss the information. The participants approached discussion with the researchers as equals, making eye contact when speaking and sharing their stories and opinions. There were sidebar conversations and vignettes, generally revolving around the participants’ families and personal

experiences that provided additional context and confirmation for questions included in the instrument. One woman discussed the differences between the generations in her family regarding openness and access to information about health and sexual health topics. She remarked that her children were aware of so much more than her own generation, and much of this awareness comes from media such as TV. Hence, they were pleased with the inclusion of the option—awareness through TV media. This was not a general rule for all because one woman stated that her parents, like many others, did not talk about sensitive sexual issues with her because they lacked information.

Two women noted that certain questions could create some discomfort for respondents, remarking that their parents or mothers were open about some sexual issues but only in a general sense. Mothers often refrained from mentioning specifics such as HIV and would talk around the topic without clearly stating what they meant. Therefore, the women suggested that question and response wording continue to specify “HIV or HIV test” in their narrative to limit confusion and facilitate comfort levels with matters pertaining to sex and HIV. Women also discussed the issue of comfort with questions in terms of access to comfortable and safe testing sites and staff who speak Spanish. These were important determinants of HIV testing behavior, and they were comfortable answering questions targeting these issues.

One woman reported that she had been tested for HIV 3 times, once because it was mandatory because of her pregnancy and twice voluntarily during the course of other physical health exams. She discussed the importance of the location where the topic of HIV was discussed and where HIV tests were provided. Places where Latinas feel more comfortable and places where Spanish is spoken are more likely to be effective locations. Overall, all women expressed comfort and satisfaction with the inclusion of these specific concepts as response options in the instrument.

Truthful Responses

When the women were asked if they would change their answers if the questionnaire was given to them by a health care provider or HIV counselor, all said that they would still answer truthfully regardless of the change in personnel. However, one woman did remark that it was possible that other women would not answer as truthfully in the same circumstance. She gave the example that people often lie about whether or not they smoke when questioned by doctors. She suggested that women might do the same thing in terms of disclosing some of their own behaviors related to HIV. The women also suggested that worry or suspicion about a partner’s infidelity be included as one of the answer options for the question “Why would you get tested for HIV?” The researchers asked if they thought this question could be too sensitive and would offend the future participants. The women said that it would not offend them but may deter others from responding. However, some women would be likely to answer truthfully because the information in the questionnaire indicated that answers would remain private.

Culturally Relevant

When questioned about the relevance of the topic of HIV and the questions, all women felt that it was relevant to their personal health and that of other Hispanic/Latinos whether one had the disease or not. However, the women provided some interesting feedback on the cultural nuances

and meanings of certain words or concepts. For example, moments before administering the questionnaire, a mistranslation of the concept of “a romantic girlfriend” was noted by the researchers, and the participants were asked if they understood the translation of this concept after the fact. All five women confirmed they did not understand that the translation was supposed to signify “a romantic girlfriend” and gave advice on which words to use to make this clear on future questionnaires.

The women noted that the answer option “Because I want to be able to care for my child/family” for the question “Why would you get tested for HIV?” was confusing. One woman’s first impression was that the answer response implied that she was pregnant and that she wanted to be tested to care for her unborn child. After learning what the researcher intentions were for the meaning of this answer choice, all women agreed that simply saying “for my family” would be more effective. One woman also suggested that for the same question, perhaps including an answer option of “To provide an example for my children and family” would also touch on the same or a similar meaning. Another example of cultural relevance was the insights shared by one woman who commented that her mother had told her to be careful when men get “hot.” This was something she initially took to literally mean “be careful when the temperature of men’s skin gets hotter.” She suggested that all questions referring to sex with men or male partners be clearly written to avoid this confusion.

In general, the women assessed the remaining questions as relevant to their cultural context but also offered additional reasons why women would or would not seek HIV testing. One woman mentioned that a motivator for testing included “what goes on outside the home”—referring obliquely to men’s extramarital liaisons. Another expressed concern that women should as a rule get tested for HIV—stating that “one never knows what goes on outside the home,” including prostitution, promiscuity, and the infidelity of one’s partner. They noted that men often will not agree to wear condoms during these sexual encounters and that this could put themselves and others at risk. Thus, a response option was included—“Because it is possible that my partner is cheating on me”—as was recommended. Another participant mentioned that one practical way for women to have the support and participation of male partners is to impress on the male partner the desire for both partners to be tested because it is better for both of them to have more information about HIV overall. This would help shift emphasis toward the caring aspect of a Latino couple’s relationship and reduce the likelihood of suspicion and blame. This insight was used to add the response category—“knows my husband/partner wants me to get tested”—to the instrument.

Discussion

The women who participated in the pretest process were striking in their openness and willingness to discuss HIV-related issues and provided detailed and candid feedback. Because of their openness, the research team received invaluable suggestions on how to edit, customize, and improve the H-TEA tool for use with Hispanic/Latino women. The cognitive interview discussion process revealed conversational dynamics which provided useful illustrations of the cultural context of HIV testing—related attitudes and behaviors among Hispanic/Latino women in the Southern United States. All women engaged in the discussion. They appeared to enjoy the opportunity to share their views and experiences. There was openness across age groups and

generations as women talked around the issues. The group gave valuable feedback on the original design and generated confidence in the redesigned assessment. They made specific recommendations, including simplifying wording and correcting repeated answer choices and mistranslations, and suggested new items for inclusion.

The participants confirmed that Hispanic/Latino women would typically respond truthfully to the questions once they understood what was being asked. They also pointed out instances where answer choices were repeated and mistranslations had occurred. Based on their recommendations, changes that we made in the instrument included specifying the time during which respondents have heard about the HIV test, omitting the answer choices that are repeated exactly or were viewed to be too similar, simplifying the wording of the concept of “being HIV tested for one’s family,” and adding answer choices for the questions mentioned by participants. All the participants contributed to the discussions, actively listening to the others’ stories and laughing on multiple occasions as a group. We speculate that because the participants were friendly with each other before the pretest situation, the semistructured interview portion with its resulting vignettes and stories was highly comfortable, facilitated self-disclosure, and relatively balanced participation.

The cognitive interview in this pretest process reinforced the centrality and importance of cultural appropriateness and competence when doing research with linguistically and culturally diverse samples. This is especially relevant when creating and implementing data collection instruments. Ideally, the items, constructs, and measures must make sense and have meaning to the intended audience. The administration of any data collection instrument must be sensitive to the literacy and comfort levels of participants. The cognitive interviewing process helped clarify wording and concepts to better reflect regional nuances. This, the women pointed out, was important for a more understandable instrument for use with the participants of background similar to those we were likely to encounter in our target population in the designated sampling area. At the same time, we needed to be flexible in our administration of this instrument, making sure to have both a semiprivate self-administration and oral face-to-face format to accommodate limited-literacy individuals. As an added bonus, our receptiveness to the guidance provided by the pretest participants went a long way in terms of their appreciation for us, recognizing them as “experts” in this revision process. This created an added level of trust that is often difficult to establish with underserved and marginalized groups. Overall, this was an important step in building social capital for future community-based collaborations for HIV research and prevention with Hispanic/Latino populations.

Limitations

There were some limitations associated with the cognitive interview pretest process and with our specific approach. First, the cognitive interview process was time and resource intensive and required specific training and expertise on the part of the research team. Although we did our best to match ethnicity and language of the team to those of the women, we had to institute additional training to ensure that our team could set aside regional biases and embrace the expressions of the participants as valid and relevant. Second, oral administration of the instrument for a limited-literacy participant increased the face-to-face time with the research team. Thus, the team had to be careful not to express impatience in light of the rapid completion

of the self-administered instrument. Third, women who participated in the pretest phase were recruited through personal contacts of one member of the research team. It is possible that other women may not have answered the questions so candidly or in such great detail as these women did. These drawbacks are outweighed by the benefits of the cognitive interview process, given the richness of discussion and suggestions received for enhancing the proposed assessment instrument. Moreover, the backgrounds of the women who participated in the pretest reflected those of the target population of interest in our larger study and those to whom the tool would be administered in future. Overall, the process supplied recommendations from an emic (insider's) perspective. This approach yields an instrument that is much improved and highly tailored for the target population—Hispanic/Latino women residing in our region of the Southern United States.

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