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Addressing Risk and Reluctance at the Nexus of HIV and Anal Cancer Screening

Lana Sue I. Ka'opua, PhD, DCSW, LSW^{1,2}, Kevin Cassel, DrPH², Bruce Shiramizu, MD^{1,2}, Rebecca L. Stotzer, PhD¹, Andrew Robles, MA¹, Cathy Kapua, BSW³, Malulani Orton, BA³, Cris Milne, RN¹, and Maddalynn Sesepasara, HS³

¹University of Hawai'i–M noa, Honolulu, HI, USA

²University of Hawai'i Cancer Center, Honolulu, HI, USA

³Life Foundation of O'ahu, Honolulu, HI, USA

Abstract

Anal cancer disproportionately burdens persons living with human immunodeficiency virus (PLHIV) regardless of natal sex, sexual orientation, gender expression, and ethnic identity. Culturally competent communications are recommended to address health disparities, with sociocultural relevance ensured through constituent dialogic processes. Results are presented from six provider focus groups conducted to inform the promotion/education component of a Hawai'i-based project on anal cancer screening tools. Krueger's focus group methodology guided discussion queries. Verbatim transcripts of digitally recorded discussions were analyzed using grounded theory and PEN-3 procedures. Adherence to an audit trail ensured analytic rigor. Grounded theory analysis detected the overall theme of risk and reluctance to anal cancer screening, characterized by anal cancer not being “on the radar” of PLHIV, conflicting attributions of the anus and anal sex, fear of sex-shaming/-blaming, and other interrelated conceptual categories. PEN-3 analysis revealed strategies for destigmatizing anal cancer, through “real talk” (proactive, candid, nonjudgmental discussion) nested in a framework of sexual health and overall well-being, with additional tailoring for relevance to Native Hawaiians/Pacific Islanders, transgender persons, and other marginalized groups. Application of strategies for health practice are specific to the Hawai'i context, yet may offer considerations for developing strengths-based, culturally relevant screening promotion/education with diverse PLHIV in other locales.

Keywords

anal cancer screening; cancer disparities; cultural competence; HIV; Native Hawaiians/Pacific Islanders; sexual minorities

BACKGROUND SIGNIFICANCE

Anal cancer is on the rise in the United States, especially among persons living with human immunodeficiency virus (PLHIV; American Cancer Society [ACS], 2014, National Cancer

Institute, Surveillance, Epidemiology, and End Results Program, 2014). Over the past decade anal cancer incidence and mortality rates in the United States general population have increased annually by 2.2% and 3.7%, respectively (National Cancer Institute, Surveillance, Epidemiology, and End Results Program, 2014). Examination through meta-analysis reveals that incidence rates for the seropositive population are 30 times higher than for the seronegative population (Shiels, Cole, Kirk, & Poole, 2009). Anal cancer is caused by human papilloma virus (HPV) infection and most commonly transmitted through sexual intercourse (anal, vaginal) and other sexual activities; notably, persons with immune systems compromised by HIV may be less able to fight off HPV infection and, thus, are at elevated risk for most squamous cell cancers (ACS, 2014). A comparison of 13 North American-dwelling cohorts followed over a 10-year period detected substantially higher rates of anal cancer incidence per 100,000 among PLHIV (131 for men who have sex with men [MSM], 46 for other men, 30 for women) versus non-PLHIV (2 for men, 0 for women; Silverberg et al., 2012). The disproportionate burden of this malignancy is of significant concern in the present landscape of cancer control for PLHIV, and early detection of anal cancer or anal intraepithelial lesions (AIN) is crucial to treatment success (Shiels et al., 2009; Shiramizu et al., 2012; Silverberg et al., 2012). Although screening guidelines lack medical consensus and tools, many experts recommend that PLHIV participate routinely in AIN screening (digital rectal examination, anal cytology testing, or anal papanicolaou test; ACS, 2014). The published literature is not definitive on the acceptability of screening procedures to PLHIV men, women, and transgender (TG) persons. A regional study of HIV service providers suggests that AIN screening participation of ethnically diverse MSM and TG may be influenced at least partially, by culture-specific factors (Newman, Roberts, Masongsong, & Wiley, 2008). Novel screening tools (e.g., ambulatory or home kits) for early detection complemented by culturally competent education may offer the prospect of improved survival and enhanced quality of life for adult PLHIV (Newman et al., 2008; Shiramizu et al., 2012).

Hawai'i's population is diverse in ethnic/racial and gender identifications, with cultural variations frequently observed in cancer screening utilization patterns (Hawai'i State Department of Health, Hawai'i Health Surveillance, 2010). No ethnic/racial group constitutes a majority with Native Hawaiians (NH), Japanese, and Whites accounting for about 60% of the population. Among U.S. states, Hawai'i has the highest proportion (5.1%) of persons identifying as lesbian, gay, bisexual, transgender (LGBT); it is speculated that general acceptance of LGBT persons permits greater willingness to self-identify (Gates & Newport, 2013). General acceptance notwithstanding, a survey of Hawai'i-dwelling LGBT individuals reveals challenges in accessing the health care system and low/no use of preventive health services due to gender identity concerns (Stotzer, Ka'opua, & Diaz, 2014).

Native Hawaiians and Other Pacific Islanders (NHOPI) comprise about 0.2% of the total U.S. population, with the majority of this population living in Hawai'i (U.S. Department of Health and Human Services Administration, Office of Minority Health, 2014). The U.S. AIDS case rate for NHOPI is twice that of the White population, and the HIV cumulative infection rate for Pacific Islanders from the U.S.-affiliated Pacific Islands (USAPI) is higher than the U.S. national rate for Whites (40.6–107.6 vs. 7.0, per 100,1000). While prevalence of anal cancer/dysplasia among Hawai'i-dwelling PLHIV is not fully known, results from a

multiethnic HIV cohort study detected abnormal anal cytologies in about 50% of NH participants (Payam et al., 2011). Although there was no significant ethnic variation in AIN prevalence, researchers noted that NH results may underestimate abnormalities due to this group's low/no participation in clinical studies. Culturally competent communications are recommended to address current disparities, with sociocultural relevance established through constituent dialogic processes (Airhihenbuwa, 1995; Ka'opua, 2008; Ka'opua et al., 2014; Shiramizu et al., 2012).

The current study aimed to inform the promotional/educational component of a larger research project comparing adherence to AIN screening methods (ambulatory screening, screening in the clinical setting) and, thus, is consistent with this journal's mission to advance application of evidence-based and promising practices for health promotions/education in the context of community-based research praxis. This article reports results from six provider focus groups (FGs) that describe perceived influences to PLHIV participation in AIN screening and identification of culturally competent promotion/education strategies.

METHOD

Sample recruitment was purposive. On receiving approval from relevant institutional review boards, investigators publicized the FG study to public and private nonprofit organizations in the three counties (islands) that together provide service to 95% of all PLHIV living in the State of Hawai'i (Hawai'i State Department of Health, HIV/AIDS Surveillance, 2012). Fourteen agencies were approached and 12 agencies (4 AIDS service organizations [ASOs], 3 community health centers, 3 sexually transmitted infections (STI)/HIV testing sites, 2 NH health organizations) participated. Providers of all disciplinary backgrounds were invited to participate. A total of six FG were conducted. The purpose of the first five groups was to elicit community-specific descriptions of screening influences and strategies for AIN screening promotion/education.

The purpose of the sixth group was to confirm, clarify, and/or extend the information provided by the first five groups. All members of this sixth group ($n = 5$) were qualified by the information-rich feedback each had provided in one of the earlier groups.

The final sample included 28 providers. Twenty-two (78.6 %) identified as social services providers and six (21.4%) identified as health services providers. Years in HIV-related practice ranged from 1 to 25 years ($M = 12$, $SD = 6.3$). Age ranged from 27 to 72 years ($M = 44$, $SD = 10.42$). About 61% identified "female" as their natal sex and current gender/identity expression. A minority reported gender identity as male (36%) or TG (3%). Participants identified sexual orientation as heterosexual (57%), homosexual (29%), bisexual (11%), and fluid or changing (3%). Highly trained cofacilitators from the research team moderated the interviews, providing a permissive, nonthreatening environment that allowed participants to freely share unique views. Participants provided informed written consent, responded to a sociodemographic survey, and commenced discussion. Discussion queries were designed to provide high-quality data within the social context of groups at elevated risk for anal cancer. A semistructured schedule of questions based on Krueger's

(2002) FG methods was used. All queries proceeded from general to more specific concerns. Query types included the following: introductory (e.g., words associated with anal cancer), transitional (e.g., exploration of associations), key (i.e., screening influences, intervention implications), and ending or summary (i.e., most important discussion points) questions.

Analyses involved use of grounded theory (GT; Strauss & Corbin, 2008) and the PEN-3 model for developing culturally appropriate health interventions (Airhihenbuwa, 1995). GT analysis yielded constructs, categories (groups of similar constructs), and theory (system of interrelated categories) related to PLHIV participation in AIN screening. GT findings were subjected to a PEN-3 analysis and led to articulation of educational/promotional strategies. As detailed in Table 2, trustworthiness or analytic rigor was ensured by establishing credibility (confidence in observational veracity), transferability (patterns of sociocultural relationships described), confirmability (findings shaped by participants), and dependability (consistency in results, replicable procedures; Lincoln & Guba, 1985).

RESULTS

Grounded Theory

Across FGs there was general concordance on screening influences. Six interrelated categories (groups of similar concepts; see Figure 1) were identified that taken together enunciate an overall theme of risk and reluctance situated in the experiences of Hawai'i-dwelling PLHIV. Participants used the term *risk* in two ways: (1) chance of developing cancer and (2) social-psychological risk originating from interactional processes perceived as threatening. Perceptions of threat were linked to "reluctance" or hesitation to discuss anal cancer/dysplasia and participate in AIN screening. Both PLHIV and providers could affect/be affected by risk and reluctance.

Reluctance is a normal reaction to being screened, but with anal cancer screening there is more hesitancy. Providers sometimes overlook that screening involves a set of other risks not often discussed ... in disclosing personal, sexual information there are risks of discrimination, stigma, and assault on a person's identity.

As a provider, there's reluctance to bring up health issues tied to sexuality. You may "open up Pandora's box" and then not know what to do once issues are raised or get into a labor- and time-intensive discussion that needs to fit into an already busy day.

Category No. 1: "Not on the Radar."—The expression "not on the radar" referenced the lack of awareness, knowledge, and resources relevant to anal cancer/dysplasia and AIN screening. Participant remarks tended to focus on lack of PLHIV and provider awareness:

Anal cancer screening is "not on the radar." The information isn't out there, not part of our history taking forms, no guidelines for screening, no educational materials.

I'm an older HIV-positive MSM—my provider has never brought it up. Why not?!

Use of humor deflected discomfort with discussion of anal cancer:

I've never really brought it up even when there was opportunity. At a nude party someone was running around with an ostomy bag. Shocking sight. Humor kept it light ... minimized the blip on the radar screen.

Category No. 2: Legacy of Negative Meaning Making—In the absence of readily accessible, accurate, consumer-friendly information, anal cancer/dysplasia may remain synonymous with fear of suffering and death or relegated de facto to obscurity. Participants explained the social construction of meanings associated with the terms *anus* and *anal cancer*. Noted were co-occurring, conflicting meanings such as anus as site of pleasure versus source of social derision. The incompatibility of meaning making could precipitate reluctance to candid discussions on anal cancer/dysplasia and AIN screening participation:

The anus carries many different cultural meanings. It's the opening for carrying waste from the body which is considered repulsive. ... But the anus also is a source of pleasure for men and women.

The legacy of sodomy laws puts anal sex in the category of deviant, immoral, shameful behavior. No wonder there's reluctance to talk about anal cancer.

Families want to protect their loved one from judgment ... nobody is talking about it ... this contributes to anal cancer being "off the radar."

Ethnocultural meanings—Meaning construction may be grounded in traditions and beliefs specific to the cultural mores of an ethnic group. Drawing on experiences with NHOPI consumers, providers highlighted challenges in making meaning of AIN screening. Underscored is the need for sensitivity to differences between and within cultural groups. Tailored communications reflecting collectivist values, national origin/migrant status, health beliefs, and other influences were discussed:

Native Hawaiian culture is very *onaona*—in tune with fragrance and their meanings. When anal cancer advances, there's dripping of body fluids. The house smells of suffering and death.

Many Pacific Islanders come to Hawai'i for treatments unavailable in the homeland. They may not be of the prevention mind-set. Preventive health may be less of a priority compared to getting housing, jobs, fending off discrimination. The attitude may be "if there's no problem [symptoms], why talk about it?!"

Category No. 3: Sex-Shaming and Sex-Blaming—HIV-related stigma and discrimination were identified as critical factors in living with HIV and understood to reflect racism, ethnocentrism, heterosexism, misogyny, and other harmful social processes. Participants noted the pernicious association of shame or social disgrace on PLHIV adherence to treatment and screening recommendations. Specifically, they spoke of the fear of "sex-shaming" and "sex-blaming" as factors in risk and reluctance to AIN screening participation.

There's a moral tie to anal cancer and HIV. "You see what happens when you guys have anal sex?! This is what you get." This is sex-shaming and sex-blaming, a real

obstruction to getting screened because you may have to admit that you have anal sex.

Women face this, too. People put a lot of shame and stigma on Farrah Fawcett when she died from this disease ... “That’s what she deserved for having anal sex.”

Ethnocultural issues—Fear of abnormal or suspicious results may be associated with stigma and judgment from within one’s own community.

With some of our Pacific Islander patients, there’s fear of having an exam, finding out that something is wrong with private parts and facing judgment— shunning.

Category No. 4: One More Thing for PLHIV to Manage—Anal cancer/dysplasia and screening may be viewed through the lens of living with HIV as a chronic condition. Participants identifying as HIV-positive and/or of the Stonewall Generation (coming to adulthood in the 1970s) described the complexity of mediating self-concept and proactive agency alongside of their HIV diagnosis, sick role, need for continuous vigilance in health management, and lived experiences with personal and social loss across time.

In the culture of living with HIV as a chronic, stigmatized disease, PLHIV have many things to think about and do. Screening is one more worry. People from the Stonewall Generation, long-term HIV survivors like me have known a lot of loss, suffering, trauma. Anal cancer is prominent in the MSM community. Dealing with it is like a repeat performance of the HIV pandemic. Sometimes you want a break from your “more at-risk than others” status.”

Category No. 5: Not Enough “Real Talk.”—Participants iterated the need for “real talk” or candid information sharing and sensitive discussion of important health and sexual issues. Participants were inspired by early adopters initiating real talk on anal cancer/dysplasia and AIN screening.

“Real talk” is everyone’s kuleana [responsibility]. A client knew people who died from this cancer and started sharing the screening message with other PLHIV.

Not all ASO providers are comfortable talking about NADC ... training helps.

Participants agreed that provider training could enhance capacity for “real talk” with PLHIV and suggested relatively simple systems innovations that might foster opportunities for discussion.

Having questions on our agency forms and PLHIV-friendly information would be helpful in getting more complete health information and providing an opportunity for discussion.

There’s a new breed of providers who might benefit from training on sexual history taking, LGBT cultural competence, cancer screening.

Culturally competent real talk in the services encounter—Culturally tailored conversations and culturally targeted print materials were emphasized, with attention to linguistic appropriateness, health literacy levels, and sociocultural relevance.

Culture is carried in language—how you speak to someone, the words you use are important to showing respect. When speaking with older Samoans, I use formal language and describe terms that don't readily translate.

Recent migrants from the Pacific tend to be less comfortable talking about sexuality. I talk about sexual issues as part of “overall” or “family” health.

Culturally competent real talk with NHOPI male-to-female TG persons—

Traditional Hawaiian, Samoan, Tongan, and Chamorro societies recognize a third gender—*m h*, *fa'afafine*, *fakaleiti*, and *palao'ana*, respectively. In the health/social services encounter, “real talk” with *m h wahine* (umbrella term for NHOPI TG) may need to consider traditional cultural orientations, as well as discrimination in contemporary times. In tailoring “real talk” for this group, it may be crucial to demonstrate sensitivity toward both ethnocultural and sexual minority issues. Participants suggested “bundling” or packaging screening information with other health concerns (e.g., hormone therapy) so as to “incentivize real talk” on screening.

M h wahine sisters appreciate communication that's straightforward. Real talk works when providers use our chosen name, ask about and listen to our concerns. That's the beginning for talking about screening.

For *m h wahine* use screening messages that appeal to their desire to be attractive for business and pleasure.

Use a “bundling” model with different kinds of information relevant to me as a trans-person—like culturally competent health care resources and anal health communications.

Category No. 6: Modifying What's Worked in HIV/STI and Other Health Promotions—Evidence-based and practice wisdom (solutions to real-life situations) approaches used in prevention and control of HIV/STI and other stigmatized diagnoses were suggested.

We learned in the 1980s how to talk about HIV/AIDS prevention and treatment. It's important to look back at some of those strategies and adapt them to anal cancer and screening.

In addressing risk and reluctance of PLHIV consumers, participants emphasized a strengths-based orientation, embedded in an overall strategy of health and wellness, with use of “normalizing” (validation of a person's concerns) approaches that implicitly destigmatize anal cancer. Such approaches were seen as communicating acceptance and empowering of diverse ways in which sexual pleasure and intimacy are expressed. To initiate “real talk,” participants suggested,

Promotional campaigns cannot be fear-based. People are more receptive to messages that support their health and wellness without stigma. This is promoted by messages like: “I'm checking all the windows of your body ... one of those windows is your anus.”

Promotions with women—Participants endorsed the need for gender-sensitive promotions but reported that funding constraints short-circuit such promotions. As a group, women were viewed as particularly “under the radar.” Attention to inclusion of women in promotions broadly aimed at PLHIV was recommended, with targeted effort to increase awareness among gynecologists and others providing care to women. Other systems’ innovations and culturally competent, gender-sensitive marketing were suggested.

Hawai‘i is considered a low-incidence state. At the ASO, we look to how we can step up the game to services for all ... becoming a Patient Centered Medical Home may be a way to provide more attention to women.

NHOPI cultures tend to be collectivist ... messages for NHOPI women should involve ensuring a living legacy for the multigenerational family.

Promotions to engage communities—Social venues, businesses, Internet-based medium, and cultural activities were suggested as opportunities for “real talk” aimed at increasing community awareness.

In our rural community, we stay connected through social gatherings, social media, text messages, websites, e-mail ... good ways to get “real talk” going.

PEN-3: Addressing Risk and Reluctance in Screening

The PEN-3 analysis highlighted strategies and approaches to address risk and reluctance in AIN screening, including: emphasis on preventive health; screening messages on sexual health, pleasure, and/or intimacy; “real talk” initiated by providers in service settings and by credible lay health messengers in communities; use of print, mobile, and Internet-based medium; attention to additional tailoring of visual, sociocultural, and linguistic elements relevance for NHOPI, women, and TG persons; and provider training on anal cancer/dysplasia and culturally competent strategies. Table 3 summarizes the educational dimensions of perceptions (beliefs, attitudes), enablers (systemic factors), and nurturers (cultural norms) by nature of influence (positive, existential or neutral, negative). Applications for health promotion/education practice specifically, are described.

DISCUSSION

Data collection and sampling methods limit application of results. The nature of data collection (FGs) is subject to biases of recall (what is remembered) and social desirability (reporting “what” may meet with others’ approval). The convenience sample likely advantages the perspective of providers, particularly those inclined to address emerging service concerns, frontline practitioner/educators, and females. Notably, perceived screening influences are filtered through a frontline provider lens. Although several participants volunteered that they were HIV-positive, HIV status was not part of the eligibility criteria.

Indicated is the need to elicit screening influences from a PLHIV sample that includes persons of more marginalized statuses and possible inclusion of organizational leaders and policy makers who might expand on upstream systems factors.

Limitations notwithstanding, the study had a number of strengths. The convenience sample of providers was criterion-based, thereby fulfilling an essential requirement of GT and yielding rich information, as well as practical suggestions on the experiences of both PLHIV and health care providers in the context of screening. Two analytic methods were applied and an audit trail used to establish rigor (Lincoln & Guba, 1985). The audit offers considerations for investigators seeking to conduct a similar study.

Findings from this study are congruent with those from other studies. Similar findings include the need for: increased awareness and knowledge of anal/other non-AIDS–defining cancers among PLHIV and providers, culturally competent promotions, and attention to living with HIV as a chronic illness (Burkhalter et al., 2013, Newman et al., 2008; Rangel & Adam, 2014). These findings have implications for future inquiries: (1) a meta-synthesis (Walsh & Downe, 2005) that systematically integrates results from related qualitative studies to advance a theory of risk and reluctance to AIN and possibly other non-AIDS–defining cancers screening among PLHIV, (2) development/feasibility testing of educational products (consumer website, print education, provider training curriculum), and (3) specifying of measureable constructs and hypotheses for use in testing screening education/promotions in tandem with biomedical screening innovations.

CONCLUSION

Findings underscore the pervasively, negative influence of ethnocentric, heterosexist morality on risk, reluctance, and AIN screening. Participants discussed this as PLHIV vulnerability to “sex-shaming/-blaming.” To address such vulnerability, screening approaches must move beyond the paradigm of behavior change predicated on knowledge and rational decision making (Rangel & Adam, 2014) and might include “real talk” on everyday risk management in the context of stigma and discrimination. Disclosure of highly sensitive obstacles may be difficult for persons marginalized by minority statuses. Culturally competent, culturally safe barriers counseling (discussion of obstacles and solutions in specific cultural context, with honoring of cultural preferences) is used to positive effect in screening for other malignancies and should be considered in AIN screening promotion/education (Gierisch et al., 2010; Holden et al., 2010; Ka'opua et al., 2014). Integration of strategies that address perceptions of risk and reluctance to screening may advantage translation of biomedical screening innovations to community settings and, ultimately, potentiate public health benefits for all.

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Figure 1.
Grounded Theory: Overarching Theme and Core Categories

Table 1**Glossary**

AIDS: Acquired immune deficiency syndrome
AIN: Anal intraepithelial neoplasia refers to appearance of abnormal cells in the anal canal; untreated high-grade AIN may progress to anal cancer
ASO: AIDS service organization
FG: A focus group, composed of people convened to participate in guided conversation on an issue or product that may be slated for social marketing
GT: Grounded theory, an inductive research method used to systematically generate theory with procedures for detecting conceptual categories
HPV: Human papilloma virus of which there are about 30-40 types that may affect the genital area
LGBT: Lesbian, gay, bisexual, transgender
MSM: Men who have sex with men
NADC: Non-AIDS-defining cancer or all malignancies other than Kaposi's sarcoma, non-Hodgkin's lymphoma, and cervical carcinoma)
NH: Native Hawaiians, the indigenous people of the Hawaiian Islands
NHOPI: Native Hawaiians and Other Pacific Islanders
PAP test: Papanicolaou test, a method for detecting potentially precancerous or cancerous processes
PEN-3: Framework for assessment of focus group and other types of qualitatively gathered data; such assessment, subsequently, may be used to develop culturally relevant health programs
PLHIV: Person living with the human immunodeficiency virus
SOGI: Sexual orientation (lesbian, gay, straight, bisexual, straight, questioning) and gender identity (person's feelings about self as masculine, feminine, neither, or both)
STI: Sexually transmitted infection, diseases passed from one person to another through sexual and/or genital contact
TG: Transgender, an umbrella term that includes transwomen (natal sex male, female gender identity), transmen (natal sex female, male gender identity), and other kinds of gender variation
USAPI: U.S.-affiliated Pacific Islands; includes three nations with U.S. treaty (Compact of Free Association) agreements treaties and three U.S. territories (American Samoa, Commonwealth of the Northern Mariana Islands, and Guam)

Table 2**Audit Trail of Grounded Theory and PEN-3 Procedures**

Stage	Procedures for Ensuring Trustworthiness of Results
1	<i>Credibility (confidence in truth of observations and results)</i> : On completion of a focus group, facilitators debrief impressions of discussion procedures and content.
2	<i>Transferability (obtaining thick description)</i> : Digitally recorded focus group discussion immediately is transcribed <i>verbatim</i> . Facilitators complete initial review of transcript and make memo notes on emerging concepts and exemplary quotations.
3	<i>Credibility and transferability</i> : Each transcript is independently coded by at least two research team members. All transcripts are continuously analyzed and compared by research team. Sections of transcripts are filed by concepts and categories of similar concepts.
4	<i>Confirmability (extent to which findings are shaped by participants and not biased by investigator interest)</i> : Senior colleagues who are not part of the research team periodically review coding system of concepts, categories, emergent theory.
5	<i>Credibility</i> : Preliminary summary of grounded theory analysis is reviewed by a sixth focus group composed of individuals qualified by information-rich observations shared in previous group discussions. As indicated, revisions are made.
6	<i>Establishing credibility, transferability, confirmability, and dependability (demonstrating consistency in results)</i> : PEN-3 is applied to grounded theory; Stages 3-5 are repeated.
7	<i>Establishing dependability (demonstrating consistency in results and trustworthiness)</i> . Final analyses are written and linked to published literature.

Table 3

PEN-3 and Grounded Theory: Addressing Anal Cancer Risk and Reluctance by Dimensions, Implications

Educational Diagnosis	Positive Influence	Existential Influence	Negative Influence
Perception (beliefs and attitudes)	<p>Early adopters already discussing anal cancer and AIN screening</p> <p><i>Implications</i></p> <p>Involve early adopters in mentoring/training others on culturally competent “real talk” about anal cancer/dysplasia and AIN screening</p> <p>Foster network(s) of lay health community educators and popular opinion leaders</p>	<p>Anecdotal knowledge on impact of anal cancer in PLHIV population</p>	<p><i>Not on radar:</i> Providers and consumers lack accurate knowledge</p> <p><i>Negative, conflicting meanings:</i> Diverse perceptions of anal sex and AIN screening</p> <p><i>Fear of sex shame/blame,</i> stigma, and discrimination</p> <p><i>Screening is one more thing to worry about</i> when living with HIV as chronic condition</p> <p><i>Implications</i></p> <p>Assess consumer knowledge, attitudes, and screening history</p> <p>Promote/initiate education and candid discussion; attend to cultural safety and competence</p> <p>Normalize anal sex and AIN screening as part of sexual health and wellness</p> <p>Establish reminder system using Internet, mobile, or other medium</p>
Enablers (systemic factors)	<p>Identifiable MSM/TG networks, opinion leaders, and common venues, medium used</p> <p><i>Implications</i></p> <p>Use intercept approaches to increase AIN screening awareness</p> <p>Develop/promote website for PLHIV emphasizing sexual health and pleasure, with information on anal cancer/HPV, AIN screening, and screening testimonials</p> <p>Tailor for relevance to MSM, TG, women, with emphasis on NHOPi</p>	<p>State legislation for LGBT marriage and civil rights creates opening for diversity, albeit with continuing opposition from some groups</p> <p>State is implementing Patient Affordable Care Act; hopeful prospect of opportunities for health equity but presently unclear if AIN screening will be covered</p>	<p><i>Not on radar.</i> Providers lack forms to elicit information on anal cancer and screening</p> <p>Paucity of PLHIV educational materials</p> <p><i>Real talk:</i> Provider discomfort compromises “real talk”</p> <p><i>Modifying what's worked:</i> Funding streams prioritize MSM; identify creative ways for reaching women</p> <p><i>Implications</i></p> <p>Develop agency forms, print and Internet-based materials featuring “real talk”</p> <p>Offer provider training on AIN, screening, sexual history taking, education, and counseling</p> <p>Feature women in promotions</p> <p><i>Not on radar:</i> Recent USAPI migrants, persons with history of being medically un-/underinsured may lack experience with preventive health services</p>
Nurturers (cultural norms)	<p>Physical attractiveness is valued by men, women, and TG persons</p> <p>TG persons in sex and entertainment industries are business-oriented</p> <p>NHOPi cultures stress well-being of intergenerational family/community collective</p> <p><i>Implications</i></p> <p><i>Modifying what's worked:</i></p> <p>Promote message of caring for one's physical health as important to staying attractive</p> <p>Promote staying healthy as good for business</p> <p>Promote self-care as integral to caring for others</p> <p>Reinforce modeling healthy behavior as means for educating family members—as part of responsibility to the family collective.</p>	<p>Affected persons, families, and community networks may wish to protect loved ones from anal cancer-related stigma, sex-shame/sex-blame, and discrimination.</p>	<p><i>Fear of sex shame/blame:</i> Persons in close knit ethnic or rural enclaves risk social ostracism.</p> <p><i>Implications</i></p> <p><i>Real talk:</i> Increase health literacy through personal, Internet-based, and community-based communication strategies</p> <p><i>Screening is one more thing to worry about:</i> Emphasize screening as part of comprehensive health and “bundle” (integrate) AIN screening with promotion of other types of screening</p>

NOTE: AIN = anal intraepithelial lesions; PLHIV = persons living with human immunodeficiency virus; MSM = men who have sex with men; TG = transgender; LGBT = lesbian, gay, bisexual, transgender; NHOPi = Native Hawaiians and Other Pacific Islanders; USAPI: U.S.-affiliated Pacific Islands.