Published in final edited form as:
J Mens health. 2011 March 1; 8(1): 50–55. doi:10.1016/j.jomh.2010.11.002.

Health Promotion: Results of focus groups with African-American men

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Abstract

Background—Almost half (49%) of the people diagnosed with HIV/AIDS in the United States (US) are African-Americans. Although African-Americans represent only about 13% of the overall population, they continue to account for a higher proportion of cases at all stages of HIV/AIDS. Most documented interventions targeting the African-American population have focused on women, children, men who have sex with men or drug addicts.

Methods—Six focus group sessions with African-American men (39) and women (15) were conducted in a heterogeneously populated American city. We used a pre-focus group questionnaire to collect data about the socio-economic background of the participants. In our focus group sessions we examined the feasibility of instituting a health promotion program for African-American men.

Results—The men who participated in the sessions showed great interest in attending the health promotion program. They had no prior knowledge of positive behavioral practices that could promote their individual health and well-being. HIV infection rates in the African-American population remain the highest in the US.

Conclusion—The results of our focus group sessions showed that the heterosexual African-American men were eager to learn how to protect themselves against communicable and non-communicable diseases in health promotion programs.

Keywords

African-American men; Heterosexual; Health promotion; HIV prevention; Focus group

Introduction

Nearly 49% of all HIV positive and 42% of all AIDS cases newly diagnosed in the United States (US) are African-Americans, although they constitute only 13% of the population. Only 34 of the 50 states in the US report their data regarding HIV infection. Male infection

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rates are more than twice as high than female infection rates with rates of 136.8 per annum compared to 60.6 per annum for females [1]. It is believed that the mode of HIV transmission for men is mainly sexual contact with other men, injection drug use or high-risk heterosexual contact [1]. Sexually transmitted diseases (STDs) continue to be experienced at higher rates within the African-American community than in other communities. A main factor of transmission is the lack of awareness of risky behavior and the effect of HIV status [1]. Very often the husband constitutes the main risk factor for a wife [2,3]. These factors explain the high infection rates.

Almost a quarter of all African-Americans live below the poverty line and a disproportionate number are afflicted with HIV/AIDS or related diseases [4]. Poverty limits access to health care, as does negative attitudes (by both the provider as well as the patient), cultural beliefs and the stigma associated with HIV infection and other life style diseases [5]. Roderick [6] found that 83% of chronic illnesses were related to behavioral factors, which were influenced by social factors. Behavioral modification interventions are, therefore, essential in addressing the health issues of African-American men [5].

A review of the published literature (using PubMed research in 2010) revealed that out of 157 HIV intervention studies, fewer than 10% had been conducted with heterosexual men, focusing on their behavior patterns, their needs and their beliefs [7-11]. The main focus in most studies was on children, adolescents, women, college students, men who have sex with men, truck drivers, HIV positive people and drug users [12-16]. The literature review suggested there was a lack of risk reduction studies focusing on heterosexual men whose behaviors and attitudes predispose them to risky sexual practices.

Focus groups were organized, with the aim of collecting qualitative information to address the feasibility, acceptability, and logistics of conducting a trial to test the efficacy of a health promotion intervention for African-American men. A second objective was to identify African-American men's salient behavioral beliefs, normative beliefs, and control beliefs that were relevant to sexual risk behavior and the cultural and contextual factors associated with such behavior.

Method

We used focus group sessions because they are a useful tool for examining the perception of African-American men concerning men's willingness to participate in a health promotion program [17-19]. We conducted six focus group sessions, three sessions with African-American men only, one session with African-American women only, one session with African-American heterosexual couples, and one session with African-American men and women who were not in a relationship with each other. Altogether there were 54 participants, 39 African-American men and 15 African-American women. Each group had between six and 12 participants. All participants understood themselves as being heterosexual men or, in the case of female participants, heterosexual women. They all shared an interest in learning about health promotion and healthy life style to improve their own life.

The participants were recruited via flyers and advertisements in the *Metro*, a free newspaper in the Philadelphia area. Participants responded by calling a specific phone number to set up an appointment. Screening criteria were: age group, between 18 and 45 years; self identifying black or African-American; declared themselves as heterosexually active; did not intend to move out of the area within the next 12 months. The participants were then invited to take part in a focus group session. The participants completed an anonymous pre-questionnaire.

With the participants' permission the sessions were audiotaped, and additionally members of the research team took notes. The data were transcribed verbatim by the moderator and subjected to content analysis [20,21]. Further measures to ensure rigor included participant checks [22] and assurance of data saturation by the end of the data gathering process [23]. The content analysis began with reading through the transcribed interviews and listening to the audiotapes. Data were then assigned to units of meaning, which were subsequently organized into emergent themes. The thematic areas were: respondent's knowledge about HIV transmission, STDs, health risk behavior, and health promotion issues.

Each session was facilitated by a skilled moderator and lasted between 60 and 90 minutes. During the session refreshments were served. All participants received $50 as a token of appreciation for their time.

The study was approved by the institutional research board (IRB) of the University of Pennsylvania.

Results

The program was introduced to the participants as a health promotion program, where men would learn about prevention of risk behavior, and chronic diseases. The majority of men showed excitement about the idea of a health promotion program for men and were keen to participate in such a program. They suggested that we should include information about the location of facilities that could offer screening for prostate cancer, and training about the prevention of lifestyle diseases, such as high blood pressure and diabetes. They also expressed interest in hygiene education, and cessation of smoking and use of drugs.

The age of the participants was between 19 and 45 years, with a mean of 42.6. All of the participants were black and all but two were African-American. About 67% (36) of the participants were single, only 17% (9) were married, but 13% (7) were living together with a woman. One participant was divorced and another was widowed.

Approximately 35% (19) of the participants had a high school diploma, about 24% (13) had less than a high school diploma, and one participant had no formal schooling, about 28% (15) had some college education, while three (5.5%) had a four year college degree and three (5.5%) had a post graduate degree. Nearly a quarter, 24% (13) had a full time position, almost half, 44% (24) of the participants were unemployed, while 17% (10) held a part-time job and 13% (7) were retired. The majority of participants, 93% (50) were heterosexual, three men reported being bisexual and one man mentioned being on the down low (this means a man who is heterosexually active as well as homosexual). About 87% (47) said they had been sexually active in the past 3 months, but the remaining 13% (7) said they had not. Two participants reported having been diagnosed with an STI, but nine (17%) said they had been diagnosed as HIV positive.

Only 33% (18) always used a condom, while more than a quarter, 27.8% (15) said that they never used a condom, about 18.5% (10) used them half of the time, 14.8% (8) less than half of the time, and five (9.3%) used condoms more than half of the time. The questions included in the focus group meetings were: (1) interest in a health promotion program for African-American men; (2) acceptability and personal evaluation of health education materials/strategies; (3) perceptions and personal evaluation of health education for heterosexual men; (4) knowledge and health beliefs about health-related issues such as HIV/AIDS; (5) issues related to HIV testing resources; (6) HIV/AIDS preventative behaviors and strategies; (7) health promotion programs.

All of the participants in the focus groups said that the health promotion project was a good idea in that it would cover things that needed to be talked about but that "*nobody talks*". They believed that men would want to participate in this kind of program. The main barriers to participation included transportation, poor location, and concern about other people recognizing them when they attended such sessions or that they accidentally would be revealing their HIV status. Several strategies to persuade African-American men to participate were suggested: these included selecting convenient times and locations for the sessions, offering monetary compensation, and advertising through flyers, health care workers, health fairs, using radio stations with large African-American audiences and advertising in the *Metro* (a free newspaper in the greater Philadelphia area). The best times to hold such a program were considered to be during weekdays, particularly Wednesdays or Thursdays, after 5 pm or on weekends, particularly Saturday mornings. Participants agreed that the best location to hold the project would be an informal setting, like the university conference room where the focus group meetings were held, close to transportation and with easy access to parking. There was a diversity of opinion about whether the gender of the facilitator would matter. Some participants thought men would be less honest with a woman. Some said men would be more comfortable and open with a woman: " *Some men can't talk to a dude*." Some participants felt that gender did not matter "*as long as the person knows what he or she is talking about*" and "*can meet them at their level, as long as they know where they come from*."

Behavioral beliefs were solicited concerning the consequences of using condoms. The most frequently cited good consequences of using condoms were "*they prevent unwanted children*" and "*STDs*" and "*keeps you from dying*." The most frequently mentioned negative consequences of using condoms were that "*there is no feeling or pleasure*", using them "*breaks the mood*", "*they cause irritation on the privates*", "*they make a person break out*", and "*they don't taste good*". The participants offered ways of overcoming the negative hedonistic beliefs about condoms. For instance, some men said they liked "*the woman to put the condom on them*". Other participants mentioned using condoms in foreplay. We also solicited normative beliefs concerning the referents that would approve or disapprove of condom use. Those who would approve included doctors, an HIV positive partner, people who care about the man, and "*the lover he is cheating with*." Those who would disapprove included the man's main partner, his wife, the girlfriend he has sex with all the time, and someone in a hurry. In the mixed gender group, there were also comments about having to be careful about women poking holes in the condom to get pregnant.

We solicited control beliefs concerning factors that would inhibit or facilitate condom use. The things that made it hard to use condoms included "*lack of knowledge*" about how to use condoms, being in the "*heat of the moment*", having to slow down the process, having to break the mood, being too anxious, "*not having it with you*", "*not being able to afford to buy them*", and "*not having time to use it*". Aspects that make it easy to use a condom were "*preparing for the situation*", "*having a whole lot of them*", and "*carrying condoms all the time*". As one man put it, "*if you're going to be promiscuous, make it a habit of having it with you*." When asked about the female condoms, the participants felt that there was not enough education about the female condom.

The participants said that men could say "*no*" to sex if they did not have condoms. They felt it was realistic to send the message: "*if you don't have one, then don't have sex!*" However, they also said that after being with a woman for a while, men do not use condoms because of trust and closeness. They said men use condoms outside of their regular or steady relationship because they want to prevent the one with whom they are cheating from becoming pregnant. They explained that if "*his*" woman found the man carrying condoms, she would assume that he is cheating. The mixed-gender group felt that although a woman

in an on-going relationship might react negatively to the idea of using condoms, a take-home assignment with a pamphlet and information about condoms might mitigate that reaction and was a good idea. The all-female group concurred that having take-home assignments would make it easier for men to talk to their partners about using condoms. They said, "*that would make it better and give them a reason; yes, they can be more open and they would have proof; it's something they can do together*." For the most part, there was consensus that men were unlikely to use condoms when under the influence of alcohol and drugs. However, one man said, "*If I go out to drink, I make sure that I have a condom. It doesn't make a difference*."

The men had a clear idea of gender roles and saw themselves as the "*heads of the household*", the "*provider for the family*" as well as "*role model, leader and inspiration*" for their children. However, when it came to their views about women there was less consensus agreement. Some saw women as their "*nurturer and caregiver*", but some used negative terms, such as "*a bitch, who is out there to get them*". Some of the men took a more biblical stand on the role of the woman, with the view that the woman has to obey her husband and not be demanding towards him. Others believed that women needed to be free in order to develop in any way they wanted to. When asked about possible barriers to living up to these expectations the participants mentioned lack of communication, the society they live in, and finances.

The participants with children believed that children today become sexually active between the ages of 12 and 17, which was much earlier than they themselves became sexually active.

The men admitted to having different types of relationships. For example they had a main partner, and a second partner. Partner number two is considered to be the one preventing the men from "*moving around*" to other women. Most men admitted that after being with a woman for some time they would no longer be using condoms. When asked about the different relationships, they believed that men had between 3 to 5 concurrent female partners. All participants believed that most men would have sex outside their stable relationship or marriage. The reasons were that most men were not satisfied with what they "*got at home*" and therefore felt attracted to another woman or even several women.

In general, participants believed that men do talk to their women about sex. One reason is that they feel that they "*want to please her*". Some participants admitted that they actually might not have enough knowledge to talk "*about sex and condom use*" but they felt it was important. However, they expressed their fear of losing the woman by doing this. Participants felt that the woman should tell the man what she wanted regarding sex. Although men strongly believed that they are the "*king*" of sex and should take the lead with regard to sexual decisions, the "*woman should have the responsibility of telling the man what they want with regard to sex*". The men also felt that "*their*" woman should talk to them about everything and be honest.

Asked about the activities they share with "*their*" woman, the men said these are activities like going to the cinema, shopping malls, theatre, travel and dinner The roles within their relationship centered on activities around daily life, home and money, but were not necessarily established by the men. Participants felt that their background influenced them.

The difference in culture depended on where they came from, or where they grew up, and where they lived. All men believed that it is important to be guided by a father figure who is a role model. They did not believe that women could bring up boys to be responsible in adult life. All men felt that young men needed to be taught about condom use whilst the older men would need other health-related information.

Some focus groups included women, the population of sexual partners of our target population, to solicit their views on men's sexual behavior and the likely reactions of the men's partners to attempted changes in sexual behavior. The women had a more negative view of the men. They expressed their feelings that most "*men would just be out there having sex*". They felt that "*they* [the men] *were not willing to stay in a committed relationship*" and were most often "*not willing to take over responsibilities for a woman or their children*". Most women said that "*men would also not be willing to use a condom*" or for a short time only. Most of the women believed that men would only be "*interested in playing around*" and very "*few were interested in keeping up a real relationship*". They expressed their frustration that most men would not want to look after a child, but rather "*spent time with their friends*". In general they gave a very negative picture of the men in their environment.

The results of these focus group sessions indicated that many men do not understand how to prevent infection or protect themselves against lifestyle diseases. Most of the focus group participants did not perceive themselves as being at risk when they have unprotected sex with their primary sexual partners even if they themselves engaged in risky behavior such as unprotected sex with other partners.

Discussion

The focus group sessions aimed to ascertain and understand the educational needs of black and African-American men. The main findings of the sessions indicated that while most participants did not know the details of HIV/AIDS transmission, they did know details about some STDs and the ways to prevent infection. These findings are similar with regard to risk-taking behaviors and are consistent with other studies [24-28].

The focus groups' findings suggested that any designed intervention with African-American men is feasible, acceptable, and logistically possible. Participants showed great interest in the proposed project and offered appropriate ways to recruit men and appropriate times and places to hold the project. The behavioral, normative, and control beliefs, for the most part, were similar to the beliefs in other populations. For instance, there were prevention behavioral beliefs regarding the ability of condoms to prevent STDs, and hedonistic beliefs about the adverse effects of condom use on sexual enjoyment. There were normative beliefs regarding, most importantly, sexual partner. Although doctors were mentioned, there was no specific reference to peers or the church as a source of normative influence. The control beliefs included technical skills in using condoms correctly without ruining the mood, availability beliefs regarding having condoms when needed, impulse control beliefs to use condoms in the heat of the moment, and negotiation skills to overcome partner resistance to condom use.

This qualitative study had specific limitations deriving from the study design as well as the research paradigm. It should be acknowledged that since data from focus groups are open to multiple interpretations, comments from the respondents should be interpreted within the social and environmental context in which they were provided. Such health education programs are needed for adult men as a means of providing tools and information to help decrease lifestyle diseases, including risky behavior.

Acknowledgments

A grant award from the CFAR funded this research. The authors wish to express their appreciation to the CFAR as well as to the referees, participants and staff of the Department of Health Behavior and Communication for their support.

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