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## Methodological Considerations for Conducting Focus Groups in HIV Prevention Research Among Black Men Who Have Sex with Men

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### Abstract

**Introduction:** Focus groups are an important learning tool in HIV prevention research among U.S. Black men who have sex with men (BMSM), for whom incidence persists. Focus groups are useful in designing interventions, but many have struggled to engage BMSM in research. To optimize the utility of focus group methodology on HIV prevention among BMSM, this paper offers methodological considerations for conducting and managing focus groups with BMSM.

**Methods:** Perspectives come from the process of conducting nine focus groups (N = 52) to explore the role of religion and spirituality in the lives of BMSM in Baltimore City and how these concepts could be used to inform local HIV prevention interventions.

**Results:** Themes from field notes captured important concepts to consider regarding the following: recruitment and retention, recruiting from within the social network, screening for HIV status, focus group stratification, and focus group facilitation.

**Discussion:** Considerations and recommendations for mitigating the challenges in focus group research and enriching data collection with BMSM are outlined.

### Keywords

Focus groups; HIV prevention; Black MSM; culture

### Introduction

Focus groups have been a particularly important learning tool in HIV prevention research among Black men who have sex with men (BMSM), for whom incidence continues to disproportionately impact in the U.S. At current rates, recent estimates suggest a 50% lifetime HIV risk among BMSM (Centers for Disease Control and Prevention [CDC], 2016; Hess, Hu, Lansky, Mermin, & Hall, 2017). Efforts to reduce incidence and improve health outcomes among BMSM are urgently needed. Focus groups are helpful by explicitly using

the group interactions to gather information about community attitudes or perceptions of a topic (Kitzinger, 1995; Kitzinger, 1994). Studies have used focus groups among BMSM to highlight socio-cultural experiences such as racism, homo-negativity, and stigma from family and healthcare providers, all of which create barriers to HIV prevention and optimal sexual health (Cahill et al., 2017; Dangerfield II, Harawa, McWells, Hilliard, & Bluthenthal, 2018; Han, Lauby, Bond, LaPollo, & Rutledge, 2010; Voisin, Bird, Shiu, & Krieger, 2013).

Obtaining the views and perspectives within groups is crucial in documenting health issues, assessing community needs, and designing interventions (Barbour, 2008; Davidson, Halcomb, & Gholizadeh, 2013; Halcomb, Gholizadeh, DiGiacomo, Phillips, & Davidson, 2007). The capacity for recent biomedical HIV prevention approaches such as pre-exposure prophylaxis (Anderson et al., 2012; CDC, 2014) and HIV treatment adherence (Attia, Egger, Müller, Zwahlen, & Low, 2009; Rodger et al., 2016) could be expanded if the target population most impacted by HIV is actively engaged in the development and implementation of these strategies (Magnus et al., 2014; Mayer et al., 2013). Studies have documented how medical mistrust among BMSM inhibits optimal participation in prevention behaviors, HIV treatment, and research (Cahill et al., 2017; Dale, Bogart, Wagner, Galvan, & Klein, 2016; Dangerfield II et al., 2018; Magnus et al., 2014; Mays, Cochran, & Zamudio, 2004). There has been an increased use of focus groups as a research method to elicit richer data and develop interventions for BMSM (Cahill et al., 2017; Dangerfield II et al., 2018; Harawa et al., 2008; Holloway et al., 2017; Hussen et al., 2013). However, while researchers have provided recommendations for other subpopulations (Halcomb et al., 2007; Jarrett, 1993; Kennedy, Kools, & Krueger, 2001), the literature describing good practice for designing and facilitating focus group discussions among BMSM is lacking. Moreover, few have had substantial success in reducing the extremely high incidence of HIV among BMSM or engaging BMSM in HIV research (Anderson et al., 2012; Jones et al., 2008; Magnus et al., 2014; Maulsby, Sifakis, German, Flynn, & Holtgrave, 2013; Millett et al., 2012; Wilton et al., 2009). Unique cultural experiences for BMSM as both sexual and racial minority men might inhibit optimal research and focus group participation. Strategies to recruit and engage BMSM in focus groups for HIV prevention research have not been adequately described.

To optimize the utility of focus group methodology on HIV prevention, this paper offers considerations for conducting and managing focus groups in HIV-related research among BMSM. The methodological, practical, and ethical difficulties that arose in an HIV prevention study of BMSM — related to recruitment and retention, recruiting from within the social network, screening for HIV status, focus group stratification, and focus group facilitation — raised several issues that current focus group methods inadequately address (Davidson et al., 2013; Happell, 2007; Jarrett, 1993; Kitzinger, 1995). These nuanced concepts require clarification because sensitive cultural norms and interactions impact study participation, group dynamics, and quality of the rapport with facilitators and other focus group members. Highlighting the methodological considerations in focus group research among BMSM is critical in obtaining quality data and protecting participants (Halcomb et al., 2007). Considering lessons learned from this focus group study will improve the field's ability to ethically gather more in-depth, culturally relevant data to improve interventions and reduce HIV incidence for BMSM.

## Methods

### Study Design and Participants

Data and perspectives come from the process of conducting nine focus groups of BMSM in Baltimore City (N=52) as part of The B'More Men's Study to Explore Religion, Spirituality, and HIV Prevention and Treatment. The goal of the study was to explore the role of religion and spirituality in the lives of BMSM in Baltimore City and identify how these concepts could inform local HIV prevention interventions. Focus groups were stratified by self-reported HIV status and age cohort to capture generational differences in attitudes and preferences for interventions for HIV-negative and HIV-positive BMSM separately. Groups were stratified as follows: three groups of HIV-negative men ages 18-29 (n=8, 6, and 5), two HIV-negative groups ages 30-45 (n=6 and 4), two HIV-positive groups of men ages 18-29 (n=7 and 5), and two groups of HIV-positive men ages 30-45 (n=6 and 5).

Participants were recruited from a combination of active and passive recruitment strategies. Passive recruitment included distributing fliers at community-based organizations and events that BMSM were known to frequent throughout Baltimore City. For active recruitment, research staff randomly asked individuals from community-based venues such as local coffee shops, night clubs, and community-based organizations to participate in the study. Participants were also asked to refer up to two other individuals to the study. Recruitment flyers were developed to appeal to men who identified as HIV-negative and HIV-positive separately. Focus groups were scheduled by providing interested volunteers with up to three focus group time slots for participation. Once at least five participants were confirmed for a time slot, all volunteers were contacted to confirm their continued interest and availability for study. Study team members then followed up with participants on the day of the meeting to confirm participation. Participants who brought volunteers to the focus group were taken to a separate room to privately screen for the study. Participants were compensated \$40 and provided refreshments during the meetings. Those who referred others were compensated \$10 for each eligible volunteer they referred.

Two experienced qualitative investigators who live and work in the Baltimore City community (the first two authors) facilitated the groups. One facilitator led the discussion and recorded field notes, the other operated the digital recorder, observed group dynamics, and took field notes. Each group began with the facilitator discussing the purpose and ground rules for discussion (e.g., one person speaks at a time, respect each other's comments). Facilitators used a semi-structured focus group guide developed in consultation with key informants and local community-based organizations who had strong ties to the target population (Table 1). Specifically, focus group interview domains of importance and cultural relevance were provided by key informants within the community, then key informants reviewed the focus group guide and provided additional recommendations for focus group guide refinement. Separate interview guides were developed for HIV-negative and HIV-positive men. Each focus group lasted between 60 and 90 minutes. All study procedures were approved by the Johns Hopkins School of Medicine Institutional Review Board.

## Identifying Themes for Methodological Considerations for Conducting Focus Groups among BMSM

Both focus group facilitators recorded field notes during each focus group. Field notes were organized through a process of abductive analysis, closely analyzing notes in light of relevant theoretical frameworks (Timmermans & Tavory, 2012; Winder, 2015). Specifically, notes from each focus group were independently reviewed by both facilitators, then themes related to the methodological and pragmatic issues that impacted study engagement were discussed by both facilitators. Themes were identified through reflexive debriefing whereby both facilitators outlined and agreed upon salient issues and domains (Berger, 2015; Mauthner & Doucet, 2003). Key themes that emerged from reflections that were recorded in field notes and are described below.

## Considerations for Conducting Focus Groups in HIV Prevention Research among BMSM

Through reflexive debriefing, methodological and pragmatic themes that impacted study engagement were elucidated by facilitators. Field notes and debriefing revealed important concepts to consider regarding the following: recruitment and retention, recruiting from within the social network, screening for HIV status, focus group stratification, and focus group facilitation. These concepts, along with considerations and recommendations for mitigating challenges, are outlined in Table 2 and described along the process of research design and data collection.

## Facilitators and Barriers to Recruitment and Study Participation

Volunteers were willing to participate in the research because of the rapport with facilitators who were young, Black, gay-identified men in the Baltimore community, despite their voiced concerns and reservations about providing information for the research institution. Participants voiced reservations about contributing to research for the affiliated institution due to perceptions of cultural incompetency, exploitation, and dismissiveness regarding the needs of the community. Some explicitly made statements such as “*We need more people like us doing this work because ‘those people’ don’t really care about us.*” Some volunteers who were initially interested in participating in the focus groups declined full participation because the focus group was being conducted at the research institution. Based upon comments such as these, two focus groups were conducted at community-based venues that were preferred among the participants who otherwise would not have participated in the study. Rapport with the study team, coupled with having participants refer other volunteers to the study, was key in effectively recruiting BMSM. The study team communicated with participants at least twice prior to focus group participation to clarify the study objectives and remind interested participants of focus group meeting times. This contributed to the study team’s ability to conduct seven of the nine focus groups of at least five BMSM within eight weeks. Of note, participants mentioned a desire for researchers who were not necessarily BMSM to socialize with the population at community-based events and other activities where BMSM frequent to build rapport and mitigate medical and research mistrust.

## **HIV Status and Recruiting from Within the Social Network**

Some participants who referred volunteers brought individuals from within their social network for eligibility screening immediately prior to the focus group and these individuals were taken to a private office for screening. However, in one instance, a participant who was referred to a group of HIV-negative men revealed in the screening that he was HIV-positive and was therefore not able to join in the group that was occurring that evening. He was subsequently rescheduled for another group but had to navigate through the reason why he could not participate in the group with his friend who referred him. While the study team did not disclose his HIV status, the study team had to manage the dynamics of the participant inquiring about why his friend could not participate. To maintain the confidentiality of the referred participant's HIV status, the study team ultimately told the individual who referred him that he "declined participation in the study," which could have raised suspicions about the volunteer's HIV status.

## **Screening, HIV Status Disclosure, and Focus Group Stratification**

Participants could screen as eligible into either of the HIV status groups via self-report. In instances in which participants self-reported being HIV-positive during screening, some who recognized friends or people they knew in the meeting declined focus group participation and mentioned being uncomfortable discussing issues related to being HIV-positive among individuals they knew. In one of the young HIV-positive groups, some who remained in the group shared their views and experiences related to religion and spirituality but did not share any HIV-related information at all. In other groups of HIV-positive men, participants were reluctant to discuss issues related to their HIV status, despite knowing that they were meeting with other HIV-positive men. Facilitators had to continuously remind participants of the goals of the study, that the information they shared was confidential, and prepare participants for HIV-related questions. Specifically, for questions about how participants manage their HIV treatment regimens, the facilitator had to prompt, "These next few questions may be sensitive, but we would like to learn more about living with HIV." Facilitators had to continue to prompt participants for subsequent HIV-related questions to establish and maintain emotional comfort and encourage participation.

Conversely, one participant who self-reported being HIV-negative during screening disclosed being HIV-positive in the group. While the reasons for this specific self-disclosure are unknown, targeted focus groups centered on the HIV prevention among BMSM could be a safe space for health care discussions and potentially change norms around HIV disclosure. This could suggest that one-on-one, in-depth qualitative interviews might be a more appropriate HIV research method among BMSM.

## **Facilitating Focus Groups with BMSM**

Although participants were asked not to name individuals or organizations, some revealed the individuals and organizations that negatively impacted them. Others were current or past members of these organizations. These disclosures made it difficult to elicit data from participants affiliated with those organizations or groups. While all participants signed informed consent forms and were reminded that information was confidential, disclosure of sensitive information within the group, such as ideas on sexuality or past traumatic

experiences, could have also impacted the dynamics among peers. This was particularly noted in the two focus groups of seven and eight participants. Moreover, disagreements about supportive and protective factors of BMSM's health emerged. Managing disagreements in the focus group context required a nimble and iterative approach. Specifically, facilitators had to continuously remind participants that all opinions were welcomed and that information that was shared should be respected and remain confidential. Smaller groups of between five and seven BMSM might be optimal for managing and eliciting rich data in HIV research. Challenges can emerge when discussing sensitive information about attitudes toward community health, experiences of BMSM, or interactions about organizations and leaders within communities.

### **Observations During Focus Group Facilitation**

Across groups, participants who were well-known community members or referred others to the groups dominated the focus group discussions. In some instances, participants who were referred did not speak until the one who referred them shared his opinions. Particularly among the younger groups, field notes documented how participants who seemed older or "more masculine" also dominated the discussion within groups. This led the focus group moderator to target participants who were not sharing to offer insights to the group. Additionally, some younger participants informed us that they wanted to speak more but just were not sure what to say and/or they did not want to get into a disagreement with the more vocal participants. Facilitators should be mindful of various levels of engagement, be able to manage group dynamics, and encourage full participation of group members.

Particularly for HIV-positive participants, focus groups became a space for BMSM to share feelings about their identities as Black gay-identified men in Baltimore City more than an opportunity to inform HIV interventions. As some reflected on personal histories that led to sexual risk-taking and HIV-vulnerability, others affirmed feelings of futility and histories of abuse and abandonment. For older HIV-positive BMSM, participants spent most of the meeting reflecting on the past when they had limited social support as gay-identified men, experienced social/religious stigma, and were vulnerable to HIV. In those groups, meetings evolved into group therapy more than research focus groups for the intervention as members shared thoughts on how to overcome the factors that increased their HIV vulnerability and ways they believed they could "heal themselves." Since questions about religion and spirituality led participants to these kinds of reflections, focus group facilitators allowed them to share their feelings, and were sensitive and mindful to not abruptly transition the discussion back to the original goals of the research. After meetings, participants explicitly mentioned to the group facilitators that they "appreciated the opportunity to share in a group like this." Facilitators learned to incorporate time for these kinds of reflections in subsequent groups.

### **Discussion**

The present work outlines lessons learned and considerations when conducting HIV research using focus groups among BMSM. Important issues related to recruitment and retention, managing groups, and HIV status disclosure emerged. HIV stigma and lack of support for

BMSM persists and impacts the quality of research engagement. While the presence of others enhances the richness of the data (Calder, Embrey, & Tait, 1977; Kitzinger, 1994), for some BMSM, the focus group methodology might not be the best way to elicit HIV-related data. The facilitator is less in control of a focus group than is the interviewer in a one-on-one interview (Fitzpatrick & Boulton, 1994; Morgan, 1996), which could impact data collection, depending on the research question.

Regarding recruitment and study retention, using study team members who were recognized as welcomed members of the target population along with allowing participants to refer other volunteers exponentiated study enrollment, despite barriers of institutional (i.e., medical and research) mistrust. Many have struggled with recruiting BMSM in HIV research and healthcare and have required multiple strategies to facilitate recruitment (Benoit, Pass, Randolph, Murray, & Jr, 2012; Koblin et al., 2013; Magnus et al., 2014; Wei, McFarland, Colfax, Fuqua, & Raymond, 2012). Having study team members who established a rapport with BMSM was a key component of successful recruitment and managing focus groups. Other research has shown that having study team members who are members of the target population and investing intensive time and effort with minority populations is critical in gaining access, generating the sample, and facilitating group rapport (Jarrett, 1993; Magnus et al., 2014; Winder, 2015). However, more research is needed to identify ways that non-BMSM researchers and allies might socialize with the population at events to implement this preference from participants.

Facilitators should explore preferences for the location of focus group participation with BMSM and groups should be conducted at a location agreed upon by focus group members. Organizing groups at a time and place that causes minimal upset for participants and in is a place that makes them comfortable is key (Happell, 2007). When possible, key stakeholders and community organizations should also be engaged to support recruitment (Halcomb et al., 2007) and can also act as seeds in snowball sampling. These individuals or organizations are invested in the wellbeing of the population beyond the scope of the study. This suggests that in HIV-related studies, the referral process should be explained after focus group participation so that referral and screening comes after “seeds” participate in the study. Smaller groups of between five and seven BMSM might be optimal for managing and eliciting richest data in HIV research. Additionally, for studies in which HIV status is an enrollment contingency, participants recruited through social network strategies should always be screened over the phone or another private safe space prior to the focus group. Facilitators should be mindful of various levels of engagement, be able to manage group dynamics, and encourage full participation of group members.

Relying on self-reported HIV status in focus groups among BMSM can cause challenges in data collection. In focus group studies in which HIV status is an enrollment contingency, participants should always be screened over the phone or in another private safe place in advance of the meeting. If possible, confirmatory HIV testing should be done prior to enrollment to ensure proper categorization of focus group members. In focus groups of BMSM stratified by HIV status, groups should be facilitated by trained and trusted members of the target population. To maintain rapport, decrease discomfort, and elicit optimal data, participants should consistently be reminded of the goals of the study and that information is

confidential. Facilitators should have the skills to manage disagreements during discussions and prepare participants for sensitive questions about HIV, sexuality, and possible histories of violence.

Limitations should be acknowledged. The parent study included a convenience sample of BMSM who were recruited in part through social networks, which limits the application of current methods on a more diverse sample of BMSM. Additionally, beyond the number of volunteers who were recruited from participants, we were unable to quantify the relative yield of volunteers from other recruitment strategies. However, few have highlighted the important methodological considerations of focus group methods in HIV research among BMSM. Future research should quantify the relative yield of various recruitment strategies on research participation among BMSM.

Sensitive topics can produce divergent views in any context. More work is needed to learn ways to circumvent barriers to research participation for BMSM populations. However, we found that despite challenges, focus groups can provide an opportunity for BMSM to share their experiences as urban sexual minority men in a therapeutic way that could also increase rapport with the research community. The present considerations to maximize focus group participation in HIV research among BMSM align with existing recommendations for approaches in community-based participatory research and cultural competency in clinical and research settings (Davidson et al., 2013; Halcomb et al., 2007; Levy et al., 2014; Lucas et al., 2014). Reminding participants of the goals of HIV prevention, health promotion, and that their contributions are important to maintaining productive discussion. It is important that facilitators can empower BMSM to share their perspectives and remind participants that they are a part of the process of reducing HIV and promoting community public health.

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**TABLE 1**

Focus group guide domains and example research questions among HIV-negative and HIV-positive Black men who have sex with men (BMSM)

<b>Focus group</b>	<b>Focus group guide domains</b>	<b>Example research questions</b>
HIV-negative and HIV-positive BMSM	Religion and spirituality	How do you incorporate religion and spirituality in your life? What practices do you engage in with your religion/spirituality? How does your religion/spirituality help you during difficult periods?
	Religion, spirituality and same-sex attraction	How have you experienced homophobia or stigma in your religious or spiritual journey? What kept you in that space if you stayed? How does your sexuality influence your religious/spiritual practices?
HIV-negative BMSM	Religious and spiritual support programs for HIV prevention	What additional religious or spiritual programs or support would you be interested in to help you reduce your risk of getting HIV? If programs or services that help men such as yourselves reduce their risk of getting HIV wanted to include religious elements in their programs or services, in what ways could they do this that would be helpful to you? Thinking about your religious or spiritual beliefs, what are your thoughts on the use of PrEP for prevention among people not currently living with HIV?
HIV-positive BMSM	Religious and spiritual support programs for HIV treatment and care	What religious or spiritual programs or supports are available to BMSM to help manage HIV? What religious or spiritual programs help you deal with HIV in relationships, help you take your medicine every day, or help you with doctor visits? What about the programs or supports are helpful? What about the programs or supports are disliked? What additional religious or spiritual programs or supports would you be interested in help BMSM living with HIV?

**TABLE 2**

Considerations and recommendation for conducting focus groups among Black men who have sex with men (BMSM)

<b>Consideration/challenge</b>	<b>Recommendation/strategy</b>
1. Recruiting BMSM	Incentivized referrals from key stakeholders Incentivized referral from study participants Outreach from community-accepted members of the target population Provide options for focus group locations and explore preferences for focus group locations
2. Scheduling participants	Provide up to three meeting times for focus group participation Confirm meeting times with continuous ( 2) follow-up contacts with volunteers prior to study participation from members of the population who have rapport with the community and key stakeholders
3. Screening	Screen volunteers prior to meeting via phone or at another  Discourage participants from bringing friends to meetings for screening immediately prior to the group Conduct confirmatory HIV-testing prior to study enrollment private and safe place
4. Managing focus groups	Remind participants that information is confidential Focus questions on community attitudes rather than individual experiences Limit groups to between five and eight participants Encourage participants to talk amongst themselves not necessarily to the researcher Build in time for personal reflections that might not support the original research question