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The Black Man's Country Club:

Assessing the Feasibility of an HIV Risk-Reduction Program for Young Heterosexual African American Men in Barbershops

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Abstract

Despite increasing HIV/AIDS morbidity and mortality, focus on young heterosexual African American men is limited. Nontraditional community-based prevention programs may be most effective for this demographic. Barbershops are one potential venue; however, barbers' and barbershop owners' views on the concept are less known. This paper describes attitudes and beliefs among barbers and barbershop owners regarding delivering a barber-facilitated, skills-based HIV risk-reduction intervention to their clientele. Participants believed that young heterosexual African American men were at significant risk for HIV and highly regarded the intervention model. This novel work contributes a voice to the literature that is infrequently heard.

Keywords

health; HIV/AIDS; men of color; qualitative research; sexual health promotion

African American men accounted for 70% of new HIV infections among all African Americans in the United States in 2009.¹ This rate is more than 6 and a half times as high as that of White men, and 2 and half times as high as that of Latino men.¹ Of the 18,335 African American men who were newly diagnosed with HIV in 2009, 72% were between the ages of 15–44.¹ The primary mode of HIV transmission among African American men is men who have sex with men (73%).¹ Although HIV infection among heterosexual men is low overall compared with other groups of men, HIV infection in heterosexual men is highest among African American men (65% vs 18% and 15% for their Latino and White counterparts, respectively).² Similarly, the rates of AIDS diagnosis in heterosexual men are highest among African American heterosexual men (62% vs 22% and 16% for their Latino

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and White counterparts, respectively).² These data indicate that young heterosexual African American men are disproportionately affected by HIV/AIDS.

Various meta-analyses^{3–5} of HIV/sexually transmitted infection (STI) behavioral interventions targeting African Americans have established that such interventions have effectively reduced HIV/STI transmission among African Americans generally. None within the published literature, however, have differentiated results by age group and sexual orientation. A meta-analysis of the efficacy of 44 HIV/STI behavioral interventions for African American heterosexual men in the United States (1988–2008)⁶ suggests that only 7 of the behavioral interventions intended to reduce HIV/STI transmission focused on African American men specifically. These findings exhibit the need for the development of more risk-reduction interventions focused specifically on young heterosexual African American men. Culturally situated, theory-based interventions that integrate culture and formative research with activities and goals to address issues around which the interventions are organized are most effective.^{7–11} This framework is instrumental in producing sustainable behavior change because it uses cultural expression and voices from the target population,^{7,9} and increases the cultural acceptability of the intervention when disseminated.¹² Barbershops are one potential setting to culturally situate HIV risk-reduction interventions for young heterosexual African American men.

Barbershops

Historically, barbershops in African American communities have been an important cultural institution.¹³ Deemed “the Black Man’s Country Club,”¹⁴ barbershops nationwide consistently attract African American men across the lifespan. They are a unique place where men gather for a haircut, along with discussions and debates about local happenings, racial and electoral politics, sports, news, and sexual encounters.^{13,15,16} Barbershops present a unique location for health promotion due to the established trust and rapport barbers have with their clients. Furthermore, barbers can be effective change agents in regards to their clients’ behaviors.^{17–20}

A number of projects have implemented health promotion programs in barbershops on topics including cardiovascular disease, diabetes, nutrition, hypertension, physical activity, and prostate cancer.^{19–24} Two programs have utilized barbers to disseminate HIV education to clients.^{25,26} Collectively, these studies suggest that barbershops can be effective venues for prevention, detection, and referral for health problems that affect African American men.

Nontraditional, community-based HIV prevention programs may be most effective for young heterosexual African American men.^{9,27} Barbershops are one potential venue that is culturally situated and contextually appropriate. Focus groups with young heterosexual African American men indicate that the young men would be amenable to receiving HIV/STI prevention information from their barbers.²⁸ However, data on HIV risk-reduction programs in barbershops from the perspectives of barbers and barbershop owners are virtually nonexistent. In this study, we explored the feasibility of implementing an HIV/STI prevention program in barbershops for young heterosexual African American men, the possibility of barbers serving as facilitators, and recruitment barriers and strategies. This paper describes attitudes and beliefs among barbers and barbershop owners regarding delivering a barber-facilitated, skills-based HIV risk-reduction intervention to their clientele. As we consider programs that prevent or intervene in chronic illness, such as HIV, this novel work advances the science by adding the voice of promising community partners.

THEORETICAL FRAMEWORK

This study was framed around the Theory of Planned Behavior,²⁹ which provides a structure for researchers to understand attitudes toward behavior and design effective interventions.^{8,9,30,31} Approaches based on a solid theoretical framework, and formative research with members of the study population, are the most effective in changing HIV risk-associated sexual behavior.^{32,33} The theory hypothesizes that behavioral intentions are a combination of one's attitude toward performing the behavior, his/her subjective norms about the behavior, and his/her control of the behavior;³⁴ in turn, behavioral intentions are the antecedent to actual behavior.

Behavioral beliefs

Behavioral beliefs are best understood as positive or negative attitudes toward performing a specific behavior.³⁵ More specifically, attitudes are based on an individual's beliefs about performing the behavior, weighed by his/her evaluation of the consequences of performing or abstaining from the behavior.³⁶

Normative beliefs

Normative beliefs are the perceived social norms or social pressure regarding engagement in or abstention from a specific behavior. Specifically, a subjective norm is based on an individual's perception that specific individuals or referents think he/she should perform or abstain from the behavior.³⁴ More simply, an individual is motivated to comply with what he/she thinks is "normal."

Control beliefs

A control belief (perceived behavioral control) captures the degree to which a person thinks the choice to either perform or abstain from a behavior is under their control and that he or she has the skills to do so.³⁴

Intention and Behavior—Behavioral intention is one's goal regarding carrying out a behavior; intention is influenced by one's beliefs (behavioral, normative, and control). Intention is the antecedent to behavior. Behavior may be defined as the transmission of intention into action.³⁵

METHODS

In the summer of 2008, we engaged barbers and barbershop owners in discussions to better understand the HIV/STI prevention needs of African American men, and the potential for barbershops to serve as venues for HIV risk-reduction programs. We used reports from the AIDS Activities Coordinating Office in the Philadelphia Department of Public Health to strategically focus our recruitment to zip codes with the highest HIV/AIDS prevalence rates. Specifically, barbers and barbershop owners were targeted from zip codes: 19023, 19131, 19132, 19146, 19147, 19149, 19151, and 19159; the HIV/AIDS prevalence rates across these zip codes ranged from 104 to 668 per 10 000 at the time of the study.³⁷ In this manner, we were able to obtain buy-in from and hear the voices of potential intervention partners in the most significantly burdened areas of the city. Barbershop owners (n = 5) participated in one focus group. The barbers (n = 14) were divided into 2 focus groups. The study was approved by the Institutional Review Board of the University of Pennsylvania.

Questionnaire

The brief study questionnaire captured demographic information including participants' age, race/ethnicity, as well as details on their careers as barbers/barbershop owners. We also collected detailed information on the barbershops and clients including the number of clients served per week, the average length of time clients spend in the barber's chair, and the percentage of African American male clientele aged 18–24. The questionnaire concluded with open-ended items to elicit participants' behavioral, normative, and control beliefs about delivering HIV/STI prevention programs through barbershops such as: *How likely is it that you would participate in educating men on preventing sexually transmitted diseases, including HIV/AIDS, at your shop? What would make it hard for you to participate in this type of program?* and *What are some good things you think would happen if you participated in this type of program?*

Focus group script

We used a semistructured focus group guide to lead the conversations with barbers and barbershop owners.³⁸ The goal of this elicitation work was to inform the development of an intervention. Specifically, we used the focus groups to identify: (1) perceived outcomes, (2) facilitators and barriers, and (3) characteristics and qualities.³⁹ The final script focused on attitudes, interest, feasibility, and culturally relevant themes to be used in a culturally situated, theory-based HIV risk-reduction intervention for young heterosexual African American men. Sample questions included: *Do you think a barbershop is a good place to have an HIV prevention program? Do you think barbers should provide the education to their clients? What strategies could we use for encouraging owners to offer this program in their barbershops?* and *What topics should we include in the program?*

Procedures

Three focus groups took place at the University of Pennsylvania; 2 with barbers and one with barbershop owners. The first group included 6 barbers, the second group 8 barbers, and the final group comprised 5 shop owners. Upon arrival, the research team provided participants with a name tag and the consent form. Prior to the focus group, the facilitator read the consent form aloud to all of the participants. Participants gave consent to participate by signing the consent form. Once participants provided consent, they were asked to complete a short questionnaire (described above). When this activity was completed, the focus group began. Doctoral level research assistants who had extensive training in focus group moderation facilitated all of the discussions. The moderator ensured that all participants had an opportunity to contribute and elicited feedback from those who spoke less often. The focus groups each ran about 90 minutes. Focus groups were audiorecorded and 2 note takers were also present to detail environment, body language, and main themes. Each barber/shop owner received \$25 for their participation.

Data analysis

Data analysis included transcribed audio-recordings and notes. The research team compared the transcripts to the audiorecordings for accuracy and insertion of inaudible notations. We then triangulated the transcripts with notes to get a more complete understanding of the focus group session.⁴⁰ The research team reviewed all files and created code lists based on initial readings. To increase reliability, 2 independent coders used the generated code list. When discrepancies in coding occurred, the 2 coders met with the research team for final determinations. We used Atlas ti 6.0⁴¹ to manage the data and for the coding process. Once transcripts were coded, we developed themes using an inductive method, highlighting specific and general themes.⁴² The research team evaluated and refined the themes. We used

quotes to highlight the themes presented. Demographic survey data were managed using SPSS version 17.0.⁴³

RESULTS

Findings among barbers

The mean age of the barbers was 36 years old (range 22–46); all were African American males. The majority (79%, $n = 11$) had worked at their current barbershop for more than 1 year, and had been employed as barbers for more than 5 years (86%, $n = 12$). Ninety-three percent ($n = 13$) indicated that 40% or more of their clientele were African American men aged 18–24. More than three-fourths (79%, $n = 11$) provided more than 50 haircuts weekly, and 86% ($n = 12$) reported that more than half of their clients were “regulars.” The participant quotes that follow have not been altered and reflect participants’ exact words during the discussions.

The barbers saw themselves as “counselors” and believed they operated similar to a “bartender”—an individual who facilitates an atmosphere where clients feel comfortable discussing their issues and concerns. As one man described, “We’re the community, a place to open up where people tell us a lot of info.” They saw their roles as ones that are respected due to their experience and ties within their communities. One participant shared,

“they [young men] will listen to you, they look up to a lot of dudes on the streets, but we’re the next best thing. Barber words are considered when making decisions; they see us doing what we have to do without selling anything or doing something wrong.”

Overall the group believed that young heterosexual African American men aged 18–24 “need help and there are not a lot of options for them.” They shared that there was a significant amount of unsafe sexual behavior occurring and that their young clients were at serious risk for adverse sexual health outcomes, including HIV and other STIs. In their perception of their roles to “give back” to the community, they saw delivery of a skills-based HIV/STI prevention program as an opportunity to reach and engage young men in a positive manner. When asked if they would serve as a facilitator for the intervention, all said yes. The participants said that barbershops were the perfect setting for this type of work, and that barbers would be the best facilitators. One shared “Everybody comes to the barbershop, it’s universal for old and young.” Another stated, “This is their neighborhood, boys and barbers feel comfortable, people come to [barbershops] to get advice.” A third thought “A lot of the young males respect and listen to what barbers say. It’s like being a psychiatrist.” The participants talked about knowing HIV-positive individuals and wanting to learn more information for themselves and their clients, as well as their desire to help young men in the target demographic.

The barbers had mixed opinions as to whether male or female barbers should facilitate the intervention. Those who believed gender would not matter highlighted “it don’t matter. If you’re making sense to the client and what the issues are.” The counterargument was that “you need a man because a lot of these young men have no male figure in their lives” and “guys’ respect for women is down these days.” Others were indifferent and thought that ultimately it was about “who clients are comfortable with and who their barber is.” Overall, the barbers saw themselves as community advocates and were vested in providing education to young male clients. This included a keen interest in delivering skills-based HIV risk-reduction information to their clientele.

Findings among barbershop owners

On average, the barbershop owners were also 36 years old (range 26–40); all were African American males. Four had shops that were open for more than 4 years; 2 exclusively served men. All shop owners reported that 40% or more of their clientele were African American men aged 18–24. Three shops served more than 40 clients on a weekly basis.

The barbershop owners described their shops as “the Black Man’s Country Club.” They were supportive of the project as a whole and of their barbers being involved as facilitators. They confirmed the strong positive role that their barbers play in the communities in which they work, as well as the level of trust and intimacy shared between barbers and their clients. Participants noted that this esteemed level of barber–client connectedness would facilitate project attendance and success; barbers were described as the “messengers.” They supported using their shops as locations for the intervention and indicated that barbershops were the best way to reach young heterosexual African American men aged 18–24. They were very clear, however, that making their shops available for intervention delivery could not interrupt their general flow of business.

The owners also had mixed feelings as to whether males or females should deliver the intervention content. In support of using only male barbers one shared, “[men] got power, you can be respected.” Although another believed, “some young men respect women more than men because they’re used to living with women, they didn’t have fathers in their lives.” Uniquely, the owners had questions about how they would be able to maintain and sustain the intervention once the research study was over and the “money runs out.” Although concerned about the logistics of implementation and sustainability, the barbershop owners were unanimously in support of delivering an HIV/STI prevention intervention in their respective shops. They believed that using barbershops as venues and barbers as facilitators were the most effective means of reaching young heterosexual African American men.

Feedback on intervention implementation

Both the barbers and barbershop owners believed that their clients aged 18–24 were at significant risk for HIV. The overwhelming majority highly regarded our intervention model. Though most would support a group-level intervention if it were required, the majority reported that delivering the intervention “one-on-one” was better for the target age group. They perceived that privacy would be a valid concern among their clients, and that a group format would prohibit openness and honesty. One barber conjectured that his clients would say, “I will not talk about things like HIV ‘cause they will think I got it’.”

When asked for recommended topics to include in the program, participants discussed early parenting, the job search process, HIV/AIDS and STIs, erectile dysfunction, drugs/alcohol, self-respect (self-esteem), aggression/violence, diabetes, prostate cancer, and cigarette smoking. Some thought it would be best to deliver the content later in the week; “the end of the week since most will be partying, so it’s good to communicate the information to them before doing anything.” Others believed that running the intervention on a Monday when the shop was closed would be the best way to maintain privacy and confidentiality.

Perceived barriers to program implementation included: clients being “afraid that their business will get out,” money (“need payment for motivation to keep going”), scheduling/timing (“program must be on a slow day”), “lack of knowledge,” absence of buy-in from owners and barbers, and program content (discussion of “homosexuality”) that would cause shops to lose business. Each of the groups brainstormed solutions to the identified barriers. These included: assure clients’ confidentiality through a “one-to-one” format; compensation for clients, barbers, and barbershop owners; “offer program while hair is being cut” to maintain client’s attention and interest; adequate training for facilitators; implementing the

program on “slow days;” and strictly targeting the intervention content toward heterosexual relationships.

The participants also shared insight on the best ways to recruit their clients, as well as other barbers and shop owners. They believed the best ways to get the word out to the target demographic were to have “popular people” (celebrities or respected figures) in the neighborhood distribute flyers, host an event such as a block party or basketball tournament, use social media, provide free condoms, and have research participants recruit others by word-of-mouth. Word-of-mouth was also perceived to be the most effective means of engaging other barbershop owners and barbers. The participants described how individuals in their positions would be more open to allowing their shop to participate in the program or serve as an intervention facilitator if information about the program came from another barbershop owner or barber. In addition, they suggested that the research team could support their word of mouth referrals with opportunities for free advertisement of their services through the program.

STUDY LIMITATIONS AND STRENGTHS

There were limitations to this study. The study consisted of a small convenience sample ($N = 19$). Thus, the results are not generalizable to all African American barbers and barbershop owners. Also, self-reported data could result in response bias and limited recall. However, the methods used in the study including the utilization of both questionnaires and focus groups provided participants two opportunities to provide data on the topics discussed. In a focus group setting, not all participants are willing to disclose and share information. Thus, certain participants may have been more inclined to answer questions on the survey. The results do however demonstrate the feasibility of implementing a barber-facilitated, skills-based HIV risk-reduction intervention, and the willingness of barbers and barbershop owners to support this type of program.

DISCUSSION

With persistently high rates of HIV/STI infection among young heterosexual African American men, there is an immediate need for culturally tailored HIV-prevention programs specifically for this population. Previous studies have demonstrated that the barbershop is a culturally relevant and feasible setting for health-promotion programs.^{18,21,28,44–47} Barbers and owners have trusted relationships with African American men and many topics, including health, are discussed in barbershops.⁴⁴ However, a dearth of studies has explored the barbershop as a potential venue for HIV-prevention programs specifically for young heterosexual African American men. Furthermore, few studies in the published literature have explored the feasibility of barbershops as venues for HIV-prevention education from the perspective of both barbers and barbershop owners. Our focus groups provided an opportunity to explore the feasibility of delivering skills-based HIV-prevention education to young heterosexual African American men in barbershop settings. This unique study contributes the voices of barbers and barbershop owners to the literature. In addition, we innovatively highlight positive aspects of African American culture by showcasing the barbershop as a promising community partner in health-related issues.

Barbers

Our findings support existing research on the characteristics of barbers as respected community advocates who are well-positioned and willing to engage their clients and community around issues of HIV risk.^{14,18,22,44,47} The barbers discussed at length their desire to provide back to the community especially to young African American males who are in need of a positive role model. They expressed that their trusting relationships with

clients would lead to a successful HIV/STI-prevention program in their barbershops. In regards to program implementation, barbers raised the importance of the program being delivered on “slow days” to maintain the flow of business, to deliver the intervention one-on-one to maintain privacy, and during the haircut in order to maintain client interest. In summary, barbers were aware of the need for HIV/STI-education programs among their young clients, had a desire to learn more about HIV and STIs, and were willing to facilitate HIV risk-reduction interventions for African American males.

Owners

Barbershop owners were enthusiastic about the possibility of providing an HIV-prevention program in their barbershops. Owners emphasized the importance of barbershops as a highly frequented and valued community venue for reaching African American males aged 18–24. Also barbershops serve as a meeting place for young African American men,²⁸ demonstrating the potential to access the target population. Because many men use a barbershop, it could be an ideal location to enhance uptake of an intervention, reduce attrition, and promote sustainability. Furthermore, barbershop owners reaffirmed the significance of the barber–client relationship and discussed the impact that their barbers could have in providing HIV education messages to their young male clients. Owners also provided specific implementation and recruitment strategies that would lead to developing a successful HIV-prevention program for young heterosexual African American men.

CONCLUSIONS

Efforts are needed to increase the availability of culturally relevant interventions to reduce the risk of HIV/STIs among young heterosexual African American men. These findings support the development of a barber-facilitated, skills-based HIV risk-reduction intervention for the target population. Barbershops that serve this target group appear to be an ideal setting to reach and engage young heterosexual African American men, and barbers can potentially serve as important individuals to engage in the facilitation of this process. Barbers can serve as sexual health advocates and trained facilitators at the community level to play a significant role in reduction of HIV risk. As science shifts toward translating interventions into real world settings, which have significance to the populations at risk, our study is both timely and relevant. Future studies should focus on designing, testing, and disseminating sexual risk-reduction interventions in barbershops for young heterosexual African American men.

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