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Alternative Locales for the Health Promotion of African American Men: A Survey of African American Men in Chicago Barbershops

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Abstract

African American men (AA) carry unequal burdens of several conditions including cancer, diabetes, hypertension, and HIV. Engagement of diverse populations including AA men in research and health promotion practice is vital to examining the health disparities that continue to plague many racially and ethnically diverse communities. To date, there is little research on best practices that indicate locations, community areas and settings to engage AA men in research and health promotion. Traditionally, the AA church has been a key area to engage AA men and women. However, changing tides in attendance of AA parishioners require additional information to identify areas where AAs, particularly, AA men congregate. The AA barbershop has been identified as a place of social cohesion, cultural immersion and solidarity for AA men but specific sub-populations of AA men may be underrepresented. To further investigate additional locales where AA men congregate, this study engaged AA barbers and clients in several urban community barbershops in Chicago, Illinois. 127 AA men over age 18y/o receiving grooming services in 25 Chicago area barbershops across 14 predominantly AA communities were consented and recruited for a quantitative survey study. The self-administered surveys were completed in ~15 min and \$10 compensation was provided to men. Descriptive statistics were reported for demographic variables

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Compliance with Ethical Standards

Conflict of Interest None.

and for frequency of responses for locations to find AA men of specific age ranges for health promotion and screening activities. Outside of the traditionally used churches or barbershops, the top recommended recruitment sites by age were: 18–29y/o– city park or a recreational center; 30–39y/o– gym, bars or the street; 40–49y/o– various stores, especially home improvement stores, and the mall; and 50y/o+– fast food restaurants in the mornings, such as McDonalds, and individual's homes. The study participants also reported that locations where AA men congregate vary by age. Findings from this study illustrate that AA barbers and barbershops remain a key stakeholder in health promotion among AA men. The findings also demonstrate the need for additional research to examine best practices for identifying locations where diverse groups of AA men that vary by age and sexual orientation may congregate in order to support increased health promotion among AA men.

Keywords

African American men; Barbershop model; Health promotion; Recruitment methods

Introduction

African American (AA) men in the United States experience health disparities in comparison to Whites from a number of major diseases including cancer, cardiovascular disease, cerebrovascular disease, HIV/AIDS, and diabetes [1, 2]. Notably, AA men have higher rates of diabetes, cardiovascular disease, and obesity than White men; moreover, the new AIDS case rate is strikingly higher for Black men (104.1/100,000) compared to White men (13.7/100,000), as well as all other groups [1–3]. AAs suffer from health disparities in part due to poorer access and engagement in screenings and health promotion activities. There has been a national focus on the development of multifaceted solutions to eliminate racial and ethnic health disparities in AA boys and men [3, 4].

There is evidence that engaging AA men in community settings where they generally congregate is a vital part to solutions and interventions aimed at mitigating health disparities in AA males. Churches and barbershops are common community settings where AA males are targeted for health outreach and education [5–10]. However, church attendance is low for AA men relative to women [11, 12]. Barbershops represent culturally safe spaces and barbers are often considered key opinion leaders for AA men [13]. The Black barbershop promotes community involvement beyond getting haircuts; clients and barbers forge relationships and discuss current events and community news [14]. Applying this principle, intervention studies have sought to use the barbershop setting and barbershop employees to promote health competency, awareness, and screenings [15, 16]. Health promotion and screening studies have targeted a variety of conditions facing AA men, with prostate cancer and hypertension being the most commonly targeted issues [17]. Other studies have addressed numerous health issues including, but not limited to, diabetes, cardiovascular disease, sexual health, and overall wellbeing [17, 18].

Many disease-focused interventions, such as prostate cancer and HIV prevention, have been performed in churches or barbershops to target both young and elderly AA men [19]. In our

prior study, we found the mean age for barbershop clients was 39.3 years old (SD = 12.6 years), whereas the mean age of barbers was 40.7 years old (SD = 10.0 years,) with few men over age 50. Our data and others suggests that many key demographics of men may not be present in large numbers in many community barbershops or churches, potentially limiting intervention reach and effectiveness [14, 17, 20]. Given the need to identify locations to find specific subsets of AA men, our objective was to ask community dwelling AA men for locales beyond churches and barbershops where AA men can be found for the purposes of undergoing health promotion interventions. If new sites can be identified and interventions can be feasibly conducted, innovative locale-specific models for promoting the health and wellness of specific at-risk sub-populations of AA men in new culturally relevant spaces may be developed.

Methods

Study Design

This is a quantitative survey study of AA men 18 years and over who were clients of barbershops located in predominately AA neighborhoods in Chicago. Participants completed a self-administered survey to identify locations other than the church and barbershop where AA men would be present and amenable to receiving physical and mental health screenings and education. We sought to identify the demographic characteristics of men receiving grooming services in Chicago area AA-serving barbershops. Specifically, the study investigated the age range most commonly served by barbershops in order to identify men that may be inaccessible for health promotion via barbershop health interventions. Study participants provided written consent and were compensated \$15 US for their participation. The Adler University Institutional Review Board approved this protocol.

Barbershop Selection

Chicago is one of the racially and ethnically diverse cities in the country. It is a city made up of 77 community areas that comprises diverse populations that is reflective of the US by race and ethnicity and other social and demographics factors. Chicago area census data was reviewed to identify the 14 communities with AAs composing more than 40 % of the total population of the 77 neighborhoods/community areas [21]. Barbershops were initially identified using Google and the search query “African American barbershop located in [name of neighborhood/community area], Chicago, Illinois.” Sixty-six barbershops were identified. We randomly selected barbershops within each neighborhood and called their listed phone numbers and asked to speak with a barbershop manager/owner. The manager/owner was asked if the barbershop served mostly AA clients and asked for verbal consent for us to visit their barbershop to conduct the study after a brief description of the survey study. Twenty-eight barbershops within 14 predominately AA community areas in Chicago were ultimately selected as sites for this study. Three had very low attendance and were excluded due to lacking clientele. Thus, 25 barbershops were included in the study.

Research Coordinator Characteristics

The research team consisted of the supervising principal investigator (AA female), two graduate students (2 of either 2 AA females, 1 Caucasian male, or 1 AA male), and 1 or both

of the two co-investigators (AA males). All team members were adults over the age of 18 who had completed Human Subjects Research training. To ensure the research coordinating staff approached the barbers with a level of cultural familiarity and understood some generalizable cultural norms of barbershops, the research team was trained by a key community stakeholder with rooted engagement with AA males in barbershops and other settings. The research coordinators were trained by Mr. Marcus Murray of Project Brotherhood with a 90 min didactic lecture, a mock participant recruitment session and supervised participant recruitment in the barbershop due to his 15 year history of community engagement, peer health education and conducting culturally tailored health interventions in Chicago's AA communities.

Participant Recruitment

The team visited barbershops from March to May 2015 during busy times on a Friday between 2 and 5PM and Saturday between 9AM–2PM. The target population was AA men over the age of 18 residing in Chicago. The goal at each site was survey completion by five men (1 barber and 4 clients). Of the 28 pre-selected barbershops, the study team was refused entry at three barbershops leaving 25 participating shops, 25 barbers and 102 clients. Upon entering the barbershops, the research team confirmed with the manager or owner that it was acceptable to interview the men sitting in the barbershop. Men waiting to be served were typically the first individuals approached for participation in the study. An overview of the study as well as the risks and benefits of participation were discussed prior to obtaining written informed consent.

From all participants. A self-administered survey was distributed and participants were instructed to ask clarifying questions to study team members. Clients received \$15 for survey completion; barbers were given \$15 to compensate for the cost of one missed client.

The survey administered to participants was developed utilizing feedback from three former community health workers. These key informants were AA males who were also clients of predominately AA barbershops in Chicago. Additional assistance was provided by a community health leader, Marcus Murray of Project Brotherhood, with vast experience in designing and implementing health promotion interventions in barbershops.

Respondents were asked to list the locations where they would be most comfortable receiving health screenings and education in free response questions. "Besides churches and barbershops, list places where African American men age [i.e. 18–29, 30–39, 40–49, 50–64, or 65 years and older] can be found to participate in health education or screenings. Please provide as many responses as you would like." The responses were then compiled into Excel spreadsheets. Initially each unique response was counted separately. Answers were then re-reviewed and tallied for each time the unique response was mentioned for each age group. Based on the similarities of answers, the responses were then grouped into themes (example: gym, LA Fitness and YMCA gym categorized as gym; mall and shopping center were coalesced into mall) and the responses were totaled. The top five responses based on the percentage of the total responses for that age group were then reported for each age group.

Results

Participant Demographics

The mean age of the men were 39 y/o (Fig. 1) and 92.9 % self-reported African–American racial identity (see Table 1). Nine of the other respondents were African born Americans, Hispanic Blacks or Caribbean Blacks. In terms of sexual orientation, 96.9 % of the men reported that they were heterosexual and 2.4 % reported that they had sex with both men and women. Nearly 97 % of the men completed high school, 22.2 % of the men had at least completed college education, while 14.5 % of the men were unemployed and over 35 % of the men earned less than \$30,000 per year.

Top 5 Locations by Age Results

Based on the responses provided by the participants of this study there are locations other than barbershops or churches in which groups of AA men can be found, depending on the age group (see Table 2). For AA men between the ages of 18 and 29, most participants suggested the city park or a recreational center such as the YMCA. Participants also stated that the gym or schools are locations where AA men ages 18–29 tend to gather.

For the 30–39 age group, it was proposed that the gym, bars or the street were the best places to find AA men. Gyms included fitness centers such as LA Fitness or Planet Fitness, where men go to work out or seek personal trainers. Bars or lounges were the second most commonly listed places followed by various neighborhoods, or street corners.

When asked about the location of AA men ages 40–49, many men recommended going to various stores or the mall. Although the store was a recommendation for all age groups, home improvement stores arose in many responses for this particular age group. The response “stores” was then followed by going to individual homes or local bars and clubs.

When asked for suggestions of locations for AA men ages 50 and up, the top response was to recruit in fast food restaurants such as McDonalds in the morning. The second most frequent response was going to individual homes. The third most frequent response was a medical facility such as a doctor’s office, clinic, or hospital. These responses were followed by going to nursing facilities and recreational centers.

Recruitment Methods/Incentives

The participants were also asked to identify methods of recruiting AA men of various ages for health screenings. The most frequent recruitment method recommended for AA men ages 18–29 was going from door to door. The respondents suggested going to the residences of these men to encourage them to get more health screening or checkups. The second most frequent recommendation for health screening recruitment was utilizing incentives. The incentives that were most suggested were monetary or various forms of food. Other recruitment methods mentioned were various types of electronic media such as Facebook.com or the internet.

Similar to the 18–29 age group, AA men ages 30–39 were stated to be most easily recruited through general conversation at various locations. The second most common response was

the use of incentives such as food or money, to encourage health screenings. The third most frequent recommendation was utilizing more traditional flyers or pamphlets with health information. When asked how to recruit AA men ages 40–49 for health screenings, the highest number of responses indicated in-person conversations in various locations. This recommendation was followed by flyers or pamphlets and the use of incentives.

For the 50 and older age group, the most frequent suggestion was recruitment through the use of incentives such as money, food, or gift cards. The second most common recruitment method was talking with the men in various settings to encourage health screenings. A third common recommendation was including health screening information on flyers or pamphlets.

There appeared to be a trend in recommendations for all age groups that involved more face-to-face interaction such as word of mouth, simply having conversations with individuals as they left grocery stores, or approaching them outside of other locations. There were various responses that indicted the way in which health professionals interacted with the community when conversing could play a major role. Responses within the domain of recruitment via conversation observed across the four age groups focused on approaches such as being polite, calm and open about the importance of screenings. The use of incentives was also consistently a top recommendation for all four age groups and the most common response within this category was food or money.

Discussion

Engaging AA men in research and general public health practice is gaining widespread attention. Research findings and health reported data continue to show that AA men carry some of the largest burden of disease in several areas. As a result, evidence based information that identifies places to engage AA men in research and public health screening and health navigation are vital. Additionally, information that can provide relevant areas where AA men congregate by city and community area is of specific relevance to engaging AA men in research and public health practice. In Chicago area barbershops, AA male clients suggest that there are several additional places beyond churches and barbershops to provide health education and screenings for AA men.

For young AA males under 30, places for physical activity and school campuses seem to be feasible targets. In fact, HIV prevention efforts resulting in demonstrated health behavior change have already occurred for sexually active heterosexual AA college students and programs targeting the same age group have also been effectively conducted in barbershops [22, 23].

Gyms and bars are mentioned for men from 30 to 49 years of age. Gyms often provide club members with access to health-related vendors and resources including outside massage therapists, chiropractors and nutritionists. It seems likely that many health promotion and screening interventions can be performed in the settings of gyms and recreation centers. Bars have been central locales for health promotion in gay communities and largely have focused on sexual health promotion and HIV prevention [24, 25]. Although there is limited research

on the use of bars as a venue for heterosexual AA men, bars and other alcohol-serving venues seem suitable as well.

Home improvement stores and other stores with predominately male clientele could be explored and seem like practical venues (see Table 2). However, given that home improvement stores feature men engaged in manual labor, threats to masculinity or perceived vulnerability may be less tolerated among AAs in these settings. Research has cited that threats to masculinity can serve as a barrier for AA males getting screened for engaging in health promoting activity [26]. Therefore screening and interventions in these spaces will have to work with men who frequent these stores to develop culturally appropriate and effective messaging for health promotion activities.

For men over age 50, the responses suggest a belief that men retract from public activities and spend most of their time inside their residences. In fact, there was a limited presence of men over the age of 50 and there were very few men over age 64 in Chicago area barbershops. In Table 3, there is a progression in the level of engagement people feel is needed to incentivize men to engage in health education and screenings. In the 18–29 years old group information exchange is largely through handing out materials but in the 40–49 and 50+ age groups, men suggested face-to-face meetings and conversations about the risks and benefits of screenings.

Taken together, the survey results suggest that men over age 40 require more persuasion in order to be screened or participate in health education. Additionally, barbers reported in our prior publication that they felt unable to influence the decision making of men over the age of 30 years old [20]. Therefore there are important implications to the design of locale-specific health promotion interventions using trained health workers for many screen-detected diseases in the elderly.

The most commonly cited place for men over age 49 years old was a restaurant such as McDonald's® or Dunkin Donuts®. Additionally, morning breakfast restaurants were specifically referenced by 15 % of study participants. Many participants stated that older AA men congregate in these locations from 6 to 8AM to read the newspaper, play chess and socialize. The utility of these locations needs to be assessed in future studies as it may appear that these locations for eating may seem antithetical to health promotion.

Home and Senior Living Facilities/Nursing Homes. Doctor's Offices/Hospitals was cited commonly cited as another potential location. Many AA men do not access medical centers, which was part of the rationale for the development of the barbershop model. However, group homes such as senior living facilities, group homes, halfway houses and large residential gated communities may be feasible health promotion sites. Restaurants were mentioned by many men, with McDonald's®, Dunkin Donuts®, and morning break-fast restaurants specifically referenced. The utility of these locations needs to be assessed in future studies.

There was a paucity of non-heterosexual men or a lack of men willing to identify as non-heterosexual in our study. There needs to be further investigations into potential sites for AA men who have sex with men (MSM). It may be that AA non-heterosexual men are less likely

to reside in predominantly AA communities or receive grooming services within those neighborhoods. It may also be beneficial to identify community areas/neighborhoods in Chicago that have a high population of AA MSM and identify safe places where AA MSM congregate.

Bars have been effectively used for sexual health promotion in gay communities and may be a potential place to reach AA non-heterosexual men [24, 25]. Health promotion in AA heterosexual and Gay, Bisexual, and Queer males, may be feasible within bars that service these sub-populations. Further research is warranted to reach this vulnerable population.

A significant finding and implication of our prior paper was that barbers felt unable to influence the health decisions of men over age 30, further limiting the effectiveness of barbers and likely any peer health educator without empowerment training and continued motivation.

For example, educating the public on prostate cancer screening with peer health educators requires very specific training or education to empower the health educators and to avoid confusion for the men taking part in the education [27, 28].

Limited access to mental health care is increasingly viewed as a major cause of health morbidity and disparity. To our knowledge, there are no mental health interventions that have been conducted in any of the aforementioned settings. Time constraints and competing interests have been noted in barbershop settings so community based participatory research principles will be needed to assess the feasibility and ensure the sustainability of mental health interventions [14, 16, 29].

Limitations

Our sample consisted of middle-aged AA men who were largely heterosexual. This sample may not be representative of AA youth, non-AA Blacks or of non-heterosexual AA men in Chicago or elsewhere. Sub-group analysis is limited by the sample size to look at specific age groups within our sample. Our sample seemed to include men who had health insurance, which could represent a sampling bias. This bias is unlikely as only four men (3.1 %) declined to participate across all barbershops. There were no questions inquiring about feasibility of engaging men in the various settings which will have to be explored in future studies.

We did not include questions on the method or feasibility of health education delivery in the suggested locales. We did not assess the delivery method of the health promotion intervention and cannot address whether health professionals, computer kiosks, barbers or additional mechanisms should be used.

Conclusions

Several key sub-populations of AA men are not enriched in AA barbershops in Chicago, specifically elderly and non-heterosexual men. This has important implications for health education and screening interventions especially given the focus on hypertension, prostate

cancer and HIV prevention of many barbershop interventions. AA men suggested alternative spaces such as gyms, bars, home improvement stores, schools and senior citizen homes where AA men may be found in higher frequency beyond that of barbershops and churches. Further research into the demographics of the men found in these locales and the development of feasible mental health interventions in these settings is warranted given the strong potential to impact the overall health and wellbeing of high-risk AA men and to reduce health disparities.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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References

- Centers for Disease Control and Prevention. CDC health disparities and inequalities report—United States, 2011. *MMWR Surveillance Summaries*. 2011; 60:1–114.
- American Cancer Society. Cancer facts and figures for African Americans 2012–2013. Atlanta: American Cancer Society; 2013.
- Jones DJ, Crump AD, Lloyd JJ. Health disparities in boys and men of color. *American Journal of Public Health*. 2012; 102(Suppl 2):S170–S172. [Centers for Disease Control and Prevention. (2011). CDC health disparities and inequalities report—United States, 2011. *MMWR Surveillance Summaries*, 60(Suppl), 1–114.]. [PubMed: 22401517]
- Kaiser Family Foundation. Putting men's health disparities on the map: Examining racial and ethnic disparities at the state level. Washington, DC: Kaiser Family Foundation; 2012.
- Li J, Linnan L, Rose J, et al. Promoting men's health within barbershops: Barber/owner survey results and implications for intervention planning. *Preventive Medicine*. 2011; 53(3):207–208. [PubMed: 21683732]
- Luque JS, Rivers BM, Kambon M, Brookins R, Green BL, Meade CD. Barbers against prostate cancer: A feasibility study for training barbers to deliver prostate cancer education in an urban African American community. *Journal of Cancer Education*. 2010; 25(1):96–100. [PubMed: 20146044]
- Drake BF, Shelton RC, Gilligan T, Allen JD. A church-based intervention to promote informed decision making for prostate cancer screening among African American men. *Journal of the National Medical Association*. 2010; 102(3):164–171. [PubMed: 20355345]
- Holt CL, Wynn TA, Lewis I, et al. Development of a barbershop-based cancer communication intervention. *Health Education*. 2009; 109(3):213–225.
- Hess PL, Reingold JS, Jones J, et al. Barbershops as hypertension detection, referral, and follow-up centers for black men. *Hypertension*. 2007; 49(5):1040–1046. [PubMed: 17404187]
- Victor RG, Ravenell JE, Freeman A, et al. Effectiveness of a barber-based intervention for improving hypertension control in black men: The BARBER-1 study: A cluster randomized trial. *Archives of Internal Medicine*. 2011; 171(4):342–350. [PubMed: 20975012]
- Kong B. Community-based hypertension control programs that work. *Journal of Health Care Poor Underserved*. 1997; 8(4):409–415.
- Odulana AA, Kim MM, Isler MR, Green MA, Taylor YJ, Howard DL, Godley PA, Corbie-Smith G. Examining characteristics of congregation members willing to attend health promotion in African American churches. *Health Promotion Practice*. 2014; 15(1):125–133. [PubMed: 23493800]

13. Wright EII, Calhoun TC. From the common thug to the local businessman: An exploration into an urban African American barbershop. *Deviant Behavior*. 2001; 22(3):267–288.
14. Releford BJ, Frencher SK Jr, Yancey AK. Health promotion in barbershops: Balancing outreach and research in African American communities. *Ethnicity and Disease*. 2010; 20(2):185–188. [PubMed: 20503901]
15. Releford BJ, Frencher SK Jr, Yancey AK, Norris K. Cardiovascular disease control through barbershops: Design of a nationwide outreach program. *Journal of the National Medical Association*. 2010; 102(4):336–345. [PubMed: 20437741]
16. Ferdinand KC. The Healthy Heart Community Prevention project: A model for primary cardiovascular risk reduction in the African-American population. *Journal of the National Medical Association*. 1995; 87(8 Suppl):638–641. [PubMed: 7674364]
17. Luque JS, Ross L, Gwede CK. Qualitative systematic review of barber-administered health education, promotion, screening and outreach programs in African-American communities. *Journal of Community Health*. 2014; 39(1):181–190. [PubMed: 23913106]
18. Linnan LA, D'Angelo H, Harrington CB. A literature synthesis on health promotion research in salons and barbershops. *American Journal of Preventive Medicine*. 2014; 47(1):77–85. [PubMed: 24768037]
19. Ravenell J, Thompson H, Cole H, Plumhoff J, Cobb G, Afolabi L, Boutin-Foster C, Wells M, Scott M, Ogedegbe G. A novel community-based study to address disparities in hypertension and colorectal cancer: A study protocol for a randomized control trial. *Trials*. 2013; 14:287. [PubMed: 24011142]
20. Moore N, Wright M, Gipson J, Jordan G, Harsh M, Reed D, Murray M, Keeter MK, Murphy A. A survey of African American men in Chicago barbershops: Implications for the effectiveness of the barbershop model in the health promotion of African American men. *Journal of Community Health*. 2016 Aug; 41(4):772–779. DOI: 10.1007/s10900-016-0152-3 [PubMed: 26831485]
21. City-Data.com. Chicago, Illinois Neighborhood Map—Income, house process, occupations, boundaries. <http://www.city-data.com/nbmaps/neigh-Chicago-Illinois.html>. Accessed September 10, 2015
22. Aronson RE, Rulison KL, Graham LF, Pulliam RM, McGee WL, Labban JD, Dingman D, Rhodes SD. Brothers leading healthy lives: Outcomes from the pilot testing of a culturally and contextually congruent HIV prevention intervention for black male college students. *AIDS Education and Prevention: Official Publication of the International Society for AIDS Education*. 2013; 25(5):376–393. DOI: 10.1521/aeap.2013.25.5.376. [PubMed: 24059876]
23. Brawner BM, Baker JL, Stewart J, Davis ZM, Cederbaum J, Jemmott LS. “The black man’s country club”: Assessing the feasibility of an HIV risk-reduction program for young heterosexual African American men in barbershops. *Family and Community Health*. 2013; 36(2):109–18. [PubMed: 23455681]
24. Blank S, Gallagher K, Washburn K, Rogers M. Reaching out to boys at bars: Utilizing community partnerships to employ a wellness strategy for syphilis control among men who have sex with men in New York City. *Sexually Transmitted Diseases*. 2005; 32(Suppl 10):S65–S72. [PubMed: 16205296]
25. Kelly JA, Murphy DA, Sikkema KJ, et al. Randomized, controlled, community-level HIV-prevention intervention for sexual-risk behaviour among homosexual men in US cities. *Lancet*. 1997; 350:1500–1505. [PubMed: 9388397]
26. Powell W, Adams LB, Cole-Lewis Y, Agyemang A, Upton RD. Masculinity and race-related factors as barriers to health help-seeking among African American men. *Behavioral Medicine*. 2016; 42(3):150–163. [PubMed: 27337619]
27. Allen JD, Kennedy M, Wilson-Glover A, Gilligan TD. African-American men’s perceptions about prostate cancer: Implications for designing educational interventions. *Social Science and Medicine*. 2007; 64:2189–2200. [PubMed: 17399877]
28. Grant CG, Davis JL, Rivers BM, et al. The men’s health forum: An initiative to address health disparities in the community. *Journal of Community Health*. 2012; 37(4):773–780. [PubMed: 22105601]

29. Ferdinand KC. Lessons learned from the healthy heart community prevention project in reaching the African American population. *Journal of Health Care Poor Underserved*. 1997; 8(3):366–371.

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Fig. 1.
Age distribution of the respondents

Table 1

Demographic and socioeconomic characteristics of survey participants

Age (years) (N = 127)	N (%)
18–29	24 (19.7 %)
30–39	51 (41.8 %)
40–49	22 (18.0 %)
50–64	21 (17.2 %)
65	4 (3.3 %)
Race/ethnicity (N = 127)	
African American	118 (92.9 %)
African born or first generation African	2 (1.6 %)
Hispanic black	1 (0.8 %)
Other	6 (4.7 %)
Married (N = 127)	
Yes	32 (25.2 %)
Sexuality (N = 127)	
Heterosexual	123 (96.9 %)
Men who have sex with men and women	3 (2.4 %)
Other	1 (0.8 %)
Education level (N = 126)	
Grammar school	4 (3.2 %)
HS diploma/GED	94 (74.6 %)
College	17 (13.5 %)
Post college	9 (7.1 %)
Other	2 (1.6 %)
Employment status (N = 124)	
Full-time	79 (63.7 %)
Part-time	18 (14.5 %)
Not employed	18 (14.5 %)
Retired	5 (4.0 %)
Student	4 (3.2 %)
Annual income (\$) (N = 117)	
<30,000	41 (35.1 %)
30,000–74,999	38 (32.4 %)
75,000	20 (17.1 %)
Not specified	18 (15.4 %)
Has health insurance (N = 92)	
Yes	84 (91.3 %)

Table 2

Top places suggested by age to find AA men for health promotion

Age range	Locale ranking	Site/locale	Frequency of responses	Percent of total responses (%) ^a
18–29 years, N = 135 responses	#1	Park/recreational centers	25	18.5
	#2	Gyms	24	17.8
	#3	Schools	22	16.3
	#4	The street *	21	15.6
	#5	Store/malls	13	9.6
30–39 years, N = 132 responses	#1	Gyms	22	16.7
	#2	Bars/lounges	19	14.4
	#3	The street *	18	13.6
	#4	Work	16	12.1
	#5	Park/recreation center	15	11.4
40–49 years, N = 114 responses	#1	Stores/home improvement Stores	16	14.0
	#2	Home *	15	13.2
	#3	Bars/clubs	15	13.2
	#4	Gyms	13	11.4
	#5	Work	11	9.6
50+ years, N = 120 responses	#1	Restaurant/fast food	19	15.8
	#2	Home *	17	14.2
	#3	Doctor's offices/hospitals	15	12.5
	#4	Nursing facilities/senior homes	14	11.7
	#5	Park/recreation center	8	6.7

^aDespite the question wording, some men answered church or barbershop. Those answers were excluded from the tallied responses and are not in the percentages listed

* Authors expressed concern for the feasibility of this site as an intervention model

Table 3

Top recruitment methods suggested by age to encourage AA men for health promotion

Age range	Locale ranking	Recruitment method	Frequency of responses	Percent of total responses (%)
18–29 years, N = 116 responses	#1	Going door to door to encourage health screenings	22	19.0
	#2	Providing incentives for health screening	17	14.7
	#3	Utilizing social media sites	15	12.3
	#4	Conducting or encouraging screenings at sports events	13	11.2
	#5	Passing recruitment information from person to person	12	10.3
30–39 years, N = 102 responses	#1	Talking to various individuals in person	22	21.6
	#2	Providing incentives for health screening	21	18.6
	#3	Handing out or posting flyers and pamphlets	19	17.6
	#4	Recruitment utilizing various forms of media	13	15.7
	#5	Passing recruitment information from person to person	4	14.7
40–49 years, N = 102 responses	#1	Talking to various individuals in person	22	21.6
	#2	Handing out or posting flyers and pamphlets	17	16.7
	#3	Providing incentives for health screening	14	13.7
	#4	Going door to door to encourage health screenings	8	7.8 %
	#5	Explaining the risks of not being screened and benefits of being screened	7	6.9
50+ years, N = 102 responses	#1	Providing incentives for health screening	20	19.6
	#2	Talking to various individuals in person	19	18.6
	#3	Handing out or posting flyers and pamphlets	19	18.6
	#4	Going door to door to encourage health screenings	11	10.8
	#5	Explaining the risks of not being screened and benefits of being screened	7	6.9

Respondents answered the following question: “What method would you use to recruit AA men for health education or screenings?”