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POPULATIONS AT RISK ACROSS THE LIFESPAN: POPULATION STUDIES

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Barber-led sexual health education intervention for Black male adolescents and their fathers

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Abstract

Objective: To explore barbers' attitudes and beliefs regarding the feasibility and acceptability of a barber- led STI/HIV risk reduction intervention for fathers and their preadolescent and adolescent sons.

Design and Sample: A qualitative descriptive design was used. Twenty-two barbers were recruited from barbershops and a barber school in central North Carolina.

Measures: A combination of five focus groups and two key informant interviews were conducted.

Results: The following themes were generated: (1) The barbershop was embraced as a venue for an adolescent sexual health father–son intervention, (2) Barbers desired more information about STIs and HIV among Black male youth, (3) The use of incentives to engage barbers and fathers was important, and (4) Time commitment of barbers for a barber-led intervention varied.

Conclusion: The trust established between barbers and the Black community presents an opportunity for pre-adolescent and adolescent STI/HIV risk reduction programs that include the role of fathers. Intervention programs can be tailored to address this important intervention opportunity.

KEYWORDS
adolescent, African-American, barbers, focus groups, sexual behaviors, sexually transmitted infections

1 | INTRODUCTION

Black males between the ages of 13 and 17 are disproportionately affected by sexually transmitted infections (STI) such as chlamydia, gonorrhea, syphilis, and human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) when compared to adolescents of other races (Centers for Disease Control and Prevention [CDC], 2014). Although they comprise only 9% of the U.S. population, African-Americans currently account for over 50% of HIV infections among all young people and an HIV infection rate among young Black gay or bisexual men is twice that of young White men (Satterwhite et al., 2013). In 2015, Black males were more likely to report having sexual intercourse for the first time before they were 13 years old than their White counterparts (58.8% vs. 39.5%), and more likely to report having intercourse with four or more persons during their lifetime (28.2% vs. 9.96%) (Kann et al., 2016). These statistics support the need for effective sexual health education among this population.

Providing sexual health education to adolescents in nontraditional settings and increasing parental involvement can address STI disparities for this population (D'Cruz et al., 2015; Maria, Guilamo-Ramos, Jemmott, Derouin, & Villarruel, 2017; Randolph, Coakley, Shears, & Thorpe, 2017). Parent–youth sexual health communication interventions are an effective strategy in addressing this health disparity (Akers, Schwarz, Borrero, & Corbie-Smith, 2010; Guilamo-Ramos

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et al., 2012; Randolph et al., 2017). The majority of sexual health interventions focus on parent–daughter communication with the mother as the primary sexual health educator. Few studies have engaged fathers as sexual health educators and even fewer have focused on Black fathers. One potential reason for the lack of inclusion of Black fathers' in adolescent sexual health communication interventions are Black men's overall lack of trust for the health care system and research (Lang et al., 2013).

One proven way to build trust while in the Black community is through offering health promotion and prevention interventions in partnership with barbershops. Barbershops have been effective venues for programs focused on health promotion and disease prevention in the areas of hypertension, prostate cancer, and HIV for Black adult men 18 years and older (Brawner et al., 2013; Jones, Steeves, & Williams, 2009; Victor et al., 2011). Jemmott and colleagues (Brawner et al., 2013; Jemmott, Jemmott, Lanier, Thompson, & Baker, 2016) used barbers in the barbershop setting for a HIV risk reduction program focused on heterosexual young adult men 18–24 years of age. In this 2-day risk reduction intervention, barbers focused on knowledge, condom use, and decreasing the number of sexual partners. Participants supported the barbershop setting for sexual health interventions, stating that they trusted their barbers, were comfortable in this setting, and had long-lasting relationships with barbers. This lasting relationship is essential for the sustainability of interventions and helps to examine the efficacy of an intervention over time.

Although the barbershop setting has been used for Black adult men age 18 and over, only one study has identified feasibility for support of a barber-led intervention for young adolescents (Johnson, Speck, Bowdre, & Porter, 2015). While this study collected quantitative data, minimal work is available to hear the voices of barbers and their perspectives. No studies to date have actually used barbers and barbershops for sexual health-related content focusing on the sexual health outcomes of Black preadolescent and adolescent boys age 10–17.

Barbershop interventions are potentially culturally situated and contextually appropriate for adolescent sexual health interventions; however, data on sexual health education programs from the perspectives of barbers are limited. These data are important to ensure that barbers are willing to engage in a sensitive conversation around sex and adolescents. Thus, the purpose of this study was to explore barbers' attitudes and beliefs regarding the feasibility and acceptability of a barber-led sexual health education intervention for fathers and their preadolescent and adolescent sons age 10–17.

2 | METHODS

2.1 | Design

A qualitative descriptive design was used in this study (Sandelowski, 2000). A combination of five focus groups and two key informant interviews were conducted with a total of 22 male adult barbers. Eligibility criteria included full-time barbers or barber students who were 18 years or older and whose clients were primarily African-American men.

2.2 | Procedures

We recruited through word of mouth and flyers in barbershops and barber schools in two counties in North Carolina that had a high number of STI/HIV cases among Black youth. Eligible participants were scheduled to meet with two members of the research team at the barbershop or barber school. Barbers were provided with an overview of the purpose of the study, completed informed consent and were given information about STI and HIV prevalence in Black male youth. Focus groups were facilitated by an RA who had extensive training in focus

TABLE 1 Focus group interview guide

1.	How do you view your role as a barber?
1a.	How do you think your customers, specifically Black fathers view you as a barber?
2	What are your thoughts about barbers being recruiters and advocates for a sexual health related study?
3	What do you think fathers see as the primary concern for their adolescent sons?
4	Do you think the barbershop is a good place to recruit Black fathers and their sons for a sexual health related study? Why or why not?
5	What are some advantages and/or challenges to recruiting Black fathers and their adolescent sons in barbershops for a sexual health related study?
6	What are some ways to recruit Black men for a sexual health related study focused on STI/HIV prevention in adolescent males?
7	How would you approach a father about him and his son participating in a sexual health related study? What would you anticipate his response to be?
8	What would you need to help increase your comfort as a recruiter and advocate for a sexual health related study?
9	What type of incentives would you suggest for barbers to participate as recruiters?
10	What type of incentive would you suggest for fathers and their sons to participate in a study?

group moderation. The groups were audio recorded and lasted approximately 90 min. Key informant interviews were conducted with two of the barbers after focus groups were completed and analyzed to gain additional insight. Each barber received a $40 gift card for their participation. Institutional Review Board approval was received from the Duke University prior to the initiation of any study-related activities.

2.3 | Data collection instruments

2.3.1 | Demographic and technology assessment

This study questionnaire captured demographic information including participants age, marital status, employment, education, as well as the number of male and female children barbers have, if they reside in or outside of their children's home, and if they were biological fathers, stepfathers, father of adopted son, or a father figure. We also collected information about the use of technology to elicit the feasibility of including technology in training barbers to be educators.

2.3.2 | Focus group script

We used a semi-structured focus group guide to lead the conversations with the barbers. Sample questions included: What are your thoughts about barbers being recruiters and educators for an adolescent sexual health intervention? What are some ways to recruit Black fathers for a sexual health related study focused on STI/HIV prevention in adolescent male youth? What types of incentives would you suggest for barbers and fathers to participate in an intervention? (Table 1).

2.3.3 | Key informant interview script

The following questions were asked in individual interviews with two barber owners: Tell me about the clientele you serve on a weekly basis (e.g., age, fathers who bring their sons, how often do clients come to the shop, average amount of time clients spend in the shop for one visit, percent of regular/return clients, clients who are preadolescent/adolescent age)? What do you see as some of the advantages and challenges of having barbers as educators for adolescent sexual health in the barbershop setting? What strategies could we use for encouraging barbershops to offer this program? What topics should we include in the program?

2.4 | Data analysis

Data analysis included verbatim transcriptions of audio-recordings and notes which were compared for accuracy. NVivo, a qualitative data analysis software program was used to manage the data and for the coding process. Transcripts were coded by the principal investigator (PI) and research assistant (RA), using conventional qualitative content analysis and an inductive method to identify themes (Hsieh & Shannon, 2005). First transcripts were read multiple times by PI and RA without coding, to get a sense of general perspectives, and text highlighted to represent units of meaning. Units were labeled with codes which categorized these meaning units. Themes were developed based on the generated codes. The PI evaluated and refined the themes by comparing these to the original quotes.

3 | RESULTS

The mean age of the barbers was 33 years old (range 19–43); all self-identified as African-American or Black. Nine of the 22 participants were full-time barber students who served Black male clients across the life span. The remaining 13 participants were full-time licensed barbers who served primarily Black male clients. The majority of participants (n = 11) had never been married, 7 were married, and 4 were either divorced or separated. The majority of participants (n = 12) had completed 1–3 years of college or technical school, nine participants completed grade 12 or general education development (GED), one completed some high school, and one completed 4 years of college. Eighty-six percent (n = 19) of the barbers were also fathers, nine of whom were fathers of preadolescent or adolescent sons.

Four major themes were generated from the interviews: (1) The barbershop was embraced as a venue for an adolescent sexual health father–son intervention, (2) Barbers desired more information about STIs and HIV among Black male youth, (3) The use of incentives to engage barbers and fathers was important, and (4) Time commitment of barbers for a barber-led intervention varied.

3.1 | The barbershop was embraced as a venue for an adolescent sexual health father–son intervention

Full-time barber students and licensed barbers both shared perspectives of embracing the role of educator. In fact, the barbers saw themselves as "psychologists" and "counselors." All participants believed that barbers and the barbershop are "safe havens" to have discussions about sexual health for adolescents. One barber stated, "You can become a man in the barbershop; barbers are like father figures." All barbers perceived themselves as being influential; someone who their clients will listen to and they believed that it was important for them to guide and direct people who come into their paths. Barbers reported developing a relationship with their clients because they see them on a weekly or bi-weekly basis. When asked why the barbershop was a good place for a father–son intervention, one barber stated it's the "… best place to recruit a father and a son. It's the most vulnerable time; it's like being at church." Another stated, "90% of Black males of all ages are going to the barbershop."

Barbers also perceived the barbershop to be a trusted place for young boys and adult men and an ideal setting for programs targeting these populations. They shared that discussions of sex, women, and politics often were topics of clients and other barbers. A participant said, "The culture of the barbershop is the same from shop to shop." Another stated, "The cut is only a part of it. The other part is the social part. Men want some place to be able to talk." The barber shop for Black men provides this place. Barbers also reported that fathers as

well as mothers bring their young sons to the barbershop at least bi-weekly for haircuts. When the father brings their son, they are likely to get their hair cut at that visit as well.

In the key informant interviews, barbers shared the demographics of their clientele. This was important to know in order to assure that the population of interest was served at the barbershop. For example, if a shop had clients who were primarily 50 years of age or older, this shop would not be as effective in reaching adolescents and may not embrace the barbershop as the best venue for an adolescent intervention. One owner stated that his clientele consisted mostly of Black males ranging in age from 17 to 40. He reported that about 40% of clients were fathers and these fathers bring their sons with them to the barbershop. He stated, "I give combos sometimes, I give a discount for father and son haircuts." When asked specifically about how many male youth are served, he stated, "I serve about 20% pre-adolescent/adolescent age right now. That population is growing; I am a new shop–been open about 6 months. Majority of my male youth right now are high school and college age." The owner of the barber school when asked about his client demographics shared similar results, "We serve mostly Black men from the age of 2–50; I would say probably 60% are fathers and 40% are fathers with sons." Additionally, this owner reported, "We serve about 25% of clients who are 12–17 and under age 10, I would say about 15%–20%."

The barbershop setting proves to be a good setting for consistency and retention. All owners report that clients spend on average an hour in the shop at each visit. All key informants report that clients visit the shop at least every 1–2 weeks. As one barber stated, "They generally do not go past 2 weeks to come." Retention of clients in all shops was good as at least 90% of the clients were return clients that visited the shop on a regular basis.

3.2 | Barbers desired more information about STIs and HIV among Black male youth

The majority of barbers were unaware of the prevalence of STIs and HIV among Black male youth. All barbers in our study responded in shock about the percentage of Black youth impacted by STIs and HIV. Most barbers requested more information on the numbers specific to their community. As one barber stated, "We have these conversations about sex all the time in the shop, but it would hit home to know more about how these diseases are affecting our community, so we can share the numbers- the numbers you shared got my attention."

Barbers also requested having more information on STIs and HIV available on posters and other media in their shop. They thought that having this information in the shop would be a conversation starter. All barbers shared that they often talk about social issues, including sex. One barber said, "This already happens. We talk about sex in the shop even when moms drop their teens off." Barbers did express, however, that having the facts to support their conversations could add value to the conversation. A barber said, "We need to educate fathers and young boys, but we need to be educated ourselves on what to say."

We also asked the two key informants about the challenges and barriers of using barbers as educators. They confirm the need for more information and education of barbers and shared their perspectives on the topics most important to include in this education. One owner reported, "Depends on the person doing it; it's based on the motivation of the barbers. I think most barbers will not have a problem doing this if they are educated properly. I think they need to be educated properly in order to inform the public and remain credible." Another stated, "One of the biggest challenges would be informing the barbers. A lot of barbers are not informed of what the numbers are [for STIs and HIV among Black male youth]. Once we get information, we share it, so the key would be to get the information to the barbers. For the most part, people trust their barbers. Barbers also have a lot of influence on the teens that we see."

Barbers suggested that the following topics be included in their education as well as a part of a father–son intervention: safe sex practices, abstinence and waiting to get married, consequences of unsafe sex, the influence of friends on sexual health decisions, and homosexual sex and protection. Referencing the topic of the influence of friends, one owner stated, "In our community you learn things from your friends. Our mentality is the more women you have- you the man around here. We need to change this mindset." In this statement, the participant is referring to a belief that manhood is associated with the number of women a man has and that this belief needs to change among men. On the topic of homosexuality, one owner shared an explanation for why this topic is important to discuss: "This population is growing. I'm not going to say that I'm with that, but it's the truth. If we act as if it doesn't exist the AIDS rate will continue to grow. It may be a hard pill to swallow for some people, but it's the truth."

Although not the focus of our interview, barber owners stated a need to be trained on the delivery of an intervention. They suggested videos, face to face meetings, social media and conference calls as ways in which to deliver training for barbers. Although the perspectives about the delivery methods varied among barbers, face to face contact was consistently reported as a necessary component of the training. One barber owner summarizes this in his statement, "To be honest I think it should be more hands on like a class where they [barbers] can ask questions and role play. Role play should be done for everyone who goes through it. This should be done at least once a year. It shows more dedication. I pay more attention and more engaged with face to face delivery."

3.3 | The use of incentives to engage barbers and fathers was important

When asked about incentives to engage and retain barbers and fathers in a sexual health education program, barbers had some thought provoking suggestions. The majority believed that their role as an educator should not be incentivized with monetary gifts. One barber stated, "Incentives (monetary) is like a bribe. What happens when resources die? Can we still get information out?" Barbers believed that they could be perceived as "selling something," by their clients instead of allowing their passion and leadership for their community to be the driver for their decision to be engaged in educating about adolescent sexual health. Another barber stated, "The incentive is the knowledge

itself; the knowledge becomes the award." This barber was referencing his role as an educator. He felt being able to guide fathers and their young male clients in a more informative way that could impact their sexual health was an award within itself.

Although barbers did not support individual incentives for barbers to participate in an intervention, they did suggest incentives for the barbershop as a facility. Barbers suggested incentives such as gift cards from supply stores that sold items that the barbershop needed for their day to day operation. Another suggested payment for their annual state fees for license renewal, which ranges $40–60. These perspectives were reported across both groups: full-time barber students and licensed barbers.

When asked about incentives for fathers, barbers believed that fathers should receive an individual incentive for their participation. Because the majority of barbers were also fathers, their perspective represented fathers as well. Overwhelmingly, barbers agreed that an incentive for fathers should focus on building the father–son relationship and increasing opportunities for father–son communication. Monetary incentives would not accomplish this; however, offering tickets for admission to a baseball or basketball game would promote relationship building. Other suggestions were admission to community events or activities that would facilitate father–son interaction.

3.4 | Time commitment of barbers for a barber-led intervention varied

Time for barbers and barber students to be engaged in an intervention is an important factor to consider for the sustainability of a barber-led intervention. The full-time barber students compared to licensed barbers had more flexibility in their scheduling and more time available for focus groups. This may be an indication of their time commitment for delivery of a sexual health education intervention. Time to participate in the focus groups varied between groups. Barber students had time integrated in their daily schedule to commit for a 2-hr focus group. However, it was a challenge to identify times when full-time barbers had availability for 2 hr of dedicated time. Time is an important factor in engaging barbers and can impact the sustainability of barber-led interventions.

4 | DISCUSSION

Our findings support existing research on the characteristics of barbers as respected community leaders who are well positioned and willing to engage their community around issues of STI/HIV (Baker et al., 2012; Brawner et al., 2013; Jemmott et al., 2016; Nathan, 2013). However, our study extends current research and provides evidence of barbers' willingness to educate their clientele about adolescent sexual health. There are limited studies involving barbers that have focused on the sexual health outcomes of male youth 10–17 of age. Additionally, no other studies to date involving barbers have considered full-time barber students as educators. Engaging full-time barber students can be beneficial in a number of ways. First, barber students see male clients who are fathers and young boys. Secondly, they may have more time to engage in HIV prevention activities as a part of their training and practice hours. In their current curriculum, barbers have an educational module on HIV prevention and infection control. Adding additional content about the incidence and prevalence of HIV in their community would be reasonable and appropriate. Finally, engaging barber students allows them to understand the prevalence of STIs and HIV among Black male adolescents before they become full-time licensed barbers, thus giving them an opportunity to have a greater impact with their clients because of the knowledge obtained.

Barbers in our study expressed their desire to give back to the community especially in ways that would positively impact Black male youth. This perspective of barbers giving back to their communities is consistent with other barbershop studies (Baker et al., 2012; Jemmott et al., 2016). However, prior studies have explored these perspectives of barbers working with adult male populations. In our study, barbers reported that their trusting relationships with fathers and young boys would also lead to a successful sexual health education program in their barbershops; thus, extending the role of the barber to working with another subpopulation of the Black community—preadolescent and adolescent males.

To increase their comfort in recruiting and advocating for adolescent sexual health education, barbers stated that their comfort would increase if they knew more about what they should say in an encounter with a father and/or son. Barbers reported a need for more information on the facts and rates of STIs and HIV among youth in their community and how to have sexual health conversations with fathers and young boys.

There were strengths and limitations to this study. The methods used in the study, including the use of a Black male researcher to facilitate the focus group discussion were beneficial to the study outcomes. In a focus group setting, not all participants are willing to disclose and share information. Having a RA who knew the culture of the barbershop as a Black male and father may have increased the trust and comfort of study participants. Future studies can explore these factors further from the perspective of Black male study participants. The study consisted of a small convenience sample (N = 22). Thus, the results are not generalizable to all Black barbers. The results demonstrate the feasibility and acceptability of using barbers as sexual health educators for Black fathers and their preadolescent and adolescent sons to prevent STIs and HIV.

4.1 | Implications for future research and relevance to public health nursing

There are important implications from this study. Barbers and barbershops were identified as important places for adolescent sexual health education. By combining promising health promotion and prevention barbershop approaches with efforts aimed at enhancing the quality of father–adolescent communication around risk behaviors, public health nurses can develop and implement programs that can be tailored to address this important intervention opportunity. Barbershops were also identified as an important venue for the distribution of

health information for Black adolescent males. More efforts should be taken by public health nurses to disseminate evidence-based health information for this population through these venues and evaluate the impact that barbershop distribution has on the reach and uptake of this information. As such, public health programs that build their capacity to provide health education to their clients are likely to not only have an impact on the health outcomes of their clients but also of their families and communities. Research methods that allow for family and community level impact analysis are needed to capture the potential benefits from this approach.

Our study begins to explore the training needs of barbers for the sustainability of an intervention. Future studies should consider the training components of a barber-led intervention and develop procedures and protocols that can be generalized to other barbershop interventions. Time commitment for full-time barbers can be a challenge; however, barber students may be able to commit to the time required. The role of barber students should be explored further for program sustainability. Finally, future studies involving barbershops for adolescent health should also consider the role of mothers who accompany their sons to the barbershop.

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