Participation, Culture and Identity: Engaging Young African American Men in HIV/AIDS Prevention*

Rena G. Boss-Victoria
Olúgbémiga T. Ekúndayò
Sia Nowrojee
Morgan State University

Abstract

Young African American men face particular risks and challenges related to HIV/AIDS. Properly engaged, they also provide an important resource for improving public health indicators within the African American community. This paper puts forth an intervention that engaged young minority men and their advocates. The intervention used participatory research methods and an approach that acknowledged and addressed issues related to identity, culture, and spirituality in the design and the implementation. The planning and intervention methodologies, theoretical approaches, and practical activities are explained along with a survey on HIV and general health knowledge. Survey findings, conclusions, and implications for practitioners are discussed as they concern the efficacy of this approach

*Research funded by DHHS/OMH Cooperative Adreement #US2MP022-001-03-1

for HIV/AIDS prevention with minority populations and for broader public health applications.

Background And Need

In December 2002, the Office of Minority Health (OMH) commissioned a demonstration project to reduce and prevent the spread of HIV/AIDS in minority communities across the United States. The project was implemented through a New Minority Male Health Disparity Consortium of Historically Black Colleges and Universities (HBCUs), led by the Chivers-Grant Institute at Morehouse College. Participating institutions included Morgan State University in Baltimore, Maryland; Wilberforce University in Wilberforce, Ohio; Lincoln University in Nottingham, Pennsylvania; and Bowie State University, in Bowie, Maryland. The goal of the project was to engage hard-to-reach segments of minority populations, particularly young African American males, and provide health education programs to reduce the spread and prevalence of HIV/AIDS in these populations. Working cooperatively, the consortium institutions agreed upon specific tasks. Morgan State University's Center for HIV Prevention, Evaluation, Policy and Research (hereafter, CHPEPR) was assigned the task of developing a model for community engagement, research and education while creating an understanding or profile of the needs of young African American males for use by other participating institutions. To fulfill this assignment a pilot project, the New Minority Male Health Project, was implemented in Baltimore by CHPEPR.

Young African American males were selected because they are a hard-to-reach population, facing particular vulnerabilities and challenges with regard to their health and health behavior. Additionally, there is growing awareness of the important role of men in the achievement of family and community health. The promotion of healthier lifestyles through increased knowledge and improved health-seeking behaviors by men is an important way to reach men as well as their families and communities. This has been found true, even in contexts such as breastfeeding that traditionally are thought of as female (Sorenstein 2000; Cohen 2002).

The model developed by CHPEPR to reach young males included three activities: (1) Community engagement and profiling; (2) special event planning and execution; and (3) survey research.

All three activities were developed and conducted with two approaches in mind. First, CHPEPR would utilize Community-based Participatory Action Research (CBPAR) for engagement of a range of community stakeholders with young African American men in the process of educating about HIV/AIDS and other health issues. Second, CHPEPR would develop a model for addressing complex, interrelated issues related to identity, culture, and spirituality in order to engage young men effectively. Through this process, CHPEPR developed a participatory and culturally appropriate model through which to engage young minority males about their health, while strengthening their support systems by opening interactions with a range of stakeholders in minority communities.

Increasing Stakeholders on HIV/AIDS and African American Men

Traditionally, young men have been ignored by those health services that typically address issues related to sexuality and sexual health. This is especially so in such areas as contraception and sexually transmitted diseases, including HIV/AIDS. The result has been that sexual health services are generally inhospitable to men and geared toward women (Schultz and Hedges 1996). However, efforts to reach out to men are not new. In the 1970s, The Office of Family Planning of the Department of Health and Human Services funded a series of demonstration projects to encourage the involvement of men in such services. Title X of the Public Health Services Act was then established to assist both individuals and couples with family planning. The advent of heterosexual HIV/AIDS in the 1980s raised the stakes to involve men with renewed focus on the male protective device, the condom. In the 1990s, there was increased focus on the overall role of men in family life, through programs addressing responsible fatherhood. However, while these are important steps in acknowledging both the vulnerabilities and responsibilities of men in sexual and reproductive health, there is still little consensus on what is needed to comprehensively address the reproductive and sexual health needs of men (Sorenstein 2000).

In addition to vulnerabilities related specifically to health, young men face other challenges that affect their ability to engage in safer sexual practices. The dominant social construction of African-American masculinity in this country does not allow the availability of op-

portunities for minority males to engage in alternative lifestyles that enhance economic and social well being, or even to ask for help in accessing appropriate resources. Popular media and mainstream culture encourage and reward "macho" and "tough" persona in minority males, while discouraging sensitivity and gentleness (Miedzian 1991). In addition, mainstream institutional structures tend to punish these attitudes in minority males while glamorizing the same in white males, creating a deep ambivalence and confusion in minority males toward functional and nurturing relationships that promote healthy living. Predatory sexuality with little communication is generally the accepted norm for young men, hampering safer sexual practices. While some of the most innovative sexual health services for men come from the gay community, homophobia and fear of being labeled homosexual, prevent heterosexual, bisexual and homosexual minority males from accessing them. This fear also undermines the willingness of young African-American men to acknowledge fear or doubt with regard to sexual activity, weakening prevention strategies, which do require such acknowledgment (Schultz and Hedges 1996).

Young African American men face an additional set of social challenges. Disproportionately represented in school dropout rates and prison statistics nationwide, these young men face considerable pressures. Poverty, crime and racism color the lens through which they make choices about their sexual behavior and their general health. Historical distrust of traditional health services, reinforced by current experiences, may discourage them from accessing existing health services and information. Few health services that acknowledge and address the full range of circumstances facing this population are truly accessible. When services for young men are a part of a maternal and child health center, they are unlikely to be used by them due to the perception that the services are for women and babies, not for men. Additionally, there is little information for these young men that demonstrate the links between the range of risky behaviors they may engage in and the range of consequences they may face. Many young men do not feel at risk; most get information concerning sexual issues from their friends, pornographic industry, prejudice-laced literature and a generally hostile media. Some do not speak to anyone and no one tells them anything. Those that do speak are

often told to "act like a man" without being told, or given any opportunity to learn, what it is to be a man. Finally, with regard to either services or information, little has been offered by way of hope to this population that is so in need.

To reach effectively young African American men with the range of challenges they face and the paucity of services they can access, the net must be cast wider and deeper. There is a need for participatory and community-wide efforts to increase the range, depth and number of stakeholders engaged. Given that minority young men rarely patronize general sexual health services, there is a need for outreach beyond those traditional health settings. Given the interrelated factors that encourage risk taking by young men, be it in the areas of education, crime or sexuality, there is a need to involve players from all aspects of community life. There is also the need to critically examine and test common perceptions of the young minority male, match those with their self-perceptions and measure the results against reality in order to determine congruence and validity (Freire 1993:166). Through this kind of outreach, community participation and perceptual validity, it will be possible to demonstrate to these young men, and have them take personal ownership of, the reality that the risks they take in an area of their lives can have tremendous consequences for themselves and their community.

Epidemic Proportions and Rising: Young African American Men and HIV/AIDS

Two demographic groups have been hardest hit by the HIV/AIDS epidemic in the United States — men and African Americans — making African American men a particularly vulnerable group. According to the Centers for Disease Control and Prevention (hereafter, CDC), at the end of 2001, there had been 800,000 people diagnosed with AIDS; 57 percent of those had died and there were 363,000 persons living with AIDS in the United States. Almost 85 percent of those 800,000 people diagnosed with AIDS were male. Of these, a full third (34.3 percent) were Black or African American (not Hispanic), compared to the 12 percent of the total population made up of African Americans. In the age group 13-25, the total incident cases of AIDS in 2001 were almost 30,000, out of which over 70 percent were male. The overall AIDS rate for adult and adolescent males is highest in the Black population at 109.2/100,000. Of the 15,600 AIDS

deaths in 2001, over half (51.5 percent) were Black (Centers for Disease Control 2001).

These rates are reflected in Baltimore, Maryland, the site of the intervention. In fact, Baltimore's HIV rates are among the highest in the country, with 2 percent of all residents estimated to be infected and one out of every 20 adults known to be infected (Baltimore City Council 2002). According to the Maryland AIDS Administration, Baltimore had the third highest incidence of AIDS case reports for any major metropolitan area in the United States during 2001, with 50 cases per 100,000 people. This despite decreasing numbers of AIDS cases since the mid-1990s due to the introduction of protease inhibitor therapy.

Baltimore City is home to less than 15 percent of Maryland's population, and yet, is home to over 50 percent of its HIV cases (Maryland Department of Health and Mental Hygiene 2003). According to the CDC, there were 1,287 reported cases of AIDS in Baltimore in 2001, a 33.1 percent increase from the year 2000. While these numbers are high, they are probably conservative due to methodological challenges inherent in current surveillance systems, and the fact that the CDC estimates that one third of all persons with HIV have not even been tested. The Baltimore Commission on HIV/AIDS estimated the number of unreported cases of HIV in Baltimore to be as high as 6,000 (Baltimore City Council Commission 2003).

In 2000, males made up 58 percent of new infections in Baltimore City. At the end of 2001, African Americans represented 89 percent of all new reported cases of HIV in Baltimore, with more than 3 in 100 African American males infected. In 2001, African American men had the highest HIV rates among men in Baltimore, at 77.6 percent of those infected, and among all HIV cases, at 45.5 percent.

These rates are compounded by other health and social risk factors. The HIV rates are reflected in, and compounded by, equally high rates of syphilis, gonorrhea, Hepatitis C and substance abuse among the population; all of which indicate a prevalence of high-risk behaviors associated with HIV transmission. According to the CDC, the prevalence rates of gonorrhea and syphilis in Baltimore City, while on the decline, rank first and third highest in the country,

at 949 and 38, respectively, per 100,000 people Maryland Department of Health and Mental Hygiene 2003). These rates are eight and thirty times, respectively, the national rates.

Heterosexual exposure accounts for the majority of new HIV cases among males (45 percent) in Baltimore, signaling an important shift in the epidemic from exposure through homosexual anal sex and intravenous drug use. However, intravenous drug use remains an important means of exposure, responsible for 41 percent of all new cases among males in 2002 (Maryland State AIDS Administration 2002). Baltimore's high rates of injection drug use are reflected in the high number of emergency room visits, with an average of 195 per 100,000 people in 2001. Additionally, it is estimated that 86 percent of injection drug users in Baltimore have Hepatitis C (Baltimore City Health Department 2003). With a 138 percent rise in reported cases of Hepatitis C (from 875 in 2000 to 2046 in 2001), it is clear that intravenous drug use, a key transmission route of HIV remains a serious problem in Baltimore.

Access to testing, treatment, and other services is hampered by socioeconomic status, particularly in the African American community, as demonstrated by a range of indicators. In 1999, 22.9 percent of Baltimore residents and 18.8 percent of all families had incomes below the federal poverty level. The median household income for Black residents was $31,488 with a per capita income of $13,488, compared to $54,604 and $21,280 respectively for their white counterparts (United States Census Bureau 2000). Baltimore's infant mortality rate is almost two thirds higher than the Maryland State rate, at 13.5 infant deaths compared to 8.3 infant deaths per 100,000 live births. Similarly, the city's high low birth weight rate of 15 percent is almost double that of the state rate. With over 15 percent of the16-19 age group not enrolled in school, and not graduated from high school in 2000, education faces significant problems in Baltimore. Among individuals 25 years and older, 9.4 percent had less than a 9th grade education and 22.2 percent did not have a high school diploma. Unemployment is high, with 43.4 percent of Baltimore residents not in the labor force in 2000.

Clearly, a range of health, social and economic factors in Baltimore City facilitates the epidemic of HIV/AIDS. These factors increase the vulnerability of communities, contributing to the spread

of HIV and compounding its impact. To be effective, any HIV/AIDS intervention must address these factors and how they affect both individual and community health-related behaviors (Baltimore EMA 2003; Chunn 2002). This is especially true with those most vulnerable, such as young African American men.

Identity and Cultural Vulnerabilities of Young African American Men

Young African American men face particular risks with regard to their sexual health. These risks are interrelated with other risky behaviors in all areas of life, including family life, education, peer groups, work, and crime. Many of these behaviors have been shaped by mainstream social constructions of what it means to be male and Black in America.

As discussed previously, mainstream constructions of gender define "maleness" and masculinity in terms of strength, aggression, and lack of fear. The roles oF "protector" and "provider" underpin these expectations. These definitions often leave men with little outlet to express and address vulnerabilities and contradictions they may face, with considerable consequences for health seeking behaviors and health status. This is compounded for men of color, who must also face restrictions due to race.

Since the 1850s, scholars and writers, such as W.E.B. DuBois (1899), James Weldon Johnson (1933; 1989) and Zora Neal Hurston (1937), have expounded on the social constructions of race and gender in America and their impact on Black manhood. Slavery, freedom, the Northern migration of blacks, the Civil Rights Act, the Black Liberation Movement and more recently, gang warfare, 'buppydom' and the status of celebrity have all affected how black men are viewed in America and how they define themselves. Further, scholarship has clearly delineated how these externally imposed and internally constructed definitions impact individual behaviors and group status (Hunter and Davis 1992:464-479; Ross 1998:599-626). This body of work demonstrates the connections between race, socioeconomic status, cultural constructions of masculinity and manhood and an emerging sense (or lack thereof) of individual agency and empowerment. Generations of unresolved racism, socioeconomic disadvantage, and violence combined with alienating constructions of mas-

culinity and manhood has undermined a sense of agency in Black males. This in turn has had devastating consequences for African American communities.

Mainstream culture has presented Black males as "a reigning symbol of aggressive American manliness'" (Hunter and Davis 1992; Ross 1998). The very characteristics valued in white men — strength, invulnerability, and even aggression — are exaggerated and devalued in Black men. Society then assumes unearned justification in fearing and (at best) ignoring or (at worst) penalizing Black men. At the same time, while Black men are expected, like other men, to protect and provide for their families, they are often unable to do this. This contradiction leads to 'extreme pressures on Black males to prove they are men in a society that denies them access to acceptable routes to economic and social correlates of manhood' (Richardson 1992; Oliver 1989). The gender and racial expectations for Black men can also be isolating, placing them beyond nurturing relationships with family, community and indeed other Black men; relationships that ultimately could save them. Given these pressures and isolation, many Black males, particularly those in communities experiencing poverty, have taken up the charge of violence and destruction, to the detriment of themselves, each other, and the communities to which they could be contributing positively.

While these behaviors may conform to mainstream expectations of Black men, they do not in fact reflect many African American cultural norms and expectations. Scholars describe African American values as being rooted in various African cultures and are related to cooperation; promotion and conservation of the group around the individual; and a comfort with nurturing feminine and masculine qualities. These values are often linked to spirituality, as well as concrete and affective aspects of behavior. They provide meaning, purpose to lives, and ultimately affect other behavior (Juntunen, Nikkonen, and Janhonen 2002). Additionally, these values often contradict mainstream Eurocentric values of individuality and independence (Roberts 1994; Richardson 1992; Artazcoz 2004). It is perhaps in failing to live up to these cultural expectations that many Black men, particularly young men, lean toward exaggerated playing out of stereotypes, such as 'hoodlum' or 'player' or 'deadbeat dad' (Oliver 1989; Artazcoz 2004). For young men, the socialization process be-

comes confused and contradictory and the consequences for sexual health, and, indeed, family and community health are disastrous.

When actually asked, "What do you think it means to be a man?" Black men's conceptions have less to do with mainstream stereotypes and more to do with the African American cultural values described above. In rating attributes of "being a man," indicators such as "sense of self, " "resourcefulness/responsibility," "parenting and family," "goal oriented," and "provider," rated at the top. Qualities such as "authority," "manliness," "ownership," "sexuality," and "power" were at the bottom of the list (Roberts 1994). Whether these men could actually live by this ranking of attributes was not part of the study. What is significant is that the qualities that put so many young Black men at risk of their health, safety, and. indeed, their lives were actually rated much lower by Black men themselves, than those qualities that could contribute to healthy lifestyles.

Most scholars and policy makers agree that most social policy and programs fail to address the complex interplay of factors that influence the identity, behavior, and sexuality of African American men (Hunter and Davis 1992; Ross 1998; Oliver 1989). They go on to suggest the integration of African American cultural and spiritual norms to counter destructive trends. This integration could be achieved in different ways. An example is given in the study mentioned above, where Black men were given the opportunity to define themselves (Hunter and Davis 1992; Ross 1998). Another suggested changing the ways in which Black men relate to each other (Roberts 1994). Still others suggest the creation of socialization rituals and specific values that introduce young Black men to Afrocentric principles and guidelines to live by (Oliver 1989; Juntunen et al 2002).

Little has been done to explore the utility of such approaches to health education. Given the serious risks that young Black men face, and the lack of existing services, it is crucial that new ways are sought to reach this challenged population. It is with these ideas that the CHPEPR intervention was designed. It utilized African American values such as cooperation, participation, and group well being, as well as the integration of African American and African culture, art and spirituality.

Community-based Participatory Action Research

Community-Based Participatory Action Research (hereafter, CBPAR), first developed in Tanzania, East Africa, has been used extensively in the social sciences to mobilize communities for empowerment, linking the research or information gathering process to inform concrete action and community mobilization. It is only recently that CBPAR has been applied to health issues, providing a useful methodology through which to engage and call attention to hard-to-reach populations, such as young Black men. CBPAR allows the community and practitioner to engage without intermediaries, to organize the community to identify needs and address them (Green and Mercer 2001; Carr 2001; Hull 1992). Participatory researchers must demonstrate the significance of their work for the lives, needs, and aspirations of community members; identify and understand community needs and values; and build relationships with community members (Nash 1993; Bailey 1992; Hull1992). In short, the researcher learns how to be an organizer and an activist, working with the community to identify and address needs. This can be a particularly useful approach when working with hard-to-reach populations. They generally distrust public and private sector systems, science, and academia. According to Bailey (1992), there are five necessary steps, which are cyclical, overlapping, and iterative, in using participatory research to mobilize through the development of community-based consortia:

1. Entry, which involves dialogue between researchers, community members, and other stakeholders, with the objective of developing a collaborative relationship and system for exploring the communities issues, focusing on both assets and needs;
2. Methodical data collection by a team of researchers and community members;
3. Data analysis and feedback to be conducted with the community;
4. Action planning and implementation through the development of action plans to address issues jointly identified and validated by researchers and community members; and
5. Assessment of action results by gathering additional data.

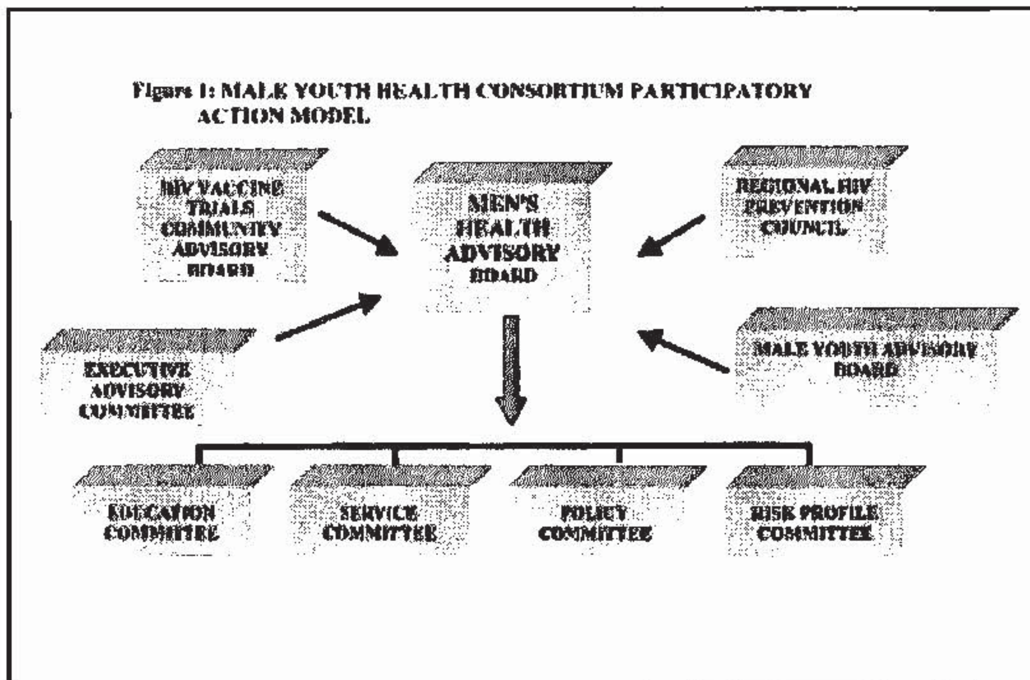

Figure 1: MALE YOUTH HEALTH CONSORTIUM PARTICIPATORY ACTION MODEL

Using this framework, step one was to develop a system to ensure a participatory, engaged approach and a partnership between researchers and community stakeholders.

A Men's Health Advisory Board was convened, with several committees to drive the overall process. Existing structures, already working on HIV/AIDS in communities of color, were also engaged, including the Regional HIV Council and a local HIV Vaccine Trial Network (HVTN) Community Advisory Board (CAB). Additionally, representatives were included from community- and faith-based organizations, academia, communities, and other stakeholders in Baltimore. Efforts were made to include stakeholders working with young men in a variety of ways, not just on health or HIV/AIDS. They were recruited through a series of meetings and events. The overall system was coordinated by CHPEPR, which facilitated the designation of a variety of tasks identified by the various units within the model structure. The Executive Committee designed models and monitoring tools, including the HIV Profile Matrix and the Male Youth HIV/Health Risk Profile survey, as well as the overall research and evaluation component of the project. Meetings within this system utilized participatory methods to produce logistical, management, and project plans (Juntenen et al 2002). From these meetings, the project was designed, with a focus on engaging young

men through events centered on spirituality, culture, and art, for HIV/ AIDS prevention and health promotion activities.

Special Events

Based on the community mobilization and cultural perspectives described above, a series of special events for young men and their advocates were developed and executed. These events utilized a cultural and spiritual framework to address issues such as cultural identity and manhood and their application to sexual health and HIV prevention. Using art, discussion, and sports, these events engaged young men and their advocates in a variety of ways, to provide information on HIV prevention and health promotion. Participants were recruited from *Rites of Passage Collectives* in Baltimore that works with young Black men to help them identify and define those personal attributes that can strengthen their self-identity. *Rites of Passage Collectives* is a nation-wide network of training centers that utilize Afro-centric approaches, paradigms, and spirituality to educate young men about adulthood responsibilities and duties. They utilize experiential techniques that include spiritual activities, learning from elders, and didactic information sharing as well as discussions and community participatory projects.

Through a partnership with a community-based organization, *Oyo Traditions Cultural Institute*, a spiritual and cultural event entitled *The Enlightened Warrior*, was hosted. The event brought together 150 Black men aged 9-60, from the target areas around the universities, as well as from New York City and Richmond, Virginia. The conference goal was to demonstrate and emphasize practices for personal excellence in thought, speech, and behavior. Using experiential and participatory activities, conference organizers utilized both traditional West African and current group learning methodologies, including African drum workshops, video shows of Ogun, the Yoruba divinity of technology and war, Ifa (an African traditional spiritual, medical, and service system) lecture on "omolúwàbí" (Abimbola 1976), a "well-born and raised person," and songs. Activities focused on the exploration, re-discovery, reclamation, and re-orientation of the psychosocial, behavioral, cultural, historical, and spiritual customs of West Afri-

can, Yoruba traditions in the lives of modern African American males. Through the invocation of spiritual energy, conference participants sought to explore ways to transform the lives of African American males through the daily demonstration of healthy norms and standards related to *Iwa Pele* or 'good character.'

An "Afrikan Heritage Walkathon" was organized by a community-based organization, *Afrikan Heritage Walkathon, Incorporated*, in collaboration with the CHPEPR and other community-based organizations including *Journey: African American Outdoor Sports Association*, whose goal is to provide African Americans with opportunities to enjoy nature and sports. The goals of the walkathon were to raise funds for African-centered youth education; provide HIV/AIDS prevention and health promotion materials to participants; and bring together different segments of the community to address community concerns. Participants wore African clothing and they used calling drums to draw attention to the walkers as they passed through a predominantly African American neighborhood, creating a positive and festive atmosphere. After reaching their destination, walkers participated in a "leadership and followership" discussion in the format of traditional Yoruba meetings in West Africa. Together, elders and youngsters discussed community issues, such as quality of neighborhood life and health problems, such as substance abuse and HIV/AIDS.

Finally, a weeklong series of tours, workshops, galas, and health screening activities under the title of *Heroes in the Struggle* was organized around an exhibition of African Americans who distinguished themselves in the fight against HIV/AIDS. At this event, local and national heroes' were profiled through photos and biographies in an exhibition at the Morgan State University Murphy Arts Center. Heroes featured included both men and women, and homosexuals and heterosexuals. Local political leaders and policy makers addressed the issue of HIV prevention policy and the need to strengthen the connection between academia, community and public service and policy leadership. Youth participated from schools and various youth services agencies in Baltimore City, as well as from colleges and high schools in Wilberforce, Ohio, and Lincoln, Pennsylvania. By participating in workshops on health and health screening activities, the young men were

encouraged to think of themselves as able heroes in the struggle against HIV/AIDS. One day of the week was devoted to addressing men's health issues, including sexually transmitted diseases, HIV/AIDS, prostate disease, diabetes, mental health and cardiovascular diseases as well as access to health care for inner-city men. Young men participating in vocation training and young fathers' organizations also participated and were encouraged to complete the Minority Male Health Risk Profile Survey. Another day focused on women's health issues and included presentations by the Maryland State AIDS Administration HIV Prevention Division. The seminar session focused on increased risks for heterosexual transmission and men's role in preventing transmission.

With regard to advocates of young men, activities included a Regional HIV Council Conference organized by CHPEPR. The activities brought together community- and faith-based organizations, academia, and other stakeholders to discuss status of HIV vaccine development; the priorities of the recently funded minority male project; and to review the role and responsibilities of CBOs with the objective of planning the next steps for the *Heroes in the Struggle* Campaign. Millennium Health and Human Services Development Corporation, an established community-based organization, coordinated a committee-planning meeting and facilitated the formation of the minority male youth Community Advisory Board. This meeting brought together 40 community- and faith-based organizations from the Baltimore-Washington, DC region. They applied a participatory action model (Bailey 1992; Carr 2001; Hull 1992; Small 1995; Small 1995; Chappell 2000; Roberts and Dick 2003; Horne and Costello 2004; Hammel, Finlayson and Lastkowsky 2003). Their efforts resulted in the formation of committees with mandates to devise ways to include programming and materials in policy, educational, research, and program planning efforts that would benefit Black adolescents and young adults.

Survey

As step two in the participatory process, a 24-item questionnaire was designed to evaluate participants' basic knowledge, attitudes, and behaviors related to HIV/AIDS and common causes of death within Baltimore City. The questionnaire had three sections: 1) Socio-demographic profile, 2) HIV knowledge, attitudes and behavior risk

profile, and 3) Health, knowledge and attitudes risk profile. The HIV risk profile included nine questions, some multiple choice, on HIV prevention. The Health profile included nine questions in multiple choice format, developed using CDC epidemiological data for Maryland to assess knowledge of lifestyle risk behavior factors associated with the top eight causes of morbidity and mortality in Maryland Anderson 2001). The survey questions were designed with a focus on those factors that are threatening the survival of young black men, particularly in urban communities.

The survey instrument was reviewed through the Morgan State University Institutional Review Board process and the various school systems participating in *Heroes in the Struggle* event, including the Baltimore City Public School System. The instrument was validated with a sample of participants at the *Enlightened Warrior* event. Survey respondents from schools and youth service centers were recruited during the events, as well as through school counselors, with parental approval. A database was developed and data analyzed using SPSS 11.0™. Data summaries were performed with measures of central tendency. The answered were scored such that high scores reflected lower risks for HIV/AIDS.

Findings

Lessons Learned from Community-Based Participatory Action Research

The participatory methods were useful in creating an environment and opportunities for representatives of community-based organizations and young men themselves to express their ideas and priorities in an open, non-judgmental setting. Informal discussions, as well as more structured focus groups, were utilized in the planning stages to identify issues of importance and activities that young participants might enjoy. These discussions were important in the design of the subsequent successful events. The participatory methods also provided an opportunity to assess and appreciate the relative strengths of participating organizations. This resulted in participating organizations being given tasks related to what they already did well, giving them a chance to highlight their activities during project events, and encouraging their stake in the ongoing project.

At the same time, participatory methods created several challenges for both academia and partners. Given the range and number of partners, it was sometimes difficult to ensure that all participants understood the process. This was particularly difficult given that partners came from many different sectors, not just Public Health practice or HIV/AIDS prevention, and had different priorities and different modes of operating. Communication was therefore difficult at times, necessitating an ongoing commitment to the participatory process by the research team, including developing new ways to communicate with partners, based on this commitment. For example, partners were asked for clarification on their perspectives and these were integrated into the plan, based on their feedbacks. The issues thus addressed included transportation, safety, security, and program scheduling. The researchers were therefore able to operationalize participants' thoughts with fidelity, based on resource limitations. A case in point was a Rites of Passage program for which a more conducive atmosphere was created in which sensitive information could be openly shared with compassion. Because researchers were working with a wide age range, communication had to be presented at different appropriate levels to produce access to knowledge in a supportive environment. This enabled the participants to repeat the information based on their own level of understanding and still be effective in influencing behavior for primary prevention of HIV infection transmission.

Lessons Learned from Special Events

The special events, with their focus on cultural heritage and spirituality were effective in drawing and keeping the attention of participants. Young men who would not ordinarily be engaged in health information were easily drawn to the health activities that were integrated into self-improvement workshops, sporting events and community discussions. Multi-disciplinary methodologies that drew on both traditional African values and systems and current Western values and realities gave participants a range of tools and information to draw on to create both personal and community solutions.

The *Heroes in the Struggle* event was useful in creating a connection between the profiled 'heroes' and the young participants, demonstrating the possibility of the participants themselves becom-

ing future heroes in the fight against HIV/AIDS. By focusing on both men and women's health, participants were able to learn about how their behavior directly affects their own health, as well as the health of their partners and families.

During the special events, which highlighted spirituality and art, researchers learned that information could be effectively communicated through mass media campaigns based on the spirituality and art of the community. Researchers were able to disseminate information regarding difficult issues faced by young people such as

1. Handling unwanted sexual advances
2. Identifying and managing peer and adult pressure
3. Revealing discrimination and abuse faced by young people
4. Redefining what it means to be a real man
5. Addressing popular misconceptions about adolescent men.

In addition, the art allowed researchers to highlight the contributions of Black youth to their communities. This technique motivated and energized participating youth. They began to see themselves creatively as resources for HIV prevention and care. They gained life skills for empowerment, for putting new knowledge into practice, and for making informed decisions about their health. Further, researchers were able to find common ground for engaging city leaders and policy makers, to focus attention on minority male youth and the impact of the HIV epidemic. Through this effort, city leaders and policy makers recognized the magnitude of the HIV/AIDS epidemic and set the policy agenda for legislative and executive action. Subsequently a state of emergency was declared by the city mayor.

Finally, by allowing men of all ages to come together, participants were given the opportunity to focus on themselves and their choices and behaviors in a non-judgmental environment. Many participants had not had the opportunity to come together with other men in such positive environments. By bringing men of different ages together, the events were also useful in creating inter-generational alliances to address community and health issues.

Survey Results

The survey results and methodology will be discussed in more detail elsewhere. However, the main findings, as they relate to step

three of the participatory model and as they relate to HIV/AIDS will be discussed here. The survey had 81 respondents, 43 percent from Baltimore, 37 percent from Pennsylvania, and the rest resided elsewhere. Three quarters of respondents were male and two thirds were never married. Nearly half were between 11-25 years of age, the other half were aged 26-40. Over half the respondents were in middle or high school or GED level. Almost 40 percent had been educated ablove high school. A majority of respondents were employed. However, up to 58 percent earned less than $10,000 per year. Twelve percent earned over $50,000. The sample was a small, cross-sectional and convenience sample, and thus had some methodological weaknesses. However, its utility was in providing a valid, profile of young African American men for the geographic areas covered.

Most respondents had some knowledge of the existence of, and risk factors for, HIV transmission. For example, 86 percent knew that kissing was not a means of HIV transmission and 98 percent knew that HIV was transmitted through unprotected sex. Of the respondents, 65 percent knew someone with AIDS and 58 percent knew someone being treated for HIV or AIDS while 68 percent knew where to go in their neighborhood to get an HIV test. With regard to possible risk behavior, 67 percent had had one sexual partner or less and 22 percent had used drugs in the past year. Notably, 58 percent agreed with the statement "HIV/AIDS is a disease made and spread to kill Black people."

Generally, the survey results demonstrate that respondents have considerable knowledge about the processes and risks for HIV transmission, spread and prevention. They also seemed to be familiar with people living with HIV/AIDS and were aware of services providing both testing and treatment. However, as has been amply demonstrated, knowledge of risk does not necessarily translate into behavior modification (Janz 1984). This is particularly true for already hard-to-reach populations, such as young African American men.
The survey results indicate that further inquiry is necessary, in collaboration with community stakeholders, to identify what menu of services and intervention will be appropriate for the youth to take their knowledge and apply it to their behavior. This would move the consortium toward steps four and five in the participatory action research model.

Conclusions and Implications for Practitioners

There is a need for interventions that stress community engagement and participation. Community engaged participation in public health practice is an effective means of connecting with community members and ensuring the sustainability of an intervention. By involving representatives from a range of organizations, including those not working on health, the intervention was able to secure a commitment from various sectors in the community, regarding interest in the project, project implementation, and next steps.

*There is a need to acknowledge and address African American experiences and cultural frameworks.*The high percentage of respondents who believe that HIV/AIDS is part of a conspiracy against Black people indicates a "disconnect" between knowledge about HIV/AIDS and cultural attitudes, and the behaviors that may flow from those attitudes. For example, distrust and consequent avoidance of existing services may be the outcome of this belief. Researchers also discovered that there is a strong need to make information available and actively disseminated on a continuous basis with the position that being informed can transform those perceived to be hard to reach and unreliable into active and reliable contributors to disease prevention and health promotion efforts. These findings confirm the need for health interventions that integrate culture, particularly with hard-to-reach populations that do not utilize existing services. It also confirms the need for a participatory model made up of community stakeholders that can effectively address difficult cultural issues. Practitioners working with hard-to-reach communities should therefore view consistent and persistent cultural and participatory processes as important tools to both reveal and address difficult issues. This intervention demonstrated the utility of such a perspective.

*Reach young African American men by relating to them and their interests.*By creating opportunities for young African American men to come together and engage in a wide variety of activities of interest to them (cultural, sporting, spiritual, and self-improvement activities), the project was able to effectively conduct a survey and provide health screening and education. In turn, the survey process became an essential tool for engaging participants to

understand and examine their own knowledge base and engender insight into behavior change and consequent participation in prevention and health promotion efforts.

Create an expanded community network to address HIV/AIDS. By involving representatives from organizations working with young men in a variety of sectors — not only health — the project effectively expanded the number and range of stakeholders involved in HIV/AIDS prevention with young African American men. Given that many of the public health crises we face today are rooted in behavior and impacted by socioeconomic and cultural factors, public health practitioners should create partnerships with stakeholders in multiple sectors. There must be a commitment to bring people together at every level from a range of sectors – government and non-governmental, faith-based and secular, community-based organizations, industry and business, academic and research bodies, corporate and private foundations, and of course, community members, including young people. Using participatory action research modalities, these diverse and sometimes divergent sectors can be mobilized and coordinated to achieve community-set goals and objectives for an identified common cause.
Practitioners can learn from communities.

A key implication of the Participatory Action Research process is that researchers do not merely "study" a 'target community.' Rather, researchers collaborate with, and learn from, communities. Through this partnership, researchers and practitioners are able to gain insight and increase competence with regard to the knowledge, attitudes, beliefs, needs, and behaviors of community members, as well as ideas and approaches to address emerging community needs. At the same time, researchers should maintain and achieve their research tasks and objectives through organized and rigorous data collection and management. To make this shift from 'external researcher' to research partner with communities, the practitioner must become conscious of his/her own belief systems and their influence on the perception and judgment of the community under study. This includes religious, philosophical, technical, and social belief systems. Once this awareness is achieved, the practitioner is better able to engage with communities, and can effectively obtain authentic information.

Participatory action research is a continuous learning process. Through participatory action research, researchers learn to learn from rather than study a target population. This implies gaining from the community new insight and competence in knowledge, attitudes, beliefs, perceptions, and approaches to addressing community needs. While retaining the basic functional skills for implementing tasks and achieving objectives, the practitioner will need to be conscious of his or her own belief systems and views, and how these can affect the whole process of engaging the community. A practitioner's belief systems and views can cloud or pollute the true picture of the community. The most insidious of these views and paradigms are religion, philosophy, prior "technical knowledge," and one's social background. The practitioner therefore needs personal, continuous quality improvement in thought, language, and activities. One effect of this consciousness is that the community opens up to the practitioner. An offshoot of this is that the practitioner stands to obtain more useful and relevant information than was envisioned. This requires development of an organized data collection and management system for tracking the learning processes. Therefore, it is important that the practitioner develop tools from those community experiences and communications that are valid and reliable for that community.

References

Abimbola, Wande. 1976. *If·: An Exposition of If· Literary Corpus.* Ìbàdàn: Oxford University Press.

Anderson, Robert. 2001. "Deaths: Leading Causes for 1999." US Centers for Disease Control and Prevention (CDC), Division of Vital Statistics: *National Vital Statistics Report*, Volume 49, Number 11, October 12.

Artazcoz, L., J. Benach, C. Borrell, and I. Cortes. 2004. "Unemployment and Mental Health: Understanding the Interactions among Gender, Family Roles and Social Class." *American Journal of Public Health* 94: 82.

Bailey, Darlyne. 1992. "Using Participatory Research in Community-Based Consortium Development and Evaluation: Lessons from the Beginning of a Story." *The American Sociologist* Winter: 71-82.

Baltimore City Council Commission on HIV/AIDS. 2002. *Final Report, March 2002.* Retrieved January 12, 2003 (http:/www.baltimorecitycouncil.comHIV_finalreport.html).

Baltimore City Health Department. 2003. "HIV/AIDS Program Indicators, Reporting Period: March 13, 2003 through March 26, 2003." (CitiStat Reports and Maps, Health Department, March 26, 2003, p. 7). Baltimore, MD: CitiStat. Retrieved February 15, 2005 (http://www.ci.baltimore.md.us/news/citistat/reports.html).

Carr, Deborah. 2001. "An Evaluation of Three Democratic, Community-Based Approaches to Citizen Participation: Surveys, Conversations with Community Groups and Community Dinners." *Society and Natural Resources* 14: 107-126.

Centers for Disease Control and Prevention (CDC). 2001. *United States HIV and AIDS Cases Reported through December 2001.* Year-end edition. Vol. 13, No. 2.

Chappell, Anne. 2000. "Emergence of Participatory Methodology in Learning Difficulty Research: Understanding the Context. *British Journal of Learning Disabilities* 28: 1, 38-43.

Chunn, J.Carrington. (ed). 2002. *The Health Behavior Imperative: Theory, Education and Practice in Diverse Populations.* New York: Kluwer Academic/Plenum Publishers.

Cohen, R., L. Lange, and W. Slusser. 2002. "A Description of a Male-Focused Breastfeeding Promotion Corporate Lactation Program." *Journal of Human Lactation* 18:1. DuBois, W.E.B. 1899/1996.

The Philadelphia Negro: A Social Study. With a new introduction by Elijah Anderson and a special report on domestic service by Isabel Eaton. Philadelphia: University of Pennsylvania Press. Freire, Paolo. 1993.

Pedagogy of the Oppressed. Translated by M.B. Ramos. New York: Continuum.

Green, Lawrence and Shawna Mercer. 2001. "Can Public Health Researchers and Agencies Reconcile the Push from Funding Bodies and the Pull From Communities?" *American Journal of Public Health* 91: 1926-29.

Hammel J, M. Finlayson, and S. Lastkowsky. 2003. "Using Participatory Action Research to Examine Outcomes and Effect Sys-

tems Change in Assistive Technology Financing." *Journal of Disability Policy Studies* 142: 98-108.

Horne, M. and J. Costello. 2003. "A Public Health Approach to Health Needs Assessment at the Interface of Primary Care and Community Development: Findings from an Action Research Study." *Primary Health Care Research & Development* 4: 340-352.

Hull, B. L. 1992. "From Margins to Center? The Development and Purpose of Participatory Research." *The American Sociologist* Winter 15-28.

Hunter, A.G. and J.E. Davis. 1992. "Constructing Gender: An Exploration of Afro-American Men's Conceptualization of Manhood." *Gender and Society* 6: 464-479.

Hurston, Zora Neale. 1937. *Their Eyes Were Watching God.* New York: Harper/Collins.

InterGroup Services, Inc. (IGS). 2002. *Comprehensive Plan for HIV Service Delivery: Baltimore EMA 2003-2005.* Baltimore, Md.: IGS, September. Retrieved February 18, 2005 (http://www.baltimorepc.org/readingroom.htm).

Janz, N.K. and M.H. Becker. 1984. "The Health Belief Model: A Decade Later." *Health Education Quarterly*, Spring.

Johnson, James Weldon. 1989a. *The Autobiography of an Ex-Coloured Man*. New York: Random House.

______. 1933b. *Along This Way: The Autobiography of James Weldon Johnson*. New York: Viking Press.

Juntunen, Anitta, Merja Nikkonen, and Sirpa Janhonen. 2002. "Respect as the Main Lay Care Activity Among the Bena in Ilembula Village of Tanzania." *International Journal of Nursing Practice* 8: 210-220.

Maryland Department of Health and Mental Hygiene. 2003. "Baltimore City HIV/AIDS Epidemiological Profile, Fourth Quarter 2004." (AIDS Administration Statistics). Baltimore, MD: AIDS Administration. Retrieved February 18, 2005. (http://dhmh.state.md.us/AIDS/epictr.htm).

________. 2002. *Midyear Report*, June. Baltimore, MD: AIDS Administration.

Miedzian, M. 1991. *Boys Will Be Boys: Breaking The Link Between Masculinity and Violence.* New York: Anchor Books, Doubleday.

Nash, Fred. 1993. "Church-Based Organizing as Participatory Research: The Northwest Community Organization and Pilsen Resurrection Project." *The American Sociologist* Spring: 38-55.

Oliver, W. 1989. "Black Males and Social Problems: Prevention through Afrocentric Socialization." *Journal of Black Studies* 20 (September): 15-39.

Richardson, F.C. 1992. "The Plight of Black Males in America: The Agony and the Ecstasy." *Negro Educational Review* 43: 3-10.

Roberts, G. and B. Dick. 2003. "Emancipatory Design Choices for Action Research Practitioners." *Journal of Community Applied Social Psychology* 13: 486–495.

Roberts, G. 1994. "Brother to Brother: African-American Modes of Relating Among Men." *Journal of Black Studies* 24 (June): 379-390.

Ross, Marlon. 1998. "Search of Black Men's Masculinities." *Feminist Studies* 24 (Fall): 599-626.

Schultz, J. and W. Hedges. 1996. "Hearing Ourselves Talk: Links Between Male Sexuality and Reproductive Responsibilities," in Zeidenstein, S and K. Moore (eds). *Learning About Sexuality: A Practical Beginning.* New York: The Population Council & International Women's Health Coalition.

Small, S.A. 1995. "Action-Oriented Research: Models and Methods".*Journal of Marriage and Family 57:* 941-955. Sonenstein, F.L. (ed). 2000.

Young Men's Sexual and Reproductive Health. Toward A National Strategy: Framework and Recommendations. Washington, DC: Urban Institute.

United States Census Bureau. 2001. *U.S. Current Population Survey*, March 2001. Retrieved February 18, 2005 (http://pubdb3.census.gov/macro/032001/pov/new25_001.htm).