African American Men’s Perceptions of Factors Influencing Health-Information Seeking

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The lack of health information is one of several factors implicated in the poor health status of African American men. Although a growing body of research delineates the obstacles to African Americans’ engagement in preventive health behaviors, relatively little is known about the barriers that adversely affect men’s involvement in health-information seeking. This article presents qualitative data on African American men’s information seeking through an analysis of focus group data. Three research questions are addressed: (a) What health-information concerns and needs do African American men have? (b) How do African American men describe their efforts to obtain health information? and (c) What factors facilitate or inhibit health-information seeking by African American men? The implications of the data and suggestions for future research are provided.

Keywords: health communication; African American men; health-information seeking; multicultural issues; health education

Information seeking involves the act of gathering information to clarify or confirm knowledge about a particular topic (Anderson-Lewis, Kohler, & Green, 2003). Well-informed patients are more apt to maintain a sense of control regarding their illness than are individuals with limited information, and they are better able to cope with the ambiguity of illness outcomes and treatment consequences (Evans & Clarke, 1983; Felton & Revenson, 1984; Lerman et al., 1993; Viney & Westbrook, 1984). In addition, well-informed patients may engage in treatment planning and may comply with therapeutic regimens more readily than those who are ill informed (Eraker, Kirscht, & Becker, 1984). These behaviors ultimately influence recovery from an illness. Correspondingly, there is documented evidence that having inadequate health information can have detrimental health consequences (Denberg, Wong, & Beattie, 2005; Evans & Clarke, 1983).

Whereas differential health outcomes or disparities in numerous diseases are documented among African Americans, the health status of African American men is typically worse than that of African American women (Centers for Disease Control and Prevention, 2005; National Center for Health Statistics, 2005; Witt, 2006). African American men have a lower life expectancy than men in Bangladesh, Iran, Columbia, and Sri Lanka (National Center for Health Statistics, 2005; Office of Minority Health, 2006a; Witt, 2006). African American men have a lower life expectancy than men in Bangladesh, Iran, Columbia, and Sri Lanka (National Center for Health Statistics, 2005; Office of Minority Health, 2006a; Witt, 2006). African American men have a lower life expectancy than men in Bangladesh, Iran, Columbia, and Sri Lanka (National Center for Health Statistics, 2005; Office of Minority Health, 2006a; Witt, 2006). In fact, African American men have the lowest life expectancy of all racial or ethnic groups in the United States (National Center for Health Statistics, 2005). Compared to White men, African American men have a 40% higher incidence of type 2 diabetes, are 20% more likely to die from heart disease, have 8 times the Acquired Immune Deficiency Syndrome (AIDS) rate, and are 9 times more likely to die of AIDS (National Center for Health Statistics, 2004; Office of Minority Health, 2006b). Among all racial and ethnic groups, African

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American men have the highest cancer incidence and mortality rates for all sites combined and for prostate, lung, colorectal, and other specific cancers (Jemal et al., 2004; Ward et al., 2004).

The lack of health information is one of several factors implicated in the poor health status of African American men (National Cancer Institute, 2006). Although information is insufficient to encourage behavior change, it is necessary (Dervin, 2005). Dervin suggested that to accommodate the information-seeking needs and preferences of individuals in any population, it is important to understand issue involvement, situational circumstances, and sense-making needs. These components of information-seeking behavior can be quite complex. They can be based on rational or emotional processing and/or the need for certainty or the desire to remove it. In addition, at various times, there is a desire for facts, information from authorities, and/or information provided by peers. Whereas a growing body of research delineates the obstacles to African Americans' engagement in preventive health behaviors (Edwards, Johnson, Mason, & Boyle, 2002; Green & Kelly, 2004; O’Malley et al., 2001), relatively little is known about the barriers that adversely affect African American men's involvement in health-information seeking, an equally relevant health behavior. Given the health status of African American men, their health-information needs, concerns, and behaviors are of particular concern.

Much of the research on African American health-information seeking has addressed the population as a whole and reveals little about the health-information-seeking activity and needs of African American men. Some data suggest that African American men do not engage in health-information seeking as frequently as African American women do (Altman, 1985; Gollop, 1997; Maibach & Davis, 1998). Analyses of the use of the Cancer Information Service (CIS) suggested that more than 70% of African American CIS callers were female (Office of Cancer Information, 2004).

Through an analysis of focus group data, this article presents qualitative data on the information seeking of African American men. Three research questions are addressed: (a) What health-information concerns and needs do African American men have? (b) How do African American men describe their efforts to obtain health information? and (c) What factors facilitate or inhibit health-information seeking by African American men? This article extends the literature by providing information on African American men’s subjective experience of their health status, health concerns, efforts to seek health information, preferences, and health behaviors.

Methods

Focus group interviews with men, conducted as part of a larger communication-focused study to increase colorectal cancer screening behaviors of African Americans, were used to examine the health and cancer information needs of African American men. The Saint Louis University Institutional Review Board approved the research protocol.

Focus Groups

Researchers used focus group methodology to conduct this qualitative study. The current study defined focus groups as semistructured groups moderated by a group leader in informal settings to collect information from individuals believed to share a common experience (Morgan, 1997). This methodology was used in this instance because data of this type are scarce for African American men. Focus groups permit discussions that can reveal the meanings associated with a topic and how these are created within groups. The discussions allow respondents to build on or disagree with one another, thus providing an opportunity for
the observation of diverse perspectives critical in new areas (Flick, 2002). Because of these characteristics, focus groups have the ability to provide rich information that is useful in developing ideas for programs and interventions as well as hypotheses for research.

Procedures

Twelve focus groups were conducted with African American men between June 2004 and October 2004. Focus groups occurred at several public venues in the community. These venues included a public library, a municipal city hall, a church, a university-based facility, and the Neighborhood Voice Mobile Van (a van customized to facilitate community recruitment and community-based research). The sites were selected based on the ease of access for participants.

All participants received a detailed explanation of the study before providing signed consent. Before group discussions, study participants completed a demographic questionnaire that obtained information on gender, age, educational level, and income and took approximately 5 to 10 min to complete. All sessions were audiotaped, and each session’s audiotape was professionally transcribed verbatim. Refreshments were provided before and during each focus group session. At the end of each session, participants received a $20 gift certificate.

Two standardized focus group scripts were developed with advice from a multidisciplinary research team and guided group discussions. Six of the 90- to 120-min group discussions focused on participant reactions to cancer statistics embedded in written statements. The smallest group was composed of two men, and the remaining groups (five) were composed of three men. In another six focus groups, participants addressed social and cultural factors that affected cancer knowledge, diet, and cancer screening behaviors, specifically colorectal cancer screening in the African American community. Two groups were composed of three men, one group consisted of eight men, and the remaining groups (three) were composed of four men. All scripts contained sections that explored respondents’ reactions and thought processes related to community attitudes about health and health information as well as their health-information-seeking activities. The latter material is the focus of this article.

Data Collection

This was a purposeful sample of African American male volunteers. Participants were recruited via posted announcements, personal invitations through churches, and solicitations at local businesses and organizations and were residents of the metropolitan St. Louis areas targeted by the intervention. Study participants (a) were age 36 years and older, (b) had no known diagnosis of colorectal cancer, (c) were born in the United States, and (d) were residents of the metropolitan area to be targeted by the intervention. A total of 43 African American men participated in 1 of the 12 focus groups focused on reactions to cancer statistics and their presentation (n = 17) and social and cultural factors (n = 26; Thompson Sanders et al., 2005).

Data Analysis

Coding guides were developed by an interdisciplinary team of researchers from the disciplines of public health, psychology, and anthropology. Rules and categories for identifying and recording content were developed after reviewing project goals, the content of the focus groups, and the existing literature (see Table 1 for sample codes). Although these codes became the basis for the current data analysis, we supplemented codes as new issues and themes emerged in the data. We (V.L.S.T. and M.T.) read and coded the focus group transcripts individually, identifying text units that described health concerns, health-information needs, sources of health information, barriers to health, and health-information seeking. The coders then met to reach a consensus on the codes, and no code was included in the final analysis that had not been agreed on by both coders.

On completion of coding, the two coders individually formulated core ideas and general themes that emerged for each focus group. The core ideas and general themes were discussed and synthesized into a coherent set of issues and concerns. The themes that emerged did not vary by focus group type and are combined in this presentation. The discussions yielded a set of attitudes about health, health-information sources, concerns, and preferences as well as factors that influence health behavior and information seeking.

Findings

Description of Focus Group Participants

The mean age for all male participants was 49.04 years. Approximately 51.5% (n = 22) of participants
had a high school diploma or some high school education, and 36.9% \((n = 16)\) had some college or a college degree. Incomes varied, with 65.3% \((n = 28)\) of participants reporting an income between $0 and $19,999, 21.8% \((n = 9)\) reporting an income between $20,000 and $39,999, and 13.0% \((n = 6)\) reporting an income of $40,000 or more. (See Table 2 for demographics by focus group type.)

### Analytic Themes

I hate to sound chauvinistic, but we’re not, um . . . we were raised not to worry about a lot of things. The only thing, you know, you not a man unless you got a child. You not a man unless you got a job, you know. You got to be the provider. You not a man if you cry. So you know, it’s stereotypes that come with that. And then the other reason is lack of funds, lack of information. A lot of people don’t get treated because they can’t afford it. They don’t have insurance. . . . That’s pride. We’ve got that pride.

Data analyses revealed four major factors that affect the health of African American men and their health-information needs. These included definitions of health and health concerns, community norms related to male roles and behaviors, economic concerns, and mistrust. In addition to these themes, we address personal responsibility for health behavior as a variant theme that captures the contested nature of African American men’s views of these issues. Quotations from focus group participants are used to illustrate the themes discussed below.
Definitions of health and health concerns. The African American men included in focus group discussions described health as the absence of pain and symptoms, with the ability to fulfill daily roles and obligations.

I mean, like me as a black man . . . working and moving and going. I figure if I'm healthy, you know what I'm saying, why worry about it.

A great deal of discussion focused on a holistic health perspective, emphasizing the importance of mind and spirit in physical health.

Me, I'm a religious person. So I always have to add my, my spirituality in all of this . . . my spirituality and my spiritual awareness and what I eat, I'm hearing myself and putting that positive energy within me, you know?

When I feel like I'm really happy is when I'm, um, physically adequate and mentally adequate. Also spiritually adequate. That's when I feel like I'm really happy.

For participants in these groups, health was the result of genetics, family history, and personal behaviors that included diet, exercise, smoking, substance use and abuse, and obtaining routine physical examinations. In addition to the issues noted above, participants cited stress as a major cause of disease. For the men participating, this stress related to earning money to care for their families and other economic and social pressures that they reported perceiving as being more problematic for African American men than for others.

Participants reported that they sometimes avoided health care interactions because of their negative health behaviors. They discussed fears and worries related to their health behavior and history. The costs of seeking health care and the men's emotional reactions to their health-behavior histories resulted in delays in seeking care unless symptoms were present.

But I, I’m currently smoking cigarettes, so I try not to even think about it, to be honest. I’ve seen movies and things like that, but, you know, it’s one of those things where . . . and the colon thing that he was talking about . . . all of that, it’s like, don’t want to, didn’t want to know, but at the same token, you want to know, but then you don’t want to know.

African American men in these groups reported a range of health concerns prompted by pain and symptoms, family history or concerns, and information that focused their attention on the unique concerns of African Americans, particularly African American men. The health issues most frequently discussed were diabetes, hypertension, cancer, stroke, and heart disease. Discussions noted changes in health attitudes that emerged as the men aged. They cited increased willingness to attend to and accept health information.

Health Information

Participants discussed information attributes that affected their attention and attitudes toward health information, noting a preference for information specifically about African Americans. They discussed the particular need for health information that was clearly relevant to them.

But most of those statistics don’t identify any racial or ethnic group, OK? So you don’t, so you’re not thinking that in your racial group, the numbers are so high because they’re across the board. But if they, I think they were to say, “Within the African American community the numbers are extremely high,” it might prompt more African Americans to be more aware and to try to do something about it.

Information typically requested included the signs and symptoms of illness, the appropriate tests and screenings, and the timing of these as well as whom to see and the location of facilities and resources. Health care providers were the preferred source of information, and participants believed that
seeing a physician for routine physical exams should ensure completion of all relevant and necessary tests and screenings.

You’d have to rely on the doctor to tell you. You have to go see a doctor . . . I just had a semi-physical.

However, participants expressed concern that health care providers might deliberately withhold information.

There’s more than what they tell you. You really can’t just believe what you’re told, because they tell you what they want you to know. They’re only going to let you know so much.

Other sources for health information were print media (magazines, pamphlets, books), television, and family and friends.

Well I get my information from my doctor and what I hear on TV.

I do my research from books and pamphlets and things like that.

The Internet was occasionally mentioned as a source of health care information. Often, the men reported that family and friends used the Internet to obtain information that was requested.

I go on the Internet to try to get as much information as I can about it [health]. Also, um, also call people that I know, um, doctors and stuff that might be able to explain it to me better.

Participants were interested in statistics that contrasted African American health to that of ethnic groups other than Whites, with additional data on the rates by gender. The most frequent concern raised was that information was not provided that explained how to improve African American men’s health. Participants wanted explanations and suggestions for actions.

Norms related to male roles and behaviors. Participants in these groups noted the influence of community norms for male behavior on health behaviors and information seeking. They stated that community norms suggest that men do not worry about their health. Men are strong, can endure pain, and do not “whine or cry.” Some men stated that illness is not an option for a man, particularly in youth and early adulthood.

When I was younger, not going to the doctor made you a man. It made you stronger, you know, um, I’m always healthy. There’s nothing wrong with him. Oh, he’s never sick, he’s never sick. But he never got a checkup and then when he did get sick it was something that was really, really rough on him, you know.

The desire to meet these social standards reportedly led participants to delay reports of pain and symptoms. Some of the men reportedly did not learn when to stop and to consider their mental and physical well-being. Others abused their health through alcohol, substances, and unprotected sex to live up to images of invulnerability. One participant described this behavior as the “culture of bad habits.”

The men discussed the role of age and education in increasing the concern for health, the desire for health information, and opportunities for change as well as the implications of past behavior on their health status.

I have high blood pressure. I take, you know, medicine for it. You know, um, I didn’t know too much about it ’til I got older, you know.

Likewise, some screening tests and exams—digital rectal exams, sigmoidoscopy, colonoscopy—were avoided because the men perceived these exams as violating their manhood.

Well I actually just went and had a physical done . . . that colon thing done. But, um, that colon thing, I ain’t doing no more. I don’t see no doctors examining me like that. Just the thought of him taking his finger and putting it up . . . un-un.

Economic concerns. Group participants discussed the role of poverty, inadequate education, and health insurance in the health status of African American men. Economic issues reportedly limit access to many resources. Participants suggested that because of their lower socioeconomic status, African American men do not receive health information that could be beneficial. They suggested that providers might not inform them of tests and screenings because of their lack of or inadequate insurance and perceived inability to pay for these services.

If you don’t have the insurance, then you are looking at them denying you your health care.
In addition, the men noted that lack of education and limited employment and income restricted them to communities with few resources. They noted that health care facilities and providers likely to promote health education and provide health information were not present in their communities. These participants described a need for health information that discussed access issues. In particular, costs, lack of medical insurance, and poverty were discussed as health-behavior barriers that information could overcome. The men in our groups stated that health materials that recommend seeking a doctor's care or screening procedures should indicate resources for those who lack insurance or the ability to pay for these services.

Mistrust. Although health care professionals and doctors were the preferred source for information, participants in these focus groups expressed misgivings about and mistrust of the health information available and provided. They most often commented on these reactions when describing health care providers who demonstrated dismissive attitudes and a lack of respect toward them.

I belong to one of them HMOs. And um, the one that I belong to don’t have any African American doctors. Because when I go there, I get the feeling that they aren’t giving me the same service as they would give to a White counterpart. They don’t take any time. You know, I sit there and I tell him something and he don’t think it’s important. Because he just flips over it . . . he doesn’t answer, you know, he doesn’t answer my question, you know.

They were unsure whether physicians would provide them with the most important and relevant information.

Sometimes there is information that is kept from you as a Black man.

They superior, that mean they supposed to get the best health and to be the most fit and all that . . . now you [believe that] that would make sure they keep you from knowing. You would never be as smart, educated, nothing as them. Because they never want you in their status to where they are. Because one day you may overcome them, if you was as fit as them in all areas.

In addition, the men noted that they did not always feel welcome in the venues, hospitals, community clinics, and health fairs where health information was available.

Black males don’t feel like they are welcome in these certain venues, even when the information’s being dealt.

The men discussed the fact that they were not privy to the source and method of data collection and analysis associated with information on African American health. Given the tendency for the data and statistics to be negative, participants discussed whether the facts were altered to be unfavorable and whether there were any positive data, trends, or information. However, materials developed by the American Cancer Society and the American Diabetes Association were specifically mentioned as credible.

Personal responsibility for health knowledge and behavior. The participants agreed that economic issues, discrimination, mistreatment leading to mistrust, and norms related to manhood adversely affect African American men’s health and health-information seeking. However, discussions emerged that focused on personal responsibility. One man framed the issue as “the choice in African American men’s lives.” Participants discussed the need for men to take control of their health and well-being instead of engaging in what they called avoidance and passivity. The men felt that many men make excuses for their failure to take care of themselves when confronted with obstacles.

It’s a choice, it’s not that they don’t feel welcome. They don’t want to know. They are occupied doing other things until it applies to them, then they want to know.

Although they were not in the majority, several men noted the availability of health information that targets African American men and discussed why African American men fail to seek and use this information. Discussions of this variant view included the identification of a variety of settings—libraries, community health clinics—that present few barriers to health-information seeking.

I keep hearing this about a lack of information. I don’t see where there’s an excuse for lack of information . . . If they wanted to come in, be concerned about it, you know where the library is.

There was no consensus on the extent to which this issue is relevant to the health outcomes of African American men, but the issue generated significant discussion and emotion.
Discussion

Although there has been an increase in data related to African Americans’ health-information seeking (Gollop, 1997; Hesse et al., 2005; Matthews et al., 2002; Shi, 1999; Williams et al., 1997), there are no data on the specific health-information needs of African American men. The lack of health information is one of several factors implicated in the poor health status of African American men (National Cancer Institute, 2006), and as Dervin (2005) stated, although information is insufficient to encourage behavior change, it is necessary. This study sought to add to the knowledge base by exploring the health-information concerns and needs of African American men. The data presented suggest that a variety of issues influence the lack of health-information seeking among African American men. In addition, these data suggest strategies for improving the health materials produced for African American men.

The men in these focus groups seemed to feel that economic concerns, community norms, and the acceptability of available information and resources inhibited health-information seeking and made health difficult to maintain. Participants reported that economic pressures and attempts to present as strong men made them reluctant to seek treatment or see a physician unless the symptoms of illness were present. Higher rates of poverty and lower rates of health insurance compared to those of White men were issues that were particularly salient for African American men. These differences have been confirmed in the literature and are believed to contribute to health disparities (House & Williams, 2000).

The influence of cultural attitudes and norms on health attitudes and behaviors has been discussed in the literature (Snowden & Hines, 1998). Although these issues are not well understood, it appears that these norms influence African American men’s attitudes toward health as well as their health and health-information-seeking behavior. The men in these focus groups described this influence in largely negative terms. Yet, the literature on culturally competent health communication has not addressed the specific issues and needs of African American men.

African American men noted the use of health-information sources previously reported in the literature. Physicians were one of the most frequent and trusted sources of health information (Evans & Clarke, 1983). Similarly, print and television were frequently cited sources of health information (Gollop, 1997; Hesse et al., 2005). Despite reported trust of physicians as sources of health information, participants discussed physician attitudes and behaviors that interfered with acquiring health information and perhaps other aspects of health care. For these African American men, dismissive attitudes and tones, lack of patient–provider relationships, and short office visits were evidence of disparate treatment. Communications that are culturally appropriate are a part of the effort to address disparities, and these findings emphasize the need to enhance cultural-competence training among health professionals (Brach & Fraser, 2000).

The participants also felt that they were given inadequate health information and health care because they were uninsured or underinsured. They noted correlations between lack of income, having health insurance, seeing a health care professional, obtaining screenings, receiving quality health care, and maintaining a healthy diet. Participants discussed the need for health information that directly addresses these access issues. These perceptions also highlight the need for health policies that ensure that those in need are able to access health care and maintain a relationship with a health professional (LaViest, Nickerson, & Bowie, 2000).

Participants expressed mistrust of the health information available. Again, the presence of mistrust is consistent with the current literature available (LaViest et al., 2000; Matthews et al., 2002). There was a perception that the majority of health information these men encountered featured European Americans, which reduced its sense of relevance for them. Given the tendency for the data reported to be negative, participants discussed whether the facts were altered to be unfavorable to African Americans. Participants also wondered about the existence of positive data, trends, or information.

Limitations

The interpretation of these focus group discussions must be approached with caution. As is true of qualitative research in general, the relative importance or influence of any preference, issue, or idea identified cannot be quantified. In addition, qualitative findings are subject to interpretive bias. Although we made an effort to include African American men of diverse backgrounds (within the target age group), the participants were not representative of a national or local sample of African Americans. Focus
groups were composed of volunteers, and it is impossible to know how individuals who chose to participate differ from those who did not. The provision of a monetary incentive may have resulted in a larger proportion of low-income participants. In addition, this sample focused on older African American men. The needs and perceptions of younger men may be different than those expressed in this article.

Implications and Directions for Future Research

The discussions presented in this article provide insights that can be used to assist African American men to meet their health-information needs.

1. Health-communication materials should provide information on resources for low-income and uninsured individuals when screening and contact with health providers are recommended. The cost considerations for other health behaviors should be addressed, as well.
2. Health-communication materials should provide health statistics that focus specifically on African American men.
3. Health statistics should be paired with culturally appropriate health-behavior messages that include diet and screening recommendations, signs and symptoms of illness, and information on access to health care.

Materials that meet these criteria may increase the perception of the information’s relevance for African American men.

4. Testimonials from potential African American male role models may address the effect of community gender-role norms and stereotypes that discourage proactive health attitudes and behaviors. Specifically, role models may address attitudes related to screening tests and perceptions of manhood.
5. Health-communication materials should also consider ways to present strategies for coping with feelings of mistrust experienced in response to health information and to health care settings.

Reactions in health care settings are important because participants look to health professionals, particularly physicians, for health information. For example, health materials might include strategies for interacting with health professionals in ways that produce outcomes that are more desirable. In addition to providing knowledge, health information presented in this manner may also address the cultural and structural barriers the participants perceived as more frequently encountered in the African American community.

Although some participants discussed feeling unwelcome in health-information venues, they did not specify how or under what circumstances the venues evoked this response. Additional qualitative research may be needed to understand the factors that foster and maintain African American men’s interest in and trust of health-information channels and venues. Future research should also attempt to discover the factors that influence African American men’s perceptions of information relevance and utility.

References


