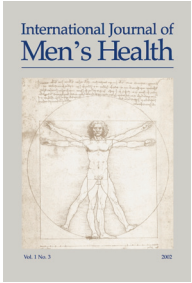

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Staying Alive: Men's Health Disparities in an Urban Context: The Results of a Pilot Study

African-American men in Baltimore, MD, participated in a focus group on issues relating to their health and quality of life. Specific topics in this pilot study included: community perceptions, the role of men in family planning, navigating the healthcare system, and overall perspective on life as experienced within an urban context. The participants were partners to women or fathers of children enrolled in a home visitation program. The relationship between low socioeconomic status and poorer health for men was discussed. The results of this pilot investigation suggest that social support is valued and increases positive health behaviors. Results also demonstrate a need for health information specific to the medical and health needs of African-American men, and the need for structured ongoing relationships with primary care providers.

Keywords: African-American men, health disparities, community, home visitation, and social support

Overall, men are less likely to graduate high school than women. African-American men (AAM) are disproportionately overrepresented in low-income jobs, which can correlate with unstable employment and low education levels (Lopez, Graham, Reardon, Reyes, Reyes & Padilla, 2012). Additionally, AAM are reported to earn 75% of what White men earn (Xanthos, Treadwell & Holden, 2010), and earnings ultimately delineate the areas in which one can afford to reside. The geographical neighborhood of residence also has an influence on the opportunities a person will be able to access. Racially segregated neighborhoods, especially those with high African-American, Hispanic, American Indian and

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Alaskan Native population rates, usually exhibit higher concentrations of poverty (James et al., 2012). Poor conditions, such as substandard housing, elevated crime rates, crowding, noise pollution, lack of community recreational activities, and constant personal safety concerns, are prevalent in these areas and discourage healthy community environments. In 2006, the homicide rate for AAM was 84.6 per 100,000 compared to 5.0 per 100,000 for White men, which is more than 46 times the rate of Whites for men ages 15–19 (Xanthos, Treadwell & Holden, 2010). Neighborhood level factors, in addition to income and educational factors, all contribute to one's socioeconomic status. Lack of opportunity, achievement gaps in education, improper police protection and surveillance, a lack of safety and recreational opportunities, and lower property values, are all factors which diminish the potential of African-American communities to grow, be empowered and flourish (Airhihenbuwa & Liburd, 2006).

Ultimately, all of the aforementioned factors influence health care access, life spans and health behaviors (U.S. Department of Health and Human Services [DHHS], 2011; Institute of Medicine [IOM], 2002; Lopez et al., 2012). Kaiser Family Foundation (KFF) reported health outcomes for men of color (MOC) in their report on Men's Health Disparities, stating that that MOC were more than twice as likely to be uninsured than White men, had gone without care due to cost over 80% more than White men had, and were 70% more likely than White men to not have an ongoing relationship with a primary health care provider (2012). With regards to the quality of healthcare received, AAM were more likely to receive lower quality health care than Whites, were more likely to receive less desirable services or treatment options (i.e., amputations), and have an overall higher mortality rate (IOM, 2002). Significant correlations have been found between uninsured status, poverty, and having or maintaining a relationship with a primary care provider (PCP). Those without medical insurance and in lower income levels were also the same group who identified as having less access to screenings, having a poorer diet, receiving poorer quality health care, and lacking appropriate health information (Thompson, Talley, Caito & Kreuter, 2009).

The accumulation of these negative factors produces a wear-and-tear effect on the minds and bodies of AAM, which has a direct effect on overall health and wellbeing. There is a growing evidence base in the research for the emotional and mental health impacts daily-encountered discrimination places on African-American men (Treadwell, Northbridge & Bethea, 2007). Research has demonstrated the linkage between low SES and poorer health. Stress has been cited as a dominant influencer of health, and is highly increased by instability of income, presence of racism, unhealthy neighborhood residence, relational conflict, and constant threats of violence (Lopez et al., 2012). AAM have the lowest life expectancy and highest mortality rate among men and women in all other racial/ethnic groups as well as shorter life expectancies and higher mortality in every age group until the age of 65, as compared to other racial groups (Airhihenbuwa & Liburd, 2012; Thompson et al., 2009; Treadwell, Northbridge & Bethea, 2007; Xanthos, Treadwell & Holden, 2010). The complexities involved with the health and wellbeing of AAM, have yet to be properly examined and thoroughly discussed by researchers in the public health field. Numerous and intricately linked factors play key roles in the health and wellbeing of AAM. Research around health outcomes and their influencing factors related to Black men and health inequalities are more crucial now than ever before. Thus, as a part of a larger study, a qualitative pilot exploration was conducted to investigate AAM's own perceptions of their paternal role, particularly throughout pregnancy, existing knowledge and attitudes regarding family planning, health care experiences, and perceptions of their neighborhoods and communities.

Methods

Setting

DRU/Mondawin Healthy Families (DRUM) began as an initiative to achieve systemic and long lasting change for Baltimore City Maryland's youngest population (ages 0–5). The collaboration of the Family League of Baltimore City and the United Way broadened DRU Healthy Families to become DRU/Mondawin Healthy Families, an organization that is centered around the goal of providing needed support and resources to pregnant women and young children of Baltimore City in order to enhance and positively influence parents, children's childhood experiences, and families overall. DRUM now stands as a non-profit designed to ensure the health and wellness of infants, with goals that include reducing adverse birth outcomes and ensuring healthy environments in the family and community that promote proper developmental growth, school readiness, and safe and nurturing homes (DRU/Mondawmin Healthy Families, Inc. [DRUM], 2013). The services provided by the home visitation program in order to achieve this goal include: safe sleeping practices, child development assessment, referrals for housing, education, employment and counseling, literacy and learning playgroups, education and activities that promote school readiness and self-empowerment, as well as parental support and skill training, and nutritional and health education. Families can be enrolled for up to five years, beginning at pregnancy until the child or children are school-ready (DRUM, 2013). Men were recruited from this organization to determine the role of men in families as sources of social and tangible support for women who are accessing services from DRUM.

Study Participant Recruitment

Subjects were recruited through a variety of methods, including flyers, word of mouth, and telephone calls. Upon initial confirmation of interest from potential participants, (n = 15) additional screening methods were utilized to recruit men who met the following criteria: African American, ages 18–35, and were residents of Baltimore City. The final group of participants were chosen based on their relationship as partners to women or fathers of children enrolled in DRUM services, as well as their residence in the Druid Heights, Upton, Reservoir Hill, Rosemont, and Mondawin communities of Baltimore City (n = 5). One focus group session was conducted with the final group of participants. Due to time constraints of the research project, additional sessions could not be conducted. The men in the focus groups were particularly open and willing to share their responses, which provided for an uncensored view into the daily lives of the participants. One participant was married. Two had completed some high school, another two had obtained their high school degree, while one had a college degree.

Qualitative Design

The pilot study's focus group was designed to be informal but semi-structured, in order to obtain the most pertinent data possible from the subjects. The principal investigator of the study facilitated the focus group session. The focus group met in a single 60-minute session located at DRUM Healthy Families community center. Participants understood their responses would in no way be linked to their personal information or influence their family's participation in DRUM and consented to audiotaping of the session. The researcher developed the focus group questions, after an examination of the literature on African-American

men's health and conversations with male staff of DRUM regarding their health related issues and community perceptions.

The questions were designed to gather information from the participants on their perceived state of medical care, such as quality and access to healthcare; family planning and practices, including male involvement in and knowledge of contraceptive decisions and birth spacing; social support systems, such as couple and family support, and community perceptions, such as perceived safety and community educational or recreational opportunities. Questions such as, "What are the greatest challenges you face living in your community?", and, "What are your thoughts on the medical care you receive?", were asked during the session. Questions were also asked to evaluate the impact of the DRUM home visitation program on the participating children and families. IRB approval was received from Morgan State University.

Data Analysis

The focus group for this pilot study, facilitated by the PI, was conducted using questions prepared a priori by the researcher, and the session was audiotaped with the permission of the participants. The recording was transcribed and salient themes were highlighted and extracted from the data in order to assess relationships and common beliefs among the participants. The emergent themes were given a code in order to facilitate data analysis and interpretation. Codes were developed on the basis of the literature as well as the focus group participants' own words. A "code" in qualitative methodology highlights "most often a word or phrase that symbolically assigns a summative, salient, essence-capturing, and/or evocative attribute for a portion of language based or visual data" (Saldaña, 2009). Ideas or patterns were identified, and the codes were used to summarize similar data and patterns in subject responses, then used to simplify the interpretation of these themes into such categories as correlates, determinants, predictors, influencing factors and/or protective factors, among others. Interpretation of qualitative data results "attach[es] meaning and significance to the analysis" (Taylor-Powell & Renner, 2003, p. 5). Data were coded to saturation, which meant that each segment of the transcribed focus group had been coded, and there were was no new meaning to be extracted from the data.

Theory and Concepts as Framework for Interpretation of Findings

Whitehead's Big Man Little Man Complex (1986) and Social Capital Theory were utilized to interpret the findings presented by this current study. The Big Man Little Man Complex was developed throughout an exploration of masculine concepts and attitudes among Caribbean men in the 1970s. Male masculinity was conceptualized by measures of strength, or "big-ness", using terms such as "big", "strong" and "respectable" to identify high status and power, whereas "little" and "weak" identified low status and power. These attributes denoted a man's ability to provide and protect, as well as social standing and education or authority. The same were also used as a means distinguishing the male's capability to woo or attract women, his "sexual prowess", and his ability to father several children (Whitehead, 1986). These values were found to have parallels amongst AAM in urban areas of the United States (Whitehead, 1997) and suggests that men in these populations with a deteriorated sense of their masculinity as defined by these attributes, would also experience feelings of insecurity as well as less actual or perceived power to improve or change their standing, circumstances, including those of their families (Aronson, Whitehead & Baber, 2003). This can

be translated to the experiences and feelings of AAM surrounding their perceived ability and power to participate in and actively improve their health and that of their families. Studies have found that AAM value and are interested in health education (Ravenwell, Johnson & Whitaker, 2006), particularly that which is specific to African-American or men's population health (Plowden Vasquez & Kimani, 2006), however, are lacking in their ability to access this type of information (Thomspon et al., 2009).

Social capital is defined by Nahapiet and Ghoshal as "the sum of the actual and potential resources embedded within, available through, and derived from the network of relationships possessed by an individual or social unit. Social capital thus comprises both the network and the assets that may be mobilized through that network" (1998, p. 243). This concept takes into account the extent of social cohesion in the community, which includes the trust and reciprocity within that network, and has also been defined as a term used in social policy, sociology and political science to describe the bonds or "glue" that bring people together in society, particularly in the context of cultural diversity (Forsyth, 2010). Social Capital Theory has a basis of a community in which positive relationships thrive and people feel more connected to one another, healthy behaviors (i.e., outdoor physical activity) are better able to be encouraged, and negative behaviors (i.e., illegal or destructive behavior) are less tolerated (Häuberer, 2011, p. 149). The current study used these theories and associated concepts to assess the potential influence that familial support, spousal support, and community cohesion had on AAM in the sample, and the extent of those relationships' influence on seeking health care.

RESULTS

The data analysis of the pilot study's focus group responses throughout coding processes resulted in five core emergent themes that surround AAM health disparities and health care experiences, all of which the participants identified as relevant, pressing, and paramount for themselves and their families. These emergent themes included access to medical care and health care experiences, attitudes and knowledge around family planning, perceptions of their residential community environments, attitudes and perceptions about law enforcement and police, and lastly, attitudes and perceptions related to social capital. Each of these themes are discussed in further detail in the following section (see Table 1).

Access to Medical Care and Health Care Experience

To assess the quality and access to medical experienced by AAM, the study participants were asked, "Where do you receive your medical care?" "What are your thoughts on the medical care you receive?" The men reported that they were often satisfied with the medical care they received. Most utilized public health care systems or state funded programs, such as Health Care for the Homeless, Medical Assistance, or clinics that provided services on a sliding scale, which allow for flexible payments based on the patient's income. A small portion of respondents received medical care through their employer. Additionally, the men reported irregularity in utilization of medical care. One respondent admitted, "I usually just go when I feel like I need to go"; others agreed. The group also reported only wanting to go when feeling it was necessary, and no regularity or relationship with a primary care provider, which is consistent with previous findings in the literature (Airhihenbuwa & Liburd, 2012; James et al., 2012; Xanthos, Treadwell & Holden, 2010). However, through-

Table 1
Description of Codes Analyzed

Code Name	Description	Domain
Community Perception	Social environment; feeling safe in the neighborhood, cohesiveness within community members, trust and friendliness of neighbors, dangerous, not safe for children, gang violence and drug trafficking, little opportunity for community or family activities.	Social, physical, environmental, psychosocial
"The City Mentality"	Mentality amongst city people; beliefs, social norms, self-centered mentality, belief that one must be rough and cannot attain anything good, perception of toughness, perception about opportunity for people in 'the hood', value of respect amongst peers and within community, dangerous streets.	Emotional, mental, psychosocial
Education	Level of education of men, quality of education (schools, programs) in the area, sense of safety and effective learning within educational institutions of the area. Bullying.	Environmental, social
Corrupt Law Enforcement	Mention of police and corruption within discussions. Profiling, false accusations of loitering, especially in high drug trafficking areas, in order to meet quotas or make bonuses, and many cannot defend themselves because of uncertainties and lack of knowledge of their legal rights. Searching without a warrant or reasonable suspicion. On duty police officers under the influence. Defend and protect each other, even called the "biggest gang in Baltimore" amongst community members. Other illegal activity.	Environmental, social
Lack of Community Development funding	Relocation of "projects" residents to area with no/little resources. Community centers and playgrounds vandalized or closed. Not conducive to healthy play for children and adolescents. Presence of drug and gang activity.	Physical environment, pyschosocial
Familial Interactions	Healthy family interactions, communication.	Pyschosocial, emotional, mental
Health Care Experiences	Most participants reported going only when necessary, rather than regularly for scheduled check-ups. Generally average experience with health care providers. Discussion whether good experiences facilitate more regularity and attention to patient's own health, as opposed to negative experiences likely to make a patient more reluctant to visit again in the future.	Public health, infrastructure of health care system, psychosocial
Health Insurance	Assessed experience with health insurance, utilization of state health care programs (State health insurance, "Medical Assistance", Healthcare for the Homeless, i.e.) and accessibility of services through employer-provided insurance.	Public health, health care system

Table 1 continued on page 74

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Family Planning	Assessed perceived men's roles in family planning, knowledge of family planning options and role in decision making within the couple, focus on financial component of raising children and choosing between methods, Differences in desires for more children between wife/husband make conversation difficult; even cause men to shy away; compromising. Past pregnancy complications.	Public health, physical
Prenatal Support	Assessed perceived men's roles in support and presence throughout prenatal process, as an encourager and motivator. Fathers made it a point to be a part of the process, even if unsure how to help, or separated from mother. Demonstrated physical and emotional benefits from father involvement, to mother-baby and mother-father relationships.	Psychosocial

out the focus group session, more of the respondents stated a desire to begin to make appointments with a primary health care provider more regularly.

Family Planning

When asked about family planning practices, the men expressed confusion and doubt as to the actual definition and significance of family planning. The men were often unaware of their role in the process and the contraception options that were available to them and their partner. One participant admitted, "I try to shy away from it", when asked about communication with his partner concerning family planning options. This highlighted the need to educate and inform AAM about family planning options and importance of those decisions within the family unit for their overall wellbeing.

When asked about the sessions with the family support worker from the home visitation program, participants reported often not joining, unless they were invited exclusively, assuming, "I thought it was just, you know, for her [the mother] and the baby." This statement powerfully unveils an ideology that family planning, as well as the decisions and knowledge surrounding it, were within the realm of the mother or female partner and outside of the men's control. On the other hand, an understanding was heavily reiterated amongst the participants surrounding their role in supporting the mother in these issues, even if not directly influencing family planning choices. DRUM family support workers often extended family planning advice and awareness of options, as per the subjects' report. The men, although unfamiliar in some aspects of the process and options within family planning decisions, understood the importance of supporting their partner throughout the prenatal period. "She did it on her own, but I made a point to be a part of it," one participant said.

Community Perceptions

"There's not much that's too good". 100% of the men in the study reported extensively negative perceptions of the safety and other factors surrounding their community environment. Gangs, violence, drugs, and lack of recreational space were factors that were negatively at-

tributed to their neighborhoods. One concerned participant shared, "that's the hardest part, right now, of raising my kids … is tryna keep my son and daughter out of a gang … they starting young." Keeping children out of the grips of gang memberships and other negative social influences was shown as a burden on parents, making raising children in these neighborhoods a struggle. "The city mentality", as used exclusively in the context of this article, refers to a set of beliefs and social norms of inner city dwellers, furthered by lack of deep connections with others and isolation as a means of portraying "toughness". "When you grow up in the hood, it's kinda like … you got that mindset where you can't be good. You gotta be bad. You gotta grow up rough," one of the participants related. There was a great concern for the young men in the community, "they [think they] gotta be a knucklehead, or they gonna come off soft." The lack of funding for activities or programs in the community, alongside such factors as few positive role models who promote educational advancement, has been shown to have detrimental effects on the community (Ravenwell, Johnson & Whitaker, 2006), visible to all. "Half the playgrounds have drug paraphernalia all over them … broken bottles and condoms and everything else," shared one participant.

Perception on Law Enforcement

Personal safety and the safety of the children in the area were important factors that the participants felt were infringed on in their neighborhoods. The walkability of a neighborhood and the feeling of safety and security brought forth by the physical environment are key factors in promoting a community's cohesiveness. These factors are largely impacted by law enforcement and the perceived degree of protection and security as a result of their presence. When officers are present and perceived to be working diligently to ensure the people's and community's betterment, people may be more likely to feel safe and engage in communal interaction more freely. However, if the presence of police is deemed a threat to the members of the community for any reason, this can produce a damaging effect on a community's social environment, as experienced by the target population. All of the study participants felt that their personal space was infringed upon by police, and were victims of racial profiling by officers in their community.

"The police are the biggest gang in Baltimore." One of the members of the focus group shared his experience, saying, "Or you sitting on your front step.… They call it 'loitering.'… Anything they can give you [a charge]". Others shared the same sentiments towards the police activity in the community adding, "they do anything to you.… They take a man in the alley, put the glove on, cavity searching, everything," as though, "they above the law." Police officers were said to have protective measures for each other covering for inappropriate conduct, and strong or aggressive measures towards community members, especially AAM.

Social Capital

Participants demonstrated a desire to see community cohesiveness. The isolation and lack of social capital was evident in reports regarding interactions with neighbors and amongst other members of the community. Comments from study participants such as, "Everybody … they just walk past you, don't speak to you," and, "a lotta people out here, they selfish, man. They all look out for themselves," demonstrate mistrust and isolation as underlying issues of the community. Another participant commented, "Community doesn't stick together." This statement speaks to participants' personal safety concerns, family security

concerns, and a general sense of worry about security about possessions (robbery, vandalism, etc.). Finally, another participant stated "One of the challenges of living in Baltimore is staying alive." This statement is a summation of the frustration, concerns, and general perceptions of their neighborhood as experienced by the men in the study.

DISCUSSION

Access to Medical Care and Family Planning

Most of the participants in the pilot study utilized public health care systems or state funded health programs, with only a small portion of respondents receiving medical care coverage through their employer. The men in the pilot study reported irregularity in checkups, and only went when they felt it was necessary. Additionally, they reported a generally average experience with their primary care provider (PCP). Communication between the PCP and AAM may often not be specific, and this communication does not seem to effectively bring forth or address the needs of this population. The lack of effective and meaningful communication between AAM and PCPs may be due to a plethora of underlying factors, including mistrust, difference in racial makeup of patient and care provider, and general vagueness in explaining experiences related to health.

The primary concerns of AAM in this study were financial in nature, and were specifically related to the costs associated with raising a child. Other issues related to family planning, such as contraceptive choice, were ideals that the men intended to allow the mother to make, generally supporting her choice, largely founded in a desire to ensure her comfort and contentment. Differing sentiments, specifically related to birth spacing and the desire for more children, often made conversations surrounding family planning difficult between partners. It may be that fathers who seek to maintain peace in the home, and avoid confrontation or contention, will avoid discussion on family planning, especially in circumstances in which goals or ideas around having children and contraceptive methods differ. The primary emotional awareness around family planning was centered on an understanding of a paternal responsibility to support the mother and child throughout the prenatal process.

Community Perceptions and Police Brutality

Fear for the safety and wellbeing of their children, exposure to violence, drugs and drug trafficking, as well as lack of positive spaces for recreation and convention were strong themes that resonated in the community, which led the men in the study to report negative attitudes about their neighborhoods. "The city mentality" was recognized as a prevailing factor, especially in the lives of young men, as a barrier to positive achievement in academics and the professional aspects of their life. The desire to hold a position of authority in the community, particularly in the eyes of those who were in and related to circles of drugs and violence, was important to young men. The intentional deviation from the opposite, a reputation of "softness", or in Whitehead's terminology, a lack of "bigness", was a strong motivator for men in the community. Positive role models promoting education and strong sense of commitment and empowerment of family and community were deemed needed and lacking.

All of the men in the study held negative attitudes and perceptions about law enforcement in their community. Dangers associated with being African American, and a target for law

enforcement and aggressive corrective measures by police, were a constant stressor for many of the men in the study. Law enforcement, rather than having connotations to peacekeeping and defense of the public rights, had ties to violence, drug-related activity, and often abuse of authoritative power and unnecessary measures of correction towards members of the community. Police also were said by the sample to have protective measures for each other, which prevents correction and accountability by the law enforcement system to amend the aggressive measures taken against community members. The lack of social capital and cohesion in the community were evident in the responses of the participants and permeated their perceptions of their neighborhood environment.

Conclusions

The results of this pilot exploration, although not fully conclusive or generalizable beyond the target demographic, elucidate and support the findings in current literature on the topic of health disparities in African-American men (AAM). The need for equalized access by utilizing cultural competency in all areas of the arena of health care was expounded by the words and language of the participants. This includes access to services and insurance, as having insurance has been correlated to increased use and affordability of healthcare services, especially as experienced by AAM (IOM, 2002). Secondly, efforts to diversify the health care workforce racially and ethnically are warranted, as patients are more likely to receive medical advice well from a health care provider of a similar race or ethnicity as their own and report satisfactory experiences with their use (James et al., 2012). Active efforts to improve the patient-health care provider relationship can produce better outcomes for the patient and a more effective relationship for both parties (Airhihenbuwa & Liburd, 2012).

Stress from lack of income or difficulties in occupational environment, racism, relational conflict and "unhealthy neighborhoods" (Ravenwell, Johnson & Whitaker, 2006) all pose threats to the health of AAM. Social support, feeling valued and appreciated by loved ones (Griffith, Ellis & Allen, 2012) has been shown to influence the health of AAM in a positive manner. Healthy behavior changes or education alone, without discussing or including the environmental, economic and social contexts in which these behavior changes occur, cannot foster the long lasting improvement in overall wellness for the target population. Social support, hand in hand with increased accessibility to health information that is appropriate and culturally relevant were welcomed and deemed crucial by participants in the sample in efforts to reduce health disparities and improve overall wellness, and these findings contribute and complement previous literature (Royster, Richmond, Eng & Margolis, 2006; Seth, Murray, Braxton & DiClemente, 2013).

The present pilot study, although meaningful to scientific literature, is not without limitations. The sample size, although small, represents a spectrum of AAM within the urban context of a city such as Baltimore. Due to the study's urban context, the results may not be generalizable to AAM in other settings. Also of note is that the men in the study were recruited utilizing a convenience sample, as the male partners of women utilizing home visitation services. Other men who are not romantically linked to women in home visitation programs may present different perspectives on AAM in an urban context. Future research in the area of men as sources of social support in family planning and pregnancy roles is warranted, as highlighted in the results section. Future studies utilizing larger sample sizes and randomized sampling strategies would certainly contribute to the growing literature base around the social determinants of health in AAM.

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