

## **Improving the Health Status of African American Men: Facts, Factors, and Solutions**

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### **ABSTRACT**

*Health disparities among African American males are well documented in the research for well over the past one hundred years. This article addresses the adverse physical and mental health outcomes of African American men by exploring the system of factors that impact the health of this population, the theoretical framework that can be used to guide interventions, and possible solutions for improving health status.*

**Key words:** African American males, Health disparities, Improving health status

## Introduction

Disparities in the health status between African Americans and White Americans are large, pervasive, and persistent over time (Borrell, Kiefe, Williams, Diez-Roux, & Gordon-Larsen, 2006). These differences have been documented through robust findings for over 150 years (Williams, Yu, Jackson, & Anderson, 1997). Reducing health disparities is one goal of *Healthy People 2010*, a program of the National Institutes of Health (NIH), intended to improve public health in the United States (Centers for Disease Control, 2010).

African Americans generally have higher rates of death, disease, and disability than Whites (Wade, 2008; Williams et al., 1997). Analyses of disparities in health outcomes by race and gender are even more alarming. On average, African American men die 6.4 years younger than White American men (Wade, 2008). African American men outnumber African American women at birth but by the time African Americans reach the 15-24 year age group, women outnumber men (Baker & Bell, 1999). African American men generally experience more severe disease, earlier onset of disease, and higher rates of complications than their White counterparts (Wade, 2008). Development of disease and death due to disease in African American men are often preventable and treatable by primary care intervention (Ravenell et al., 2006). However, African American men claim the highest age-adjusted all-cause mortality rate of any race-sex group in the United States (Ravenell, Johnson & Whitaker, 2006). Most of these deaths are linked to cardiovascular disease, cerebrovascular disease, diabetes, HIV, and cancer (Ravenell et al., 2006). Young African American males have the fastest growing suicide rate in the country (Institute of Medicine 2002) and are the top victims and perpetrators of homicide (Bureau of Justice Statistics 2005).

A comprehensive review of the physical and mental health status of African American men must first consider the history of Africans in America. This population is socially and historically unique due to centuries of enslavement followed by systematic oppression, and discrimination at political, institutional, and individual levels. Some effects of these practices endured by African Americans include lack of opportunities and access to quality resources, inferior social and economic standing, substandard education, and unequal government and public policies. Racial disparities in physical health status parallel differences in mental health status. African American men, especially, have increased risk factors for adverse mental health outcomes (Snowden, 2001).

This article addresses the adverse physical and mental health outcomes of African American men by exploring the system of factors that impact the physical and mental health of this population, the theoretical framework that can be used to guide interventions, and possible solutions for improving health status.

## Historical Context & Demographics Snapshot

Historically, research on racial differences in health was focused on the idea that blacks and whites were biologically distinct groups and observed disparities were attributed to biological differences between the races (Williams et al., 1997). Much of this research was overtly racist and conducted to provide a scientific basis for policies of racial inequality (Williams et al., 1997). Some crude explanations based on claims of genetic differences persist despite a lack of concrete evidence and more than 100 years of research exposing the limitations of underlying assumptions (Nazroo, 2003).

Before 1900, most African Americans lived in southern regions of the United States but many migrated to the West and Midwestern states in the 1920s and 1930s (Baker & Bell, 1999). According to the 2010 U.S. Census, there are approximately 42 million African Americans living in the United States. The majority of African Americans (55 percent) still live in the South and the highest concentrations of African Americans are in metropolitan areas; only 13 percent of African Americans live in nonmetropolitan areas (U.S. Census, 2010). African Americans account for 50% of the population in high poverty urban areas

nationally and between 80% and 90% of residents in some of the largest urban ghettos, such as in Detroit and Chicago (Geronimus, 2000). According to the 2010 American Community Survey conducted by the U.S. Census Bureau, 68 percent of African American children are raised by single mothers, compared to a national average of 36 percent. Single motherhood is a strong predictor of poverty – nationally, single mother headed households represent 46.5 percent of those in poverty (U.S. Census, 2010).

### **Factors Contributing to Health Outcomes in African American Men**

This paper focuses on the health of African American males in urban settings, where the majorities reside. Many factors affect health - some are universal, some impact most African Americans, and others are relevant especially for African American men. Racism and discrimination have been argued to have the most pronounced impact at the level of societal institutions by shaping socioeconomic opportunities, mobility, and life chances of minority groups (Williams et al., 1997). To this effect, racism and discrimination inherently influence most of the factors presented that contribute to the health status of African American men. Specifically, the variables discussed in this paper are socioeconomic status (education, employment, and income); health care (access, distrust, and mistreatment); and social and environmental influences (residential segregation, living conditions, and cultural norms).

### **Socioeconomic Status**

Socioeconomic status (SES) is commonly conceptualized as the social standing of an individual, class, or group. SES is one of the strongest known predictors of health variations whether measured by income, education, or occupation (Williams, 2003; Williams & Jackson, 2005). Americans with low SES suffer levels of illness during their thirties and forties not seen in groups with higher SES until 30 years later (Williams & Jackson, 2005). Death rates attributable to heart disease are two to three times higher among individuals with lower SES than among their middle-class counterparts (Williams & Jackson, 2005). Changes in health behaviors such as dietary behavior, physical activity, tobacco use, and alcohol abuse over time are patterned by social status - individuals with low SES and disadvantaged racial groups are less likely to reduce high-risk behavior or initiate new health-enhancing behaviors (Williams & Jackson, 2005). Research has shown that race and ethnicity in terms of hierarchy often determine SES (Harris & Williams, 2000). Men have elevated health risks at every level of SES but low-SES men are especially vulnerable (Williams, 2003).

#### *Education*

Education statistics reflect the disproportionate number of African American men affected by negative health outcomes. The number of years of education completed has a significant effect on mortality due to all causes, chronic diseases, unintentional injuries, HIV, and all other communicable diseases (Williams, 2003). African American males generally have a lower number of years of education than African American females and White males and females (National Center for Education Statistics, 2008). The national high school graduation rate for White males is 78 percent versus 47 percent for black males, with an additional 12 percent graduating late and 5.8 percent getting a GED (National Center for Education Statistics, 2008). African American males also have lower national college graduation rates (33.1 percent) compared to African American women (44.8 percent), White males (54.5 percent), Hispanic men (41.1 percent), Native Americans and Alaska Natives (33.8 percent), and Asian/Pacific Islanders (60.6 percent) (National Center for Education Statistics, 2008).

Research supports that the relative underachievement of African American males is not an indicator of lower intelligence; rather it is a byproduct of institutional and cultural norms and expectations. A considerable amount of evidence has shown that ethnic and socioeconomic backgrounds of students

influence how students are perceived and treated by adults who work with them in schools (Noguera, 2003). African American males more likely to be labeled as mentally retarded and placed in special education or remedial classes even while they are still very young (Noguera, 2003). African American males are more likely to be labeled as having behavioral problems (Noguera, 2003). African American males are also more likely to be punished severely, even for minor offenses, and often without regard for their welfare (Noguera, 2003). There is a greater likelihood that African American males will be excluded from rigorous classes and prevented from accessing educational opportunities that could support and encourage them (Noguera, 2003). Such practices may be unintentional but are none-the-less discouraging academically for young African American males while participation in athletics is routinely supported and lauded, sending a message that excelling in sports is more acceptable and appreciated. Evidence shows that many African American males view sports and music as more promising routes to upward mobility than education (Noguera, 2003).

#### *Employment/Occupation*

Differences in education are inextricably linked to chasms in employment. Over the last 50 years, African American men have experienced an unemployment rate twice as high as that of White men and unemployment rates tend to rise more for African American men and Hispanic men during economic recessions (Williams, 2003). Poor African American and Hispanic men are also disproportionately employed in jobs with higher rates of layoffs and lower rates of reemployment after job termination (Williams, 2003).

Unemployment alone does not contribute to the lower SES status of many African American men. Many employed African American men work the poverty-level and low-wage jobs that have grown in number in recent years (Williams, 2003). Statistics show that desirable employment opportunities are differentially distributed by race. High percentages of White and Asian men work in managerial and professional occupations, while African American, Hispanic, and American Indian men are overrepresented in lower skilled and lower paid occupations (Williams, 2003). African American men have higher exposures to toxic substances in living and work environments; and are at a higher risk of occupationally induced diseases, injuries, and death (Airihenbuwa & Liburd, 2006).

Research has demonstrated that unemployment and job insecurity are associated with increased rates of stress, illness, disability, and mortality (Williams, 2003). Specific work conditions are also more likely to lead to poor health- the combination of high job demands with little control over them and the combination of high levels of effort with low levels of reward (Williams, 2003). Jobs in which lower SES men and minority men are concentrated are characterized by low levels of income and power but high levels of stress (high demands and effort with low control and rewards) (Williams, 2003). Stressors and negative emotional states created by these working conditions can lead to health behaviors including impaired sleeping patterns, decreased physical activity, increased substance use, and the consumption of more food than usual, all of which increase risk for chronic disease (Williams, 2003).

#### *Income*

The increasing polarization of income and wealth in the United States has arrested much of the past economic gains of African Americans relative to whites, exacerbating determinant effects of race on SES (Williams et al., 1997). Poverty rates for blacks overwhelmingly surpass the national average. In 2010, 27.4 percent of blacks lived in poverty, compared to the national average of 15.1 percent and an average of 9.9 percent of non-Hispanic whites (National Poverty Center). About 10 percent of all men lived below the poverty line in 2001, but the rate for Black men (20 percent) was nearly three times the rate for non-Hispanic White men (7 percent) (U.S. Census, 2001). African American men working full time earn 72 percent of the average earnings of White men and 85 percent of the earnings of White women (Rodgers,

2008). Minority men earn less than Whites at every level of education and when looking at differences between African Americans and Whites, differences are larger for men than for women (Williams, 2003).

Despite the pronounced effect that SES has been shown to have on health, many studies reveal persistent racial differences in health when controlling for SES, suggesting other factors also account for health disparities (Borrell et al., 2006).

### **Health Care**

Racial and gender disparities in health have been argued by some to be due to the smaller proportions of African American men receiving primary and preventative health care (Ravenell et al., 2006). African American men are less likely to visit primary care physicians and less likely to have any contact with a physician than other groups (Ravenell et al., 2006). Factors such as access, distrust of the health care system and health care practices contribute to the low number of African American men that routinely see a physician.

#### *Access*

African American and Hispanic men are the least likely to be insured of all racial and ethnic categories (Satcher, 2003). Reasons for the high rate of uninsured include high rates of unemployment and lack of coverage offered to small business employees, part-time employees and lower-skilled workers (Satcher, 2003). Individuals without health insurance often postpone seeking medical care and encounter greater difficulty when trying to access health care (Cheatham, Barksdale & Rodgers, 2008). A survey conducted by Kimbro, Gordon, and Morrison among 200 African American men with low or no incomes found that these men accessed health care services in three ways: (1) via military service, (2) in prison, or (3) in emergency rooms (Smith, 2003). However, even among insured African American men, underutilization of primary care services remains a problem (Ravenell et al., 2006). A recent study found that African Americans were significantly less likely to have received healthcare in doctors' offices and outpatient settings compared to non-African Americans, even after controlling for insurance status, age, education, household income and residence, concluding that other factors significantly influence use of health care (Ravenell et al., 2006).

#### *Distrust*

Racism and distrust have been among the most often cited impediments to health care and health-seeking behavior among African American men (Cheatham et al., 2008). Medical distrust is associated with underutilization of health services and is higher among African American men (Brandon, Isaac, & LaVeist (2005). African Americans' medical distrust is linked to perceived racism, past and present racist and discriminatory practices, and medical malice traced from slave plantations to modern-day health care facilities (Brandon et al., 2005; Cheatham et al., 2008).

Of these incidents, the Tuskegee Study of Untreated Syphilis in the Negro Male (1932-1972) in which hundreds of African American men infected with syphilis were intentionally denied treatment, remains the most commonly attributed source of African American's medical distrust (Gamble, 1997). Health education researchers Dr Stephen B. Thomas and Dr Sandra Crouse Quinn have extensively studied and written on the impact of the Tuskegee Syphilis Study on participation in HIV/AIDS prevention and treatment programs (Thomas & Quinn, 1991). They have concluded that "the legacy of this experiment, with its failure to educate the study participants and treat them adequately, laid the foundation for today's pervasive sense of distrust of public health authorities" (Thomas & Quinn, 1991).

A study conducted by Brandon, Isaac, and LaVeist (2005) to examine the relationship between the Tuskegee study and present day medical distrust found that African Americans were more likely than Whites to be more distrustful of the medical establishment and more likely to believe that a study similar to

Tuskegee could happen again. Other researchers have had similar findings. One study found that African Americans were less likely than Whites to trust their physicians and more likely than Whites to admit they were fearful of being experimented on while in the hospital (Cheatham et al., 2008). Yet another study found that African Americans were more likely than White people to believe the government created AIDS to kill Black people and more likely to believe that information was being withheld from the public about HIV (Cheatham et al., 2008). As Gamble (1997) noted, African American's medical distrust and fears of exploitation can be traced to the antebellum period and the use of slaves and free Blacks for medical experimentation and dissection. While African Americans' medical distrust may be rooted in past transgressions, current medical practices still show inequities in treatment.

#### *Mistreatment*

The Institute of Medicine (IOM) report *Unequal Treatment* found that, "racial and ethnic minorities tend to receive a lower quality of health care than non-minorities, even when access-related factors such as patient's insurance status and income are controlled" (Smith, 2003). The report revealed systematic and pervasive racial differences in quality of care spanning a broad range of medical conditions (Williams & Jackson, 2005). Unequal treatment is in part attributed to stereotyping, biases, and uncertainty of health care providers (Smith, 2003). Medical treatment rates buttress report findings. African American assault victims are less likely than White assault victims to receive timely emergency transportation and subsequent quality medical care (Williams & Jackson, 2005). African Americans also receive poorer quality emergency room care (Williams & Jackson, 2005). The Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care reviewed over 100 studies that assessed racial and ethnic variation in a range of clinical procedures and controlled for potentially confounding variables, such as racial and ethnic differences in disease severity, stage of illness progression, patient preferences for treatment, types of setting where care is received, availability of procedures, suitability of intervention, and refusal rates (Smedley, Stith, & Nelson, 2003). Analyses found racial and ethnic differences in cardiovascular care, treatments of cancer, cerebrovascular disease, HIV/AIDS, asthma, renal transplantation, the use of analgesia, maternal and child health care, children's health services, mental health services, and other hospital-based services (Smedley et al., 2003).

#### **Social and Environmental Influences**

Social influences and social environment play key roles in health outcomes. The social environment in which individuals reside can have direct and indirect effects on health and health behaviors. The urban environment of many African American men innately has many deleterious influences on health including residential segregation and the related poor living conditions and cultural norms.

#### *Residential Segregation*

Residential segregation is one mechanism through which social environment can facilitate adverse health outcomes. Residential segregation is the long-standing tradition in which urban and suburban residential neighborhoods are segregated by race (Airhihenbuwa & Liburd, 2006). Neighborhoods with majority African American inhabitants typically have lower property values and higher poverty rates (Airhihenbuwa & Liburd, 2006). Middle-class African Americans live in poorer areas than Whites of similar economic status and poor Whites live in much better neighborhoods than poor African Americans (Williams & Jackson, 2005). Out of the 171 largest U.S. cities, there is not one in which Whites lives in socioeconomic conditions that are comparable to those of Blacks (Williams & Jackson, 2005). Other racial and ethnic groups experience less segregation than African Americans (Williams & Jackson, 2005). Residential segregation is inversely related to income for Latinos and Asians but remains high for African Americans at all levels of income (Williams & Jackson, 2005).



One way residential segregation directly affects health and health behaviors is through the availability of resources. African American communities have more fast-food restaurants and vendors of alcoholic beverages per capita than in White communities (Airhihenbuwa & Liburd, 2006). Both the alcohol and tobacco industries aggressively market products to poor minority communities, exacerbating residents' use (Williams & Jackson, 2005). Many of these neighborhoods lack major grocery chains, farmers' markets, and whole food markets, meaning fewer affordable sources of fresh fruits and vegetables (Airhihenbuwa & Liburd, 2006). The availability of nutritious foods is positively associated with consumption (Williams & Jackson, 2005). Simply put, residents in areas where nutritious foods are not readily available will naturally consume less of them. Also, the perception of neighborhood safety is positively correlated with physical exercise, an association that is larger for minority groups than for Whites (Williams & Jackson, 2005). Lower income and minority communities differ in the existence and quality of recreational facilities and open, green spaces (Williams & Jackson, 2005). Lack of these facilities reduces the opportunities for physical activity.

For many people, neighborhoods are a determinant of access to education and employment opportunities, of which the health effects were previously discussed. Property taxes are the primary source of revenue for school systems; hence, lower property values in segregated areas mean lower property taxes and less money for schools (Airhihenbuwa & Liburd, 2006). Some scholars posit that the degree of residential segregation is a code conveying the quality of public schools; the quality of, and access to, services, such as shopping, health care, property values, and investments of local government in making a "livable community"; and police surveillance and protection (Airhihenbuwa & Liburd, 2006). Greater segregation rates are associated with higher rates of poverty and dropout for African Americans, but lower White poverty rates (Hart, Kunitz, Sell, & Mukamel, 1998). Segregated schools have lower average test scores, less qualified teachers, more limited curricula, less access to serious academic counseling, fewer students in advanced placement courses, fewer connections with colleges and employers, more deteriorated buildings, and higher rates of teens pregnancy and dropouts compared to schools in middle-class areas (Williams & Collins, 2001).

The restricted access to education and employment opportunities, creates areas with high rates of concentrated poverty and small pools of employable and stably employed males (Williams & Jackson, 2005). In recent decades low-skilled, high-paying jobs have moved from many of the urban areas where African Americans reside to suburban areas on a massive scale (Williams & Collins, 2001). As a result, many African Americans live in areas where they can no longer access high-paying entry level jobs (Williams & Collins, 2001). Some companies explicitly rely on racial composition of areas to assist decision-making processes concerning placement of new facilities and relocating existing ones (Williams & Collins, 2001). A direct result of commercial business avoiding segregated urban areas is a lack of available services, poor quality of available services, and high prices (Williams & Collins, 2001). Generally, African Americans pay higher costs than Whites for housing, food, insurance, and other services, despite earning less money (Williams & Collins, 2001). The effects of residential segregation are so profound that Cutler et al. concluded eliminating residential segregation would lead to less Black-White differences in earnings, high school graduation rates, and reduce racial differences in single motherhood by two-thirds (Williams & Collins, 2001; Cutler & Glaeser, 1997).

Some scientists argue living in impoverished conditions alone is enough to result in elevated stress and detrimental behaviors. Neighborhoods with higher concentrations of poor people tend to have high rates of crime, unemployment, homelessness, and substance abuse (Chow, Jaffee, & Snowden, 2003). Jackson, Knight, and Rafferty (2010) posit that when chronically confronted with stressful situations in daily life, such as poverty, crime, and poor housing, individuals may engage in unhealthy behaviors (smoking, alcohol

use and abuse, drug use, and overeating, especially comfort foods) to help ameliorate resulting symptoms of stress. These behaviors that provide ephemeral relief of stress ultimately contribute to physical health morbidities, chronic physical disorders, and early mortality (Jackson et al., 2010).

This environment also associated with risk-taking behaviors such as drug use and distribution, participation in crime, and gang activity. Epidemiologists and psychologists have identified several risk factors within the social environment that when combined, are hypothesized to have a multiplier effect on risk behavior: lack of access to health care, adequate nutrition, decent housing, growing up poor and in a single-parent household, being exposed to substance abuse at a young age, educational attainment of parent, and living in a crime-ridden neighborhood are among the most often cited (Noguera, 2003). Single-parent households have also been associated with lower levels of social control and supervision of young males, which can lead to elevated rates of violent behavior (Williams & Jackson, 2005).

### *Cultural Norms*

Cultural norms and roles often dictate expectations and influence behavior, especially regarding ideals of masculinity. Wade (2008) defined masculinity ideology as “beliefs about the importance of men adhering to culturally defined standards of male behavior.” Men who differ culturally may construct different masculinity ideologies. Traditional masculinity is comprised of characteristics such as competitiveness, homophobia, restricted emotionality, physical and sexual violence, and restricted affectionate behavior between men (Wade, 2008). A growing body of research has identified traditional masculinity ideology as a barrier to health-seeking behaviors (Cheatham et al., 2008).

Courtenay (1998) examined the influences of masculinity ideology on the health risks of young men (Wade, 2008). Courtenay’s research has been the only published study examining the relationship between health behaviors and masculinity that included a sample of African American men (Wade, 2008). In this study, traditional masculinity ideology emerged as the strongest predictor of risk-taking behavioral style after a variety of psychosocial factors were controlled (Wade, 2008). Other factors associated with traditional masculinity ideology were lower educational level, lower family income, and African American ethnicity (Wade, 2008). In a study on health care behavior and compliance, Rose, Kim, Dennison, and Hill (2000) found that African American men felt compelled to preserve an image and did not want to be perceived as weak by admitting to the possibility of illness (Cheatham et al., 2008; Wade, 2008). For men of color, who are often marginalized and not allowed mainstream ways to enact male gender roles, risk-taking behavior (drug use and distribution, crime, and gang activity) provides a way that men can assert themselves as men (Wade, 2008). The belief that African Americans who work hard will never reap benefits equivalent to Whites can also contribute to self-defeating behaviors (Noguera, 2003).

Some risk-taking and self-defeating behaviors can directly impact health through health behaviors while others indirectly affect health as a result of criminality. Repercussions of criminal activities such as drug use, drug sells, crime, and gang activity can be extremely detrimental for African American males. A grossly disproportionate number of African American males are incarcerated. Crime rates may account for as much 80 percent of the disparity in incarceration but the large residual suggests African Americans are punitively policed, prosecuted, and sentenced (Pettit & Western, 2004). The exit and re-entry of inmates is geographically concentrated in the poorest, minority communities (Roberts, 2004). Incarceration is closely associated with low wages, unemployment, family instability, and recidivism; all of which can adversely affect health outcomes (Pettit & Western, 2004).

The range of factors that have been presented all impact the health of African American men; sometimes singularly but often one or more of these factors interact. Therefore, improving health status would require a multi-faceted theory and intervention. The next section will discuss theoretical framework that can be used to guide health promotions, programs, and interventions.



## Theories of Change

Many theories are currently used to guide health treatment and promotion (Glanz, Rimer, & Viswanath, 2008). The Health Belief Model (HBM), developed in the early 1950s, is one of the most cited conceptual frameworks in health behavior research, used to explain change and maintenance of new behaviors and as a model for designing interventions (Glanz, et al., 2008; Janz & Becker, 1984). The HBM posits that health related behavior depends mainly upon two variables: (1) the motivation to avoid illness (or get well, if ill) and (2) the belief that a specific action will prevent (or improve) illness (Janz & Becker, 1984). More specifically, factors that influence these variables are currently conceptualized among six dimensions (Glanz, et al., 2008; Janz & Becker, 1984).

The first dimension of the HBM is *perceived susceptibility*. This dimension refers to an individual's subjective perception of the likelihood of developing or contracting an illness (Janz & Becker, 1984). Perceived susceptibility includes belief in a diagnosis as well as overall susceptibility (Janz & Becker, 1984). The second dimension is *perceived severity*. Perceived severity refers to assessments of the seriousness of a condition, including medical and social consequences (Glanz, Rimer, & Viswanath, 2008; Janz & Becker, 1984). Medical consequences include pain, disability, and death (Janz & Becker, 1984). Social consequences include effects on work, family life, and social relations (Janz & Becker, 1984). The third dimension of the HBM is *perceived benefits* (Janz & Becker, 1984). Perceived benefits refer to an individual's beliefs that action is feasible and will effectively reduce disease threat (Janz & Becker, 1984). The fourth dimension of the HBM is *perceived barriers*. Perceived barriers refer to impediments to following the recommended course(s) of action (Janz & Becker, 1984). A type of cost-benefit analysis is hypothesized to occur, where an individual weighs the perceived efficacy of actions (*benefits*) against the risk (*susceptibility*) and outcome of illness (*severity*) and perceptions of how unpleasant, expensive, dangerous, time-consuming, and inconvenient action might be (*barriers*) (Janz & Becker, 1984). The fifth dimension, *cue to action*, was not present in the original HBM but has been present in variations of the model since 1958 (Janz & Becker, 1984). A cue to action is the trigger necessary to begin the decision making process (Janz & Becker, 1984). A cue to action can be internal, such as illness and symptoms, or external, such as health campaigns or social interactions (Janz & Becker, 1984). The sixth dimension, *self-efficacy*, was added to the HBM in 1988 (Glanz, Rimer, & Viswanath, 2008). Self-efficacy refers to an individual's confidence in the ability to successfully carry out the behavior necessary to produce the desired outcome (Glanz, Rimer, & Viswanath, 2008). A wealth of research buttresses the importance of self-efficacy in the initiation and maintenance of behavioral change (Glanz, Rimer, & Viswanath, 2008).

The HBM also assumes that diverse demographic, sociopsychological, and structural variables can influence an individual's perceptions and indirectly health behaviors (Glanz, Rimer, & Viswanath, 2008; Janz & Becker, 1984). As discussed throughout this paper, in the case of African American men, demographic, sociopsychological, and structural variables undoubtedly influence health behaviors. While the HBM acknowledges indirect effects of these variables, it focuses on individual behavior change based on cognitive or behavioral logic that changing attitudes, beliefs, and behaviors will ameliorate a problem (Dutta, 2007). Lupton (1994) argued that health promotions based on the universal logic of scientific rationality draw upon assumptions about the constitution of health risks rendering them absent of cultural context and unresponsive to the sociocultural-economic contexts within which health experiences are located (Dutta, 2007; Lupton, 1994). Therefore, to be most effective, health promotions and interventions must be culturally competent.

The concept of culture has emerged as a topic of interest among health professionals as awareness has grown that culture needs to be taken into account when considering how health communication is theorized and practiced (Dutta, 2007; Herman, Tucker, Ferdinand, Mirsu-Paun, Hasan & Beato,

2007). Culturally-centered approaches have gained popularity in recent years as research on culturally competent health care has grown exponentially (Herman et al., 2007). Culturally-centered approaches put culture at the core of health communication practices (Dutta, 2007). They attempt to change social structures surrounding health through dialogue with the target population that creates space for marginalized cultural voices (Dutta, 2007). Some believe this type of culturally-centered approach is necessary in health communications and interventions, citing that while promotions which only target surface characteristics of culture increase audience interest and initial receptivity compared to those void of culture, they are also unlikely to result in behavioral change (Kandula, Khurana...). They believe health promotion interventions are more likely to influence behavior change when they impact the deeper structures of the culture, such as the target groups' unique facilitators and barriers to behavior change and explanatory models about the causes of health and illness (Kandula, Khurana...).

This paper asserts that to significantly improve health disparities, a culturally-centered medium, based on awareness and knowledge of the factors that influence African American men's health status, must be used to influence individual dimensions, as conceptualized in the HBM. Following are two examples of programs piloted to address how African American men perceive susceptibility, severity, benefits, and barriers to illness, as well as cues to action, and self-efficacy through culturally centered means. Both programs also have necessary components to help manage the negative effects that education, employment, and income; access to, distrust of and mistreatment by the health care system; residential segregation, cultural norms, racism, and discrimination have on health.

## **Comprehensive Programs and Interventions**

### *Project Brotherhood*

Project Brotherhood (PB) was developed as a community based outreach program for African American men residing in the Woodlawn and surrounding south side communities of Chicago, Illinois. Chicago has the second largest African American population in the nation; accounting for 32.9 percent of the city's population (U.S. Census, 2010). An average of 21.4 percent of the city's population lived below poverty from 2007 to 2011, compared to a national average of 14.3 percent (U.S. Census, 2011).

The south side of Chicago has a long-standing reputation of being one of the city's most dangerous, impoverished areas. Most of the Woodlawn area sits in the 60637 zip code. The community extends into the 60649 zip code. According to 2010 Census data, the 60637 zip code is 78.6 percent African Americans (U.S. Census, 2010). According to the American Community Survey, 35.4 percent of the population lives below poverty (US Census, 2010). The 60649 zip code is 95.5 percent African American (U.S. Census, 2010). According to the American Community Survey, 26.3 percent of this population lives below the poverty level (US Census, 2010).

PB goals are to increase health awareness in Black men, defining health as complete physical, mental, social, economic and spiritual well-being. PB's mission is to increase health awareness in Black men by training Black men and providing preventive health messages and literature in a cultural and gender specific way. PB understands that it takes more than doctors to improve the health of Black men and employs a multi-disciplinary approach. Innovative methods are used to reach Black men including having a barber in the clinic that cuts hair for free during each session, routinely having a PlayStation in the clinic and basketball hoop set up in the parking lot where condoms and HIV prevention talks are delivered. Lay health workers distribute health education and promotion materials at local barbershops, a summer softball league and on streets. Free food is always featured as part of the PB sessions. PB has primarily Black physicians and staff. Staff routinely provide public transit fare cards for men needing transportation assistance to PB or job interviews.

PB provides medical services, social services, fatherhood classes, manhood development/rites of passage classes, Qi-Gong classes, mentoring, and free haircuts. Medical services include pre-employment physicals and diagnosis and treatment of chronic medical conditions such as hypertension, diabetes, and asthma. A social support group convenes weekly to discuss a broad range of health and social issues. The fatherhood class is a structured eight week, intensive course designed to empower and prepare African American men to successfully live out their roles and responsibilities as fathers to their children and families. Manhood development/rites of passage is a six week specialized program to promote self-esteem and positive behavior through a culturally and gender specific venue. An alternative therapy for stress reduction, Qi Gong, classes are offered monthly. Qi Gong uses breathing techniques and slow graceful movements to develop Qi and as method for stress reduction and to improve health.

PB's Saving Our Youth (SOY) initiative has an emphasis on mentoring high school students. Mediums such as art and hip-hop are used to promote STD/HIV and unplanned pregnancy prevention, healthy decision-making and self-esteem building. A Red Cross trained barber gives free haircuts during support group sessions.

PB has been operating for 10 years and enjoyed much success, including recognition by the Centers for Disease Control as a program that can help reduce health inequities.

#### *Soulsville Wellness Initiative for Men*

The Soulsville USA Wellness Initiative for Men (S.W.I.M.) is a health promotion, patterned after PB, designed to enhance the potential for young males to be healthy representatives of their community in Memphis, Tennessee. The mission of S.W.I.M. is to provide the wellness and social services necessary to improve the overall health and well-being of young males in the South Memphis community. Memphis has the sixth largest population of African Americans in the nation, accounting for 63.3 percent of the population (U.S. Census, 2010). An average of 26 percent of the population lived below poverty from 2007 to 2011, compared to a national average of 14.3 percent (U.S. Census, 2011).

South Memphis is a neighborhood mainly comprised of the 38126 zip code, one of the poorest in the city; some of this community extends into the 38106 zip code. The residents of the 38126 zip code are 96.2 percent African American (U.S. Census, 2010). According to the American Community Survey conducted by the U.S. Census Bureau, 61.6 percent of people living in the 38126 zip code live below the poverty level (U.S. Census, 2010). The 38106 zip code is comprised of 96.9 percent African Americans (U.S. Census, 2010). According to the American Community Survey, 41.7 percent of those living in the 38106 zip code live below poverty (U.S. Census, 2010).

S.W.I.M. utilizes a culturally-centered group mentoring approach to promote the philosophy of self-help, mutual aid, and the historical truth regarding the present state of African American men in the community (Washington et al., 2007). S.W.I.M. services emphasize empowerment through self-determination; therefore activities and services are designed, developed, driven, and delivered by African American Men and for African American Men with the assistance of others when needed.

Services offered by S.W.I.M. include social support groups, wellness assessments and counseling, HIV testing, blood pressure checks, parenting and manhood development classes, employment readiness training, ex-offender re-entry support, technology training (GED prep and driver's license prep testing), voting rights classes and free haircuts. S.W.I.M. also offers wellness seminars on diet and nutrition; heart health and hypertension; drug addiction, substance abuse, and nicotine addiction; cancer education; and asthma prevention. The program provides critical linkage to Memphis area service providers in addition to onsite services. S.W.I.M. is a part of the Lemoyne Owen College Community Development Corporation, Soulsville USA Wellness Center. Clinic services are rooted in the community and guided by the belief that

community-driven, asset-based, and culturally specific actions are needed to begin the process of decreasing health disparities. Analysis of preliminary S.W.I.M. outcome data is still pending.

PB and S.W.I.M. are located in communities that resemble many of the neighborhoods in which African American men reside: poor with little racial diversity and limited resources (CITE). For some members of these communities, every factor/barrier discussed that negatively affects health outcomes for African American men is applicable and maybe additional factors not discussed. The grass roots approach of PB and S.W.I.M. is designed to meet participants where they are and facilitate physical and mental growth and healing. The culturally centered nature of these interventions and range of services allows them to influence the dimensions of the HBM while addressing each tier of the system of factors contributing to the adverse health and mental health outcomes of urban African American men.

PB and S.W.I.M. negotiate perceived susceptibility by educating participants about illness and diseases, prevalence, how they are contracted, and providing screenings. The programs address perceived severity by educating participants about illness and disease, prognoses, and mortality rates. The perceived benefits are presented through education about different treatments available, prevention efforts, and *remission rates*. Perceived barriers are also addressed through education about the resources available to them and by the services offered on site and linkage to other services. Cues to action are influenced or triggered via education, screenings, and dialogue with health professionals. All of these services are couched in a culturally centered approach- they are rendered by trusted individuals with whom clients can identify in communities and settings clients are comfortable. PB and S.W.I.M. encourage self-efficacy through health education and offering a spectrum of empowering skill-building classes and trainings.

Services offered by PB and S.W.I.M. also address factors contributing to inferior health outcomes of African American men. Both programs offer services that can directly affect the three facets of socioeconomic status discussed: education, income, and employment, such as transportation to job interviews, pre-employment physicals, employment readiness training, technical training, ex-offender re-entry support, and free haircuts can help participants before job interviews. PB and S.W.I.M. tackle the issues African American men face with the health care system such as access, distrust, and mistreatment dead on. They are easily accessible- operating out of the communities in which the target population resides. Distrust of and mistreatment by the health care system is offset by professionals with whom clients can identify that can empathize with participants and are knowledgeable of the differential treatment they may have experienced. The social and environmental influences that impede health care are also addressed. However, some influences such as residential segregation, racism, and discrimination may be unavoidable regardless of changes the participants make. Services offered, such as manhood development/rites of passage classes, stress reduction classes, mentoring programs, and social support groups, can help manage the negative effects of those unavoidable situations as well as improve the negative impact of other social and environmental influences like living conditions and cultural norms. For high-risk and/or marginalized populations such as African American men, the culturally centered approach within a community based intervention establishes a positive relationship with the health care system and encourages active involvement in developing good health outcomes.

### **Future Directions**

Health communications, services, and interventions should continue to move toward cultural competence. Culturally centered community based interventions may screen and provide some treatment but they are also a preventive effort. With proper emphasis on prevention many of the poor and disparate health outcomes seen in African American men can be avoided.

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