THE ROLE OF SOCIAL AND CULTURAL FACTORS
ON PREVENTIVE HEALTH SERVICE
USE AMONG YOUNG, RURAL,
AFRICAN AMERICAN MEN:
A NARRATIVE INQUIRY

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A DISSERTATION

Submitted in partial fulfillment of the requirements
for the degree of Doctor of Philosophy
in the Department of Health Science
in the Graduate School of
The University of Alabama

TUSCALOOSA, ALABAMA

2017
ABSTRACT

African American men suffer disproportionately from preventable illnesses such as cancer and heart disease. Yet, African American men are least likely to use preventive health services that could potentially decrease their risk of developing these diseases in older age. The purpose of this study was to explore social and cultural factors that influence the use of preventive health services in a community-based sample of rural African-American men ages 18-34 in the Mississippi Delta county of Quitman.

The Andersen Behavioral Model of Health Services Use and Critical Race Theory were the guiding frameworks for this study. Narrative inquiry was the method used for this study. Data for this study were collected from 10 African American men between the ages of 18-34. Participants of this study were residents of Quitman County, Mississippi, a rural area in the Mississippi Delta. The findings from this study were organized into three manuscripts that detail important concepts from the overall dissertation study. Several methods were used to analyze the data including: narrative analysis, thematic narrative analysis, and poetic transcription.

Findings from this study indicated predisposing factors such as age and attitudinal beliefs, resources within the community and illness level affected the decision of African American men within this age group, to engage in preventive care. In addition to these findings, data also revealed the influence of experiences of fear and the struggle to create healthy identities. Lastly, data from this study suggest fathers as important role models for young men. Implications and recommendations are provided throughout each article.
DEDICATION

This dissertation is dedicated to my family, my friends, and my community. To my parents, Charles and Patricia, who may not have understood the grueling process but continued to pray for me each day. To Timotheus, my partner, who encouraged and supported me each step of the way. I am forever thankful for the community in which this research was conducted and I am proud to be a product of Quitman County, Mississippi, my home. This achievement is not mine alone but ours.
LIST OF ABBREVIATIONS AND SYMBOLS

CRT Critical Race Theory
I am pleased to have this opportunity to thank the many faculty members, colleagues, and friends who helped with this research project. I am most appreciative of the dissertation committee. I would like to thank Dr. David Birch, the chairman of this dissertation, for sharing his wisdom, excitement, and support of both the dissertation and my academic progress. A special thank you to Dr. Kelly Guyotte for her qualitative expertise that helped to shape this product. I would like to thank all of my committee members, Dr. Angelia Paschal, Dr. Derek Griffith, and Dr. Brian Gordon for their invaluable input and support during this dissertation process. This research would not have been possible without the support of my fellow graduate students who are now lifelong friends: Wanda, Amanda, and Andrew. I am forever grateful for each of you.
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CHAPTER ONE INTRODUCTION

“Our lives begin to end the day we become silent about things that matter.”

Dr. Martin Luther King, Jr.

African American men in America face many challenges in achieving and maintaining good health. Many of these unhealthy responses stem from social circumstances and cultural norms, as well as the cumulative experience of discriminatory treatment (Joint Center for Political and Economic Studies, 2004). As a result, African American men in the United States have poorer health and die younger than men of other ethnic backgrounds and suffer extremely high rates of chronic conditions (Bonhomme & Essuon, 2012; Gadson, 2006). The life expectancy for Black males in the U.S. is shorter than that of white males and even Black females. Overall life expectancy for African American men in the United States is 69.7 years, compared to 75.7 years for white men (Chae et al., 2014). Chronic life stressors, racial differences, and social factors create disparities in care for African American men and hinder their ability to confidently manage their health (Elder et al, 2013). Understanding African American men’s health care utilization has become an important priority in the efforts to reduce health disparities among this population (Stevens-Watkins & Lloyd, 2010).

The male tendency to suppress the expression of need and minimize pain may be reflected in lower male engagement in preventive health care visits (William, 2003). Many African American men are invisible in health care settings until their health conditions are
severe. The tendency of African American men to disengage from the health care system often begins at an early age as they discontinue visits with school nurses or a primary care physicians as they age (Gilbert, 2013). Men, in general, are less likely to use preventive health services, often delaying important screenings such as blood pressure, cholesterol and routine check-ups (Bonhomme & Essuon, 2012). Compared to women of the same population, African American men, are less likely to participate in preventive health care, contributing to measurably worse health outcomes (Bonhomme & Essuon, 2012). With these things in mind, African American men’s health is at a critical point and it is imperative that researchers understand the factors that influence these poor health outcomes. The disparate outcomes of this group present a demand for researchers to focus on understanding the “why” of these outcomes.

**Quitman County, My Backyard: Background of Study Area**

Mississippi has a long-standing reputation of being ranked among the least healthy states in the country. Geographic location often place individuals who live in rural areas at increased risk for health conditions, impairment in physical and mental functioning, and higher mortality rates. These individuals are often characterized as having lower education levels, lower income, and predominately of racial and ethnic minority status (Lower Mississippi Delta Nutrition Intervention Research, 2004). As defined by the federally sanctioned Lower Mississippi Delta Commission, the Lower Mississippi Delta (LMD) region is comprised of 219 counties and parishes in portions of Arkansas, Louisiana, Mississippi, Missouri, Illinois, Tennessee, and Kentucky connected to the Mississippi River. Of these states, Mississippi has the highest percentage of residents living in rural areas at 69%. Though the state is characterized as predominantly rural, the highest proportion of the population of rural Mississippi residents live in the Delta counties (Lower Mississippi Delta Nutrition Intervention Research, 2004).
The Mississippi Delta region, an area in the Northwest part of Mississippi with a population of approximately 553,000, includes the following 18 counties: Bolivar, Carroll, Coahoma, Desoto, Holmes, Humphreys, Issaquena, Leflore, Panola, Quitman, Sharkey, Sunflower, Tallahatchie, Tate, Tunica, Warren, Washington, and Yazoo. The 18-county Mississippi Delta region consistently ranks among the most disadvantaged areas in the nation, with approximately one-quarter of its population living below the federal poverty level and is often described as one of the most “unhealthy places” in the United States (Cossman, Cossman, Jackson-Belli, & Cosby, 2003). In addition, the disparate health and poor health outcomes in the region are exasperated by social and environmental conditions such as low educational attainment, high rates of poverty and high rates of uninsured.

Residents of the Mississippi Delta region experience age-adjusted rates of death considerably higher than both state and national rates and marked racial health disparities exist (Short, Ivory-Walls, & Loustalot, 2014). The area possesses a uniqueness that is rich in both cultural heritage and history with almost 60% of the total population in the Delta consisting of African Americans compared to 37% of the total state population, and 12% of the total national population (Mississippi Delta Health Collaborative, 2012). In addition to some of the worse health and health outcomes in the nation, the Delta region also has some of highest poverty rates, lowest income levels, and lowest levels of educational achievement in the nation (Southern Education Foundation, 2008). In 2009, 27.2% of uninsured individuals were African American males. Among that group, African American males between the ages of 18-34 were the highest percentage (46.2%) of uninsured residents (Kerstetter, 2009). These social and environmental conditions only compound the burden of health disparities in the Mississippi Delta.
The Mississippi Delta region as a whole continually ranks lowest in health outcomes, Quitman County, Mississippi ranked 81st in health outcomes compared to the other 82 ranked Mississippi counties (University of Wisconsin Population Health Institute, 2015). Quitman County has a population of 7,678 and includes the communities of Marks, Crenshaw (mostly in Panola County), Crowder (partly in Panola County), Falcon, Lambert, Sledge, Allen, Barksdale, Belen, Birdie, Bobo, Chancy, Darling, Denton, Essex, Hinchcliff, Locke Station, Longstreet, Oliverfried, Riverview, Sabino, Vance (partly in Tallahatchie County), Walnut, West Marks, and Yarbrough. (Quitman County Mississippi Genealogy & History Network, 2009; US Census, 2014). The population of Quitman County encompasses 69.1% African Americans with approximately 28.4% white. When considering social and economic factors, 68% of the population graduated high school or higher and 13.7% obtained a bachelor’s degree or higher. Of the total population, 12.7% of county residents are unemployed compared to 9.2% of the state’s unemployment rate. The median household income between the years of 2009-2013 was reported at $22,863 (US Census, 2014).

In 1966, Dr. Martin Luther King, Jr. made two visits to the town of Marks in Quitman County due to the intense and visible economic disparity in the county. It was at this place that he began the launch of the Poor People's Campaign. Dr. King’s visit highlighted the living conditions in Marks, which were mired in abject poverty during the transition period when farm implements displaced field hands (Lackey, 2014). Though Dr. King’s visit was nearly fifty years ago, today, 40.7% of Quitman County residents continue to live in poverty. Reports from the County Health rankings and Roadmaps place Quitman County 79th in clinical care measures (University of Wisconsin Population Health Institute, 2015). A reported 29% of adult residents are uninsured, with 41% reported not being able to seek medical care due to cost. The patient to
primary care ratio is higher than that of the state with 8,134 patients for every one primary care physician compared to the state ratio of 1,900 patients for every one primary care physician (University of Wisconsin Population Health Institute, 2015). Due to limited availability and issues of accessibility, 65.7% of residents seek medical care outside of the county (Wynveen, 2010). Other clinical care measures continue to paint the picture of disparate health conditions.

Though the statistics provided for this area are grim, it is not just another study site for research. It is the fertile soil in which I was rooted. It is my home. Because of my relationship with the participants in this area, I thought it best to fully share my position and place within this work. As I continued to find the right words to describe my relationship to this research, the only word that came to mind was investment. The members of the community that was the site of this study have invested in me from the very beginning. They were the fathers who showed up to special events, the coaches who taught me how to play tee ball, the ministers who fed my soul and contributed to my spiritual growth, my very first friends who took trips to places unknown and shared our dreams while riding in the back of the bus. They have always been concerned about me and invested in me. So, I see this work as my opportunity to invest in them. To make their voices heard, to share their experiences and to let the world know that they are survivors, they are warriors, they are resilient. Everything that I am, to them I owe.

**Paradigm and Assumptions**

As the focus of my research has continually evolved I now find my worldviews residing within the transformative paradigm. The transformative paradigm emphasizes that the “agency rests in the persons in the community working side by side with the researcher toward the goal of social transformation” (Mertens, 2015, p#). This paradigm directly addresses the politics in research by confronting social oppression at the levels in which it occurs. The transformative
researcher situates herself side by side with the less powerful in a joint effort to bring about social change (Mertens, 2015). This paradigm places importance on the lives and experiences of traditionally marginalized groups such as women, minorities, and persons with disabilities. The transformative paradigm emerged from the dissatisfaction with research conducted with other paradigms, that was either irrelevant or misrepresented the lives of people who experience oppression. The ontological basis of this paradigm emphasizes the belief that which seems “real” may instead be reified structures that are taken to be real because of historical situations. Thus, what is taken to be real needs to be critically examined via a critique of its role in perpetuating oppressive social structures and policies (ibid). Epistemologically, the transformative paradigm focuses on the meaning of knowledge as it is defined from a prism of cultural lenses and the power issues involved in the determination of what is considered legitimate knowledge (ibid).

Because the focus of my study was on men of color, particularly African American men, this paradigm is helpful in understanding the way oppression is structured and reproduced in their lives. Transformative research examines the inequities based on gender, race or ethnicity, socioeconomic status and how these inequities are linked to political and social actions. My interest in social justice work within health lies in my desire to advocate for change within communities like my own; as well as employing a critique of the current practices. For me, it is the dismantling of these “gold standards” and being able to take a more critical lens to issues in public health as well as re-humanize research. My desire to focus my research on Black men in many ways stems from my childhood and the conversations I have had with my father about his health. His case is not unique and, in many ways, is very similar to Black men in our area. Living in an under-resourced rural community in the South provided a unique backdrop to study issues
of race, masculinity, and health. Embedded within the exclamation of every outcome is a story and a person whose lived experiences under hegemony shaped their quality of life.

Transformative methodologies exemplify participatory research through the inclusion of voices from the margin (Ladson-Billings, 1998). Also, having my own experiential knowledge and shared history as ‘other’ under racial hegemony will help to strengthen my relationship with future participants (ibid). It provides deeper meaning to my subjectivities and how I relate to my work. The acknowledgment of history’s influence in the lives of African Americans is truly essential to understanding how to make changes for future generations. The tenets of critical race theory require us to confront our histories and accept them as truths, those “racial realisms” as mentioned by Ladson-Billings (1998).

**Purpose of Study**

Much research has been focused on improving the lives of women while little attention has been paid to understanding the struggles of African American men. Because quantitative research has frequently revealed that they do not engage in preventive health services, Black men have been written off as discordant and uncooperative (Burgess, Warren, Phelan, Dovidio, & van Ryn, 2010). Yet research has not focused enough on understanding their experiences from their perspectives and through their words. Additionally, few studies have considered the intersection of race, gender, and age on men’s decisions to seek care (Griffith, 2012; Griffith, Metzl, & Gunter, 2011). The purpose of this study was to explore social and cultural factors that influence rural African-American men’s use of preventive health services in the Mississippi Delta. The following research questions were used to uncover these concepts:

1. How do African American men ages 18-34 in a rural Mississippi community construct and narrate meanings of health?
2. How have past experiences shaped African American men in a rural community perceptions of the healthcare system?

3. How do social and cultural factors influence rural African American men ages 18-34 use of preventive health care services?

**Theoretical Framework and Conceptual Model**

The theoretical assumptions of the Andersen’s Behavioral Model of Health Services Use and Critical Race Theory were used to explore rural African Americans narrations of health and use of preventive health services. Andersen’s Behavioral Model of Health Services Use was used to explore perceptions and sociocultural factors that influence young adult African American men’s use of preventive health services. The model suggests health care utilization is determined by three factors: predisposition to use services (sociodemographic), enablement or impediment of use (e.g., economic and social), and their need (e.g., health and functional status) for care (Andersen, 1995).

Situated in the transformative paradigm, the use of Critical Race Theory (CRT) as a framework was intended to understand the way men construct stories about their experiences in relationship to their health. Critical Race Theory is defined as a “theoretical and interpretive mode that examines the appearance of race and racism across dominant cultural modes of expression” (Brizee, Tompkins, Chernouski, & Boyle, 2015, para 1). Racism has been the driving force for structuring opportunities in health care which often neglects or is unattainable by those in most need. Such that, individuals who are members of ethnic and racial minorities are more likely to experience barriers to receiving health care and are less likely to have health insurance (Wyatt et al., 2003; Cuevas et al., 2013). Critical Race Theory has been used to examine the ways race and racism are intensely entrenched within social structures, practices,
and discourses. The central tenets of Critical Race Theory highlight the importance of revealing the perspectives and history of people of color (Crenshaw, 1995; Ford & Airhenbuwa, 2010). Using narrative was a way to legitimize the experiences of African American men, critique the voice of the powerful to "expose, break open, and revise unjust systems" (Madison, 2012, p. 37). Critical Race Theory incorporates counterstorytelling and draws on the experiential knowledge, of people of color and their communities. Reynolds (2010), discuss counterstorytelling as a “methodological means that uses oral interpretation to convey their experiences that are often not validated by the dominant culture” (p. 148).

**Methodological Approach**

The methodological perspective associated with this study was narrative inquiry. Using the narrative approach, researchers seek to understand meaning in narrated/told events and in human interactions. Narrative inquiry provides a premise that through stories, human beings, come to understand and give meaning to their lives (Clandinin & Connelly, 2000; Trahar, 2009). It is grounded in interpretive hermeneutics and phenomenology and involves the gathering of narratives focusing on the meanings that people attribute to their experiences. In narrative inquiry, narratives are considered a vital human activity that structure experience and gives it meaning (Kramp, 2004, p. 103). Because traditional health research tends to be more focused on outcomes, the impact of the experience itself is often disregarded (Bell, 2002). Therefore, the use of narrative inquiry helped to understand the way men constructed stories about their experiences in relationship to their health.

Narrative inquiry in qualitative research is both a method and analysis. The words “narrative” and “story” are used interchangeably in the literature on narrative inquiry. Hinchman and Hinchman (1997) define narratives as “discourses with a clear sequential order that connect
events in a meaningful way for a definite audience and thus offer insights about the world and/ or people’s experiences of it” (p. xvi). As a research approach, narrative inquiry provides an effective way to systematically study personal experiences and meaning. It is also helps researchers to understand how critical events have been constructed by active subjects (Kramp, 2004; Webster & Mertova, 2006). Narrative as a methodology can be used to both collect the data and present the data gathered. Thus, narratives can also be the method for how you write and report the data. Narrative inquiry is beyond the mere gathering of stories but strives to attend to the way the story is constructed, as well as the cultural discourses (Trahar, 2009).

Significance of Study

An overarching goal of Healthy People 2020 is to achieve health equity, eliminate disparities and improve the health of all groups (United States Department of Health and Human Services [HHS], 2015). Thus, improving the health of racial and ethnic groups is a step in the direction of achieving that goal. African American men continue to suffer disproportionately from preventable health conditions. Furthermore, past studies exploring this topic have not sought to understand the distinct factors that affect men between the ages of 18-40. Prior research has reported that younger age (19-39 years) and male gender were risk factors for not visiting a physician during the previous year (Andersen et al., 2002).

Therefore, this study provides an understanding of preventive health services use in younger adult African American males. How underuse of preventive services impacts African American men’s health is not fully understood. Yet this underuse considerably impacts their risks for increased morbidity and delay of treatment for preventable deaths (Hammond, 2012). I believe that by telling these stories of the men in my community, the health education field will have a greater understanding of Black men. It will help me to defeat the idea of the “single story”
as the only evident truth of Black men in rural America. For so long they have been neglected just like the crumbling landscape in which they live. So, by that, I feel deeply connected to this issue because I see the inequity and my own experiential knowledge will help to shape this research. Because so much of health education training is rooted in individual behaviors, I wanted to take a different approach by looking at the larger societal factors such that impede health.

Summary

The purpose of this study was to explore young, rural African American men’s use of preventive health services from a qualitative perspective. Chapter 1 lays the foundation of this study and begins with an introduction to the topic area including a discussion of the study purpose, introduction of research questions, discussion of the significance of the study, my connections to the research, paradigms and assumptions, purpose of the study, theoretical frameworks and conceptual model, methodological approach, and a summary of the chapter. Chapter 2 details a comprehensive review of the literature on the topics of gender, and preventive health services use. Several theoretical frameworks guide this study, and they include, Behavioral Model for Health Services Use and Critical Race Theory. Chapter 3 discusses the study methodology including the rationale for using a qualitative exploratory design, critical decisions to selecting narrative inquiry as a method, identification of the study population, and procedures for qualitative data collection phases. As qualitative studies lend themselves to creativity and flexibility the structure of the findings will be organized after data analysis is complete to best present the results. Chapter 4 provides three distinct manuscripts that support data from the overall study. The final dissertation chapter, Chapter 5 presents reflections on my experience in the field and researching within my own community.
Definition of Key Terms

*Behavioral Model of Health Services Use* provides measures of understanding conditions that either facilitate or impede medical care utilization (Andersen, 1995).

*Critical Race Theory (CRT)* is a theoretical and interpretive mode that examines the appearance of race and racism across dominant cultural modes of expression (Brizee, Tompkins, Chernouski, & Boyle, 2015).

*Culture* is the patterns of ideas, customs and behaviors shared by a particular people or society. These patterns identify members as part of a group and distinguish members from other groups. Culture may include all or a subset of the following characteristics: ethnicity, language, religion and spiritual beliefs, gender, socio-economic class, age, sexual orientation, geographic origin, group history, education, upbringing, and life experience (Canadian Pediatric Society, 2016).

*Emphasized femininity* is reciprocally constructed in a subordinate relationship to hegemonic masculinity. Emphasized femininity represents the cultural ideal of women as weak, passive and compliant with men’s sexual desires (Connell, 1995).

*Gender* refers to the attitudes, feelings, and behaviors that a given culture associates with a person’s biological sex (American Psychological Association, 2011).

*Health disparities* are differences in morbidity, mortality, and access to health care among population groups defined by such factors such as socioeconomic status, gender, residence, and race or ethnicity (Dressler, Oths, & Gravelee, 2005).

*Healthy People* is the federal government’s science-based prevention initiative aimed at improving the health of all Americans. It is a statement of 10-year national health objectives.
intended to identify the most significant preventable threats to health and to establish national goals to reduce these threats. (United States Department of Health and Human Services, 2016).

*Hegemonic masculinity* is a social ascendency achieved in a play of social forces that extends beyond contests of brute power into the organization of private life and cultural processes (Connell, 1987).

*Hegemony* (hegemonic) is the process by which dominant culture maintains its dominant position (Connell, 1987).

*Intersectionality* the study of overlapping or intersecting social identities and related systems of oppression, domination, or discrimination (Crenshaw, 1989)

*Masculinity* is what society deems appropriate behavior for a “man”; term often used to identify a set of characteristics, values, and meanings related to gender (Connell, 1995)

*Narrative Inquiry* is a way of understanding experience. It is a collaboration between researcher and participants, over time, in a place or series of places, and in social interaction with milieus (Clandinin & Connelly, 2000).

*Narrative* is a story with a plot that is topically centered and temporally organized (Riessman, 2008)

*Preventive care* includes health services like screenings, check-ups, and patient counseling that are used to prevent illnesses, disease, and other health problems, or to detect illness at an early stage when treatment is likely to work best. (Centers for Disease Control & Prevention, 2015).

*Racism* refers to a system that structures opportunity by categorizing population groups and unequally advantaging others through the distribution of resources (Jones, 2000).
*Rural* encompasses all population, housing, and territory not included within an urban area (United States Census Bureau, 2015).

*Social factors* markers that distinguish major differences between groups of people in a given society such as education, income and occupation, ethnicity and race, religion, political affiliation, and geographic region (Armenakis & Keifer, 2007)
CHAPTER TWO REVIEW OF LITERATURE

“Of all the forms of inequality, injustice in health care is the most shocking and inhumane.”

Dr. Martin Luther King, Jr.

Chapter two begins with a historical perspective of race relations in the United States. The intent of this section is to orient the reader to the presence of social structures that underlie the health problems we see today. This chapter further reviews empirical evidence that addresses the health status of African American men in the United States, preventive health services use among African American men, and social and cultural influences on African American men’s health. This chapter then follows with a section addressing the theoretical framework and conceptual model used to understand the multiple influences of social and cultural factors on African American men’s health. The words African American, Black, Black American, people of color, and minority will be used as presented in reviewed literature.

**A Historical Perspective: Race Relations in the United States**

Historically, racial categorization has been rooted in racism. The resultant racial classification schemes have had an implicit or explicit relative ranking on various racial groups. Gee, Walseman, and Brondolo (2012) stated, “from crib to coffin, race is invented, recorded, and reported. The classification of people’s race, on their birth certificates, college applications, medical charts, and death certificates highlights the central role of racial stratification in US society” (p. 967). Within the U.S. context, whites have always been at the top of socioeconomic
spectrum, leaving Black Americans and other people of color struggling to rise to the top (Williams, 1999). The construct of racism can enhance our understanding of racial inequalities in health and there are a multitude of definitions and meanings that are used to define racism in America. However, it is equally important to understand that the act of racism is based upon the socially constructed concept of race. The categorization of race in the United States fails to account for group differences and nativity by aggregating all Blacks into a single racial category based solely on skin color. Yet there are significant differences between American Blacks, those who identify as African Americans and Caribbean Blacks. Though they share biological similarities, there are significant differences in socioeconomic status, education levels, and health. As an example, immigrant Blacks tend to live healthier lives and are less likely to experience racialized stress and discrimination (Griffith, Johnson, Zhang, Neighbors, & Jackson, 2011). Therefore, using race as a categorization is problematic because nonblack minorities are often misclassified as white which may cause an underestimate of the death rates of other minority groups such as Hispanics, American Indians and Asian and Pacific Islanders (Williams, 1999). As these examples indicated, consideration of ethnic heterogeneity among Blacks in the U.S. is often neglected in research on health disparities (Griffith et al., 2011). Not only does race not accurately capture the differences between groups of people, it also fails to note the differences within populations.

The categorization of race often captures a combination of social class, culture, and genetics. Jones (2000) described race as a proxy of class and genetics; when referencing race the same notation one would make on a medical form is the same race a police officer or judge would note (Jones, 2000). As such, the notion of race gravely impacts the daily life experiences of minority groups within this country. The variable “race” is not a biological construct that
reflects inherent differences, but a social concept that accurately captures the influences of racism (Harrison, 1994; Jones, 2000). When defining racism, Williams (1999) referred to it as an ideology of inferiority that categorizes and ranks various groups, negative attitudes and beliefs about outgroups, and used to justify unequal treatment of members of outgroups by individuals and societal institutions. Sue, Capodilupo, and Holder (2009) define racism similarly as a “complex ideology composed of beliefs in racial superiority and inferiority and is enacted through individual behaviors and institutional and societal policies and practices” (p. 329) Silva (1996) and Jones (2000) both refer to racism as a system that structures opportunity by categorizing population groups and unequally advantaging others through the distribution of resources. This unequal allocation of resources always disadvantages one group while another group advances at the expense of the subordinate group.

Racism is a complicated social classification that captures differential attainment of power and capitals within society (Wyatt et al., 2003). In the U.S. discussions of racism and race-related issues are most often viewed through the lens of Black versus white with no respect to cultural differences. Most often the word is only thought of in terms of overt actions displayed by prejudiced individuals. Yet there are different forms of conduits of racism. Jones (2000) provides a theoretical framework for understanding racism on three levels: institutional, personally mediated, and internalized.

Societal institutions (governments, healthcare facilities, businesses, churches, schools, and others) are culprits in defining systems that suppress and ostracize groups of people (Graham, Brown-Jiffy, Aronson & Stephens, 2011). In 1967, Carmichael and Hamilton created the term institutional racism which described the elusive forms of racism. This system of racism was often legalized and perpetuated through laws, practices and societal customs (Wyatt et al.,
For example, laws and practices embedded in institutions such as the criminal justice system, health care system, and housing have shaped individuals’ socio-economic opportunities, as well their upward mobility. Racist practices within these spaces are directly linked to life chances of racialized groups, in which institutional racism is often thought of as “inaction in the face of need” (Wyatt et al., 2003, p. 316).

Personally mediated racism as described by Jones (2000) is the interpersonal experience of discrimination and racial prejudice and is what most individuals perceive when they think of racism. Jones contends that the stresses of daily racism provide the pathway by which personally mediated racism impacts health. Personally mediated racism can be intentional overt acts of prejudice and discrimination or it can be covert unintentional acts from person to person. Those covert omissions often considered microaggressions are just as egregious as overt displays of prejudice and discrimination (Jones, 2000). Yet unconscious racism or microaggressions—commonplace verbal comments or behavioral slights that insult toward people of color—have a cumulative impact on the life of experiences of Blacks in America (Jones, 2000). Microaggressions stimulate constant feelings of anxiety and stress that continues to marginalize Blacks.

Racism can also be internalized which causes racial minorities to accept the dominant racist attitudes and stereotypes about themselves. This form of internalized racism puts them at greater risk of stereotype threat. Although this paper does not focus on any particular manifestation of racism, internalized racism is another pathway by which stress enters the life course. Jones (2000) defines internalized racism as “acceptance by members of the stigmatized races of negative messages about their own abilities and intrinsic worth” (p. 1213). This form of racism is characterized by the individual of the subordinate group not believing in others who
look like them, and not believing in themselves. The individual then limits his or her ability to recognize their full potential by placing limits on “one’s spectrum of dreams, one’s right to self-determination, and one’s range of allowable self-expression” (ibid). Internalized racism, in essence, is a self-deprecating activity that allows communities of color to concede to the idea that “the white man’s ice is colder.” This notion of “white is right” manifests in individuals devaluing their own ancestral culture to in turn embrace “whiteness” (ibid). Individuals who have experienced this form of racism often feel pressured to represent their race in fear of confirming a racialized stereotype as they often have a sense of duality in the roles. Though not often considered when thinking of acts of racism, internalized racism does affect an individual’s self-esteem and image (Jones, 2000).

**Experiences of racism over the life course**

Across history, race has been used to separate groups and provide validation of inferiority. The emergence of deeply embedded notions of black people as a dangerous race has become crucial to the idea of black inferiority in modern urban America. The legacy of slavery, Jim Crow, and legal segregation has affected how society views African American men as well as how these men view themselves. During the era of slavery, captivity of Africans was justified on the basis that Africans were an uncivilized lesser race that needed to be controlled (Alexander, 2012). Under the country’s constitution, slaves were defined as three-fifths of a man which facilitated the establishment of the racial caste system of slavery. It furthermore, proved that Blacks were devalued in comparison to their white counterparts.

With the death of slavery came the rise of new forms of enslavement. With many enslaved individuals leaving their plantations in search of a life post-slavery, an attitude of fear surmounted in whites. Post-slavery stereotypes depicted black men as savage and aggressive
predators who would rape white women and attack white men. On this notion, black codes were enforced to govern and control the newly freed African Americans and vagrancy laws were enacted which made it a crime to not work and directly targeted newly freed African Americans. During that time, all free Blacks over the age of eighteen were required to have written proof of a job at the beginning of each year. Those without proper documentation were deemed vagrants and imprisoned (Alexander, 2012; Blackmon, 2008).

Jim Crow was the name given to the racial caste system which operated primarily in southern states between 1877 and the mid-1960s (Alexander, 2012). Jim Crow laws comprised a legal system that emerged from white supremacist rhetoric following reconstruction (Alexander, 2012; Constitutional Rights Foundation, 2016; Nash, 2011). This racial caste system was more than a series of rigid anti-black laws functioning to legitimize African Americans as second-class citizens, these laws continued the subjugation of Blacks by mandating the segregation of public establishments which included schools, transportation, restrooms, restaurants and drinking fountains for whites and blacks. The remaining effects of Jim Crow, which eliminated the physical signs of segregation, are due in part to landmark court cases such as Brown v the Board of Education, the resistance of activists such as Rosa Parks, the Montgomery Bus Boycott, Dr. Martin Luther King, Jr., numerous marches, lunch counter sit-ins, the Freedom Riders and the Civil Rights Movement, (Alexander, 2012; Nash, 2011). The 1964 Civil Rights Act and Voting Rights Act that followed fulfilled the promise of full citizenship and equal protection under the law as stated in the fourteenth amendment (Constitutional Rights Foundation, 2016; Legal Information Institute, n.d.).

The magnitude of these accomplishments supported the push toward a more equal society, yet segregation still remained the primary mode used by institutions to enforce racial
inequality in the United States. Longstanding beliefs about black inferiority led to the development of policies that helped whites avoid social contact with Blacks were aimed at physical residential separation (Williams, 1996). Through the use of cooperative efforts of major societal institutions, this physical separation became legalized. Housing policies, discriminatory banking and lending practices and other restrictive practices pushed blacks into certain residential areas (Williams, 1996). Racial residential segregation is the foundation for the disparities seen today between Black and whites. At every level, segregation has led to disparities in socioeconomic status and has shaped the conditions that have damaged the health of African Americans in the United States (Williams & Collins, 2004).

In 2008, the United States elected its first Black president, Barack Obama. This prolific accomplishment would have one believe that America was moving to a post-racial era but racial tensions in America have not dissipated since his election. Racism is still a system in full operation today. The ingrained racism within these institutions were the foundation of legal segregation that has led to the figurative and literal demise of Blacks in U. S. society. These mechanisms are still employed and are often subtle to recognize which allows their presence to go unnoticed while producing deleterious effects on African Americans. Still today, African Americans face harsher restrictions for criminal offenses, are subjects of racial profiling and police brutality (Kinner & Wang, 2014)

Racism has also been the driving force for structuring opportunities in health care often neglecting or unattainable by those in most need. Individuals who are members of ethnic and racial minorities are more likely to experience barriers to receiving health care and are less likely to have health insurance (Cuevas et al., 2013; Wyatt et al., 2003). Lack of access to care and health insurance cannot explain all of the disparities in health. The restriction and segregation
through institutionalized racism is evident in different types of insurance. These limitations influence the quality of services that are provided. Thus, biases and prejudices are rampant in the American health care system due to the legacy of racial inequality (Johnson, Saha, Arbelaez, Beach & Cooper, 2004). The history of racism is still present and is evident in higher infant mortality rates among people of color, gaps in educational achievement, income, and other markers of health (Delgado & Stefancic, 2012). The past remnants of racism within American society continues to implicate people of color today.

Experiences of racism and discrimination magnify the volume of stress and may contribute directly to the physiological stimulation that is an indicator of stress-related diseases such as hypertension, high blood pressure and cardiovascular disease (Harrell, Hall, & Taliaferro, 2003). Although stress is not recognized as a leading cause of disease morbidity and mortality, it has a confounding relationship when added to other social determinants of health. Because of this, many researchers are now emphasizing chronic stress as an important determinant of racial/ethnic disparities in health (Hicken, Lee, Morenoff, House, & Williams, 2014). The experience of racism as a stressor can have a negative influence on the mental, emotional, and physical health of individuals of color. Race-related stress can occur as the result of both acute and chronic encounters with racial discrimination at all levels. Harrell (2000) defines race-related stress as the interplay between individuals and their environment that occur from the dynamics of racism and discrimination. This type of stress in response to racism and discrimination threatens the well-being of the individual and taxes the physiological responses of the body (Crockett, Grier & Williams, 2003).

Smith, Allen and Danley (2007) consider race-related stress in terms of racial battle fatigue. This taxing of the body is a result of constant coping with racial aggressions in hostile
environments. The experience of racial microaggressions and racism is a unique form of
gendered racism experienced by African American men. Occurrences of racial discrimination
create a particularly distinctive stressor and may affect disease risk via mental health pathways as
well as through behavior patterns (Chae et al., 2014). The factors that affect the health of adult
men often begin with early childhood exposure to poor social and economic conditions. This
continuation of adverse forces into adulthood often limit African American men’s utilization of
preventive health benefits compared to other demographic groups (Bonhomme & Essuon, 2012).
These chronic life stressors, racial differences, and social factors create disparities in care for
African American men and hinder their ability to confidently manage their health (Elder et al,
2013).

There are racial implications of poor health outcomes experienced by men of color. African American men who experienced greater levels of racism during their personal life experiences caused the biological aging process to accelerate (Chae et al., 2014). The daily experiences of racism whether through institutions, individuals, and or through internalization continue to act as a confounder in most diseases that affect African American men. This cumulative impact often referred to as “weathering” is triggered by prolonged periods of exposure to stressful environments is key to understanding racially charged disparities in African American men’s health outcomes (Das, 2013). Using nationally representative data from the 2005-2006 U.S. National Social Life, Health, and Aging Project, this study queries the mechanisms underlying worse metabolic outcomes blood-sugar control and cardiovascular health among black than white men ages 57-85. Results indicate that contrary to much of the academic literature as well as media accounts, older black men’s social isolation, poor health behaviors, or obesity may not play a major role in their worse metabolic problems. Instead, these
outcomes seem to derive more consistently from a factor almost unexamined in the literature chronic inflammation, arguably a biological “weathering” mechanism induced by these men’s cumulative and multi-dimensional stress. These findings highlight the necessity of focusing attention not simply on proximal behavioral interventions, but on broader stress-inducing social inequalities, to reduce men’s race disparities in health (Das, 2013).

**Health Status of African American Men in the United States**

Racial and ethnic health disparities remain a public health challenge for African Americans in the United States. Nationally, African Americans fare worse in every condition compared to other racial and ethnic groups (Centers for Disease Control [CDC], 2014). Disparities in health account for the differences in quality of life measures such as morbidity, mortality and health care accessibility most often defined by groups of lower socioeconomic status and race (Dressler, Oths, & Graavlee, 2005). The racial gap in morbidity and mortality has continued to widen over the years (Williams, 1999). Much of the poor health outcomes experienced by African Americans is due to a combination of factors that include ethnic/racial backgrounds and socioeconomic status. Health disparities between African Americans and other racial and ethnic populations are striking and apparent in life expectancy, death rates, infant mortality, and other measures of health status and risk conditions and behaviors (CDC, 2014). The leading cause of death for African Americans (males and females) is heart disease. However, African American males are 30% more likely to die from heart disease than non-Hispanic white males. In the United States, African American men are at higher risk for hypertension and major cardiovascular events, such as cardiac death, myocardial infarction, 60% higher risk for stroke death (American Heart Association, 2007; Centers for Disease Control and Prevention, 2006; National Center for Health Statistics, 2009; Office of Minority Health, 2008).
As a result, African American men in the United States live sicker and die younger than men of other ethnic backgrounds and suffer extremely high rates of chronic conditions (Bonhomme & Essuon, 2012; Gadson, 2006). Overall life expectancy for African American men in the United States is 69.7 years, compared to 75.7 years for white men (Chae et al., 2014). Compared to white men, African American men have a 37% greater chance of developing lung cancer (American Lung Association, 2007). African American men are more than nine times likely to die from AIDS as their white counterparts; more than twice as likely to die from prostate cancer than white men (American Cancer Society, 2014b; American Lung Association, 2007; Office of Minority Health, 2008). Though the perception is that health and younger age are synonymous, young African American men account for higher percentages of preventable death compared to men of other racial and ethnic groups (Rich, 2001). Among young African American men, the mortality rate for homicides is 51.5 per 100,000 of the population compared with 2.9 per 100,000 of the population for their white counterparts (Centers for Disease Control and Prevention, 2010).

African American males in America face many challenges in achieving and maintaining good health. Many of these unhealthy responses stem from social circumstances and cultural norms, as well as the cumulative experience of discriminatory treatment (Joint Center for Political and Economic Studies, 2004). Even when accounting for the varying degrees of socioeconomic status, social environmental factors adversely affect their health. Beyond socioeconomic status and biological disease specific to men, health inequities experienced by African Americans may be influenced by a combination of physiological, psychological, social, cultural, or environmental factors (Griffith et al., 2012). Yet, these factors alone cannot
adequately explain the full extent of health disparities in the African American community (Cuevas et al., 2013).

**Preventive Health Service Use among African American Men**

Many African American men are invisible from health care settings until their health conditions are severe. The trend of African American men who become disengaged from systems, such as the health care system, begins early as they stop visiting a primary care physician or school nurse as they age. The male tendency to suppress the expression of need and minimize pain may reflect in lower male engagement in preventive health care visits (Williams, 2003). Understanding African American men’s health care utilization has become an important priority in the efforts to reduce health disparities among this population (Stevens-Watkins & Lloyd, 2010).

Preventing disease before it starts is crucial to helping people live longer healthier lives (CDC, 2013). Preventive services can also help those with early phases of slow disease progression. Preventive care includes health services like screenings, check-ups, and patient counseling that are used to prevent illnesses, disease, and other health problems, or to detect illness at an early stage when treatment is likely to work best. Receiving recommended preventive services along with making healthy lifestyle choices are vital steps to optimal health and well-being (Centers for Disease Control & Prevention, 2015). For example, eating healthy, exercising regularly, avoiding tobacco, and receiving preventive services such as cancer screenings, preventive visits and vaccinations are just a few examples of ways individuals can stay healthy. Despite the benefits of many preventive health services, too many go without needed preventive care.
Men, in general, are least likely to use preventive health services, often delaying important screenings such as blood pressure and cholesterol and routine check-ups. In addition, they also wait longer after the onset of symptoms before seeking care and underutilize clinically appropriate health services. African American men, in particular, are less likely to participate in preventive health care than women, contributing to measurably worse health outcomes (Bonhomme & Essuon, 2012). Understanding African American men’s health care utilization has become an important priority in the efforts to reduce health disparities among this population (Stevens-Watkins & Lloyd, 2010). Many African American men are invisible from health care settings until their health conditions are severe (Griffith, Allen, & Gunter, 2011). The trend of African American men who become disengaged from systems, such as the health care system, begins early as they stop visiting a school nurse or a primary care physician as they age (Gilbert, 2013).

Black men living in rural areas experience many barriers to health care access which can contribute to health disparities. These barriers include high uninsured rates, healthcare workforce shortages, and access to care also creates additional strains for men in rural areas (Lu, Mieskowski, Oliver, Eichorst, & Allen, 2015). Black men in rural areas tend to make up the majority of uninsured residents (Kerstetter, 2009; Lu et al., 2015; Rich, 2001). Access to healthcare is often limited by a shortage of rural health care providers, with less than 10% of all physicians choosing to practice in rural settings (Rural Health Information Hub, 2014; Wynveen, 2010). Additionally, because many individuals in rural areas have limited transportation, the distance required to seek care outside of the area also creates a barrier. It is worth noting that services available in rural areas are less likely to include specialized or high-intensity care (Lu et al., 2015; Rural Health Information Hub, 2014). As a whole the physical environment of rural
areas poses added strains to accessing needed care and negatively impacts an individual’s
decision to seek preventive services.

Yet barriers remain and form the basis for individuals’ avoidance of seeking treatment or
engaging with the health care system (Aronson et al., 2013). Marginalized individuals often feel
a sense of distrust with the health care systems which could easily be perpetuated in the African
American community. While some African Americans viewed doctors as good sources of
specific health information, frequent changes in treatment (e.g., medications or therapy) have
been found to alarm some patients and leave them feeling that they are being studied or
experimented upon (Ogedegbe, Mancuso, & Allegrannte, 2004; Rose et al., 2000). Blacks were
often used for medical experimentation in the name of medical discovery (Feagin & Bennefield,
2013). A history of malice and unethical practices such as the Tuskegee syphilis study and the
unauthorized use Henrietta Lacks cancer cells, continue to plague the thoughts of present day
African Americans (Washington, 2007). These instances of unethical practices continue to
perpetuate a sense of avoidance and fearfulness of the healthcare system within the black
community. Difficulties experienced in the clinical setting may lead to avoidance, impaired
communication and poorer adherence to treatment (Aronson et al., 2013). Thus, this type of
avoidance behavior continues to place African American individuals at greater risk for
developing diseases and not engaging in preventive measures to slow down disease progression
or the development of certain diseases.

There is a complete disconnect between African American men and the health care
system. In addition to various personal barriers, concerns about missing work, financial
constraints, and competing priorities were factors that decreased the likelihood of seeking care
(Griffith, 2015; Ravenell, Johnson, & Whtitaker, 2008). The fear of a negative diagnosis may
also influence men’s use of health care procedures (Ravenell, Johnson & Whitaker, 2008; Rose et al., 2000). The experiences of others, family, and friends may support African American men’s fears of utilizing health care or create concerns that upon seeking care, serious problems may be identified (Rose, Kim, Dennison, & Hill, 2000). In general, African Americans receive poorer quality medical care for various health conditions. Additionally, the gendered differences in medical encounters also lower male engagement in preventive health care. During appointments, health care providers tend to spend more time with women than men and are less likely to offer additional services, health information, and counseling that can change behaviors and lead to improved health (Williams, 2003). Overall rates of individual counseling provided by doctors for men with known risks for poor health tend to be low.

Steele and Aronson first introduced the term stereotype threat in 1995, and defined it as a “disruptive psychological state that people experience when they feel at risk for confirming a negative stereotype associated with their social identity be it race/ethnicity, gender, sexual orientation, or social class” (Aronson et al., 2013, p 50). Stereotype threat in the clinical setting may act as physiological and psychological trigger as a result of high-effort coping which may have detrimental consequences for behavior. Research suggests that perceptions about how they will be treated, particularly racially discordant interactions between patients and healthcare providers, may induce stereotype threat significantly lowering the rates of usage by African American men (Aronson, Burgess, Phelan, & Juarez, 2013; Stevens-Watkins & Lloyd, 2010).

Griffith (2011) examined the factors that influenced older urban African American men’s medical help seeking. Study findings suggested that fear was a factor in the choice but participants continued to seek care. However, participants reported that they were particularly uncomfortable with the tone physicians used when talking to them (Griffith, 2011). Additionally,
men felt the recommendations offered by healthcare providers was not useful information on how to make lifestyle and behavior changes. Patient-provider relationships are also important factors in the decision to seek care. All patients, no matter racial or ethnic identity, who have greater trust in their physicians tend to be more satisfied with their care, more likely to adhere to their physicians’ recommendations, and less likely to change physicians (Murphy, Chang, Montgomery, Rogers, & Safran, 2001).

Practitioners who laud themselves as colorblind have been reported to have lower levels of empathy and cultural competence (Stevens-Watkins & Lloyd, 2010). This denial of race is reflected in their approach to care which often neglects the reality of inequity. African American men have described how negative help-seeking experiences might prevent them from returning for preventive or routine checkups and screening. When African American men perceive their health care providers as compassionate this increased the likelihood that the men would be motivated to return for future care (Rose et al., 2000). Men reported being particularly appreciative of health care providers who seemed to understand what was meaningful to the patient and took into consideration aspects of their lives that influenced men’s abilities to schedule and keep medical appointments (Rose et al., 2000). In addition to patient-provider relationships, Griffith (2011) noted that following receipt of care, support from spouses, the results from medical examinations, and men’s desire to fulfill social roles were instrumental factors in following medical advice. Thus, the sociocultural environment has been noted as potential dynamics that impede the use of preventive health services.

**Social and Cultural Influences on African American Men’s Health**

In recent years, social scientists and social epidemiologists have turned their attention to a growing range of social and cultural variables as antecedents of health (IOM, 2006). These
variables include socioeconomic status, race/ethnicity, gender and sex roles, immigration status and acculturation, poverty and deprivation, social networks and social support, and the psychosocial work environment, in addition to cumulative characteristics of the social environments such as the distribution of income, social cohesion, and social capital (IOM, 2006). Research focusing on uncovering the root causes of disparities have unveiled that social factors such as low socioeconomic status, inadequate neighborhood conditions, discrimination, reduced access to quality education, employment, access to quality health care, and incarceration have a major bearing on the health inequities affecting young African American men (Rich, 2001; Xanthos, Treadwell, & Holden, 2010). Finally, conditions in the social environment may become inherited or generational as parents continue to pass on their disadvantage to their children (Xanthos, Treadwell, & Holden, 2010).

Understanding health from a sociocultural angle focuses on the significance of religion, tradition, politics, economics, history, and a society’s view of science are factored into a person’s overall well-being (Armenakis & Keifer, 2007). Armenakis and Keifer (2007) have emphasized the importance of the community perception of health care provider and to recognize the role providers play in a social or cultural system. While research has illustrated the importance of considering the underlying social determinants of health, approaching men’s health through gendered pathways helps to identify how men orient social and cultural resources to mitigate external forces that may adversely affect their health (Griffith, Metzl, & Gunter, 2011). The gendered expectations that are imposed on members of each sex are shaped by race, ethnicity and other key social structures and identities. Thus, it is critical to understand how sex and gender intersect with other aspects of men’s social identities (Griffith, Metzl, & Gunter, 2011).
Early understanding of men’s health led to the development of sociocultural model which challenged the approach of the traditional “biomedical model” (Sabo, 2000). The sociocultural model explained health in illness with regard to the multiple influences of personal beliefs, cultural practices, social conditions, emotions and environment (Sabo, 2000). The analysis of men’s health issues advanced during the early 1980s increasing the dialogue around the study of men and masculinity. Early sex-role theorists saw masculinity as “an inner, psychic process that is tied to an outer web of sex roles and gender expectations” (Sabo, 2000). This discussion was oriented around ideas that boys were socialized to emulate masculine behavior which in turn put them at greater risk for illness and early mortality. Harrison, Chin, Ficarrotto, and Warning (1992) used sex-role theory to explain the linkage between mortality and the demand to perform within the expectations of the male role.

As research on men’s health continued to grow, critical feminist analysis of men, masculinity and health emerged during the 1990s. Drawing from the early theories of sex-role theory, critical feminist thinkers stressed that power differences shaped gender identity and behavior. They argued that gender identity was not simply imposed on individuals through socialization but individuals were active constructors in their own gender identity and subsequent behaviors (Connell, 1995; Courtenay, 1999). Gender is often considered as a performance, in that individuals actively work out, revamp and maintain their gender identity while negotiating with social and historical constructions of power dynamics. The construction of masculinity is often associated with unhealthy behaviors placing men at risk for higher poor health outcomes. Drawing from Courtenay, Sabo (1996) argues that many gender scripts for men encourage behaviors that influence their risk for illness, whereas women are encouraged to be
knowledgeable about their bodies. He further explains that that men who demonstrate their masculinity correctly would be less concerned about his health and well-being:

He would see himself as stronger, both physically and emotionally, than most women. He would think of himself as independent, not needing to be nurtured by others. He would be unlikely to ask others for help. He would spend much time out in the world and away from home. The intense and active stimulation of his senses would be something he would come to depend on. He would face danger fearlessly, take risk frequently, and have little concern for his own safety (p. 21).

Men’s constructions of gender are not solely based within the societal confines of men’s lives but also perceived within the context of cultural definitions of femininity. Connell (1987) theorized the social constructions of masculinity and femininity with reference to “hegemonic masculinity” and “emphasized femininity.” The concept of emphasized femininity is reciprocally constructed in a subordinate relationship to hegemonic masculinity. Emphasized femininity represents the cultural ideal of women as weak, passive, and compliant with men’s sexual desires. Hegemonic masculinity refers to the prevailing ideals of masculinity which accentuates male dominance over women, physical strength and emotional inexpressivity (Connell, 1995; Sabo, 2000).

Conforming to ideals of hegemonic masculinity pose potential health risks for men. For example, a man who conforms to hegemonic masculinity by consistently denying symptoms or pain may establish himself as brave or manly before his family and peers but may also increase his risk for developing chronic diseases. The concepts of hegemonic masculinity and emphasized femininity provide insight in the ways gender identity is constructed and how it influences health behavior and outcomes (Sabo, 2000). Generally, health-promoting behaviors are associated with
femininity and health-deterring behaviors are associated with masculinity; thus, men’s adherence to predominate masculine ideals are theorized to contribute to the disparity between men’s and women’s health outcomes (Griffith et al., 2012). Men often will prefer to risk their physical health at the expense of being perceived as feminine to others.

Within society, hierarchical relationships of masculinities exist that conceive to the dominant or hegemonic ideal (Connell, 1995; Courtney, 2000)). In the United States, the normative forms of hegemonic masculinity are defined by race, sexual orientation, socioeconomic position, and possession of certain traits such as unemotional, stoicism, confident and dominant (Fleming, Lee, & Dworkin, 2014; Griffith, 2012). In essence hegemonic ideals speak to white heterosexual, middle-class males as the dominant figure of masculinity. Thus, gender intersects with structural racism in complex and dynamic ways to influence the cultural schemas that shape Black American men’s lives and health outcomes. African American men’s ethnic identity and definitions of race, ethnicity, identity and ideals of masculinity are often shaped by experiences with white American society. For African American men, notions of masculinity are viewed as symbols of economic prosperity and social standing which causes them to grapple with attempting to fulfill or reject these societal roles (Griffith, Metzl, & Gunter, 2011). This perception often leads African American men in a space of negotiating and reorienting themselves to a new definition of manhood (Coles, 2008).

The health profile of men suggests that additional health risks are linked to masculinity (Griffith, Metzl, & Gunter, 2011). Yet, studies seeking to understand how African American men negotiate masculine role norms and health are limited. Men of color account for the largest percentages of gender health disparities (ibid). Gender is seen as an interrelated determinant of health in that it can be used to explain disparities seen in other determinants like income and
employment (Phillips, 2005). In the context of public health, men’s expression of self, through representation, internalized notions of masculinity, social norms, and gender pressures often increase the likelihood of morbidity and mortality (Griffith et al., 2012; Hammond, 2012). In examining the association between masculinity and the health of men of color in the United States, Griffith et al. (2012) explained how some conditions are unique to men which account for higher prevalence of certain diseases. Investigators suggest that “men of color may construct their identities beyond sex and gender in an effort to fulfill certain roles in relation to their spouses, children, and other family members or to remain accountable to other men” (Griffith et al., 2012, p. S188). Due to this perception, the identities of men of color intersect and create unique masculinities that are often not captured in traditional quantitative research (Coles, 2008; Griffith et al., 2012).

Hammond and Mattis (2005) investigated meanings of manhood. Findings from this study illustrate the most frequently endorsed categories of manhood. These themes include responsibility-accountability, autonomy, providing-waymaking, moral rectitude-virtues, and surviving-overcoming. As well considerations for traditional roles of men, Coles (2008) share how men of color establish their own concepts of masculinity by piecing together fragments of hegemonic masculinity that they have the capacity to perform. Previous research links masculinity to men’s mortality, health behavior, and usage of preventive health services among African American males. Researchers speculate that men delay using preventive health services because of traditional social constructions of masculinity, which prescribe extreme self-reliance, stoicism, and health care avoidance for men (Hammond & Mattis, 2005; Hammond, 2012; Letho & Stein, 2012).
Hammond (2012) examined the association between everyday racial discrimination and depressive symptoms and the narrowing role of two dimensions of masculine role norms, “restrictive emotionality” and “self-reliance.” Using a cross-sectional study design, Hammond (2012) surveyed 674 African American men aged 18 and older who were recruited from barbershops. Findings from the study suggest that everyday racial discrimination was associated with depressive symptoms within all the age groups. The article provides future implications for research that address the mental health of African American men, reduce racism and social norms. The mental health aspects that are presented in this article can be linked to the physiological symptoms that lead to health issues such as hypertension. The social norms attributed to masculinity can also be barriers to utilization of health care services for African American men.

Beliefs about masculinity and manhood can lead men to take actions that harm themselves or cause them to refrain from engaging in health-protective behaviors (Williams, 2003). Empiric research suggests that men who endorse more traditional masculine norms tend to underutilize healthcare services (Hammond, 2012). While women are more likely to engage in preventive health-promoting behaviors, men more often engage in behaviors that increase the risk of personal injury, morbidity, and mortality (Courtney, 2000). This partaking in high-risk behaviors is often demonstrations of cultural norms of masculinity, a product of the ways in which men construct and reinforce their masculinity (Courtney, 2000; Williams, 2003).

Additionally, cultural factors can have a positive or negative effect on health. Social cohesion or ‘connectedness’ is related to the health of individuals and communities. However, culturally supported norms of masculinity can damage African American men’s orientations and health behaviors. When considering the influence of cultural norms and the social and cultural
beliefs of African Americans in the United States, it must be considered in a gendered context (Griffith, 2015; Griffith, Metzl, & Gunter, 2011). Black American men often embody their efforts to fulfill socially and culturally valued roles in context of economic, educational, and social barriers and challenges. Despite the changes and flexibility in gender roles over time, the family provider role continues to be a salient aspect of African American men’s identity (Griffith, Metzl, & Gunter, 2011). In order to change an individual’s behavior to improve their health, one must understand the way that people think about health and the particular meaning they ascribe to being healthy. In order to fully address disparities in young, rural, African American men’s health, it is important to attend to the social and cultural components of their health.

Conceptual and Theoretical Framework

This study was guided by the theoretical assumptions of the Andersen Behavioral Model of Health Services Use and Critical Race Theory. The theoretical basis of each framework provided the lens through which rural African Americans narrations of health and use of preventive health services will be explored.

Behavioral Model of Health Services Use

The Andersen Behavioral Model of Health Services Use was first developed during the 1960s. It began as a behavioral model used to provide measures of understanding conditions that either facilitated or impeded medical care utilization (Andersen, 1995). Since its initial development, the model has undergone substantial changes but still continues to be a relevant approach to understanding factors that influence health services use. The model suggests that an individual’s access to and use of health services is considered to be a function of three characteristics: predisposing factors, enabling factors, and need factors (Andersen, 1995).
Andersen’s final model, (Figure 1. Andersen’s Behavioral Model of Health Service Use) illustrates the main components of the recursive nature of the model and portrays the multiple influences on use and subsequently health status. Predisposing factors constitute those socio-cultural characteristics that exist prior to illness. These factors include social structures such as the individual’s education, occupation, ethnicity, social interactions and culture. The model also considers health beliefs: attitudes, values and knowledge that people have concerning and towards the health care system. Predisposing factors also consider demographics such as age and gender.

Figure 1. Andersen’s Behavioral Model of Health Services Use

The model’s second concept is enabling factors or the logistical aspects of obtaining care. These factors consider the influence of both community and personal resources that must be present for use to take place. These community and personal resources that determine an individual’s use include: access to and availability of services, proximity of services to where people live and work, health insurance, income, waiting time, and regular source of care. The need factors
(perceived and evaluated need) consider how the individual perceives their own general health as well as how they experience symptoms of illness, pain, and worry (Andersen, 1995). Evaluated need relates to the kind and amount of treatment provided by the healthcare professional (Andersen, 1995). By considering factors beyond the individual’s personal health beliefs, the model illustrates how the health outcome is affected by predisposing factors, perceived need and the individual’s need for services. The model is a more integrative approach to understanding the specific behavior of health services use.

Babitsch, Gohl, and von Lengerke (2012) conducted a systematic review of studies that utilized the Andersen model for health services use. In the review, the authors highlight 16 studies published between 1999 and 2011. The studies were conducted in different geographic locations, including the United States, Canada, Australia and Germany. All of the previous studies that have used this model gathered data through traditional quantitative methods. When examining gender and age in combination, Andersen et al., (2002) suggested that younger age (19-40) and male gender were risk factors for not visiting a physician during the previous year. Of the reviewed studies, one studied utilized qualitative focus groups in development of the survey and only one study exclusively focused on African American men (Hammond, Matthews, Mohottige, Agyemang & Corbie-Smith, 2010; Insaf, Jurkowski, & Alomar, 2012). These two studies also focused primarily on social and cultural norms including traditional health beliefs and its influence on utilizing health care services.

Insaf, Jurkowski, and Alomar, (2012) took a qualitative community-based participatory research (CBPR) approach to understand the sociocultural factors influencing delay of routine health care among Latinas. Data for this study were gathered using 70-item survey, derived from previous focus groups. The survey was administered among 287 Latinas from the Capital
District, NY. The Andersen model of healthcare utilization was used to assess predisposing, enabling and need factors influencing delay in seeking care. Items that measured delay in medical care using were derived from the National Health Interview Survey (NHIS) questionnaire and the focus groups. The predisposing factors included age, marital status, education, immigrant status, acculturation, health beliefs and health care preferences. Health insurance coverage, perceived accessibility of care based on previous experience were considered enabling factors. Using the model, researchers defined need factors as whether or not a participant had a history of chronic illness, in conjunction with the predisposing and enabling factors (Insaf et al., 2012). Findings suggest that 70% of women reported delaying care. Among predisposing factors, women who were not married, preferred a Latino doctor or used alternative medicine were likely to delay care. Regarding enabling factors, women who were uninsured or experienced discrimination during prior health care visits were most likely to delay care. The results of the study emphasize the importance of sociocultural factors in modifying health behaviors (Insaf et al, 2012).

Hammond et al. (2010) used Andersen’s model and theory of reasoned action as a framework to understand the psychosocial factors associated with routine health examination scheduling and receipt. The cross-sectional study sampled 386 African American men from barbershops and academic institutions in Michigan, Georgia, and North Carolina between 2003-2004 and 2007-2009. The study assessed predisposing factors as age (range 18 to 78), level of education, and marital status defined as currently married or unmarried. Enabling factors were described as annual income which ranged from less than $20,000 to greater than or equal to $40,000, employment status (employed full-or part-time and unemployed), health insurance status, and usual source of care (Hammond et al., 2010). Physical and mental health status were
used to measure need factors. Results suggest that traditional male role norms around disclosure of personal illness had a negative impact on African American men’s routine health examination receipt (Hammond et al., 2010).

**Critical Race Theory**

Critical Race Theory (CRT) has been used to examine the ways race and racism are intensely entrenched within social structures, practices, and discourses. In discussing the origins, scholars often mention that though "theory" is a part of the title, CRT is not a behavioral or epidemiological theory; rather, it draws iteratively from theory, different methodologies, and work to keep equity at the forefront of the research, scholarship and practice (Ford & Airhihenbuwa, 2010). Critical Race Theory emerged in the 1970s and is rooted in civil rights litigation. Early writers such as Derrick Bell, Alan Freeman, Richard Delgado, Kimberle Crenshaw began to criticize the legal system for its role in racially based social and economic oppression in the United States (Crenshaw, 1995; Delgado & Stefancic, 2012). Delgado and Stefancic (2012) present the basic tenets of CRT. The first proposition suggests that “racism is ordinary and not aberrational;” it has become commonplace and a part of the everyday experience of most people of color in the United States (p. 7). Due to the ordinariness of racism, it is difficult to address because it is often not acknowledged. The second theme of CRT, is “interest convergence” also referred to as “material determinism” or “racial realism” in the literature. Racism is a system that advances the interests of the dominant group, “the current system of white-over-color ascendancy serves important purposes, both psychic and material, for the dominant group” (p. 8). The third tenet points out that races are social constructions and are not objective, inherent or genetic endowed. The fourth concept of CRT draws attention to the shifting perspective of racializing different minority groups by the dominant society at different
Intersectionality, a term introduced by Kimberle Crenshaw, and anti-essentialism are present within this tenet (Crenshaw, 1989; Delgado & Stefancic, 2012). Intersectionality acknowledges that everyone has overlapping and often conflicting identities due to race, sex, class, national origin, and sexual orientation (Delgado & Stefancic, 2012). Although intersectionality is normally applied to black women, it is also applicable to black men. Similar to black women, black, men’s identities straddle the intersection of race and gender (Gilbert & Ray, 2015). Lastly, CRT acknowledges that people of color have a unique voice due to a shared minority experience of oppression that white people are unlikely to know (Delgado & Stefancic, 2012).

Critical Race Theory incorporates counterstorytelling and draws on the experiential knowledge, of people of color and their communities. Using narrative is a way to legitimize the experiences of African American men, critique the voice of the powerful to "expose, break open, and revise unjust systems" (Madison, 2012, p. 37). Reynolds (2010), discuss counterstorytelling as a methodological means that uses “oral interpretation to convey their experiences that are often not validated by the dominant culture” (p. 148). The central problems examined using CRT include the circumstances that serve to exclude and disadvantage cultures or groups, such as racism, homonegativity, heterosexism, inequities, identity, hegemony or unequal power relations, as well as the outcomes resulting in disparities in morbidity and mortality. Critical Race Theory and critical theory, in general, are concerned with empowering human beings to rise above the restraints placed on them by race, gender, and sexuality (Graham, Brown-Jeffy, Aronson, & Stephens, 2011).

Ackerman-Barger and Hummel (2015) merged Critical Race Theory (CRT), Critical Race Theory in Education (CRTE), and narrative inquiry in a study designed to capture the
educational experiences of nurses of color. Critical Race Theory was used as a framework in a study to give voice to those who experienced institutional racism. Addressing these issues through storytelling reveals the "omnipresence of race" meaning that, for "people of color in the U. S., race is a social construct that is ever present in institutions such as education and health care and hinders people of color from access to and full benefit from these institutions" (p. 40).

Ackerman-Barger and Hummel (2015) used narrative inquiry as a way to expose the educational disparities based on race experienced by nurses of color during their time as nursing students. The researchers used individual interviews to gather the narratives of seven nurses. Interviews were conducted using face-to-face, phone, and Skype as methods to accommodate the schedules and geographic location of the participants. Additionally, participants submitted voluntary written reflections of their educational experiences. Researchers used thematic narrative analysis to uncover themes in the education experiences of the participants. Two recurring themes emerged from the data: experiences of exclusion and benefits of inclusion. For each theme, the investigators provided a narrative that corresponded to the broader theme. Embedded in the larger theme of experiences of exclusion were sub-themes including: survived social prejudice, required to defend self, identified as different, confronted by racism, proceeded with caution, made to feel guilty and feel like an outsider and discouraged from pursuing a nursing career (Ackerman-Barger & Hummel, 2015). Though the participants shared experiences of exclusion they also had positive experiences termed as benefits of inclusion. The sub-themes included being rewarded for endurance, supported by others, mentored by faculty, defended by peers, referred to academic resources, validated for who one is, and encouraged to succeed. Critical Race Theory provided the opportunity to reveal racism through the narratives of the participants (Ackerman-Barger & Hummel, 2015, p. 45).
Several spin-off movements spread beyond the initial law discipline and began to appear in education, ethnic studies, sociology, and health care. Ford & Airhihenbuwa (2010) discussed the use of Critical Race Theory in health education practices. This article details the use of CRT as a potential way to understand the power of racism in contributing to mortality, morbidity, and overall health based on an assigned race. It offers public health practitioners and researchers a way of understanding the root causes of health disparities. The authors suggested that health for all cannot be achieved if structural racism continues to persist (Ford & Airhihenbuwa, 2010).

**Summary**

This chapter reviewed the historical influence racism on the health of African American men in the United States. This chapter presents empiric evidence on the health status of African American men in the United States, preventive health services use among African American men and social and cultural factors that influence preventive health services use. Lastly, the chapter presents the use of the theoretical framework and conceptual models: Andersen’s Behavioral Model of Health Services Use and Critical Race Theory in structuring the study. The concepts presented in this chapter along with the application of theoretical frameworks provided a basis for understanding the influences of social and cultural factors on African American men’s health.
CHAPTER THREE METHODOLOGY

"People are always tellers of tales. They live surrounded by their stories and the stories of others; they see everything that happens to them through those stories and they try to live their lives as if they were recounting them.”

Jean Paul Sarte

Chapter three details the overall study design, data collection methods, and data analysis resulting from the qualitative approach. Narrative inquiry serves as a methodology for this study. Data will be collected through semi-structured interviews. This chapter details selection criteria and the process of using faith-based organizations for participant recruitment. The rationale for choosing interviews as the method of data collection is presented. Narrative analysis thematic narrative analysis, and poetic transcription were used to analyze data derived from this study. Finally, a discussion on member checking as a validation measure closes the chapter.

Narrative Inquiry

The methodological perspective associated with this study was narrative inquiry. Using a narrative approach, researchers seek to understand meaning in events and in human interactions. Narrative inquiry is grounded by the premise that through stories, human beings, come to understand and give meaning to their lives (Clandinin & Connelly, 2000; Trahar, 2009). Understanding narrative helps the researcher to comprehend context and the individual in his narrative environments (Kramp, 2004, p. 105). Through this context, the individual begins to
connect and position particular experiences as they happen. The past offers a way to contextualize ethnic minorities’ current experiences through the perspectives of the participants, positioned and understood from a historical context (Graham, Brown-Jeffy, Aronson, & Stephens, 2011).

The use of narrative inquiry provided a forum to understand the way men constructed stories about their experiences in relationship to their health. This approach required that the researcher "centers on the attempt to achieve a sense of the meaning that others give to their own situations" (Smith, 2005, p. 12). Graham et al. (2011) also suggests that narrative inquiry is a useful medium “in which intersectionality plays out in a complex manner without being watered down or only marginally taken up” (p. 88). Thus, narrative inquiry as a method provided an outlet in which to examine race, sex, class, national origin, and sexual orientation. The use of narratives is attuned to the ways in which the combination of identities shape the experiences of individuals. Storytelling is an important part of ethnic minorities’ cultural experience. Whereas, African Americans have traditionally used storytelling as a tool for communicating and sharing information (Graham et al., 2011). Recent studies highlight the fact that storytelling may be a particularly effective way to enhance health communication and encourage behavior change within racial and ethnic populations who possess a rich tradition of storytelling (Kreuter et al., 2007). These findings also indicate the potential of storytelling as a means of acquiring vital data that otherwise would not be obtained through traditional methods (Lee, Fawcett, & DeMarco, 2016; Reynolds, 2010).

Narrative inquiry as a method helped in the identification of sociocultural factors that influence population health outcomes (Lee, Fawcett, & DeMarco, 2016). The use of Andersen’s Behavioral Health Services Use Model also denotes sociocultural factors as variables of
predisposing factors used to explain behaviors as per Green, Kreuter, Deeds, and Patridge (1980). The use of this conceptual model in conjunction with the narrative approach helped create understandings of the social and cultural factors that promote or deter African American men’s decision-making. While Andersen’s model accounted for predisposing factors such as age, gender, and ethnicity, it also considered the impact of the structure of healthcare facilities within the community as an enabling factor to predict use. This takes into consideration how medical care facilities are organized and how the types of services that are offered influence the decision. Thus, this provided a premise for understanding the connections between race and structures as factors that influence an individual’s use of preventive services. The omnipresence of race in institutions such as healthcare continue to hinder people of color, particularly African American men’s access and benefits from the health care system (Ackerman-Barger & Hummel, 2015). In alignment with the basic storytelling element of Critical Race Theory (CRT), narrative inquiry was used to capture the inequities experienced by young adult African American men. CRT uses narratives for counterstorytelling and draws on the experiential knowledge, the shared history of both the researcher and participant as ‘other’ under racial and cultural hegemony.

The central tenets of Critical Race Theory highlight the importance of revealing the perspectives and history of people of color. Through storytelling, disparities in health can be exposed and solutions for addressing racial health disparities can be sought. The use of narratives has the potential to provide a catalyst for conversation on how to change health education and promotion programs that holistically meet the needs of African American men. In my study, using narrative was a way to legitimize the experiences of African American men, critique the voice of the powerful to "expose, break open, and revise unjust systems" (Madison, 2012, p. 37). Stories are powerful tools for minority communities as they provide a means to give voice and
reveal life experiences to others. Delgado and Stefancic (2012) express the use of narrative in CRT as a means to “provide a language to bridge the gaps in imagination and conception that give rise to the different. They reduce alienation for members of excluded groups, while offering opportunities for members of the majority group to meet them halfway” (p. 51).

For example, Kendrick, Anderson, and Moore (2007) used ethnography and participatory research strategies to share the stories of African American men aged 18-25. The study demonstrated that African American men may not verbalize their symptoms according to diagnostic manuals and suggested that clinicians glean information from the patient’s story. This study was important in revealing why African American men must have a voice in planning interventions and making decisions about their health care. Having the opportunity to share their stories was empowering to the patients and helped practitioners effectively provide care. Thus, eliciting history through storytelling, I can come to understand why African American men do not engage with health care system to utilize preventive health services.

Participant Selection

The magnification of adverse health problems made Quitman County a prime backdrop for exploring the unique health experiences of the men in the community. As the research question required detailed accounts of the experiences of a specific group, a purposive sampling was used. As this study relied on data from interviews, theoretical saturation was reached around 10-12 interviews and as new material did not surface (Flick & Uwe, 2002). Inclusion criteria for this study was as follows: self-identification as Black or African American male, 18-34 years of age, and current or past residence in the study geographic area, Quitman County, Mississippi.
Participant Recruitment

Faith-based organizations have proven to be useful sites for study recruitment as well as setting for health promotion programs (Markens, Fox, Taub, & Gilbert, 2002). The Black church is a cultural symbol for the Black community and is an ideal setting for recruitment given its historical role in promoting education, business, and political activism. Several studies have found that the Black church is an important conduit through which underserved groups become informed about preventive care and receive pertinent health information (Markens, Fox, Taub, & Gilbert, 2002). As such, for this study, participants were recruited through local churches in the study area using flyers and announced during church service. A list of 40 predominately black churches in Quitman County, MS was retrieved from a key informant. A recruitment letter was mailed to the pastor of each church along with an attached flyer to provide details about the study. The study recruitment letter detailed the purpose of the study, inclusion criteria, and estimated time allotted for interviews, brief highlights of the study purpose and my contact information (see Appendix A). The flyer also provided the inclusion criteria and contact information (see Appendix B). After the letters, were mailed, in-person contact was made, particularly since some faith-based organizations may were not easy to reach by phone, and mailing addresses were not provided for all churches. The researcher contacted each pastor and asked for permission to visit the church during service to explain the study.

Face-to-face communication was an effective way of reaching out to a particular congregation or leader. Once the pastor agreed, the researcher visited each church and explained the study and asked for help in recruiting participants. Speaking to a congregation puts a face on the invitation and further gives credibility to the leader’s interest in the study. It was communicated to the congregants that if they are interested in participating or willing to share
information about the study, they should contact the researcher listed on the flyer. The researcher kept a list of interested participants and scheduled follow-up calls to schedule times for the interview.

**Consent**

Approval from the University of Alabama Institutional Review Board (IRB) regarding all data collection procedures was obtained prior to beginning the study. After recruitment, if participants agreed to participate, a time was scheduled to obtain consent before beginning the study. An approved informed consent was read and explained to the participant to ensure he understood the nature of the study and agreed to participate. If the participant indicated his willingness, then a signed consent was obtained (see Appendix D for informed consent). The participant had the option to not answer any question that may have made him uncomfortable, without any penalty. All participants were informed of the voluntary nature of the study, including information that they could withdraw from the study at any time without penalty. Participants were also provided with a letter describing the purpose of the study, the procedure used to protect their anonymity and confidentiality, and the nature of their participation.

The confidentiality of participants was stressed and several strategies were used to preserve confidentiality. Participants were interviewed using a pseudonym in order to protect their identity. This pseudonym was linked to demographic survey data and used in the reporting of results. The survey was used to collect information such as the participant’s age, educational and income level, and time since last visit with a medical professional. All data collection records were kept locked in the researcher’s office at the University of Alabama. The list with participants’ pseudonyms was kept in a separate locked file; only the researcher had access to this file. In reports of the results, only fictitious names were used. Audio recording took place
during interviews and information from the audio files was transcribed for data analysis. After transcription and upon completion of this study, all information contained on the audio files was erased and discarded.

**Pilot Study**

Pilot interviewing took place prior to initiation of the full study. Interview questions were piloted during a focus group. The focus group included four male participants who were residents of the study area and lasted 60 minutes. Feedback from the pilot study informed the interview questions for this study which eliminated the need for multiple pilot interviews. As the interest in the study was high before initiation of the pilot, the researcher only piloted the survey and questions with one individual. The participant selected to participate in the pilot was an African American male, between the ages of 18-34 and resided in the study area. The participant was selected from one local church in the study area. Piloting provided the researcher with an opportunity to employ my recruitment methods to gain volunteers for the interview. The participant was asked to complete an informed consent form before engaging in the study. A copy of the questions was sent in advance of the session to ensure that participants would not anticipate difficulties responding. The pilot study was conducted to obtain comments on how the interview questions were perceived. Secondly, it was conducted to revise the structure of questions which included adding and removing questions that were not meaningful. Written memos were kept to chronicle my reflective process during the pilot.

**Data Collection**

**Demographic Survey**

As demographic information on each participant was essential to this study, participants completed a short survey to capture background information before beginning the interview and
after consenting to participate. The survey included questions about the participant’s age, county of residence, marital status, socioeconomic status (income, employment, and education), household size and health insurance status (see Appendix C). Questions pertaining to insurance status and primary care physician use were derived from the 2007 Health Insurance Survey. Participants were given an identification number and pseudonym that was linked to the interview data. This allowed me to provide contextual information to support the data from the interviews.

**Interviews**

Qualitative methods, such as interviews, are believed to provide a deeper understanding of social phenomena that would not be obtained from purely quantitative methods, such as questionnaires (Gill, Stewart, Treasure, & Chadwick, 2008). Interviews are, therefore, most appropriate where detailed insights are required from individual participants. Interviews can be used to explore the views, experiences, beliefs and motivations of individual participants.

Semi-structured interviews consist of several key questions that help to define the areas to be explored but also allows the interviewer or interviewee to diverge in order to pursue an idea or response in more detail. This interview format is used most frequently in health care, as it provides participants with some guidance on what to talk about, which many find helpful (Gill, Stewart, Treasure, & Chadwick, 2008). The flexibility of this approach, particularly compared to structured interviews, also allows for the discovery or elaboration of information that is important to participants but may not have previously been thought of as pertinent by the interviewer (Gill, Stewart, Treasure, & Chadwick, 2008). The purpose of the research interview is to explore the views, experiences, beliefs and/or motivations of individuals on specific matters. Thus, narrative interviews that focused on the meanings individuals derived from their experiences was used as the method of data collection for this study. The aim of narrative
interviewing is to elicit descriptions of how things are experienced first hand by those involved (Gregory, 2010). Additionally, due to the potential discussion of sensitive health-related topics, a group setting may not be appropriate for disclosure of such intimate information (Gill, Stewart, Treasure, & Chadwick, 2008).

For this study, interviews took place in a quiet place agreed upon by the researcher and the participant. All interviews were audio-recorded using a laptop and, the interview guide used was based on the pilot interview that was conducted. Each individual interview lasted approximately 60-90 minutes. The face-to-face interviews were informal and open-ended, and were carried out in a conversational style. The focus of the interview was on the participants’ personal health beliefs, definitions of health, individual experiences, and factors that influenced their use of preventive health services. To provide more opportunities to elicit narrative responses, the interview questions were more topically centered. This approach allowed the respondent to construct answers in ways they find meaningful (Riessman, 2008). The following interview questions were developed to align with the research questions and draw on key themes from previous research (Griffith, Brinkley-Rubinstein, Thorpe, Bruce, & Metzel, 2015).

1. **Research Question One:** How do African American men ages 18-34 in a rural Mississippi community construct and narrate meanings of health?

   **Interview Questions:**

   1. Tell me what being healthy means to you. Describe what being healthy means to you as a man.

   2. Tell me about your health.

   3. How does living in Quitman County affect your health?
2. *Research Question Two:* How have past experiences shaped African American men in a rural community perceptions of the healthcare system?

   Interview Questions:
   
   1. Tell me about the first time you decided to seek medical care on your own.
   2. Tell me about some of your most memorable moments when seeking care.
   3. Tell me what it’s like to be a young Black man seeking care in Quitman County.
   4. Tell me about the places you seek care.

3. *Research Question Three:* How does social and cultural factors influence rural African American men ages 18-34 use of preventive health care services?

   Interview Questions:
   
   1. What are some stories you’ve heard or been told over the years about doctors or the health care system?
   2. How does your gender, age, class or race affect your perception of the healthcare system?
   3. Tell me about a time when you decided not to seek medical care.
   4. While you were growing up, how involved was your father or your father figure in your medical care?
   5. When you were growing up, what kinds of things did men in your community do that affected their health? What lessons did you learn from the men in your community about being a man and taking care of your health?
   6. How does being a man influence your health seeking?
   7. Tell me a story about a time when you were seeking care and became aware of your race, age, gender or class? (provide example)
8. What would you suggest we do to encourage more men to go to the doctor for routine care?

**Data Analysis Procedures**

**Transcription**

The first step of the analysis of the narratives was to reduce the data by transcribing the audio recorded interviews. Transcription involved close observation of data through repeated careful listening. Transcription occurred at the completion of each interview. The data were transcribed verbatim, noting pauses and other breaks as well as non-lexical utterances. The transcripts along with the audio file were stored in an Nvivo file. When conducting interviews and recording, a non-identifying variable, a number was given to the participant’s interview. This participant number was used to identify the transcription and any other documents that were linked to the participant. A master list of the participant’s name and the number assigned to each participant was kept at a location that is different from where the data were kept to avoid a breach in confidentiality. After completing the transcription process, the transcripts were checked against the original recorded audio to ensure accuracy.

**Narrative Analysis**

Data were analyzed using three techniques: narrative analysis, thematic narrative analysis, and poetic transcription. The data set for each participant was conceptualized as a large narrative constituted of many intertwining small narratives. These small narratives, collectively, formed the unit of analysis. Narrative analysis or narrative methods are a product of what was termed the "narrative turn" in social science research, which has been described and analyzed as a response to the lack of human stories in traditional social science in the 1960’s (Kramp, 2004). Early works delineating the historical foundations of narrative methods included works on life
histories and oral narratives. The focus of these methods were life stories that described the personal experiences of poverty, inequality, sexism, and many other social and cultural experiences (Chase, 2005).

Narrative analysis focuses on the extended account as the analytic unit. Kim states “narrative analysis or narrative mode of analysis is based on narrative cognition that attends to the particular and special characteristics of human action that takes place in a particular setting” (2012, p. 197). Each participant transcript was read and re-read to create the narrative. Using Clandinin and Connelly (2000) as a guide, the stories were explored within three dimensions: temporality, sociality, and spatiality. Temporality considers how the story changes from the past, present and into the future (Clandinin & Connelly, 2000; Haydon, van der Reit, & Browne, 2015). Within the social dimension, the narrative framework considers the relationships between the storyteller, those within the story, and how the story changes depending on who receives it (Clandinin & Connelly, 2000). Spatiality accounts for where the narrative was experienced and shapes how the narrative is told (Clandinin & Connelly, 2000).

Using Polkinghorne’s concepts of narrative analysis, each narrative was arranged into a coherent whole which sustained the richness of the story (Kim, 2012). Within this method, I focused on the events, characters, and actions described in the data and put them together in a plot to produce a coherent story (Kim, 2012, p. 197). Within each narrative, I weaved in direct phrases and text from the raw interview transcript to keep the voice of the participant alive. This method of narrative analysis helps the reader understand why and how things happened in the way they did, and why and how the participants acted in the way they did. It is a means of filling in the gaps between events and actions to show the significance of the lived experience in the final story.
Narrative Thematic Analysis

Thematic analysis is frequently used to analyze qualitative data. Thematic narrative analysis focuses on the content of the story rather than the interaction between the narrator and listener (Ackerman-Barger & Hummel, 2015; Riessman, 2008). This method focuses on the discovery of salient constructs in the storied data in which the concepts are inductively derived from the data similar to that of grounded theory (Kim, 2012). Although thematic analysis is often confused with grounded theory, thematic analysis seeks to keep a story “intact” by theorizing from the case rather than across cases (Riessman, 2008, p. 53). This process uses the transcribed text to look for patterns, narrative threads, and tensions across an individual’s experience in the narrative environment (Clandinin & Connelly, p. 132; Kim, 2012). In thematic analysis of narratives, the findings are arranged around descriptions of themes that are found within each individual account. Thus, the qualitative data analysis is both a description of the story and the themes that emerge from it (Creswell, 1998)

After transcription was completed, I analyzed the data by immersing myself with it through repeated readings of the transcripts. After I read and familiarized myself with it, I generated an initial list of ideas from the data and what was interesting about them. Next, I started the initial patterns in which codes will identify a feature of the data (Braun & Clarke, 2006).

Once all data have been initially coded & collated, I then sorted the different codes into potential themes, and organized all the relevant coded data extracts within the identified themes. A theme was coded if it captured something important about the data in relation to the research question, and represented some level of patterned response or meaning within the data set. After devising a set of candidate themes, I then worked to refine the candidate themes (Braun &
Clarke, 2006). During this process, it became evident that some candidate themes were not really themes as there were not enough data to support them or the data are too diverse. Separate themes were broken down to help reveal additional information about the data.

The final process of the thematic analysis involved reviewing and refining the themes. This included reviewing to consider whether they appeared to form a coherent pattern. If the themes did not fit a coherent pattern they were reconsidered and reworked to create a place within the final data sets (Braun & Clarke, 2006). Lastly, as part of the refinement process, I identified whether a theme contained any sub-themes (Braun & Clarke, 2006). Detailed memos were kept throughout the entire process of data analysis. For each individual theme, a detailed narrative was provided. As well as identifying the ‘story’ that each theme tells, I also considered how it fits into the broader overall ‘story’ about the data in relation to the research questions to minimize overlap.

**Poetry and Poetic Transcription**

Poetic inquiry can be used as an analytical or reflexive approach as well as a representational form in qualitative work (Prendergast, Leggo, & Sameshima, 2009). Philosophically, poetic inquiry is aligned with the work of historical poets who were and are dedicated to using poetry to communicate experiences of “memory, identity, place, relationality, hope, fear and/or desire” (Prendergast et al., 2009, p. xxxvii). Poetry as an inquiry can be an effective way to recreate and confirm the lived experience of others while evoking the reader’s emotional response to produce a shared experience (Carr, 2003; Freeman, 2006). Poetic inquiry is also frequently seen as poetic transcription, a representation of participant data. It is suggested that poetic transcription is similar to the practice of *found poetry*, which involves using the words
found within the data to create poems (Prendergast et al., 2009). Glesne (1997) defines poetic transcription as the following:

Poetic transcription approximates poetry through the concentrated language of interviewee, shaped by researcher to give pleasure and truth. But the truth may be a ‘small t’ truth of description, re-presenting a perspective or experience of the interviewee, filtered through the researcher. It may not reach the large “T” truth of seeing “with the eyes of the spirit” for which poetry strives. (p. 213)

Poetic transcription involves transforming the raw interview transcripts into poetry (Glesne, 1997). After transcribing the interviews, I immersed myself in data by reading through each transcript. Using Glesne’s work (1997) as a guide, poetic transcriptions were created to support themes within the data that may arise. I used my interview notes and memos to generate major themes and followed the thematic analysis process. After generating themes, I then searched the interview transcripts for text that supported each theme. I used an excel spreadsheet to organize the segments of the interview transcripts, the narrative that was composed using narrative analysis, and the poetic transcription that was created using the raw text from the transcript. Each poetic transcription was unique to the voice of the participant. I used short stanzas to represent speaking rhythm and to keep words together. The poems were written in chronological order to follow the narrative and to be linguistically faithful to the transcript (Glesne, 1997). I refrained from breaking down verb tenses or juxtaposing phrases from other segments of the text. Lastly, I used repetition to convey essential thoughts and the emotions that were expressed in the speaker’s voice when telling his story.
Member Checking

This process of member checking ensured accurate representation of the participant. Member checking is when data, analytic categories, interpretations, and conclusions are tested with members of the groups from whom the data were originally obtained (Harper & Cole, 2012; Lincoln & Guba, 1985). Several positive aspects are associated with this process in qualitative research. Member checking provides an opportunity to understand and assess what the participant intended to do through one’s actions (Creswell, 1998; Creswell & Miller, 2000). Secondly, it gives participants an opportunity to correct errors and challenge what are perceived as wrong interpretations. It also provides the opportunity to volunteer additional information which may be stimulated by the review process. Lastly, it provides an opportunity to summarize preliminary finding and to assess adequacy of data as well as to confirm particular aspects of the data. Member checking served as a means of ensuring validity within the data.

Before publication and final review, participants were contacted to review the data. Each participant was emailed a copy of his transcript and the constructed narratives derived from the interviews in the articles in chapter four to review during the member checking process. Participants were given two weeks to review the information and offer any revisions. During this time, only two participants contacted the researcher to state that they were not in objection to the information provided. These two participants were also the only two that offered poems that will be discussed in chapter four.

Summary

Chapter three presented narrative inquiry as the methodological approach, the connections of the theoretical frameworks to the methodology, participant selection, recruitment and consent. Following that presentation, a brief review on the use of pilot testing was provided.
The chapter also provided details related to the use of a demographic survey and interviews as data collection methods, as well as the data analysis procedures: transcription, narrative analysis, thematic narrative analysis, and poetic transcription. Lastly, details on the use of member checking as a validation measure closed the chapter.
CHAPTER FOUR RESULTS

“There is no greater agony than bearing an untold story inside you.”

Maya Angelou

Chapter four presents findings from the study in the form of three manuscripts. The first manuscript provides findings using Andersen’s Behavioral Model of Health Services Use to explore predisposing, enabling, and need factors that affect young, rural, African American men’s decision to seek care. The second manuscript uses poetic transcription and Critical Race Theory to focus on stories about mortality surrounding being a Black man in America and mortality surrounding the healthcare system. Within those experiences, fear was a recurring influence in determining future decisions to seek preventive care. As such, I felt that representing the data in the form of poems would be a profound way to depict experience of the participant and engage the reader. The final manuscript provides data to support the influence of familial support and male social networks on health seeking behaviors among 18-34 year-old African American males. Each article presented in this chapter provides background, methods, presentation of findings, implications and recommendations for the field of health education to move rural, African American men’s health to the forefront. Although the three individual manuscripts present findings from the research, the not all data relevant to the study research questions is presented in the manuscripts. The following section presents findings (or data) to addresses the three research questions in totality.
Analysis of Research Questions

1. Research Question One: How do African American men ages 18-34 in a rural Mississippi community construct and narrate meanings of health?

   a. Across the interviews there was a heavy influence on health as being mentally, spiritually, and physically fit. Most definitions included maintaining healthy practices such as eating nutritious foods and exercising. Others stated that health was the overall well-being of an individual which included being free of physical ailments, pains, and having mobility.

   b. Health was also described as ensuring that everything in the body was working well together and getting checkups; simply put health was described as just feeling good and feeling well.

   c. Constructions of health were shaped by the geographic location. Participants shared that being healthy was limited to the choices they had in the community. They noted that there was a lack of resources within the community which causes individuals to give up on eating better and engaging in exercise. There is a lack of fresh foods available and to be healthy one might have to drive to a neighboring town to get fresh grocery.

2. Research Question Two: How have past experiences shaped African American men in a rural community perceptions of the healthcare system?

   a. Several participants described the influence that historical injustices such as Tuskegee and local incidents that have shaped how they view the health care system. Participants were cautious after learning about those instances but it did not deter them from seeking care.
b. Participants detailed events of being seen by medical professionals who were not certified. Individuals who have had unpleasant experiences at local facilities are not likely to continue seeking care. Additionally, facilities that do not offer specialized care such as obstetrics/gynecology, gastroenterology, or critical care are bypassed in this community as individuals are more trusting of facilities they consider to be high level due to the availability of more specialized services. Some participants also expressed that they were confident that the individuals employed at the local hospital and clinics were competent due to positive personal experiences and the experiences of others.

c. Most participants shared that their perceptions of the health care facilities in the community have been influenced from the stories of family and others in the community as many do not use the local facilities.

d. Experiences of family members such as death due to lack of adequate diagnosis, watching family members consistently be readmitted for issues, have created a general discomfort with hospitals and clinics resulting in avoidance behavior and a negative perception of local facilities.

e. Additionally, others view the healthcare system primarily as a business that is not centered around wellness but in keeping individuals sick. Doctors push drugs and services that the patient does not always deem necessary.

3. **Research Question Three**: How do social and cultural factors influence rural African American men ages 18-34 use of preventive health care services?
a. Understanding health from a sociocultural angle focuses on the significance of religion, tradition, politics, economics, history, and society’s view of science are factored into a person’s overall well-being.

b. Participants tied their religious beliefs of the to their decision to seek care and to stay informed about their health often stating phrases such as the “body is a temple.”

c. Race was not an essential factor in the decision to seek care as experiences of personally-mediated racism within the health care system were not addressed. However, experiences of racism were realized in day-to-day encounters such as racial profiling while driving to work or microaggressions through social media. Also, in regards to race, some participants stated that they felt more comfortable with Black doctors and were more likely to seek care from Black doctors.

d. Male gender also influenced how the participants perceived the health care system. Several participants stated that most men did not view doctors as necessary and that feelings of machoism, pride, and not wanting to feel vulnerable deterred them from seeking care when needed. Fear of a negative diagnosis also impacted their decision to seek care.

e. Income and health insurance were two factors that were commonly discussed together. Most participants stated that not being able to pay for services beyond the coverage of the health insurance was problematic.

f. In the community, most men stated that there were very few positive examples of men who engaged in preventive care. Most men in the community were deemed as unhealthy due to smoking and drinking. Yet these men used the negative
decisions of men in the community as a motivator for them to make healthy decisions.

g. Education was considered to be a positive and negative factor that contributed to the decision to seek care. Several participants noted that sometimes high levels of education can be a hindrance as individuals are more likely to rely on health-related sources on the internet to diagnose symptoms. Yet, researching symptoms also helped participants to be able to confidently discuss their health problems with a physician when seeking care.

**Manuscript One: Using narrative inquiry to explore predisposing, enabling, and need factors that influence young, rural, African American men’s decision to seek preventive care**

**Abstract**

African American men suffer disproportionately from preventable illnesses such as cancer and heart disease. Yet, African American men are least likely to use preventive health services that could potentially decrease their risk of developing these diseases in older age. The purpose of this study was to use narrative analysis and Andersen’s Model for Health Care Services Use to examine factors that contributed to the preventive health decision-making among young, rural African American men. Interviews were conducted in a community-based sample of ten African American men between the ages of 18-34. Data were analyzed using narrative inquiry methodology. The study indicated predisposing factors such as age and attitudinal beliefs, resources within the community and illness level affected African American men within this age group’s decision to engage in preventive care.
Introduction

Preventive health care such as immunizations, screenings, and annual checkups, are an important aspect in helping to reduce morbidity and mortality. Yet, men are least likely to use preventive health services, often delaying vital screenings such as blood pressure and cholesterol and routine check-ups (Bonhomme & Essuon, 2012). Men also tend to wait longer after the start of symptoms before seeking care and underutilize clinically appropriate health services (Bonhomme & Essuon, 2012). This leads to patterns of episodic care for treatment and inconsistencies in care. Previous research has stated that younger age (19-39 years old) and male gender was both risk factors for not visiting a physician during the previous year (Andersen et al., 2002).

Many African American men are invisible from health care settings until their health conditions worsen or become severe (Gilbert, 2013; Griffith, Allen, & Gunter, 2011). Among racial and ethnic populations, African American men are least likely to participate in preventive health care compared to African American women. This delay in care contributes to significantly poorer health outcomes within this population (Bonhomme & Essuon, 2012). Thus, understanding African American men’s preventive health care use has become an important priority in the efforts to diminish health disparities among this population (Stevens-Watkins & Lloyd, 2010). African American men who reside in rural areas experience many barriers to health care access which can contribute to health disparities such as high uninsured rates, healthcare workforce shortages, transportation, distance and access to quality care, and lack of specialized health care services (Lu, Mieskowski, Oliver, Eichorst, & Allen, 2015; Rural Health Information Hub, 2014; Wynveen, 2010). The physical environment of rural areas poses
additional strains to accessing needed care and negatively impacts an individual’s decision to seek preventive services (Rural Health Information Hub, 2014).

Past studies exploring this topic have not sought to understand the distinct factors that affect men between the ages of 18-34. The purpose of this study was to use narrative analysis and Andersen’s Model for Health Care Services Use to examine factors that contributed to the preventive health decision-making among young, rural African American men. Building on these previous studies, we conducted a narrative analysis of stories told by African American men ages 18-34 in the community through interviews. The following research questions guided the study:

1. How do social and cultural factors influence rural African American men ages 18-34 use of preventive health services?

2. How have past experiences shaped African American men in a rural community perceptions of the healthcare system?

**Conceptual Model.** The Anderson Behavioral Model of Health Services Use was first developed during the 1960s and began as a behavioral model used to provide measures of understanding conditions that either facilitated or delayed medical care utilization (Andersen, 1995). The model suggests that an individual’s access to and use of health services is considered a function of three characteristics: predisposing factors (sociodemographic), enabling factors (economic and social), and need factors (health and functional status) (Andersen, 1995; Andersen & Newman, 2005). It also considers the impact of the structure of healthcare facilities within the community as an enabling factor to predict use. This takes into consideration how medical care facilities are organized and how the types of services offered influence the choice.

Per Andersen’s model, predisposing factors constitute socio-cultural characteristics that exist prior to illness. These factors include an individual’s age, gender, education, marital status,
occupation, ethnicity, social interactions, and culture (Andersen, 1995; Andersen & Newman, 2005). Additional predisposing factors include attitudinal beliefs such as an individual’s values and knowledge concerning health care system. Enabling factors or the logistical aspects of obtaining care consider the influence of both community and personal resources that must be present for use to take place. These community and personal resources that determine and individuals’ use include: access to and availability of services, proximity of services to where people live and work, health insurance, income, waiting time, and regular source of care. The need factors (perceived and evaluated need) consider how the individual perceives their own general health as well as how they experience symptoms of illness, pain and worry (Andersen, 1995). Evaluated need relates to the kind and amount of treatment provided by the healthcare professional (Andersen, 1995). By considering factors beyond the individual’s personal health beliefs, the model illustrates how the health outcome is affected by predisposing factors, enabling resources, and the individual’s need for services. The model is a more integrative approach to understanding the specific behavior of health services use.

Several studies have used the model to focus on social and cultural norms including traditional health beliefs and its influence on utilizing health care services (Hammond, Matthews, Mohottige, Agyemang, & Corbie-Smith, 2010; Insaf, Jurkowski, & Alomar, 2012). Of the reviewed studies, one studied utilized qualitative focus groups in development of the survey and only one study exclusively focused on African American men (Hammond, Matthews, Mohottige, Agyemang, & Corbie-Smith, 2010). Insaf, Jurkowski, and Alomar (2012) conducted a study to understand the sociocultural factors influencing delay of routine health care among Latinas. Focus groups were conducted and guided the development of a 70-item survey instrument. The researchers collected responses from 287 Latinas from the Capital District, NY. The Andersen
model was used to assess predisposing, enabling, and need factors influencing delay in seeking care. Findings suggest that approximately 70% of Latinas reported delaying care. Among predisposing factors, such as marital status and doctor preference, women who were not married were more likely to delay care. Additionally, women preferred a Latino doctor or used alternative medicine. In regard to enabling factors, lack of health insurance and experiences of discrimination during prior visits contributed to the delay of care (Insaf et al., 2012).

The second study used Andersen’s model and Theory of Reasoned Action as a framework to understand the psychosocial factors associated with routine health examination scheduling and receipt in a sample of African American men (Hammond et al., 2010). The cross-sectional study sampled 386 African American men recruited from barbershops and academic institutions in Michigan, Georgia, and North Carolina. The study assessed predisposing factors as age (range 18 to 78), educational level, and marital status (currently married or unmarried). Enabling factors were described as annual income which ranged from (n ($≤20,000- ≥$40,000), employment status (employed full-or part-time and unemployed), health insurance status, and routine source of care (Hammond et al., 2010). Findings from the study suggest that traditional male role norms around disclosure of personal illness had a negative impact on receipt of routine health examinations among African American men (Hammond et al., 2010).

**Design and Methods**

Narrative inquiry was the methodology used for this study. Using the narrative approach, researchers seek to understand meaning in events and in human interactions. Narrative inquiry aids in the identification of sociocultural factors that influence population health outcomes through storytelling (Lee, Fawcett, & DeMarco, 2016). The use of Andersen’s conceptual model
in conjunction with the narrative approach will help to understand the social and cultural factors that promote or deter African American men’s preventive health decision-making.

**Sample Recruitment and Data Collection** Prior to beginning the study, approval from the university Institutional Review Board (IRB) regarding all data collection procedures was obtained. Participants were recruited through the use of faith-based partnerships with 12 local churches in a rural county in the Mississippi Delta. Each pastor of the church received a mailed recruitment letter and flyer that provided details about the study. Pastors were asked to share the recruitment letter with members of their congregations during service and to post the flyer in a visible area. The study recruitment letter detailed the purpose of the study, inclusion criteria, estimated time allotted for interviews, brief highlights of the study purpose and contact information. Additionally, information about the study was shared on my social media outlets to reach participants outside of the local church. Inclusion criteria for this study were as follows: self-identification as Black or African American male, 18-34 years of age, and residence (current and past) in the study geographic area. Written consent was obtained from each participant before beginning participation in the study.

As the research questions required detailed accounts of the experiences of a specific group, a purposive sampling was used and stories were gathered from 10 men. Each interview was recorded using a handheld digital audio recorder. The length of time for each interview varied from 60-90 minutes. A descriptive demographic survey was used to collect data from the participants before conducting the interview. Pseudonyms were used to protect participant identity as well as names of places referenced in participants’ stories. Participants were asked a set of guiding questions about current health status, memorable moments when seeking care, and places in which they seek care (Table 1).
Table 1. Guiding questions for interviews

<table>
<thead>
<tr>
<th>Interview Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Tell me about your health.</td>
</tr>
<tr>
<td>2. How does living in County affect your health?</td>
</tr>
<tr>
<td>3. Tell me about the first time you decided to seek medical care on your own.</td>
</tr>
<tr>
<td>4. Tell me about some of your most memorable moments when seeking care.</td>
</tr>
<tr>
<td>5. Tell me what it’s like to be a young Black man seeking care in County.</td>
</tr>
<tr>
<td>6. Tell me about the places you seek care.</td>
</tr>
<tr>
<td>7. What are some stories you’ve heard or been told over the years about doctors or the healthcare system?</td>
</tr>
<tr>
<td>8. How does your gender, age, class or race affect your perception of the healthcare system?</td>
</tr>
<tr>
<td>9. Tell me about a time when you decided not to seek medical care.</td>
</tr>
<tr>
<td>10. While you were growing up, how involved was your father or your father figure in your medical care?</td>
</tr>
<tr>
<td>11. When you were growing up, what kinds of things did men in your community do that affected their health? What lessons did you learn from the men in your community about being a man and taking care of your health?</td>
</tr>
<tr>
<td>12. How does being a man influence your health seeking?</td>
</tr>
<tr>
<td>13. Tell me a story about a time when you were seeking care and became aware of your race, age, gender, or class?</td>
</tr>
</tbody>
</table>

**Data Analysis**

Analysis of the narratives began by transcribing the audio recorded interviews. The data were transcribed verbatim, noting pauses and other breaks as well as non-lexical utterances. All names and identifying information were changed to unique codes to ensure the identity of the participant was protected. After transcription, the researcher engaged in repeated readings of the transcripts to gain a holistic understanding of the participants. Each participant’s transcript was read and re-read to find responses that offered thoughts on the decision to seek that discussed predisposing, enabling, and need factors within each participant narrative. The data were then analyzed narratively using Clandinin and Connely’s (2000) three-dimensional framework: temporality, sociality, and spatiality. Temporality addressed how the story changes with time.
While sociality considers the interaction of the storyteller with others within the story, and spatiality considers where the narrative was experienced (Clandinin & Connelly, 2000). Plotlines were identified and a written account in chronological form was composed (Polkinghorne, 1995). Afterwards the composed narratives were categorized by the three factors (predisposing, enabling, need) using the Andersen framework. Each account was then member checked by the participant to ensure that anonymity was maintained and the composed narratives were a valid reflection of the experience. While the other text has been revised and synthesized for clarity.

**Findings**

**Demographics.** Characteristics of the study population are presented in Table 2.

Participant ages ranged from 18-33 with a mean age of 26.6 years. Most the participants were unmarried, had completed high school or higher education and had income levels of $31,000 to $40,000 or more. Only two participants in the sample did not have health insurance and two participants were currently unemployed. The time since last visit to a health care professional ranged from never visiting, two months being the most recent visit and two years being the longest time since last visit. Four of the ten participants stated that they did not have a primary care physician who they consistently visited for care.

Table 2. Demographic information of participants n=10.

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Current Residency in County</th>
<th>Marital Status</th>
<th>Educational Level</th>
<th>Income</th>
<th>Employment</th>
<th>Time Since Last check-up</th>
<th>Health Insurance Status</th>
<th>Personal family doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stanford</td>
<td>28</td>
<td>Yes</td>
<td>Never married</td>
<td>Graduate or professional degree</td>
<td>$31,000 to $40,000</td>
<td>Full-time</td>
<td>2 years</td>
<td>Insured</td>
<td>Yes</td>
</tr>
<tr>
<td>Lorenzo</td>
<td>29</td>
<td>Yes</td>
<td>Never married</td>
<td>Bachelor’s degree</td>
<td>$31,000 to $40,000</td>
<td>Full-time</td>
<td>2 months</td>
<td>Insured</td>
<td>No</td>
</tr>
<tr>
<td>Dewayne</td>
<td>28</td>
<td>No</td>
<td>Unmarried relationship</td>
<td>Graduate or professional degree</td>
<td>More than $41,000</td>
<td>Full-time</td>
<td>2 years</td>
<td>Insured</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Narrative Analysis. The findings of the narrative analysis are presented in this section.

The stories of seven participants: Trenton, Sam, Joshua, Dewayne, Lorenzo, Miles, and Stanford are presented to highlight each component of the conceptual model and provide context for understanding the decision to seek care. Direct phrases as stated by the participant are in bold and weaved throughout the narrative; while the other text has been revised and synthesized for clarity.

Predisposing Factors

Age. Andersen (2005) suggests that although age is described as a predisposing condition it is not considered a reason to seek health care. However, participants in the study noted that their age was a determining factor in their choice to seek health care.

Trenton, 23, Student

As I got older I scheduled my appointments but being at back at home makes it easy to rely on my parents. I have been so used to them making my appointments and telling me when and where I need to go. Sometimes I still feel like I’m a lil’ child. Being here, it’s
like I’m still a baby waiting on them to tell me when to go this appointment. When I move out and really get out on my own I will go more often. I know that’s what I’m supposed to do.

Sam, 26, Coach

For me, my main problem with going to the doctor for preventive care is with age. I think well I’m too young for this or I’m too young for that. You know you think as a young person you won’t have a lot medical problems. And like you said just a few minutes ago, like how I don’t know the symptoms and this that and the other. I just feel like I’m 26 years old. I ain’t got to worry about that. Usually you think about old folks, but now you got kids you know with diabetes. About three years ago, my brother was diagnosed with diabetes. He’s probably had it much longer than that and he had high blood pressure as well. He’s is just three years older than me. If I really sit down and think about it, three years is not a big difference. It really makes you think, like you can have this problem too. The problem with age you think that you’re young, you’re superhuman, and these things won’t happen to you.

Stanford, 28, Teacher

When I was younger, I was very, very reckless with my eating habits. It was a competition to see if I could eat a double quarter pounder or some hot wings with two hours of each other. You know, I didn’t care. I could eat anything and you know I would never gain weight. As I got older I couldn’t do that anymore. My mindset shifted. When I first turned 26 I knew I had to make a change I wasn’t 18-19 no more. I felt my body shifting and changing and I just knew it was time. Especially now that a lot of my friends have problems with their health and I’m the same age as them it can happen
to me. So, it really opened my eyes that just because I’m in my mid-20s that don’t mean that I’m invincible that I’m off limits.

Miles, 26, Industrial Worker

I’ve always felt like health was important but I was more so focused on the outside; whether I could fit my clothes. I can’t really say what changed but something did change and I realize now that I done got older. I have experienced a few things down the road that got me to thinking that it wasn’t enough just to look good on the outside. Even though nothing is wrong, now that I’m 26, I realize the older you get the more at risk you become for certain illnesses. Especially if you not taking care of your body and if you have a family history of high blood pressure, cancer, all that type of stuff going on. I see it a lot different. It’s like it’s a must.

Throughout the stories, we see how each participant grapples with the idea of seeking care. Several participants noted that because of their age, preventive care is not a necessity. Additionally, participants talk about the age in which they realized that they needed to change their mindset and start to truly practice health habits. Age affected the participants in a way that affected their self-efficacy to schedule appointments and to seek care on their own. The narratives of Stanford and Miles detail the rise in their awareness and need to utilize medical care as they began to get older. In Stanford’s narrative, he mentions turning 26 as the age in which he began to shift his perspective. Twenty-six is also the current ages of both Sam and Miles, who are also starting to be more proactive about their health. Sam mentions that in younger age individuals them that they are “superhuman.” Yet, his brother’s diabetes diagnosis proves that younger individuals are susceptible to illness as well. Stanford also shares how the diagnosis of friends his age has assured him that just because he is young he is not invincible.
Race.

Sam, 26, Coach

One time I went to the doctor for a cold and I was sitting there a long time. It was a few more other people waiting too. These other people, some white people, come in after me and they were called back before I was. I was there before them unless they had an appointment for 7 weeks ago, but I doubt it. I really doubt it. I didn’t make a big deal about it at the time but I was thinking to myself what’s the deal with that? You know these black folks came in before them but you didn’t call them. Sometime I get in the mode and I just think being African American you get slighted in every situation. I can’t say that race was a part of that situation but sometimes it could play a role. Most times I don’t care, I just want to be seen by whoever is available. I’m not going to this doctor place because they got white doctors here or go to this doctor because he’s Black. In all the years I’ve gone to Foster Medical Center for care I’ve never seen a Black doctor. I’ve only gone to one Black male doctor and he had a clinic in Cattica. My mom used to go to him all the time and she was like go and see what the Black doctor say, so I went. Most of the time I’ve felt like the white doctors have treated me fairly. Yet with all the stuff that’s going on now I do think about where they really care about my health before I chose to go to a doctor. Sometimes I wonder if they are really telling me the truth. Or will they you know give me the right diagnosis? Will
they really prescribe me? Do they really care? All these episodes start playing in your head and you start to think what if they apply this to this situation to medical care?

In the interviews with the participants, race was not primarily a determining factor in their decision to seek care. Sam’s narrative depicts the subconscious thoughts of how race could be present when seeking care. He shares a story about waiting much longer for the doctor than another family who was white. Though Sam mentions that he did not bring attention to the situation with any staff of the facility, he pondered if their immediate care was because of their race. He also shares important notes on race of the medical provider. Due to the shortage of doctors within the rural areas, Sam has been seen by the same doctor since his childhood. He also notes that there has never been a Black doctor in the area. Since he has not had much experience with Black doctors he does not have a point of reference to determine if there was any difference in his care. Other participants have also stated that they only choose to visit Black doctors, most of which are outside of the county in which they reside.

**Gender.** Gender is a unique component within the context of the participant’s stories, as gender was often racialized and centered within cultural practices. African American men’s ethnic identity and definitions of race, ethnicity, identity and ideals of masculinity are often shaped by experiences with White American society. Thus, gender intersects with structural racism in complex and dynamic ways to influence the cultural schemas that shape Black American men’s lives and health outcomes.

Dewayne, 28, Musician

**I think a lot of guys go through this macho complex. I don’t want to say we feel like we’re too proud or prideful.** Sometimes I think we feel like we know ourselves and the doctor can’t tell me something about myself I don’t already know. I think it stems
from who you are around. Like my dad isn’t like that but I had a grandfather that
wouldn’t go to the doctor and he lived to be 90 years old or something like that. So,
you thinking, well I don’t have to go, my grandfather didn’t have to go to the doctor.
My grandma just made him some of her special this and that and he was straight. I
guess when you around that all the time you grow up with that and that’s all you know.
So, I don’t not even think it’s just the machoism. Honestly, I don’t think health is just
important to a lot of us. I think that’s what it is. I just don’t think it’s important
until it has to be.

Sam, 26, Coach

Some men I know they feel like they macho. They don’t need to go to the doctor and
next thing you know something really wrong. I feel like maybe that’s the case with
me but I don’t know. I really don’t have a problem with doctors but it’s certain stuff that
as a guy make me feel uneasy about going to the doctor. Like for example, having a
colonoscopy done. This one guy told me about the time he went to get a colonoscopy and
then he was like the man stuck his finger in his behind. After hearing that I wasn’t going
to go up there. I just don’t know if I feel comfortable with a man sticking his finger in
my behind even if it is for my health. You know as a man that’s off limits. You just
don’t do stuff like that. Even if it was a woman doctor, I still wouldn’t be comfortable
with that. You thinking man you wouldn’t be comfortable with nothing like that.

Dewayne and Sam’s narratives both convey ideas of masculinity and machoism as a
factor in not seeking care. Previous research suggests that men delay using preventive health
services because of traditional social constructions of masculinity, which prescribe extreme self-
reliance, stoicism, and health care avoidance for men (Hammond & Mattis, 2005; Hammond,
Dewayne shares that his ideas of masculinity are shaped by the men in his life, his grandfather and his father. His story points to how one individual who may not seek care becomes a point of reference for the entire family. His grandfather living to the age of 90 could be seen as a success story of someone who did not use medical services but seemed to have lived a quality life. He also mentions that for most men, health isn’t important until it has to be which in most cases disease progression is often severe. Sam also speaks about feelings being macho. Although he begins his story stating that he does not consider himself macho, he comes to the realization that he is uncomfortable with certain aspects of examinations. Other participants in the study also allude to the invasive nature of examinations as a barrier to care. Sam’s narrative also points to the idea of normative heterosexual male ideals by stating, “as a man that’s off limits.” The idea of engaging in a rectal exam during a colonoscopy is unsettling to him as a cisgender heterosexual male who has also never had an annual examination.

**Attitudinal beliefs.** Some individuals are more inclined to use health care services than others (Andersen & Newman, 2005). This propensity toward use can be determined by individual characteristics such as the intimate nature of age, race, and gender, which exist prior to the onset of specific illness (Andersen & Newman, 2005). Attitudinal beliefs are a byproduct of age, gender, and societal norms within the study population. As denoted in the previous sections, participants felt that because of their age they were primarily healthy and not in need of health care services. Beliefs about masculinity and manhood can lead men to take actions that harm themselves or cause them to refrain from engaging in health-protective behaviors (Williams, 2003). Other participants mentioned that “it’s every aspect of the whole ordeal,” meaning being male and having an attitude that because you are young you are not likely to get sick.
Participant narratives also point to the use of home remedies as a method of treatment and even prevention. Thus, cultural beliefs are shaped generational practices. Though race was not mentioned as a factor, Stanford discussed how traditions are formed due to racial injustices. He shares how home remedies were created because African Americans like his grandparents were not allowed to be admitted to public hospitals. Because of structural racism within health care systems, many young African Americans still ascribe to old practices even though the circumstances have changed.

Enabling Factors. The enabling factors reflect the status of the individual in his society as measured by characteristics such as education and occupation of the family head. These characteristics suggest what the life style of the individual may be, and they point to the physical as well as social environment of the individual and associated behavior patterns which may be related to the use of health services (Andersen & Newman, 2005). The following stories discuss income, health insurance and the perception of quality care within the community.

Income and health insurance

Joshua, 30, Minister

Income does play a part in my decision and maybe even other men. Sometimes that’s the first thing we think of. Sometimes I don’t have any extra money to give to a doctor today. Especially when you feel like all they want is your money and they don’t care about your health. The last time I went to the doctor they wanted me to schedule another appointment just to come view my results. Then they tried to put me on some vitamins and schedule another appointment just to see how those were working. I feel like it’s all a part of their plan, to put you on some more pills. Just so they can bring you back. Every time they bring you back that’s some more money.
Dewayne, 28, Musician

In 2011, while I was working at the youth center I think I got strep throat. I ended up having to go to the doctor because I had let it get to a point where I got an ear infection in both of my ears. At the time, even though I was working I didn’t have health insurance. I think that’s another reason why a lot of black males don’t go to the doctor because I don’t think a lot of them have health insurance. I really hadn’t gone to the doctor much on my own so I was oblivious to the process. When you grow up, you really grow up and I had to learn the hard way. I don’t think I understood that when you reach a certain age you’re not under your parent’s health insurance anymore. So, I’m thinking all I had to do was pay for the prescription and everything. So, I pay for the prescription and everything and I went to the doctor two weeks later I got like a three-hundred-and-fifty-dollar doctor bill. So, I think that’s what deters a lot of black males going as well. You don’t have the cash or health insurance and that’s major.

Sam, 26, Coach

One time I had a cold and I had to decide whether to drive to Delltown to Foster Medical Center or just go and grab something from Walmart. The closet Walmart to me is about 30 minutes which is about the same distance as the clinic just different directions. Before deciding what to do, I was really thinking about how much it was going to cost. Like, if I go to the doctor’s office, insurance will pay this amount and you still got to pay $100-150 or something. Or I could just go to Walmart pay seven dollars for some Tylenol or Robitussin. So, I decided to go the doctor because I knew I could get a shot and a prescription and wouldn’t get billed that day because I didn’t have any money to go buy some cough syrup somewhere. So, cost does affect it a lot. I know, for me
personally cost would play a decision and probably for the majority of people in the County that don’t even have insurance to pay nothing.

In 2009, 27.2% of uninsured individuals in the Mississippi Delta were African American males. Among that group, African American males between the ages of 18-34 were the highest percentage (46.2%) of uninsured residents (Kerstetter, 2009). In the narratives of Joshua, Dewayne, and Sam, enabling factors such as income and health insurance were connected. All three individuals have health insurance provided through their jobs, are employed and have the income to pay for services however other individuals in the county may not. Yet, despite all the aforementioned factors, income, the ability to pay for services and health insurance affected their decision. For Joshua, it seemed that having insurance was another way for doctors to continually profit off patients by having them come back for seemingly unnecessary visits. Participants discussed not knowing that payment would be requested at the time of visit and not having disposable income for illness related care.

Dewayne’s narrative alludes to a lack of understanding as to how the healthcare system works. During his visit for strep throat, he was under the impression that his expenses would be covered by his parent’s insurance. He was unaware of the he was no longer covered by his parent’s insurance and was surprised when he received a bill. He was not prepared to handle the cost incurred for his visit. Sam’s story provides another glimpse into how income and insurance are connected. He details the decision to either seek the necessary care and be billed or use the little money he had money to buy over the counter drugs. Theses narratives are important as they detail how even when individuals have health insurance not having disposable income to pay for the additional expenses becomes problematic.
Source of care. Source of care within the context of rural communities is essential to the decision to seek care. The location of services, number of facilities, types of services provided, and the competency of the personnel were all revealed in the narratives shared by the participants. These components might be linked to utilization because of local norms concerning how medicine should be practiced or overriding community values which influence the behavior of the individual living in the community.

Joshua, 30, Minister

I’ve lived in the county since my family moved here in 1995. I didn’t know there was a doctor clinic in the County until 3 or 4 years ago. All the years I’ve been here I didn’t even notice that the building beside the community center was a clinic. I just thought we had a lil’ hospital. The truth is I’ve never gone here. My parents always took us to Cokeville when we needed to get something done. So now, going to the clinic in the county never comes to my mind. Plus, I always heard the rumors do not go to that hospital. One time I heard somebody telling me the people that work at the hospital are not certified. How is that possible? People would always say don’t go there or you’ll die. Another reason I didn’t go there is because I knew that they didn’t deliver babies. My high school classmate was one of the last babies born at the county hospital and that was in 1986. If you a hospital that do not deliver babies, then what are they doing? I feel like in order to get good care you need to go to a place that deliver babies. We don’t trust nobody if you don’t deliver babies.

Lorenzo, 29, Politician

When I was younger we used to go see Dr. Dollar. I remember him being a really good doctor. He was always family oriented. I don’t think he is practicing here anymore.
Honestly, I don’t think I would go to the doctor here in the County. If I’m going to go to a doctor now I would probably go to doctor may be like in Buford because I know Buford has those high-level facilities. Buford is about 45 minutes away from Delltown. I feel like if you need to get an answer then and they are going to be able to give you that answer. **Another reason I wouldn’t go to the County is because the doctors in the County always refer you to the doctors in Buford.** So, I would rather just go ahead and go to the doctors in Buford instead of going to the County and have to pay two bills. I look at it like this, why create a bill at the County when I could’ve went to Buford and have that one bill. I mean I guess it’s kind of being proactive but then I think it’s still not fair to the people in the County that come here to work.

Trenton, 23, Student

Growing up here, **we basically only have one option to go to either a hospital or a clinic.** The clinic only had one or two doctors and they were just general practitioners and basically they just prescribed the same medicine for every condition. They give you antibiotics for everything at the clinic. If you come in for a cold they give you antibiotics. You fall they give you antibiotics. Even if you go the hospital which is the other option, it’s the same two doctors that have admitting privileges there. If you can make it we try to at least get you to Buford or Mustenville depending on what your condition is. The health system here is a last resort. I remember one time in particular, I had a fever when I was in kindergarten and my parents got me up in the middle of the night and they took me to the hospital in Delltown. I didn’t know at the time but **the person that gave me a shot wasn’t a nurse.** My mom worked at the hospital and told me when I was older that the lady had never been to nursing school. She
was working under the license of a doctor administering shots as an LPN. She wasn’t even close to being a nurse not even a CNA.

Within these narratives is the evidence of how rurality shapes the perception of the facilities. Additionally, the perception of being seen by unqualified individuals is a deterrent to using the local facilities as depicted in Trenton’s narrative. Because of the lack of specialized services offered in the county, participants shared that they would rather drive to a neighboring town to seek care. Lorenzo’s story conceptualizes how there is not a need to seek care in the county because he would likely be referred to another facility in a different county. Instead of creating two bills for the same services, he chooses to go to the place that already has high level services. Additionally, Joshua’s story depicts how the reputation and trust of a particular facility is built upon the types of services that are provided. These experiences have shaped the decision to seek care in other areas when the perception of the local area is negative.

**Need factors.** In order for the individual to use health services, the individual or his family must perceive that illness is likely to occur when predisposing and enabling conditions are present (Andersen & Newman, 2005). Illness level characterizes the most immediate cause of health service use. In conjunction with the perception of illness by the individual or his family, a clinical evaluation is also included in the model. Once the individual seeks care from the healthcare system the nature and degree of that care is partially determined by them (Andersen & Newman, 2005). The following two stories discuss how participants have evaluated their personal need for medical services.

Dewayne, 28, Musician

*If I go to the doctor it would probably have to be for an emergency or something. I can gauge how my body feels. I know the difference in my body whether it’s just a*
consistent dull pain if it’s something hindering my every day activity. I can feel it. I know when something serious. In my mind, I’m thinking about if this pain is familiar but if it’s something I haven’t felt before then it’s time to go to the doctor. I remember when I was in college I thought I was having heart palpitations. I used to be in church and felt like my heart was beating too fast and I went to the doctor. So, one thing about it I was quick about going and that was the last time I went about something serious. For three days, I went through testing to see what was wrong. I got a EKG and it turned out to be fine. The whole experience was nerve-wracking from just sitting in the waiting room coming back for my results. I was really expecting him to come back and tell me I had to have a heart transplant or I had a hole in my heart. I mean that’ll give you a heart attack right there. The doctor told me I had a heart as healthy as a horse. Sometimes you get paranoid and stuff especially when you got friends and you compare your ailments and stuff with them. I guess that experience too is a reason why a lot of guys are scared to go to the doctor. They compare other peoples’ situations.

Stanford, 29, Teacher

I think I have the mindset that I’m really not that sick. Growing up you know, we used to fake sick when you didn’t want to go to school. We had to go through hoops and loops to prove to our parents that you was sick. We didn’t have babysitters like that so no one could stay at home with you if you were sick. I can remember being on my way to school one morning and I threw up in the car. My dad just gave me a Sprite or some cod liver oil and took me on to school. You really, really had to prove you were sick. If it was something you could take like a ginger ale or Sprite or something, you took that
and you were going to school even if you did just finish throwing up. So, I guess I got that mentality unless I’m dying, I’m good. I can just take this or that, regurgitate the sickness and I will feel better. I’ve carried that with me all through life. I’m not really that sick not yet. I think it’s embedded.

Within Dewayne’s narrative, he explains how he assesses his need for care. He mentions that if it is something that he’s felt before then he is less likely to go the doctor. Additionally, if it is a new feeling, then his awareness and need for care is heightened. His experience in seeking care for his perceived heart palpitations was deemed a serious matter in need of a professional opinion. However, after confirming that the issue was not severe, his experience also waiting for the results could be used as a deterrent. Throughout the interviews, participants allude to knowing their body and being able to decipher when something is wrong. However, this idea of trusting our bodies should also be confirmed by a professional opinion.

Conclusion

This research fills a significant gap in the literature on preventive health services use among 18-34 year-old African American men in rural community setting. As this study reports on qualitative findings of a small sample, it is not meant to be generalized to all African American males, and is specific to one geographic location. The findings from this study instead provide valuable insights from the participants’ stories of their experiences. It is important to note that a purposive sample was used to collect data and demographic data provide was self-reported. Despite these limitations, our study moves the literature beyond simple documentation of lack of preventive health services use towards a more detailed understanding of specific experiences among a population of men at greatest risk for disparities. To our knowledge, this
study is one of few existing investigations using narratives that address a broad range of factors associated with African American men ages 18-34 preventive health utilization.

**Implications**

Findings from this study provide an opportunity to develop culturally appropriate programs to increase African American men’s efficacy and engagement in healthcare system. The interpretive findings reveal that the decision to seek care is a compilation of factors such as sociodemographic characteristics, quality of services, and severity of illness. Using narratives allows the researcher to come to understand the interplay of all factors. Information gleaned from the narratives would be beneficial in thinking of innovative ways to reach this population.

Particularly, data from this study suggest that the perception of age is an essential factor to consider. Findings suggest that the perception of health begins to shift when African American men are in their early 20s. The likelihood of them seeking routine care is a byproduct of their shift in perception. As they age, they become more inclined to visit a doctor as they begin to recognize changes within their body. This is an important time to push messaging that promotes patient education and the need for preventive care services within this before they reach adulthood (Speros, 2005). Age also is paramount to understanding how to engage with the healthcare system. This suggests that there is a need for more patient education that seeks to inform males on what to do when they visit a doctor. This includes understanding how health insurance works, the cost of services, what to expect during certain examinations, as well as, being able to communicate with a provider during the visit (Ravenall, Whitaker, & Johnson, 2008). Health care practitioners could begin to illicit patient history during episodic care. This would not only begin to formalize the patient provider relationship and build trust but would become a segue into ensuring that patients come back for routine care. Furthermore, increased
experience with health care providers at an early age with parental support and patient education could help to increase the self-efficacy of men and their comfort level during examinations.

Additionally, African American men’s identity is intertwined with their social status and role within the context of their family (Hammond & Mattis, 2005). Investigators suggest that “men of color may construct their identities beyond sex and gender in an effort to fulfill certain roles in relation to their spouses, children, and other family members or to remain accountable to other men” (Griffith et al., 2012, p. S188). Due to this perception, the identities of men of color intersect and create unique masculinities that are often not captured in traditional quantitative research (Coles, 2008; Griffith et al., 2012). As they age, more social responsibilities are added and taking care of themselves is no longer about self. Instead, self-preservation is for the well-being of the family unit. Thus, health education messaging and future programming could be tailored to young men who are married and fathers. For example, promoting images of being healthy for the family may entice more men to engage in preventive health behaviors. Perhaps this early initiation of positive behaviors can work to decrease the trend of African American men who disengage from the health care system as they age.

Armenakis and Keifer (2007) have emphasized the importance of the community perception of health care provider and to recognize the role providers play in a social or cultural system. Sources of care in rural communities are also important to consider. Individuals who distrust in healthcare system are a byproduct of the stories they have either heard or lived experiences (Ravenell, Whitaker, & Johnson, 2008). Individuals who have had unpleasant experiences at local facilities are not likely to continue seeking care. Thus, patient-provider relationships at every level are also important factors in the decision to seek care. Previous research suggests that patients who have greater trust in their physicians and the facilities in
which they receive care tend to be more satisfied with their care, more likely to adhere to their physicians’ recommendations, and less likely to change physicians (Murphy, Chang, Montgomery, Rogers, & Safran, 2001).

Additionally, facilities that do not offer specialized care are bypassed in communities as individuals are more trusting of facilities they consider to be high level. The stories shared by the participants of this study suggest that they are unlikely to use facilities that they do not trust (Murphy, Chang, Rogers, & Safran, 2001). Though some of the participants had only heard about the local facilities, the information shared with them by family or friends alters their perception of the quality of care provided. Researchers who aim to understand factors that influence care must not discredit stories that have been passed down from one generation to generation as simply misconceptions. To fully address disparities in young, rural, African American men’s health, it is important to attend to the social and cultural components of their health. Using narratives as a method to learn about participants’ experience provide insight on how to improve health services for African American men to decrease health disparities.

Manuscript Two: Lift Every Voice: Using Poetic Transcription and Critical Race Theory to represent young, rural, African American Men’s Experience

Abstract

Chronic life stressors, racial injustices, and social factors create disparities in care for African American men often hindering their ability to confidently manage their health. African American men in the United States have poorer health and die younger than men of other ethnic backgrounds and suffer extremely high rates of chronic conditions. The study that informed this article focused on preventive health services use among rural, African American men ages 18-34. This article details the process of using poetic transcription to share stories of race and
mortality and the health care system and mortality. Found poetry or poetic transcription was used to analyze the interview transcripts to interpret experience depicted in the interviews. Six stories and poetic transcriptions, and two participant reflection poems are presented and analyzed using Critical Race Theory. The narratives and poems presented reveal experiences of fear of the health care system and experiences of fear during racially charged situations the impact of this experiences on African American men’s identities. Using poetry as an analysis of interview data gives validity to the participants’ self-representation and offers a way for researchers to re-see a static data-driven text and offer new insights for the field of public health.

Introduction

During the summer of 2016, I began collecting data to complete my doctoral studies in Health Education and Promotion. My dissertation was focused on factors that influenced young, rural, African American males, ages 18-34, decision to use preventive health services in an effort to reduce health disparities. This study addressed a gap in the literature among this population who had previously been under-researched. Previous research shows that African American men in America face many challenges in achieving and maintaining good health (Bonhomme & Essuon, 2012). Many of these unhealthy responses stem from social circumstances and cultural norms, as well as the cumulative experience of discriminatory treatment (Joint Center for Political and Economic Studies, 2004). Therefore, African American men in the United States have poorer health and shorter life expectancy than younger men of other ethnic backgrounds (Bonhomme & Essuon, 2012; Gadson, 2006). Chronic life stressors, racial differences, and social factors create disparities in care for African American men and hinder their ability to confidently manage their health (Elder et al, 2013).
As such, I was interested in understanding how past experiences, race, gender, socioeconomic status and societal ties were operating in their decision to visit a healthcare professional for routine examinations. In my quest to find answers to these questions, I gained so much more; an opportunity to listen to my brothers. Through my research, I had the opportunity to spend time with African American men where I grew up, a rural county in the Mississippi Delta. Through these conversations, I was offered a glimpse into the facets of their lives I did not know and better understand the complex social and cultural issues at play when it comes to their health care.

While I was collecting data for my dissertation, my daily life was inundated with stories of police killings of unarmed Black men. Even as I tried to focus on my dissertation, I was struggling to understand what was happening and wondered how other Black men were feeling. I was just recovering from the news of Alton Sterling’s death, a Louisiana man who was shot outside of a convenience store when news broke of Philando Castille’s death in Minnesota. Castile’s death was live streamed on Facebook by his girlfriend who had their young daughter in the car. It was merely a matter of 24 hours before Alton Sterling’s Black life vanished and a new name was before us. Since I was interviewing Black men, I was compelled to ask questions about life as a Black man within the current social climate. It became necessary for me to situate the conversations and narratives of “Blackness” within the current social climate as well as to provide a space for the participants to express what was on their mind.

Through the interviews, many participants expressed their woes with being Black yet they, surprisingly often acknowledged that it is not always hard. These conversations spoke to a new research area that I did not begin the study with. As the researcher centering myself in a transformative paradigm, which addresses the politics in research by confronting social
oppression at the levels in which it occurs, I felt it was my responsibility to share these narratives of “Blackness.” The stories they shared for some of us within the African American community are all too familiar—spread across our news outlets, manifested in our daily lives, yet not always the stories we read in peer-reviewed public health education journals.

**Theoretical Perspective**

Stories are powerful tools for marginalized groups as they provide a means to give voice and reveal life experiences to others. The use of narrative in Critical Race Theory provides a “language to bridge the gaps in imagination and conception” (Delgado & Stefancic, p. 51). Storytelling helps to “reduce alienation for members of excluded groups, while offering opportunities for members of the majority group to meet them halfway” (ibid). Critical Race Theory incorporates counternarratives and draws on the experiential knowledge, of people of color and their communities. Commonly used in Critical Race Theory, counterstorytelling offers a different perspective to dispute the commonly held belief or truth by the dominant culture (Delgado & Stefancic, 2012; Reynolds, 2010). Methodologically, it reveals and conveys experiences that are often not validated by the dominant culture (Reynolds, 2010). The central tenets examined using CRT include the circumstances that serve to exclude and disadvantage cultures or groups, as well as the outcomes resulting in disparities in morbidity and mortality (Graham, Brown-Jeffy, Aronson, & Stephens, 2011). The first tenet suggests that “racism is ordinary and not aberrational,” meaning it has become commonplace and a part of the everyday experience of most people of color in the United States (Delgado & Stefancic, 2012, p. 7). Due to the ordinariness of racism, it is difficult to address because it is often not acknowledged. The second tenet of CRT, is “interest convergence” also referred to as “material determinism” and/or “racial realism” in the literature. This tenet states that racism is a system that advances the
interests of the dominant group (Delgado & Stefancic, 2012). The third tenet addresses races as social constructions that are not objective, intrinsic or genetically endowed. The fourth concept of CRT draws attention to the everchanging perspective of racializing different minority groups by the dominant society at different times. Lastly, CRT acknowledges that people of color have a unique voice due to a shared marginal experience of oppression that white people are unlikely to know (Delgado & Stefancic, 2012).

In thinking about the best way to represent these stories I was drawn to poetry. Poetic inquiry as a method can be an active response to social issues. Poetic transcription involves making poetry from the raw interview transcripts (Glesne, 1997). Collins (2015) described the use of poetic transcription as an invitation to participate, to empathize, to be awakened, and outraged. It provides a connection that draws the reader in a way that traditional research writing does not. Using the words from the transcript to “make a point, or evoke a feeling told, heard, and felt” (Glesne, 1997, p. 206) either by myself or the participant during the interview. When thinking of a way to honor and represent the voices of the participants in the study, I wanted to invite the reader into the life of the participant in a way that produced empathy which would move the reader from occupying a space of simply knowing that these experiences happen but moving them to action.

The Process

This study involved a purposive sample of ten African American males ages 18-34 who currently or previously lived in a rural county in the Mississippi Delta. To recruit participants for the study, I mailed a letter to the pastors of twelve local Black churches in the county, along with a flyer to provide information outlining the aims of the study. Pastors were encouraged to share the recruitment letter with members of their congregations. The study recruitment letter detailed
the purpose of the study, inclusion criteria, and estimated time allotted for interviews, and contact information. Additionally, information about the study was shared on my social media outlets to reach participants outside of the local church. I collected data using in-depth narrative interviews. Each interview lasted 60-90 minutes. The use of open-ended questions allowed the participant to speak freely and tell stories that were important to him. As the focus of this study was primarily on preventive health services use, responses to the following questions were important for this article.

1. Tell me about yourself. Tell me about your life as a young Black male living in a rural area such as Quitman County?

2. How do you feel as a black man in America right now? In the South? How do recent events of Black/African American men affect your ideas/perceptions of health?

3. Tell me about some of your most memorable moments when seeking care.

The interviews were audio-recorded, transcribed and completed transcript was sent to each participant. Using Glesne’s (1997) work as inspiration, I transformed the interview transcripts into poems. After transcribing the interviews, the process began with me reading and re-reading the interview transcript of each participant. Using my memos and notes after reviewing the transcripts, I searched each participant transcript for responses to interview questions that included the experience of being a Black man in America, stories heard about the healthcare system, and memorable moments when seeking care. Segments of the interview were sorted and placed into an excel file to separate the transcript, the composed narrative, and the poem. I read through the transcript and began to piece together the aspects of each participant’s story using three to five words to create short stanzas that were concise yet blunt and the poems
were organized chronologically to follow the transcript and were linguistically faithful to the transcript (Glesne, 1997). I refrained from breaking down verb tenses or using phrases from other segments of the text. Instead, I used literary devices such as repetition and word choice to convey the emotions that the interviews evoked in me.

The process of developing the narratives was done in tandem with making the poetic transcription. Using Clandinin and Connelly’s (2000) framework, the participants’ stories were explored using the contexts/dimensions of temporality, how the story changes with time, sociality, interaction with others within the story, and spatiality, where the narrative was experienced (Clandinin & Connelly, 2000). Following Polkinghorne (1988) notions of emplotment, I identified plots in each participant’s transcript to create a story that weaves together complex events. From this process, two focus areas emerged, narratives that depict race and mortality and the healthcare system and mortality. During the member checking phase, I solicited poems from the participants to further support the presented themes.

**Voices of Race and Mortality: Being Black and Male in America**

The arrangement of these poems is a progression of what happens to Black men in America and offers counternarratives to the dominant narratives of Black men as a threat and reveal the restraints placed on Black men by society. Three poetic transcriptions follow: *Following the Protocol, Strange Encounter, Just for Us.* The stereotype that follows them places them in unwarranted situations and often leaves them in states of confusion and uncertainty. The last poem in the series, *Um...being Black,* serves as a transitory poem to connect to the three poems that discuss Black male identity to the concepts of health. The last two poems, *Home and 2006* focus on the past experiences of the participants. During the process of member checking, two reflective poems emerged: *Fear Not* and *Living to Die.*
These poetic transcriptions provide varied portraits of the participants; however, the dominant theme voiced throughout the narratives of each participant is fear. The fear manifested in the day-to-day activities of the participants trickles down into how they perceive health. I then follow up with an analysis of each poem. These stories are important representations of the converging identities of being Black, young, and male. In the constructed narratives, the boldfaced text represents actual phrases spoken by the participant and weaved throughout the narrative; while the other text has been revised and synthesized for clarity.

**Sam’s Story: Following the Protocol.** Sam and I share a few things in common beyond growing up in the same area. I met with Sam at his job and as he walked me out to my car he noticed that we had the same license plate. I had just recently purchased a new car and was thrilled to tell him about how my fears of being pulled over by the police were now quieted. I was officially legal. So, not only did we share the same license plate, during our conversation we shared our mutual fears of being Black dealing with the police.

**Box 1:** Sam discusses the protocol for driving while black.

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<th>Co-constructed Narrative</th>
<th>Poetic Transcription</th>
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<td>When I was in college I met a Black guy he was a doctor. He worked in Branland and told me that every night while he was on his way home he would get stopped by the police. Every night whether it be different police he’d get pulled over because he was a black guy in a nice car. He told me that they would pull him over and say that they were just checking for license registration and all that. But there really was no reason for pulling him over. He was just a black guy driving a nice car. It’s a part of the norm so it doesn’t even bother most people anymore. Stuff like that doesn’t happen around her as much because its’ pretty much a small</td>
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community with a small police force. Majority of the officers here are Black and I’m not saying they won’t do anything but the chances are less. Even with the highway patrolmen I think they are majority black. But with all the police killings nowadays the thought still run through your mind. Especially when I’m driving in some of these other places like Dovan County. I’m always careful. I make sure I’m stopping at all the lights and stop signs. I make sure my seatbelt is on and that I follow the speed limit because I’m sure those guys weren’t expecting to die after being approached by the police. So, you know we can never say what happened in those situations. So, I always try to be extra careful when I’m in places where there’s a high white police presence. Everybody is on high alert. You know maybe any one wrong move, you fidgeting or something there’s no telling how that will turn out.

Sam’s poem “Following the Protocol” was one of the first poems I created. His narrative really struck me during the transcription process. I repeated the words “being” and “last” to emphasize how his existence as a Black man when encountering white police officers might be his last. He details the protocol that unfortunately many Black people must learn. In every situation, we are told it is our duty to learn how to deal with police officers first but never their duty to treat us as human beings first. Sam also speaks to being pulled over by the police as a norm. This type of racial profiling is normal for Black males even when they are affluent figures in the community. Here we see the first tenet of Critical Race Theory that speaks to experiences of racism or racially charged situations being the norm. We also see in Sam’s narrative how the dominant society views any Black man as a suspect. This perception is more often affixed to poor Black men but still implies that all Black men despite socioeconomic advancement are
suspected to be involved in criminal activity (Jones, 2014). Black men are often characterized as murderers, thugs, and rapists; thus, it is hard to accept that they can be doctors who drive nice cars (Jones, 2014). Because of the images of Black males in the media, the dominant society associates Blackness as intrinsically negative; however, Critical Race Theory disputes that notion and highlights the fact that race indeed is not biological but a social construction.

**Miles’ Story: Strange Encounter.** Miles moved away from home in search of a better opportunity for his family. Aside from hanging out with family, sports, and school, there wasn’t much to do in the small town and not many job opportunities. He now lives in a larger metropolitan area about 50 miles away from where we grew up. The move wasn’t easy for Miles as he was not able to find work for 4 to 5 months. Moving away put Miles in a situation he never experienced before in his hometown. For him, it was a strange encounter that left him scared, confused, and lost.

**Box 2:** Miles shares his first encounter with the police.

<table>
<thead>
<tr>
<th>Co-constructed Narrative</th>
<th>Poetic Transcription</th>
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<tbody>
<tr>
<td>About a year and a half ago when I moved up here to Dansford, I got pulled over by the police. It was late, probably around 12 or 1 am when I went to the store to get a pop. I was pulled over for not having a tag on my car. The police asked why I didn’t have a tag and I explained to him that I’d just gotten the car and I had the paperwork and I could show him. He didn’t want to hear it. I tried to tell him I got the paperwork here in the car and I could show him. He didn’t want to hear it. The first cop made me get out of the car while he searched the car but didn’t find anything. Then about 10 minutes later two K-9 units show up. They brought out the dogs and searched me and the car. Didn’t find nothing. I had to follow them to the police station with one car in front and one behind me. I waited at the station for about 30-45 minutes it’s now about 1 or 1:30 in the morning. My late store run</td>
<td>Strange encounter</td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Late store run</td>
</tr>
<tr>
<td></td>
<td>Just for a pop</td>
</tr>
<tr>
<td></td>
<td>Late store run</td>
</tr>
<tr>
<td></td>
<td>Pulled over by a cop</td>
</tr>
<tr>
<td></td>
<td>New car</td>
</tr>
<tr>
<td></td>
<td>No tag</td>
</tr>
<tr>
<td></td>
<td>but the paperwork</td>
</tr>
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<td></td>
<td>I got</td>
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</table>
wife didn’t even know where I was because they took my phone so I couldn’t call. They didn’t even allow me my one phone call to let her know. She thinks I’m at the store. Then they came back out and told me I was free to go.

I could tell him
I could show him
If he’d let me
He didn’t want to
Hear it
I could tell him
I could show him
If he’d hear me

I couldn’t

Searched me
Searched the car
Searched everything

Late store run
Just for a pop

It’s morning at the station and
I’m still with the cops

Miles’ story is one that I have seen countless times on the news but have rarely heard firsthand from the victim. In most cases when I read about incidents with police and Black men the headline results in death. It was clear from his narrative, Miles felt that he was racially profiled which for many Black men is expected. This proposition again speaks to the ordinariness of racism as a function of our everyday lives. In the poetic transcription, I used first
person point of view as I wanted to keep the story central to how he told it to me. I wanted to keep it alive and impactful. The poem was told in chronological order to follow the conversation but to also acknowledge the fear he felt. In this situation, Miles was at the mercy of the officers, control was not in his possession. I repeated the phrase “I couldn’t” to depict his loss of power in that moment. This speaks to the second CRT tenet of white over color. Within this tenet and Miles’ poem we see the dominant group, white cops, exert their power over Miles merely because he is a Black male in a predominately white area (Delgado & Stefancic, 2012). The title “Strange Encounter” is a play on words because, for many Black men, this encounter is strange yet familiar. This familiarity and expectedness of being racially profiled supports how our lives have become racialized and experiences of racism are ordinary.

**Trenton’s story: Just for Us.** Trenton is a recent college graduate who was spending time with his parents during the summer break. For Trenton, this period of post-graduation is a time of uncertainty. He has not secured a new job but is hopeful that he will not have to move back home to live with his parents. The end product would result in him becoming a teacher to live comfortably. Fortunately, the primary jobs in the county are the education system. When I asked Trenton about his life as a Black male he stated that nothing out of the ordinary was happening. Though he could not recall any racially based experiences he was disheartened that there was no justice.

**Box 3: Trenton speaks of justice.**

<table>
<thead>
<tr>
<th>Co-constructed Narrative</th>
<th>Poetic Transcription</th>
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</thead>
<tbody>
<tr>
<td><strong>I think something definitely needs to be done. It’s a shame that just because of the color of our skin that these things happen to us.</strong> Even when all the evidence is there and you can clearly see what happened we still don’t get justice. <strong>We end up dead or hung in jail cell.</strong> I feel like our case always gets</td>
<td><strong>Just for Us</strong></td>
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<tr>
<td>Just for us</td>
<td></td>
</tr>
<tr>
<td>It never happens</td>
<td></td>
</tr>
<tr>
<td>Because of our color</td>
<td>We end up dead</td>
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</table>
pushed aside and we never know what happens. **We never get justice. Just for being Black.** Every time I get in my car and travel I definitely think about it. You know that could’ve been me. With every instance, I try to put myself in that person situation and figure out what did that person do differently or what triggered it. I ask myself what would I have done so I wouldn’t get shot or be in jail.

<table>
<thead>
<tr>
<th>Or hung in a jail cell</th>
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<tbody>
<tr>
<td>Justice for us</td>
</tr>
<tr>
<td>We never get justice</td>
</tr>
<tr>
<td>We get pushed to the side</td>
</tr>
<tr>
<td>Evidence is all there</td>
</tr>
<tr>
<td>You can clearly see</td>
</tr>
<tr>
<td>Justice for us</td>
</tr>
<tr>
<td>It’s just a shame</td>
</tr>
<tr>
<td>It never happens</td>
</tr>
<tr>
<td>We never get justice</td>
</tr>
<tr>
<td>You see</td>
</tr>
<tr>
<td>Just for being</td>
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<tr>
<td>Black</td>
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Trenton’s narrative centers himself within the collective. His use of the term “we” is a shared experience. In creating the poem from Trenton’s narrative, I used the word “we” to illustrate his connection to other individuals. By using the word “we” and “us,” I bring out the fifth tenet of CRT. This tenet communicates the shared minority experience of race and racism by people of color that white people are unlikely to know. Additionally, Trenton’s statement that justice is exclusive to whites is another illustration of the second tenet of CRT, “racial realism.”

When white individuals are murdered by Black people, justice is swift (Eberhardt, Davies, Purdue-Vaughns, & Johnson, 2006). Many times, their cases are solved even without the mountains of evidence from video footage and public outcry.

As the last poem within this series, Trenton’s words paint the picture of what happens to Black males as a result of the encounters described by Sam and Miles. In his narrative, the word “hung” elude to the plight of Sandra Bland, a young Black woman who was found hung in her jail cell after being pulled over by a Texas state trooper. The evidence that he suggests is that of
cellphone footage, dash cam and other images captured through video surveillance. The use of the word “evidence” also points to the deaths of other Black men such as Eric Garner, Walter Scott, Laquan McDonald, Keith Lamont Scott, and many more. Footage of their public executions were circulated across social media platforms. Even when the evidence is “clearly” there the deaths of people of color become “justifiable homicides.” In each case the verdict has been a disappointment and justice is never for us.

Dewayne’s Story: Um…being Black. Dewayne moved out his parents’ house after completing college. As any young adult, could share, living at home with your parents after being on your own is not always a peaceful experience. Dewayne now lives in a neighboring town, which is about 21 miles away from his job. Dewayne described his job as a musician as being extremely stressful and demanding. Though his job puts him in stressful situations, his stress begins early in the morning just by simply being Black.

Box 4: Dewayne explains his life as a Black male and how it affects his health.

<table>
<thead>
<tr>
<th>Co-constructed Narrative</th>
<th>Poetic Transcription</th>
</tr>
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<tbody>
<tr>
<td>Um being a black male is even if you your license is straight, your tag is straight and you got your seat belt on, you still fear. Even when you know you aren’t speeding if a policeman come by and he pass you still think he’s going to hit a u-turn. It is always a constant feeling of being judged and compared to other Black men. Sometimes I feel like I can’t be myself or I can’t dress down or people won’t take me serious. They think we all ghetto and ignorant but ignorance has no color. It’s just like every time somebody does something its compared to me. I bear the load. So being a black person it’s just hard sometimes. Especially when you don’t follow the stereotype and you’re still stereotyped. I can’t even go to Kroger without people looking at me or pass by a car and hear someone lock their door. It’s typical. We stay in Mississippi so I would be naïve to say that I don’t</td>
<td>Um...being Black</td>
</tr>
<tr>
<td></td>
<td>Um</td>
</tr>
<tr>
<td></td>
<td>Being Black</td>
</tr>
<tr>
<td></td>
<td>License straight</td>
</tr>
<tr>
<td></td>
<td>Tag straight</td>
</tr>
<tr>
<td></td>
<td>Seat belt on</td>
</tr>
<tr>
<td></td>
<td>Still feel fear</td>
</tr>
<tr>
<td></td>
<td>Um</td>
</tr>
<tr>
<td></td>
<td>Being Black</td>
</tr>
<tr>
<td></td>
<td>Judging me</td>
</tr>
<tr>
<td></td>
<td>It’s compared to me</td>
</tr>
<tr>
<td></td>
<td>I bear the load</td>
</tr>
<tr>
<td></td>
<td>It’s hard</td>
</tr>
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<td></td>
<td>Um</td>
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</table>
see racism at least one or more times a day. I see racism everyday especially Charmville. It starts early in the morning. Every morning there is always this same group of people in front of Kroger. I think it’s the Klan. These people they ride with the confederate flag, I mean they hit donuts every day in the parking lot. It’s crazy because there are signs posted that say no loitering. Buy if you were black and you’re there doing anything police is right there. But you know if you are Caucasian aww they let them hit donuts and you can see the tire marks. It doesn’t just stop there. Every day I see confederate flags in lawn shops or on the back of motorcycle as I am passing by. Even on social media I see passive aggressive tweets and Facebook statuses from my white friends.

So, my stress as a Black man starts off am I gone make it to work without getting stopped for something? It really does have a lot to do with stress, just being black puts you at higher risk for lot of diseases like Alzheimer’s, prostate cancer, diabetes, and hypertension. What isn’t? I hate to use this word but sometimes I feel like we’re cursed. You know we got all these ailments, the injustices, the health problems, you feel like just you’re cursed.

Critical Race Theory acknowledges that people of color have a unique voice due to a shared minority experience of oppression that white people are unlikely to know (Delgado & Stefancic, 2012). Dewayne’s story is unique in that it bridges the concepts in which the original
study seeks to discuss while also acknowledging other societal issues that come with Black identity. In his narrative, we see two tenets of CRT. By using words like “typical” and “everyday” we see the first CRT tenet that suggests that racism is ordinary, not aberrational. It has become commonplace and a part of the everyday experience of most men of color in the United States (Delgado & Stefancic, 2012). Secondly, Dewayne’s discussion of how he feels judged and compared to other Black men is an example of the second CRT tenet. This tenet within Dewayne’s narrative points to how the dominant society racializes different minority groups at different times. Even though he does not fit the stereotype that the dominant culture ascribes to he still bears the load.

The last portion of this poem leads us into the resulting health status. Dewayne shares how the injustices that Blacks face due to race lead to the proliferation of diseases like diabetes, hypertension, and cancer. Experiences of racism and discrimination magnify the volume of stress and may contribute directly to the physiological stimulation that is an indicator of stress-related diseases such as hypertension, high blood pressure, and cardiovascular disease (Harrell, Hall, & Taliaferro, 2003). Although stress is not recognized as a leading cause of disease morbidity and mortality, it has a confounding relationship when added to other social determinants of health that leads to unequal life chances (Hicken, Lee, Morenoff, House, & Williams, 2014). Critical Race Theory provides a lens to consider how the criminalization of Black males across the life course limits the formation of healthy racial and gender identities. Not being able to formulate these positive identities poses a threat and risk to healthy lifestyles for Black males (Gilbert & Ray, 2015).
Voices of Health and Mortality: Being Black in the Medical System

The last poem in the previous series, *Um...being Black*, serves as a transitional poem to connect to three poems that discuss Black male identity to what was the topic of my dissertation study perceptions of health prevention. The previous section highlights how Black identity is shaped by experiences of racism which can be manifested in adverse health outcomes. Next I present two poems, *Home and 2006*, which focus on the past experiences of the participants. Primarily, within the following poems we see how mortality of family members have shaped the participants’ perception of the health care system and their personal health.

**Sam’s Story: Home.** I met with Sam on Saturday afternoon as he was spending the day preparing his classroom for the new school year. Sam is 26 and he teaches at one of the local schools. We sat near his desk, I in a small chair at one of the computers. Our casual conversation began with him talking about his love for football, his role as coach, and our life in the Mississippi Delta. Sam grew up about 30-35 minutes away from the central city in what he termed as the country. Most of his life has been in the county, as all his family live together along the same road. Although he spent several years in another area for college, his desire was to always come back home. As Sam and I were discussing previous experiences with the doctor, he shared that he has never really gone for routine checkup. Much of his experience has only been for treatment of colds, surgery on his knee, and headaches. Even though he has health insurance, transportation, and the means to pay for care, he never really had a reason to go when he was younger but that changed when his grandfather passed away due to colon cancer.

**Box 5:** Sam’s decision to seek care shaped by his grandfather’s death.

<table>
<thead>
<tr>
<th>Co- Constructed Narrative</th>
<th>Poetic Transcription</th>
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</thead>
<tbody>
<tr>
<td>In 2011, when I was 21, I lost my grandfather to colon cancer. <strong>He was 81.</strong> He never talked about</td>
<td><em>Home</em></td>
</tr>
</tbody>
</table>
having any pain or problems so we didn’t know. In August, he went to the doctor’s office in Mustenenville. The day he told us to take him to the doctor my mom was like something really has to be wrong. **He is usually like I’m okay, I’m alright. He was complaining about having real bad stomach pains. His stomach was real tight because his bowels was all backed up so he was really weak. We had to help him get in the car.**

So, when we got to the doctor’s office we found out he had colon cancer. We didn’t know he wasn’t eating until the doctor told us that he was malnourished, which was hard to believe because **my mama cooked for him every day.** But he [grandfather] was having problems moving his bowels. After that, the doctor sent him to the hospital in Mustenville. They kept telling us that he was getting better. He stayed there for a month or so before he was transferred to Glenwoods. **The doctors said they couldn’t repair his colon** so he ended up having one of them bags. They kept telling us that he was getting better but he never came home. It seemed like he was doing good. He died at the hospital in Glenwoods.

I never had a reason to not go the doctor growing up. **I’m only 26. I have health insurance, transportation,** but if I had a reason now it would be his death. **I know it might sound crazy but I’d rather not know than to know. I don’t want to hear them say well, “Mr. Sam we got this that and the other.”** What bothered me most was the fact that he [grandfather] went to the same doctor every month but they never said anything about him being sick, nothing. **The same people that operate Foster Family Medicine run the lil spot in Mustenenville. He was doing alright before he came to the doctor or whatever. So, me personally, I’d rather not know than to know.**

<table>
<thead>
<tr>
<th>He was 81</th>
<th>He never complained</th>
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<tbody>
<tr>
<td>He was good until</td>
<td>He went to the doctor</td>
</tr>
<tr>
<td>He asked us to take him</td>
<td>He never asks</td>
</tr>
<tr>
<td>He was complaining</td>
<td>He had pains in his stomach</td>
</tr>
<tr>
<td>He never complained</td>
<td>He was diagnosed with colon cancer</td>
</tr>
<tr>
<td>He went to the hospital</td>
<td>He stayed</td>
</tr>
<tr>
<td>It seems like…</td>
<td>He was doing good</td>
</tr>
<tr>
<td>He died in the hospital</td>
<td>He never came back</td>
</tr>
<tr>
<td>Home</td>
<td></td>
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</tbody>
</table>
In creating Sam’s poem, *Home*, I reflected a lot on his upbringing and the importance of being at home with his family. The central person in Sam’s story is his grandfather. To illustrate the importance of his grandfather, I started each stanza with the word “He.” Everything that happened to “He,” Sam’s grandfather, became a direct influence on his decision. Sam’s story sent me on a rollercoaster ride of emotions. I felt his sorrow which helped me understand his justification. The passing of Sam’s grandfather gave him a reason to not trust medical professionals since Sam’s grandfather had monthly appointment at a local clinic yet they did not have the foresight to catch his colon cancer. Marginalized individuals often feel a sense of distrust with the health care systems. Attitudinal reasons for health care avoidance are also evident. African-Americans distrust the health care system, especially African-American men (Bonhomme, 2012). I use the word “distrust” as I find it better representation; “mistrust” implies that it is misplaced and not validated (Aronson, Burgess, Phelan, & Juarez, 2013; Ogedegbe, Mancuso, & Allegranate, 2004; Rose et al., 2000). Sam’s distrust in the medical system is based on his experience with his grandfather. Sam’s narrative highlights how the experiences of others, such as family may support African American men’s fears of utilizing health care. His statement, “I rather not know” reveals the concerns that upon seeking care, serious problems may be identified (Rose, Kim, Dennison, & Hill, 2000). As with the case of Sam, the fear of a negative diagnosis may also influence men’s use of health care procedures (Ravenell, Johnson & Whitaker, 2008; Rose et al., 2000).

**Stanford’s Story: 2006.** Stanford recently moved back after spending several years away. During our conversations, he talked about how hard it has been for him adjusting to the culture of home. He shares that it has been hard for him to maintain the healthy habits he was practicing before he moved back to his hometown. At home, it’s hard to eat healthy and places to
get fresh food are nonexistent. He describes the resources as being limited. Although Stanford confesses to not eating healthy or always engaging in physical activity as he knows he should, he does not currently suffer from any known health problems. Stanford’s family has been very instrumental in discussing reasons to seek preventive care which may be in part of family history of cancers, hypertension, and other diseases. One of his most memorable moments that shifted his awareness of prevention was the death of his aunt, his mother’s sister from breast cancer.

**Box 6:** Stanford’s cancer scare a defining moment.

<table>
<thead>
<tr>
<th>Co-Constructed Narrative</th>
<th>Poetic Transcription</th>
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<tr>
<td>In 2006, my aunt, my mom’s sister died from breast cancer. My aunt’s death was really hard for my mom. It was hard to watch her going through everything. At that time, I was a freshman in college at Mountain Valley about 18-19 years old. It hadn’t been too long since my aunt passed from breast cancer when I noticed a lump in the shower at school. <strong>I honestly thought that I had testicular cancer.</strong> I read a book about signs of testicular cancer so I thought I had it. I immediately couldn’t sleep or eat just thinking it runs in the family so I might be next. I told my dad about it and let him know that I might have cancer. I have never really been sick before. You know I had my episode with asthma but that hadn’t been since third grade. <strong>I was never diagnosed as a little child. Just you know playing after school during field day and collapsed. It alerted me.</strong> Especially after my aunt died of cancer, seeing the lump scared me. Honestly, it scared me. You know I’ve had checkups for jobs but that was the first time I had gone just to see what was up. That was one of my biggest recollections of going to the doctor.</td>
<td>2006 True story… 2006 my aunt died Breast Cancer Honestly… I thought I had it You know In the shower I see a lump I read a book Immediately… I couldn’t eat I couldn’t sleep I thought of my mom Seeing her going through Thinking… It scared me It runs in the family I’m next</td>
</tr>
</tbody>
</table>

Stanford’s poem was written to express how the death of close family members can affect the decision to seek care. The poem follows the chronology of story and details the day he saw a
lump. I used first person point of view because I wanted to keep the authenticity of Stanford’s voice. By using introductory words in the stanza like “honestly,” “immediately,” and “thinking” I wanted to show the process. Stanford’s fear is heightened due to the recent death of his aunt and his family history. As mentioned in Dewayne’s poem, “Um…being Black,” Stanford’s fears of a possible cancer diagnosis may be because of his race; as the risk for cancer and other diseases is increased if you are Black. Yet, fear is interesting in that is has a duality that works positively or negatively towards the behavior. Unlike Sam, who has decided to not seek care, Stanford’s fear of a possible cancer diagnosis was a wakeup call. It was in that moment that fear served as motivation to go and get a checkup. Again, we see how the experiences of family support and African American men’s fears of utilizing health services (Rose, Kim, Dennison, & Hill, 2000).

Reflections

The following reflection poems coincide with the earlier poetic transcriptions on health and mortality. They provide another layer to the manifestation of fear among younger Black males. The reflective poems came about in an attempt to engage the participants in poetic transcription during the member checking process. Each participant was invited to read through the transcripts and make revisions they felt would best represent their experience. Following the revisions, the participants were asked to create found poems that represent feelings of fear as they expressed during the interviews. I provided examples on how to do poetic transcription and offered other modes of expression. In a way, what I wanted was a restricted expression of self but the product that I received could not be restricted. Joshua (Box 7) and Stanford (Box 8) instead created new poems that captured conversations within the full interview. These poems
take us through the internal processing and possible ramifications of not seeking medical care at earlier stages.

**Joshua’s story: Fear Not.** Joshua was one of the few participants that I talked to who regularly visited a physician for routine preventive care. It had become a norm for him now but though he visited for his annual checkup, he wasn’t always so eager to seek treatment. It is normal for most Black men, to only seek care when they perceive that something is wrong. Joshua’s reflection poem entitled, “Fear Not” is also an ode to his religious upbringing. The Bible teaches us that the body is our temple, to fear not but have faith that all things will work out for our good. The use of the words “perfection” and “imperfection” could portray the aging process as our youthful bodies begin to have aches and pains. Within his poem, Joshua acknowledges the need for doctors as they help with the adjustments as we grow older and our imperfect bodies begin to change.

**Box 7.** Joshua’s reflection poem.

```
Fear Not

I said…. My life is fine.
  all doctors are not conducive or a necessity

  Until…..
  I received those midnight aches, pain, sharp pains.
    Then, I knew the imperfection of life.

  It seemed…..
  As if my world and view have changed
  As if my limbs of perfection have tampered

  I traced…. That my life needs adjustment.
    The adjustments of doctors.
```
Stanford’s story: Living to Die. Stanford was very vocal in discussing the lack of resources in the area. Throughout our conversation, he frequently mentioned how hard it is for him to eat healthy while living with his parents. There are not many healthy options available in the area. Most restaurants are mom and pop eatery’s where everything is often fried. So, for Stanford, these comfort foods have become harmful foods and have been culprits in the demise of family members.

Box 8. Stanford’s reflection poem.

Living to die

As I’m dressed in all black saying my farewells a thought creeps in the back of my mind making me reconsider everything about life. Maybe it’s time for a checkup maybe I should take my father’s advice or maybe I should just forget about it and finish this chicken and rice. You would think I would learn by now after watching family members suffer various ailments from high blood pressure to high cholesterol. But it is Sunday dinner today and the fried chicken and mashed potatoes look great. As I take bite after bite on my plate I can't help but wonder if it's too late.

You don't understand soul food is all I know but I don't think I'm ready to go the doctor that's for sure. Then I think about my uncle john who missed out on his son’s life. It is true I'm a product of my environment I would love to eat healthy but where? how? So I continue eating these ribs knowing that I'm planning my own demise. I will go to the Dr someday but these chitterlings sure delicious on my plate. As I wipe the tears from my eyes looking at my uncle's obituary I wonder to myself if I'm just living to die.

In Stanford’s earlier narrative, we learned about the passing of his mother’s sister to breast cancer. We saw how her untimely death alarmed him about a possible cancer diagnosis of his own that subsequently influenced his decision to seek care. Yet, Stanford’s aunt was not the only relative to die, his mother’s brother also died during the same time frame. Stanford’s poem brings up an important discussion about the influences of the environment on health. He ponders if he is strong enough to change because he knows that if he doesn’t his demise will be same as his uncle. He, like Joshua, understands the need for a medical visit but questions whether or not
he can truly commit. He also acknowledges that he is not the sole decision maker but that he has been shaped by his environment in a way that makes him question is he truly living an optimal life or is he just living to die? His last line is extremely powerful and highlights the difficulties of maintaining a healthy lifestyle.

**Discussion**

In this article, I explored how Critical Race Theory along with poetic transcription have the potential to help us understand the power of racism in contributing to mortality, morbidity, and overall health. The experience of racial microaggressions and racism is a unique form of gendered racism experienced by African American men. Occurrences of racial discrimination create a particularly distinctive stressor and may affect disease risk via mental health pathways as well as through behavior patterns (Chae et al., 2014). Poetry as a method allows the reader to be transported and become familiar with the daily stressors of Black men. For example, during my interviews, participants Stanford and Sam discussed feelings of fear associated with watching the health of family members decline as a major factor influencing their decision to seek care. Though they did not experience any pains or were they hospitalized, they were indirectly affected. The death of close family members contributed to Stanford’s motivation to seek care and Sam’s reluctance to seek care. These and the other stories presented offer powerful counternarratives. The use of narrative inquiry and Critical Race Theory as a methodology helped to understand the way men construct stories about their experiences in relationship to their health and how these experiences put Black men at risk for formulizing healthy identities. Additionally, the narratives that are centered around Black identity and police brutality open a new realm of research. Thus, future research using Critical Race Theory or Public Health Critical
Race Theory, more specifically, could explore the unaddressed public health challenge of deaths of Black males by police (Gilbert & Ray, 2015).

Using poetic transcription to create found poems offers public health practitioners and researchers a way of understanding the root causes of health disparities by relying on and honoring the narratives of minority and underrepresented populations. Health for all cannot be achieved if structural racism continues to persist (Ford & Airhihenbuwa, 2010). Additionally, as researchers we must give ourselves the opportunity to move outside of the rigidity of just “doing” research. In choosing to provide a space for the participants of this study to examine race within the context of their life and to express feelings of fear, we might have been a starting point to breakdown toxic hegemonic masculinities. Thus, the process of interviewing became essential to opening new lines of research just as it was therapeutic for the participants to be listened to, to be heard. Using narrative and Critical Race Theory provided an opportunity to legitimize the experiences of Black men, to critique the voice of the powerful to "expose, break open, and revise unjust systems" (Madison, 2012, p. 37). It is my hope that bringing together Critical Race Theory and poetry, the reader is awakened and moved to dismantle the idea of the “single story” to lift every voice.

Manuscript Three: Like Father, Like Son: A qualitative exploration of social support networks on the well-being of African American men and health-seeking behaviors

Abstract

African American men’s preventive health usage is determined by a multitude of factors such as age, income, and access to care. Additionally, the support of family and friends may influence men’s decision to seek care. Previous research has suggested that spousal support and support within other social networks was beneficial to older African American males’ preventive
health engagement. However, little is known about the social support and male social networks of African American males between the age of 18-34. The purpose of this article is to present the results of a study on the influence of fathers within the familial network of African American men ages 18-34. Using narrative inquiry and thematic narrative analysis, this study presents findings that support the need for social support within younger males’ social networks. Findings suggest that fathers are important role models of health for young men and attribute to the future health seeking decisions of African American men as they age. Data presented provide implications and recommendations for health education research focused on social support as a means to decrease health disparities among African American men.

**Background**

Access to care, income, health insurance, and experiences of racism within the health system have all contributed to the decision of African American men to seek care or not seek care (Xanthos, Treadwell, & Holden, 2010). In addition to these factors, previous research has suggested that social networks are an important consideration when examining healthcare utilization behaviors (Ochieng, 2011; Pullen, Perry, & Oser, 2014). Strong interpersonal relationships and support networks can potentially reduce the risk of many problems, ranging from the common cold and depression to heart attacks and strokes. Familial ties have been reported as an aspect in getting African American men to seek medical care for follow-up visits (Griffith, Allen, & Gunter, 2011). Female family members such as wives, sisters, and mothers have been mentioned as influencing men to seek medical care (Norcross, Ramirez, & Palinkas, 1996). Additionally, spousal support has been instrumental in helping older African American males to initiate healthcare visits, adhere to doctors’ recommendation, and maintain routine
checkups. As a whole, Griffith, Allen, and Gunter (2011) suggested that familial support has positive impacts on helping older African American men adopt healthy lifestyle changes.

Though African American men receive support from female family and friends, support from male family and friendship networks may be paramount to the decision to seek care. Hammond, Matthews, and Corbie-Smith (2010) suggest that African American men draw support from other males when they make decisions about their health. Consequently, male social networks could help to promote health-enhancing norms when the choice is reinforced by men close to them (Hammond, Matthews, & Corbie-Smith, 2010). Less is known about the effect of social networks and support for younger, African American men’s preventive care usage. Younger men who are unmarried lack the spousal support that research suggests is central to older African American men’s decision to seek care (Griffith, Allen, & Gunter, 2011; Hammond, Corbie-Smith, & Matthews, 2010). For this group, familial support from parents, particularly male figures like fathers and uncles, and other male social networks may have an influence on the decision to seek care and adopt other healthy behaviors. This article focuses on the role of fathers’ influence within the familial network of young African American men ages 18-34. The data presented in this article emanate from a study exploring social and cultural factors that influence the use of preventive health services among this population.

**Method**

The participants of this study were a purposive sample of 10 African American males ages 18-34 in a rural county in the Mississippi Delta. Table 1 provides an overview of demographics for the five selected participants whose narratives revealed information pertaining to the influence of fathers. To secure participants for this study, a recruitment letter was mailed to the pastors of 12 local Black churches in the study geographic area, along with a flyer to
provide information outlining the aims of the study. Pastors were encouraged to share the recruitment letter with members of their congregations. The study recruitment letter detailed the purpose of the study, inclusion criteria, and estimated time allotted for interviews, and contact information. Additionally, information about the study was shared on social media to reach participants outside of the local church.

The study protocol was approved by the university’s Institutional Review Board. Prior to participation, each participant received an oral explanation of the study and informed written consent was obtained. Participants were told of the voluntary nature of the study and that participation in the study would remain confidential. As such, participants’ names were changed to pseudonyms chosen each participant to protect anonymity. Additionally, names of places referenced in participants’ interviews were changed to pseudonyms chosen by the researcher.

Table 3. Demographic information of selected participants (n=5)

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Marital Status</th>
<th>Educational Level</th>
<th>Income</th>
<th>Employment</th>
<th>Time Since Last check-up</th>
<th>Health Insurance Status</th>
<th>Personal family doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stanford</td>
<td>28</td>
<td>Never married</td>
<td>Graduate or professional degree</td>
<td>$31,000 to $40,000</td>
<td>Full-time</td>
<td>2 years</td>
<td>Insured</td>
<td>Yes</td>
</tr>
<tr>
<td>Lorenzo</td>
<td>29</td>
<td>Never married</td>
<td>Bachelor’s degree</td>
<td>$31,000 to $40,000</td>
<td>Full-time</td>
<td>2 months</td>
<td>Insured</td>
<td>No</td>
</tr>
<tr>
<td>Dewayne</td>
<td>28</td>
<td>Unmarried relationship</td>
<td>Graduate or professional degree</td>
<td>More than $41,000</td>
<td>Full-time</td>
<td>2 years</td>
<td>Insured</td>
<td>Yes</td>
</tr>
<tr>
<td>Sam</td>
<td>26</td>
<td>Never married</td>
<td>Bachelor’s degree</td>
<td>$31,000 to $40,000</td>
<td>Full-time</td>
<td>Never</td>
<td>Insured</td>
<td>No</td>
</tr>
<tr>
<td>Joshua</td>
<td>30</td>
<td>Never married</td>
<td>Graduate or professional degree</td>
<td>More than $41,000</td>
<td>Full-time</td>
<td>6 months</td>
<td>Insured</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Data were collected using in-depth narrative interviews and recorded using a handheld digital audio recorder. Additionally, a descriptive demographic survey was used to collect data from the participants before conducting the interview. Andersen’s Behavioral Model of Health
Services Use and Critical Race Theory served as guiding frameworks for the study development (Andersen & Newman, 2005; Delgado & Stefanic, 2012). The Andersen model suggests health care utilization is determined by three factors: predisposition to use services (sociodemographic), enablement or impediment of use (e.g., economic and social), and their need (e.g., health and functional status) (Andersen, 1995). Critical Race Theory is framework that examines the presence of race and racism within an individual’s lived experience (Delgado & Stefanic, 2012).

Narratives were gathered through individual in-depth interviews lasting 60-90 minutes. During the interview, participants were asked about previous experiences with the healthcare system, perceptions and beliefs, current health status, and health behaviors. The use of open-ended questions allowed participants to freely tell their stories. As the focus of this article is on male social networks, the data for this article was obtained during a study on preventive health care usage among young, rural, African American men. The data presented were obtained primarily from the following three interview questions.

1. How does your gender, age, class or race affect your perception of the healthcare system?
2. While you were growing up, how involved was your father or your father figure in your medical care?
3. When you were growing up, what kinds of things did men in your community do that affected their health? What lessons did you learn from the men in your community about being a man and taking care of your health?

Data for this study were analyzed using thematic narrative analysis. This analytic process included transcribing the audio recorded interviews. Initial themes were generated using reflective memos and notes the research kept during the interview and transcription process.
Following the formation of themes, the researcher presented the findings in narratives supported by the participant’s interview data where direct phrases from the participant transcript were bolded; while the other text has been revised and synthesized for clarity. Stories from five of the ten participants are presented in this paper as their narratives illustrate the influence of fathers as social support and their health seeking behaviors. This process yielded four broad themes: Diagnosis of Male Family Member, Early Involvement of Fathers in Care, Support in the Transition to Adulthood.

Findings

Familial influence and support manifested in several ways. Participants detailed how the diagnosis of a male family member altered their perception of health. Primarily, the stories are centered around the diagnosis of the participants’ fathers. Two of the participants’ fathers suffered from chronic conditions. The diagnosis served a motivation for the participants to change their own health practices. Additionally, having their father involved in their care during childhood has shaped how they view health. Lastly, participants noted that although they were now adults, there was still uneasiness with clinic experience. Thus, having someone with them during the visit would improve the likelihood of seeking care.

Diagnosis of Male Family Member. Stanford is 29 and works as a school teacher. His account puts an emphasis on how the medical diagnosis of his father has challenged him to become more proactive.

In February of last year my father was diagnosed with prostate cancer. He had to completely change and had to go on this regimen. He had to change his eating habits and start eating non-fatty foods. He had to stop eating pork because he had to keep his blood pressure at a certain level. Basically, he had to cut out all the foods he loved to
eat and my dad loved to snack. Giving up all the things he loved was a big change for him. So, my family and decided that we would make the change too to support him. We all were going to eat healthy. We even started to get the church onboard with helping my dad through this change. Instead of eating hot dogs during break time after Sunday school, we gave him nutrigrain bars or fruit cups instead. So, we started with little things and now it has become habitual. Watching my father cut back like that made me think I could do it too. Ever since then I’ve been feeling so much better. Just feel so clear.

Lorenzo’s story is similar to Stanford’s and provides another example of the influence of fathers on younger males’ decision to improve their health. Lorenzo is 30 and unmarried, and working on a second degree. Lorenzo has lost both of his parents to preventable illnesses. His account details the impact the death of his father had on his decision to take action.

My father died in 2010, a few months after I graduated college. He had heart disease. My father never wanted to go to the doctor. Our church had a health conference for the men and he was screened there. His first visit to the doctor was two years before he passed. We would tell him that he needed to go to the doctor and get a checkup but he would never go. He worked a lot and had other unhealthy practices like not eating right or exercising. He would never go to the doctor. He would always say I’m good don’t worry about it and that’s my outlook on it. That’s why I changed my views on it because that could be me. I wouldn’t want to lose my father. I wouldn’t want my children to lose me because I was hard headed and didn’t want to listen to them.

The two narratives provided depict the positive influence to seek care from a negative diagnosis. Both Stanford and Lorenzo discuss how learning about the diagnosis of their fathers
motivated them to be more health conscious. Stanford’s narrative reveals the twofold nature of support. His family’s decision to support his father during his illness helped to strengthen the support within the family structure. In essence, both Stanford and his father are able to find support within the family. For Stanford, his father became a role model of health. Unfortunately, Lorenzo decision to become healthy came after the death of his father. Within his narrative, he notes how the death of his father changed his outlook. He also alludes to changing his behavior for the sake of his future family, something he wishes his father would have been more adamant about. Though Stanford’s and Lorenzo’s fathers were forced to change their behaviors, watching them manage their illness made the choice to become healthy more appealing.

**Early Involvement of Fathers in Care.** Joshua is 31 and is the oldest of four kids. Joshua recalls the first time his father took him to get a prostate exam. This visit became symbolic and established norms for his younger brothers.

My parents have always been vocal in making sure my siblings and I are taking care of ourselves. Especially, *my mom, she was the one that told me about Black males being subject to prostate cancer.* So, she always pushed me to go even though I knew nothing was wrong with me. My father goes to the doctor on a regular basis. When I was 18 we went together to get a prostate exam. It was something he started with me and my brothers. Since I was the oldest, I was the first to go and *I’ve been pretty regular on it* since then.

In the previous story, Joshua details a preventive health visit with his father. In Sam’s story, we see a shift in the purpose of the visit from prevention to treatment. Sam is 26 and has spent most of his adulthood living near his family. For Sam, as a child, going to the doctor with
When I was in high school, my dad took me to my physical therapy appointments. I was so glad that mama didn’t have to take me to one because I knew how she was going to be from past experiences. She was going to be in the way and try to treat me like a baby. I was 17 at the time. I’d rather him take me then my mama. But it was different having my dad take me. He was just going to sit in the lobby till I was finished. Let the folks do what they do. If it had been my mama she was going in the back even if they didn’t offer. I was happy when he said he could take me. I didn’t feel like dealing with her. Like when I was younger if he would’ve taken me to the doctor’s office that would have been better too.

Joshua and Sam’s narratives illustrate how the presence of their fathers aided in increasing their autonomy. Joshua’s story is important because it details how early involvement in care can influence future decisions. Because Joshua and his father both went to their appointment together, it reinforced the importance of taking care of his body. His father’s actions shaped his perspective of what it means to be healthy as a man. It also began to normalize routine care within the family structure. Sam’s story paints a similar picture. The presence of Sam’s father in waiting room gave him the autonomy that his mother often did not provide. This type of exposure to the healthcare system is needed. Males need to be able to communicate with their providers on their own, make decisions regarding their health, and to become comfortable within healthcare settings.

Continued Need of Support in the Transition to Adulthood. Dewayne is 28 and recently moved to a neighboring city. For Dewayne, calling home whenever he was ill was
normal. He could always count on his mom or dad to tell him exactly what to do. However, going alone became an issue for Dewayne as he describes in his story.

As I child, I never really was sick other than the minor problems like stomach virus or a cold. When I was a freshman in college, I got the flu like once. That was the first time I had ever gone to the doctor by myself. I went to the health department that was near campus but I actually left. I went in and signed my name. It was just too many sick people everywhere. Everybody’s sick! So, I got in my car and left. I just went by Walmart and got something to take and I went to my folk’s house. They had some leftover prescription and I took that. I guess I left because I didn’t like the feeling. I guess I was still young, and I was used to my parents being there.

The clinical experience was an essential component of Dewayne not seeking care as this was his first time seeking care without a family member. He described the paranoia he felt and the uneasiness of being alone. Ultimately, not having someone either a parent or friend physically there was a barrier which caused him to leave the facility and resort to self-medication. Dewayne’s narrative provides an opportunity for two potential solutions. As we saw with Sam, if Dewayne been given more opportunities to interact with the healthcare system while accompanied with a parent he may not have left his visit. Secondly, his narrative points to the need of physical support when seeking care. He even agrees that had someone been with him he would not have left. Having someone there holds the individual accountable and ensures that he follows through.

Discussion

The stories that these participants shared reveal the importance of male social networks. Historically, familial and social networks have been crucial for Black families (Ochieng, 2011;
Pullen, Perry, & Oser, 2014). The findings of this study suggest that the decision to seek care and to adopt healthy behaviors is partly determined by linkages to male family members. Several of the narratives above suggest that fathers are important role models of health in younger males’ care as the negative and positive health behaviors exhibited by fathers have effects on future health behaviors. Therefore, having fathers as active members in their son’s care at an early age may be beneficial to future choices. Additionally, having fathers as a part of routine care visits increases the future autonomy of males as they become more comfortable with the healthcare system. Providing resources for families to educate parents about the appropriate visits throughout childhood would also beneficial. Findings from this study suggest that engagement in the healthcare system should start early, as it may help to increase the self-efficacy of men as they age.

In addition to family members, male social networks are also important to the development of gender roles and norms. Attitudinal beliefs about the healthcare system are shaped by other male figures within the familial and social networks (Andersen & Newman, 2005; Williams, 2003). However, culturally supported norms of masculinity can damage African American men’s orientations and health behaviors. When considering the influence of cultural norms and the social and cultural beliefs of African Americans in the United States, it must be considered in a gendered context (Griffith, 2015; Griffith, Metzl, & Gunter, 2011). If African American men have more positive representation of healthy men within their social networks, they may be more likely to associate being healthy with positive gender and cultural norms. Thus, health-seeking behaviors must become normative within the culture to become effective.

**Strengths and Limitations.** It is important to note that a purposive sample was used to collect data and demographic data provide were self-reported. As this study reports on qualitative
findings of a purposive sample from one geographic location. Thus, this limits the transferability of our results but can be beneficial to understanding behaviors within this population. The findings from this study instead provide valuable insights from the participants’ experiences. Despite these limitations, our study provides counternarratives that suggest that fathers may have positive implications on preventive health usage as participants age. This study is one of few existing investigations that address familial support on preventive health seeking behaviors among younger African American males, ages 18-34, using narratives.

**Implications.** This research has implications for the development of future community level health education interventions that target African American males between the ages of 18-34. Since support during visits was determined as a factor in the delay of care, it may be important to develop health education programs that focus on male mentoring. For example, mentoring programs focused on academic, career, social and personal goals have helped to foster strong relationships. Personal development mentoring supports mentees during times of personal or social stress and provides guidance on decision-making and have helped to reduce high-risk behaviors (ibid). Additionally, mentoring has the potential to introduce social and cultural activities that may not have been previously experienced (ibid). These programs that encourage one-on-one relationship building between men could help to create accountability and offer ways for men to become more engaged in their care when they have a partner. This may entail, sitting in the waiting room during a visit, or just riding with the individual seeking care to their scheduled visit.

Additionally, because several participants noted their fathers as central to shaping their current health behaviors, potential health education programs could target new fathers. These programs could be used to engage new fathers in newborn checkups and culminate the
institutionalization of routine checkups, thus making preventive health a normative part of the family culture. Overall, it is expected that getting younger men ages 18-34 to become active partners in their health is essential to decrease the likelihood of poor health status in older age. Lastly, future research should employ a quantitative study to explore the density of African American male social networks and the relationship to future health seeking behaviors for men ages 18-34 (Enyia, Watkins, & Williams, 2016). Additionally, society cannot expect to advance the health status of the nation if the health needs of African American men continue to be a silent and therefore ignored issue. Moving forward, we must focus on the health of African American men to achieve more optimal community health in the United States and worldwide (Bonhomme, 2007).
CHAPTER 5 REFLECTIONS

“Change will not come if we wait for some other person or some other time. We are the ones we've been waiting for. We are the change that we seek.”

Barack Obama

Chapter five presents my reflection of the entire dissertation process. This chapter begins with a reflection on going back home to begin data collection for the dissertation. Throughout the chapter I share experiences working with individuals in the community. The third portion of the chapter provides insight into what I have learned as a researcher which also addresses the strengths and limitations of the study. The chapter closes with an original poem that reflects upon my dissertation experience.

Ruby Slippers: Going Home

As I reflect on this journey, I’m reminded of Dorothy from the Wizard of Oz as she clicked her heels, she repeated the words, “there’s no place like home. There’s no place like home.” While I was growing up in Quitman County, it was always my dream to move away. I was tired of driving miles away just to enjoy the simple things in life like watching a movie, eating at a restaurant after 9 pm, or just being able to buy groceries that were fresh. The lack of resources was truly my motivation to run away and never look back. Yet, even when I have had to opportunity to leave, I have never strayed too far from home. Deep down inside, I knew that I
needed Quitman County just as much as I felt they needed me. It has been instilled in me from an early age that my education was not just for me to but for the collective rising of my people. I could not be selfish and leave my community behind. Being able to use my home as the place for my dissertation study was monumental.

From the very beginning, the support from the community for this study was amazing. Through personal connections, I was offered a place to work when it got too loud at home, a place to interview the participants if I felt unsafe and most importantly, and access to the churches in the community for recruitment. They shared my flyers, told their sons and other family members about my project and helped me to reach my goal. Although, I am from Quitman County, I still needed to prove myself, like any other researcher that I was trustworthy. I went to sporting events, joined the local coalition, and went to revivals and attended church programs. It was necessary for those who had not seen me in years to be able to put a face with a name when the letters would be read in church. During the recruitment phase, I learned just how important it was to make personal connections with people. Even people who did not meet the inclusion criteria, offered stories about their experiences. There was truly genuine excitement in providing me with information that could potentially help with my research.

During the data collection phase of the study a lot of things were happening in the community. The local grocery store which is the only grocery store in the county was possibly going to close. This would have been devastating for those who could not go outside of the county to buy food. During the time of the study, news released that after 39 years the county hospital would be closing its doors. This came at a time when I was grappling with the importance of the research I was doing. Essentially, the hospital had not functioned as a full-service facility since the early 80s but the closure of this facility meant goodbye to the
emergency care. In the event of an emergency, residents would have to travel 15-20 miles away which is a substantial amount of time given the potential severity of the case. For many residents, emergency care from this hospital has been a life saver and often a primary source of routine care. The disappearance of the hospital created another deficit of health care options within the county. Although some residents believe it was not a quality place, for some it has been the only place. So, on October 31st, without divine intervention, the Quitman County Hospital closed its doors. As of now, the ambulatory service and nursing home have remained open. It just seems that my community is in perilous times. Aside from the few dollar stores in the area, everything else seemed to be fading away. The hospital became central to the narratives of the participants, as many of their most memorable moments and perceptions of healthcare were shaped by their experiences at that facility. Though there was nothing that I could personally do to save the hospital, I was invigorated to use this first study as a segue into future studies that document the needs of rural communities.

Me, Myself, and I, the Researcher

To create trustworthiness and ensure rigor of the qualitative data several methods were used as suggested by Guba and Lincoln (1985). First, to establish credibility of the data I employed member checks. This was done to collect feedback from the participants after transcription was completed. I individually emailed each participant a copy of his transcript and asked that he would review and ensure that the interview transcript reflected the words during the interview. A second member check was done after each manuscript presented in chapter four was completed. A printed copy of the transcript was given to each participant. Again, participants were asked to review and ensure that the constructed narratives were true representations of what was discussed during the interview. Of the ten participants of the study
five participants contacted me to state that there were no revisions to be made to the documents. To ensure a level of confirmability of the data I used bolded text throughout the constructed narratives. The bolded text within the narratives were direct phrases from the participant transcripts. I weaved in bolded text and synthesized other text to maintain a level of transparency as well as to maintain the credibility and integrity of the data. I also kept detailed memos and notes to express thoughts and ideas that I gleaned during research activities.

As a researcher, I have learned that going into the community to engage in research presents many difficulties. Due to the nature of the study, there was limited time to build a stronger rapport within the community. Ideally, it would have been best to make repeated interviews with the participants and to spend more time in the study area. I was not completely able to reach all individuals primarily those who are of lower socioeconomic status. The participants of this study were highly educated and had high levels of income limited the transferability of the findings. They do not completely reflect the population as a whole but is a subset of men who are still a part of this community. In the future, I will take steps to ensure that there is adequate representation within the sample by allotting more time for data collection and using a variety of recruitment methods.

The perspectives that these individuals bring is still important as they also highlight shared experiences of other men who may not be like them socioeconomically. The narratives presented in the data depict the linkages between social determinants of health and how these determinants operate within the decision to seek care. They address a gap in the literature specifically on men between the ages of 18-34 irrespective of socioeconomic status. The narratives also reveal the need for increased patient education, which most participants lacked. The stories from the participants highlight a new area of research on race and police
relationships. Despite economic advantages, Black men are still likely to face discriminatory
treatment. Lastly, while listening to the interviews I noticed how participants used the words “to
be honest” or “true story” before beginning to recount an experience. For some this may have
been the first time they have had an opportunity to voice their opinions and offer ideas. It also
highlights the power of using counternarratives to disrupt the dominant society’s story. Their use
of these phrases alone points to the need for more authentic stories to aid in moving the
conversation around men’s health.

In addition to the limited diversity of the participants, I experienced several issues during
the recruitment phase of the study. Individuals who verbally stated that they would agree to
participate in the study often failed to commit to a scheduled time. Additionally, some did not
respond to my attempts to reconnect and reschedule a time. Also, during the time of recruitment,
there was a heightened level of violence within the community. As a female student entering a
male space I was not comfortable approaching individuals through snowballing methods.
Ensuring that I was safe was a primary concern which limited the involvement of additional
participants. Lastly, unknown to me, the place I established as a safe space to interview
individuals closed during the recruitment phase of the study.

Further considering my positionality, my gender did not seem to affect the types of
responses in which I garnered from the participants. In fact, it might be because I am female that
the male participants were more willing to be vulnerable and share sensitive information with
me. Previous research has noted that women are influential in getting men to seek care. Another
rewarding aspect of this process was having participants tell me that I was a source of
information. Being a part of the interviews made the participants aware of their need to engage in
routine care. Several even stated they would be getting “the works” done at their next visit and
become more proactive about their health. Additionally, participants shared ways to entice other young men their age to go to the doctor. Among their recommendations were more health forums in each town in the county to ensure that everyone has access to the information. I learned that most of the time whenever there is something going on in the community it usually only happens in one or two places. Consequently, individuals who live in the northern end of the county, approximately 20 miles away are not able to attend. In addition to suggesting more programs that are geographically accessible, participants suggested having sporting events for community people like basketball jamborees and designating time for individuals to briefly speak and provide health-related information. Lastly, participants shared how stories from individuals suffering from illnesses were powerful for them. It was stated that hearing from real people who were going through certain diseases would make it more real to younger men. This is truly important as that suggestion speaks to the power of narratives.

Overall, this has been more than just a research project for me but truly a life-changing experience. Having had my first substantial research project done at home made me a better researcher. I have always been sensitive to the need to have research conducted by people from the community. This project has made me more sensitive to the needs of participants in a study. They are not subjects but partners. I learned the importance of not being dismissive of people’s struggles and even though traditions may seem antiquated, they come from a place of necessity. As I researcher, I learned that there is beauty in flexibility and that sometimes the rigidity of “doing” research stifles creativity. This dissertation has allowed me to merge my inner artist with the scholar in a discipline that does not often see this type of work. Most importantly, as a researcher I must listen for the things that are not said. When I shared the poems, I created and the participants’ poems in the full manuscript the first words were “wow.” They were proud of
their works and excited about knowing that their words would be published. Though my community may lack resources, there are true gems in the men that I encountered during this phase. They are strong, yet vulnerable, intelligent and dedicated to becoming better for the next generation. Just having the chance to spend an hour with them has furthermore convinced me of the strength of my community to overcome and to push through. Their lives are important, their history is our history, and their voices are no longer silenced and hidden in the margins. I honored my promise that I would do work that was meaningful. It is my hope that they are proud of what we have accomplished together. This is just the beginning of us rising.

**Rising**

Ruby slippers, wings

And other magical things

I wished would take me away

I left you alone miles away

Yet I kept you close to me

But in my heart is where you'd stay

It wasn't time

It wasn't right

I wasn't ready

You needed more from me

than

Me as who I was
I needed to grow

You remained the same

No change

You waited because I belonged to you

You laid in the ashes, ruins, despair

Separated but never apart

I changed for you

I grew for you

I worked for you

I focused for you

I studied for you

I tested for you

I stressed for you

I cried for you

I struggled for you

I went back for you

And I pushed through

for you

I became better at the things I do

Because I took what I knew

So that we could become better

Us two
I traded in my wings and gave away my ruby slippers
for a pen and some paper to write your words
    To tell your story
    To sing you story
    To dance your story
    To paint your beauty and your glory
    To make your blackness become light
    To bring you out of the darkness of night

My love for you is no longer hidden in the depths of my heart
    Everything I am to you I owe
    For the wings, you gave me to set me free
    I brought them back and two for you
    For freedom is not mine alone but for us
        This is for us
        Flying and rising
REFERENCES


Southern Education Foundation. (2008). Miles to Go - Mississippi. Atlanta, GA.


Dear Pastor,

My name is Ashley White and I am doctoral student at the University of Alabama. I am currently working on a study called “Study Title TBD” The purpose of this study is to understand why African American men do not use healthcare services. Your help in assisting with recruitment of participants would be greatly appreciated.

Participants should self-identify as being (a) African American or Black, (b) male, and (c) between the ages of 18 and 34 (d) and live in the Quitman County area. Participants will be asked to participate in an interview at a location in the area.

This study will not take a great deal of your time. Involvement in this study includes participating in a 60-minute one-on-one interview to take place at a time and location of the participants’ choosing. The entire study will take about 1 hour of your time. We would ask those men who go to your church about:

- if they use health care services,
- whether they have a primary care physician,
- their experiences when interacting with health care providers,
- how often they use health care services,
- factors that influence their decision to seek care and
- how they define health.

All of these questions will be in asked during the interview. You can see examples of these questions if you would like.

Your church and the members will not benefit directly from the study. However, you may feel better knowing that you helped researchers learn about this important topic.

Please consider sharing this letter and flyer with the members of your congregation. If you have further questions please contact me at anwhite9@crimson.ua.edu or 205-657-6972. You can also contact my faculty advisor, Dr. David Birch, at (205) 348-9087 or dabirch@ches.ua.edu. If you have questions about your rights as a person in a research study, call Ms. Tanta Myles, the Research Compliance Officer of the University, at 205-348-8461 or toll-free at 1-877-820-3066.

Thank you for your time and your attention!

Warmest regards,

Ashley White
Ashley White, MPH
Doctoral Student
University of Alabama
Health Education and Promotion
Research Study Opportunity

We are looking for people who self-identify as:

- African American or Black
- Male
- 18-34 years of age
- Residents in Quitman County
- Willing to be interviewed

If you are interested you may be eligible to participate in a research study about men’s health. Participation in this study could help health educators develop programs to improve the health of African American men.

Please contact Ashley White, at 205-657-6972 or anwhite9@crimson.ua.edu

Questions about your rights as a person in a research study, call Ms. Tanta Myles, the Research Compliance Officer of the University of Alabama, at 205-348-8461 or toll-free at 1-877-820-3066.
APPENDIX C: DEMOGRAPHIC SURVEY

Background Questions

1. What is your age? _____

2. Are you a resident of Quitman County?
   a. Yes
   b. No
   c. If no, specify your county__________________

3. Are you African American?
   a. Yes
   b. No

4. What is your marital or partnership status?
   a. Married
   b. Divorced
   c. Separated
   d. Widowed
   e. Member of an unmarried couple
   f. Never married

5. What is your level of education?
   a. Less than high school
   b. Graduated from high school or earned a GED
   c. Some college or technical school
   d. Bachelor’s degree
   e. Graduate or professional degree

6. What is your employment status?
   a. Full-time employed
   b. Part-time employed
   c. Unemployed
   d. Retired

7. What is your annual income?
   a. Less than $20,000
   b. $21,000 to $30,000
c. $31,000 to $40,000  
d. More than $41,000

8. Including yourself, how many people live in your household? ____

9. How many children live in your household who are less than 18 years old? ____

10. What is your current health insurance status?
   a. Insured
   b. Uninsured

11. If you are insured, what type of insurance do you have?
   a. private health insurance offered through an employer or union
   b. a private health insurance plan that you bought yourself
   c. Medicaid
   d. Medicare
   e. health insurance through ANY other source, including military or veteran’s coverage

12. Do you have a personal or family doctor, or other health care professional such as a nurse that you usually rely on if you need medical care?
   a. Yes
   b. No
   c. Yes more than one
   d. Don’t know

13. About how long has it been since you had a routine check-up by a doctor or a health professional?
APPENDIX D: INFORMED CONSENT FORM


Researchers: Ashley N. White, Doctoral Student, The University of Alabama
You are being asked to take part in a research study. This study is titled “A Modern Day John Henry: Exploring Masculinity, High Effort Coping and Health Behavior Engagement in African American Men.” Ms. Ashley White, who is a graduate student at the University of Alabama, is doing the study.

What is this study about?
This study will help us get information about the barriers to using preventive health care services among African American men.

Why is this study important or useful?
This study is important to understand why African American men do not use healthcare services. The results from this study will help to design programs to better health outcomes for African American men.

Why have I been asked to be in this study?
You were asked to be in this study because are an African American male over the age of 18 who lives in the study area.

How many people will be in this study?
Approximately 15 other people will be in this study.

What will I be asked to do in this study?
Your time in the study starts after you consent or state that you understand. It includes completing a 60-minute interview and a 60-90 minute focus group session. This will help to understand your views of masculinity and health. The entire study will take about 2 ½ hours of your time.

Will being in this study cost me anything?
The only cost to you from this study is your time. You will not receive money for being in this study.

What are the risks (dangers or harms) to me if I am in this study?
There is little risks for taking part in this study. Potential discomforts or stress may occur when sharing personal experiences. You may choose not to answer a question if you do not want to talk about it. You can also stop the survey at any time. If later you decide that you want to remove yourself from the study, you can do that, too.

What are the benefits (good things) that may happen if I am in this study?
There are no benefits or good things that may happen if you are a part of this study.
How will my privacy be protected?

The interview will take place in a room or area that feels comfortable and private to you. You may also choose the place to do the interview.

How will my confidentiality be protected?

Please note that the information you provide in this study is confidential. To ensure confidentiality participants and investigators will be asked not to use participants’ real names throughout the study. Participants will be asked to not share information discussed during the session. Participants will be interviewed using a false name in order to protect their identity. All data collection records will be kept locked in the investigators office at the University of Alabama. The list with participants’ names and identification will be kept in a password-protected digital file or separate locked file; only the researcher will have access to this file. In reports of the results, only group data or false names will be used. Audio recording will take place during focus group sessions. Information from the audio files will be transcribed for data analysis. After transcription, all information contained on the audio files will be erased and discarded. All data are available to you for review or editing. Information collected will only be used in direct link to this study and will be deleted/destroyed once the study is completed.

What are the alternatives to being in this study?
The alternative to being in this study is not to participate.

What are my rights as a participant?
The alternative to being in this study is not to participate. Taking part in this study is voluntary. It is your free choice. You can refuse to be in it at all. If you start the study, you can stop at any time. There will be no effect on your relations with the University of Alabama.

The University of Alabama Institutional Review Board (“the IRB”) is the committee that protects the rights of people in research studies. The IRB may review study records from time to time to be sure that people in research studies are being treated fairly and that the study is being carried out as planned.

Who do I call if I have questions or problems?
If you have questions, concerns, or complaints about the study right now, please ask them. If you have questions, concerns, or complaints about the study later on, please call the investigator Ms. Ashley White at 205-657-6972 or email at anwhite9@crimson.ua.edu

If you have questions about your rights as a person in a research study, call Ms. Tanta Myles, the Research Compliance Officer of the University, at 205-348-8461 or toll-free at 1-877-820-3066.

You may also ask questions, make suggestions, or file complaints and concerns through the IRB Outreach website at http://osp.ua.edu/site/PRCO_Welcome.html or email the Research Compliance office at participantoutreach@bama.ua.edu.

After you participate, you are encouraged to complete the survey for research participants that is online at the outreach website or you may ask the investigator for a copy of it and mail it to the
University Office for Research Compliance, Box 870127, 358 Rose Administration Building, Tuscaloosa, AL 35487-0127.

_________________________________________________________________
Signature of Research Participant  Date

_________________________________________________________________
Signature of Investigator  Date

Your signature below indicates that you give permission to be audio taped during interview and/or focus group (circle one or both).

_________________________________________________________________
Signature of Research Participant  Date
February 15, 2016

Ashley White
Dept. of Health Science
College of Human Environmental Sciences
Box 870311


Dear Ms. White:

The University of Alabama Institutional Review Board has granted approval for your proposed research.

Your application has been given expedited approval according to 45 CFR part 46. Approval has been given under expedited review category 7 as outlined below:

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies

Your application will expire on February 11, 2017. If your research will continue beyond this date, complete the relevant portions of the IRB Renewal Application. If you wish to modify the application, complete the Modification of an Approved Protocol Form. Changes in this study cannot be initiated without IRB approval, except when necessary to eliminate apparent immediate hazards to participants. When the study closes, complete the appropriate portions of the IRB Request for Study Closure Form.

Please use reproductions of the IRB approved stamped consent forms to provide to your participants.

Should you need to submit any further correspondence regarding this proposal, please include the above application number.

Good luck with your research.

Sincerely,

[Signature]

Carpaneto C. Myles, MSM, CRMC, CIP
Director & Research Compliance Officer
February 13, 2017

Ashley White  
Department of Health Science  
College of Human Environmental Sciences  
The University of Alabama  
Box 870311


Dear Ms. White:

The University of Alabama Institutional Review Board has granted approval for your renewal application. Your renewal application has been given expedited approval according to 45 CFR part 46. Approval has been given under expedited review category 7 as outlined below:

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Your application will expire on February 12, 2018. If your research will continue beyond this date, complete the relevant portions of Continuing Review and Closure Form. If you wish to modify the application, complete the Modification of an Approved Protocol Form. When the study closes, complete the appropriate portions of FORM: Continuing Review and Closure.

Please use reproductions of the IRB approved stamped informed consent form to obtain consent from your participants.

Should you need to submit any further correspondence regarding this proposal, please include the above application number.

Good luck with your research.

Sincerely,

[Redacted]  
Carpenter T. Myles, MSM, CIM, CLP  
Director & Research Compliance Officer  
Office for Research Compliance