An Ecological and Intersectionality Approach to Understanding African-American Men's

Perceptions of the Intersections of Gender, Race, and low SES and

Social Determinants of Health

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Abstract

Social Determinants of Health (SDH) are the conditions under which people are born, grow, live, work, and age shaped by money, power, and resources that influence health outcomes and quality of life. Historically, African-American men have been disproportionately impacted by SDH. This qualitative study focused on heterosexual African-American men and utilized an adaptation of the Q-SDH Social Ecological Model and an intracategorical intersectionality conceptual framework to explore: 1) How do African-American men describe and experience the multiple intersections of gender, race, and socioeconomic status (SES)? 2) How is the intersectionality of African-American men's gender, race, and SES associated with individual health behaviors, psychosocial and biological factors, community contextual factors, socioeconomic and structural factors? and 3) How do African-American men perceive their self-agency with respect to health and wellbeing? A secondary aim of the study was to collect information on African-American men's insights about educational opportunities regarding SDH.

There were 15 self-identified low-income heterosexual African-American men between ages 18 and 44 who participated in the study. Data was collected through semi-structured, one on one, 60 to 90 minute interviews that were recorded and transcribed. The modified grounded theory methodology was utilized to analyze results.

Seven themes that demonstrate how participants' individual level experiences as African-American men reflect macro socioeconomic and structural inequalities were identified: (1) "It's Hard to Be a Black Man in America": Intersectional Self-concept, (2) "We Got to Be Warriors, We Got to Be Soldiers": Gender Role Strain, (3) "You're Going to Take the Working Route or the Drug Route": Pressures of Employment and Unemployment, (4) "Black Men get Treated Like Trash": Discrimination and Microaggressions, (5) "The Police Kill Us, Beat Us, and Steal From Us": Police Surveillance and Harassment, (6) "Once I Started Selling Drugs, I Started Getting Locked Up": Crime and Punishment, and (7) "What are the Resources in My Community?": Access to Resources.

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Introduction

African-American men have the lowest life expectancy rate and higher morbidity and mortality rates than all other racial, ethnic, or gender groups in the United States (The Henry Kaiser Family Foundation, 2007). African-American men also have the worst health outcome measures for cancer, cardiovascular disease, hypertension, diabetes, HIV/AIDS, and the highest homicide rates (DHHS, Office of Minority Health, 2009) (DHHS, Office of Minority Health, 2010) (Xanthos, Treadwell, & Holden, 2010). African-Americans make up 13% of the United States population (United States Census Bureau, 2015). There are 20 million African-American men comprising of 48% of African-Americans (United States Census Bureau, 2015). The third world health status of African-American men in one of the richest and medically advanced countries is a disturbing paradox (Gadson, 2006).

Secondary research "demonstrated the independent effects and intersection of multiple social determinants on the health and well-being of African-American men" (Ornelas, et al., 2009, p. 553)(Williams, 1999) (Williams & Collins, 2001). Social Determinants of Health (SDH) are "conditions in which people are born, grow, live, work and age shaped by the distribution of money, power, and resources and are mostly responsible for health inequities, the unfair and avoidable differences in health status" (World Health Organization, 2015, p. 1). The SDH that pose a significant impact on African-American men's health status as a group are housing segregation, racial discrimination, low socioeconomic status (SES), incarceration, and lower quality health care. The health status of African-American men has a devastating impact on the functioning of individuals, their families and the community at large and is a public health crisis.

Health behavior and belief and community participatory research on African-American men, driven by United States Healthcare Policy, has provided preliminary information regarding

social contextual and structural barriers to maintaining health. Researchers posited "theoretically driven multilevel analytic models are needed that will identify how characteristics of physical and social environment relate to each other and combine with individual predispositions and characteristics in additive or interactive ways to influence health" (Williams & Collins, 2001, p. 116). Empirical evidence has demonstrated the utility of ecological (Gilbert, et al., 2015) (Mitchell, Watkins, & Modin, 2013) (Robinson & Cheng, 2014) (Scott & Wilson, 2011) and intersectionality (Bowleg, 2013) (Bowleg, Malebranche, Teti, & Tschann, 2013) (Griffin, Ellis, & Allen, 2013) (Johnson III & Rivera, 2015) (Rogers, Sperry, & Levant, 2015) frameworks for exploring African-American men's perceptions of SDH on their health and well-being.

Research on African-American men and SDH could be expanded using both ecological and intersectionality perspectives concurrently. The majority of research on African-American men and SDH was conducted before the implementation of intersectionality studies on this population (Bowleg, Malebranche, Teti, & Tschann, 2013). This research will utilize these two complementary frameworks by combining an adaptation of the Q-SDH social ecological model (Mitchell, Watkins, & Modin, 2013) with an intracategorical intersectionality framework (Murphy, Hunt, Zajicek, Norris, & Hamilton, 2009). This conceptual framework provides an opportunity for an in-depth exploration of African-American men's perceptions of SDH by examining how intersections of gender, race, and SES interdependently combine with individual health behaviors, psychosocial and biological factors, community context, socioeconomic and structural factors to impact health status and well-being and agency. Understanding African-American men's' perceptions of SDH is an important step toward developing racial, gender and SES specific interventions that could improve service utilization and health outcomes for this minority population.

A secondary aim of this study is to gather information on African-American men's insights about educational interventions to educate people on SDH. The Commission on Social Determinants of Health (CSDH) (2008) indicated it is important to raise public awareness of SDH to gain support for advocacy and policy efforts aimed at addressing individual, community, and structural level determinants of health.

Research Questions

1) How do African-American men describe and experience the multiple intersections of gender, race, and SES?

2) How is the intersectionality of African American men's gender, race, and SES associated with individual health behaviors, psychosocial and biological factors, community contextual factors, socioeconomic and structural factors?

3) How do African American men perceive their self-agency with respect to health and wellbeing?

Background and Significance

Rationale for Research to Expand Knowledge About African-American Men's Perceptions of Social Determinants of Health

African-American Men's Health Status

There are 17.3 million African-American men comprising of 48% of African-Americans (The Henry Kaiser Family Foundation, 2007) and 13% of the United States population (United States Census Bureau, 2015). African-American men have the lowest life expectancy rate and higher morbidity and mortality rates than all other racial, ethnic, or gender groups in the United States (Plowden & Miller, 2000) (Ravenell, Johnson, Jr. , & Whitaker, 2006) (The Henry Kaiser

Family Foundation, 2007) (Ornelas, et al., 2009). They have the worst health outcome measures on cancer, cardiovascular disease, hypertension, diabetes, HIV/AIDS, and the highest homicide rates (DHHS, Office of Minority Health, 2009) (DHHS, Office of Minority Health, 2010) (Xanthos, Treadwell, & Holden, 2010). African-American men are 1.2, 1.6 and 1.9 times more likely to develop cases of lung, prostate, and stomach cancer than white men (American Cancer Society, 2013). African-American men are 2.4 times more likely to die from prostate cancer than white men (American Cancer Society, 2013). African-American men's survival rates for lung, colon, and pancreatic cancer are five years less than non-Hispanic white men (DHHS, Office of Minority Health, 2009).

African-American men have high rates of chronic illness and are more likely to die as a result of those illnesses (Xanthos, Treadwell, & Holden, 2010). African-American men (and women) are 30% more likely to die from heart disease than non-Hispanic whites (DHHS, Office of Minority Health, 2010). African-American men are two times more likely to die from diabetes and other diabetes-related illnesses than their non-Hispanic white male counterparts (DHHS, Office of Minority Health, 2013). African-American men (and women) are twice as likely to die of viral Hepatitis C than whites; and men had double the death rate than women (Everhart, 2008). African-American men have 7.8 times the HIV/AIDS rate as white males and are seven times more likely to die of AIDS (DHHS, Office of Minority Health, 2011). According to the National Center for Health Statistics (NCHS) (2007), homicide is the leading cause of death for African-American males ages 15-34 and the fourth leading cause for men ages 35-44. The "overall death rate for African-American men is 1.3, 1.8, 1.7, and 2.4 times that of White, Hispanic, American Indian/Alaska Native and Asian or Pacific Islander men respectively" (The Henry Kaiser Family Foundation, 2007, p. 1). The third world health status of African-American

men in one of the richest and most medically advanced countries is a disturbing paradox (Gadson, 2006).

African-American men's health status has a devastating impact on the functioning of the individual, their family, and the community at large and is a public health crisis. As a societal issue African-American men's health status deeply "affects spouses and children, diminished productivity, poverty associated with widowhood, fatherlessness leading to increased risk of drug and alcohol use, lower college expectations, and more encounters with the criminal justice system" (Enyia, Watkins, & Williams, 2014, p. 73).

The financial cost associated with the disability and early death of African-American men is enormous (Enyia, Watkins, & Williams, 2014). African-American men who are business owners and employees play a critical role in the financial stability of families and the economy (Enyia, Watkins, & Williams, 2014). American businesses lose billions in productivity and tax revenue when men are absent from the economy due to health-related reasons (Enyia, Watkins, & Williams, 2014) (Giorgianni, et al., 2012). African-American men's total direct medical care costs were $447.6 billion, and indirect cost were $317.6 billion, with the largest portion of the direct cost associated with premature mortality (Thorpe, Richard, Bowie, LaVeist, & Gaskin, 2013). Health expenditures for all populations are expected to rise. When a group of citizens has the highest morbidity and mortality rates of any group in the country, it is not surprising there are associated societal and economic costs.

Social Determinants of Health (SDH) Among African-American Men

Health disparities are the result of lifelong unsatisfactory social and economic conditions that influence health behavior, lifestyle, and healthcare access (Commission on Social Determinants of Health, 2008). The social and economic determinants of African-American

men's health and well-being have a long history. Secondary research highlighted the intersectionality of a myriad of social determinants impacting African American men's health and well-being (Ornelas, et al., 2009). The World Health Organization (WHO) (World Health Organization, 2015) defines Social Determinants of Health (SDH) as "the conditions in which people are born, grow, live, work and age shaped by the distribution of money, power and resources and are mostly responsible for health inequities, the unfair and avoidable differences in health status" (p. 1). The SDH that have a significant impact on African-American men as a group are low socioeconomic status (SES), housing segregation, racial discrimination, incarceration, and lower quality health care (Xanthos, Treadwell, & Holden, 2010). These multilevel and intersecting social and economic determinants and their precipitating factors have combined and resulted in the overall poor health status of African-American men.

Housing Segregation, Discrimination, and SES.

A seminal report by Williams' (1999) provides an in-depth overview of the way housing segregation, racial discrimination, and SES contributed to the poor health status of African-Americans compared to all other racial and ethnic groups. Williams collected data from the National Center for Health Statistics and the U.S. Census over a forty-five-year period from 1950-1995 (Williams, 1999). He laid out a compelling argument for how residential segregation and discrimination limited access to adequate education and economic opportunities, healthcare, and healthy living environments for African-Americans and contributed to their poor health status (Williams, 1999). Residential context contributed to the high rates of violent crime, drug use, and homicide experienced by African-Americans (Williams & Collins, 2001). Further, racial residential segregation negatively affected marriage rates, family structure, increased the

rate of female lead households and reduced access to resources to maintain health (Williams, 1999).

Despite the 1968 Civil Rights Act that made housing discrimination illegal, 2000 Census data revealed African-Americans continued to live in residential isolation that perpetuated urban poverty and health disparities (Williams & Collins, 2001). To eliminate housing segregation 60 percent of African-Americans living in large metropolitan areas, especially in the Northeast and Midwest, would require relocation to less segregated areas (Williams & Collins, 2001).

Housing segregation accounted for racial differences in academic achievement and limited economic success. African-American students in segregated neighborhoods attended schools with less qualified teachers, less rigorous curriculums, less academic counseling, lower expectations for going to college, poorly funded schools in need of repairs and updated textbooks, higher dropout rates, higher pregnancy rates and fewer students attending college than whites (Williams & Collins, 2001). Further, teachers with low expectation pushed African-American students towards training and employment instead of college (Williams & Collins, 2001). This limited African-Americans upward mobility in SES due to lack of education and competencies needed to compete for jobs that required advanced skills and training and increased the need for of low-skilled, high paying jobs placed out of reach.

Williams and Collins (2001) elaborated on residential segregation and delineated information on disparities by gender, race, and SES. African-Americans and whites' education and SES statistics demonstrated African-American men's health status is affected disproportionately at all income levels across white or African-American female groups. African-American men have the highest homicide rates no matter the educational level than white men (Williams & Collins, 2001). Researchers noted that Native Americans living on

reservations were another group that experienced similar outcomes as African-Americans when compared to whites due to their segregated and marginal residential context further demonstrating segregation contributed to health disparities (Williams & Collins, 2001). These authors noted that mental health was the one area where segregation by race appeared beneficial (Williams & Collins, 2001).

Economic Discrimination and SES

Institutionalized employer discrimination via consistent negative racial stereotyping and corporate discrimination where U.S. and foreign companies used racial composition of areas to determine where to locate or relocate plants resulted in significant and detrimental job losses in African-American communities throughout the Northeast Region of the United States (Williams, 1999). This region is where most African-Americans lived in urban communities. Corporate discriminatory practices also contributed to unhealthy land use. For examples, most landfills were located in African-American communities, more abandoned factories, and more liquor packaged good businesses and bars (Williams, 1999). Corporate discrimination resulted in the creation of food deserts due to the unwillingness of supermarket chains to locate in these areas (Williams, 1999). Due to housing segregation and economic discrimination, African-Americans were less educated, had higher unemployment rates, and paid more for products and services such as food, insurance, and housing needed to maintain a healthy lifestyle (Williams, 1999).

For a short time in the 1960s and 1970s, during the Civil Rights Movement, there was a reduction of the disparity in SES between the races that resulted briefly in a narrowing of the health status, morbidity, and mortality gaps between 1968-1978 for whites and African-Americans (Williams & Collins, 2001). Following widespread social and economic policy changes on a federal level between 1980 and 1991, SES and health status of marginalized

populations widened and so did morbidity and mortality rates, excess deaths, and infant mortality (Williams & Collins, 2001). The change in health status that followed changes in SES demonstrated significant impact SES has on health status. At all income levels and across the forty-five-year period African-Americans men had lower SES and higher morbidity and mortality rates than white American men (Williams, 1999).

The Impact of Over-policing and Incarceration on African-American Men and Families.

In 2014, there were 2.2 million people incarcerated in the United State (Bureau of Justice Statistics, 2016) with African-American men making up 37% of those incarcerated in state and federal prisons (Bureau of Justice Statistics, 2015). African-Americans represent the largest percentage of the incarcerated population, even though they represent 13 % of the United States population (United States Census Bureau, 2015). African-Americans "make up over 44.8% of those arrested for violent crimes" (Scott & Shears, 2007). The source of this discrepancy implies an inherent pathological reason African-American families are predisposed to criminal behavior; however, economic, policy and societal changes put them at greater risk for incarceration (Brewer, 2007).

Racial biases in policing, prosecutorial discretion and sentencing guidelines tell a story of inequity in our penal system for African-American youth and men. African-American men are arrested, convicted, and incarcerated more than other racial and ethnic groups (Treadwell, Xanthos, & Holden, 2013). Police are nine times more likely to kill African-American men in an encounter than other Americans (Swaine, Laughland, Lartey, & McCarthy, 2015). The "school to prison pipeline" describes an increasing link between unfair disciplinary action toward African-American boys and young men and incarceration (Fenning & Rose, 2007). The prison system in the United States and our penal policies do not provide fair adjudication or have in

place systems for reform, reunification, or support for African-American families placing them at risk. Society in the United States has historically withheld from African-Americans the basic rights and opportunities available to whites including employment, education, housing, and political capital. In urban areas today, the harsh reality of a legacy of systematic exclusion of equal access to social, political, and economic resources continue to be demonstrated by the crime rates for African-Americans. Without adequate employment opportunities for those who want to work, African-American working low-income families are simply trying to survive. The current penal codes put even middle class and wealthy African-Americans at risk for incarceration (Roberts, 2004). However, the poorest Africa American men and women live in racially and economically segregated neighborhoods that incur the highest prison rates (Roberts, 2004).

The fact that 900,000 African-American men are incarcerated presents a threat to the African-American family. African-American men represent approximately 44% of the total incarcerated population, "a social dynamic, along with homosexuality, leaving many African-American women facing life alone" (Johnson & Staples, 2005). The probability of African-American men spending time in prison is twice that of Hispanics and three times the rate of white males (Scott & Shears, 2007). One contributing factor to this staggering rate is the types of crimes committed by African-American men (Scott & Shears, 2007). The crimes they commit result in stiffer penalties and are mostly perpetrated on other African-Americans, therefore African-Americans are more likely to be victims of violent crimes (Scott & Shears, 2007).

The victims of staggering incarceration rates of African-American men are the children of these inmates. Over half of incarcerated African-American men lived with their children before incarceration (Roberts, 2004). Before incarceration, the vast majority of men provided

financial support for their family (Johnson & Staples, 2005). Emotional and economic support provided by fathers virtually evaporated with his arrest (Roberts, 2004). The children of African-American inmates are likely to have problems with social functioning. They may display "acting out behaviors such as running away or truancy" (Johnson & Staples, 2005). Boys are likely to have more problems than girls (Johnson & Staples, 2005). Children continue to love and care for fathers' who are incarcerated and would like them to come home (Johnson & Staples, 2005). Many children feel guilty and believe they could have prevented his incarceration (Johnson & Staples, 2005). The African-American family's structure destabilizes by the removal of fathers (Roberts, 2004).

Healthcare Providers as a Social Determinant of Health

Healthcare access and equity have been designated as determinants of health for African-American men (Xanthos, Treadwell, & Holden, 2010). Historically, access to quality health services presented a challenge for African-Americans in segregated residential areas. Many African-American communities did not have multidiscipline-based healthcare facilities to address their health concerns. Where accessible, in racially segregated communities healthcare facilities and professionals' discriminatory practices adversely affect the overall health and mental health of African-Americans (Williams, 1999). Discriminatory practices by health professionals have been documented across a variety of health care settings public and private, academic teaching hospitals and non-teaching hospitals (Smedley, Stith, & Nelson, 2003). African-Americans who were denied preventive screenings, treatment, and medications that whites routinely received, also suffered poor health and mental health outcomes as compared to their white counterparts (Williams & Collins, 2001). Historically, health providers' overt discriminatory practices and other well-known egregious health-related crimes such as the Public

Health Service study in Tuskegee, Alabama contributed to African-American's men's (and African-American women's) mistrust of healthcare professionals, healthcare institutions, and researcher in general.

Access to quality health care and services continues to be a challenge for African-American men. Moreover, gender stereotypes affect the quality of care received by African American men in particular (Treadwell, Xanthos, & Holden, 2013). Healthcare risk factors can be distinguished from behavioral risk factors because they are beyond African-American men's control (Xanthos, Treadwell, & Holden, 2010). African-American men faced with providers who lack cultural competence and who consciously or unconsciously possess biased negative stereotypes regarding minority populations are less likely to access quality care (Treadwell, Xanthos, & Holden, 2013).

Across a multitude of diseases and health related services, African-Americans received subpar care and have poorer health outcomes as compared to white contemporaries (Smedley, Stith, & Nelson, 2003). Xanthos, Treadwell & Holden (2010) discovered, "disparities could not be explained by clinical factors (e.g., stage of disease presentation, severity of disease) or socioeconomic factors (e.g., health insurance status); furthermore, they are associated with higher mortality in African-American men". These researchers also found that African-American men who struggle with mental health challenges are more likely than white men to be prescribed older psychotropic medication that have serious side effects (Xanthos, Treadwell, & Holden, 2010). African-American men diagnosed with physical illnesses such as cancer and other diseases may not be given information about the risk factors or behavioral changes and choices that can improve prognosis (Woods, Montgomery, Belliard, Ramírez-Johnson, & Wilson, 2004). Research on the role of provider-level factors that influence African-American men's health

aligns with the lived experiences of African-American men. These men are keenly aware of the challenges they face getting good healthcare from providers (Woods, Montgomery, Belliard, Ramírez-Johnson, & Wilson, 2004).

Research has demonstrated the intersection and effects of SDH on the health and quality of life for African-American men (Williams & Collins, 2001). As Williams and Collins (2001) argue, "theoretically driven multilevel analytic models are needed that will identify how characteristics of physical and social environment relate to each other and combine with individual predispositions and characteristics in additive or interactive ways to influence health" (Williams & Collins, 2001, p. 116). Despite evidence that social and economic determinants have a major impact on African-American men's health, studies focused on health behaviors, beliefs, and lifestyle are limited by ineffective and inadequate governmental policies and funding streams (Green & Allegrante, 2011).

Literature Review

Health, Health Belief, and Health Care-Seeking Strategies to Address Health Disparities in African-American Men.

United States Healthcare Policy traditionally focused intervention and research funding on health behavior, lifestyle, and healthcare sector strategies to ameliorate health challenges (Green & Allegrante, 2011). Research to explore and improve the health status of African-American men focused on health behaviors like visiting doctors, exercise, diet and cultural factors like African-American male beliefs and cultural attitudes regarding illness and delaying doctor's visits to reduce chronic illness (Gadson, 2006). Prior thought was African-American men engaged in "choice" behaviors more than women that "increase risk of disease, injury, and death, including use/overuse of tobacco, alcohol, and other drugs, as well as high-risk sexual

activity and violence" (Xanthos, Treadwell, & Holden, 2010, p. 14). Identifying unhealthy behavior as choice behavior is moving toward blaming the victim for unhealthy coping mechanisms developed for dealing with difficult social circumstances (Xanthos, Treadwell, & Holden, 2010).

Nearly twenty years ago, seminal research conducted by David Williams, (1999) was the catalyst for research on African-American men's perceptions about health. Qualitative studies, in line with healthcare policy, focused on improving African-American men's health status employed a variety of health models to explore African-American men's perceptions of factors that influenced their health, health belief, health seeking behavior and lifestyle changes needed to improve health (Mount, et al., 2012) (Plowden & Miller, 2000) (Plowden, Wendell, Vasquez, & Kimani, 2006) (Plowden & Young, 2003) (Ravenell, Johnson, Jr. , & Whitaker, 2006). Plowden and Young (2003) concluded that African-American men were less likely to seek primary and secondary care, and that was a significant predictor of their health care status. African-American men are concerned about their health despite their underutilization of primary health care (Ravenell, Johnson, Jr. , & Whitaker, 2006). African-American men defined health as the lack of illness and ability to perform normal activities and illness when normal activities, like working, were compromised by health related symptoms (Plowden & Miller, 2000) (Plowden & Young, 2003) (Ravenell, Johnson, Jr. , & Whitaker, 2006). For older African-American men, health was related to functioning independently (Ravenell, Johnson, Jr. , & Whitaker, 2006). Participants identified African-American male hypermasculinity as detrimental to developing behaviors that lead to getting preventive care, screening, and treatment for chronic disease (Mount, et al., 2012).

Research has also found evidence that African-American men do not believe medical professionals are interested in their well-being (Mount, et al., 2012). Participants in one such

study reported feeling disregard by health care providers, and experienced fear and anxiety of the academic-medical setting due to mistrust related to faulty medical advice, previous research, and lack of cultural competency—all of which were experienced as barriers to care (Mount, et al., 2012) (Plowden & Miller, 2000) (Plowden & Young, 2003) (Plowden, Wendell, Vasquez, & Kimani, 2006). Participants identified limited knowledge about health issues and community resources for health care as additional barriers (Mount, et al., 2012) (Plowden & Miller, 2000) (Plowden, Wendell, Vasquez, & Kimani, 2006). Participants also identified powerlessness, fatalism, a belief that life and death are determined by God, prohibitive cost, inconvenience, and transportation as barriers to seeking health care (Plowden & Miller, 2000). In spite of these perceived barriers, the majority of study participants thought seeking care was important (Plowden & Miller, 2000) (Ravenell, Johnson, Jr. , & Whitaker, 2006); however, Plowden and Young's (2003) study participants did not think seeking primary preventive care was important. Participants identified susceptibility, especially when another family member had a disorder, or another person their age, race, and sex as motivators for health seeking behavior (Plowden & Miller, 2000). Participants looked at the severity of the consequences for not seeking treatment for a particular illness, with disability and death being motivating factors for seeking treatment (Plowden & Miller, 2000).

Studies have also indicated that African American men consider the following as important social factors for seeking care and being compliant with health provider recommendations: trust and support of family, significant others and identified kinship (Plowden & Miller, 2000)(Plowden & Young, 2003) (Plowden, Wendell, Vasquez, & Kimani, 2006). Other factors included trusted community members providing outreach, such as politicians from the community, outreach workers, church members, fraternity members, labor union members,

DJs, and media sources (Plowden, Wendell, Vasquez, & Kimani, 2006). Community members, church members, fraternity member, DJs, and media personality were considered important for disseminating health related information to African American men (Plowden, Wendell, Vasquez, & Kimani, 2006). Recommendations were that outreach should occur in places familiar to African-American men, for example, barber shops, health clubs, and other places where men play sports (Plowden, Wendell, Vasquez, & Kimani, 2006).

An additional factor that has been reported to influence healthcare access and utilization is the existence of a safe and caring environment in which providers are culturally competent (Plowden, Wendell, Vasquez, & Kimani, 2006). Along these lines, researchers have identified the need for health promotion to address heterosexual and homosexual men equally to unify all African-American males and improve a nonjudgmental atmosphere (Mount, et al., 2012). Research further suggests that knowledge about how a particular health care service or medicine improves health outcomes is an important consideration for African-American men (Plowden, Wendell, Vasquez, & Kimani, 2006).

Ravenell, Johnson, and Whitaker (2006) examined a significantly diverse group of African-American men's (n=71) perceptions of the health and health influence using a behavioral model of health services utilization framework. Focus groups were made up of targeted subgroups which included adolescents, trauma survivors, HIV-positive men, homeless men, men who have sex with other men (MSM), substance abusers, church-affiliated men and a mixed group recruited from an urban area in Chicago (Ravenell, Johnson, Jr. , & Whitaker, 2006). Negative influences identified by participants included stress associated with lack of income and related problems such as lack of insurance and not being able to afford healthcare services, stress associated with racism in employment, negative portrayal of the community in

the media, stress of living in unhealthy neighborhoods plagued by crime and over-policing, and stress associated with intimate relationships (Ravenell, Johnson, Jr. , & Whitaker, 2006). Domestic violence was of concern for MSM, due to law enforcement and the media not taking allegations of abuse seriously (Ravenell, Johnson, Jr. , & Whitaker, 2006). The church-affiliated focus group put more focus on spirituality as integral to health. For health maintenance, study participants identified healthy lifestyle changes (i.e. proper nutrition, smoking cessation, and abstinence from drugs and alcohol), managing stress, spirituality including prayer and belief in a higher power, preventive medication, and self-education regarding their health (Ravenell, Johnson, Jr. , & Whitaker, 2006).

Plowden and Young's (2003) research addressed the importance of social system components essential for meeting individual needs including beliefs about health and illness, support from significant others, access to resources, and an accepting environment to receive healthcare. Implications for research and practice posited the need to understand factors that inhibit or motivate this population to engage in the healthcare system, participate in primary and secondary prevention, and having a caring environment within the healthcare system (Plowden & Young, 2003). Practice implications point to the need for providers to understand how to address the concerns regarding perceived discrimination and African-American men's priorities regarding health care. Plowden and Young (2003) concluded that understanding African-American motivation and barriers to seeking health care, increasing community awareness of resources, increasing resources in the community, and providing culturally competent providers and culturally congruent interventions are necessary to improve health outcomes (Plowden & Miller, 2000). Further, the researchers identified implications for policy that provide for more equitable distribution of resources (Plowden & Young, 2003).

Community-based participatory research has examined the social factors that influence health and health seeking behavior of African-American men (Griffith, Rodela, Matthews, Cotten, & Eng, 2007)(Ornelas, et al., 2009) (Royster, Richmond, Eng, & Margolis, 2006). Community members, health and human service professionals, business owners, other civic organization leaders (Royster, Richmond, Eng, & Margolis, 2006) and faith-based organizations (Ornelas, et al., 2009) (Royster, Richmond, Eng, & Margolis, 2006) were brought together to work on this research. The researchers wanted to identify the "medical, psychological, social, economic, cultural and political forces that influence the health of African-American men" (Royster, Richmond, Eng, & Margolis, 2006, p. 391).

Results from these studies (Griffith, et al., 2007) (Ornelas, et al., 2009) (Royster, Richmond, Eng, & Margolis, 2006) supported previous research findings that male gender socialization reduced care seeking behavior until health reached a point that it interfered with normal functioning. Insured and uninsured African-American men underestimated the risk of their health (Royster, Richmond, Eng, & Margolis, 2006). African-American men perceived risky behaviors, poor diet, lack of exercise, smoking, drinking and doing drugs as items African-American men perceived impacted health (Royster, Richmond, Eng, & Margolis, 2006). Young men in this study had conflicting behavior, they exercised more, but also smoked and drank (Royster, Richmond, Eng, & Margolis, 2006). Researchers were surprised that two groups mentioned mental health as a factor impacting their health though this was in the literature (Royster, Richmond, Eng, & Margolis, 2006). The homeless men indicated mental illness was often a factor contributing to homelessness and the recreation center group associated mental illness with college-related stress (Royster, Richmond, Eng, & Margolis, 2006).

Researchers identified differences in environment and behaviors of men with different

SES due to differences in educational attainment, economic stability, and accessibility of health

care (Royster, Richmond, Eng, & Margolis, 2006). Poor men perceived more discrimination

from health care providers than more economically stable men despite evidence that both groups

were being discriminated against in health care settings (Griffith, et al., 2007) (Royster,

Richmond, Eng, & Margolis, 2006). The results indicated availability, resources and settings,

and information regarding testing and affirmative health services impacted decision making

(Griffith, et al., 2007). For example, participants diagnosed with prostate cancer reported a

routine physical exam led to the diagnosis (Griffith, et al., 2007). Despite having insurance, other

participants indicated they never received a prostate exam (Griffith, et al., 2007). The

examination process was not necessarily a result of a decision on the part of the participant, but

more a decision of the health care provider (Griffith, et al., 2007). Not being able to access

adequate care due to racism and socioeconomic status negatively affects not only prostate

screening but the health status of African-American men in general (Griffith, et al., 2007).

Other research indicates that men with less education were more likely to work for

businesses that do not provide insurance or approve of them taking off for a doctor's

appointment (Royster, Richmond, Eng, & Margolis, 2006). Lack of insurance due to

unemployment or underemployment and poor insurance make preventive care and sick care

prohibitive due to cost (Griffith, et al., 2007). Economically disadvantaged men perceive few

positive role models in the community, police stereotyping, incarceration, criminal records, and

murder rates out of control as factors impacting their health (Royster, Richmond, Eng, &

Margolis, 2006). Men with less education and economic opportunity are more likely to live in

unhealthy and unsafe, violent, drug infested social environments (Royster, Richmond, Eng, &

Margolis, 2006). With limited economic opportunities, the responsibility to provide for their family also impacted these men's health-seeking behavior.

Men with more education and economic stability demonstrated an awareness of such obstacles but did not experience them in their neighborhoods (Royster, Richmond, Eng, & Margolis, 2006). Those men with higher SES and educational attainment had a better understanding of social determinants of health (Ornelas, et al., 2009) (Royster, Richmond, Eng, & Margolis, 2006). Their perceptions do not reflect the perceptions of African-American men with low SES that lack education and employment, live in high crime areas, and as a result are at higher risk for morbidity and mortality (Ornelas, et al., 2009). Research in this area suggests the need to target interventions based on SES and living environment (Royster, Richmond, Eng, & Margolis, 2006).

The Community-based participatory research studies described above have significant limitations. Insurance and income information was inferred from educational attainment and employment status and biased by the sample of community members (Royster, Richmond, Eng, & Margolis, 2006). Study results are limited because the focus groups were part of a larger study, and the focus group questions were not designed based on the structural framework used (Griffith, Rodela, Matthews, Cotten, & Eng, 2007) (Ornelas, et al., 2009). Further, the only data formally collected on participants was race and place of residence and researchers felt they could have used more information on SES, age, insurance status, cancer history and other demographic information (Griffith, et al., 2007). Ornelas, et. al (2009) engaged men in understanding their perceptions about SDH. The group of men who participated were stable, educated, lower middle class to upper middle class, lay health advisors (Ornelas, et al., 2009). Their perceptions don't reflect the perceptions of low SES, lacking education and employment, live in high crime areas,

and as a result are at higher risk for morbidity and mortality as aforementioned above (Ornelas, et al., 2009).

Implications for practical application focused on the importance of social and economic changes to improving health status. Targeting adult education and job training to men who lack education can increase their income potential and allow African-American men another way to express masculinity that does not risk their health (Royster, Richmond, Eng, & Margolis, 2006). Lay health advisors may play a prominent role in the education of other African-American men about social determinants of health and health care (Royster, Richmond, Eng, & Margolis, 2006). Participants wanted more health information from the church and the local health department (Griffith, et al., 2007). This study highlighted the importance of the health department, health facilities, and providers to provide timely and accurate information. Despite limitations of health, health behavior, and health system models of research and practice, these studies were some of the first to focus on social determinants of health and well-being and moved research toward multilevel analytic models for examining SDH.

Ecological Studies Examining SDH

Ecological theory and model, developed by Urie Bronfenbrenner, has been used to inform public health research and intervention due to its ability to observe reciprocal relationships between people and their immediate environment to larger sociocultural, political, and institutional arrangements (Kemp, 2009) (Scott & Wilson, 2011). Ecological models have recently seen an increase in use in studies regarding SDH and African-American Men (Enyia, Watkins, & Williams, 2014) (Gilbert, et al., 2015) (Mitchell, Watkins, & Modin, 2013) (Robinson & Cheng, 2014) (Scott & Wilson, 2011) because it provides a foundation for looking

at multifaceted community conditions and exploring possible linkages between perception about SDH and health (Scott & Wilson, 2011).

Ecological models provided a framework for identifying individual factors, community context factors, and socioeconomic and structural factors associated with health outcomes (Robinson & Cheng, 2014). Studies using adapted ecological models validated historical research and subsequent research studies regarding African-Americans health status and its relationship to socioeconomic/structural determinants of health (Robinson & Cheng, 2014). Robinson and Cheng (2014) (n=2,926) found affluent African-Americans with more education, economic opportunity and access to resources have better health outcomes. African-Americans with low SES, living in unsafe neighborhoods, with high rates of crime, poor housing and experiencing discrimination have poor health outcomes (Robinson & Cheng, 2014). Research using ecological conceptual frameworks supported the finding that SES is the leading indicator of health (Gilbert, et al., 2015)(Mitchell, Watkins, & Modin, 2013) (Robinson & Cheng, 2014) (Scott & Wilson, 2011).

Ecological studies examined individual factors including health behavior, psychosocial and biological factors and findings supported previous research. Scott and Wilson's (2011) study on African-American men (n=18) with low SES identified stressors over daily needs outweighed concerns for health and health promotion, healthy foods, and places for healthy exercise. African-American men were not focused on health unless they were sick (Scott & Wilson, 2011) or a family history of illness existed (Mitchell, Watkins, & Modin, 2013). Robinson and Cheng's (2014) study (n=2,926) of African-Americans found psychosocial factors such as chronic levels of stress and mental illness resulted in poor health outcomes (Robinson & Cheng, 2014). Exercise associated positively with good health (Robinson & Cheng, 2014). Individual biological

factors that result from unhealthy living environments associated with low SES such as "high blood pressure, heart problems, diabetes and obesity were negatively association with health outcomes of Africa Americans" (Robinson & Cheng, 2014, p. 906). For example, older African-American men with low SES who lived in segregated environments over their lifespan demonstrated a high prevalence of hypertension, obesity, diabetes, and heart disease (Gilbert, et al., 2015). Age-related factors contributed to overall health outcomes. Older African-Americans demonstrated poorer health outcomes than younger African-Americans (Robinson & Cheng, 2014). Living in public housing negatively impacted health outcomes no matter the individual's health behaviors, psychosocial factors, and biological factors (Robinson & Cheng, 2014). Gilbert, et al.'s (2015) study of African-American men (n=111) identified an accumulation of risk factors that characterize life course socioeconomic position suggest "the health-damaging effects of socio-economic deprivation both in childhood and adulthood are additive or aggregate over the lifespan and undermine health status in middle age" (p. 301).

Community contextual and relational level factors were examined, including social support and community connectedness, and support for prior studies was mixed. Social capital, a social determinant of health, was identified as the value of social relationships and their reciprocity (Scott & Wilson, 2011). Robinson and Cheng (2014) operationalized social support as support from "family, friends, and church and community connectedness as belonging to clubs, community associations or neighborhood helping groups" (p. 902). Prior studies (Plowden & Miller, 2000)(Plowden & Young, 2003) (Plowden, Wendell, Vasquez, & Kimani, 2006) identified the importance of social support from family and significant others, churches and other organizations for promoting health care access and behaviors. Robinson and Cheng (2014) found deficits in social support in poor communities had a negative impact on African-Americans'

overall health outcomes. Churches, historically regarded as pillars of African-American communities, have become fragmented, compete with one another and provide health activities for their members only, forgoing opportunities for collaboration and wasting funding through redundancy (Scott & Wilson, 2011). Additionally, public health officials turn to churches as venues for health promotion, and pastors hold power to determine agendas for health activities in the community (i.e. during HIV prevention activities, health workers could discuss abstinence but not condom use) (Scott & Wilson, 2011). As a result, heath workers had to find other venues in which to reach African-American men (Scott & Wilson, 2011).

Past generations of African-Americans could find employment through community engagement, church activities and civic organizations such as the NAACP (Scott & Wilson, 2011). The majority of young African-Americans are not connected to the church or other organizations and do not have the employment opportunities that existed for the older generation and drugs have become a viable alternative for many (Scott & Wilson, 2011). An unwritten tracking policy directed Africa American youth, predominantly boys toward trade instead of college prep limiting their chances for college due to not having the adequate classes needed for admission (Scott & Wilson, 2011). Relatively few African-American males go to college while many are unemployed or resort to the drug trade to earn income (Scott & Wilson, 2011). Subsequently, there has been a proliferation of drug use and trade in many communities and an increase in incarcerations for drug and violent crimes.

At the structural level, SES and racism were found to be health determinants in ecological studies (Scott & Wilson, 2011). The majority of African-Americans live below the poverty level (Scott & Wilson, 2011). Political positions in a Southern community were based on family connections and race. Therefore, whites control agency funding and community fixtures

like free recreation (Scott & Wilson, 2011). Communities, churches, and civic organizations are segregated by race, and so are resources (Scott & Wilson, 2011). At the environmental level, healthy food sources are limited, so proprietors set prices and decide what foods were available (Scott & Wilson, 2011). Structural racism reduces education and employment opportunities (Scott & Wilson, 2011).

Poverty and SES affected health outcomes. People with less than 12 years of school who lived below the poverty level had better health because they qualified for Medicaid (Robinson & Cheng, 2014). However, people with income above the poverty level had too much income to qualify for Medicaid and not enough income to purchase insurance had poorer health outcomes (Scott & Wilson, 2011). Participants perceived whites being treated better by doctors (Scott & Wilson, 2011). Unconscious or conscious bias created barriers to accessing medical screenings, health care information and supportive relationships with a primary care doctors that impacted cancer and other health related outcomes (Mitchell, Watkins, & Modin, 2013). Mitchell, Watkins, and Modin (Mitchell, Watkins, & Modin, 2013) (n=558) found when older African-American men with health insurance had a relationship with a health provider who discussed family cancer history, they were more likely to get a cancer screening. Research supports earlier studies that health provider level decisions impact African-American men's health access.

Research using ecological models gathered rich information at micro, mezzo, and macro levels that supported previous studies conducted over the last almost 20 years. There is an ever-growing body of knowledge that validates the existence of social and structural SDH that negatively impact African-American men (and women). Ecological studies noted similar implications for practice as prior studies using other conceptual frameworks. Researchers advocated for more funding for research and program to address SDH (Enyia, Watkins, &

Williams, 2014). Future research should consider the social context in which African-American men define and demonstrate masculinity (Enyia, Watkins, & Williams, 2014). The literature reinforces the importance of addressing structural barriers by enforcing antidiscrimination legislation toward eliminating discrimination in education, employment, and housing availability for African-Americans (Enyia, Watkins, & Williams, 2014) (Gilbert, et al., 2015) (Robinson & Cheng, 2014). Efforts should also be aimed at providing job training for ethnic minorities to reduce employment inequities and replacing inferior housing stock in low-income communities (Robinson & Cheng, 2014). Other strategies include increasing the number of African-American male teachers and faculty and applying equitable justice to eliminate the education to prison pipeline (Enyia, Watkins, & Williams, 2014). Improving health care access could be accomplished by extending hours beyond regular work day to accommodate African-American men's work schedules (Enyia, Watkins, & Williams, 2014) (Robinson & Cheng, 2014). The literature also notes the importance of incorporating ideas from African-Americans regarding how to improve their neighborhoods to increase safety, educational and economic opportunities, and increased opportunities for recreation (Enyia, Watkins, & Williams, 2014). Research highlights the need for contextual specific interventions including capacity building for community health workers, developing social networks within the African-American community, collaboration with city officials, and advocacy skills training (Scott & Wilson, 2011). Along these lines, cultural competency training for health care promoters, providers, and agencies should be provided to address racial biases, attitudes and practices toward Africa American men because providers are a significant pathway to care (Enyia, Watkins, & Williams, 2014) (Mitchell, Watkins, & Modin, 2013) (Scott & Wilson, 2011). Finally, researchers themselves need to practice in a culturally competent manner that encourages African-American

men to participate in research studies, making sure the participants understand the importance of their help in developing interventions that are gender, race, and SES specific to improve the health status of this group of people (Gilbert, et al., 2015)

Significant to future research, ecological framed studies have posited that the impact of social and individual health behaviors, psychosocial factors, and biological factors have not been fully flushed out, and that doing so holds the potential to increase understanding and reduce the negative impact of such socioeconomic/structural determinants factors (Robinson & Cheng, 2014). Future research should look at psychosocial factors, stress, coping strategies, measures of personality and discrimination characteristics that are important factors to understanding specific social contexts and events (Gilbert, et al., 2015). Future research could also examine the role of community contextual factors in more depth (Robinson & Cheng, 2014). Without using the term "intersectionality," studies on SDH have looked at the intersection of socially constructed factors affecting African-American men. Early historical studies on African-American men examined the interdependent effects and intersection of multiple social determinants on their health and well-being including race, sex, and SES (Williams, 1999) (Williams & Collins, 2001). Subsequent studies on African-American men and SDH explored health disparities as they relate to race, sex, and other socially constructed environments such as racially segregated rural and urban areas; however, these studies did not examine the dynamic relationship between these social identities, and cultural and demographic variables.

Intersectionality Studies on Africa-American Men's Key Characteristics and Context.

Crenshaw (1989) developed the intersectionality perspective to explain the dynamic relationship between social identities, cultural and demographic variables that mutually constitute each other. Intersectionality as a theoretical framework asserts multiple social

identities such as race, ethnicity, gender, SES, and sexual orientation interact on an individual level (micro level) and reflect interlocking social-structural level (macro level) inequalities (Bowleg, Malebranche, Teti, & Tschann, 2013) (Murphy, Hunt, Zajicek, Norris, & Hamilton, 2009)**.** Interlocking patterns of social identities impact how people access power and privilege, influence social relationships, and construct meaning that shapes life's experiences (Anderson, 1996). Intersectionality advances understanding of "a person's social location, his or her place in society, that is formed by the intersection of social constructions that mark privilege and oppression, and is essential to capturing the complexity of that person's experiences, including his or her actions, choices, and outcomes" (Murphy, Hunt, Zajicek, Norris, & Hamilton, 2009, p. 7). Intersectionality provides a framework for examining the complexity of human experience (Murphy, Hunt, Zajicek, Norris, & Hamilton, 2009).

Black women's intersections of race and gender have historically been the focus of Intersectionality Theory (Crenshaw, 1989). Intersectionality theory's utility has progressed beyond African-American women's studies to include heterosexual, homosexual, and bisexual intersectionality studies of African-American men (Bowleg, Malebranche, Teti, & Tschann, 2013) (Rogers, Sperry, & Levant, 2015) (Griffin, Ellis, & Allen, 2013) (Bowleg, 2013). Another goal of the intersectional approach is to examine social and health consequences of key characteristics, aspects of identity, and context (2008).

Griffin, Ellis, and Allen (2013) used an intersectional approach to examine the sources of stress that affect the lives, health, and well-being of African-American men from the perspective of African-American men (n=150) and significant African-American women (n=77) in their lives. Stress contributes to high rates of unhealthy behaviors, chronic diseases, and premature mortality among African-American men (Williams, 2003). The African-American men in this

research were over 30 years old, majority married and over 50 percent had difficulty paying bills (Griffin, Ellis, & Allen, 2013). African-American women were reporting information about men in their lives who met the criteria of the African-American men in the study (Griffin, Ellis, & Allen, 2013). The two key sources of stress in African-American men's lives identified by both men and women were "(a) men's desires, efforts, and struggles to fulfill socially and culturally important roles; and (b) being both African-American and men in a racially stratified society" (Griffin, Ellis, & Allen, 2013, p. 255).

Examining the intersection of race and gender, researchers found African-American men (n=17) endorsed traditional Western masculine norms (Rogers, Sperry, & Levant, 2015). However, African-American men experience racist gender role strain (Rogers, Sperry, & Levant, 2015). African American men experienced institutional and systematic barriers to fulfilling traditional male roles (Rogers, Sperry, & Levant, 2015). African-American male beliefs about masculinity have previously been found to have an impact on health (Mount, et al., 2012) (Griffith, et al., 2007) (Ornelas, et al., 2009) (Royster, Richmond, Eng, & Margolis, 2006). Roger, Sperry, and Levant found African-American men negotiated masculinity between their minority and the majority culture and constantly threatened by racial oppression (Rogers, Sperry, & Levant, 2015). Consequently, they developed a culturally unique version of Western masculinity (Rogers, Sperry, & Levant, 2015).

African-American men desire to be role models, providers, and protectors for their families (Rogers, Sperry, & Levant, 2015). African-American values including spirituality, quality education, and historical knowledge about African-American heritage were viewed as necessary to being a role model (Rogers, Sperry, & Levant, 2015). Participants expressed the importance of mental fortitude and physical strength to being an African-American man (Rogers,

Sperry, & Levant, 2015). Men felt being a man meant the ability to take care of yourself over the lifespan (Rogers, Sperry, & Levant, 2015). Men identified the importance of familial relationships and the experience of having an absent father led to having to define masculinity on their own (Rogers, Sperry, & Levant, 2015). Most men in the study wanted control in their relationships with women, but expressed a desire for flexibility in roles as well (Rogers, Sperry, & Levant, 2015). A small minority felt women wanted to control relationships and that this had the effect of pushing African-American men toward white women (Rogers, Sperry, & Levant, 2015). One limitation of this study was that triangulation of data suggested information regarding the themes protector, religion and spirituality, and fatherhood lacked confidence (Rogers, Sperry, & Levant, 2015). Also, it was a small young sample (mean age 27.65 years) from the Midwest and not representative of the African-American male populations elsewhere (Rogers, Sperry, & Levant, 2015).

Men identified societal racism and discrimination in society, employment, and daily life as being stressful (Griffin, Ellis, & Allen, 2013). Unemployment and retirement were stressful for older African-American men (Griffin, Ellis, & Allen, 2013). Family-related stress such as marital problems, family conflict, and spouse's illness or death (Griffin, Ellis, & Allen, 2013). African-American women, not men, identified African-American men's stress associated with getting older and deteriorating bodies (Griffin, Ellis, & Allen, 2013). This identification is in line with prior research (Plowden & Miller, 2000) (Plowden & Young, 2003) (Ravenell, Johnson, Jr. , & Whitaker, 2006) that indicates men do not think about health until they cannot perform daily activities. Study participants identified the intersection of race, ethnicity, age, marital status, and other factors such as racism, economic, and societal stressors combined to create a unique experience for the African-American men in this study (Griffin, Ellis, & Allen, 2013).

Bowleg, Malebranche, Teti and Tschann's (2013) intersectionality study of low SES Africa American heterosexual men (n=30) found this group experienced being African-American men in intersectional and not additive terms. This study looked at intersectionality of race, gender and SES and the implications for HIV prevention research and intervention (Bowleg, Malebranche, Teti, & Tschann, 2013). In describing what it meant to be an African-American man and "highlighting the link between their multiple social identities of race, gender, and SES and socio-structural factors such as racial discrimination, poverty, unemployment and incarceration" participants commented on the difficulty they experienced (Bowleg, Malebranche, Teti, & Tschann, 2013). Racial discrimination was frequently mentioned by participants in this study (Bowleg, Malebranche, Teti, & Tschann, 2013). Study participants provided no dialogue that included SES in the description of African-American men (Bowleg, Malebranche, Teti, & Tschann, 2013). Racial discrimination in the workplace was related to harsh and stiffer penalties for lateness and not being recognized as competent (Bowleg, Malebranche, Teti, & Tschann, 2013). Participants experienced racial and gender intersectionality with regard to negative stereotypes and microaggressions (Bowleg, Malebranche, Teti, & Tschann, 2013). A limitation of this study was the intersectionality framework was applied after the study and did not allow researchers to examine intersectionality at the micro and macro level associated with HIV risk behaviors (Bowleg, Malebranche, Teti, & Tschann, 2013). Nonetheless, researchers suggested an intersectionality perspective focused HIV research on micro and macro interventions to address individual behavioral as well sociostructural issues like poverty, racial discrimination, and incarceration (Bowleg, Malebranche, Teti, & Tschann, 2013).

Lisa Bowleg (2013) examined the intersections of race, gender and sexual orientation experienced by African-American gay and bisexual men (n=12) living in an urban area. This

study provided an opportunity to explore the simultaneous intersectionality of privilege and oppression of African-American men who are privileged due to gender and oppressed due to race, gender, and sexual identity (Bowleg, 2013). Gay and bisexual African-American men described an inability to separate their intersecting identities associated with race, gender and sexual orientation that were interlocking and mutually constitutive (Bowleg, 2013). Focusing on one category would not provide the depth of understanding and conceptualization provided by focusing on the intersection of that category with another category like gender or sexual identity (Bowleg, 2013). Looking at the intersection of the categories of race, gender and sexual orientation explained how unlikely the social advantage of being a man would be experienced when the other two categories intersected with gender to create disadvantage (Bowleg, 2013).

Social processes in the United States around race based on the visibility of being African-American when compared to normative Whiteness, and the role of racial discrimination and bias, were found to promote early racial identity and nonvisible (for some participants) sexual identity (Bowleg, 2013). In support of "intersectionality's tenants about the interplay between intersecting micro and macro level factors, narratives of the men in this study underscore how race, gender, and sexual identity interlock to reveal intersecting micro and macro level racism, heterosexism, and gender bias" (Bowleg, 2013, pp. 759-760). Negative stereotypes that identify African-American men heterosexual and gay men as "dangerous, thugs, unintelligent and hypersexual" require these men to self-monitor so that white people and other African-Americans would not fear them (Bowleg, 2013, p. 760). African-American gay men experienced racial discrimination and prejudice daily such as denied promotions, racial profiling by police, and experiencing microaggressions of others (i.e. watched while shopping, difficulty getting a cab, and women holding their pocketbooks when you pass) similar to participants in the

aforementioned study (Bowleg, 2013) (Bowleg, Malebranche, Teti, & Tschann, 2013). African America men are pressured by white gay men to give up the African-American part of their identity to feel welcomed in the white gay community (Bowleg, 2013). Heterosexism and gender role norms in African-American communities were challenging for African-American gay men who feared being outcast by family and promoted staying closeted and passing for heterosexual (Bowleg, 2013). Outside the oppression of their interlocking social identities, participants identified strengths that allowed them to be introspective about life, social equality and psychological growth, freedom from social gender norms regarding marriage, children and supporting a household, and to develop the character to deal with racism from whites and African-Americans (Bowleg, 2013). This study was limited due to is small size but advanced knowledge about the intersectionality of race, gender, and sexual orientation in Africa-American gay men. The study suggests African-American men, gay or heterosexual, have much in common and discourse between the groups could improve their lives (Bowleg, 2013).

The small body of intersectionality research on African-American men has validated and expanded prior research findings. As previously examined, "an abundance of scholarship on the intersections of Black men's race, gender, and SES exists; however, it was published before the emergence of intersectionality scholarship" (Bowleg, Malebranche, Teti, & Tschann, 2013, p. 31). Intersectionality research demonstrated how systems of power and oppression merge with African-American men's intersections of race, gender, and SES (Bowleg, Malebranche, Teti, & Tschann, 2013). These intersections make African-American men vulnerable to job discrimination, unemployment, over-policing and harassment, and incarceration (Bowleg, Malebranche, Teti, & Tschann, 2013).

Research indicates that understanding the stress associated with being African-American and male may provide key information needed to overcome barriers to and improve positive health behaviors and health outcomes (Griffin, Ellis, & Allen, 2013). Without fully understanding how African-American male gender norms and efforts to fulfill societal roles contribute to overall poor health status, we cannot develop interventions to affect positive change in their health status (Griffin, Ellis, & Allen, 2013). Research has pointed to the need to incorporate a strengths-based perspective along with the examining the deficits of African-American men's interlocking marginalized social identities (Bowleg, 2013). Intersectionality research has captured nuances of African-American men's perceptions about the intersectionality of the social factors affecting their day to day lives and impacting their long-term health outcomes. However, this research is in its' infancy, and additional research is required to expand on these findings toward developing interventions at all social and structural levels.

Finally, the Commission on Social Determinants of Health (CSDH) (2008) indicated it is important to educate the public on SDH impacting populations so they can act to deal with individual, community, and structural level determinants of health. The Canadian government has conducted studies to understand adolescent perceptions of SDH (Kenney & Moore, 2013) (Woodgate & Leach, 2010). Research finding were used to change health curriculum taught to students in Canadian schools. Understanding African-American men's thoughts about similar programming themselves and younger African-American males is the first step toward research focused on developing preventive educational interventions.

Conceptual Framework

This study will integrate ecological and intersectionality frameworks by utilizing an adaptation of the Q-SDH social ecological model (Mitchell, Watkins, & Modin, 2013) coupled

with an intracategorical intersectionality framework (Murphy, Hunt, Zajicek, Norris, & Hamilton, 2009). Researchers have suggested using complementary methods, including ecological and intersectionality frameworks, to capture the nuanced, contextualized nature of African-American men's lived experiences (Gilbert, et al., 2016).

The Q-SDH model was adapted from the social ecological model developed by Dahlgren and Whitehead (Whitehead & Dahlgren, 1991). Dahlgren and Whitehead developed their SDH model as part of the World Health Organization (WHO) program on equity and health. The minority population in Queensland, Australia suffers from health disparities due to circumstances similar to ones associated with African-American men including low SES, racism and discrimination, job stress, social isolation, and traumatic experiences (Queensland Government, 2011). The Q-SDH model is divided into three subcategories—socioeconomic and structural determinants, community context, and individual factors, and an overall quality of life category (Robinson & Cheng, 2014). See Appendix A for a copy of the Q-SDH model. In the Robinson and Cheng's (2014) study, which also utilized the Q-SDH model, quality of life was one question about health status. This study will include multiple questions regarding health status and well-being.

Intracategorical intersectionality studies call for the researcher to select at least two intersectional categories (i.e. race, gender, and SES) of oppression and identity (McCall, 2005). There is much evidence that suggests African-American men are not a homogenous population and examining them from an intersectional perspective that considers identifiers such as race, gender, sexual orientation, and SES, may yield novel ways of looking at SDH that can help to guide in developing effective interventions. Intersectionality's utility is in exploring influences of social locations on various subjective life experiences.

A combined ecological and intersectionality conceptual framework provides an opportunity for an in-depth exploration of African-American men's perceptions of SDH by examining how intersections of gender, race, and SES interdependently combine with individual health behaviors, psychosocial and biological factors, community context, socioeconomic and structural factors to impact health status, perceived wellbeing and agency. Understanding how these factors interdependently interact to impact the ability to make decisions and access services will provide information toward developing culturally sensitive racial, gender and SES specific interventions that empower this minority population to envision and act on multilevel choices regarding SDH and health service utilization that may improve their health status and well-being.

Methods

The purpose of this qualitative study is to explore how a small group of urban African-American men perceive the intersectionality of gender, race, and SES and the ways in which these intersectional identities and experiences interact with and are affected by individual health behaviors, psychosocial and biological factors, community context, socioeconomic and structural factors to impact health status and well-being and agency. A qualitative intensive interview study was determined to be a good fit for this study of African-American men because it allows for an in-depth exploration of participants lived experience and worldview and potentially insight into the micro-level process that maintain larger dynamics in society (Krueger & Neuman, 2006). Intersectionality Studies on African American men and SDH are limited, thus a modified grounded theory method was utilized. According to Charmaz, qualitative research offers the researcher a systematic way to collect and analyze data (Charmaz, 2014). Intensive interviews provided a method for gathering in-depth information on African American men's perceptions.

The in-depth interview explored the following questions: (1) How do African-American men describe and experience the multiple intersections of gender, race, and SES? (2) How is the intersectionality of African American men's gender, race, and SES associated with individual health behaviors, psychosocial and biological factors, community contextual factors, socioeconomic and structural factors? (3) How do African America men perceive their self-agency with respect to health and wellbeing? A secondary aim of the study was to gather information on African-American men's insights about educational interventions to educate people on SDH.

Sample Size and Recruitment Procedures

A purposeful sample of 15 African-American men, with low SES, were recruited from the Baltimore Metropolitan community. In qualitative research a sample as small as 12 participants is acceptable when researching a relatively homogenous group (Guest, Bunce, & Johnson, 2006). Participants were recruited through direct contact, advertising in community centers, churches, barbershops and snowball sampling through study participants and the researcher's education and work related contacts. Approval was obtained from facility management before placing advertisements in any facility (See Advertising Flyer Appendix B). All interviews were conducted by the co-investigator face-to-face and audiotaped. Each interview consisted of questions that are primarily open-ended. Each in-depth interview lasted approximately 60-90 minutes. Each participant received an in-person or phone interview to screen for eligibility based on inclusion criteria. Fifteen African-American men met the inclusion criteria and participated in the study.

Inclusion/Exclusion Criteria

Inclusion Criteria

- Adult males who self-identify as African-American and Non-Hispanic.

- African-American adult males that are heterosexual

- African-American adult males who speak English as their primary language.

- African-American adult males between the ages of 18 and 44.

- African-American adult males who live in an urban environment.

- African-American males with low SES earning less than or equal to $15,000 per year legally or illegally.

Exclusion Criteria

- Men over 44-years-old.

- Men who do not self-identify as African-American.

- African-American men who have sex with other men.

- Men who self-identify as Hispanic.

- Men who do not speak English as their primary language.

- Severe mental health or medical disorder that would impede participation in the interview.

- Under the influence of a substance that would impede participation in the interview.

- Anyone that does not want to interview alone.

- African-American adult males living in a rural area.

- African-American men making more than $15,000 in income each year legally or illegally.

Participant Characteristics

_____

Characteristics of Interviews (N=15)

_____

Characteristic/Distribution	Numbers /Frequencies
Ages	18-41 (Age Range)
Age 18	1
Age 20	1
Age 21	1
Age 23	1
Age 25	1
Age 26	2
Age 28	1
Age 31	1
Age 33	1
Age 34	1
Age 39	2
Age 40	1
Age 41	1

_____

Relationship Status	
Single	2
Single - Exclusive	11
Single - Non-Exclusive	2

_____

Education

8th Grade Special Education	1
9th Grade	2
9th Grade GED	1
10th Grade	2
11thGrade, GED, Trade School	1
12th Grade	2
12th Grade Some College	3
12th Grade Trade School	2
GED Trade School	1

_____

Spiritual or Religious Practice

Islam	2
Christianity	2
Christianity & Islam	2
Catholic	1
Baptist	1
Spiritual	1
Belief in God	1
None	5

_____

Employment

Unemployed	8
Self Employed	1
Part Time	1
Full Time	5

_____

Annual Income

$0	4
$2,001 - $3,000	4
$8,001 - $9,000	1
$9,001 - $10,000	1
$11,001 - $12,000	1

$12,001 - $13,000	1
$13,001 - $14,000	1
$14,001 - $15,000	2

_____

Community
African American Only	6
Predominantly African American & Caucasian	3
Predominantly African American, Hispanic & Caucasian	1
Burmese, Caucasian, 10% African	1

American, 10% Korean	
Predominantly African American, Caucasian, Filipino	2
Predominantly Caucasian, African American, Puerto Rican	1
Predominantly African American, Latino	1

_____

How Many Residents in Household
One	1
Two	3
Two Adults, One Child	2
Two Adults, Two Children	1
Two Adults, Three Children	1
Two Adults, Four Children	1
Three Adults, One Child	1
Three Adults, Two Children	1
Four	2
Five	1
Twenty-Two	1

_____

Rent or Homeownership

Rent	8
Own	1
Live with Parent	4
Live with Friend	1
In-Patient Substance Abuse	1

_____

Incarcerated

Never	3
0-1 years	2
1-2 years	1
3-4 years	1
4-5 years	3
5-6 years	1
6-7 years	1
8 -9 years	1
10 years	1
20 years	1

_____

Participant Profiles

Before completing the interview, participants completed the face sheet that inquired

about demographic information (see Appendix D). The following patient profiles contain

information gathered during this process.

Andrew is a 39-year-old African-American heterosexual male who is disabled and receives monthly Social Security Disability Income totaling $8,400 per year. He was shot ten times during a robbery and kidnapping attempt as he was trying to get away. He is trying to get back together with his longtime girlfriend after using drugs and getting into treatment for heroin and cocaine addiction. He lives in a predominately African-American community with a few Caucasians. The housing is dilapidated, and many are vacant. At an early age, he began selling drugs to support his family, and that impacted his education. He completed the 9th grade. He has been incarcerated twice for nine months. He is a practicing Muslim. He only sought health care when he was sick before getting clean, and now he is learning about preventive care. He has Hepatitis C and is trying to stay clean long enough to qualify for treatment. He prays for emotional support and is learning to talk to others. He recently got a merchant's license and is selling handmade jewelry. He lives alone. He has health coverage.

Bobbie is a single 23-year-old African-American heterosexual male who recently came home from prison after three and a half years. He was incarcerated for robbery. He is unemployed due to his criminal record. He indicated his income is less than $10,000 per year. He is getting mental health treatment for ADHD and substance abuse treatment for Cannabis Addiction. He is a spiritual person who has practiced both a Christian religion and Islam. He lives next to the projects in Baltimore City. The community has all African-American residents. He rents space from his grandmother who is a homeowner. Four people live at the residence. He was significantly impacted by the loss of an education scholarship opportunity in the 5th grade. A racist teacher reported to Boys Latin, a private all-boys school in Baltimore City, which he had gotten into a fight after he received acceptance to the school. He completed 12th grade. He has health coverage.

Clayton is a single 39-year-old African-American heterosexual male living in a predominantly African American community with a few Caucasians. He lives at Tuerk House in an inpatient unit with twenty-two other men. He is receiving treatment for Alcohol Addiction and other drugs. When he is not inpatient, he lives with his grandmother in public housing projects. He is currently unemployed and receiving $185 monthly from Social Services. He is also receiving mental health treatment for Depression and Anxiety Disorders. He has two chronic health disorders, Hypertension and Type II Diabetes. During a robbery attempt, he was stabbed in the back and lungs, his lung collapsed, and he was hospitalized for five days; he has not pain from those injuries. He is a practicing Muslim and attends mosque at a local college (Johns Hopkins). He was incarcerated for four and a half years. He got his GED. He has HVAC and small business management training. He has health insurance.

David is a single 26-year-old heterosexual African-American male. He is in an exclusive dating relationship. He graduated from the 12th grade and went to trade school to become a dental assistant, and he went to school to get a CDL license. He works at a pallet recycling company and earns less than $15,000 per year. He is not religious but uses meditation in an African spiritual practice. As a child, he was treated for ADHD. He smokes tons of weed daily but is not in substance abuse treatment. He has been smoking since age 16 when trying to fit in by hurting others and being hurt by others. He lives in a community that consists of African-Americans only. He lives with his mother who is a homeowner; however, there a lot of vacant houses in her neighborhood. He has been robbed, shot, and beat up by a group of people. He was incarcerated for four years. He has health coverage and concerns that the president will repeal Obamacare.

Edward is a 26-year-old single heterosexual African-American male in an exclusive relationship. He finished the 10th grade. He is getting $185 per month in cash and food stamps from Social Services. There are vacant houses around their neighborhood. He is getting outpatient substance abuse treatment for Opioid addiction. He is getting treatment for PTSD, Anxiety Disorder, and Bipolar Disorder. He and his sister were robbed at the Light Rail; his sister was shot and killed in front of him. He lives with a friend in an African American community where some houses have been rehabbed. He is unemployed due to his criminal record. He was incarcerated for five years for drug distribution. He has health insurance.

Frank is a 21-year-old heterosexual African American male. He graduated 12th grade and had some college credit. He is young and just starting out on his own. He lives with his girlfriend in an apartment complex. Last year he moved from a drug-infested neighborhood to a nicer neighborhood. He lives in a predominantly African-American neighborhood with a few Latinos. His mother died a couple of years ago of drug abuse and addiction. He used to smoke marijuana regularly to reduce stress but has since reduced his use to occasionally. He works part-time with his father doing construction. He works about 5-6 months a year, and when he is working, he makes about $500 per week. He reported it add up to less than $15,000 per year. He just applied for health insurance.

Greg is a 20-year-old single heterosexual African-American male who lives with his mother and two younger brothers. He identifies as Catholic but has not attended church since he was 12. He graduated from 12th grade and had some culinary college credits. He recently quit his

job working in the culinary field due to his pay. He cares for his brothers while his mother works. He has hereditary hypertension as his father, grandmother, and his little brother all have. He is not getting treatment for his hypertension at this time. He smokes marijuana frequently. He lives in a mixed neighborhood, but all African-American in his block. The people are homeowners where he lives, but there are some vacant houses nearby.

Harry is a 28-year-old heterosexual African American male. He was recently acquitted of three attempted murders he was falsely accused of after three years in prison. He was stabbed in the head while in prison. He has been in and out of jail most of his adult life for drug-related offenses. He reports being incarcerated for six to seven years. He currently lives with his mother, another adult, and two children. He is not working due to his prison record and his inability to read and write well. Harry has four children and recently saw the youngest one's birth; he had missed all the others due to incarceration, Harry is getting treatment for Depression and Anxiety Disorders at the local community health center. He takes care of his children while his long-term girlfriend (in a relationship for 13 years) goes to work. She is pregnant with their fifth child. He completed 9th grade. He is unemployed and getting $185 per month and food stamps from Social Services. He has health insurance.

Isaac is a 41-year-old single heterosexual African-American male. He recently came home from prison after being incarcerated for 20 years. He completed 10th grade. He worked at Amazon briefly, but his drug use interfered with going to work. He is now in treatment for Opioid addiction. He has Hepatitis C. He lives in an African American only community in his deceased mother's home with two other adults and one child. He is trying to figure out life and how to do things like taking care of his health. He was robbed, and he robbed someone in the past. His mom was a single parent, and he felt he needed his dad for a role model. He has health insurance.

Jerome is a 33-year-old heterosexual African American male that grew up in Baltimore City in an African-American neighborhood; however, he currently lives in a community largely made up of Burmese refugees and a few Koreans. He is in court-ordered substance abuse treatment for alcohol use. He reports he does not have a drinking or any other substance abuse problem but cigarettes. His father died when he was thirteen and "I lost my mind." As a child, he was incarcerated for four to six years for car theft, theft, and assault. As an adult, he was incarcerated for two weeks as an adult for harassment. He believes a positive role model could have changed his life. He has been shot and stabbed. He follows Christ, but is studying Islam. He lives with his girlfriend and four children. They rent where they live. He is employed as a steward at the casino. His income is $485 bi-weekly. He completed 12th grade and had some training as an auto mechanic. He has health insurance.

Kevin is a 31-year-old single heterosexual African-American male who graduated from high school and has some college experience. He lives in a mixed community of predominantly African American and some Caucasians. He currently rents and lives with another adult. He has been in a relationship for two years. He was incarcerated for two weeks once. He was employed as a sales manager, but his dependence on heroin interfered with his ability to work. He is currently in mental health and substance abuse treatment for ADHD and Opioid dependence. He

currently receives $185 social services and food stamps. He is a practicing Christian. He has health insurance.

Lamont is a 40-year-old single heterosexual African American man lives in a predominantly African American Community with a few Caucasians and Puerto Ricans. He is in an exclusive dating relationship. He has a history of substance abuse and has been clean for seven months after outpatient treatment at the community health center. He is currently receiving mental health treatment for depression at the community health center. He was in special education classes and completed the 8th grade. He lives with his girlfriend and three children in a place they rent. He was incarcerated for eight and half years. He attends church regularly with his girlfriend and their children. He put in job application after job application and started calling and telling people he knows he had a record, but he asked for a second chance until the manager at KFC hired him. He makes around $13,000 per year.

Marvin is a 34-year-old single heterosexual African American man who lives in a predominantly African American community with a few Caucasians and Latinos. He works as a general cleaner making $7.50 per hour. He used to sell drugs and went to jail for ten months. He tries to set a good example for his children. He can't use his CDL license and work as a driver because of his record. He lives with his girlfriend and one of his children. They rent a rehabilitated house in a pretty stable working class community. He completed the 11th grade and later got his GED. He has health insurance now that he is working.

Nathan is a 25-year-old heterosexual African American man who is engaged to be married. He lives in an African-American community with a few Latinos. He lives in a public housing project. He completed the 9th grade and later got his GED. He is getting mandated mental health treatment for Bipolar Disorder and Antisocial Personality Disorder. He believes in Jesus Christ. He completed 9th grade and later got his GED. He is unemployed and has no income. He has been robbed, beat up, shot, and stabbed. He was incarcerated for ten years. He has health insurance.

Owen is an 18-year-old single heterosexual African American man who graduated 12th-grade last year. He is in an exclusive dating relationship. He has had no college or specialty training. He lives at home with him Mom, who owns their house and a younger sibling. He lives in a predominantly African American community with a few Caucasians. He has never been arrested or used drugs. He is looking for employment, putting in applications all the time, but no one is calling him back. He is the only participant who gets preventive primary and dental care. He is also the only participant that endorsed having his father in his life regularly. He has health insurance.

Statement of Human Subjects

Once participants agreed to meet with the researcher, all questions regarding the study,

informed consent, payment, and the recording process were addressed. Each participant reviewed

informed consent before the in-depth interview, and all questions were answered. The risks of

participation were minimal and explained in detail in the University of Pennsylvania Informed

Consent (see attached Appendix C). Each participant agreed to meet in a convenient area in

Baltimore City for the interview. Each interviewer took place in a safe and quiet location. Each

interviewee was given information to reach the Primary Investigator and the University of

Pennsylvania Institutional Review Board for any reason. The interviewee was informed that in

the unlikely event the participant becomes emotionally distressed during or after the interview

they would be provided with resources to address these issues. Participants were informed they

could stop the interview at any time with no penalty.

Participants in this study were informed they would not directly benefit from

participation in the study. However, the interviewee was informed they might benefit from the

experience of telling their story. The information gathered from participants remained

confidential throughout the study process. Participants audio recordings were assigned a number

after each interview. Each participant was assigned a pseudonym for use throughout and

following the study process. Audio recordings were maintained on a password-protected

computer that was locked in a cabinet. Once the study has completed, the recording will be

deleted. Transcripts and other materials like informed consent are locked in another cabinet. All

documents with identifying information like the informed consent and face sheet will be

destroyed at study completion. Each participant was paid $25 in the form of a Visa Vanilla Gift

Card after completing the interview (Appendix D).

Setting

Each interview took place in an area convenient for the interviewee. The locations were

quiet and provided enough privacy for the interview to be conducted without interruption.

Twelve interviews were conducted at the health center where the researcher worked before or

immediately following a regular work day. Interviews were done with the permission of the

health center's administration. Three interviews were conducted at a local library.

Data Collection

The researcher used the Interview Guide to collect information for the study. The

guide begins with thanking the participant for agreed to participate in the interview and

instructions that will help the recording process. This was followed by a face sheet questions

used to collect demographic information. Finally, the in-depth interview was used to collect data.

Interview questions broadly focused on how African-American men feel about being a man and

the things that influence their health. The first set of questions focused on African-American men

and masculinity. The second set of questions focused on individual, psychosocial, and biological

factors. The third set of questions focused on community contextual factors. The fourth set of

questions focused on social and economic factors. Finally, the last set of questions focused on

agency, how African-American perceive things that impact health and well-being. Interviews

lasted approximately 60-90 minutes including time to process informed consent and the

Interview Guide.

Data Analysis

The data analysis was based on the methods of grounded theory, originally put forth by

Glaser and Strauss (1967) that posited a systematic inductive process for qualitative analysis.

Charmaz (2014) developed a modified form of Glaser and Strauss's grounded theory, which was

used for this study. Data were collected through in-depth interviews and systematically analyzed

starting with initial line by line open coding, followed by focused coding, and finally theoretical

coding. This method of collecting data allowed the participants to express in their own voices,

their worldviews, and insights into micro-level processes that maintain larger dynamics in society (Krueger & Neuman, 2006).

Initial Coding is the first step in the coding process, and it involves coding line by line (Charmaz, 2014). According to Charmaz (2014), "initial coding should stick closely to the data. Try to see actions in each segment of the data rather than applying pre-existing categories to the data. Attempt to code with words that reflect action". Following these instructions, initial codes were completed line by line that reflected action as much as possible.

Focused Coding is the second step where the researcher begins to "synthesize, analyze, and conceptualize larger segments of data" (Charmaz, 2014). Review of interview data and line by line coding resulted in a list of approximately 350 concepts. The researcher compared and analyzed concepts, and grouped them into relevant categories. This process resulted in 51 categories.

Theoretical Coding is the last step the researcher uses to "not only conceptualize how your substantive codes are related, but may also move your analytic story in a theoretical direction" (Charmaz, 2014). During this iterative process, the researcher continued to compare and analyze concepts and relationships and finally grouped them into seven theoretical categories or emergent themes.

Research Quality and Rigor

To address issues of rigor the researcher engaged in purposeful sampling, prolonged engagement and persistent observation of the data, publicly disclosing methods and research processes, a recent criterion for study validity, and memoing (Vincent A. Anafara, Brown, & Mangione, 2002). Study participants were recruited using homogenous sampling with the aim of getting a sample of African-American men who were heterosexual and had low SES.

Prolonged engagement and persistent observation of the data revealed changes needed to the interview guide and a study domain that needed additional coding. After the first two interviews, there were questions that needed additional probes to illuminate participants' responses. Additional probes were added to increase the depth of information collected. The same questionnaire was used to explore men's experiences for the first three interviews. Subsequently, the questionnaire was adjusted with the additional probes. In Domaine E of the In-Depth Interview that addresses Agency, the question regarding how being an African-American man has impacted your health and well-being was partialized when more explanation was needed for the participant to understand the question. After the initial coding, focused coding, and thematic coding were partially completed, the researcher felt that Domaine E needed additional analysis and that domain was re-coded to explore the data fully. Re-coding this domain allowed the researcher to capture information regarding the connection between self-agency and role strain; and access to care as a category impacting agency. Providing this information serves to disclose changes to research process and methods.

Memoing allows the researcher to capture "thoughts, capture the comparisons and connections you make and to crystallize questions and directions to pursue" (Charmaz, 2014, p. 162). Further, memoing is a "crucial method in grounded theory because it prompts you to analyze your data and codes early in the process" (Charmaz, 2014, p. 162). Memos were captured on the transcript to remain close to the data and categories. Memos were also captured in a journal from the beginning of the study through drafting the conclusion. This allowed the researcher to capture questions, make observations, and suggestions for sampling, questionnaire changes, and anything that came to mind regarding process or content that would assist with analyzing data through the emergence of themes.

Reflexivity Statement

I have been working with populations that have health disparities for over 20 years. Initially, as District Director for a Congressional Office, I was charged with working to reduce health disparities in minority populations in Baltimore City and Baltimore County. Baltimore City had HIV/AIDS rates comparable to a third world country in three zip codes. I worked with multiple organizations to form an umbrella organization, funded by President William Clinton HIV/AIDS' initiatives, to reduce duplication of efforts and services and to expand capacity for treatment. After leaving the Congressman's office, I worked for Office of Policy and Planning at the University of Maryland. Within this office is the Center for Excellence on Health Disparities. As the Senior Policy Coordinator, I worked on health issues related to cancer and other tobacco-related diseases. I worked with a multidisciplinary team to bring health screenings and treatment to underserved populations in the state of Maryland. In my current role as a Licensed Certified Social Worker-Clinical (LCSW-C), I work in Baltimore City providing mental health services to minority populations with low SES at a Federally Qualified Health Center. Additionally, I am the Behavioral Health Consultant on a multidisciplinary medical team providing mental health services for clients getting treatment for substance abuse, Hepatitis C, and HIV/AIDS. Over 20 years of experience working with minority populations experiencing health disparities has impressed upon me the importance of interventions to address the needs of underserved populations. The minority populations I work with live at or below the poverty level, have reduced access to adequate education, accessible healthcare, and must manage other structural and cultural mechanisms of oppression. Nevertheless, I always keep in mind that disadvantaged minority populations bring their set of strengths and capabilities to bear on difficult circumstances. Personal research and knowledge of/and experience working on health

disparities in African-American populations provides the foundation I need to develop rapport and engage participants in this research. More recently than ever, I have been exposed to racist rhetoric and practice. I must keep in check my passion for this work to maintain objectivity.

Results

In this section findings from the study are reported. As mentioned in the introduction, the purpose of this study was to explore African-American men's perceptions of SDH by examining how intersections of gender, race, and SES interdependently combine with individual health behaviors, psychosocial and biological factors, community context, socioeconomic and structural factors to impact health and well-being and agency. A secondary aim of this study was to gather information on African-American men's insights about introducing educational interventions on SDH. Data was analyzed using modified grounded theory methodology.

Results from the iterative process of analyzing the data revealed seven themes that demonstrate how participants individual level experiences as African-American men reflect macro socioeconomic and structural inequalities: (1) "It's Hard to Be a Black Man in American" Intersectional Self-concept, (2) "We Got to Be Warriors, We Got to Be Soldiers": Gender Role Strain, (3) "You're Going to Take the Working Route or the Drug Route": Pressures of Employment and Unemployment, (4) "Black Men get Treated Like Trash": Discrimination and Microaggressions, (5) "The Police Kill Us, Beat Us, and Steal From Us": Police Surveillance and Harassment, (6) "Once I Started Selling Drugs, I Started Getting Locked Up": Crime and Punishment, and (7) "What are the Resources in My Community?": Access to Resources. Results also highlight African-American men's perceptions of SDH and interest in educational opportunities regarding SDH.

The following sections provide an examination of emergent themes. Direct quotes are provided to illustrate the emergent constructs. Some quotes were edited for clarity. Each participant received a pseudonym and quotes are presented under that name. Some excerpts are attributed to more than one theme as they are interrelated and overlap.

"*It's Hard to Be a Black Man in America*": Intersectional Self-concept

Crenshaw (1989) developed the intersectionality theory to explain how the dynamic relationship between social identities, cultural and demographic variables such as race, ethnicity, gender, SES, and sexual orientation mutually constitute each other. Analysis of interviews highlights African-American men's self-identity cannot be sufficiently explained in additive terms. Consistent with intersectionality theory, men in this study describe their identities as African-American men in intersectional terms.

Participants quotes highlight explicitly and implicitly the intersectionality of race and gender. Isaac highlights the link between race and gender in explicit intersectional terms. He explains that he could not respond to a question asking him what it meant to be a man without including his race in the description:

Yeah, well just manhood in general or black manhood? Well, I don't know I can't speak for manhood in general. -Isaac

Similarly, the following participants excerpts explicitly describe an intersectional self-identity:

When you a Black man, you got to be cautious, you already assumed to be angry, not responsible. – Lamont

Being a Black man is a constant struggle. You gotta have patience, strength, same as any man but a Black man gotta have a little bit more, because we get looked at a lot more and go through a lot more. -Nathan

Right now, I am a young Black man that has finished school and is successful. -Owen

As a Black man, I have to try a little bit harder and do a little bit more. -Greg

While describing the discrimination African-American men encounter, Bobbie and

Kevin's excerpts highlight implicitly the intersectional self-concept:

America paints this picture like every Black man is so bad when it's not true. I know some good brothers out here for real. It's hard to be a Black man in America for real. It's hard. It's hard. – Bobbie

To be a Black man, it's tough. I think to be a Black man is to be a male with social hindrances already to overcome. That must be overcome in order to succeed. -Kevin

When discussing being a Black man, Harry began to discuss the struggle of African-

American people. Harry implicitly describes the intersectional self-concept, as he describes

himself while he ponders going "back to Africa":

I would love to go back to Africa. I'm Black African-American, but I love being a Black African-American man. We've been through so much. Our people, our family, we've been through so much. Slavery and all that and we've made it through it. We made it and what Martin Luther-King and them did for us. They opened the doors for us today. They did a lot for us. We sit on the front, and Black females sit on the front of the bus if we want. -Harry

Participants also describe identities at the intersection of race, gender, and SES. Andrew

highlights being an African-American/Black man as difficult, hard, and a struggle at the

intersections of race, gender, and SES:

Being a Black man, it's harder to maintain the American dream when you have to worry about surviving every day. You got to worry about food and shelter at a young age. It's kind of hard. -Andrew

Edward highlights the intersectionality of race, gender, and SES as it relates to social

eligibility while seeking suitable intimate partner relationships:

I mean me being a Black man, I'm going to use a female for example, they expect you to have money, you gotta have bling bling, you gotta have at least two to three cars, a big house, you gotta have a pocket full of money. Made me wanna have that image so I could have me a nice girl. -Edward

Isaac posited an intersectional self-concept in the excerpt above; however, below

he makes a contradictory yet salient point regarding adaptation. This sort of self-assessment and

adaptation allows African-American men to mediate conditions of oppression to advance in life.

The following quote illustrates his perception:

It's just at some point life is what you make it. It's not the color of your skin. It's not where you live at. It's all in what you do. If you put your best foot forward, you get a lot of positives scenarios. If you act like you have no sense or you look like you want to be a fool, no one is going to take you serious. -Isaac

"We Got to Be Warriors, We Got to Be Soldiers": Gender Role Strain

African-American men are at risk for gender role strain due to structural inequalities, urban poverty, and racial/ethnic inequalities (Bowman, 2006). Role strain occurs at the intersection of race, gender, and SES for this group of African-American men. The two key sources of stress in African-American men's lives were "(a) men's desires, efforts, and struggles to fulfill socially and culturally important roles; and (b) being both African-American and men in a racially stratified society" (Griffin, Ellis, & Allen, 2013, p. 255). Study participants experience underemployment or unemployment, live in under-resourced communities, face discrimination from police, peers, community members, and employers. Role strain can be observed in this group through their perceptive appraisals of difficulty as they navigate important roles of provider, protector, father, and student.

The following participant excerpts reflect the emotional effects of struggling to fulfil society expectations as a father and protector:

I know that what I'm here to do certain roles (referring to being a father and friend) being a human being and a man supposed to do, but sometimes I neglect them. Hurt sometimes beyond hurt, there have been times, I never wanted to commit suicide, but I was a little hurt that I woke up. I just made some bad decisions in the past. -Andrew

Well if you are poor like me, I don't know how healthcare would be the main priority. I don't think that would be something obtainable for me on a month to month basis to be able to pay a premium or every month hundreds of dollars for my family and me. It would be like for me to pay for insurance or buy food. I mean I don't know. I think I would have to go with the food. – Andrew

Being a father it made me happy, it made me proud and happy. But a lot of stuff that's going on out here, it hurt me inside like I cried. I may smile and all that around people but deep down inside, I'm crying. I can't read and write for real. I can a little bit. If you tell me to sit down and write a paragraph, it's going to be like a lot of misspelled words and all that like. -Harry

I'm a father, provider, and protector. I try and humble myself, and I actually grind out a lot. When I'm on a job, outside of work, I'm always trying to find a way to make a dollar…We got to be warriors, we got to be soldiers. We got to be the front runners of everything in the household, outside of the house make everything complete, without the chaos or destruction being shown throughout everything we're going through. -Jerome

I'm a provider, protector, father. I provide for my kids, try my best to protect them. I feel as though I am not doing as much as I should be doing. -Lamont

Greg assist his mother with two younger brothers because he is unemployed and waiting for someone to respond to his applications for employment. Helping out with his brothers provides a way for him to fulfill societal expectations of contributing to the household:

Provider for my little brothers. My mother has got to go to work. Whatever she got to do, I got to help out with my little brothers. I think I'm doing pretty good. It's not my first time trying to help out with people kids. Emotionally, I get to see them grown up, that's the big part of my life. -Greg

Limited opportunities for employment result in African-American men feeling they have little choice but to turn to crime to meet societal expectations:

Then it's like you know what I'm saying you don't want to see it, you don't want to be a part of it, but you here and you ain't got no choice. You going to take a working route or the drug route. It's only one or two things that can happen out of that. And it's not that many opportunities for jobs and stuff so basically, it's just fall in line. -Edward

Kevin's excerpt describes how his efforts at meeting societal expectation are currently derailed due to drug addiction:

I am a protector, well sometimes provider, but I also play negative roles in the community. I mean I sold drugs in the community. I bought drugs. I played both sides. I also coached. I mean because you could be positive in your own house and there are people that try to reach out and be positive in the community too. Depending on the community you could get backlash for that. I feel like I have the potential to, but I'm not doing that right now. And I'm not doing it right now because I am at one of the lowest points of my life due to the path I've taken (He is in substance abuse treatment for opioid addiction). If I could fulfill these roles, I would feel good about myself. -Kevin

Owen, a younger participant, explains the difficulty he faces as an African-American man

living in a neighborhood that has a tempting drug culture:

It's hard being a Black man around here. Cause drugs and stuff like that is tempting, so you got to make sure you don't do it. Owen

Edward describes attending schools in neighborhoods where administrators did not have

control of the student body. This educational environment did not leave room for him to fulfill

societal expectations of student. He befriended disruptive students to remain safe:

First of all, the schools that I went to was on blocks and the people was representing so they thought they ran them schools. Either you are running with them in their school or you are getting beat up -Edward

"You're Going to Take the Working Route or the Drug Route": Pressures of Employment and Unemployment

Nine of the 15 participants in this study were unemployed. Data revealed unemployment

was associated with criminal history and felony records. Younger participants' narratives

indicate a lack of opportunity and unfair pay as reasons for unemployment. Men are also waiting

to hear back from employers regarding applications for employment. Participants express a

desire to be employed.

Edward succinctly describes how limited job opportunities lead to drug-related

activity:

Then it's like you know what I'm saying you don't want to see it, you don't want to be a part of it, but you here and you ain't got no choice. You going to take a working route or the drug route. It's only one or two things that can happen out of that. And it's not that many opportunities for jobs and stuff so basically, it's just fall in line. -Edward

The following narratives highlight criminal records and continued involvement with the

penal system hindering ability to obtain gainful employment:

First, of course, I am a protector. I'm striving to be a working man. That's what I am doing now. I see myself getting a trade. Working and providing for my family. For myself as well. Getting out and getting my own. Now, I'm just learning about what my credit score is and stuff. I got more than enough potential. And if I didn't have these felonies and the background I'd been working. -Bobbie

I'm not working because of my background due to me going to prison. Jobs turn me down. Really ain't too many job opportunities and the females already got that sewed up. The young females got that sewed up. It's really nothing for me for real. -Edward

It's hard for me right now. I'm trying to get a job more than disability, and all they do is bring up my record. They just judge me from off my record and all. We are nothing but a number, we're just a number, our social security number, just a number to them. -Andrew

I'm not working because Parole and Probation put me in a program and I don't have time to work. I need to work. I support myself. I just live day by day. -Nathan

Lamont was consistently denied employment due to his criminal record. He repeatedly appealed to the manager of a Kentuck Fried Chicken restaurant to give him a chance. The manager gave him a chance, and he is currently employed at that establishment. His excerpt also highlights the struggle to find employment with a criminal record:

It's very hard being a Black man because nine times out of ten (He was denied employment.). My confidence kept dropping lower and lower. I kept trying to apply and get a job. Nobody would give me a chance. My criminal record. So, I started thinking and I talk to the person, "Can you please just give me a chance, I never had a chance? My whole life, I done all the wrong things, but could you just please give me a chance to prove to myself to you that I can do this?" -Lamont

Harry is not working because he never finished school, started selling drugs at a young age, and lacks sufficient skills in reading and writing. His excerpt highlights how lack of basic skills impede the ability to become employed.

I can't read so like I be embarrassed. I don't know what, like trying to read something and they give me a list of things you have to do for the day. I ain't even got nowhere to start it. -Harry

The following excerpts describe drug addiction interfering with the ability to maintain employment:

I'm not working because wasn't going. I wasn't seeking or even trying to go to work when I was in the active addiction. You know because that was simply, it would have taken up too much of

my time, you know. And I'm not working now because I just got out of treatment but I'm looking. -Isaac

All man, employment, the pressure to be working, pressure to be masculine, the pressure to be more of a man than the next man. Just the pressure of making things happen. Like at the end of the day everybody looks at you. You know what I'm saying. - Kevin

Data revealed participants desire to get fair wages for the work they perform. Greg like other participants would like to receive fair wages for his efforts as his narrative describes:

I just resigned from a job. I wasn't satisfied with my pay. Umm, I'm not doing anything right now. I was trying to get a job from Giant. I'm just waiting for them to call me right now. -Greg

Frank and Marvin, are underemployed. Both men have skill sets that should allow employment at a higher salary. Frank works for his father's small construction company part-time and would like to work construction full time. Marvin works as a general cleaner; however, he has a Commercial Driver's License (CDL), but is unable to work as a driver due to his criminal record.

"Black Men get Treated Like Trash": Discrimination and Microaggressions

African-American men's narratives reveal racial discrimination and microaggressions at the intersection of race and gender. Discrimination consists of actions taken to deny equal rights based on prejudice and stereotyping (Fiske, 2010). Racial microaggressions are "brief, commonplace, and daily verbal, behavioral, and environmental slights and indignities directed toward Black Americans, often automatically and unintentionally" (Sue, Capodilupo, & Holder, 2008, p. 329). Racial discrimination and microaggressions were from people, usually Caucasians, that suspected participants of being incompetent or criminals.

Participants experience individual and institutional level discrimination. Frequently, African-American boys are punished harsher than other students for the same infractions. Bobbie describes a "racist teacher" taking away his opportunity to attend a private school:

I had a chance to go to a private school. I had an academic scholarship. I applied 5th grade to Boys Latin. I took the test and passed. They were sending letters to my house. We look forward to seeing you on campus. I was going to Ferman L. Templeton, and I got into a fight. After that, this racist teacher wrote the school and told them I got into a fight. It was over from that. -Bobbie

Participants describe discrimination in employment. David's excerpt describes how

a coworker with a seriously ill son was fired for what should have been an excused absence:

We get treated like no one cares about us. No one cares about Black men on my job. They not paying us enough for the work we do. One Black guy son was in the hospital for brain cancer, and he got fired for calling out. It was ridiculous. -David

Isaac discusses the employment ceiling that exists for Black men because of racism:

Wow. It's hard, it's hard. I don't want to blame everything on the White people, you know, but it's been indoctrinated throughout generations that you're not as good. I just feel like as a Black man I'm always going to have a ceiling. I'm always going to have a ceiling. I feel like no matter what even with us having a Black President, you know I just feel that like, there's always going to be a ceiling there for us because racism isn't going anywhere. - Isaac

Greg describes automatically being identified with things that go wrong on the job because he is

a young Black man:

I feel like when I'm working, since I'm a young Black man, when stuff go wrong, they're just automatically thinking it's my fault even if they know I do a good job. I feel everybody's always looking down on me and they don't know what I can do. -Greg

Edward describes the police and others in the community negatively categorizing and

treating all Black men in a disrespectful manner:

Black men get treated like trash in my community. They ain't got no respect, they think all Black men is in that same category, they just not doing nothing for themselves or nobody, so they treat all of us the same. By the Police, by everybody. -Edward

Data revealed microaggressions experienced in the context of employment and health

care. The following excerpts highlight microaggressions while trying to maintain employment:

It was more so a power thing because you working there. It was like do this and do that, you know what I'm saying. Basically, I was like the only Black man working there, a million and one people on this clock, and I'm the only one that had to punch in. -Edward

He kept saying wipe that wall, there ain't nothing wrong with the wall, the wall clean. Chips are already stacked up, make sure they are stacked up and it look right. But I was working for the White man. But it's like the chips are already lined up right, nothing wrong with them, line it up, line it right. He would say start it over do it right. -Harry

The following excerpt highlights an example of microaggressions in health care:

Some doctors treat white people with a little more open arms and a little more respect. -Kevin

In the excerpt below, this participant highlights microaggressions due to lack of insurance:

Before I had insurance, doctors always made me wait longer, and they were anxious to discharge, or they'll say nothing is wrong, or they give me referrals and say you have to go to these people. It wasn't about being Black; they made us all wait that didn't have insurance. -Lamont

"The Police Kill Us, Beat Us, and Steal From Us": Police Surveillance and Harassment

Data reveals police presence is normal in most communities described by participants. Participants note crimes such as robbery, prostitution, murders, shootings, and most prevalent drug dealing activity. Participants experience police surveillance and harassment at the intersection of gender, race, and SES. Participants note frustration that police are not able to garner differences between African-American men committing crimes and men working and taking care of their families legally. Participants narratives highlight police stopping or following them for unofficial reasons, illegal searches, brutality, and extortion.

Participants cannot afford to live in more affluent neighborhoods. Data reveals participants think police observe and harass for unofficial reasons. The following excerpts highlight unofficial surveillance and harassment of African-American men and others in their communities:

Well police, bad, primarily, my daughter's mother is white and when we walk down the street a lot and I can't count how many time the police just ride beside us looking while we are walking. -Andrew

It's a lot of harassment; it seems like they just think everyone in that community is doing some something wrong just because we live where we live. We live there because that's where we can

afford to live. I don't even go outside. I live in a disability senior citizen building. It's people with disability, and it's a lot of senior citizens that don't like to sit outside because of the people around the neighborhood and the police. The police will just walk up and shine lights. It feels like you are in a box, in a cage something like you are being controlled. You are not being protected. It's the opposite way. Like everybody is a criminal until proven innocent. -Andrew

It's very hard to be a Black man. In this era and back then. It's just hard because you got the police. I'm just saying in general, if nine times out of ten you keep seeing on TV, we ain't talking about just Baltimore, we are talking about all over the United States. These young Black people are getting killed by the police we are supposed to have trust in. Like me for example, I will come through with a work uniform and stuff on and they still stop me. I guess they don't want to see you around. -Lamont

When the police pull up on us they would say, "Are you all gangsters?" Just because we're Black males walking up the street, we got to be gangsters? We're going to basketball practice, why we got to be gangsters? Why we got to be that just because of where we living at? Cause there's all the money that my mother can afford. They are the real gangsters. They are the ones out here getting away with everything. -Harry

The police don't treat the people in the community with the respect that they should I think. The things they do to us. It's not right. -Kevin

Police illegally search, extort, and brutalize African-American men even to death. In the

following excerpts participants describe these police actions:

In my community, the police harass Black men, keep checking everybody like they don't know who the drug dealer and who ain't the drug dealers. They treat everybody the same. The protectors are the ones you need protection from. -Nathan

They are disrespectful right, they jump out on you and just snatch you, like drag you down to the ground. Beat you, you know, literally, like for nothing. The disrespect part is just they threaten you. You know what I mean, you understand? And so that that right there, that's enough right there. -Isaac

It's going on all around the world. I know it has been going on for years. Before the body cameras came, before people were calling up and reporting, they hop out beat us up take our stuff. Make us go get them something, extorting us. That's why we hate them. -Edward

In my community the police kill us, they beat us, they steal from us. They got all these laws and they break every single one of them on a daily basis. In my community, we just can't stand the police. -David

The community I used to live in they don't really like the police because the police are killing the Black males on the streets and things like that. – Frank

One participant did not have any experiences with police surveillance or harassment in his community. The following narrative highlights what happens when the police do not respond promptly because of where they live:

They police don't even come around like that where I live. There's been times like when my uncle had all his tires stolen off the car, and the police didn't come for like 45 minutes to an hour, and he had to go to work. -Greg

"Once I Started Selling Drugs, I Started Getting Locked Up": Crime and Punishment

Twelve of 15 participants reported incarceration at some point in their lives. The Face Sheet inquired about incarceration and length of time if the participant responded affirmatively. The In-Depth Interview questions did not inquire about incarceration. Narratives about incarceration were captured throughout interviews. Some narratives overlap with other categories.

Participants' narratives included incarceration for selling drugs and robbery. The following excerpts explicitly describe incarceration:

I support myself you know asking my people for stuff, you know what I'm saying. I even been to jail for drug dealing, selling drugs. -Edward

So, once I started selling drugs around there, I just started getting locked up, getting charges. I was getting older while I was locked up. What really messed my head up was when they locked me up for the three attempted murders that I didn't have anything to do with. So, I'm like all the other stuff like the drugs and all that. I had nothing to do with the attempted murder. I told them, I had something to do with the drugs and stuff. They know I had something to do with it. But that night I had nothing to do with it and that really open up my eyes like they are locking people up for nothing now. -Harry

I've had friends murdered. I've been locked up for robbery. I've had friends locked up for murder. I've had friends locked up for kidnapping. On the crime standpoint. I been in fist fights and stuff like that, But, no, I wasn't hurt by crime myself. - Bobbie

Other participants' narratives highlight a criminal record or felony on their record.

First, of course, I am a protector. I'm striving to be a working man. That's what I am doing now. I see myself getting a trade. Working and providing for my family. For myself as well. Getting

out and getting my own. Now I'm just learning about what my credit score is and stuff. I got more than enough potential. And if I didn't have these felonies and the background I'd been working. -Bobbie

It's very hard being a Black man because nine times out of ten (He was denied employment.). My confidence kept dropping lower and lower. I kept trying to apply and get a job. Nobody would give me a chance. My criminal record. So, I started thinking and I talk to the person, "Can you please just give me a chance, I never had a chance? My whole life, I done all the wrong things, but could you just please give me a chance to prove to myself to you that I can do this?" -Lamont I'm not working because Probation and Parole put me in a program and I don't have time to work. I need to work. I support myself. I just live day by day. -Nathan

"What Are the Resources in My Community?": Access to Resources

The social and economic determinants of African-American men's health and well-being are the result of lifelong unsatisfactory conditions that influence health behavior, lifestyle, and healthcare access (Commission on Social Determinants of Health, 2008). In urban areas today, the harsh reality of a legacy of systematic exclusion of equal access to social, political, and economic resources continues and is revealed in participants' narratives.

When describing how resources come into the community, some participants described informal resources. Participants narratives highlight resource streams such as telegrams, churches, donations, and word of mouth:

By the phone. Instagram and all that. -Lamont

Right now, we are going to the churches, and they are helping us out. Like they just gave us a basketball goal to put up in our complex. -Harry

I've seen in the city people giving out coats to kids, feed the homeless, some good things going on. Baltimore got some good things and we also got some bad things. So, it's like that you know what I mean. -Bobbie

Word of mouth. One person stumbles across something and willing to share with the rest of the people. And it just gets around. -Andrew

When describing how resources come into the community, a few participants identified formal resources streams like taxes, grants and government funding that helped support schools,

roads, and infrastructure, but did not feel the resources needed to improve the community

members' lives were coming into the community. The excerpts below reveal participants' views

on formal resources:

From like the city funds, city-state funds. There are general bulk funds that's going to all the schools. -Greg

I guess the taxpayers. -Marvin

I guess the government, I guess. -Owen

What are the resources in my community? I'm serious. I'm saying you don't see it. If there is resources there, like you don't see it. -Isaac

Two participants described local government directing resources to maintain city-owned

property and to fund police and Bureau of Alcohol, Tobacco, Firearms, and Explosives *(ATF)*

needs:

Any resource that benefit us having something to do beside ripping and running the streets and shooting each other? We don't have no resources for us to take our mind away from the violence. But as far as the city coming to fix their streets, yeah, the city always come to fix their stuff. They always come and cut the grass and all that. But it's never anything geared toward us. -David

In Baltimore City, there's no money for the recs. They stripped it all because they wanted to put on body cameras on the police and ATF and task forces to continually keep things down. When I was growing up and we had recreations and everything, there wasn't so much going on. I don't know. Private people and private businesses probably support the recs. But the library is the most awesome thing in the community. That's one thing that stays intact and up to par. People donate books to the library and so forth and so on. So, I guess that's how that works. -Jerome

When describing whether the government had control over people's health, participants

describe government mistrust and government control of resources needed for health and well-

being. Excerpts below illustrate government power and control of resources:

Whatever that free insurance we got the government says what we eligible for and how often. I got some glasses last year, and I lost them, and I can't get another pair for two years when they say I can. So, I just got to pay out of pocket if I want to see. -Clayton

The government has control of everything. Producing this negative poisonous food, these GMO foods that we are eating, by having a stronghold on the distribution of the food and importing other foods and all various things. Yeah, the government is wicked. If you look at it on a worldly aspect, the government gives you the ability to be complacent and stuck in one position, so they give you housing and food stamps and all of that. So far as me navigating through society and all that as a Black male, I don't have many grievances. None of this stuff is a true benefit to me for real, but it's there the resources are there. -David

I think they got control over the football games, so yeah they probably got control over our health. I guess if you got the money you get treated right, if not than you wait until the people with the money get treated first and then it's your turn no matter what. The dude that come in there with the money with a step throat and you can come in there with no money with a broken leg; you gotta wait they going to treat him with the strep throat first and maybe if its somebody else comes in with some money and then you can get in.-Edward

Because you know with the healthcare, look at Donald Trump when he's trying to repeal Obamacare. Like who wouldn't want everyone to have insurance? -Isaac

Yes. Because the way they raised prices for medication, and everybody can't get that type of medication. -Lamont

Yes. Because they dictate like the payments, they gonna hike up the insurance taxes, so they going to have to charge you more. -Marvin

Yeah. Cause they got the cure that they don't want to give us. We ain't got no money they ain't curing nobody. They let us die. If we ain't got the right healthcare or the right money. -Nathan.

I really don't know about that. I guess yeah, they control because they gave you the stuff like the medicine and Obamacare. -Owen

Frank did not think the government had control over people's health. His excerpt below describes self-determination over diet determining health status:

I would say no kind of. Cause like you can always go to the market or something and get some fruit or vegetables and get the food that you need to stay healthy, drink milk and things like that. So, I don't necessarily think the government makes you go out and eat fast food every day so you can have bad health or anything, it's like that. -Frank

African-American Men's Perceptions of Social Determinants of Health

Social Determinants of Health are the conditions in which people are born, grown, live, work, and age influenced by the distribution of wealth, power, and resources that influence health status (World Health Organization, 2015). African-American men in the study identified

SDH impacting their health and wellbeing including biological factors, self-determination,

lifestyle, health seeking behaviors, community contextual factors, socioeconomic and structural

factors.

Two participants excerpt highlight biological factors that impact African-American

men's health and wellbeing:

Yeah, I got high blood pressure. Me, my great-grandmother, my grandmother, my father, my little brother. -Greg

I guess with the types of foods I've eaten and hereditary; I have like diabetes that runs in my family. So, things like that it's hereditary. -Kevin

Participants described self-determination, based on Western male socialization, as a

factor impacting their health and wellbeing:

Umm far as that, that is all up to me. Cause no outside deity is going to make sure that I have good health. -David

Not really. Not much of nothing because I have been very healthy. It's just at some point life is what you make it. It's not the color of your skin. It's not where you live at. It's all in what you do. If you put your best foot forward, you get a lot of positives scenarios. If you act like you have no sense or you look like you want to be a fool, no one is going to take you serious. - Jerome

Narratives highlight lifestyle factors including diet, drug use, and stress impacting health

and wellbeing:

The food and what we take in, that's first and foremost. What you put in your system which is produced, comes out. So, if you're not eating healthy, you going to be sick. If you eat right, you should be awesome. -Jerome

Oh, being a black man, that diet has definitely impacted my health. Definitely destroyed my health unknowingly. It wasn't done intentionally by my people, but it is what it is. -David

Drug and alcohol abuse, overeating, not exercising, not eating right, umm health unprotected sex, umm lack of sleep, that's about it. -Clayton

They don't live the right lifestyle. They just everybody always getting high or you don't go the hospital. -Nathan

Fast food, smoking, drinking stuff like that, stress. -Greg

Drugs and unhealthy eating, stress too, you know what I mean. -Bobbie

Participants identified community contextual factors impacting the health and wellbeing

of African-American men:

Bars around, every corner around our way. Impacts their health because I don't drink, but drugs they on every corner so that impact too. -Harry

Oh, because you got the bars, you got the drugs and all this in our community. You can't go out in the county and go from around the corner you just stopped at five bars. -Lamont

The drugs like the marijuana and stuff that go around the hood, something like that. -Owen

Participants excerpts highlight socioeconomic and structural social factors

including racial discrimination, lack of insurance, low SES, and police harassment and

incarceration that impact African-American men's health and wellbeing. Frank, Greg, and

Kevin's excerpts highlight racial discrimination:

Sometimes if you a Black male you would probably get judged off how you present yourself. Say if you go to an interview or something like that and you go in there not professional or anything like that they probably judge you off your appearance. -Frank

I feel like when I'm working since I'm young, when stuff go wrong they're just automatically thinking like it's my fault even if they know I do a good job. -Greg

I face a lot of racism. Especially in relationships and stuff like that. -Kevin

Andrew, Marvin, and Isaac's excerpts highlight lack of insurance as a SDH:

I would say the lack of insurance. I don't experience it personally which is a blessing, but I hear some people I talk to about don't have insurance don't have the certain opportunities I have. - Andrew

Bad dieting, lack of health insurance, that's mainly lack of health insurance. -Marvin

Lack of insurance, the lack of even, even seeking um treatment for anything you know and just being, being ignorant to the fact that they, they need you know, like just not knowing. -Isaac

The following excerpts highlight the SDH low SES identified by participants:

I mean me being a Black man, I'm going to use a female, for example, they expect you to have money, you gotta have bling bling, you gotta have at least two to three cars, a big house, you gotta have a pocket full of money. Made me wanna have that image so I could have me a nice girl. -Edward

I never had no house. I was always just living with somebody. I'm probably going to get something now. -Edward

For housing, I have never really sure enough applied for it but, my funding at his point in time is not there to equivalate housing. – Jerome

I'd say because society caters to women that's what I think. I guess they look at them as the ones who have the kids and stuff. And they feel as though a man shouldn't be dependent on anything they should they if they need housing they should go and get it. -Marvin

The following three excerpts highlight the participant identified SDH police harassment and incarceration:

Well, I'm going to put it to you this way. I didn't even have time to even be able to start living my life as an adult to in order to even look at health or anything like that because from the time I was 20 till I was 27 I was incarcerated. I came home, and I stayed home for approximately seven months, and I was gone from 27 to 40. So, I didn't have like all my 20s and 30s were spent in prison incarcerated. - Isaac

It was all for nothing. I stayed out there for three years out of my kids' life. I got stabbed in my head and put in lock up. I was sitting in the cell, talking to myself, losing my mind in there, and for something that I didn't do, not a month, three months, but three whole years. I done cried to myself and all that a like, looking at pictures and all that wishing that I could jump in the pictures or in the phone. -Harry

Like with the police or like with older people. They totally treat all young Black men the same way. They don't they can't tell the difference. - Nathan

At the end of each interview, participants were read a paragraph regarding SDH and Africa-American men (See Interview Guide Appendix D). Subsequently, they were given the opportunity to describe their interest in learning about SDH. Lastly, they were asked what they thought about providing an opportunity for African-American boys and young men to learn about SDH. Eleven participants wanted to learn about SDH. Jerome and Nathan indicated they did not want to learn about SDH. Isaac and Kevin thought possibly they would be interested in

learning about SDH. All participants thought African-American male youth should learn about

SDH. The following excerpts illustrate participant perspectives on SDH education for African-

American boys:

I believe that if I had someone to play the whole tape and not just the instant that showed jail, all these people died or was hooked on their own stuff. And the people I grew up with that got hooked up in that lifestyle. Like me, I have been shot up ten times; I got body pains forever. On and off drugs all my life. A lot of them still incarcerated. I've seen old friends just coming home, from when I grew up that I haven't seen since I was 16 and I am 39. Like you said all those social and all those elements like how you start getting locked up. They need to teach that in school. All these things like you saying bring that to somebody. Everybody don't have good parents. Or two parent homes, some people got the grandmother. -Andrew

Yes. I thought it was just my life going back and forth to prison it wasn't nothing so yeah. They should learn in elementary school. -Clayton

They start teaching them lies in elementary school. Why not start teaching something that will have a benefit? So, elementary school. -David

Eleven or twelve. That's when they start feeling themselves. Smelling themselves. Start thinking they grown. -Edward

I would say probably seventeen, probably sixteen or seventeen when they could fully understand everything and be able to take in everything they have been told about their health. Probably so they could take it more serious. -Frank

Yeah. I say when they get age of 7 or 8. First and second grade. That's when they are learning. They catch on around that time. Like my son, once he got into first grade, I taught him how to do everything. Like he wanted to know everything. He wants to learn everything like he's so smart, all As. -Harry

I don't want to learn. You can teach young ones. I may have graduated college and been some type of doctor somewhere. Or a lawyer. Or a Social Worker you never know. -Jerome

I don't want to learn. Teach them in high school. I was going to say ten, but ten, fifth grade, six grade and seventh grade it's only girls on your mind and nothing else. Yes thirteen, eighth grade. Some will listen. -Nathan

Discussion

This qualitative study used an adaptation of the Q-SDH social ecological model and an intracategorical intersectionality conceptual framework and grounded theory methodology to explore urban African-American men's perceptions of the intersectionality of gender, race, and SES; and how they interdependently combine with individual health behaviors, psychosocial and biological factors, community context, socioeconomic and structural factors to impact health status and well-being and agency. The ecological and intersectionality conceptual framework provided the conceptual foundation for the researcher to examine African-American men's understanding and the nuances of how these factors interdependently interact to impact their lives on multiple levels. Narratives of 15 self-identified low-income African-American heterosexual men provided insight into how individual level experiences reflect interlocking macro socioeconomic and structural inequalities.

The discussion will address African-American men's intersectional self-concept and how it is manifest through social identities of race, sex, and SES that are interdependent and mutually constitutive. Secondly, the discussion will address how African-American men's social identities are associated with gender role strain, police surveillance and harassment, incarceration, racial discrimination and microaggressions, employment and access to resources. The discussion will also address African-American men's perceptions of SDH and educational opportunities for themselves and African-American youth to learn about SDH. Finally, implications for research and practice, as well as study limitations will be discussed.

Intersectional Self-concept

Crenshaw's (1989) intersectionality theory posits social identities, cultural and demographic variables such as race, ethnicity, gender, SES, and sexual orientation mutually

constitute each other. Analysis of interviews highlight African-American men's self-concept is intersectional at race and gender, interdependent and mutually constitutive. These findings echo Bowleg, Malebranche, Teti and Tschann's (2013) intersectionality study of low SES African-American heterosexual men (n=30) that indicated African-American men's social identity is intersectional and not additive. Intersectionality research demonstrated how systems of power and oppression merge with African-American men's intersections of race, gender, and SES (Bowleg, Malebranche, Teti, & Tschann, 2013). Intersectional social identities and their manifestations increase African-American men's venerability to job discrimination, unemployment, over-policing and harassment, and incarceration (Bowleg, Malebranche, Teti, & Tschann, 2013). Participants commented on the difficulty they experienced while "highlighting the link between their multiple social identities of race, gender, and SES and socio-structural factors such as racial discrimination, poverty, unemployment and incarceration" (Bowleg, Malebranche, Teti, & Tschann, 2013, p. 28). Participants in the current study addressing the same factors frequently described experiences as hard, difficult, and a struggle. Racial discrimination was also frequently discussed in relation to experiences at the intersectionality of gender, race, and SES. Participants' narratives illustrated how individual level experiences of the intersections of race, gender and SES and Gender Role Strain reflect macro socioeconomic and structural inequalities such as unemployment, police surveillance and harassment, incarceration, discrimination and microaggressions, and access to resources.

Gender Role Strain

African-American men are at risk for gender role strain due to structural inequalities, urban poverty, and racial/ethnic inequalities (Bowman, 2006). Gender role strain as a stressor becomes more prominent in different phases of life as African-American men try to meet gender

role expectations under difficult circumstances and experience failures associated with social and cultural norms (Griffin, Ellis, & Allen, 2013). African-American men in this study experienced gender role strain as they navigated the important roles of provider, protector, father, and student. At the intersections of race, gender, and SES, narratives described experiences of underemployment or unemployment, living in under-resourced communities, facing discrimination from police, community members, and employers. Narratives also illustrated the emotional impact African-American men experience when trying to fulfill societal expectations.

Examining the intersection of race and gender, researchers found African-American men (n=17) endorsed traditional Western masculine norms (Rogers, Sperry, & Levant, 2015). Roger, Sperry, and Levant (2015) found African-American men negotiated masculinity between their minority and the majority culture and were constantly threatened by racial oppression (Rogers, Sperry, & Levant, 2015). Participants in this study echoed expressions of the importance of mental fortitude, and physical strength to being an African-American man (Rogers, Sperry, & Levant, 2015). African-American men expressed the importance of role models for defining masculinity (Rogers, Sperry, & Levant, 2015). Echoing research participants felt absent fathers resulted in men having to define masculinity for themselves (Rogers, Sperry, & Levant, 2015), making room for the wrong role models to lead them to criminal activity. Study participants expressed gender role strain, masculinity, and stress related to health behaviors such as not seeking care, drug use and lifestyle. Participants identified African-American male hypermasculinity as detrimental to developing behaviors that lead to getting preventive care, screening, and treatment for chronic disease (Mount, et al., 2012).

Scott and Wilson's (2011) study on African-American men (n=18) with low SES identified stressors over daily needs outweighed concerns for health and health promotion,

healthy foods, and places for healthy exercise. Men's narratives reflect this observation with only one participant seeking preventive primary and dental care. African-American men in this study were not focused on health unless they were sick; echoing findings by Scott and Wilson (2011) that men do not prioritize health unless they were sick and could not function normally. Eight participants' narratives reflect receiving care for substance abuse and mental health disorders after it impacted normal functioning. Gender role strain is a barrier to physical activity (Griffith, Gunter, & Allen, 2011). The majority of African-American men's narratives described natural and built places to exercise in their urban environment; however, most participants did not exercise. Andrew described stretching, but indicated it was not exercise. Isaac just starting to attend a local gym near his house to lift weights. Bobbie identified wanting to exercise after he found employment. Men were more focused on meeting gender role expectations within difficult socioeconomic and structural limitations than on health and wellbeing.

Pressures of Employment and Unemployment

The unemployment rate for African-American men is 8.4 percent, about twice the unemployment rate for Caucasian men (Bureau of Labor Statistics, 2017). Unemployment for African-American men is at the intersectionality of race and gender. Institutionalized employer discrimination via consistent negative racial stereotyping and corporate discrimination where U.S. and foreign companies used racial composition of areas to determine where to locate or relocate plants resulted in significant and detrimental job losses in African-American communities throughout the Northeast Region of the United States (Williams, 1999). Due to housing segregation and economic discrimination, African-Americans were less educated and had higher unemployment rates (Williams, 1999). This history of housing segregation, employer

and corporate discrimination continues in under-resourced communities today as described by narratives.

Nine of the 15 study participants were unemployed. Of the nine unemployed participants, one participant is not working because he lacks sufficient skills in reading. Two participants are underemployed. Both men have skills that should allow them to be employed at a higher salary. Many narratives associated unemployment with a criminal history and felony records preventing them from getting employment echoing Bowleg, Malebranche and Tschann's (2013) study on African-American men. Younger participants' narratives indicate a lack of opportunity as the reason they are unemployed. Narratives about employment reveal men waiting to hear back from employers regarding applications. Most participants expressed a desire to be employed. Men identified societal racism and discrimination in society, employment, and daily life as being stressful (Griffin, Ellis, & Allen, 2013).

Employment provides African-American men with a way to fulfill societal role expectations of provider and protector and determines health status across the lifespan. Unwritten tracking policies directed Africa-American youth, predominantly boys toward trade instead of college prep limiting their chances for college due to not having the adequate classes needed for admission (Scott & Wilson, 2011). A minuscule number of Africa-American males go to college while many end up unemployed or in the drug trade (Scott & Wilson, 2011). Subsequently, there has been a proliferation of drug use and trade in many communities and an increase in incarcerations for drug and violence related crimes.

Discrimination and Microaggressions

African-American men face the challenges of racial discrimination and suffer microaggressions daily (Bowleg, 2013). Racial discrimination disadvantages African-Americans

by treating them as inferior beings and denying equal access and opportunity (Sue D. W., 2003).

Racial discrimination removes opportunities for African-American men to obtain employment

and educational opportunities and increases chances of having negative experiences with police

and others in the penal system and the education system. Racial microaggressions are "brief,

commonplace, and daily verbal, behavioral, and environmental slights and indignities directed

toward Black Americans, often automatically and unintentionally" (Sue, Capodilupo, & Holder,

2008, p. 329). African-American men experience racial discrimination and prejudice daily such

as being denied promotions, racial profiling by police, and experiencing microaggressions of

others (i.e. watched while shopping, difficulty getting a cab, and women holding their

pocketbooks when you pass) (Bowleg, Malebranche, Teti, & Tschann, 2013). Participants

narratives reflect racial discrimination and microaggressions at the intersection of race and

gender. Racial discrimination and microaggressions were from people, usually Caucasians, that

suspected participants of being incompetent or criminals.

Participants in the study described discrimination and microaggression related to

encounters with police, community members, teacher, employers, and doctors. Participants

described daily encounters of racial discrimination and microaggressions from incidents

involving the police. As discussed above in Police Surveillance and Harassment and

Incarceration, participants are stopped, frisked, falsely arrested, followed as they walk with

partners, and harassed for being in their neighborhood.

African-American students in segregated neighborhoods attended schools with less

qualified teachers, less rigorous curriculums, less academic counseling, lower expectations for

going to college, poorly funded schools in need of repairs and updated textbooks, higher dropout

rates, higher pregnancy rates and fewer students attending college than whites (Williams &

Collins, 2001). Participants narratives addressed segregated, poorly funded schools that needed repairs and textbooks that were missing pages or had damaged pages. Participants discussed teachers removing educational opportunities and having lower academic expectations. Participants discussed teachers who were surprised when they were knowledgeable on subjects in the classroom. These types of experiences impact students emotionally, reduce self-esteem, and contribute to lower performance by African-Americans (Sue, Capodilupo, & Holder, 2008). Further, teachers with low expectation pushed African-American students towards training and employment instead of college (Williams & Collins, 2001). This limited African-Americans upward mobility in SES due to lack of education and competencies needed to compete for jobs that required advanced skills and training (Williams & Collins, 2001).

Research has demonstrated racial discrimination in the workplace was related to harsh and stiffer penalties for lateness and not being recognized as competent (Bowleg, Malebranche, Teti, & Tschann, 2013). One participant described an incident where a coworker was fired for calling in because his son was hospitalized with brain cancer. Another participant, the only African-American employee at a previous employer, was the only employee punching a clock. In addition, a participant had to repeat unnecessary task multiple times at the whim of an employer.

Participants echoed Scott & Wilson's (2011) study describing whites being treated better by doctors. Participants described doctors treating Caucasians better and with open arms. One participant described discrimination based on SES. He and others waited for patients with insurance to get treated before patients that did not have insurance. Unconscious or conscious bias created barriers to accessing medical screenings, health care information and supportive relationships with a primary care doctors that impacted cancer and other health related outcomes (Mitchell, Watkins, & Modin, 2013). Discriminatory practices by health professionals are

documented across a variety of health care settings public and private, academic teaching

hospitals and non-teaching hospitals (Smedley, Stith, & Nelson, 2003).

Discrimination and microaggressions implicitly and explicitly relay the message that

African-Americans are inferior. These types of messages can have a cumulative and traumatic

effect on African-Americans over the lifespan (Sue, Capodilupo, & Holder, 2008).

Police Surveillance and Harassment

The stereotypical belief that African-American boys and men are "criminal is deeply

embedded in the collective American consciousness (and unconscious)" (Trawalter, Todd, Baird,

& Richeson, 2008, p. 9). African-American men are more likely to be killed in an encounter

with police than any other group of Americans (Swaine, Laughland, Lartey, & McCarthy, 2015).

African-American boys are harshly disciplined for school infractions that are linked to arrest and

incarceration (Fenning & Rose, 2007). Men with less education and economic opportunity lived

in unhealthy and unsafe, violent, drug infested social environments (Royster, Richmond, Eng, &

Margolis, 2006). Participants noted crimes such as robbery, prostitution, murders, shootings, and

most prevalent drug dealing activity, buying and selling, are an everyday part of life. Police

presence is an ongoing fact of life in communities described by participants in this study.

Participants experienced police surveillance and harassment at the intersection of gender, race,

and SES.

Participants noted frustration that the police are not able to garner differences between

African-American men committing crimes and men who are working and taking care of their

families legally. Participants narratives provided occurrences of police stopping or following

them for no apparent reason, beatings, illegal searches, extorting money and drugs, and false

arrests. One participant spent three and half years in prison for false charges of three attempted

murders; he eventually received an acquittal on all charges. While incarcerated, he was stabbed

in the head in prison and could not get an attorney to take his case because the incident was not

recorded and his previous felony record. Participants felt they needed protection from the police.

Men with low SES men perceived few positive role models in the community, police

stereotyping, incarceration, criminal records, and murder rates out of control as factors impacting

their health (Royster, Richmond, Eng, & Margolis, 2006). Police surveillance and harassment

and incarceration of African-American men are interdependent and overlapping categories.

Crime and Punishment

African-American men are arrested, convicted, and incarcerated more than other racial

and ethnic groups (Treadwell, Xanthos, & Holden, 2013). Incarceration for African-American

men intersects at the social identities of race and gender. There are 2.2 million people

incarcerated in the United State (Bureau of Justice Statistics, 2016) with African-American men

making up 37% of those incarcerated in state and federal prisons (Bureau of Justice Statistics,

2015). The probability of African-American men spending time in prison is twice that of

Hispanics and three times the rate of white males (Scott & Shears, 2007). Twelve of the 15 study

participants reported incarceration for a variety of crimes with sentences ranging from months to

twenty years. Racial biases in policing, prosecutorial discretion and sentencing guidelines

disproportionally impact African-American youth and men. Another contributing factor to this

staggering rate is the types of crimes committed by African-American men (Scott & Shears,

2007). The crimes they commit result in stiffer penalties and are mostly perpetrated on other

African-Americans. Therefore, African-Americans are more likely to be victims of violent

crimes (Scott & Shears, 2007). Participants narratives are fraught with stories of life impacted

by crimes like robbery, shootings, and attempted kidnapping. One participant was stabbed in the

back and hospitalized for five days. Another participant saw his sister murdered in front of him as they were being robbed at the light rail.

Residential context contributed to the high rates of violent crime, drug use, and homicide experienced by African-Americans (Williams & Collins, 2001). Without adequate employment opportunities for those who want to work, African-American men are just trying to survive by turning to alternative means of making a living. Incarceration makes African-American men more vulnerable to gender role strain because criminal records reduce employability and the ability to meet Western gender role norms. In urban areas today, the harsh reality of a legacy of systematic exclusion of equal access to social, political, and economic resources continue to be demonstrated by the crime rates and incarceration for African-American men.

Access to Resources

The social and economic determinants of African-American men's health and well-being are the result of lifelong unsatisfactory conditions that influence health behavior, lifestyle, and healthcare access (Commission on Social Determinants of Health, 2008). Robinson and Cheng (2014) (n=2,926) found affluent African-Americans with more education, economic opportunity and access to resources have better health outcomes. African-Americans with low SES, living in unsafe neighborhoods, with high rates of crime, poor housing and experiencing discrimination have poor health outcomes (Robinson & Cheng, 2014). In urban areas today, the harsh reality of a legacy of systematic exclusion of equal access to social, political, and economic resources continues.

African-American men with low SES in this study described informal and formal resource streams and government control of resources. When addressing questions regarding how resources come into the community, participants described under-resourced communities.

Most participants identified informal resource streams such as telegrams, churches, donations, and word of mouth. A few participants identified formal resources streams like taxes, grants and government funding that helped support schools, roads, and infrastructure, but did not feel the resources needed to improve the community members' lives were coming into the community.

When describing whether the government had control over people's health, African-American men perceived self-agency over decisions regarding their health. However, participants described government mistrust and government control of resources needed for health and well-being. Narratives described government control over foods distribution and that government allowed poisonous foods with GMOs to be distributed that impacted health. Participants described the government having control over access to medical treatment including medicine distribution, determining eligibility for insurance, and distribution of resources covered by insurance like glasses. Participants described the lack of insurance as a determinant of health.

When viewing narratives in their entirety, participants described limited access to adequate housing, education, employment, and healthcare resources. Most participants described living in segregated housing communities with old housing stock. Schools were old and needed repairs, books, and supplies. Teachers tried to teach in overcrowded classrooms, where students struggled to learn, and teachers could not adequately address all students' concerns. Employment opportunities were limited by years of racial discrimination by employers and corporations. Healthcare providers either intentionally or unintentionally discriminated against minority and poor patients. Further, study participants' narratives described discrimination and microaggressions from police, employers, and healthcare workers that reduced access to resources through a prism of intersectionality.

African-American Men's Perceptions of Social Determinants of Health

Social Determinants of Health are the conditions in which people are born, grown, live, work, and age influenced by the distribution of wealth, power, and resources that influence health status (World Health Organization, 2015). African-American men in the study identified the social determinants impacting their health included biological factors, lifestyle, health seeking behaviors, community contextual factors, and socioeconomic and structural factors.

Participants' narratives in-line with long-standing health care policy identified biological factors, lifestyle, and health seeking behaviors that impact their health and wellbeing (Green & Allegrante, 2011). Participants described biological factors including heredity and chronic health disorders like diabetes and hypertension. Robinson & Cheng (2014) found individual biological factors including hypertension, cardiovascular problems, obesity, and diabetes are the result of unhealthy living environments associated with African-Americans low SES. Participants described self-determination, based on Western male socialization, as a factor impacting their health and wellbeing. Examining the intersection of race and gender, researchers found African-American men (n=17) endorsed traditional Western masculine norms (Rogers, Sperry, & Levant, 2015). African-American men were not focused on health unless they were sick (Scott & Wilson, 2011) or a family history of illness existed (Mitchell, Watkins, & Modin, 2013).

Narratives highlight lifestyle factors including diet, drug use, and stress impacting health and wellbeing. African-American men perceived risky behaviors, poor diet, lack of exercise, smoking, drinking and doing drugs as items African-American men perceived impacted health (Royster, Richmond, Eng, & Margolis, 2006). Scott and Wilson's (2011) study on African-American men (n=18) with low SES identified stressors over daily needs outweighed concerns for health and health promotion, healthy foods, and places for healthy exercise. As a societal

issue African-American men's health status deeply "affects spouses and children, diminished productivity, poverty associated with widowhood, fatherlessness leading to increased risk of drug and alcohol use, lower college expectations, and more encounters with the criminal justice system" (Enyia, Watkins, & Williams, 2014, p. 73). Robinson and Cheng's (2014) study (n=2,926) of African-Americans found psychosocial factors such as chronic levels of stress and mental illness resulted in poor health outcomes (Robinson & Cheng, 2014). Negative influences identified by African-American men included stress associated with lack of income and related problems such as lack of insurance and not being able to afford healthcare services, stress associated with racism in employment, negative portrayal of the community in the media, stress of living in unhealthy neighborhoods plagued by crime and over-policing, and stress associated with intimate relationships (Ravenell, Johnson, Jr. , & Whitaker, 2006).

Participants identified community contextual factors impacting the health and wellbeing of African-American men. Participants describe bars on many corners encouraging alcohol use. Participants described communities with drugs bought and sold daily. Men with less education and economic opportunity are more likely to live in unhealthy and unsafe, violent, drug infested social environments (Royster, Richmond, Eng, & Margolis, 2006).

Participants identified socioeconomic and structural factors that impact African-American men's health and wellbeing including lack of insurance, racial discrimination, low SES, police surveillance and harassment, and incarceration. Participants describe the lack of insurance and lack of understanding of the need for healthcare impacting African-American men's health. Lack of insurance due to unemployment or underemployment and poor insurance make preventive care and sick care prohibitive due to cost (Griffith, et al., 2007).

Participants described racial discrimination in employment as impacting African-American men's health and wellbeing. Structural racism reduces education and employment opportunities (Scott & Wilson, 2011). Society in the United States has historically withheld from African-Americans the basic rights and opportunities available to whites including employment, education, housing, and political capital.

Economically disadvantaged men perceive few positive role models in the community, police stereotyping, incarceration, criminal records, and murder rates out of control as factors impacting their health (Royster, Richmond, Eng, & Margolis, 2006). Participants identified police surveillance and harassment, and incarcerations as SDH. The current penal codes put even middle class and wealthy African-Americans at risk for incarceration (Roberts, 2004). However, the poorest Africa American men and women live in racially and economically segregated neighborhoods that incur the highest prison rates (Roberts, 2004). Racial discrimination, low SES, police surveillance and harassment, and incarceration are SDH impacting African-American men's health and wellbeing that are supported in the literature (Bowleg, 2013) (Bowleg, Malebranche, Teti, & Tschann, 2013) (Enyia, Watkins, & Williams, 2014) (Gilbert, et al., 2015) (Griffin, Ellis, & Allen, 2013) (Johnson III & Rivera, 2015) (Mitchell, Watkins, & Modin, 2013) (Robinson & Cheng, 2014) (Rogers, Sperry, & Levant, 2015) (Royster, Richmond, Eng, & Margolis, 2006) (Scott & Wilson, 2011). These multilevel and intersecting social and economic determinants and their precipitating factors have combined and resulted in the overall poor health status of African-American men.

The Commission on Social Determinants of Health (CSDH) (2008) indicated it is important to educate the public on SDH so they can take action to deal with individual, community, and structural level determinants of health. African-American men in this study

described individual level factors and socioeconomic and structural factors impacting health, wellbeing, and self-agency. However, they did not articulate an understanding of the influence macro-level factors have on health-related decisions and health outcomes. The majority indicated a willingness to learn more about SDH. All participants thought that school age children would benefit from learning bout SDH that impact their health and well-being across the lifespan. Responses described how this information could have influenced their life choices, health and wellbeing outcomes.

Limitations of the Study

There are several limitations to this study. The study is qualitative with a small sample size (n=15), and all participants came from one geographic location, Baltimore, Maryland. Generalization to the broader populations is limited. Triangulation and peer examination were not conducted in this study. These two processes may have strengthened reliability. Finally,

In-depth Interview questions that ask men to describe their experiences as African-American men may have prompted them to respond in terms of the intersectionality of race and gender only.

Recommendations for Research and Practice

This ecological and intersectionality conceptual framework provided an opportunity for an in-depth exploration of African-American men's perceptions of SDH. Most studies on SDH and African-American men were completed before the development of intersectionality theory (Bowleg, Malebranche, Teti, & Tschann, 2013). The small body of intersectionality research on African-American men has validated and expanded prior research findings (Bowleg, Malebranche, Teti, & Tschann, 2013). Intracategorical research on low SES African-American men could be expanded by including men from different geographic locations living under the

same conditions. For example, an intersectionality study of low SES African-American men in Baltimore, MD, Philadelphia, PA, and Washington, DC. Intercategorical studies with other races of men with low SES could also provide information toward developing interventions that improve the health status of this population of men.

Future intersectionality research could illuminate aspects of gender role strain and how it manifests at the intersection of race, gender, and SES. Intersectionality research to expand knowledge of gender role strain and stress associated African-American men with low SES fulfilling roles of provider, protector, and role model and processes of adaptation may lead to innovative interventions (Bowman, 2006). Research indicated understanding the stress associated with being African-American and male may provide key information needed to overcome barriers to and improve positive health behaviors and health outcomes (Griffin, Ellis, & Allen, 2013). Future studies could examine toxic masculinity and how it impacts the health and wellbeing of African-American men. Without fully understanding how African-American male gender norms and efforts to fulfill societal roles contribute to overall poor health status, we cannot develop interventions to affect positive change in their health status (Griffin, Ellis, & Allen, 2013). Interventions should address the importance of improving social and economic conditions. Targeting adult education and job training to men who lack education can increase their income potential and allow African-American men another way to express masculinity that does not risk their health (Royster, Richmond, Eng, & Margolis, 2006).

Discrimination and microaggressions relay a message that African-American men are inferior and have a cumulative and traumatic effect over the lifespan (Sue, Capodilupo, & Holder, 2008). African-American men's narratives provide examples of experiences with discrimination and microaggressions over time that create stress and feelings of inferiority.

Research could explore the cumulative mental health effects of discrimination and microaggressions. Addressing mental health challenges associated with racial microaggressions may assist African-American men in learning coping skills needed to function better in their daily lives (Sue, Capodilupo, & Holder, 2008).

African-American men in this study thought it would be useful to learn more about SDH impacting their health and wellbeing including housing segregation, racial discrimination, incarceration, and lower quality healthcare and that it would be beneficial to teach African-American male youth about SDH. The Canadian government has conducted studies to understand adolescent perceptions of SDH (Kenney & Moore, 2013) (Woodgate & Leach, 2010). Research findings were used to change health curriculum taught to students in Canadian schools. Research could explore similar SDH programming for African-American adult males and youth.

Conclusion

African-American men describe an intersectional self-concept perceived through social identities of race and gender that are interdependent and mutually constitutive. At the intersection of race, gender, and low SES African-American men describe their experiences as difficult, hard, and a struggle. Their struggles are associated with trying to fulfill Western male role cultural norms. African-American men in this study experience gender role strain while trying to fulfill the roles of provider, protector, father, and student within difficult socioeconomic and structural limitations. Gender role strain, masculinity, and stress were detrimental to healthy behaviors like getting exercise, preventive care, and treatment for chronic illnesses, and promoted unhealthy behaviors like drug use and negative lifestyle choices. Narratives reflect

how their individual-level experiences at the intersection of race, gender, and low SES reflect macro socioeconomic and structural inequalities.

At the intersection of race, gender, and low SES, African-American men in the study perceive the determinants impacting their health and wellbeing include biological factors, lifestyle, health seeking behaviors, community contextual factors, and socioeconomic and structural factors. Participants identify heredity and chronic health disorders, lack of insurance, racial discrimination, employment, drugs in their environment, police surveillance and harassment, and incarceration as significant factors impacting their health status. These multilevel and intersecting social and economic determinants and their precipitating factors impact health and wellbeing and agency.

Despite identifying multilevel SDH impacting their health status, African-American men also comprehend health and wellbeing self-agency through Western male cultural norms. Participants indicate they are in control of health decisions, health-related behavior, and lifelong well-being through the choices they make. However, responsibility to provide for the family, availability of resources, limited educational and employment opportunities, community contextual factors, and socioeconomic and structural SDH impact decisions related to health and wellbeing. Education and job training interventions are important for improving social and economic conditions for African-American men and provide an opportunity for them to meet Western male cultural norms. Providing education on SDH to African-American men is important to raise awareness, promote advocacy, support for policy efforts, and to address individual, community, and structural level determinants of health.

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Appendix A

Q-SDH Social Ecological Model

Socioeconomic & Structural Determinants	Community Context	Individual Factors			Population Health Outcome
Income Inequality Poor working conditions Educational attainment Occupational Skill Level Environmental Factors-Drugs & Neighborhood Crime Rate Poor Housing Community Cohesion Food Supply Discriminatory Experiences	Perceived Social Support Community Connectedness	**Health Behavioral** Smoking Alcohol Consumption Self-Harm & addictive Behavior Physical Activity	**Psychosocial** Coping Self-esteem Chronic Stress Depression Mental State	**Biological** Blood Pressure (Hypertension) Heart Problems Blood Sugar Levels (Diabetes) Body Mass Index (Obesity)	Quality of Life

Appendix B

Recruitment Flyer

THE UNIVERSITY OF PENNSYLVANIA SCHOOL OF SOCIAL POLICY AND PRACTICE IN PHILADELPHIA, PA IS CONDUCTING A STUDY ON

HOW AFRICAN-AMERICAN MEN IN THE BALTIMORE METROPOLITAN AREA FEEL ABOUT BEING A MAN AND THE THINGS THAT INFLUENCE THEIR HEALTH

You may qualify for this research study if you are an **African-American man between the ages of 18 and 44** who earns less than or equal to $15,000 per year and can participate in a 60 to 90-minute interview.

There is minimal risk to participate in this interview. You may feel emotional distress over discussing things that relate to you.

You will receive a $25 visa card for your participation. **Contact Georgia Jennings by email at gejenn@sp2.upenn.edu or by phone at 443-226-2583.**

_____

Georgia Jennings
gejenn@sp2.upenn.edu   or 443-226-2583

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Appendix C

Informed Consent

Title of the Research Study: An Ecological and Intersectionality Approach: African-American Men's Perceptions of the Intersections of Gender, Race, and
SES and Social Determinants of Health
Protocol Number: 826154
Principal Investigator: Lina Hartocollis, Ph.D., LCSW, Address: 3701 Locust Walk, Caster Building, Room B-22, Philadelphia, PA 19104-6214, Phone: 215.898.5503, Email: lhartoco@sp2.upenn.edu
Co-investigator: Georgia Jennings, Address: 4701 Falls Road, Baltimore, MD 21209, Phone: 443-226-2583, Email: gejenn@sp2.upenn.edu
Emergency Contact: Lina Hartocollis, Ph.D., LCSW, Address: 3701 Locust Walk,
Caster Building, Room B-22, Philadelphia, PA 19104-6214, Phone: 215.898.5503, Email: lhartoco@sp2.upenn.edu

You are being asked to take part in a research study. This is not a form of treatment or therapy. It is not supposed to detect a disease or find something wrong. Your participation is voluntary which means you can choose whether on not to participate. If you decide to participate or not to participate there will be no loss of benefits to which you are otherwise entitled. Before you make a decision, you will need to know the purpose of the study, the possible risks, and benefits of being in the study and what you will have to do if you decide to participate. The research team is going to talk with you about the study and give you this consent document to read. You do not have to make a decision now; you can take the consent document home and share it with friends, family doctor, and family.

If you do not understand what you are reading, do not sign it. Please ask the researcher to explain anything you do not understand, including any language contained in this form. If you decide to participate, you will be asked to sign this form, and a copy will be given to you. Keep this form, in it you will find contact information and answers to questions about the study. You may ask to have this form read to you.

What is the purpose of the study?

The purpose of the study is to learn more about

- *African-American men's perceptions of the intersectionality of gender, race, and Socioeconomic Status (SES) and how they interdependently combine with Social Determinants of Health (individual health behaviors, psychosocial and biological factors, community context, socioeconomic and structural factors) to impact health status and well-being.*
  - *This study is being conducted as part of the requirement for the Co-Investigator's dissertation.*

Why was I asked to participate in the study?

You are being asked to join this study because you meet the criteria for participation:

- *You identify as an African-American male and Non-Hispanic.*
- *You are heterosexual.*
- *You speak English as your primary language.*
- *You are an adult male between the ages of 18 and 44.*
- *You are an adult male who lives in an urban environment.*
- *You earn less than or equal to $15,000 per year.*

How long will I be in the study?

- The study will take place over a period of 1 day. The session will last approximately 2 hours.

Where will the study take place?

- *Each interview will take place in a public area convenient for the interviewee. The location will be quiet and provide enough privacy for the interview to be conducted without interruption.*
- *If the participant cannot identify an area that is safe and convenient, the researcher will suggest a public place, safe and quiet place and provide reimbursement for public transportation cost in the event this should occur.*
- *Transportation will not be provided by the researcher.*

What will I be asked to do?

- *Participate in an in-depth interview that will last for about 60-90 minutes.*
- *You will be asked to answer a series of questions.*
- *You will be asked to allow the researcher to record the interview.*

What are the risks?

Physical, psychological, social, legal and other risks are minimal as would be expected going to the library, church, hospital or community health center.
You may feel emotional distress over discussing problems related to yourself or others in your family or community.
You may feel uncomfortable participating in a research study.
Social risk are should there be a breach in confidentiality are embarrassment and stigmatization.
In the unlikely event you become emotionally distressed during or after the interview, the interviewer will provide your with names and numbers of individuals or agencies that can provide further assistance.

How will I benefit from the study?

Participating in this study will not directly benefit you. You may benefit from the experience of telling your story. However, your participation could help us understand how African-American men feel about being a man and the things that influence their health, which can benefit you indirectly. In the future, this may help other people to develop interventions that can help improve the health of African-American men.

What other choices do I have?

Your alternative to being in the study is to not be in the study.

What happens if I do not choose to join the research study?

You may choose to join the study or you may choose not to join the study. Your participation is voluntary.

There is no penalty if you choose not to join the research study. You will lose no benefits or advantages that are now coming to you, or would come to you in the future. Your therapist, social worker, nurse, doctor or the researcher will not be upset with your decision.

If you are currently receiving services and you choose not to volunteer in the research study, your services will continue.

When is the study over? Can I leave the study before it ends?

The study is expected to end after all participants have completed their interviews and all the information has been collected. The study may be stopped without your consent for the following reasons:

- o The PI feels it is best for your safety and/or health-you will be informed of the reasons why. o You have not followed the study instructions
- o The PI, the sponsor or the Office of Regulatory Affairs at the University of Pennsylvania can stop the study anytime

You have the right to drop out of the research study at any time during your participation. There is no penalty or loss of benefits to which you are otherwise entitled if you decide to do so. Withdrawal will not interfere with your future care.

If you no longer wish to be in the research study, please contact Lina Hartocollis, Ph.D., LCSW, at 215.898.5503 and take the following steps:

- *You can provide Lina Hartocollis with your name and the name of the study and provide her with information regarding why you want to withdraw from the study.*
- *There are not consequences for withdrawing from the study.*
- *You may feel emotional about your participation and withdrawal from the study.*

How will confidentiality be maintained and my privacy be protected?

We will do our best to make sure that the personal information obtained during the course of this research study will be kept private. However, we cannot guarantee total privacy. Your personal information may be given out if required by law. If information from this study is published or presented at scientific meetings, your name and other personal information will not be used.

- *Your interview will be assigned a number and pseudonym after the interview. Audio tapes will be stored on a password-protected computer that will be stored in the Co-investigator's home office. Once the study has completed, the recorded files on the computer will be destroyed. Other materials like informed consent with demographic information will be stored in a locked cabinet. There is only key to the cabinet. The informed consent and any other information with identifying information will be destroyed at study completion. If information from this study is published or presented at scientific meetings, your name and other personal information will not be used.*

What happens if I am injured from being in the study?

There is minimal risk to participate in this interview. You may feel emotional distress over discussing things that relate to you. In the unlikely event the participant becomes emotionally distressed during or after the interview, the interviewer will provide them with names and numbers of individuals or agencies that can provide further assistance.

We will offer you the care needed to treat injuries directly resulting from taking part in this research. We may bill your insurance company or other third parties, if appropriate, for the costs of the care you get for the injury, but you may also be responsible for some of them.

There are no plans for the University of Pennsylvania to pay you or give you other compensation for the injury. You do not give up your legal rights by signing this form.

If you think you have been injured as a result of taking part in this research study, tell the person in charge of the research study as soon as possible. The researcher's name and phone number are listed in the consent form.

Will I have to pay for anything?

- *If you have to pay to travel for the interview, you will receive $3.00 or a token to get public transportation back to your original destination.*

  Will I be paid for being in this study?

- *You will receive a $25 gift card at the end of the interview.*

Who can I call with questions, complaints or if I'm concerned about my rights as a research subject?

If you have questions, concerns or complaints regarding your participation in this research study or if you have any questions about your rights as a research subject, you should speak with the Co-Investigator by contacting her at 443-336-2583. If you still have concerns contact the Principal Investigator listed on page one of this form. If a member of the research team cannot be reached or you want to talk to someone other than those working on the study, you may contact the Office of Regulatory Affairs with any question, concerns or complaints at the University of Pennsylvania by calling (215) 898-2614.

_____

When you sign this document, you are agreeing to take part in this research study. If you have any questions or there is something you do not understand, please ask. You will receive a copy of this consent document.

Signature of Subject:

_____

Print Name of Subject:

_____

Date: _____

Appendix D

Interview Guide with Face Sheet and In-depth Interview

Interview Guide

Introduction (5 minutes)

Good _____. Thank you for agreeing to participate in this research interview regarding how African-American men feel about being a man and the things that influence their health. My name is _____ and I'm going to conduct your interview.

Before we start, let me suggest some things that will help with the interview.

• Speak up and speak clearly because the interview will be recorded.

• Maintain confidentiality: The researcher will not link your name to any of the written documentation generated because of this interview.

Face Sheet Information

I will explain each category in layman terms and gather information to complete the Face-Sheet.

I would like to gather some basic information from you that will assist with understanding who you are and some of the things that impact your life.

1) What is your age?

2) What is your sex? Sexual orientation? (Heterosexual, Bisexual, Gay, or other)

3) What is your relationship status? (Married, partnered, widowed, single-exclusive dating or non-exclusive dating)

4) With which racial category do you identify? (African-American, Caucasian, Native American, etc.?)

5)   With which ethnic category do you identify (Hispanic, Non-Hispanic?)

6)   Do you have spiritual or religious practice?

7)   What is the highest grade that you completed?

8)   Any college education or specialty training?

9)   Are you employed?

10)   What is your occupation?

11)   What is your annual income?

12) What is the racial makeup of your community? (African-American only, mixed, if so

who lives in your community?)

13)   Do you have health coverage?

14)   Do you rent or own where you live?

15)   How many people live at your residence?

16)   Have you ever been incarcerated? For how long?

17)   How were you recruited?

In-depth Interview (60-90 minutes)

A.   African American Men and Masculinity

The questions in this section began with questions about men in general and moved on to

questions about African American men in particular.

1)   Can you describe what it means to be a man? (PROBE: In general, Caucasian,

Indian, Korean, African American, etc.)

2)   What characteristics should a man possess? (PROBE: For examples, honesty,

strength, etc.)

3)   What roles do men play in the community? (PROBE: Caucasian, Indian, African American, etc.).

4)   How would you define masculinity? (PROBE: What roles are designated by society for male persons?)

5)   How would you define femininity? (PROBE: What roles are designated by society for female persons?)

6)   What are some of the struggles of manhood?

7)   Do you think it is important for men to be respected? (PROBE: Why or why not?)

8)   Can you describe what it means to be an African-American man?

9)   What characteristics should African-American men possess?

10)   What roles do African-American men play in the community? (PROBE: Negative and positive roles.)

11)   What roles do African-American women play in the community? (PROBE: Negative and positive roles.)

12)   Can African-American men take on positive roles your community? (PROBE: Why or why not?) (Are the opportunities there?)

13)   What roles do you play in your day to day life? (PROBE: For example, provider, protector, community or church leader, etc.? Why or why not?)

14)   Are you able to fulfill these roles? (PROBE: Why or why not?)

15)   Does fulfilling these roles impact you emotionally? (PROBE: Why or why not?)

16)   Do you think it is important for African-American men to be respected? (PROBE: Why or why not?)

B.   Individual, Psychosocial, and Biological Factors

1) How do you cope with stress?

2) Have you ever turned to alcohol or other substances to reduce stress? (PROBE: If yes, how young were you when you first felt the need to use these substances? Has your use changed over time?)

3) Do you smoke cigarettes or marijuana? (PROBE: If yes, which one or both? How young were you when you started? Has your use changed over time?)

4) Have you ever been diagnosed with a mental health or substance abuse disorder? (PROBE: If yes, what was the diagnosis if you know?)

5) If so, did you receive treatment? (PROBE: Why or why not?)

6) Do you have a spiritual or religious practice? (PROBE: How do you go about this practice?)

7) Where do you buy food? (PROBE: Are you able to purchase food near where you live? How far do you have to travel?)

8) How would you describe your eating habits? (PROBE? Do you eat vegetables daily? Drink milk or eat other dairy products?)

9) When do you seek out healthcare? (PROBE: When you are sick? Or before you get sick?)

10) Does anyone in your life encourage you to get healthcare? (PROBE: If yes, what is your relationship to this person?)

11) Have you been diagnosed with any chronic health disorders? (PROBE: Such as hypertension, heart problems, cancer, diabetes, kidney disease, obesity, Hepatitis C, or HIV/AIDS?)

C) Community Contextual Factors

1)   Can you describe what housing looks like in your neighborhood?

2)   Can you describe the people who live in your community? (PROBE: African-American only or mixed?)

3)   How do people provide support for each other in your community?

4)   What civic or community organizations are in your community?

5)   Who can you turn to for emotional or financial support?

6)   Did you go to public schools in Baltimore City? (PROBE: If no, where? If yes, where?)

7)   Did your school have enough books and supplies? (PROBE: If no, what didn't you have?)

8)   Did the building need repairs? (PROBE: If yes, what repairs were needed?)

9)   Did being an African-American man in any way impact your education? (PROBE: If yes, how?)

10)   Can you describe the kinds of crime in your neighborhood? (PROBE: Have you been personally impacted?)

11)   Are there places to exercise in your community? (PROBE: If yes, where and what kind? If no, do you ever get exercise outside your community? If yes, where and what kind?)

D)   Social and Economic Factors

1)   Have you lived in Baltimore City your whole life? (PROBE: If yes, where? If no, where else have you lived?)

2)   Can you describe how African-American men get treated in your community?

3)   Can you describe how African-American men get treated at your job? (PROBE: If client works)

4)   Can you tell me why you are not working? (If not working)

5)   How do you support yourself? (If not working)

6)   How does your community get along with the police? (Why?)

7)   Do the police respond when called for assistance? (PROBE: If no, how does the

neighborhood handle the situations?)

8)   Do you have access to "good" healthcare? (PROBE: Why or why not?)

9)   How do healthcare providers treat you when you go to the doctors? (Why)

10)   How do healthcare providers treat others where you go to the doctors?

E.   Agency

1)   What are some of the things you think impact African-American men's health?

2)   What strengths do you possess to deal with the day to day challenges you face? (PROBE:

If any listed, how did you learn/acquire these strengths?)

3)   How do resources come into your community?

4)   Does the government have control over people's health? (PROBE: If yes, how do they

control people's health?)

5)   How has being an African-American man impacted your health and welling over your

lifetime? (PROBE: Health and health care, social relationships, and getting basic

resources like housing, food, protection and wants)?

6)   Is there anything I didn't ask that would help me better understand your experience as an

African-American man and how that has impacted your health and well-being?

7)   Have you ever heard of Social Determinants of Health? (PROBE: If yes, where did you

hear the term, and what does it mean to you?)

I am going to read you a short paragraph about Social Determinants of Health and ask you a couple more questions?

Social Determinants of Health (SDH) are the "conditions in which people are born, grow, live, work and age shaped by the distribution of money, power and resources and are mostly responsible for health inequities, the unfair and avoidable differences in health status" (World Health Organization, 2015, p. 1). The SDH that have a significant impact on African-American men as a group are low socioeconomic status (SES), housing segregation, racial discrimination, incarceration, and lower quality health care (Treadwell, Xanthos, & Holden, 2013). These multilevel and intersecting social and economic determinants and their precipitating factors have combined and resulted in the overall poor health status of African-American men.

1)   If you had the opportunity, would you like to learn more about Social Determinants of Health impacting African-American men?

2)   Do you think young African-American men or boys could benefit from understanding the Social Determinants of Health impacting their lives? (PROBE: At what age?)

Closing (5 minutes)

This concludes our interview. Thank you again for your participation and helping to add to the understanding of how men feel about being a man and the social determinants that impact their health.