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Can the Health Needs of African American Men Be Met Through Public Health Empowerment Strategies?

by Deborah Prothrow-Stith
and Eric Whitaker

Health promotion and disease prevention efforts, which use empowerment strategies and emphasize community control, are essential to overcoming the legacy of medical malfeasance and successfully improving the health status of black males. This discussion depicts the legacy of harm and presents the case for empowerment strategies; it also describes one Boston community-based program example of utilizing an empowerment strategy and concludes with a challenge to all health professionals to become enablers of empowerment rather than obstructions to it.

The Natural Tension Between Health Care and Empowerment

It seems obvious that public health practitioners who work in conjunction with individuals who know and live in communities of color will be more effective than those who do not. Yet we know that giving others power and control is a “radical” concept and its promotion and utilization within public health creates a natural tension. This tension exists between public health and empowered people and communities. As an institution, public health collects data on health outcomes, interprets that data, decides which health risks it will address, designs interventions and marshals resources necessary to change the habits, behaviors and outcomes of an at-risk community. Often the intervention is thrust upon a community and it is told — “*This will be good for you. Now take your medicine.*” Accepting the theory of empowerment means public health must recognize it does not have all of the necessary tools to accomplish real change, especially for our most disenfranchised at-risk groups, like African American men.

In planning public health initiatives, the need to rely upon the indigenous culture and social structure and to use special strategies to empower those in the targeted culture is often more obvious when the practitioners are



from a different culture or when they speak a different language. However, when addressing problems “at home” practitioners appear more likely to ignore this necessary and natural partnership.

The under-utilization of health care institutions by African American men in the face of greater problems and health needs has been well documented by providers, public health practitioners, and academicians. Addressing the unmet need has been the challenge for many urban, community-based programs. Many such programs, initially designed to meet the needs of women, are now developing and implementing strategies to reach men.

Practitioners working to prevent HIV, smoking, cancer, violence, tuberculosis or other health problems have empowerment as a goal. There are many other impressive efforts to utilize this concept and apply it to the practice of public health. Alcoholics Anonymous and the women’s self-help movement represent such empowerment-based challenges to traditional medicine and health care which can measure their successes in lives saved. Examples within the African American community include national efforts like the National Black Woman’s Health Project.

If there is hope for improving the health status of African American males, then it lies in those examples of community-led self-help empowerment activities where the medical establishment has been willing to or forced to give up control and follow.

The Black Male Clinic

Building on the empowerment literature with its history in the “social action ideology” of the sixties, R. Braithwaite describes the community organization and

development (COD) approach as “engaging African American communities...in health education and health promotion programming [through efforts]...designed to foster community control and empowerment.”¹ He further states that, “health promotion is likely to be successful when the community at risk identifies its own health concerns, develops its own prevention and intervention programs, forms a decision making board to make policy decisions and identifies resources for program implementation.”² An example of the successful use of several COD strategies to plan and implement a new program is found in the origins of the Black Male Clinic of the Harvard Street Neighborhood Health Center (HSNHC). Established in 1969 as an outgrowth of the City’s well baby clinic and incorporated as an independent entity in 1976, HSNHC serves Roxbury, Dorchester and Mattapan neighborhoods. These neighborhoods were described as “death zones” because they have the greatest excess mortality in the state of Massachusetts for cancer, stroke, homicides, diabetes, chronic obstructive pulmonary disease, injury and motor vehicle crashes—every disease category measure except suicide.³

The sense of ownership and control over the clinic by participants spilled over into the community and became a rallying point for black men.

Approximately 7,000 people make 45,000 visits to HSNHC each year, about 34 percent are covered by Medicaid (including a state sponsored managed care plan), 20 percent private pay and 33 percent free-care/uninsured. Eighty-three percent of the patients are African American, fourteen percent are Haitian and other Caribbean and three percent are Latinos. The staff has a similar ethnic profile and many speak Haitian Creole and Spanish.

Seventy percent of the patient visits are females and a majority of the male visits are by children under age five. The under-utilization of HSNHC by black males was an ongoing concern which acutely increased when statistics showed an alarming decline in life expectancy. The center’s director, an African American man, developed a strategy designed to directly address the problem and increase clinic utilization. The process yielded a conference co-sponsored by the Massachusetts Department of Public Health along with several community organizations and resulted in a specialized clinic for black men.

Increasingly focus groups are being used by health and human service providers to assess client needs and gather feedback. This valuable tool of the trade is also utilized extensively by advertising agencies and corporations to determine the appropriateness of a product, to further develop a product, and to determine the optimal ways to

market a product. It is also used to attract new clients. A trained facilitator is used to engage discussions among small groups of people from the target audience. Participants respond to several guideline questions and statements. Discussion is encouraged, especially soliciting group responses to ideas raised by group participants.

Focus groups were used to answer the question: “How can HSNHC get black men to utilize its services in greater numbers?” This methodology was selected because a more quantitative survey methodology would have limited the results to those answers researchers included as questions. Traditional surveys constrain the respondent to the answers that are on the page; the designer must presuppose all the possible answers.⁴ Focus groups, though less quantitative, were deemed a better way to get information in this setting because they:

- 1) provide the researcher information on the full range of responses;
- 2) allow greater depth of information with secondary and tertiary level explanations;
- 3) yield greater clarity, so that any unclear answers can be discussed;
- 4) enable less literate participants to fully participate;
- 5) are more reciprocal and provide greater information to participants; and,
- 6) demonstrate concern and interest to the participants which can assist in public relations.⁵

Nine groups of ten men ages 30 to 70 from HSNHC’s target neighborhoods met to discuss questions designed to determine how to make HSNHC more attractive to black men, how to market the clinic to black men and how to encourage men to seek and keep medical appointments. The data from these sessions are hardy, a usual outcome of qualitative research. Common themes and original ideas were culled to develop the clinic and design a marketing strategy. Several critical points emerged from these sessions:

- 1) participants did not generally receive an annual physical exam;
- 2) when physicals were received they were mandated by work;
- 3) participants did not know the HSNHC had services for men; they thought it was a clinic for women and children;
- 4) confidentiality was a major concern;
- 5) costs associated with health care were a major concern;
- 6) there were previous bad experiences with the medical establishment being “unfriendly” to participants; and,
- 7) there was concern for experimentation without their knowledge and other unethical practices.

Several specific suggestions were made for where and how to market clinic services. A particular emphasis was placed on getting family members to encourage men to seek health care. The success of this effort can be measured in the enthusiastic response of the participants, the initiation of the marketing campaign, and in the increasing clientele for the Black Male Clinic. The sense

of ownership and control over the clinic by participants spilled over into the community and became a rallying point for black men. Focus groups are a strategy for empowerment particularly when a service or policy is directly related to the outcome.

Overcoming the Legacy

Community and individual empowerment strategies must be incorporated in public health programs if we intend to improve the health status of black males. The creative community public health specialist must confront and convince the traditional paternalistic institutions that unless the advice and consent of the affected community is solicited and heeded, efforts will be futile. Successful programs like the Black Male Clinic can be used as models for other community-based health efforts.

Focus groups, long used by marketing firms, offer planners an ideal tool to guide strategic program development. By design, the focus group relies on its target audience to set standards, garner opinions and reach conclusions. The process should be incorporated in the very earliest project planning stages to utilize the free form give and take of this marketplace of ideas.

The challenge to the American health care community in its effort to improve health outcomes for black males and other groups, depends on the willingness of the system to identify itself as a barrier to empowerment. The institutions must begin to listen to the voices and ideas of the disempowered and become agents for rather than barriers to change.

Notes

¹R. Braithwaite, "Coalition Partnerships for Health Promotion and Empowerment." *Health Issues in the Black Community*. (San Francisco: Jossey-Bass, 1992).

²Ibid.

³C.D. Jenkins, R.W. Tuthill, S.I. Tannenbaum and C.R. Kirby, "Zones of Excess Mortality in Massachusetts." *The New England Journal of Medicine*, 296:1354 (1977).

⁴F.J. Fowler, *Survey Research Methods*. (Newbury Park, CA.: Sage Publications, 1988).

⁵R.A. Krueger, *Focus Groups: A Practical Guide for Applied Research*. (Newbury Park, CA.: Sage Publications, 1988). Also see P.N. Shamdasani and D.W. Stewart, "Focus Groups: Theory and Practice." *Applied Social Research Methods*. (Newbury Park, CA.: Sage Publications, 1990).

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