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The Impact of Community Churches and Barbershops on Preventive Care Utilization Among African American Men

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
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Walden University
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Abstract

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MPA, Keller Graduate School of Management, 2010

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Professional Administrative Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Public Administration

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Abstract

Preventive health care screening plays an essential role in reducing chronic diseases and mortality rates; yet, even as health care access has increased, African American men's utilization of preventive screenings remains low in rural areas. The purpose of this qualitative case study was to investigate why African American men are not utilizing preventive care services and ascertaining the impact that social determinants may have on their utilization of these services. The theoretical framework of this research study comprised the social-ecological modal and health belief model to investigate the barriers to preventive care utilization in the African American community. Twelve African American religious men in a rural county in South Carolina participated in semi structured interviews over the telephone and cloud-based video conferencing using a qualitative research approach. Data were analyzed using NVivo and manual coding, resulting in the following emergent themes and subthemes related to each research question and the social determinants of health: lack of trust in the health care system, systemic racism, cultural and religious impact, and lack of health care insurance and access to care. The research findings also showed the importance of collaborative partnerships with local barbershops, churches, and governmental agencies to increase preventive health care screenings in rural areas. This research study has implications for positive social change including identifying the role the social determinants of health have on the preventative care utilization of African American men, which could be used to reduce the mortality rates of this population and help them develop healthier lifestyles.

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Dedication

I would like to dedicate this doctoral study to my mother, Chappelle Stevenson. Thank you for being the best mother, friend, and ultimate backbone when I needed it throughout life and this doctoral process. You are my voice of reason and my cheerleader who believed in me when I did not always believe in myself. Every test taken, every paper submitted, you have always been there to let me know I could do it and to stop second-guessing myself. I am forever grateful for your love and motivation!

To my dad, Spencer, thank you for being you! As a child, I watched as you worked a 50+ hour work week to provide for my family and make sure we never wanted for anything, and I will always hold you in reverence for that. You are the epitome of a hard-working man that put your family first, and I will never forget the sacrifices you made for our family. You are the strongest and best man I know!

To my beautiful grandmother, Helen Heath Tucker, you have been my cheerleader since I was born, and your unconditional love and laughter have helped me on the cloudiest of days. Thank you for always picking up the phone and being there for me when no one else was. I love you so much that there are no words to convey how much you mean to me. I cannot imagine completing this journey of life without you!

To my husband, Chris, thank you for going along this journey with me, understanding the time requirements, and encouraging me to pursue and complete this degree. Thank you for listening to me and caring about me. Thank you for always trying to move mountains to lessen the burden when you knew I was stressed. Thank you for being you and being excited for my passion, even if it was not your passion.

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Table of Contents

List of Tables

List of Figures

Section 1: Introduction to the Problem

Background of the Problem

In the United States, the eight leading causes of death are cancer, chronic lower respiratory diseases, heart disease, stroke, diabetes, influenza, Alzheimer's disease, and accidental deaths (Schmidt, 2016). Despite the constant technological advancements in treating and diagnosing chronic diseases, evidence has shown that underrepresented groups experience higher mortality and morbidity rates than nonminority's (Cunningham et al., 2017). Achieving health equity occurs by eliminating health disparities, starting with the proactive use of preventive health care services. Preventive health care decreases health care costs and can reduce mortality and morbidity rates by preventing the onset of diseases through early detection (Grootjans-van Kampen et al., 2014). While African Americans are the third-largest ethnic population in the United States, they account for the highest death rate and shortest survival rate from cancers compared to European Americans (Cunningham et al., 2017). Possible explanations for higher rates of chronic disease in African Americans range from social determinants, quality of medical care, and environmental factors, with large proportions of racial differences still unexplained.

High rates of chronic diseases create challenges and costs for the health care systems and the public due to the health care system primarily focusing on infectious disease problems (Bauer et al., 2014). In contrast, health care physicians focus more on health care delivery. According to Hambleton et al. (2015), regular observations from death registrations, health surveillance, and epidemiological studies have showed African Americans to have worse health than European Americans in the United States. The

National Center for Health Statistics (2017) published a health status report comparing the leading causes of death from 1980-2015, with African Americans ranking highest in heart disease, diabetes, and chronic respiratory diseases. The United States spent $3.6 trillion in annual health care expenditures, of which over 90% went toward individuals with chronic and mental health conditions (Crowley et al., 2020). Projections expect health care to account for 19.7% of the U.S. gross domestic product by 2028, which could see a reduction if there is an increased emphasis on preventive care (Keehan et al., 2020).

Oates et al. (2017) completed a descriptive study that determined that African Americans in the southeastern states have increased rates of chronic disease and worse health-related behaviors than the rest of the U.S. population. Rural areas make up a large segment of the southeastern states; yet residents of these rural areas have fewer qualified health care providers and a further distance to travel for quality health care resources than those living in metropolitan areas. Residents in rural areas are often more focused on facing crucial issues, like crime, economy, housing, and social problems, ranking their health care further down their list in priorities (Saulsberry et al., 2016). The health disparities that African Americans face, when coupled with rural residents' barriers to health care access, make it even more critical for African Americans to increase their preventive care services utilization.

Cost; access to health care; and social factors that include unemployment, poverty, obesity, smoking, and inactivity are explanations for exacerbating chronic diseases in the African American community (Holman, 2020). Beyond genetics'

contribution to chronic diseases, the current health system has focused mainly on treating illness rather than making prevention a significant focal point (Farshad & Randall, 2012). Understanding chronic disease patterns and social determinants that impact preventive services is vital to targeting prevention and treatment resources, increasing public awareness of existing health disparities, and creating positive social change in the African American male community.

Problem Statement

The racial disparities in African American men's health are highly documented, showing a higher mortality rate and higher occurrences of chronic diseases than any other gender and race group in the United States (Shikany et al., 2018). In South Carolina, the current health status of African American men in rural areas reflects inadequacies in the consumption and delivery of health care and the use of preventive care services (Williams & Rucker, 2020). Even though there is a lower percentage of African Americans in the population of South Carolina, African Americans are 43% more likely to die from a stroke and 47% more have diabetes than European Americans (South Carolina Department of Health and Environmental Control, 2020). Several researchers have focused on the preventive care utilization of people of color; however, few have explored African American men's attitudes, beliefs, and perceptions in rural areas in South Carolina (O'Neal et al., 2014). Identifying and addressing racial disparities within health care is necessary to tackle the nation's health care system issues and help shape public policy decisions and legislation in local rural communities. While researchers have highlighted the various barriers to utilizing health care services, a literature gap exists on

how social determinants can impact preventive care utilization, which this study addresses. Therefore, I conducted this qualitative, interpretive, case study to identify the attitudes, beliefs, and perceptions of African American men while also investigating the impact of social determinants on their utilization of preventive care services with the goal of increasing the screening utilization of African American men in rural areas in South Carolina.

Purpose Statement

The purpose of this qualitative case study was to develop an in-depth understanding of African American men's reasons for not utilizing preventive care services by ascertaining the impact of social determinants on their health care utilization. The central phenomenon studied in this case study was how African American males living in rural areas experience preventive health care services. The specific focus was multifaceted and allowed for the exploration of African American men's lived experiences through their perceptions, attitudes, and beliefs about preventive health care and how social determinants may impact the utilization of preventive care services in rural areas. Understanding African American men's lived experiences in rural areas could help develop strategies to increase preventive care services utilization and awareness of chronic diseases. In this study, I explored the preventive and health screening initiatives, or lack thereof, in a core partnership with an African Methodist Episcopal (A.M.E.) church in a rural area of South Carolina.

The partnering A.M.E. church in rural South Carolina has a legacy that has lasted in for over 100 years and continues to be active in the African American community. Due

to potential health concerns and participant safety during the COVID-19 pandemic, the semi structured interviews occurred remotely instead of in person at the A.M.E. church as originally planned. The interviews, while held remotely, still had participation from current congregation members and allowed for the identification of the socioeconomic factors that impact preventive health care service utilization of men in rural areas. Due to the congregation's small size, participants' solicitation also occurred from male residents within the community at the barbershop located directly across from the A.M.E. church. Additional participation was obtained from other local African American churches and barbershops to round out the study sampling groups. Black barbershops are community-based structures that play a significant role in the community beyond just a place for grooming, thus I included them alongside African American churches in this study to change the trajectory of chronic diseases among African American men (see Pillay, 2011).

Current prevention and treatment programs, which have been successful for other race groups, may not be as effective for African Americans due to many underlying issues, such as social and environmental factors, distrust of health care professionals, and financial constraints (Butler et al., 2016). These underlying issues may require culturally competent intervention strategies to reduce health disparities by empowering patient health behaviors and increasing preventive health care services utilization (Butler et al., 2016). The current study findings can assist public health officials, local communities, health educators, and government officials in developing preventive screening initiatives and local partnerships. The study results can also be used to aid community leaders in

understanding the attitudes, perceptions, and beliefs of African American men needing preventive health care in rural counties in South Carolina. The results help bridge the gap in the literature and can be used to enact positive social change geared toward reducing chronic diseases among African American men in South Carolina and helping them live a healthier, more productive lifestyle.

Practice-Focused Questions

The practice-focused questions that guided this study were:

1. What social determinants impact the decision-making process to utilize preventive health care services of African American men in rural areas in South Carolina?
2. What role, if any, do the African American church and barbershop play in addressing health disparities in rural areas in South Carolina?

Nature of the Administrative Study

In this case study, the primary emphasis was on the impact of social determinants on the utilization of preventive care services in African American men in rural communities. The qualitative methodology allows the opportunity to explore a problem or issue that is complex and requires detailed understanding and creates the opportunity to empower individuals in the target population to address gaps in existing research data (Creswell & Poth, 2017). The process-focused approach of qualitative research was appropriate for this study due to the focus on the social determinants, health beliefs, and attitudes that impact the utilization of preventive care services of African American men in rural areas in South Carolina.

After weighing each the pros and cons of each research design, I decided to use a case study design because it allows for richer data collection and greater depth than other research designs. I employed a case study research design to address the research questions for an in-depth investigation of an intricate issue while also understanding real-life issues (see Harrison et al., 2017).

Researchers use an interpretive research paradigm within a qualitative case study to explore the hidden reasons behind complex, multifaceted social processes because the paradigm allows the researcher to see the world via the participants' perceptions and experiences (Thanh & Le Thanh, 2015). Interpretive research also allows the researcher to be a data collection instrument to utilize observational skills and establish trust with participants to ensure accurate data extraction.

Qualitative case study research has the distinguishing feature of using multiple data sources to strengthen the findings and allow the researcher to interpret data to tell a story. According to Creswell (2018), a researcher can collect data directly from a research participant or utilize secondary data, such as public records and public sources. The primary source of data in this case study was semi structured participant interviews. Due to COVID-19 social distancing and shelter-in-place policies, interviews were conducted only on Zoom or via telephone instead of face-to-face. The secondary data sources utilized in this case study included archival records encompassing representative data on health and population; survey records and demographics and socioeconomic characteristics, health behaviors, environment, policy, health outcomes, and vital statistic

records maintained by public health agencies, including the U.S. Census Bureau, the Centers for Disease Control and Prevention, and the National Vital Statistics Reports.

In qualitative studies, the researcher uses interviews and interactions to explore a research phenomenon to help clarify a problem or situation that is less understood (Sutton & Austin, 2015). In this case study, I collected data through extensive, semi structured interviews with open-ended questions to explore the perceptions, attitudes, and beliefs of 12 African American men about the impact of social determinants on their utilization of preventive care services. The interviews took place in the participants' natural settings. Saturation can often occur at 12 participants, but staying under 20 participants allows the opportunity to build and maintain a relationship to develop an open exchange of information, thus mitigating some bias and validity threats in qualitative research (Fusch & Ness, 2015). The semi structured participant interviews were audio taped and transcribed for verbatim data analysis.

Significance of the Study

The results of this study can be used to positively impact African American men in rural areas of South Carolina and public administrators in those communities. The results from this case study may be helpful in the promotion of social change and improve the awareness of preventive care screening services. The research findings may impact stakeholders by increasing their understanding of the importance of preventive care services in the African American male community thus unifying the stakeholders to collaborate toward health promotion intervention programs. The stakeholders within this study include African American men, government leaders, health professionals,

community and church leaders, families in rural communities, and local organizations. The study findings may lead church leaders at different A.M.E. churches to implement health promotion ministries to increase preventive care service utilization.

In this qualitative case study, I aimed to identify the social determinants that impact African American men's preventive care services utilization. Identifying those social determinants can help increase the utilization of preventive care services in rural communities in South Carolina. The findings increase knowledge on the topic and add to the body of literature about the impact of preventive care services and public policies on African American men.

This study has potential implications for positive social change by addressing the disparities in the utilization and access to preventive health care services among African American men in rural communities. Policymakers may find the results helpful when designing policies and creating laws to increase preventive care services utilization and decrease chronic diseases among African American men. Understanding the role of social determinants of health will also help health providers design preventive health programs specifically for African American men in rural areas of South Carolina.

The findings revealed how collaborating with local barbershops in health promotion program development could increase African American men's preventive care utilization. The results may also inform other African American churches about the potential for health promotion ministry in their respective churches. The study results can lay a foundation for African American barbershops and pastors to collaborate with public health officials to develop health programs in their respective communities.

Summary

In Section 1, I discussed the underutilization of preventive care services by African American men in rural areas of South Carolina. This section included the problem statement, purpose of the study, research questions, significance of the study, and summary. Section 2 will include a description of the theoretical approach, background, role of the researcher, and context of this qualitative case study. The theoretical framework, composed of the health belief model (HBM) and the social-ecological model (SEM), will be explained in detail as will its use as a lens through which to examine African American men's health care attitudes, behaviors, beliefs, and utilization of preventive care services.

Section 2: Theoretical Approach and Background

The primary motivation of this study was to detail intervention approaches that health care professionals and public health officials partnered with faith-based organizations and local barbershops can apply to empower the utilization of preventive care services among African American men. I conducted this case study to identify the social determinants of health that impact preventive health care services utilization among African American men in rural areas of South Carolina. Previous researchers had investigated the barriers to health care utilization in the African American community; however, few studies have included the impact that African American churches and barbershops have on increasing health care utilization by African American men in rural areas. There is also a lack of evidence-based program research on reducing the chronic diseases of African American men in rural areas (Buchanan et al., 2018). In this section, I provide an overview of the HBM, and the SEM used as the theoretical approach in this study to assess and understand African American men's social determinants, beliefs, and attitudes.

This study addresses gaps in the literature by focusing on African American men at risk for chronic diseases and the future development of community-based intervention programs to increase preventive services utilization by empowering individuals with education and behavioral changes. This doctoral study was guided by the following two practice-focused questions:

1. What social determinants impact the decision-making process to utilize preventive health care services of African American men in rural areas in South Carolina?
2. What role, if any, do the African American church and barbershop play in addressing health disparities in rural areas in South Carolina?

Theoretical Framework

Preventive services, including health screenings, are indispensable parts of the health care system; however, despite the apparent benefits, rates of preventive services are lagging far behind where they should be in the detection of chronic diseases at early stages to prevent illness in African American men (O'Neal et al., 2014). Theoretical frameworks are one method to explore the link between social determinants of health and health outcomes. No single conceptual or theoretical framework dominates health promotion and education in the research or practice field (Glanz et al., 2015). In this qualitative case study, I used a theoretical framework composed of the HBM and the SEM to answer the research questions.

The HBM was essential to better understanding the individual health beliefs, benefits, barriers, and perceptions of African American men in rural areas in South Carolina. The SEM aided in assessing how African American men view the environmental, community, and social factors influencing their preventive care utilization. Since the HBM is a descriptive model that predicts and explains individual attitudes and beliefs, its integration with the SEM aided in accounting for an individual's environmental and social influences to develop strategies for social change. The

implications for social change due to HBM and SEM include the development of governmental policies that can increase access to health care as well as motivate behavior change to increase utilization of preventive care services. The HBM framework aided in the development of the interview questions to explain how patient perceptions impact their perceived role and likelihood of participation in preventive care services. I utilized the SEM in the development of future health interventions for patients and the local community. The HBM and the SEM together facilitated an understanding of the factors in the decision-making process of churches and barbershops concerning the development of preventive health promotion services within their facilities.

Social Ecological Model

The SEM focuses on developing programs for what affects an individual's behavior (Golden & Earp, 2012). Too often, public health officials develop health interventions primarily focused on the roles of organizations and policies in creating individual changes when focusing on the environment and conditions where those health-promotion policies are developed (Golden et al., 2015). The SEM contains multiple levels that can influence an individual's behavior, such as interpersonal, individual, community, organizational, and public policy environment (Glanz et al., 2015). The five levels of SEM include individual (i.e., attitudes, beliefs, and behaviors), organizational (i.e., social institutions and faith-based organizations), interpersonal (i.e., social networks), public policy (i.e., local, state, and national laws that impact health), and community (i.e., relationships between organizations; Glanz et al., 2015). Combining all five levels of the model was the most effective SEM approach to help understand the

external and internal factors that may impact African American men's health behavior regarding utilization of preventive health care services for chronic diseases. The SEM can also be used to develop recommendations in creating effective strategies to increase preventive care utilization of African American men in rural areas.

The multilevel approach within the SEM focuses on how individuals and their environment influence each other by focusing on the institutional, social, and cultural environments (Golden & Earp, 2012). The SEM looks beyond health promotion to the delivery of health information to individuals, the materials provided to the public masses, the communication skills of public health officials and health care professionals, and the influence of current health policies on a community and organizational level (McCormack et al., 2017). The SEM visually depicts the relationships between individuals, their social networks, and their environments to facilitate social change and health promotion policies (Golden et al., 2015).

The SEM helped me identify African American men's health behaviors in rural areas and the social and external factors, including their individual experiences that have shaped those health behaviors. The SEM model aided in showcasing what factors influence African American men's preventive care utilization and the prevailing trends among underrepresented populations. While the SEM emphasizes the five levels of health behavior influence, the HBM helped me interpret African American men's health perceptions.

Health Belief Model

Social psychologists initially developed the HBM to understand why people failed to participate in preventive screenings or take advantage of public health programs to detect diseases early (Romano, 2020). The HBM is a theoretical framework used to help predict and understand health behaviors and guide interventions (Skinner et al., 2015). The HBM has successfully motivated people to take positive health care approaches to avoid future adverse health consequences (Montanaro & Bryan, 2014). According to Montanaro and Bryan (2014), the HBM is a framework that can predict individual chronic disease preventive screening behaviors in the following six premises:

- *Perceived benefits* and *perceived barriers* are the perceived effectiveness of an individual's efforts toward improving their health and the barriers that could block an individual from working toward improving their health.
- *Perceived susceptibility* and *severity* focus on an individual's perception of the risk of contracting a health condition and the seriousness if left untreated.
- *Cues to action* are the signals from the body telling an individual a health action is required, such as chest pains, prolonged pain, or a sudden family illness.
- *Self-efficacy* is an individual's confidence level in changing their behaviors or starting a healthy lifestyle to overcome the illness.

The HBM was applied as part of the theoretical framework of this study because individuals' beliefs and perceptions can be barriers to community strategies to increase preventive care services utilization. The implementation of Affordable Care Act (ACA)

transpired to increase disease prevention and encourage health promotion by increasing access to and making preventive care more affordable, specifically for individuals who delayed preventive care due to cost being a barrier (Luquis & Kensinger, 2019). The health behaviors of African American men in rural areas relating to perceived susceptibility, perceived severity, perceived benefits, and perceived barriers to chronic disease preventive screenings and strategies were the concepts under study encompassed in the HBM. Prior research into the HBM's impact on preventive care utilization suggested a correlation between an individual's gender and age to the perceptions of susceptibility, the seriousness of the chronic disease outcomes, and how they may influence the utilization of preventive care services (Luquis & Kensinger, 2019).

The HBM is a systematic and theoretical framework and an effective health education model focused primarily on disease prevention by determining the relationship between an individual's health behaviors and beliefs (Shabibi et al., 2017). I used this theoretical approach to develop strategies that promote engagement within the African American community regarding the developmental process of health promotion to increase preventive services utilization. According to the HBM, individuals must believe they are susceptible to disease; understand the risk and severity of their mortality; and be open to positive, healthy self-care behaviors (Dehghani-Tafti et al., 2015). Use of the HBM in this study aided in educating African American males to increase their self-care behavior adherence and reduce preventable, long-term complications from chronic diseases by empowering individuals to utilize preventive health care (see Karimy et al., 2016). This theoretical approach provided a better understanding of the health attitudes,

behaviors, and perceptions of the social determinants that impact utilization and the need for further research on prevention and screening strategies of chronic diseases for African Americans in rural areas.

The SEM's strengths empower individuals to take responsibility for their health, lead healthier lifestyles, and be less costly to prevent a disease than paying for a cure later (Anjorin et al., 2018). While the SEM helps understand why individuals behave the way they do, there are limitations within the framework. Lack of motivation to change the environment, individuals being in denial and not believing they are at risk, the difficulty in changing lifestyles in a positive direction, and the fact that not all are diseases are preventable are a few limitations of the SEM (Anjorin et al., 2018). While the SEM is well respected by researchers, it is more effective when combined with other models, such as the HBM.

The HBM was included as part of the theoretical framework for this study because it is a motivational model that aims to prevent certain health behaviors and health concerns that are asymptomatic. The HBM focuses on individuals' beliefs regarding health conditions because those beliefs can help predict individual behavior (Jones et al., 2015). Limitations to the HBM include socioeconomic status, assuming all individuals have equal access to data on health conditions, social acceptability, and habitual environmental factors that inhibit or promote a recommended health change behavior (Fleckenstein et al., 2018).

The HBM and the SEM are two extensively researched theoretical models with different goals. By combining the strength of both approaches, strategies for change are

accessible, creating a possibility to overcome the weaknesses of each theory. By combining both theories, I was able to ascertain the social determinants, health beliefs, barriers, and perceptions of African American men in rural areas that may contribute to their lack of preventative care utilization.

Definition of Terms

Health disparities: Differences in health and health care that are impactful to socially disadvantaged populations. Health disparities include ethnic, socioeconomic, age, disability, gender, and geographic location due to their contribution to an individual's ability to obtain and achieve good health (Braveman, 2014).

Health promotion: The implementation of environmental and social interventions intended to enable individuals to control their health by addressing and preventing conditions (Kumary & Preetha, 2012).

Rural areas: Low-density areas that are outside of more densely populated metropolitan urban areas. Rural areas have more open spaces with more land and fewer houses and people than urban areas with large populations (Ratcliffe et al.,2016).

COVID-19: Also known as the SARS-CoV-2 virus or coronavirus disease; an infectious disease that has resulted in a global pandemic. COVID-19 is a virus that is perceived to be spread from person to person via droplets when an infected person coughs, talks, or sneezes (Velavan & Meyer, 2020).

Relevance to Public Organizations

The federal and state government has implemented measures to try and address access to quality care in vulnerable rural communities (Bhatt & Bathija, 2018). Health

disparities are higher in the Deep South, where many African Americans live with a long history of poor health, insufficient health insurance coverage, racism, and discrimination (Miller & Vasan, 2021). Preceding the ACA, rural counties had higher concentrations of uninsured residents (Benitez & Seiber, 2018). While the implementation of the ACA provided nearly 8 million African Americans access to preventive care services, not all states expanded their Medicaid coverage to provide those services to those in need (Noonan et al., 2016). Most southern states, including South Carolina, elected not to participate in the Medicaid expansion (Noonan et al., 2016).

Without access to preventive care services, African American men go without needed health care screenings to detect lung, colorectal, or prostate cancer. Limited access to preventive care services can result in individuals having advanced and life-threatening diseases that were potentially preventable if treated and discovered earlier (Christopher et al., 2016). Beyond the diminished quality of life that African American men may lead, there are also the social, economic, and personal costs due to health care spending, reduction in workforce productivity, and less social interactions with family and friends due to debilitating illnesses (Brown et al., 2015).

Existing Scholarship and Research

Alsan et al. (2019) conducted a study in Oakland, California, where 1,300 African American male barbershop clients participated in free health screenings for cholesterol, diabetes, and blood pressure at a clinic. Initially, study participants were randomly assigned a physician that was either African American or non-African American. After being assigned a physician, participants saw a photo of their physician's race, and they

were allowed to decide what health screening services they wanted to receive. Initially, male participants had no preference on the race of their physician until they had a conversation with the physician. After participants had a conversation, the researchers found that patients felt more comfortable receiving medical treatment and preventive services from an African American physician than from a non-African American physician (Alsan et al., 2019).

Alsan et al. (2019) determined from the study findings that lack of diversity in the medical workplace and medical mistrust of the health care system are two prominent reasons that African American men receive preventive health care services less than their European American counterparts. This study further corroborated how medical distrust is a considerable disparity impacting preventive care utilization in the African American male community. As the U. S. population becomes more diverse due to more residents having different backgrounds and cultures, increasing diversity in health care and public health care sectors is needed (Bouye et al., 2016). The advantage of racial diversity in health care professions is that a person of color may receive better health treatment from a physician of a similar racial background due to better communication and cultural competence, thus providing quality health care and increasing patient satisfaction (Shen et al., 2018).

Victor et al. (2018) launched a study between February 2015 and July 2017, with 52 black-owned barbershops in a pharmacist-led intervention and a controlled approach to reduce systolic blood pressure after 6 months of participation. During the six months, the men who received their haircuts and got treated for blood pressure had a lower blood

pressure than the clients who only received a haircut and were encouraged to make doctor appointments and change their lifestyle. Initially, when the study occurred, it was only done at the barbershop with no pharmacists on-site; once the pharmacist was incorporated, the results were noticeable within 6 months of the study (Victor et al., 2018). Victor et al. determined that barbershops, with access to specialty-trained pharmacists, can reduce chronic diseases due to the convenience of having an on-site pharmacist to provide treatment. Barbers can also add immense value to community programs by their endorsement and the fact that some patrons visit their barber frequently on a biweekly or monthly basis. This study's findings highlight the benefit of community partnerships for at-risk populations to improve health and reduce health disparities in rural communities.

To successfully address the health disparities impacting African American men, underrepresented communities must develop partnerships to work toward a common goal to create change within the community. Since nearly 87% of African Americans have reported that they belong to a faith-based organization, it is natural that such organizations become a venue for health promotion programs and community health outreach (Harmon et al., 2014). Smith (2015) and the Pew Research Center conducted a nationally representative telephone survey of more than 35,000 Americans and found that 47% of African Americans attend church at least once a week, 79% found religion to be very important, with 32% of that subset being men. African American churches can address health disparities and increase preventive care utilization within their health ministries (Holt et al., 2017).

Existing Community Partnerships for Increasing Preventive Care Utilization

Communities around the United States have begun developing cross-sector community partnerships to better address residents' complex social and clinical needs (Amarashingham et al., 2018). Collaborations between the local health care providers and community-based organizations can increase efforts to reduce health disparities. In many communities, organizations with a health mission, such as a hospital or public health agency, may partner with a public or private sector partner such as faith-based organizations, small to midsize businesses, or public safety (Levin, 2016). Within these partnerships, evidence-based strategies could see future development and implementation to increase program participation and create sustainability of health programs in the African American community.

Stronghold Christian Church in Dekalb County, GA, is an example of how partnerships helped promote health and wellness in the local community by creating initiatives to address health disparities impacting African Americans (Habersham, 2018). The Stronghold Christian Church program is part of a Center for Disease Control (CDC) grant to reduce African Americans' chronic diseases in Dekalb County over a 5-year time frame. The church currently provides fitness classes during the week; due to the grant, it can partner with local organizations to provide health and fitness to the community at zero or minimal cost (Habersham, 2018). Faith-based organizations, for many individuals, are where health issues are identifiable at the early stages. The early stages are where local partnerships can help develop and advocate health services and address the social determinants of health (Levin, 2016).

Strategies Used Previously to Increase Preventive Care Utilization

Increasing the utilization of preventive care services is a prevalent concern due to the costs of chronic diseases in the United States. This proposed study focuses on barbershops and African American churches' potential relationships to increase preventive care services utilization in the African American community. There are also strategies that public health organizations have previously used by partnering with the community toward creating needed changes. Telehealth is a newer intervention designed to provide patients another access point to receive remote health care services, eliminating barriers such as transportation and time constraints. Telehealth is a video chat visit with a physician that helps those who cannot get same-day appointments or whose office business hours conflict with scheduling. While telehealth works well for educated and tech-savvy users in urban areas, it is not always beneficial for residents in rural areas or those with multiple physicians at different practices that do not coordinate their care (Holt et al., 2017).

Community health fair events are becoming more prevalent in African American communities in the pursuit of diagnosing chronic diseases early. Typically, many women and children are at these events, but men are the smallest percentage for various reasons. Many of the barriers to community health fairs are the same as why men do not go to primary care physicians for health screenings: transportation, privacy, fear of embarrassment, and distrust (Umeukeje et al., 2018). While community health fairs started to make a routine medical checkup a fun family event, for some men, it can create

a fear of being diagnosed with an illness that will need more treatments (Umeukeje et al., 2018).

Furthermore, the community health fair can lack on-site incentives and have inconvenient times and locations for local participants who may have to work or lack transportation (Umeukeje et al., 2018). The only incentive to get male attendance for some community health fairs is a free health screening, slightly enticing for those without health insurance. For others, it may feel like a waste of time to get poked and prodded, and there not be any fun activities or prizes built into the event to make the experience more enjoyable. Holt et al. (2017) detailed participants did not always turn out for community fairs due to health-related fears, while transportation and childcare issues made it hard to attend for others. Harmon et al. (2014) stated that one area of improvement is disseminating information. While many churches offer community health fairs for preventive screenings, more detailed information needs to be presented to church members to reduce their fears or promote the long-term health benefits.

Local Background and Context

With the passing of ACA in 2010, access to preventive care has increased patient access to health care for underinsured, uninsured, or unstable insurance. Even with this increased access, African American men still have higher health disparities than European American men (Shikany et al., 2018). Many chronic diseases are avoidable if preventive care service utilization occurs with early detection. With over 86% of the annual health care spending costs due to chronic diseases, future prevention, and health promotion programs necessary to reduce chronic diseases could see an impact by the

potential budget cuts facing Medicaid and Medicare (Chapel et al., 2017). As government agents face budget cuts, public organizations also decrease funds available to improve and protect the residents' health (Schmidt, 2016). One obvious way to reduce health care expenditure costs is to reduce the number of individuals with chronic diseases.

As of 2018, the U.S. Census Bureau estimates that 14% of the U.S. population was African American, with 56% living in the southern states (Tamir, 2021). In South Carolina, African Americans account for 26% of the population in urban areas, with over 40% in rural areas (Rural Action Health Plan, 2017). An effective way to address health outcomes is to understand the associated social determinants of health to implement local policies or interventions. Building local partnerships within the African American community to improve health care access can help deliver better care and close the health care gaps in rural areas. Chronic diseases and the high mortality and morbidity rate for African Americans are severe issues in South Carolina (Wang et al., 2017). As of 2018, South Carolina ranks 44 out of 50 states overall in how well it meets citizens' health care needs based on health care access, quality of care, and public health rankings (Osby, 2018).

In South Carolina and across the country, rural counties all have the same long-standing challenges regarding the access minorities have to health care services. Rural locations face a unique challenge due to the smaller size, physician shortages, constrained financial resources, and remote geographic location. The patient mix can provide another challenge. Patients in rural areas typically rely more on government-funded programs such as Medicare and Medicaid than their counterparts in urban areas. Utilizing

government-funded programs makes a patient more susceptible to higher reimbursement charges than the private health care sector. Patients in rural areas often have more complex health issues than those in urban areas. Beyond the issue of minimal health care options, the facilities that provide health care in those areas deal with high turnover staffing issues while focusing on a rural health care patient's social need. Another issue is that limited staffing impacts rural areas due to the disproportionate share of the inpatient workforce being higher than the outpatient side, where there is a greater need.

In rural areas, access to health care services and geographic barriers are two factors of social determinants of health that health care professionals can address within community outreach. Lack of transportation in rural areas is a significant obstacle to health care access resulting in delayed or missed medication use, delayed physician care, missed appointments, or poor chronic care management (Daniel et al., 2018). Due to residents living in the most segregated conditions, the only location is often in an urban area when specialist care is needed. The cost, travel, and time required to miss work can create a burden where an individual may decide against health care treatment. Residents in rural areas with low socioeconomic status face longer wait times when seeking emergency room care for illnesses than their counterparts in urban areas (Loftus et al., 2017).

Even in areas with sufficient access to health care services, a resident also needs to have the financial means to pay for services, transportation to receive the care, confidence in the physician providing the care, and the belief that they are receiving quality health care. One issue in rural communities beyond health care access is limited

resources; due to the location, residents are often more isolated due to minimal access to medical services and lack of transportation. Rural communities also face limitations for residents due to lack of technology, accessibility, and higher care costs for those underinsured and uninsured. Rural residents already experience additional health barriers related to social factors, including income, poverty, health literacy, adequate community infrastructure, and access to affordable health care services and food.

Beyond health care access issues in rural areas, many areas face the impact of health facility closures or discontinuation of health care services (Balasubramanian & Jones, 2016). When a rural community loses a health care physician or facility, it can take a very long time to gain a new one. It is difficult to recruit physicians and nurses to rural areas due to distance, technology, and pay. When a health care facility closes or physicians leave an area, it impacts a variety of patients. Patients impacted are those with no transportation, physical limitations on the distance they can travel, those with minimal income, and residents who work jobs that do not provide paid time off for doctor appointments. When health care facilities close, the emergency services closing often creates delays for receiving care when crucial situations arise that need immediate attention.

My Role, Professional Context, and Relationship to the Project

As the researcher and a South Carolina resident with personal ties to a rural town in South Carolina, my role was multifaceted and functional within this qualitative case study. My role in this doctoral study was to develop an exploratory qualitative case study that increases awareness and utilization of African American men's preventive care

services in rural areas in South Carolina. My role as a researcher was to select participants, administer, moderate research and interview questions, collect and report data, and analyze the outcomes. The semi structured interview setting was the best fit due to the participants' versatility in responses and the opportunity to note verbal and nonverbal cues that only occur when doing an in-person interview compared to an online questionnaire. Nonverbal data are essential because it allows the researcher to see if any questions make a participant nervous or struggle to answer honestly. When doing live interviews, if a participant needs clarification on a question, the researcher can clarify, thus leading to more accurate and detailed data. The populations served locally are my family's hometown. While I am not a resident there, I visit frequently and feel a personal responsibility to start locally in developing health promotion programs.

Motivations

The desire to increase utilization and mortality rates while decreasing morbidity rates motivated me throughout the stages toward completing this administrative study. Personal motivation in this research study topic was partially due to my father having high blood pressure, glaucoma, and a recent stroke, all of which were detectable early if preventive care service utilization occurred. I was already working in the health care industry and knew I wanted to impact change in the local community. Once enrolled in the doctorate program, I found an opportunity to help change lives on a larger scale than previously imagined. Motivation also appeared due to workplace conversations from coworkers who had so much insight into the topic and had family members struggling

with chronic disease management who could have found relief if they had utilized preventive care services earlier.

Potential Bias

While personal bias is a potential risk of qualitative research, by utilizing bracketing, any biases are put aside with a focus shift toward exploring the participant's responses to ensure all attitudes, behaviors, and perceptions are detailed and explored during the process. Bracketing helps a researcher set aside personal experiences and focus on observing the phenomenon nonjudgmentally (Sorsa et al., 2015). Another inherent bias is focusing narrowly on one disease, which is avoidable by focusing on chronic diseases, thus broadening the search criteria to include multiple diseases such as cardiovascular disease, cancer, high blood pressure, and diabetes. I am focused on being a researcher and creating positive social change to increase preventive health care utilization in the African American community.

Summary

This case study addressed the lack of utilization of African American men's preventive care services and the impact that African American barbershops and churches can have on increasing preventive care utilization in rural areas in South Carolina. Many African American communities in the southern states are disproportionally impacted by low education, poverty, environmental exposures, housing, racism, transportation, and health literacy, contributing to low preventive care services utilization among African Americans in rural areas (Noonan et al., 2016). The condition of our schools, workplaces, homes, places of worship, and neighborhoods all contribute to an individual's well-being,

which is why some Americans are healthier than others in the United States. High-quality access to preventive health care is a lifelong need that requires proactive efforts within the health care system and local communities (Noonan et al., 2016). There must be an understanding of what social determinants are and where they are the most significant so that health professionals and local communities can address the effects on health and improve African American men's health in rural areas. African American churches' role in the African American community is imperative because it assists families when resources are needed or provides a place for individuals to put their burdens down to God. The barbershop plays a critical role in bringing individuals of all ages and types together in an open dialog.

In Section 3, I identified the sources of evidence, clarifies how collection and analysis of this evidence will address the research questions, provides a systematic review of published literature and research, details the data collection process, and describes the analysis and synthesis of this study.

Section 3: Data Collection Process and Analysis

Despite the health insurance coverage gains due to the creation of the ACA, African Americans are still impacted disproportionately by health challenges due to chronic diseases (Noonan et al., 2016). Health disparities, social determinants, quality of medical care, and health care provider shortages in rural areas make it difficult to address African Americans' health care needs comprehensively (Rosenblatt & Hart, 2000). While these health challenges impact African Americans across the United States, higher rates are predominant in the South and for men. The purpose of this qualitative study was to gather a deeper understanding of the reasons why African American men underutilize preventive care health services by ascertaining the impact of social determinants. In semi structured interviews, 12 African American men shared their lived experiences of the barriers impacting their preventive care utilization in rural areas.

In this section, I describe the data collection process, the participant selection and recruiting methods, sampling procedures, and data analysis strategy. I collected primary data from 12 interview participants and secondary data through examining past research on social determinants of health and preventive health care. Furthermore, I identify the ethical protection of research participants, ethical issues, credibility, and trustworthiness of this research study in this section.

Practice-Focused Questions

In rural areas, African American residents tend to focus more on issues, such as economy, crime, and housing, while focusing less or not at all on issues surrounding preventive health care (Duque, 2020). Due to the prevalent chronic disease issues African

Americans face, understanding the impact of social determinants on preventive care utilization is necessary for developing prevention and treatment programs. Currently, there are gaps in the scholarly literature on how social determinants can impact preventive care service utilization in rural areas. Few researchers have explored the attitudes, perceptions, and beliefs of African American men in rural areas in South Carolina (O'Neal et al., 2014). The following research questions helped me develop interview questions that elicited the attitudes, beliefs, and perceptions of the participants' lived experiences as African American men in rural areas of South Carolina:

1. What social determinants impact the decision-making process to utilize preventive health care services of African American men in rural areas in South Carolina?
2. What role, if any, do the African American church and barbershop play in addressing health disparities in rural areas in South Carolina?

In this qualitative case study, I aimed to understand the lived experiences of African American men in rural areas to increase their preventive care services utilization and awareness of chronic diseases. The interview data collected addressed the practice-focused questions. The interview questions also addressed the participants' religious beliefs as well as their relationships with barbers and how those relationships could impact preventive care utilization. By educating rural residents and providing more access to preventive health services, I hoped to empower African American men with confidence and tips to begin the conversation. Giving African American men control over their health care by providing access in the local community via barbershops and

churches may motivate them to become proactive about their health and adhere to chronic disease treatment plans.

Sources of Evidence

The collection and analysis of data for this qualitative study provided an appropriate way to address both practice-focused questions. The evidence sources used to address the practice-focused questions included scholarly literature regarding chronic diseases and African American men's preventive health care. I selected scholarly articles based on publication chronology and relevance to the topic with a peer-reviewed article preference. Health care is a fast-changing industry, so choosing articles published within the last 5 years ensures the newest discoveries, developments, and technical advances are valid and not outdated (see Mandalios, 2013). I obtained support from current, evidence-based literature on the impact of social determinants on the target population's utilization of preventive care services. This study focused on community-based health promotion and education to increase preventive care utilization, promoting the early detection of chronic diseases in African American men.

Participant responses in semi structured interviews were also sources of evidence that clarified how social determinants may impact preventive care utilization. The evidence also clarified what role community churches and barbershops in rural areas have toward increasing preventive care utilization. Using the findings from semi structured interviews and scholarly, peer-reviewed literature, I analyzed all sources of evidence critical to understanding how social determinants impact African American men's preventive care utilization in rural areas.

Published Outcomes and Research

I located literature in the form of peer-reviewed articles and primary and secondary sources in the following databases accessed through the Walden University Library: CINAHL, Medline, ProQuest, PubMed Health & Medical Collection, Sage Journals, Business Source Complete, CINAHL Plus, and EBSCOhost. Search engines, such as Google and Google Scholar, were also used to offer a more comprehensive array of articles on chronic diseases, preventive care utilization, African American churches, and barbershops. Articles, documents, and journals referenced included items from government agencies, such as the CDC, Department of Health and Human Services (HHS), South Carolina Department of Health and Environmental Control, National Center for Health Statistics, and the U.S. Census Bureau. Furthermore, all searches conducted resulted in articles detailing African Americans' relationship with Black barbershops and churches and their health care perceptions based on their cultural and personal beliefs.

The keyword search began from the practice-focused research questions and related terms critical to the doctoral study. Key search terms and phrases included in the search were *preventive care, African American men, black churches, black barbershops, Affordable Care Act, health literacy, chronic diseases, rural health care, social-ecological model, health belief model, faith-based organizations, social determinants of health, health promotion,* and *health disparities*. The systematic literature review included peer-reviewed, scholarly journals and state and federal health action plans promoting health literacy and health education for the target population. The search was

exhaustive and comprehensive due to the use of multiple search databases and various search terms about health care access barriers. Articles reviewed were published within the last 10 years to confirm the relevance of the research and the authenticity of current health disparities still impacting African American men.

Evidence Generated for the Doctoral Study

Participants

The study participants were a sample of African American men, 21 years of age or older, who attended African American churches and local barbershops in a rural area in South Carolina. Originally data collection was going to occur in-person with 12 semi structured interviews occurring at an A.M.E. church in a rural area in South Carolina. Due to COVID-19 and socially distancing guidelines, I conducted interviews virtually over the phone or via a Zoom call. Mason (2010) stated that qualitative studies generally have a smaller sample size than quantitative studies, yet are large enough to uncover new perceptions while not becoming repetitive. The final selection was a total of 20 participants who met the study criteria. After the first 10 semi structured interviews, I noticed data saturation had been reached. To ensure data saturation had occurred, I conducted two more interviews for a total of 12 participant interviews. Fusch and Ness (2015) stated that data saturation occurs when enough data are collected to replicate the study and no new information is attainable.

I used purposive sampling in this research study to recruit participants because it is a nonrandom sampling method where participants are chosen based on specific criteria (see Palinkas et al., 2015). Palinkas et al. (2015) described purposive sampling as a

popular technique utilized in qualitative research to identify knowledgeable or experienced participants with the phenomenon in question. I selected participants based on the following specific inclusion criteria: (a) being an African American male, (b) being a member or attending an African American church, and (c) actively going to local barbershops. Participants who met the specific inclusion criteria provided relevant information about the social determinants impacting African American men's preventive care services utilization in rural areas. These participant inclusion criteria provided evidence-based options for addressing the practice-focused questions on the decision-making process of African American men to utilize preventive health care services and the role the African American community may play in addressing health disparities.

Procedures

The data collection process addressed the project outcomes via a purposive sampling of 12 African American male participants aged 21-64 that lived in a rural area in South Carolina. Their participation in semi structured interviews was voluntary. Once I was contacted by residents that met the study criteria, I scheduled a phone call to build rapport, learn more about the participant, and explain the research study in detail. The potential participant discussion included the program objectives, requirements, data collection process, and the inclusion/exclusion criteria. After completing the discussion, I sent each participant an informed consent form via email to confirm if they still wanted to participate. The average length of time for each recorded interview was between 45 and 60 minutes. Each participant was advised to find a quiet area of their home free of distractions to ensure the confidentiality of their interview responses. The timeline for

recruiting participants was over the course of 3 weeks. During a 1-month timeframe, all the one-on-one, semi structured interview sessions took place.

Semi structured interviews are standard in qualitative research and health care to gather participants' attitudes, perceptions, personal experiences, and beliefs on a research topic (DeJonckheere & Vaughn, 2019). I designed a semi structured interview protocol to optimize time, ensure consistency during each interview, and record and document participant responses along with my observations. The interview questions (see Appendix A) were open ended and developed from the social determinants of health and the subsets of both research questions, often beginning with either "how" or "what" to gain an in-depth understanding of a participant's perspective. To enhance the validity of this research study, I transcribed each interview recording verbatim. Subsequently, I reconnected with each participant to perform member checking to ensure their responses were reflected accurately in my written interpretation. Member checking or participant validation means maintaining validity in qualitative research and reducing the researcher's biases or beliefs by having participants confirm their respective results (Birt et al., 2016).

Protections

Before conducting any research, I obtained all necessary permissions from the Walden University Institutional Review Board (IRB) to ensure the ethical protections of participants were in place at the start of this doctoral study. The IRB approval number for this study is 07-24-20-0236805. Before participation, the pastor at a A.M.E. church received an informed consent form that detailed the purpose of the study, safeguarding

and data storage procedures, and how each participant had a right to withdraw at any time during the study without penalty. The pastor's role was limited to sending out the recruitment flyer in the weekly email bulletin to all church members. The pastor was not involved directly in recruiting participants because within the weekly church bulletin each potential participant received, my contact information was detailed, thus removing the pastor from needing to provide any additional assistance. Once the pastor reviewed the informed consent form, recruitment of potential participants commenced by including flyers in the weekly emailed church bulletins to notify congregation members of the study. The flyers gave an overview of the study and the specific inclusion and exclusion criteria and invited individuals who met the inclusion criteria for participation. Once a potential participant contacted me via phone or email, they received detailed information via email and verbally to provide their informed consent.

I sent the consent form to participants via email to ensure complete understanding. I also held a private conversation over the phone with each participant to answer any questions they had concerning voluntary participation, safeguarding their personal information, and the ability to withdraw from the study at any time. The consent form provided participants with a clear description of any potential risks, the implications of participation, the benefits, the study's purpose, and what they could expect during the research process. Each participant agreed that once they had a clear understanding of the consent form and the research study, they replied via email, with the phrase "I Consent" as electronic confirmation of their consent. Each participant was encouraged to save or print a copy of the informed consent form for their records. Once the consent reply email

was received, I individually scheduled the interview time with each participant. The interview questions and the correlated social determinants of health can be found in Appendix A.

The semi structured interviews of participants took place remotely. Due to the COVID-19 pandemic, all participants had the option to have their interview done via phone call, a Zoom meeting, or a Microsoft Teams meeting online to ensure social distancing. Before beginning each interview, I gave the participants the opportunity to ask any additional questions about the study and got their permission to audio record the interview. All interviews were digitally recorded to ensure the accuracy of the data collected from participants. All the data collected are stored securely on an external flash drive and my personal computer hard drive. Instead of using names to identify participants, each participant received a numeric identifier to ensure their confidentiality. I omitted all participants' names and any other identifying information throughout the duration of the study.

Additionally, aggregation of all results occurred to increase protection and ensure all participants' anonymity. The community members' responses will not be disclosed outside of this study to ensure they are not at risk of liability or withstand any damage to their credibility, employability, or financial status in the local community. Per Walden University's IRB requirements, the audio recordings and transcripts of the recordings will remain safe, sealed, and confidential for 5 years in a locked file cabinet in my home office with all coded documentation.

Analysis and Synthesis

Accurate data collection and appropriate data analysis are essential to maintaining research integrity. Data collection occurred via a semi structured interview protocol with a digital audio recorder to record all interviews to ensure integrity and validity. Before each interview, participants received reminders about the protection procedures and the confidentiality of all interview responses. To ensure accuracy after completing each interview, I reflected on the individual participant responses and how the data collected related to both research questions. I adopted both NVivo and manual coding techniques to analyze data due to being a novice qualitative researcher. Coding in qualitative research gives credibility and is an essential part of the data analysis process for researchers that use focus group or interview data (Parameswaran et al., 2020).

Immediately after completing each interview, I manually transcribed every participant's response into a Microsoft Word document to make the data simpler to code before utilizing NVivo. NVivo is a data analysis software program utilized for data management to identify patterns and themes while assisting in the data analysis process (Zamawe, 2015). NVivo aided in searching the interview responses for phrases and keywords used later to generate manual codes to ensure all data segments of importance were seen and not ignored. After utilizing NVivo to categorize the data, I manually reviewed the data collected for additional themes and patterns multiple times. Manually coding data was beneficial because I could decipher any phrases or slang terms used by participants that the computer could not understand. During this process, I began to identify emergent themes from the lived experiences of the participants. The interview

responses yielded eight core themes from the semi structured interview questions. In Section 4, I detailed the emergent themes listed below according to how they aligned with each research question:

- Lack of health care insurance and access to care (RQ1)
- Financial responsibilities for family and cost of health care (RQ1)
- Lack of attentiveness from health care providers (RQ1)
- Lack of trust in the health care system (RQ1)
- Lack of awareness of community offerings (RQ2)
- Source of health education (RQ2)
- Cultural and religious impact (RQ2)
- Systemic racism (RQ2)

The conclusions I drew from the data collected were based on the participants' responses and reflected their attitudes, opinions, and cultures. The research goal was to collect data without bias by eliminating all preconceived notions of how participants may respond and instead describe the themes and patterns directly from the data collected. Through purposive sampling, each participant received a numerical identifier to manage the integrity of the data collected, outliers, and missing information. Outliers and missing information typically are encountered during the data collection stage due to various factors, including data entry errors and participant response errors (Kwak & Kim, 2017). I did not anticipate encountering missing information and outliers due to not dealing with numerical data for statistical comparison. The analysis concluded with proposed dissemination plans for use by local community officials and partners.

Summary

In Section 3, I detailed the practice-focused questions, sources of evidence, and the data collection methods. Sources of evidence explored preventive health care services among African American men in rural areas with evidence and tools for validity. Before seeking potential participants, the solicitation of IRB approval occurred from Walden University. Once approval was received, potential participants obtained the procedures and how their confidentiality would be ethically protected. The last part of this section discussed the tools used to record and transcribe interviews, analyze data, and the methods for securing the data collected.

In Section 4 of this study, I detailed the findings of the semi structured interviews and the strengths and limitations of the research study. Recommendations addressed support community interventions and partnerships with local African American churches and barbershops to increase African American men's preventive care utilization.

Section 4: Evaluation and Recommendations

African American men in the United States experience several health disparities that result in shorter life expectancies, disproportionately suffer from chronic disease, and get diagnosed with chronic disease later in life compared with all other ethnic groups and genders (Esiaka et al., 2019). Preventive health care screenings for blood pressure, cholesterol checks, blood sugar, and colonoscopies are necessary to ensure the early diagnosis of chronic diseases. Purnell et al. (2016) described that while there have been multiple health care interventions to achieve health equity, one gap in knowledge is the need for interventions to create relationships between the health care system and the local communities. Two practice-focused questions guided this doctoral study:

1. What social determinants impact the decision-making process to utilize preventive health care services of African American men in rural areas of South Carolina?
2. What role, if any, do the African American church and barbershop play in addressing health disparities in rural areas in South Carolina?

Guided by these two research questions, the purpose of this doctoral study was to identify evidence-based strategies to address the impact of social determinants on African American men's utilization of preventive health care services in rural areas and if community collaborations could empower them to do so. In Section 4, I discuss the findings, study limitations, and the research method and design.

Summary of Sources of Evidence

After receiving Walden University IRB approval, I commenced data collection virtually through conducting semi structured interviews and a systematic review of the scholarly literature focusing primarily on research published with the past 5 years. To locate scholarly literature, I used databases accessible through the Walden University Library, such as ProQuest, CINHAL, PubMed, and Medline with full text. Additional sources of evidence included documents and articles from government agencies, including the HHS and the CDC. The articles reviewed included qualitative, quantitative, and mixed-method studies; surveys; and systematic reviews. The search terms employed were *African American men, social determinants of health, health promotion, health disparities, social-ecological model, health belief model,* and *chronic diseases.*

The scholarly literature review was an additional source of evidence to the data collected from semi structured interviews with 12 purposively selected participants. All the interview questions aligned with the practice-focused questions and multiple social determinants of health, including economic stability, neighborhood and physical environment, health care system, and community and social context. To identify themes and patterns from the participants' lived experiences, I used both NVivo software and manual coding for analysis. The conclusions reflected each participant's attitudes, beliefs, opinions, and culture from their interview responses.

Findings and Implications

In this doctoral study, 12 African American men who were between the ages of mid-20s to early-60s with educational levels ranging from a high school diploma to a

bachelor's degree were voluntarily interviewed. The 12 semi structured interviews were audio recorded, transcribed, and analyzed for disparities, commonalities, and emergent themes. After transcribing each interview, I sent each participant their transcript to review to ensure the accuracy of the data collected. During the interviews, participants were open, receptive, and eager to share their health care experiences and opinions. All 12 of the participants in the research study suffered chronic diseases, including high cholesterol, high blood pressure, diabetes, Crohn's disease, thyroid disease, and cancer. In analyzing the data, I identified the following emergent themes: a lack of trust in the health care system, systemic racism, lack of health care insurance, and access to care. The interviewees identified barriers to preventive care, such as lack of attentiveness from health care providers, cultural and religious impacts, financial responsibilities for family, and health care costs. In the following subsections, I synthesize the findings with pertinent literature identified in Chapter 2. The interpretation of research findings is organized based on the emergent themes for both practice-focused questions.

Themes

The interview questionnaire (Appendix A) addressed specific social determinants of health and the constructs of the HBM and the SEM for both practice-focused questions. After reading and transcribing interviews, I extracted significant statements and grouped them according to each practice-focused question's HBM and SEM constructs. Following that, I formulated the themes related to the social determinants of health, the SEM, and the HBM. An emergent theme may refer to phrases or sentences of a participant's account of their attitudes, beliefs, perceptions, and experiences relevant to

the research question (Vaismoradi & Snelgrove, 2019). Table 1 presents the emergent themes and subthemes for both practice-focused questions using the constructs of the HBM.

Table 1

Emergent Themes and Subthemes

Main Themes	Subthemes
Lack of health care insurance and access to care	Long waiting times Provider availability
Lack of attentiveness from health care providers	Health care professional attitude, knowledge, and behavior Dissatisfaction with health care providers Communication Comprehension
Lack of trust in the health care system	Mistrust Fear of being misunderstood Loss of confidence in physicians Fear of side effects
Financial responsibilities for family and cost of health care	Financial barriers Affordability Family and job responsibilities
Source of health education	Comprehension Health literacy Communication
Cultural and religious impact	Cultural discrimination Prayer Home remedies Cultural competency
Lack of awareness of community offerings	Technology Minimal promotions of community events
Systemic racism	Limited health care providers Upbringing Segregation Formative experiences Patient experiences

Theme 1: Lack of Health Care Insurance and Access to Care

In the interview question section related to the health care system (see Appendix A), I asked participants about their experiences accessing health care services and how they feel about going to a primary care doctor. The participants spoke at great lengths about access to care and the effects of health care insurance on their preventive health care utilization. Several participants shared being unable to see a primary care doctor due to not working because of a pending disability approval and the 2-year waiting period for Medicare. Waiting times were another grievance amongst participants who do not get paid if they miss work due to the lack of health care providers in their rural community. Participant D2SC made a familiar comment heard during the study:

> I do not enjoy going to the doctor because there are only two offices in my town, and both have fewer doctors there who also work in the major city, so the wait time to get an appointment or sit in the office was too long.

Participant D3SC echoed sentiments stating:

> Why miss time from work when the doctor's office is so short-staffed? I will wait for hours to receive treatment, and all they do is go over my current medications, take a urine test and refer me to the major city for further testing.

Due to limited health care workers, if a resident requires a specialty provider, they must drive 30 to 45 minutes away to the closest city for care or schedule an appointment on an irregular schedule when certain specialty providers come to the rural area on specific days. For a few participants who did not have access to paid time off, it was not

always feasible to miss a day of work to go to the next closest provider in a larger city for medical treatment or diagnosis in some cases until the issue became severe.

Theme 2: Lack of Attentiveness from Health Care Providers

This theme arose from participants voicing grievances about how inattentive physicians are once they are at a doctor's appointment. While considering the shortage of health care workers in that area, many participants still felt disconnected when receiving medical treatment at the local doctor's office. Participant D2SC detailed an experience of disconnect, explaining:

> Before I switched to a doctor in the metropolitan city, I saw a doctor in town who never seemed to have any patience or willingness to help me determine what was wrong or fix it. They would ask me generic questions that I had already answered and never seemed attentive to what I was telling them. I finally had to understand that this doctor's office was the only one in this town, and he was just overwhelmed, so he did not care, and that was not good enough for me. So, while I must drive further for care, they are now paying attention and helping my health improve.

Another participant felt judged by doctors with their difficulty following prior medical advice or making the participant feel stupid for not understanding some of the medical information they were receiving. Multiple participants felt that their issues went unheard and gave similar responses to Participant D1SC, who stated,

> When I first started going to the doctor for my knee, I felt that they did not communicate well with me, telling me what was going on or the changes I should

> make. It felt like I was not a person and did not matter. They would just talk to the computer screen and rush me out for the next patient.

Due to constraints attracting and keeping quality talent, residents in rural communities tend to have inferior health care and less access to quality health treatment than residents in urban communities. It is also discouraging to try to schedule a doctor's appointment, feel treated like another number, and not feel that the experience is customized to meet their needs when they are not receiving the physician's full attention.

Theme 3: Lack of Trust in the Health Care System

Medical mistrust occurs due to past experiences of mistreatment and discrimination in health care. Trust and communication are vital components of a healthy patient-doctor relationship and a tool for higher quality care and patient satisfaction (Chandra et al., 2018). African Americans' have had a long history of distrust in the public health care system due to getting less care and more often worse care than European Americans, along with a fear of being used as test subjects in medical research (Scharff et al., 2010). One prevalent experience leading to mistrust was past experiments like the Tuskegee Study, where hundreds of Black men were intentionally given syphilis and denied treatment without their consent (Kennedy et al., 2007.) Patient D9SC expressed concern about the potential COVID-19 vaccine trial, stating, "I do not know anybody who is agreeing to be in a vaccine trial when they have proven they do not care about us, and to them, we are just guinea pigs for research."

Many participants detailed prior experiences with a lack of communication when a physician would enter the room and assume the only need treatment to get a

prescription for drug use instead of having an actual health issue. Often when a patient distrusts their health care physicians, they are victim blamed and labeled as noncompliant. One participant described how the doctor did not seem interested in resolving their issues with uncertainty about getting paid when they did not have insurance. Another aspect of distrust occurs when patients have low confidence in a doctor's level of expertise and fear they will be misdiagnosed due to past experiences personally or by family or friends. Participant D4SC recalled a life-changing experience resulting in him requiring hospitalization:

> I was on a medicine called Metformin. Have you heard of it? Well, Metformin was a killer. They took me off when I went to the hospital, and a Black doctor came in and said, "I am going to tell you something…I think it is Metformin..." He then said, "Can I tell you something else? I am not supposed to tell you." He said, "Metformin is not the best medicine for people of color." So, when a diabetic doctor came in, I told him what I thought was wrong with me was Metformin. He said I agreed. As of today, you do not have to take it again. So, I have not taken Metformin since and have not experienced similar issues since.

A recent study where 1,300 African Americans were randomly assigned Black or non-Black doctors found that patients with an African American doctor received 34% more preventive care services, one reason being the feeling of trust and clear communication (Alsan et al., 2019). Those study results only strengthen the importance of trust and communication; because if all the Black men had received the same increase in services,

the cardiovascular mortality rate and life expectancy gap could reduce between African American and European American men.

Theme 4: Financial Responsibilities for Family and Cost of Health Care

Too often, in the community of African American men, providing for their family is the most important thing. Many African American men work blue-collar jobs that do not provide health insurance or have high health insurance premiums, forcing them to waive coverage to ensure they have funds available for their household responsibilities. One participant was a welder with a wife and two kids. Due to the exorbitant costs, he never acquired health insurance until he got older and started having medical problems that forced him into early retirement and qualified him for disability through the Social Security Administration. I asked the participants to tell me about their health and their access to health care services. In most participant responses, there was a recurring theme of financial barriers, affordability, family, and work responsibilities.

Participant D5SC responded,

> I cannot afford to get sick; I have to work. I do not get paid when I miss work, I do not get vacation time, so when I am sick, I have to keep going and hope it does not get worse.

Participant D4SC summarized the feelings of most participants as:

> I really think the reason our parents did not go to the doctor was that financially they could not afford to go, and that would have been money taken out of the household for an illness that would eventually go away.

A different participant spoke on being self-employed as a car mechanic and not taking days off to go to the doctor even when sick. Then there are the men who have health insurance and could go to a doctor's appointment but have higher deductibles or copayments to be paid before receiving treatment, so they elect to not go due to fear of additional fees once diagnosed.

Theme 5: Source of Health Education

Health education evolved into health promotion by empowering communities and individuals to live healthier lives throughout the years. For health education to occur correctly, it is essential to understand where patients seek health information to improve health outcomes. Studies have found that health education is critical in promoting healthy behaviors, enhancing health care program participation, and improving care quality (Zamani-Alavijeh et al., 2019). Interview participants detailed three subthemes developed from the health education source: health literacy, communication, and comprehension.

Health literacy was a recurring theme because if individuals do not fully know how to find, understand, and use health information and services, they are more at risk for health problems. Improving health literacy amongst African American men can prevent health problems and manage existing and unexpected issues when they arise. Too often, when they did go to a physician's office, they did not always comprehend the terminology and phrases used to describe their issues, so if participants went alone, they left feeling more confused than entering the office. While there are significant gaps in the literature regarding the barriers to health literacy and interventions in the African American community, a few studies have shown that the Black church is an excellent

resource for health literacy initiatives (Muvuka et al., 2020). Participant D8SC candidly shared:

> I remember when my parents went to the doctor and got pamphlets on different diseases, but now they tell us we must go online and use their patient portal. I have a smartphone, but I do not know how to use apps like that. I need my daughter's help to make my doctor appointments because I cannot figure out how to use the technology.

Communication was significant because they previously had doctors who were hard to talk to and who did not communicate easily. Two participants spoke of having a doctor of color versus White doctors and how they took notes and could talk more freely and ask questions that aided in making well-informed decisions for their future with those doctors of color. Participant D7SC explained in detail how vital communication was by remarking:

> The Black doctors I have had, I have been impressed with, and I feel I have been able to talk more freely with them. So that makes it different for me that I can be myself, and now my primary doctor is a woman, but she is an Indian woman. I can talk to her very freely. If I do not, she will talk anyway… but I like feeling comfortable telling her everything. I have learned now that when I go to doctors, I write down anything that's bothering me because if they do not know everything that's happening, they cannot give me a good diagnosis of what I need to reset and get better.

Theme 6: Cultural and Religious Impact

Culture and religion are critical factors in many individuals' lives across the globe. Many individuals consider themselves religious, and there is a separate segment that describes themselves as spiritual. The medical community training was to learn with the mindset of a scientist, which can create a disconnect for individuals who turn to religious beliefs for guidance on making health care decisions. All 12 participants were asked about their religious/spiritual beliefs, if any, and how that faith impacted their health care journey. All participants identified themselves as Christians who believed in God, with some participants leaning more toward spirituality versus others who were more religious. Many participants spoke on how their daily prayer and hope in God provided comfort during the hard times after receiving a medical diagnosis. Participant D3SC stated:

> I believe in God. Growing up, we did not go to the doctor much, but our parents always prayed a lot, so I kept that with me as an adult, and it gave me hope. My favorite saying by my grandmother was that God would not give you more than you can handle, and I carry that with me today.

Many physicians do not consider patients' religious beliefs when working through difficult medical decisions with their families. Many patients turning to their religious beliefs can reduce their anxiety, which a health professional should recognize to ensure they are providing culturally appropriate care. Patient-centered care occurs better if physicians have an enhanced cultural competency by understanding the beliefs and backgrounds of their diverse range of patients.

Home remedies were another anecdotal story from many participants who grew up in a household that did not utilize traditional medicine due to cost, religious beliefs, or culture. One participant told a story on how his family would put Vick's vapor rub on the bottom of his feet before adding socks to get rid of the flu when he was a child. Participant D11SC noted:

> We did not go to the doctor back then; you went to the doctor only if you became drastically ill; I mean, it had to be drastic. Back then, we believed in home remedies and stuff. I remember still to this day taking kerosine with a spoonful of sugar, and then you had to drink that down every year. It was supposed to keep you from getting colds, flu, and all that stuff—kerosine and castor oil.

Another participant worked in welding and stated how he always used aloe vera or fatback uncooked for burns and sores when he got married. He also told stories of growing up in a rural town with his parents and how they would give him cod liver with garlic, honey, onions, and lime juice to get rid of a common cold.

Theme 7: Lack of Awareness of Community Offerings

When participants responded about what resources they were aware of, it was a recurring answer of uncertainty regarding health fairs or wellness screenings; the only time they knew of health events was when their wives informed them. Most participants in this study reported that they had never heard of community-based screenings for chronic diseases in the local community. Two participants advised that their African American church did offer preventive health care screenings infrequently to increase activity before COVID-19. Those two participants who attended church community

events stated that the events were put in the weekly church bulletin, discussed during the church announcements, and a follow-up discussion during men's fellowship meetings. A different participant mentioned that even though there are free community events, men will often not take advantage of them due to lack of notice, interest, or access to transportation. Participant D10SC had similar sentiments, stating:

> So, when I think about the free things that we can do for each other and our community, and we do not offer them, then people say how we will not help each other, right? And then when it is offered, we won't take advantage of it.

The common feedback from all participants was the need for increasing the marketing and promotion of community events. Participant D9SC had many marketing ideas to increase awareness of events stating:

> Once COVID is over, we need to work with the radio station; they always promote events at cell phone places or schools, and when they give away prizes, people show up. We need to do that for community health fairs and work with the radio stations so more people will know and participate.

A few participant suggestions were distributing flyers listing community events to local businesses and partnering with local businesses to host events that increase advertisements. Participants reiterated how providing more services like free food and running advertisements in local newspapers would increase local participation.

Theme 8: Systemic Racism

Systemic racism includes mass incarnation, intergenerational wealth, segregation of schools and occupations, and race-based residential segregation (Gravlee, 2020).

Systemic racism is racial disparities and inequities supported by unconscious bias and long-running institutional policies based on false and negative stereotypes (Marcelin et al., 2019). On April 8, 2021, the CDC officially declared racism a public health crisis, along with the steps to address it (Pflum, 2021). Many African Americans across the country feel embedded in the economic, social, and political structure of the United States is systemic racism. A few participants echoed similar sentiments when discussing their upbringing and the segregation that continued at physicians' offices in rural communities when they were little, even though the state of South Carolina had already desegregated. Two men recounted similar stories of the racism they experienced as children.

Participant D12SC remembered:

> Growing up in a small rural town, there was a time when the same doctor's office that I go to now was segregated, and the Blacks had to enter the door on the left, and the whites had the one on the right.

Participant D6SC reminisced further, stating:

> Even if you go into the doctor's office now, you will notice that the only bathroom and water fountain are on the right side of the building, the White side. We never had the same access, and even now, nothing has changed.

When discussing segregation, South Carolina schools currently have more than 171 schools with at least 90% people of color or 90% White populated, which occurs in more than 14% of the state (Gilreath, 2020). Another issue highlighted by many participants was the increasing exposure to police brutality and how the fear of direct

contact with police has impacted their mental health. While this study focused on how to increase preventive health care, the discussion on preventable causes of death and disease shifted to a conversation of how police brutality is preventable but has never been at the forefront of public health until social media magnified it over the last few years.

Theoretical and Contextual Interpretations

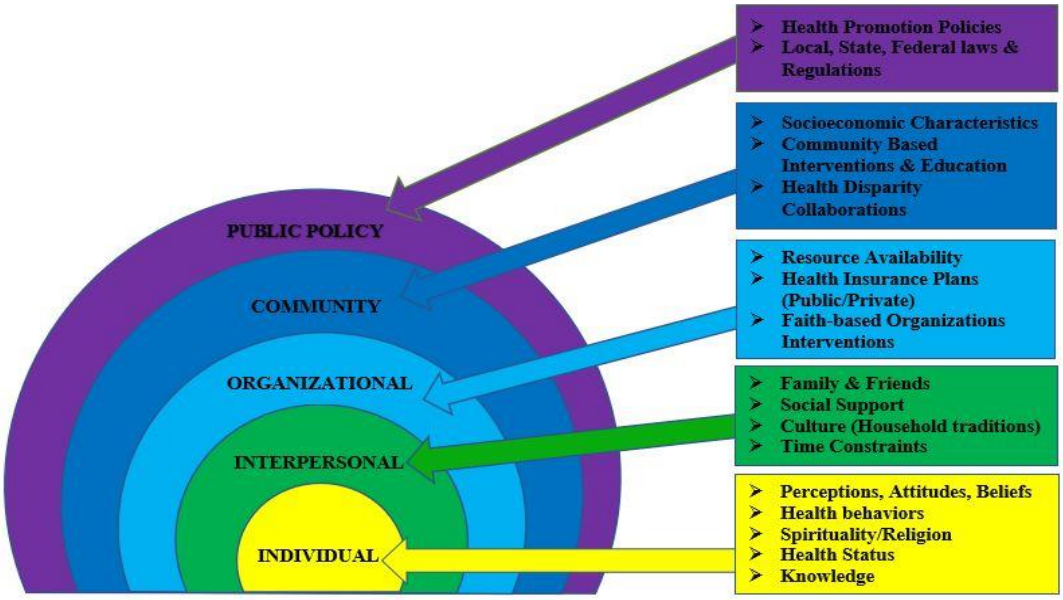
The HBM and SEM are the two theoretical frameworks that guided the development of this study to determine the impact that social determinants of health have on utilizing preventive health care services. The SEM for health promotion provides a comprehensive view of potential benefits and barriers for positive health behavior change. SEM suggests how community, organizational, interpersonal, individual, and public policy factors influence health behavior (Wold & Mittelmark, 2018). The comprehensive approaches suggested within this study are developing community partnership interventions to address the social determinants of health that impact preventive care utilization. In Figure 1, I adapted the social-ecological health promotion model to include factors influencing preventive care utilization for chronic diseases.

The base of SEM is the individual level of the participant's perceptions, attitudes, and beliefs regarding chronic diseases and preventive care screenings. The interpersonal level details the external influences of family and friends and how culture can influence health care choices. The organizational level focuses on reaching more individuals in different community sectors like schools and workplaces, health insurance plans, and resource availability to guide and support or hinder healthy behavior. Community is the fourth level and is a collective group of local organizations, businesses, and individuals

who collaborate and pool their resources to improve community health and access to care. The policy level is the final level of the governing bodies in charge of the preventive efforts and health promotion policies on a local, state, and federal level. Every SEM level can provide a potential barrier while initiating positive social change by increasing engagement amongst African American men in rural communities.

Figure 1

Social Determinants of Health



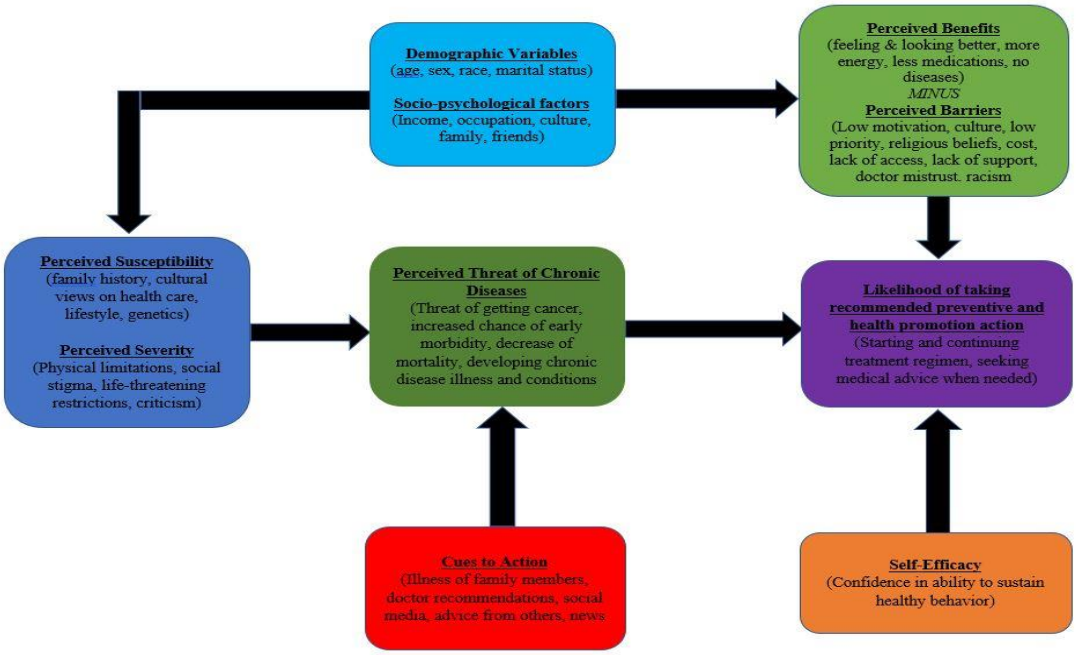
Adapted from "An Ecological Perspective on Health Promotion Programs," by K.R. McLeroy, D. Bibeau, A. Steckler, and K. Glanz, 1988, *Health Education Quarterly, 15*(4), pp. 351-377. Copyright 1988 by Sage Publications. Adapted with permission.

The study findings are also consistent with the HBM, which proposes that individuals are more likely to participate in a healthy behavior if they believe that the benefits outweigh the barriers associated with that health behavior. The HBM aided in examining individual-level beliefs and perceptions that influence preventive health care

screening behavior. The HBM, as shown below in Figure 2, also took into consideration the effect of perceived severity, perceived barriers, and perceived susceptibility on the likelihood of an African American male engaging in health-promoting behaviors in rural areas. The cues of action, self-efficacy, and perceived benefits can aid in determining whether an individual would take the subsequent steps for utilizing preventive health care screenings for chronic diseases. This study showed that most participants initially felt that the correlated social determinants of health barriers outweighed the benefits of a healthy lifestyle, explaining the higher prevalence of chronic diseases in all participants interviewed. Both the SEM and HBM apply to the social determinants of health and the specific health behaviors, attitudes, beliefs, and perceptions that can influence the preventive care services utilization regarding chronic diseases.

Figure 2

Health Belief Model



Adapted from "Historical Origins of the Health Belief Model" by I.M. Rosenstock, 1974, *Health Education Monographs*, 2(4), 328–335. Copyright 1974 by Sage Publications. Adapted with permission.

Unanticipated Limitation

An unanticipated limitation that impacted the study was the unexpected emergence of the COVID-19 pandemic on meeting participants in person. Due to the social distancing guidelines and the uncertainty of an end in sight, the initial plan of having focus groups in a barbershop setting did not occur, which could have generated a wealth of more information due to the openness of the conversation. While this limitation was unanticipated, it did not result in any significant impacts on the results.

Implications from Findings

The qualitative case study and literature review findings have implications on individuals, health care systems, rural communities, and health care institutions. Empowered and informed male patients and future behavior change can improve health and decrease chronic diseases. Community partnerships can lead to integrated health care systems and improved use of community resources. The data findings are also valuable for hospitals, governmental and nongovernmental health care institutions. The implications of the findings include the need for a more concerted effort to be made by health officials and community leaders on providing chronic disease and preventive health care education to African American men in rural areas. This study can be duplicated in other rural areas, creating more extensive results, and improving the treatment rate of African American men with chronic diseases. Health care systems,

including Medicare and Medicaid, can use the findings to restructure and enhance chronic disease screenings to increase utilization in areas with minimal access.

Implications for Social Change

While predicting social change is impossible, the goal is to encourage future researchers to review the gaps in literature and limitations in understanding the impact that social determinants have on preventive care utilization of African American men in rural areas. The research findings may enable community leaders to develop strategies to increase public interest in preventive care utilization by enabling community members to become more empowered in their health care and well-being. This study can increase community involvement and foster community partnerships for future health screening events in rural areas by addressing any current deficiencies in the current and future public health programs. A few participants suggested that the church and barbershop share preventive health care information to get prescription cost assistance, transportation access, and locations of free clinics to residents.

Finally, this qualitative study has social change implications for future health care policies; specifically, churches and barbershops collaborating with public health agencies and local health providers to decrease chronic disease and improve population health. Due to the mistrust in the African American community regarding the government, African American churches and barbershops can liaison between policymakers, local politicians, and the impacted communities. As more and more community leaders take on more roles in developing collaborative partnerships, this practice model could shift the health care narrative from disease-focused care to wellness-focused care. In many rural

areas, community leaders were not always actively involved in the decision-making process for local chronic disease screenings. Health promotion education and activities will enhance the local environment. There could be a significant social change for African American men and the entire rural community through more partnerships and collaborations to increase access to preventive health care screenings.

Recommendations

The purpose of this qualitative case study was to explore strategies that health care providers can use to develop collaborative preventive care programs to increase chronic disease screening utilization among African American men in rural communities. One of the most cost-effective ways to handle the chronic disease burden that an individual can face is routine preventive health care screening services. Therefore, innovative approaches are needed to increase chronic disease awareness and target vulnerable populations such as African American males in rural areas. The following recommendations from the findings of this study are for health care providers, public health officials, and community partners. For future research studies, I offer three recommendations, all of which are contingent on when each state in the US has opened back up fully from each state-mandated COVID-19 shutdown. The COVID-19 vaccine is being offered for distribution to all individuals 12 years of age and older when completing this study. All the states in the U.S. and even some countries across the globe have begun reopening in stages, so once churches and government offices fully open, these recommendations would have the best potential for development.

The first recommendation is to develop intervention programs and awareness campaigns geared towards collaborative partnerships with local churches and barbershops to increase chronic disease screenings in rural areas. When non-governmental and governmental agencies partner with churches and barbershops, the next step is to disseminate awareness campaigns via social media, television, radio, newspapers, social groups, church, and community meetings. Based on the study findings, when these awareness campaigns of available preventive measures occur while providing chronic disease information to individuals about the importance of early detection, there is a greater chance of increasing health literacy.

A second recommendation to ensure successful collaboration for churches and barbershops is to create a program incorporating the community colleges and university students needing internships in the nursing and health care degree types. With the program, local and state colleges and universities could provide access to their health care technology to local barbershops and churches and let students who are obtaining their degree and in need of internship hours earn those hours working locally in the community. These collaborations cost the colleges no extra money because they already have the technology and do not cost the churches or barbershops any additional cost beyond the community event itself and advertising and promotion costs.

The third recommendation includes a referral program after developing preventive screening programs to ensure participants get health treatment after the initial disease screening. After each preventive screening, every church member and barbershop customer would get a referral to a health care provider for a follow-up, depending on the

screening results. Additionally, there needs to be an institution of a quality assessment program to assess the outcome of the initial screenings to determine if the results are duplicatable at larger or smaller locations. The results from the assessments can aid local health departments and community leaders on how those preventive events could further increase access and lower chronic diseases of African American men in rural areas.

Strengths and Limitations of the Project

The systematic literature review process and the synthesis of the data collected to answer both practice-focused questions are strengths of this doctoral study. Another strength of this study was the positive reception from participants to be open and honest, which resulted in a perceived self-efficacy and abundance of knowledge to incorporate community partnerships into chronic disease screenings in rural areas. The validity and reliability of the findings from the systematic review increased due to using various peer-reviewed articles. The small sample size of the doctoral study could also challenge the accurate representation of the targeted population. Larger sample sizes could improve transferability to different ethnic groups, communities, and religious groups for future studies. The limitations within this study can influence credibility and transferability for future research, thus weakening research findings (Goes & Simon, 2017). Purposive sampling could create a potential limitation. However, the proper selection of actively religious or spiritual participants was essential to address the research questions.

Another limitation of this study was that all participants were from a rural area in South Carolina, and consequently did not represent the general population of South Carolina. Additional limitations were inevitable due to the qualitative nature of this

research study. Researcher bias is another potential limitation of this doctoral study. To increase the data's trustworthiness, I developed an interview guide while taking detailed notes on each interview by utilizing triangulation, which included an audio recording of all interviews, transcription of all data, and member checking. After completing the interview transcriptions, all participants had the opportunity to review responses for accuracy. During each interview, bracketing occurred to ensure my personal opinions and judgments on health care and preventive screenings did not influence participant responses and reduce bias.

I recommend that future research studies sample more than one rural area to ensure a more representative sample. While providing a better understanding of how some of the social determinants of health impact preventive care screening services in rural areas, this study still has more areas left to research. Future studies should explore how social determinants of health limit accessibility to preventive care services related to chronic diseases among African American men in rural areas. Recommendations for future research addressing a similar topic and using similar methods focusing on face-to-face interviews and focus group discussions. By focusing more on the face-to-face interactions, a researcher can better assess participants' responses and personal views on an in-depth level not always captured in a phone or virtual interview.

Section 5: Dissemination Plan

Dissemination Plans

The primary purpose of this dissemination plan is to increase public confidence in the findings of this qualitative study, raise awareness regarding the impact of chronic diseases, and increase the utilization of preventive care services to decrease mortality rates in the African American male community. Two primary reasons for research are creating change and raising awareness around a specific issue (DeCarlo et al., 2020). The dissemination of the research findings can assist public health officials, health care professionals, community leaders, and community barbershops and churches increase African American men's utilization of preventive care services by identifying the barriers to their utilization of such services. Dissemination of a research project is essential to close the research-practice gaps across public health and other disciplines. When there is an inability to apply new information from research, health inequalities and deficits will continue (Brownson et al., 2018). While this information is valuable to share with those interested in the subject matter, it is also critical to share with individuals unaware of the disparities impacting the underrepresented population compared to other races and ethnic groups. Prior research has shown that even though the most popular dissemination methods are academic journals and conferences, disseminating research to nonresearched audiences is equally essential (Brownson et al., 2018).

These research findings can aid in the development of intervention strategies to increase accessibility and empower individuals' self-care. Ineffective dissemination is part of the gap between research becoming public health knowledge and the findings

being applied in real-life settings (Brownson et al., 2018). I will initially disseminate the findings of this doctoral study through PowerPoint presentations to the partner organization, a A.M.E. church, and then to other Black churches that are interested in the health of African American men in the community. One strength of this dissemination plan is that multiple community leaders, professional peers, and residents in the local community are interested in the subject matter and encourage the implementation and sharing of different ideas to increase health promotion in rural areas. In this section, I detail the dissemination plan developed for the research findings of this qualitative case study.

Dissemination Audiences

Effective dissemination must factor in the source, audience, and channel (Brownson et al., 2018). Various channels, like scholarly publications, reports, formal collaborations, and websites, can be used to effectively disseminate the research (Carpenter et al., 2014). I plan to disseminate my research findings via publication in ProQuest after receiving the approval of the Office of Research and Doctoral Services. After receiving final approval, this doctoral study will be accessible to other students and available in the Walden University Library. I plan on submitting abstracts from my doctoral study to health journal publications targeting underrepresented populations, low-income families, and rural communities. Publication of the results through reputable health care journals would provide an opportunity to reach a broader audience, including policymakers, health care professionals, health care students, and the public. Ongoing

implementation of this project at community health fairs, barbershops, local churches, and health promotion events in rural areas is another phase in dissemination.

This dissemination plan primarily targets public health officials, community leaders, health care professionals, and policymakers. The audience characteristics are critical when developing a dissemination strategy. Public health has two primary audiences for dissemination: public health practitioners and policymakers. Rural health clinics, primary care physicians, and nurses are the frontline workers in managing chronic diseases, which is why there is the greatest need to provide them with the tools to educate patients on preventive care services. Health care professionals, community leaders, and policymakers are an appropriate audience for the research findings because their support would aid significantly in the implementation of community partnerships and collaborations of preventive care interventions.

Summary

The overarching goal of this doctoral study was to gain a deeper understanding of how social determinants of health may impact the utilization of preventive care services by African American men in rural areas. I have a passion for improving the quality of health for African American men and women but determined early on that men had the more urgent need. I hope that the data from this study can be a catalyst for community partnerships with community colleges, health departments, barbershops, and churches to decrease the number of men who suffer unknowingly from chronic disease conditions. My long-term goal is to find and develop new strategies to increase access to and utilization of preventive care services in pursuit of improving the lives of the

marginalized and underrepresented served population in South Carolina. Increasing knowledge and awareness of the barriers to preventive care services for African American men is crucial for developing sustainable improvements for underrepresented populations in rural areas throughout the United States.

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Appendix A: Interview Questions

Research Question 1: What social determinants impact the decision-making process to utilize preventive health care services by African American men in rural areas in South Carolina?

Social Determinants of Health	Questions	Answers
Economic Stability *Employment Income*	What is your current employment status?	• Full-time • Part-Time • Self-Employed • Leave of Absence. • Unemployed but not seeking work (i.e., retired, disabled) • Unemployed and seeking work
	If employed, how many jobs do you work?	• One job • Two jobs • Three or more jobs
	If employed, do you have insurance?	• Yes • No
Neighborhood and physical environment *Housing Transportation Safety*	What is your current housing situation?	• I have housing, and I am not worried about losing it • I have housing, and I am worried about losing it • I do not have permanent housing (staying with others, in a hotel)
	How many family members, if any, do you currently live with?	*Open-ended answer from participant*
	Do you feel physically and emotionally safe where you currently live?	• Yes • No (If no, please explain why you feel unsafe where you live?)
	Have you or any family members in your household been unable to get any of the followed when it was a necessity in the past year?	• Food • Clothing • Utilities • Child Care • Rent/Mortgage

<u>Health Care System</u> *Health Coverage* *Quality of Care* *Access to care*	Do you have any health insurance coverage, including Medicare, Medicaid, government, or employer plans?	• Yes • No If not, please elaborate on why not?
	Have you had trouble affording the costs of health insurance or medications in the past year (including premium, co-payments, deductibles, coinsurance, etc.?)	• Yes, I have had trouble paying for health insurance. • Yes, I have had trouble paying for medications. • Yes, I have had trouble paying for both. ✓ If yes, please elaborate. • No
	Have you had trouble getting access to any of the following when needed in the past year? **(Check all that apply.)**	• Health insurance coverage • Mental health care • Medical health care • Dental care • None of the above
	Have you ever been told in the last year that you have any of the following medical conditions? **(Select all that apply.)**	• High Cholesterol • Obesity • Kidney Disease • Asthma • Diabetes • Heart failure • High Blood Pressure
	Tell me about your health.	*Open-ended answer from participant*
	Tell me about your experience in accessing health care services.	*Open-ended answer from participant*
	Tell me about your experience with health care professionals when receiving health care services.	*Open-ended answer from participant*
	Please share why you think going to a primary care doctor may or may not be important.	*Open-ended answer from participant*
	What do you understand about chronic disease prevention and screenings?	*Open-ended answer from participant*
	What are your attitude and beliefs toward chronic disease preventive screening?	*Open-ended answer from participant*
	Please share how you feel about going to a preventive care wellness visit and how you think it would affect your general health?	*Open-ended answer from participant*

<u>Community and social context</u> *Support systems* *Community engagement* *Social integration*	How often do you see or talk to people that you care about and feel close to? (Do you talk to friends on the phone, visit friends or family in person, go to church or social outings?)	• Less than once a week • 1 or 2 times a week • 3 to 5 times a week • 5 or more times a week
	How often do you get the needed social and emotional support from your friends and/or family?	• I think they would be supportive and try to help motivate and ensure success. • I think I would have some support. • I do not think my friends and/or family would help or support me.
	Are you aware of any resources available in your community for chronic disease screenings? If so, what are they, and have you utilized them? If so, but you have not utilized them, then why not?	*Open-ended answer from participant*
	Are there any resources you would like to see offered in your community to increase accessibility to chronic disease screenings?	*Open-ended answer from participant*

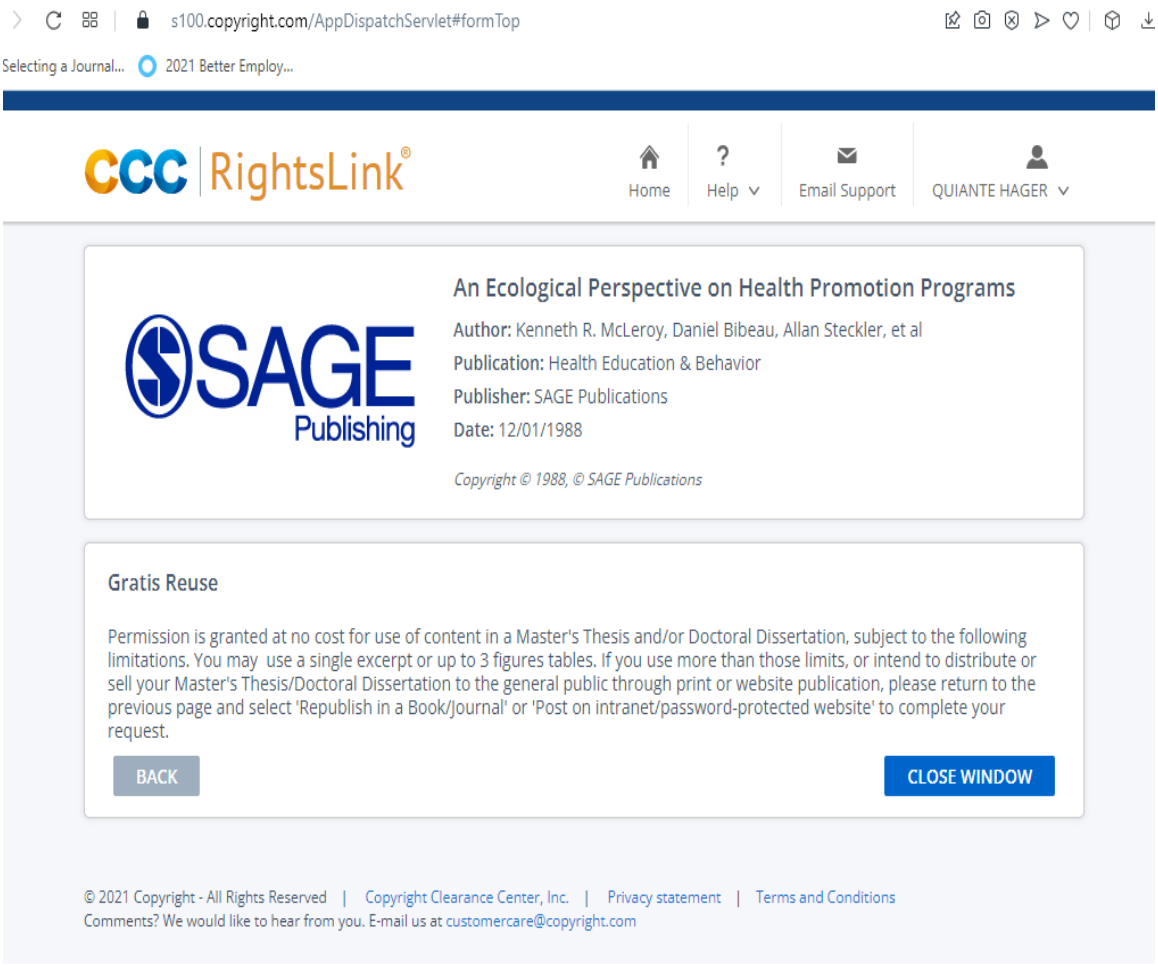
Research Question 2: What role, if any, do the African American church and barbershop play in addressing health disparities in rural areas in South Carolina?

Questions	Answers
Would you consider yourself…?	• Very religious/spiritual • Somewhat religious/spiritual • Not very religious/spiritual • Not religious/spiritual
How often do you attend church and/or church activities?	• Daily • Weekly • Two or more times per week • Monthly • Rarely or never
Do you feel that your faith and personal beliefs impact your health and decision-making process when seeking medical care? If so, how?	*Open-ended answers from participant*
Do you believe there are things the church or the local community could or should be doing to improve your health situation now? If so, what?	*Open-ended answers from participant*
Do you go to barbershops for haircuts?	• Yes ✓ If yes, how often in a 30-day timeframe? • No
How often do you come to the barbershop in a 30-day period?	• Weekly • Biweekly • Monthly
How often have you changed doctors compared to barbers? Please elaborate on why.	*Open-ended answers from participant*
Would you take advantage of the services if preventive health care screening services were offered at no cost at the barbershop? Why or why not?	*Open-ended answers from participant*
If free preventive care services were offered, would you prefer to receive them in the barbershop or at a local doctor's office, and why?	*Open-ended answers from participant*

Appendix B: Demographics Questionnaire

Questions	Answers
What is your age?	• 21-35 • 36-50 • 51-64
What is your current marital status?	• Single, never married • Married • Separated • Divorced • Widowed
What is your highest level of education completed?	• 9th-12th grade, no diploma • High school diploma or GED • Technical or Vocational college • Some College • College Graduate. • Postgraduate or Professional Degree (MD, JD)

Appendix C: Permission letter to use Social Ecological Model



Appendix D: Permission letter to use Health Belief Model