OVERTOWN MEN'S HEALTH STUDY

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COLLINS CENTER
FOR PUBLIC POLICY

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A REPORT BY THE

COLLINS CENTER FOR PUBLIC POLICY
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Miami

THE GROWTH PARTNERSHIP

Cover art: *View* by Evelyn Medina

Overtown Men's Health Study
ACKNOWLEDGEMENTS

An endeavor which begins in modest curiosity and follows an uncharted path to an unforeseen destination will owe its evolution to the grace of many hands. The Overtown Men's Health Study, as just such an endeavor, has benefited from the work, support, guidance, and faith of many wonderful people.

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EXECUTIVE SUMMARY

The Overtown Men's Health Project is an ambitious undertaking by two programs—Community Voices Miami, based at the Collins Center for Public Policy, and the The Growth Partnership, also a Collins Center initiative. The collaboration is supported by the W. K. Kellogg Foundation, the National Center for Primary Care at the Morehouse School of Medicine, and the John S. and James L. Knight Foundation.

At the center of the Overtown Men's Health Project is a detailed study, the Overtown Men's Health Study. The study utilized a survey instrument designed for the historic African American neighborhood just north of downtown Miami, Florida USA. The extensive questionnaire, administered during the spring of Y2005 to men in Overtown ages 18 years and older, assessed health status, behaviors, knowledge, and access to care. The questionnaire also captured sociodemographic data to render a richer picture of men's social and economic experiences in Overtown, asking about such matters as incarceration, homelessness, police-involvement, education, and employment.

The final sample includes 129 men of whom:

- 95 percent are African American;
- 55 percent have high school diplomas;
- 9 percent have college degrees;
- 40 percent are employed; and
- 53 percent earn less than US$10,000 per year.

Some of the most striking findings include:

- Two-thirds have been in jail or prison;
- 28 percent have lived on the streets;
- 1 in 4 has lived in a shelter;
- 1 in 5 received dental care in the previous year;
- 60 percent live with bodily pain;
- For 29 percent, the hospital emergency room is their primary health care facility;
- 47 percent smoke cigarettes;
- More than 1 in 4 is a victim of police violence;
- 60 percent report restlessness;
- 29 percent feel worthless;
- 60 percent feel "everything is an effort;" and
- 55 percent feel disabled to some degree by the state of their mental health.

While the study was not designed to make causal determinations about the phenomena it examines, we regard the findings as a call to action issuing from Overtown and similar communities. We recommend urgent pursuit of the following measures:

- Integrated approaches to service delivery, including outreach-oriented models like community health workers and social service navigators;
- Ex-offender community re-entry services and support, including the removal of statutory and regulatory barriers and repeal of the second-class status effectively accorded ex-offenders;
- Supported housing offering residentially-based self-sufficiency services;
- Supported employment to negotiate barriers to self-sufficiency through work; and
- Integrated health services, including oral and mental health care, accessible to poor and working-poor men.

We see men's health as inter-related and interdependent with women's health, child health, and community health. These issues taken together as public health must be permitted into the discussion of neighborhood revitalization and community development. Understanding men's health as a key component of public well-being and community vitality will focus our attention on unmet needs that are weakening the social structural fabric in distressed neighborhoods. Addressing the source of these vulnerabilities, we enable the well-being and family, civic, and economic participation essential to strong communities.

INTRODUCTION

PROJECT HISTORY

The central impetus for the Overtown Men's Health Study was programmatic. As policy analysts working toward socially equitable redevelopment of the neighborhood and access to social services for residents, we encountered at each turn a dearth of data about the residents. Particularly striking was the absence of primary experiential, behavioral, and attitudinal data about residents. Who are they? What do they do? What are their lives like? and What do they have to say about them? were questions we posed frequently, whether the topic at hand was how to provide affordable housing, social services, workforce development training, or civic leadership and business opportunities.

We had concern about health in particular. Many of the most socioeconomically marginal of Overtown's population seem to bear signs of the neighborhood's distress on their bodies—missing and damaged teeth, twisted and injured limbs, latter-stage syphilis rashes in the palms of hands, and what are to the habituated eye markers of long-term substance abuse. Even concerning the relatively more fortunate residents who are housed and in no apparent physical distress, we had questions about their health status and whether they are able to garner the resources to manage it.

The larger context of the study of men's health in Overtown is the convergence on one small neighborhood of many phenomena that constitute urban distress. Decades-long socioeconomic decline, isolation, and neglect of the historic African American neighborhood have set the stage for revitalization planning and the sharp and rapid increase in land values that precede the mainstream reclamation of the urban core.

As policy analysts concerned about transforming neighborhoods, it is important that we understand the realities and the current pressures—particularly the revitalization or gentrification pressures—that residents are beginning to feel in Overtown. Our programmatic approaches, for instance, to developing affordable housing and cultivating civic engagement are predicated on the notion that neighborhood realities and pressures are relevant to social and economic experience in the neighborhood. From this broad perspective, the Overtown Men's Health Study is only a very modest first step toward quantifying the relevance of social, political, and economic realities in the neighborhood to residents' experience. The men's health study provided an opportunity to pose some of our questions about experience, behaviors, and attitudes to the neighborhood's adult male population.

Initially, we envisioned the Overtown Men's Health Project as a series of four or five health fora and a small adjunct study attempting health-promoting behavior modification with six to ten men. However, we regarded the barriers to health care access for men in Overtown as an intolerable contradiction to sustainable support for the very preventive measures the fora were to advocate—whether for routine screenings, a primary health practitioner relationship, or pharmacological management of chronic conditions.

A study of men moved to the center of our endeavors, and we began developing a measure to capture data about men's health, sociodemographic characteristics, and experience in Overtown. We insisted upon a level of academic rigor rarely characteristic of efforts to engage residents in the neighborhood. At the same time, we relied upon a ground-up sensibility to customize the survey content and the data-gathering methods. We wanted to gather very personal data from men about their health and social experiences, even as we approached with an objectivity and technical seriousness the information with which they entrusted us.

Timeline

The Overtown Men's Health Project began in the early fall of Y2003 with the invitation to collaborate extended by Community Voices Miami to the Overtown Civic Partnership and Design Center.[1] We arrived at the decision to make the centerpiece of the project a study focused on men's health status and experience in Overtown in mid-Y2004, and field piloting of the survey instrument began that fall. We collected data using the final version of the instrument in March and April 2005. Analysis of the data began the following month, in May 2005, and the first presentations of findings were made in June 2005 and October 2005.

The Overtown Civic Partnership and Design Center

The Overtown Civic Partnership and Design Center, an initiative of the Collins Center for Public Policy, worked on many fronts—economic development, social services enhancement, and policy and structural reforms—to revitalize the City of Miami's historically African American neighborhood and to improve outcomes for its 8,000 residents.

The Collins Center maintains that to overcome Overtown's harsh realities—an annual median family income of US$12,052, physical blight, perceptions of prevalent crime and danger, few businesses, poor public services and infrastructure, low- or non-functioning social service organizations and governance structures—requires intervention by an organization whose sole mission is to address the neighborhood's needs. At full staff, the Overtown Civic Partnership and Design Center (OCPDC) brought to the neighborhood a social anthropologist and public policy analyst, an urban planner, and a former municipal redevelopment director, providing Overtown a depth and breadth of expertise and a dedicated capacity unprecedented in the neighborhood.

OCPDC promoted affordable housing opportunities, mixed-income and mixed-use development projects, pedestrian-friendly streetscapes, and sufficient public green space. It also advocated institutional and structural transformation. Critical among its mandates was to create opportunities for institutions to work together in new ways in Overtown.

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[1]The work of the Overtown Civic Partnership and Design Center continues under two Collins Center initiatives: TGP (The Growth Partnership), a South Florida regional effort to encourage socially equitable, economically sustainable, and environmentally sensitive neighborhood revitalization, and OCP, Inc., a resident-driven effort to establish community ownership of revenue-producing assets to fund development of affordable housing and other benefits.

Initially formed as a working collaborative of several community development corporations and neighborhood organizations, OCPDC strove to create innovative partnerships between public, private, and non-profit entities and to leverage their resources in Overtown.

OCPDC's operational metaphor was a pipeline. The initiative worked to link service delivery systems in a manner customized for Overtown residents' needs, for instance, aligning workforce development, employment sources, housing opportunities, home-buyer subsidies, resident leadership development and civic engagement, health care, and public safety. Inserting the joints, so to speak, between these resources, OCPDC attempted to organize and connect them to allow residents to access them in an integrated fashion.

An important part of the work of OCPDC was several initiatives to improve day-to-day experience and well-being among Overtown's current residents. Well-being is an expansive notion that presumes physiological health, financial health, civic participation, and personal satisfaction as the inextricable features of functional communities and individuals. OCPDC undertook a number of economic and social cooperative ventures in collaboration with residents, local leaders, institutions, and other stakeholders. OCPDC encouraged civic engagement among residents by supporting community stewardship at the city-block level.

OCPDC's pursuit of physical, institutional, and experiential transformation in Overtown was calculated to inspire and influence the redevelopment of the neighborhood in the interest of its current residents. The work of OCPDC continues in a streamlined fashion under the broader, regionally-focused Collins Center initiative called The Growth Partnership (TGP) and with the incorporation of the resident-driven cooperative venture OCP, Inc.

Community Voices Miami

In 1998, the W. K. Kellogg Foundation launched a nationwide initiative called "Community Voices: Healthcare for the Underserved," and Miami was one of 13 designated program sites in the U.S. During its first five years, Community Voices Miami focused on convening the community's health care providers, consumers, and stakeholders to work toward the goal of improving access to health care for uninsured and underserved residents of Miami-Dade County.

With renewed support from the Kellogg Foundation, Community Voices Miami moved to the Collins Center for Public Policy in June 2003. Upon joining the Collins Center, Community Voices Miami undertook to examine health policy in the areas of case management, behavioral health, community health workers, men's health and oral health. With the five new priorities, Community Voices Miami built upon its previous areas of focus: school-based health and tobacco cessation and prevention in youth populations. Community Voices Miami continues work in all seven areas.

The Overtown Civic Partnership and Design Center and Community Voices Miami shared the belief that improving a neighborhood's health profile is integral to its revitalization. Initially through OCPDC, and now through The Growth Partnership, Community Voices Miami is reaching out to the community of Overtown to uncover the main health and wellness issues, to seek innovative means of addressing them, and to facilitate the implementation of solutions. Community Voices Miami's policy goals for men's health are to work with community stakeholders to:

1. Increase awareness of health issues unique to men, both among men in distressed communities and at the policy-making levels;
2. Increase awareness among men of the importance of accessing preventive and primary health care and to enhance their capacity to do so;
3. Develop and advocate insightful alternatives to the lack of publicly-funded programs (*e.g.*, Medicaid) for men; and
4. Provide compelling evidence of the relationship between a physiologically, behaviorally, and mentally healthy community and the successful economic and sociocultural redevelopment of distressed neighborhoods.

COLLABORATIVE STRUCTURE

The primary collaborative partners in the Overtown Men's Health Project were Community Voices Miami and The Growth Partnership. The Growth Partnership's Director of Community Development April M. W. Young was the study's principal investigator. Assistant Professor of Social Psychology Dr. Stephanie Fryberg at University of Arizona led statistical analysis of data and provided extensive guidance on design of the measure. Stanford University Associate Professor of Social Psychology Dr. Jennifer L. Eberhardt and doctoral candidate Hilary Burbank provided invaluable assistance with design of the measure and interpretation and presentation of findings. Supporting the work and providing technical assistance for the preparation of this report were Dr. Henrie Treadwell and Dr. Kisha Braithwaite of the National Center for Primary Care at Morehouse School of Medicine. Also providing technical assistance with interpretation of data and presentation of this report was *American Journal of Public Health* Editor in Chief Mary Northridge.

Local partners Jefferson Reaves, Sr. Health Center, Camillus House, and Camillus Health Concern collaborated to serve as designated destinations for study participants indicating desire for medical appointments and case management services. The Miami Chapter of 100 Black Men, Inc. provided volunteers who underwent training and assisted with data collection.

Andrea N. Copeland, community leader and resident of Overtown led development of the data collection site plan, assisted with recruitment of study participants, and administered a great many surveys. Overtown resident Romando "Sweet" Battle facilitated the participation of many of those study participants living in very compromised conditions whose experiences quite explicitly illustrate distress.

DEVELOPMENT OF THE SURVEY INSTRUMENT

We developed the survey instrument over a period of about one year. Its evolution followed the range of partners, interests, and practical exigencies influencing the Overtown Men's Health Project throughout its history.

An initial narrow focus on physiological health yielded a brief model not terribly dissimilar to assessment forms health service facilities employ for an initial patient visit.

The survey instrument transformed as we inched toward the realization that the level of distress in the neighborhood meant any attempt at service delivery by the Overtown Men's Health Project would be of passing effect at best. The decision that a study was the most significant contribution we might make with our resources, and that a study should therefore be the centerpiece of the Overtown Men's Health Project, profoundly changed the importance and scope of the tool we were developing.

That there existed only the most basic empirical data about people in the neighborhood meant the Overtown Men's Health project presented an opportunity to learn not only about men's health but about their socioeconomic circumstances. A near utter dearth of experiential data meant it was a short leap thereafter to insist upon incorporation of sociocultural experience—police violence, incarceration, shelter residency, for instance—into the information we would seek.

We also looked to the National Health Interview Survey for items we might include. Enabling comparison between our neighborhood and other urban areas was an exciting prospect. Ultimately, however, several of the National Health Interview Survey (NHIS) items in which we were most interested had a "double-barrel" structure, entangling two or more variables of critical interest to us independent of one another.[2] In other instances, we felt compelled to adapt items to make them more appropriate to our context.[3] In the end, we traded direct comparability on most of the data points for a

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[2] For instance, an item in the NHIS Questionnaire reads, "Have you ever spent more than 24 hours living on the streets, in a shelter, or in a jail or prison." A study participant's affirmative response to the question would indicate he has had at least one of the three experiences. Without further clarification, which of the experiences (one or more) he has had would be unclear. For our purposes, we wished to measure the discrete frequencies of homelessness, shelter residency, and incarceration among the study population.

[3] A perhaps subtle but nonetheless compelling example is an item in the NHIS Questionnaire querying HIV risk factors. On the NHIS Questionnaire, the item reads:

> Tell me if ANY of these statements is true for YOU. Do NOT tell me WHICH statement or statements are true for you. Just IF ANY of them are.
>
> (a) You have hemophilia and you have received clotting factor concentrations.
> (b) You are a man who has had sex with other men, even just one time.
> (c) You have taken street drugs by needle, even just one time.
> (d) You have traded sex for money or drugs, even just one time.
> (e) You have tested positive for HIV (the virus that causes AIDS).
> (f) You have had sex (even just one time) with someone who would answer "yes" to any of these statements.

We incorporated this item into our survey instrument, but with an adaptation. Statement (d) we edited to reflect the range of possible transactions for which we know sex can serve as currency in our study context. Thus, in the Overtown Men's Health Study questionnaire, the statement reads: "You have traded sex for money, drugs, *food, shelter, or other favors*, even just one time" (emphasis added).

richer sense of our particular neighborhood and for results more precisely customized to our questions about our participant population.

We also constructed our survey instrument to capture data about the relationship between social identity and health-promoting and health-limiting behaviors.[4] This body of work Dr. Stephanie Fryberg is developing has been based thus far on data gathered among Native American, Anglo, and indigenous Mexican populations. The Overtown Men's Health Project presented an opportunity to assess the relationship between social identity and health behaviors among an urban male population that is predominantly African American.

Assessing the relationship between social identity and health behaviors involves analyzing scaled responses about the centrality to daily life of food-related behaviors, exercise, and other activities. It also involves measuring the intensity of identification with one's self-described social (racial/ethnic/cultural/national/linguistic) group using an adaptation of the Tsai Ethnic Identity Measure.[5]

Concerns about the length of the interviews constrained us on particular subjects in ways we regret. For instance, it would have been interesting to learn details of the incarceration experience such as the frequency and duration of men's time in correctional institutions, the nature of offenses charged and at what ages. We might have pursued the housing issues at a greater level of complexity. Further, we might have liked to know about circumstances of their upbringing, such as parental (or grandparental) presence in the household, and the occupation and income of their primary caregivers.

However, given that in the pilot stages, interviews often ran nearly one hour, we were obliged to omit rather than expand the queries included in the survey.

Overall, the Overtown Men's Health survey instrument draws upon approaches from two disciplines: social psychology and cultural anthropology. Its grounding in traditions of social psychology is reflected in the framing and organization of items in the measure for systematic analysis. The sharp focus on respondents' experience and the allowance in the measure's structure for personal anecdotes resonate with anthropological approaches to data-gathering.

The measure is extensive, including more than 100 data points. As we deployed the instrument in the field, we found it was successful in the ways we had hoped. Expressing its hybrid pedigree, it functioned as a questionnaire, organizing information for systematic analysis, and also as an interview tool or a guide for holding a very personal discussion with a study participant about himself.

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[4] It is intended to report findings on the relationship between social identity and health behaviors from the Overtown Men's Health Study in a subsequent publication.

[5] Tsai, J. L., Ying, Y., and Lee, P. A. (2000). The meaning of "being Chinese" and "being American": Variation among Chinese American young adults. *Journal of Cross-Cultural Psychology, 31(3)*, 302-322.

This straddling of disciplines and the practical duality in the way we used the survey instrument reflect our desire to both capture experience richly and deeply, and to examine it systematically for broader clues to the connections among experience, identity, and health outcomes in Overtown.

VOLUNTEER SURVEY ADMINISTRATORS

The Overtown Men's Health Study was principally an opportunity to gather data about men in the neighborhood. However, it was also an occasion for a few people from outside Overtown's boundaries to visit the setting marked by its social and physical separateness from other parts of the city, and to have an extended conversation with some of its residents.

In addition to the principal investigator and the neighborhood resident volunteer, seven people administered the surveys that comprise the study's final sample. Four additional volunteers were involved in survey administration during the pilot phases of the study. They each offered several hours to the project—to receive training, to observe and practice administering the questionnaire, and, finally, to conduct interviews and complete questionnaires with study participants. The volunteers were from many parts of the Greater Miami area: Miami Beach, Coconut Grove, Coral Gables, Bayside, Goulds, and Downtown Miami. One of the pilot phase volunteers was from Paris, France.

Among the volunteers were varying levels of familiarity with Overtown. They represented a range of professions: social worker, legislative staffer, health policy advocate, real estate agent, paralegal, property developer, global policy analyst, non-profit CEO, municipal policy maker, flight attendant, and psychologist. Several remarked about the enriching nature of the exchange with study participants. They also appreciated the deeper insight into the neighborhood that the interviews and the on-site experience yielded. They found the challenges facing particularly the younger study participants especially moving—the prevalence of joblessness, early fatherhood, the experience of incarceration, and the limited access to health care.

The principal investigator recruited and selected the volunteers primarily for their capacity to connect with people. Other considerations were their compassion, general curiosity, and the anticipation that they would appreciate the gravity and significance of the project and that they would recognize and be moved by the dignity of the residents of Overtown. Essentially that is to say, the volunteers were people who could be trusted with the precious endeavor to record the reflections of a study participant about himself and his experiences.

PROCEDURAL ETHICS

Due to the fact that the Collins Center for Public Policy is not affiliated with a university or a health institution, we were not obliged to submit our study procedures to the formal scrutiny of an internal review board on the use of human subjects for research.

Nevertheless, we carefully followed principles outlined in Stanford University's Human Research Protection Program. The central principles are:

- Respect for persons, applied by obtaining informed consent, giving consideration to privacy and confidentiality, and adding protections for vulnerable populations;
- Beneficence, applied by weighing risks and benefits; and
- Justice, applied by the equitable selection of subjects.

All parties involved in the conduct of work are also to adhere to the principles of expertise evidenced by competence to execute the research tasks, and to integrity evidenced by faithful adherence to professional principles.

The principles are contained in the guidelines of Stanford's Administrative Panel on Human Subjects in Non-Medical Research. This administrative panel is the university's Institutional Review Board (IRB) for non-medical research projects involving human subjects. The primary concerns of the IRB are that:

- Risks are minimized for subjects and are reasonable when compared to benefits;
- Participant selection is equitable;
- Privacy and confidentiality are protected;
- Participants are adequately informed of what their participation will entail (*e.g.*, risks and benefits) including written and signed informed consent in most cases; and
- A plan exists for monitoring research.

We took great care to ensure that approaches, policies, and activities in the Overtown Men's Health Study honored Stanford University's research principles and guidelines for research with human subjects in an uncompromising fashion. (See details of the study protocol in the "Methods" section.)

NEIGHBORHOOD CHARACTERISTICS

Overtown is an historically African American neighborhood north of downtown Miami. The 15-by-7 block area is home to approximately 8,000 residents, down from its heyday peak of 40,000. Ninety percent of current residents are African American. It is a young population, with 40.8 percent of residents under age 20.

Miami is consistently very near the top of the list of the poorest metro areas in the U.S., and Overtown is Miami's poorest neighborhood.[6] Fifty-five (55) percent of the population lives under the poverty level, and the median annual income is US$12,052.

At the same time, Overtown is adjacent to areas that have placed Miami among the fastest growing real estate markets in the country. Miami has been described as one of the most vigorous condominium markets in the world.[7] As a result, Overtown has found itself surrounded by high-end real estate development, both residential and commercial (see Appendix A). Evidence that Overtown is implicated in the upward market pressures is seen in neighborhood land values that have in some instances quadrupled between Y2003 and Y2005.

A VIEW FROM THE STREETS AND AVENUES OF OVERTOWN

The Overtown that residents experience differs markedly from the vision of developers and city planners—a centrally-located frontier for the next wave of half-million-dollar condominium units. The perspectives that residents shared with us about their neighborhood also differs from representations of Overtown put forth by neighborhood spokespersons and most-oft-heard dominant voices on the history and culture of the setting.

There is a colorful and richly textured consciousness of place shared among the people who inhabit and experience their day-to-day in the space that is the neighborhood of Overtown. Encoded in its locations—the specific streets, intersections, blocks, groupings of buildings, and vacant lots—is the subtle nature of events, residents, visitors, encounters, and transactions that are the substance of the neighborhood's everyday social life. The researchers who collected the data for the Overtown Men's Health Study—moving through the streets, visiting the housing complexes, spending time among squatter groups behind buildings or under trees, participating in the loitering that

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[6] According to the U.S. Census Bureau's Y2003 figures, the nation's ten poorest cities are Cleveland, Ohio; Newark, New Jersey; Detroit, Michigan; Fresno, California; Miami, Florida; El Paso, Texas; Long Beach, California; Atlanta, Georgia; Memphis, Tennessee; and Philadelphia, Pennsylvania.

[7] In a report released in Y2005 entitled "Mega Metro Bubbles," Merrill Lynch & Co. ranked Miami the hottest housing market in the U.S. for the third consecutive year. According to South Florida real estate research and consulting firm Integra Realty Resources, the median price for new condominiums more than doubled in the decade 1993 to 2003, from US$141,068 to US$305,804.

obstructs passersby on the sidewalks—were privileged a momentary close-up of the neighborhood's human account and history of place.

We include here some of the most vivid location descriptions that communicate the character of social activity. We also share some of the site-level information we learned about a more sinister aspect of social experience in Overtown: the illegal drug trade. Certainly, the transactions and the players change, moving from place to place in the neighborhood, and from visibility to invisibility. Nevertheless, the traffic in illicit drugs is a fixture in the life of the neighborhood, though perhaps reluctantly acknowledged in various quarters.

The names of places in the neighborhood change as well, moving out of currency as they are displaced by catchier labels more relevant or compelling for a given set at a moment in time. We share below some of the place labels in vogue during the spring of Y2005:

- "Dunns Hotel" designates an area immediately surrounding a building on the west side of NW 3rd Avenue between NW 9th and NW 10th streets. The building has an engraved frontispiece bearing the name.

- "Swamp City" designates an area from NW 3rd Avenue to NW 7th Avenue, and NW 9th Street to NW 5th Street. It is regarded as Overtown's roughest, most degraded area in many ways—"low-down" and "out there," in the laconic descriptions of long-time residents.

- "Jurassic Park" is an area at the intersection of NW 15th Street and NW 3rd Avenue. It is one of the most animated areas in Overtown and the site of much social activity on Friday and Saturday nights in particular. A bar and a package store are located there in a blue building across the street from Crown Supermarket. A local resident nicknamed "Ting-a-Ling" sells conch salad under the building overhang on the weekends, and is known among Black folks throughout Greater Miami for the tastiness of his cerviche. We heard two rationales for the area's designation, which is borrowed from the 1990's film about a modern-day island taken over by genetically reengineered dinosaurs. One was that this area of Overtown is called Jurassic Park because "you never know what's going to come out of there." The other was that the bar in particular is frequented by middle-aged and older residents regarded as "dinosaurs" by younger folk.

- "Bucktown" is the former name for an area from NW 10th Street to NW 12th Street, and NW 3rd Avenue to NW 2nd Avenue, sometimes extending across the railroad tracks. In past days, "all the money" was in this area where major drug dealers trafficked.

- "Death Valley" is an area where NW 12th and NW 13th streets intersect with NW 1st Court and NW 1st Avenue near the railroad tracks. It is so named for the shootings and heroin overdoses that occur here.

- "Crack Park" is located around the Metrorail station where NW 8th and NW 9th streets intersect NW 2nd and NW 1st avenues. The "homeless smokers" of crack cocaine frequent this area.

ILLEGAL DRUG TRADE

During the data collection phases of the Overtown Men's Health Study in the spring of Y2005, the centrality of crack cocaine in the neighborhood's drug market was abundantly clear. Crack is often a currency, negotiable tender among the most marginal people, enabling access to a shower, some food, or the meager lodging of a receptive squatter. The impact of this short-acting, extremely addictive, cheap substance on these most marginal groups is visible in movements (the jerky but quick and very directed gait of the habitual smoker known as the "crack walk"), in an affect simultaneously desperate and playful, in the dark ashiness of the skin, and, among the exceedingly strung out, physical wasting, hair loss, and a kind of soul-lessness and a vacancy in the gaze.

While only a few participants in the study reported use of heroin, the trade in this insidious substance also registered its effect on the neighborhood. From our observations, the primary market for heroin commutes into Overtown from other area communities.[8] However, the vehicular and foot traffic, loitering, the trademark stupefaction of the heroin "nod," and the humiliating and desperate measures to which users are driven all leave an imprint on the character of the neighborhood.

Among neighborhood residents, heroin (pronounced "HEH-RÄN" in the local vernacular) has a popular association with the presence of strange others. "When you see white folks," which includes even darker-skinned Latinos, "that means heroin," we were told more than a few times. The area near NW 15th Street and NW 1st Court was known as the center of Overtown's heroin traffic. At almost any time of day, many non-residents moved about, loitered, and transacted business here.

Illegal drugs are packaged and marketed by various groups of dealers. At the time of data collection for the study, heroin and cocaine were being distributed in seven different packages or "bags." One might prefer the product in the Green Bag, Pink Bag, Orange Bag, Yellow Bag, or White Bag. Batman was the newest bag. A package known as Blue Devil contained heroin. All bags—except Blue Devil—were available with powder or rock forms of cocaine. One could buy, for instance, a Pink Bag with crack in it or could choose powder cocaine product.

The different bags are the products of various dealer groups. Yellow Bags were reputed to be the best at the time. The Batman Bag was regarded as second in quality and was the product of a new dealer group.

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[8] Evidence strongly suggests that like Overtown's heroin market, the trade in other illicit drugs relies primarily on non-resident consumers. According to the City of Miami district police commander for Overtown, during the period January 2003 to June 2005, 76 percent of the persons arrested for drugs were not residents of Overtown.

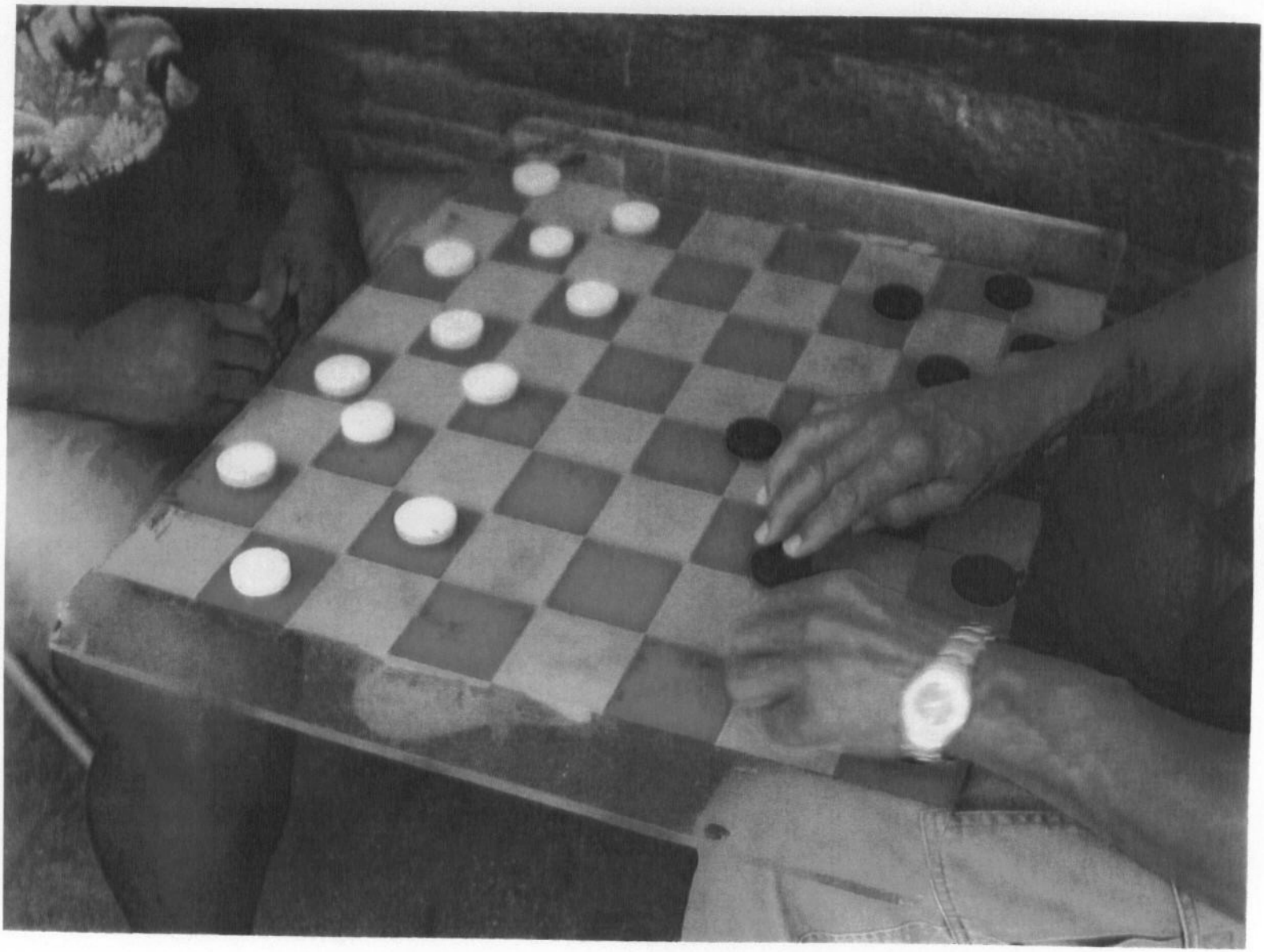
Local lore about areas within the neighborhood often contains references to the drug trade or its consequences, as is clear in residents' designations and descriptions of Bucktown, Death Valley, and Crack Park.

HOME, NEVERTHELESS

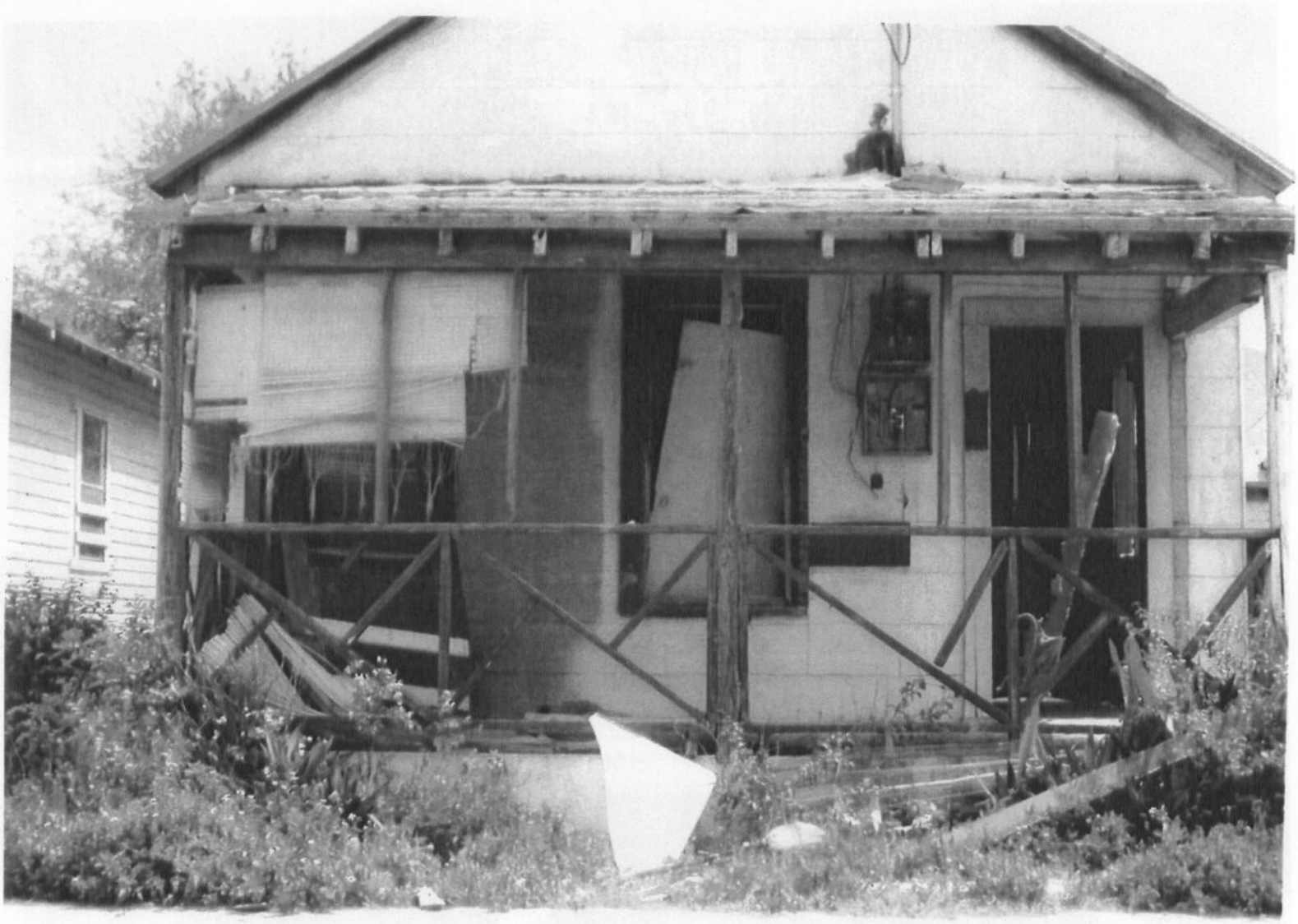
Despite the physical blight and obvious socioeconomic stress the neighborhood endures, Overtown generally has a lively character. There is often much social activity along NW 3rd Avenue and NW 2nd Avenue. Among residents, a level of comfort and familiarity consistent with home abides here. People know one another, and they know one another's families and histories. There is a palpable neighborhood pride.

Perhaps contrary to popular impressions outside Overtown, the principal investigator felt very safe in the neighborhood. She collected data, often alone, at various times of day, routinely very late into the evening, and was concerned neither for her personal safety nor property. Neighborhood crime statistics reflect a frequency of random violent crime rather lower than Overtown's reputation might suggest. Many offenses occur between acquainted parties, or in the predictably volatile exchange of drug transactions. Review of a random sample of 25 of the 59 police reports of violent crimes[9] from May 2006 gives dimension to Overtown's crime statistics and supports our assertions about the nature of crime in the neighborhood. Of the 25 police reports we reviewed, only six were accounts of incidents between unacquainted parties, and all six appeared to be drug-related.

[9] During May 2006, there was a total of 104 Computer Aided Dispatch (CAD) incidents in Overtown in which police made an arrest. In the categories of violent crime, there was 1 homicide, 6 robberies, 49 assaults and batteries, and 3 sex offenses.




DIAMOND
CAB




DUNN'S HOTEL
1947

BACKGROUND

The Overtown Men's Health Study gathered data about the health of men 18 years of age and older in the severely distressed historically African American neighborhood of Overtown, located in the City of Miami, Florida USA. Survey questions were designed to capture and measure health status, health needs and risks, health-related behaviors, attitudes about health, and access to health services. The mode of participant recruitment was direct approach by survey administrators at pre-determined sites throughout the neighborhood, and targeted adult males representative of the neighborhood's population of adult male residents. Participants were offered the option of follow-up in the form of case management services or assistance with scheduling appointments for health care. Participants were informed that they could choose to have no further contact, services, or assistance after completing the survey 35-minute questionnaire.

STUDY PARTICIPANTS

A total of 129 adult men (≥18 years of age) were surveyed at 15 sites throughout Overtown, which is a small, distinct neighborhood in the City of Miami, Florida bounded to the north by NW 20th Street, to the south by NW 5th Street, to the west by NW 7th Avenue, and to the east by the FEC Corridor (the railroad tracks of the Florida East Coast Railway). The data collection sites were: three housing complexes; three rooming houses; three commercial sites; the vicinities of two abandoned buildings/squatter sites; one large and one small public park area; and two civic/social services sites (a union hall and a community center).

All study participants were men 18 years of age and older who reside in the Overtown neighborhood of Miami, Florida. For purposes of the study, an Overtown resident was defined as a person whose primary place of residence is within the neighborhood's boundaries, or who, if homeless, answers yes to at least two of the three following queries about essential life activities: Do you spend most of your time in Overtown? Do you eat/take most of your meals in Overtown? Do you sleep most of the time in Overtown?

The study participant group included the vulnerable population of homeless men, as a significant and very visible proportion of Overtown residents is homeless.[10] Any profile that does not include homeless men would fail to accurately represent men's health in Overtown.

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[10] Estimates of homelessness vary, often widely, and are subject to question. A census of the homeless is conducted in Miami-Dade County twice every year. The total number of homeless persons in the county was 7,627 in March 2004, according to figures reported in the *City of Miami Consolidated Plan: Fiscal Years 2004-2009*. The same report marks the March 2004 number of homeless persons in Overtown at 128. In December 2005, Miami-Dade County reported 5,160 homeless, according to the *Miami-Dade County Homeless Trust Homeless Census Final Results: January 27, 2005* as reported in the Weingart Center's *Homeless Counts in Major US Cities and Counties*.

Individual survey administrators made first contact with each study participant at one of the pre-determined sites in Overtown listed above, and administered the survey immediately. Potential study participants who appeared to be part of the target participant group (males 18 years of age or older) were approached by the survey administrator and asked, "Do you live in Overtown?" Upon an affirmative response, the survey administrator would attempt to recruit the man's participation, asking, "Would you answer a few questions about men's health in Overtown? I am offering a Winn Dixie grocery store gift card worth fifteen dollars for your time."

The overwhelming majority of men approached were willing, many enthusiastically so, to participate in the study. There were only approximately 10 refusals among the 140 or so potential participants approached—a rate of 7.1 percent.

We attribute the overwhelmingly positive response to the survey among potential participants to their desire to speak and to be heard about their own lives and experiences. Many expressed pleasant surprise to be the subject of attention, both as individuals and as group members (Overtown residents, men, Black men), and that "somebody is concerned about *our* health."

INSTRUMENT

The survey instrument is a questionnaire containing 106 items. Previous iterations of the questionnaire were subjected to three-phase field testing and refinement before arriving at the final version.

VARIABLES

The survey instrument contained six primary sets of variables.

Demographic variables

- racial and ethnic identity and first-language group
- annual income, educational attainment, employment status
- marital status
- parenthood

Measures of subjective access to health care

- availability of health services
- satisfaction with health services
- geographic accessibility of health services

Measures of objective access to health care

- having a primary care practitioner
- having visited a health practitioner within the previous 12 months
- having had dental care in the previous 12 months
- having received influenza vaccination in the previous 12 months
- having been tested for HIV

Measures of physical well-being

- ratings of physical health
- ratings of intensity and frequency of bodily pain

Measures of mental well-being

- frequency of feelings of sadness, restlessness, nervousness, hopelessness, and lack of motivation in the previous 30 days
- the degree of impact of the feelings on daily activity in the previous 30 days

Behavioral and psychosocial health indicators

- incarceration history
- housing status
- illegal drug use
- tobacco use
- alcohol use
- HIV risk factors

Also part of the survey instrument were physical characteristics variables (height and weight); social identity variables measuring the associations between participants' social identity and health-promoting and -limiting behaviors; and specific morbidity variables capturing diagnosed physiological and mental disorders.

PROCEDURE

SURVEY ADMINISTRATION

A total of 129 completed questionnaires comprise the final sample from which the data set is drawn. One questionnaire was excluded from the final sample because the study participant was unable to complete the interview, and thus could not provide the survey administrator the information to complete his questionnaire.

The principal investigator administered 54.3 percent of the surveys ($n = 70$) in the final sample, followed by a neighborhood resident volunteer (24.8 percent; $n = 32$). Additional volunteers administered 20.9 percent of the surveys in the final sample ($n = 27$).

All survey administrators received extensive training by the principal investigator and had access to the principal investigator as they conducted the survey. Only the principal investigator administered surveys unaccompanied.

Each survey administrator was provided a script to guide her or his interaction with the potential and actual study participants from the initial approach to the submission of consent, questionnaire, and intake forms to the protocol director. In addition, survey administrators were each provided a clip board to the underside of which was attached an envelope for signed consent forms; at least two blue ink pens to write on the survey forms; one blank questionnaire form to complete per participant; and one US$15 Winn Dixie grocery store gift card to give to the study participant upon completion of the questionnaire form.

Potential study participants who appeared to be part of the target participant group of males 18 years of age or older were approached by an individual survey administrator and asked, "Do you live in Overtown?" Upon an affirmative response, the survey administrator would attempt to recruit the man's participation, asking, "Would you

answer a few questions about men's health in Overtown? I am offering a Winn Dixie grocery store gift card worth fifteen dollars for your time."

If the potential study participant agreed to participate, the survey administrator then proceeded to the presentation of the consent form, telling the participant that the consent form indicates his agreement to participate in the study and requires the survey administrator to give him the US$15 grocery card as compensation for his time. He was instructed that there were two copies of the consent form, both of which he was to sign, leaving one with the survey administrator and retaining one for his records.

The survey administrator then read the consent form aloud to the participant, while the participant followed along on his copy of the consent form.

Reading aloud the language of the consent form, the study participant was instructed about his rights as a participant. The survey administrator emphasized that the study participant's participation is voluntary and that he had the right to withdraw his consent or discontinue participation at any time without penalty. He was also instructed per the consent form that he had the right to refuse to answer particular questions and that his individual privacy would be maintained in all published and written data resulting from the study.

If the participant indicated that he desired clarification on any point, the survey administrator would return to the relevant language on the consent form. The survey administrators were strictly instructed not to attempt to paraphrase or otherwise depart from the content and language of the consent form.

Once the study participant was clear about the terms of the consent form, the survey administrator ensured that the participant received a copy of the consent form bearing his own signature, and the survey administrator retained one of the two signed copies, placing it in the envelope attached to the underside of the questionnaire clip board.

At each location, the survey administrators took care to draw each participant to a secure corner, outside an establishment, or to a sufficient distance to ensure they were able to complete the questionnaire with adequate privacy.

Once the consent forms were signed and a copy given to the participant, the survey administrator removed a blank questionnaire from its envelope and introduced the questionnaire to the participant, saying:

> I will read questions to you from this questionnaire. Some of them are yes-or-no questions, some ask about the degree of your experiences or feelings, and some ask you to rate how much you agree or disagree with certain statements. Some questions ask you about your choices and behaviors and the reasons you think or act a certain way.

If you'd like me to read something again, or you don't understand the question, let me know and I can read it to you again.

Remember that your answers are confidential. No one will know your name or that it was you who gave me these answers.

If you're ready, we'll begin.

The survey administrator then marked the participant's answers to each question in blue ink using one questionnaire form per participant. At this point, the survey administrator set the script document aside and read the survey questions from the questionnaire form she or he was marking on behalf of the participant.

Upon completion of the questionnaire form, the survey administrator would thank the participant for his participation in the study and would then give the participant the $15 grocery store gift card.

Before proceeding with any discussion of the follow-up options below, the survey administrator would secure the questionnaire form by placing it back in its envelope and sealing it. The survey administrator would slide the envelope through a slot in the box provided for this purpose. Only after securing and removing the questionnaire to the box would the survey administrator say to the participant: "If you would like to make a doctor's appointment and you need help doing that, we can assist you. Or if you feel you need case management services—help with concerns you have about your health, living situation, if you'd like counseling or other kinds of treatment, things like this—we can help you."

If the participant indicated that he would like follow-up assistance, the survey administrator removed an Intake Form from its envelope. The survey administrator instructed the participant as follows: "To assist you with getting the services you want, I'll need to take some information from you on this Intake Form. It will take about 15 minutes to complete the Intake Form. This is separate from the survey, and none of the answers you've given me to the survey questions will be disclosed or connected in any way to the Intake Form we're completing now. You will not be compensated for completing the Intake Form. Do you have any questions about this?"

The survey administrator would complete the Intake Form, place it back in its envelope, and seal it. The survey administrator would then slide the Intake Form through the slot in the box reserved for them. (The Intake Form box was separate from the questionnaire form box.) The survey administrator submitted both secure boxes to the protocol director immediately upon leaving the field.

CONFIDENTIALITY

Each consent form contains the participant's name and, where applicable, Social Security number. However, no personal identifying information about the participant was entered

on the questionnaire form, protecting the identities of participants and the information they disclosed.

For those participants expressing desire for case management services or assistance with scheduling medical appointments, the survey administrator completed a separate Intake Form. The Intake Form was kept apart from the questionnaire form to ensure the confidentiality of participants' responses to the survey questions.

The Intake Form includes identifying information, contact information, and personal information about health status, health knowledge, and behavioral risks. Participants were instructed that the survey administrator would submit the Intake Form to the study's protocol director.

SOCIODEMOGRAPHIC CHARACTERISTICS

Table 1 (see Appendix B) presents sociodemographic characteristics of the study participants.

The study participants ranged in age from 18 to 72 years, and the mean age was 40.2 years. The majority—95.3 percent—identify as Black/African American. The racial makeup of the study population fairly closely tracks the Census 2000 figure for Overtown, which is 90 percent Black. Three participants identified as Native American; 2 as "other[11]," and 1 as white/Anglo. Seven participants identified with multiple racial groups: 5 as Black and Native American; 1 as Black and white/Anglo; and 1 as Black and Asian.

Given the rich and complex range of phenotypes among the various cultural, ethnic, regional, and national groups in South Florida, and in keeping with Census 2000 approaches, Hispanic/Latino identity was queried separately from race. Two study participants indicated Hispanic/Latino identity, specifically Cuban/Cuban American.[12]

The popular history of Overtown locates many of its cultural traditions in the community of immigrants from the Bahamas and other Caribbean islands who settled the neighborhood in the 1800's. To learn about contemporary Caribbean island group affiliations in the neighborhood, researchers queried Caribbean descent by allowing participants to indicate their own or their parents' affiliation with one or more Caribbean national groups. More than one in four (25.6 percent) of the study population reported Bahamian descent. Another 12 participants (9.4 percent) reported descent from other Caribbean national groups.

Very few men in the study population reported being currently married (9.3 percent). Almost 70 percent report having never been married, and 14 percent indicated they are divorced. Most are fathers (59.7 percent), and of those, nearly half (49.4 percent) have more than two children. Almost 60 percent of the fathers have children younger than 18 years of age.

Only 40.3 percent of men in the study reported that they are employed and currently working for pay. Nearly 60 percent are not working—whether looking for work, neither working nor looking for work, or seasonally/temporarily employed but not working for pay at the time of their interview. Only 55 percent of study participants have a high school diploma or GED, and fewer than 9 percent have a college degree. Over half (53.1

[11] One of the participants self-identifying with the racial category "other" specified "Bahamian" as his racial group. The second participant self-identifying as racially "other" specified "West Indian" as his racial group.

[12] Both participants indicating Hispanic/Latino identity (specifically Cuban/Cuban American) self-identified racially as Black/African American.

percent) of the study participants report individual earnings less than US$10,000 per year, and 38.3 percent report a household income of less than US$10,000 per year.

HEALTH SERVICES

Table 2 (see Appendix B) presents data about the delivery of health services to study participants and their participation in health services.

Two in three (65.9 percent) of the men in the study described their health as "good" or "excellent," and 62 percent reported that compared to 12 months prior, their health was "about the same." However, nearly 40 percent reported that they have physical health problems and 60.5 percent reported experiencing some degree of bodily pain in the previous 30 days.

Only one-third of the men in the study indicated that they have a primary care physician or health practitioner. The hospital emergency room is where more than 1 in 4 (28.7 percent) go most often for their health care.

Just 1 in 5 (20.2 percent) had received dental care in the previous 12 months.

While over half (53.5 percent) indicated feeling disabled to some degree in the previous 30 days by their reported mood and depressive disorders, only about 12 percent reported needing mental health care, and even fewer (8.5 percent) had spoken to a mental health practitioner.

DRUG AND ALCOHOL USE

Table 3 (see Appendix B) presents self-reported drug and alcohol use data among the study population.

Well over half (62.8 percent) of the men in the study reported drinking alcoholic beverages. Of those who drink, 45.6 percent reported doing so three or more days per week, and more than 1 in 3 of them (34.5 percent) consumed six or more alcoholic beverages on the days they did drink.

Among the study participants 47.3 percent reported use of cigarettes.

The percentage of men in the study reporting use of illegal drugs was 40.3. Of those who reported using illegal drugs, 23.1 percent indicated they use crack cocaine; 28.9 percent use cocaine in powder form; 75 percent use marijuana; and 5.8 percent use heroin.

SOCIAL EXPERIENCES

Table 4 (see Appendix B) presents study participants' experiences with police violence, homelessness and housing, and incarceration.

Remarkably, 1 in 4 men in the study (25.6 percent) report having been victims of police violence. Of those who reported having been victims of police violence, all report the violence resulted in injury. Fifty-one and one-half (51.5) percent reported being

physically injured[13] and 69.7 percent reported being emotionally or psychologically traumatized. Notably, 10.1 percent of those who reported having been victims of police violence indicated that they still suffer from the injury or trauma at the time of the interview.

Almost 2 in 3 men in the study (65.9 percent) reported that they have been incarcerated.

The rate of homelessness—defined as living on the street, in a homeless shelter, squatting or illegally occupying a structure—among study participants was 22.5 percent. A remarkable percentage (38 percent) of men in the study had experience living on the street, and 26.4 percent have lived in a shelter.

Twenty-four of the 129 study participants elected to complete the Intake Form requesting assistance with making medical appointments or accessing case management and referral services.

[13] Thirteen of the study participants who reported suffering physical injuries from police violence offered details. Their accounts include reports of specific injuries such as a shoulder sprain, inflammation of wrists and hands from handcuffs, bites from police dog attacks, a broken ankle from kicks and stomps, head trauma from blows by a police radio, testicular damage from blows by a flashlight, and violent shaking. Four accounts are less specific, citing physical injury resulting from having been beaten up, roughed up, or thrown to the ground.

READING INTO THE STUDY FINDINGS

While it is anathema in many instances to be at all activist in the interpretation of empirical data, the researchers, funders, and program administrators involved in the Overtown Men's Health Study take seriously the charge to apply its lessons toward improving outcomes in vulnerable communities. The social-structural dynamics in a community such as Overtown are complex, and the study was not designed to elicit causal relationships in the phenomena we examined.

Nevertheless, we take some liberty below to hypothesize and here and there speculate about the meanings and implications of the data. Given the level of distress and the state of service delivery in the neighborhood, a distant, overly academic posture toward what we have collected and observed would feel rather too like indifference.

UNDIAGNOSED CONDITIONS

We devoted a good deal of time and effort in the Overtown Men's Health Study to capturing information about health conditions. We wished to know how many men have been diagnosed with a range of conditions—from diabetes to depression to sexual problems. We also wished to know whether men were following plans to control diagnosed conditions, and if not why not.

Our report rates of most diagnosed conditions were quite low. Only 9 study participants (7 percent) reported having been diagnosed with diabetes; 5 reported having been diagnosed with sexual problems of a physiological nature (4 percent); 1 reported colon cancer (0.8 percent); 1 reported prostate cancer (0.8 percent); 3 reported a kidney condition (2.3 percent); 12 reported a heart condition (9 percent); 9 reported back pain or vertebral injury or deformity (7 percent); 3 reported HIV or AIDS diagnoses (2.3 percent); and 3 reported liver conditions (2.3 percent).

Study participants reported diagnoses of hypertension, arthritis, asthma, depression and weight problems at higher rates than other disorders queried. Thirty-six reported hypertension (28 percent); 29 reported arthritis or other joint or bone conditions (23 percent); 18 reported asthma (14 percent); 18 reported depression (14 percent); and 18 reported a weight problem (14 percent).

Comparing the Overtown study participants' reported rates of some physiological disorders with national rates, we see rates in the Overtown sample are frequently much lower. For instance, serious conditions including diabetes, hypertension, and heart disease occur at much higher rates among Blacks in the nation than men report in the Overtown study. Hypertension is estimated to affect 41 to 44 percent of Blacks in the U.S. The American Diabetes Association estimates that 11.4 percent of Blacks over age 20 have diabetes. Other estimates are as high as 13 percent for Blacks, double the rate of diabetes in the general population. Cardiovascular disease rates among Black men are

approximately 41 percent. One in six men will get prostate cancer, and Black men are 70 percent more likely than white men to develop the disease.

We are likely safe to assume that the Overtown study sample is not in better health than Blacks throughout the U.S. Given characteristics, such as low income, low educational attainment, low rates of employment—indisputable risk factors for many of the conditions we queried[14]—we might argue that the men in the Overtown sample suffer undetected conditions.

Though 60 percent of the Overtown study participants indicate they had spoken to a health practitioner about their own health in the previous 12 months, two-thirds do not have a primary care health practitioner. If having a primary care health practitioner suggests that one is receiving some level of attention to his physiological health and that standard indicators are tracked to generate a cumulative health profile, only one-third of the Overtown study participants claim to benefit from such monitoring.

As such, we might speculate that the actual rates of disorders are much higher among the Overtown study participants than they report. In all likelihood, we are not unreasonable to suspect the discrepancy between the actual and reported rates of several disorders among men in the Overtown study is due to the lack of health care. Were the men in the Overtown study to receive consistent health services, we speculate that the reported rates of physiological disorders would more closely concur with, and perhaps might exceed, national rates for Black adult men.

So, for the researchers, the relatively low reported rates of physiological disorders in the Overtown Men's Health Study do not indicate a population in comparatively better health than their counterparts throughout the nation. Instead, we submit that the lower rates perhaps make an alarming suggestion: to live without health care is to live without consciousness and without opportunity to mitigate life-threatening conditions.

FEMINIZED POVERTY

In the Overtown Men's Health Study, the rates of fatherhood, marriage, employment, and incarceration taken together perhaps issue an alarming commentary about social structure in the neighborhood. While 60 percent of the men in the study are fathers, (and 60 percent of those who are fathers have children younger than 18 years of age), only 40 percent of the study participants were employed at the time of their interview. Seventy percent have never been married. Sixty-six percent have been incarcerated.

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[14] For instance, data from the Centers for Disease Control and Prevention 2003 Behavioral Risk Factor Surveillance System study of adults 18 years of age and older indicates the prevalence of multiple risk factors for cardiovascular disease is substantially higher among those with lower incomes and lower educational attainment, and those who report being unable to work. The prevalence of multiple risk factors among college graduates is 29.5 percent, while it is 59.5 percent among those with less than a high school diploma or GED. Having a household income of $10,000 or less was associated with a higher rate of multiple risk factors (52.5 percent) compared to 28.8 percent among those with household incomes of $50,000 or more. Among those reportedly unable to work, 69.3 percent have two or more risk factors for cardiovascular disease. (Data cited in the American Heart Association report, "Heart disease and stroke statistics—2006 update.")

These figures paint a picture of women essentially alone in the burden of bread-winning, of household management, and child-rearing. Census 2000 data on female-headed households in the two tracts and two block groups that comprise Overtown resonates with this impression. While women in Overtown are not much more likely to be employed than their male counterparts—30 percent of women work compared to 26 percent of men—42.2 percent (or 1,177) of the neighborhood's 2,791 households are female-headed.[15]

Overtown's households, in addition to being female-headed at significant rates, are poor. Only 400 households in Overtown earn at or above the median household income for Miami-Dade County ($35,966). The median household income in Overtown is $12,052, only 33.5 percent of the county median (see Appendix C).

HEALTH AND SOCIAL SERVICES POLICY IMPLICATIONS

The findings of the Overtown Men's Health Study sound a loud, clear call to action. Comprehensive, integrated, and supported approaches to meeting the needs of residents are required. Our assertion is that residents' needs must be understood and met holistically. In Overtown, the experience of homelessness or relegation to substandard housing, for instance, is often linked through complex socioeconomic dynamics to marginal status in labor markets, to lack of educational achievement, to poor physiological and mental health, and perhaps to a range of other factors including incarceration and the experience of violence.

INTEGRATED MODELS OF SERVICE DELIVERY

Integrated approaches to service delivery emphasize outreach. In Overtown, the outreach should consist of one-to-one contact with residents. Having very successfully engaged men using what is in effect an outreach model, our study procedures make a strong case for deployment of experienced outreach workers to approach and speak with residents in the neighborhood locations where they gather: barbershops, restaurants, parks, and open lots which are sites for routine casual exchange and ritual social activities such as dominos and checkers matches.

The outreach workers' contacts should be a mixture of education, persuasion, and data-gathering. They should share information and raise consciousness among men about prostate and cardiovascular health, for instance. They might encourage men to visit the local Jefferson Reaves Health Center or other health facilities for medical assessment and follow-up care. They might direct a homeless man to shelter and help for substance addiction.

Community health worker models, service "navigator" models, and integrated case management are just such approaches that are based on the principles of outreach, comprehensive assessment, and tailoring of holistic service plans.

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[15] The figure 42.2 percent reflects only households of two or more persons. If we include one-person households in the calculation, the neighborhood percentage of female-headed households jumps to 55.9 percent.

However, to be effective, appropriate services and adequate resources must be made available where they are lacking.

COMMUNITY RE-ENTRY

The Overtown Men's Health Study findings also indicate a need for community re-entry services for those returning to the neighborhood from correctional institutions. Pre-release transition support and ex-offender community re-entry services are critical in a setting in which the experience of incarceration is so very prevalent. (Sixty-six percent of men in the Overtown study report having been incarcerated.)

To call for attention to community re-entry in Florida constitutes nothing less than a request for transformation of the culture of corrections in the state. Florida's orientation toward punishment at the expense of rehabilitation is clear in policies such as zero-tolerance which re-institutionalizes probationers for the least violation; in the elimination of vocational and basic skills development programs in prisons and jails; in the unmet needs for counseling and other health care; and in the failure to protect those in custody from aggression by correctional staff and fellow inmates.

A repeal of statutes prohibiting employment and licensure of ex-offenders in certain fields is also critical. Amendment of ex-felon disenfranchisement provisions in the state constitution—the shameful hold-over of Civil War era efforts to bar Black people's participation in civic life—is also important to shifting the culture of corrections in Florida.

SUPPORTED HOUSING

The prevalence of homelessness among men in the sample indicates a need for a supportive approach to housing provision. Financial barriers and perhaps to a lesser degree social and psychological challenges to establishing households in the often brutal local market may contribute to the rate of homelessness in Overtown.

Rather than constituting arguments for individual dysfunction, the study findings might instead make the case for supported housing approaches that offer proximate supportive services to men transitioning from the street, correctional institutions, or other difficult experiences. Such supportive services might include on-site counseling and case management, household management assistance, curfew monitoring where appropriate, and assistance with preparation of meals.

SUPPORTED EMPLOYMENT

Supported employment is similarly designed to assist with workforce participation. Mindful of the challenges that difficult histories may pose, supported work offers both employees and employers assistance with acclimating a person with employment barriers to a new work situation.

Supported work would include training and preparation that is tailored to labor market demands and trends; on-the-job training where possible; supportive services that enhance

job-readiness such as problem-solving, household budgeting, and transportation assistance; retention support including intercession and mediation with the employer should difficulties arise on the job; and incentives such as wage support and tax credits for employers who hire and promote those with employment barriers.

INTEGRATED HEALTH SERVICES

Findings of the Overtown Men's Health Study also make a case for integrated physiological, mental, and oral health services. The study participants are not receiving what they need. While 66 percent rate their health "excellent" or "good," an equal percentage report living with some degree of bodily pain in the previous 30 days. Forty percent report that they have a physical health problem. More than half report feeling disabled to some degree by mood and depressive disorders, though less than 9 percent had spoken to a mental health practitioner about their own health in the previous 12 months. Only one in five indicated he had received dental care in the previous 12 months.

The provision to men of an integrated "package" of health services meeting and monitoring the range of their health needs should be a policy priority for the Overtown neighborhood.

SUBSTANCE ABUSE TREATMENT

Study participants reported use of illegal drugs at rates nearly quadruple national estimates of illicit drug use among Black men.[16] The rate of illegal drug use in the Overtown Men's Health Study is 40.3 percent compared to 12 percent nationally. At 17.8 percent[17], the rate of cocaine use among Overtown Men's Health Study participants is ten times the 1.7 percent rate reported for Black men nationally. While only 9.9 percent of Black men throughout the nation use marijuana, 30.2 percent[18] of the Overtown study participants report doing so. If we consider the self-report nature of the Overtown study data on illegal drug use, we might reasonably suspect that actual rates are even higher.

The issue of substance abuse clearly warrants special attention in Overtown. To rely primarily upon the interdictory approaches of law enforcement and criminal justice institutions is insufficient. Instead, we must immediately place greater emphasis in Overtown on physiological and mental health interventions by making treatment, correctional system diversion, and other supportive services available to residents.

COMMUNITY REDEVELOPMENT

The Overtown Men's Health Study also expands community revitalization discourse, at least locally, to include a subjective account of urban distress and the experience of it. The approach to the collection of data, the consideration of men's experience as a subject

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[16] National Institute on Drug Abuse (September 2003 revision). *Drug use among racial/ethnic minorities.* NIH Publication No. 03-3888.

[17] A total of 23 of the Overtown Men's Health Study participants report using either or both forms of cocaine—powder and/or crack.

[18] A total of 39 of the Overtown Men's Health Study participants report using marijuana.

of inquiry in Overtown effectively enters people into the discussion of place in a rich and detailed fashion.

The study findings make a strong argument for placing public health and community development in conversation. Too often distinct, more exchange between the two domains potentially offers much benefit to residents of distressed and transitioning neighborhoods. The redesign of streetscapes, incorporation of public green spaces, and the relocation of certain businesses can be part of an aggressive health-promoting agenda that revitalizes not only the economic and social life of a community, but its inhabitants as well.

"WHY *MEN'S* HEALTH?"

In our view, the study findings also support the assertion that improving men's health is critical to bettering public health. While this approach is seemingly commonsense, it would be no less than revolutionary were it a central tenet guiding a health and community development strategy. Morbidity and early death burdens men's families. Partners and children bear heavy economic, social, and psychological impacts of sickness, disability, and untimely demise of the men in their lives.

Burdens on the community include the interruption of men's participation in civic life, the labor force, and in the histories of neighborhoods. In addition, the costs of care to social service and health systems strain budgets and other resources. That men's mortality and morbidity is too often attributable to preventable causes adds to the tragedy of their absence from their families and communities.

Health practitioners, social service providers, and health advocates in Europe are on the right track, espousing the contingent nature of men's health and its relation to broader public health urgencies. The emphasis on the relationship between men's health and the health of the broader community is clear, for instance, in the Vienna Declaration on the Health of Men and Boys in Europe.

The Vienna Declaration adopted in October 2005 at the Fourth Biennial World Congress on Men's Health and Gender insists upon men's health as a priority. However, instead of separating the issue into its own domain, treating it as an end unto itself, the language of the Vienna Declaration situates men's health in the context of family and community well-being. (See Appendix D.) Undersigned by more than 130 individuals and organizations from 26 different countries, it issues a call to action to the World Health Organization, the European Union, and national governments. Its principles and recommendations have great resonance with the perspectives and values the Overtown Men's Health Study would indicate appropriate.

So, it is our sense that in Overtown and in similar settings, improving men's health outcomes should be among the highest priorities. Where community conditions cry out for social and economic reinvestment, where populations of women, children, and men are disenfranchised, poor, and distressed, it is imperative to empower men through health

to participate fully in social revitalization. Naturally, it is also imperative to reduce men's own needless suffering.

In this way, our answer to the oft-asked, "Why *men's* health?" is: The vitality of communities requires a focus on men's health as much as on women's health or child health. To answer the suspicion the question above betrays, we in no way intend to propose men's health as a competing alternative to women's health or child health. Instead, we choose to see men's health as well as to advocate a policy and programmatic focus on it as the crucial complement to child health and women's health. Without the full complement of these components of public health, community well-being is elusive.

CONCLUSIONS AND NEXT STEPS

It has taken many months to design the Overtown Men's Health Project, determine its focus, refine our instruments and methods of engagement, collect and interpret the data, and to begin to report findings. Through the many hours and the endeavor to be present to what we observed, we arrive at an overarching sense of urgency. There is a men's health crisis in Overtown.

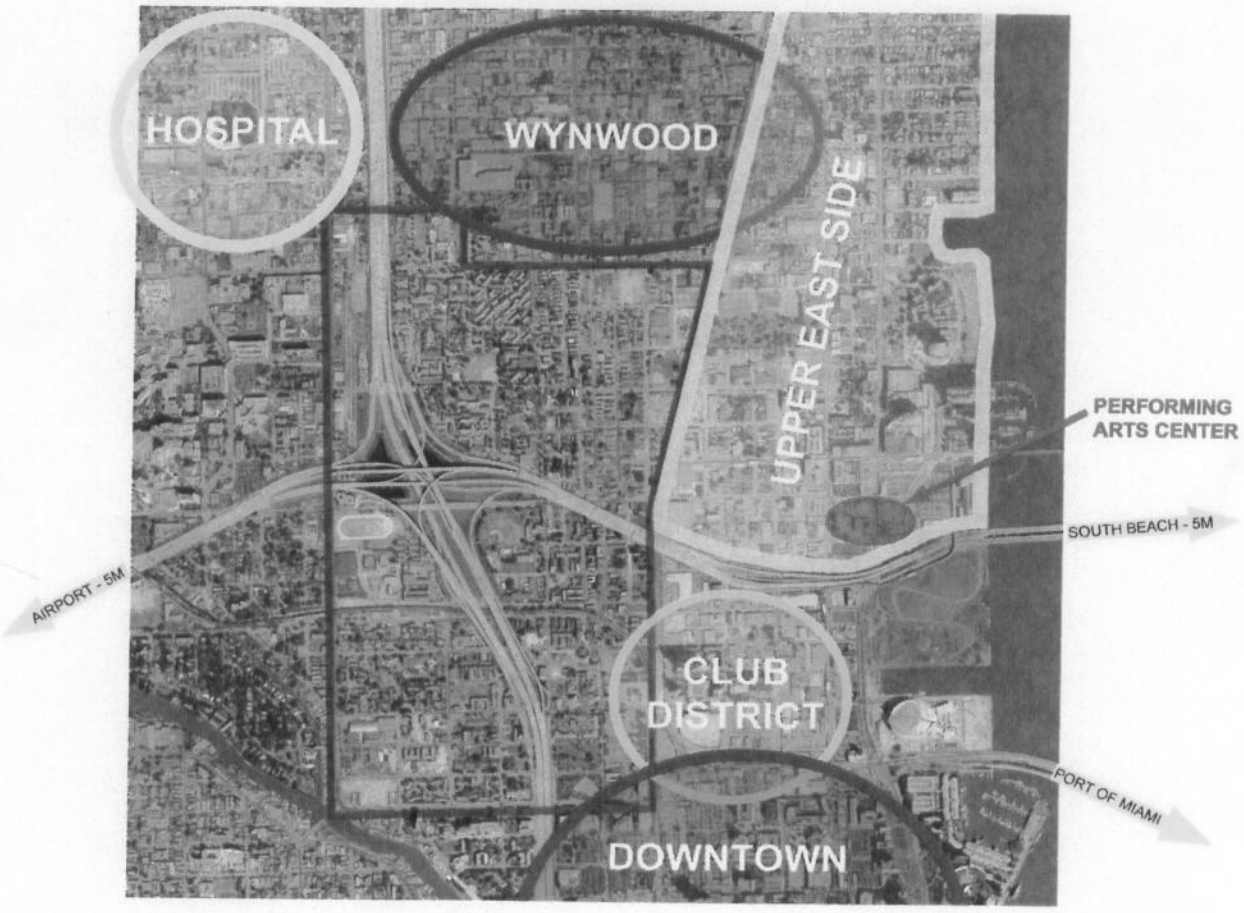
While there are many dimensions to urban distress in the U.S., perhaps we have quantified some part of its influence on the lives and prospects of a small number of men in a small neighborhood. However, what we fear is that the extremes we observe in Overtown are emblematic of a far-reaching crisis, and that the Overtown findings hint at a pattern of lived vulnerability among many populations in many quarters.

Solutions will require bold action and a shift in thinking—of paradigmatic proportions—about societal priorities. In our estimation, what the Overtown Men's Health Study has observed warrants audacious recommendations. At a minimum, we would submit that our findings call for:

- Integrated approaches to service delivery, including outreach-oriented models like community health workers and service navigators;
- Ex-offender community re-entry services and support, including the removal of statutory and regulatory barriers, and repeal of the second-class status effectively conferred upon ex-offenders;
- Supported housing offering residentially-based self-sufficiency services;
- Supported employment to negotiate barriers to self-sufficiency through work for those who are able; and
- Integrated health services, including oral and mental health care, accessible to poor and working-poor men.

Many creative and resourceful service providers attempt to meet the needs of vulnerable populations by offering the items above to the extent possible. However, their expertise and initiative require support in the form of substantial additional public and philanthropic funding.

It is our wish and our mandate that the needs of men in Overtown be met, as well as those of men in similar circumstances in other communities. It is with this motivation to see an end to crisis and lack that we dedicate the Overtown Men's Health Study.



The boundaries of the Overtown neighborhood are indicated in red.

TABLE 1. Sociodemographic characteristics of the study population: Overtown neighborhood in City of Miami, Florida USA, 2005; ($N = 129$).

	Number of respondents (n)[19]	Percentage of respondents (%)
Age group (in years)		
18-24	25	19.4
25-34	25	19.4
35-44	22	17.1
45-54	35	27.1
55-64	15	11.6
65-75	6	4.7
Race[20]		
Black/African American/of African descent	123	95.3
White/Anglo/Caucasian	2	1.6
Native American/American Indian/First Nations/Alaska Native	8	6.2
Asian or Pacific Islander	1	0.8
Hispanic/Latino identity[21]		
Cuban/Cuban American	2	1.6
Caribbean descent[22]		
Haitian	2	1.6
Jamaican	5	3.9
Bajan/Barbadian (Barbados)	1	0.8
Bahamian	33	25.6
Other Caribbean island	4	3.1
Marital status		
Never married	90	69.8
Separated	7	5.4
Divorced	18	14.0
Widowed	2	1.6
Currently married	12	9.3
Fatherhood		
Have biological children	77	59.7
Have > 2 children[23]	38	49.4
Have children < 18 years of age[24]	45	58.4
Highest educational degree earned		
None	58	45
High school diploma or GED	71	55.0
2-year college degree	6	4.7
4-year college degree or higher	5	3.9

[19] Number of cases may vary due to missing values.
[20] Survey instrument permitted respondents to report identification with multiple racial categories.
[21] Respondents could report Hispanic/Latino identity by indicating affiliation with one or more of the following national or regional groups: Puerto Rican; Cuban/Cuban American; Dominican (Republic); Mexican, Mexican American, or Chicano; Central or South American. Respondents could also choose "other Hispanic/Latino," and would be given the follow-up prompt "please specify."
[22] Respondents could report Caribbean descent by indicating their own or their parents' affiliation with one or more of the following national groups: Haitian, Jamaican, Trinidadian/Tobagonian, Bajan/Barbadian (Barbados), Bahamian. Respondents could also choose "other Caribbean island," and would be given the follow-up prompt "please specify."
[23] Of the respondents reporting that they have children.
[24] Of the respondents reporting that they have children.

Employment status		
Working for pay	52	40.3
Not working	77	59.7
With a job or business but not at work[25]	1	0.8
Looking for work	35	27.1
Not working and not looking for work	41	31.8
Personal income in US dollars		
Less than $10K	68	53.1
$10K-$14,999	14	10.9
$15K- $19,000	14	10.9
$20K-$24,999	11	8.6
$25K-$29,999	10	7.8
$30K-$34,999	4	3.1
$35K and above	7	5.4
Household income in US dollars		
Less than $10K	49	38.3
$10K-$14,999	13	10.2
$15K- $19,000	14	10.9
$20K-$24,999	8	6.3
$25K-$29,999	9	7.0
$30K-$34,999	4	3.1
$35K and above	27	21.2

[25] For instance, seasonal employees and those retained by temporary agencies but lacking a current assignment.

TABLE 2. Health services delivery/participation among the study population: Overtown neighborhood in City of Miami, Florida USA, 2005; ($N = 129$).

	Number of respondents (n)[26]	Percentage of respondents (%)
Have a primary care physician or health practitioner	43	33.3
Self-reported health status		
Excellent	23	17.8
Good	62	48.1
Fair	35	27.1
Poor	5	3.9
Very poor	4	3.1
Self-reported health status compared to 12 months prior		
Better	33	25.6
Worse	16	12.4
About the same	80	62.0
Have physical health problems	51	39.5
Experienced some degree of bodily pain in previous 30 days	78	60.5
Self-reported difficulty hearing	11	8.5
Have received dental care in previous 12 months	26	20.2
Have had vision tested in previous 12 months	47	36.4
Received care at hospital emergency room in previous 6 months	39	30.2
Report hospital emergency room as primary health facility	37	28.7
Hospitalized in previous 6 months	12	9.3
Report some degree of disability due to mental health	69	53.5
Report needing mental health care in previous 12 months	15	11.6
Have spoken to mental health practitioner in previous 12 months	11	8.5

[26] Number of cases may vary due to missing values.

TABLE 3. Self-reported drug and alcohol use among the study population: Overtown neighborhood in City of Miami, Florida USA, 2005; ($N = 129$).

	Number of respondents (n)[27]	**Percentage of respondents (%)**
Drink alcoholic beverages	81	62.8
Use tobacco	61	47.3
Number of cigarettes per day[28]		
≤ 1	2	3.3
2-10	38	62.3
11-20	16	26.2
> 20	4	6.6
Use illegal drugs or substances	52	40.3
Type of drug or substance[29]		
Crack cocaine	12	23.1
Powder cocaine	15	28.9
Marijuana	39	75.0
Heroin	3	5.8
Ecstasy	1	1.9
Prescription drugs illegally obtained	1	1.9

[27] Number of cases may vary due to missing values.
[28] Percentages calculated from total respondents (n = 61) reporting use of tobacco.
[29] Percentages calculated from total respondents (n = 52) reporting use of illegal drugs or substances.

TABLE 4. Reported social experiences among the study population: Overtown neighborhood in City of Miami, Florida USA, 2005; ($N = 129$).

	Number of respondents (n)[30]	**Percentage of respondents (%)**
Victim of police violence	33	25.6
Immediate and enduring impacts[31]		
Resulting injury physical	17	51.5
Resulting injury psychological or emotional	23	69.7
Suffer currently from resulting physical or psychological injury	13	39.4
Currently homeless[32]	29	22.5
Have ever lived on the street	49	38.0
Have lived on the street in previous 12 months	28	21.7
Have lived on the street in previous 30 days	22	17.1
Have ever lived in a shelter	34	26.4
Have lived in a shelter in previous 12 months	12	9.3
Have lived in a shelter in previous 30 days	6	4.7
Ever incarcerated	85	65.9
Incarcerated in previous 12 months	24	18.6
Incarcerated in previous 30 days	5	3.9

[30] Number of cases may vary due to missing values.
[31] Percentages calculated from total respondents (n = 33) reporting victimization by police violence.
[32] Figure includes respondents who report living on the street, living in a homeless shelter, and living as squatters or illegal occupants.

PROFILE OF INCOME IN OVERTOWN

(data based on Census 2000 for Census Tracts 31 and 34, and Block Groups 1 and 2 of Census Tract 36.01)

HOUSEHOLD INCOME IN 1999 (CENSUS 2000)

	Census Tract 31	Census Tract 34	Block Group 1, Census Tract 36.01	Block Group 2, Census Tract 36.01	**Area totals**
Total	1405	1088	198	121	**2812**
Less than $10K	639	476	98	44	**1257**
$10K-14,999	161	252	8	18	**427**
$15K-19,999	91	59	5	42	**197**
$20K-24,999	102	110	47	0	**259**
$25K-29,999	104	31	13	19	**167**
$30K-34,999	48	41	6	0	**95**
$35K-39,999	67	12	0	0	**79**
$40K-44,999	19	10	5	0	**34**
$45K-49,999	24	9	3	0	**36**
$50K-59,999	47	21	5	0	**73**
$60K-74,999	19	19	0	0	**38**
$75K-99,999	42	24	5	0	**71**
$100K-124,999	38	12	0	0	**50**
$125K-149,999	0	0	0	0	**0**
$150K-199,999	4	12	3	0	**19**
$200K or more	0	0	0	0	**0**

Median household income — **US$12,052**

Median family income — US$13,212

Percentage of families living in poverty — **52.2 percent** (909 of 1740 families)

Percentage of persons living in poverty — 55.8 percent (4330 of 7754 persons)

Overtown's median household income (US$12,052) is 33.51 percent of Miami-Dade County's median household income (US$35,966).

Only 400 Overtown households earn incomes at or above Miami-Dade County's median household income.

The Vienna Declaration on the health of men and boys in Europe

1 October 2005

We the undersigned assert that in order to improve public health and prevent disease, there is an urgent need to take specific action to address men's health. In particular, *all* men must have the opportunity to:

- Achieve the highest possible level of health and well-being.
- Access equitable and affordable healthcare services.
- Receive health advice and information appropriate to their experience and concerns.

Men's use of health services and health information is generally poor across Europe. The delivery of healthcare and information is often not appropriate for men. There is a lack of investment and research in men's health.

Men's life expectancy is unnecessarily low across Europe. Death rates from preventable causes at all ages are unacceptably high. Furthermore, there are significant and avoidable inequalities between countries.

Poor health and premature death in men also affect their families and are an unnecessary burden on health services and the wider economy.

These problems require responses that take account of the specific needs of men.

We therefore call on the EU, national governments, providers of health services and other relevant bodies to:

- RECOGNISE MEN'S HEALTH AS A DISTINCT AND IMPORTANT ISSUE
- DEVELOP A BETTER UNDERSTANDING OF MEN'S ATTITUDES TO HEALTH
- INVEST IN "MALE SENSITIVE" APPROACHES TO PROVIDING HEALTHCARE
- INITIATE WORK ON HEALTH FOR BOYS AND YOUNG MEN IN SCHOOL AND COMMUNITY SETTINGS
- DEVELOP CO-ORDINATED HEALTH AND SOCIAL POLICIES THAT PROMOTE MEN'S HEALTH.

Throughout this declaration, the term "men" includes boys and young men, and "health" includes both physical and mental health.

Health is a civil rights issue. We need a movement if we are to eliminate disparities.

—Dr. David Satcher
16th Surgeon General of the United States of America

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