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BRIEF COMMUNICATION

Addressing Black men's oral health through community engaged research and workforce recruitment

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Abstract

Background: Racism negatively affects the life experiences and subsequent health of Black men, including oral disease prevalence and outcomes. Few examples in the literature discuss how racism may affect successful, unsuccessful, and non-attempts to address Black men's oral health.

Aims: This commentary describes anti-racism approaches to address Black men's oral health through community-based participatory research, oral health promotion, and workforce recruitment.

Materials and Methods: Stakeholders from two organizations and one dental school share their experiences and key insights on how to strengthen efforts while minimizing the influence of racism on Black men's participation.

Results: Common insights identified were a need to engage a diverse range of Black men within varying social and economic contexts, race and gender concordance among program leaders and participants, and the value of partnership to reach Black men in places where they feel comfortable and supported.

Discussion and Conclusion: These examples stress the imperative of addressing racism among Black men in the development and improvement of targeted oral health interventions. They also emphasize the value of commitment from institutional leadership, relationship building with Black men, and the empowerment of Black men to lead program development and implementation efforts.

KEYWORDS

African Americans, health status disparities, healthcare disparities, men's health, oral health, racism

INTRODUCTION

Black populations experience higher rates of untreated tooth decay, severe periodontal disease, and tooth loss than White populations [1], with higher disease rates among men [2]. Black men do not have the highest incidence of oral and pharyngeal cancers, yet they have the lowest 5-year survival compared to men and women of other races [3,4]. Studies in the literature attribute Black men's poor oral health to underutilization of dental care services, low self-efficacy, and lower levels of social support to promote healthy behaviors [5–7]. Racism is also a factor; contributing to socioeconomic marginalization and subsequent poor access and quality of dental care [8–10]. The intersection of racism and gender create unique and harmful circumstances for the health of many Black men. For example, Black men may attribute their need and ability to obtain dental care in relation to their societal roles as providers, husbands, fathers, employees, community members, and so forth. However, many Black men cannot achieve success in these roles as a result of earning less income than White men and having a higher likelihood of being unemployed [11]. Such realities may also challenge their ability to secure employer sponsored dental insurance and/or pay directly for dental care [12,13]. Additionally, Black men are more likely than men and women of other racial and gender identities to be targeted, profiled, unjustly sentenced, and incarcerated for crimes [14]. This characterization of Black men as menacing,

violent, and non-upstanding citizens can incite implicit and explicit biases against them; which in turn may provide unfair justification among healthcare delivery systems to mischaracterize or not prioritize their healthcare needs [15–17]. Negative stereotypes and mischaracterization of Black men in healthcare settings may also contribute to their mistrust and underutilization of healthcare [18]. Additionally, their experiences with negative stereotypes in society may elevate their physiologic responses to microaggressions, increasing their risk of stress-related health outcomes from reduced inflammatory and immune responses, and unhealthy coping mechanisms such as overeating, smoking, and alcohol use [19].

Racism may also affect access and quality of dental care through a lack of dental providers in neighborhoods where higher concentrations of Black men reside, lack of racially concordant dental providers, poor patient-doctor communication, and historical mistrust of healthcare providers [5,20–24]. Black dentists are more likely to treat Black patients, which may help to alleviate some of those concerns [25]. Yet, only about four percent of all dentists in the United States are Black [25]. In 2020, only 1.77 percent of all dental school graduates were Black men [26], and there are few Black dental assistants and hygienists nationwide [27,28].

Strengthening efforts to address the oral health of Black men aligns with the Healthy People 2030 goal to eliminate health disparities, achieve health equity, and improve the health and well-being of all [29]. National calls to reduce race and gender-related barriers to oral health over the past two decades have been largely unanswered [30,31]. The limited number of programs described in the literature that address Black men's oral health is a barrier to developing scalable evidence-based interventions, health policies, and clinical practice guidelines. The American Association of Public Health Dentistry report, Anti-racism in Dental Public Health: A Call to Action highlights racism as a barrier to improving oral health and the challenges of addressing it among populations such as Black men [32]. Using that report as a framework, this commentary aims to contribute to the literature by presenting key insights from the work of individuals who have employed anti-racism approaches to address Black men's oral health in research, a community-based intervention, and workforce recruitment strategies. The insights come from three projects that approach efforts to improve Black men's oral health from different perspectives in three different geographic locations. In addition to differing in scope and location, the efforts described also targeted Black men representing a broad range of socioeconomic and education levels. This emphasizes the heterogeneity among Black men and the diversity of their needs.

COMMUNITY-BASED PARTICIPATORY RESEARCH (CBPR): PROJECT BROTHERHOOD

In research, racism exists by way of a lack of race and gender concordance among researchers and study populations to address Black men's historical mistrust of researchers and research institutions; which hinders their willingness to participate in research [33,34]. Project Brotherhood (PB) is a community-based organization in Chicago, IL. For over 20 years, they have developed community-based approaches to involve Black men in research. Through strategic partnerships, the organization has developed health education curricula and training programs on violence prevention, cultural competency, social determinants of health, and CBPR [35]. What has been paramount to their success is their ability to assess and facilitate barriers to conducting research with Black men (Table 1).

TABLE 1 Project Brotherhood's assessment of barriers and facilitators to health in Black men

Barriers	Facilitators
Medical mistrust	Trusted partnerships
Lack of access to care	Community-centric care models
Eurocentric care models	Culturally tailored care models
Lack of AA men as health care providers	Representative clinical staff
Monolithic and narrow definition of health	Holistic view of health
Systemic racism	Acknowledgement of implicit and explicit biases
Health care coverage	Affordable Care Act
Socioeconomic factors	Care coordination including social worker support
Hypermasculinity	Rites of passage and healthy manhood development

Source: Murray et al. [31].

Over the past 2 years, PB has explored opportunities to address oral health, starting with establishing an academic-community partnership with researchers at the University of Illinois College of Dentistry. In 2019, they formulated a research team to develop and implement a pilot survey to assess associations of self-reported dental care utilization, stress and oral health-related quality of life (OHRQoL) among a convenience sample of over 100 Black men in Cook County, Illinois. Their findings revealed that among a sample of college-educated Black men, there were significant associations of higher levels of stress with OHRQoL domains of pain and feeling self-conscious. They have since initiated projects aimed to engage Black fathers in children's oral health, and improving how dental providers communicate with Black men about oral cancer prevention.

Key insights

One of the things that the academic-community partnership has drawn attention to was a need for more oral health research with Black men that have varying life

experiences, including those at higher socioeconomic levels. There is a tendency for research with Black men to focus on low-income samples. Yet, there is a lack of available knowledge for researchers to understand how social and economic diversity among Black men may influence their oral health-related behaviors, attitudes, and beliefs [11]. Without that foundational knowledge, research may lack adequate focus and depth, or perpetuate unsubstantiated stereotypes and/or assumptions about Black men and their oral health. For example, it may be reasonably assumed that Black men at higher education levels have fewer oral health concerns. Yet, stress may be a determinant having a significant negative impact [36–38].

Another realization was the lack of oral health researchers with the interest and skills to address mistrust, cultural insensitivity, and limited numbers of Black male research participants. Being able to train Black male researchers from communities of interest has allowed PB to facilitate a comfortable environment for conducting research with Black men, that is built on trust, respect, and gratitude [39,40]. This approach has also helped to expand their network with men of various backgrounds and life experiences to conduct and participate in research, which supports the diversity of thought and perspective about health that Black men can share and learn.

ORAL HEALTH PILOT INTERVENTION: THE MINORITY MEN'S ORAL HEALTH DENTAL ACCESS PROGRAM (MOHDAP)

Racism exists by way of a lack of engagement with minority populations to improve their ability to understand and critically appraise scientific research methods and outcomes; hindering research participation and exacerbating mistrust [41]. The goals of MOHDAP were to: (1) promote increased support for translational research to integrate oral health into chronic disease interventions; (2) facilitate access for communities to oral health education, training, resource; (3) share resources and provide technical assistance opportunities that encourage and enhance participation in oral health research and dissemination activities; (4) share methods and opportunities for communities to advocate for oral health policy change; (5) build community capacity to support continued oral health interventions.

This pilot CBPR intervention was led by a community-based organization in Atlanta, GA in partnership with an academic medical institution, reversing the typical role of serving as a project lead and establishing community ownership of the intervention. The CBPR infrastructure facilitated engagement of community residents and stakeholders in implementing and evaluating its oral health agenda aimed to achieve the aforementioned goals.

MOHDAP addressed the overwhelming need for Black males ages 21–60 to obtain health information to increase awareness regarding the importance of oral health and to improve access to oral health services. The primary aim of this intervention was to provide low-income Black men in underserved communities with oral health knowledge that would enable them to increase awareness and understanding of oral health, and to improve their leadership role in influencing their peers and family on how oral health can positively affect their overall health.

Fifty-two out of 90 applicants were selected to participate in MOHDAP, with 56.3% of participants living below the Georgia poverty level and the majority unemployed. Participants were trained to facilitate peer-led oral health promotion and education. Changes in their oral health knowledge and attitudes were assessed using a pretest and posttest study design, and a post experience satisfaction survey [42].

Key insights

The success of MOHDAP relied on the strength of community leadership using CBPR through the formation of a community advisory board. Using this approach, researchers and participants were able to establish trusting relationships, maintain cultural appropriateness of the project's messaging, retain program participants throughout the project, and continue the project beyond the funding cycle. To the best of our knowledge, many programs have not explicitly identified the unique needs or considered the culture and community context of Black men using a CBPR approach to inform the planning and implementation of oral health intervention strategies. Additionally, this approach may have helped to increase the recruitment and retention of Black men in the intervention. The success of MOHDAP exemplifies the need for appropriate cultural contexts, concordant leadership, and capacity building strategies for oral health projects involving Black men.

WORKFORCE DIVERSITY: UNIVERSITY OF MICHIGAN SCHOOL OF DENTISTRY'S (UMSD) PROFILE FOR SUCCESS PROGRAM

Black men experience some of the worst oral health outcomes when compared to men and women of other racial and gender identities due to discrimination and negative stereotyping in healthcare settings, mistrust of healthcare providers, and underrepresentation as oral healthcare professionals. Having more Black men matriculate dental school may be beneficial, but barriers must be understood and addressed [26]. Medical education has explored the issues more than dental education, but they are likely

similar. In 2015, the Association of American Medical Colleges reported that Black males are underrepresented in medicine due to: (1) underperformance in grades K-12; (2) lack of professional role models; (3) negative social portrayals that reduce career expectations and perpetuate biases in schools and workplaces, thus reducing Black males' pursuit of healthcare careers; (4) high costs of health professional education; and (5) lack of information regarding pre-health professions' education and application preparation [43].

For over three decades, the UMSD has developed and coordinated several initiatives that have increased the enrollment and matriculation of under-represented minority students at dental schools throughout the United States. Approximately 500 students of color have participated in the Profile for Success program at UMSD since 1994; with nearly 60% going on to enroll in dental school or are currently practicing dentists [44]. Approximately 30% of Profile for Success participants have been men of color.

Key insights

Much of UMSD's success in getting Black men into dental school has been through active recruitment to address the aforementioned barriers. Successful recruitment efforts have involved relationship building, mentorship, targeted program development, and priority setting among pre-dental stakeholders at Historically Black Colleges and Universities (HBCUs) and Minority Serving Institutions (MSIs) to establish undergraduate-dental school pipeline programs that expose Black men to dental school environments. Successful efforts have also involved establishing peer networks among Black students to facilitate peer information exchanges about the dental school application process that Black men may have less access to, such as dental admissions test preparation, internships, and research opportunities [45]. Historically, UMSD has graduated the third largest number of Black dentists, following HBCU dental schools, Howard University and Meharry Medical College School of Dentistry. This example illustrates the value in dental schools being intentional about prioritizing and funding the recruitment of Black men into dental schools.

CONCLUSIONS

If progress towards change is the goal, academic and funding institutions should intentionally initiate and support innovative ideas to research Black men's oral health, as well as support the replication and scale of projects similar to the ones mentioned in this paper. Despite what has been reported in the literature about the influence of racism on Black men's overall health, the mechanisms for how racism specifically affects Black men's oral health is understudied. There are several reasons why that may be the case. Oral health researchers may not have an interest in or feel comfortable researching Black men's oral health issues. Those researchers may also lack the levels of social capital, awareness, and cultural competence to effectively recruit Black men for oral health research, and effectively analyze and disseminate results [35]. Both PB and MOHDAP stress the importance of this in their approaches by ensuring that men involved in the research feel comfortable accessing their own networks for research recruitment. They also emphasize the importance of conducting research in networks and communities where Black men are seemingly more comfortable. Profiles for Success uses a similar approach in their efforts to go to HBCUs and MSIs, where Black men are more likely to feel valued and supported [45]. Furthermore, due to limited research funding and competition, funders may not view research on the oral health issues of Black men as capable of producing more generalizable and sustainable outcomes when compared to other research proposals [46]. Black men's mistrust and limited belief that research will benefit themselves and/ or their communities are historical issues that also minimize their participation [35,47].

There is also a diverse range of Black male life experiences and attitudes about oral health that should be studied. The invisibility of Black men in many social environments exacerbates stigmas and stereotypes and bolsters a negative collective identity; mischaracterizing diversity among Black men [11]. It also does little to reduce discrimination, victim blaming, complacency, and the normalization of poor oral health among Black men [48].

Such diversity and the distinct ways that racism affects Black men's health calls for unique approaches that take into account the underlying mechanisms of how racism may shape their worldviews. The lack of those perspectives in oral health research and oral health workforce initiatives, combined with prevailing inequity, sets a precedent for individuals in positions of power and influence, ie. researchers, research funders, dental school admissions committee members to support community-based efforts. A common thread in the examples presented in this paper to address that phenomenon is the inclusion and empowerment of Black men with knowledge, trust, and leadership to guide interventions. This equitable approach is a valuable attribute of CBPR [49], especially in lieu of the lack of representation, interest, perception of importance, intention, and priority to address Black men's oral health at tables where decisions are made on various project aims and approaches.

The Sullivan Commission on Diversity in the Healthcare Workforce suggests that increasing racial representation with an interest in addressing oral health inequities in dental research, practice, and professional leadership may provide a critical mass to increase momentum towards change [50]. However, due to historical and persistent structural racism, that level of racial

representation is not likely to occur [51,52]. Black men's life experiences, the social and environmental influences that determine their interest, motivation, and preparation for dental school are complex, and have implications for how Black men may perceive a dental career. Those complexities should be studied and addressed if efforts to increase the number of Black men in dental careers are to be successful.

The imperative to reduce oral health inequities acknowledges the value of Black men's health to the overall health of American society, and their inclusion in how we learn about and provide oral healthcare. This commentary draws attention to how racism can be addressed to improve oral health research and workforce inclusion among Black men, and provides examples for others to model.

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