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The Stroman Effect: Participants in MEN Count, an HIV/STI Reduction Intervention for Unemployed and Unstably Housed Black Heterosexual Men, Define Its Most Successful Elements

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Abstract

Interventionists often prioritize quantitative evaluation criteria such as design (e.g., randomized controlled trials), delivery fidelity, and outcome effects to assess the success of an intervention. Albeit important, criteria such as these obscure other key metrics of success such as the role of the interactions between participants and intervention deliverers, or contextual factors that shape an intervention's activities and outcomes. In line with advocacy to expand evaluation criteria for health interventions, we designed this qualitative study to examine how a subsample of Black men in MEN Count, an HIV/STI risk reduction and healthy relationship intervention with employment and housing stability case management for Black men in Washington, DC, defined the intervention's success. We also examined the contextual factors that shaped participation in the study's peer counseling sessions. We conducted structured interviews with 38 Black men, ages 18 to 60 years ($M = 31.1$, $SD = 9.33$) who completed at least one of three peer counseling sessions. Analyses highlighted three key themes: (a) the favorable impact of Mr. Stroman, the lead peer counselor, on participants' willingness to participate in MEN Count and disclose their challenges—we dubbed this the "Stroman Effect"; (b) the importance of Black men intervention deliverers with relatable life experiences; and (c) how contextual factors such as the HIV/AIDS epidemic, needs for housing and employment services and safe spaces to talk about challenges, and absentee fathers shaped participation. We discuss the study's implications for sustainable programs after funding ends and future multilevel health interventions to promote health equity for poor urban Black men.

Keywords

Men's health interventions, qualitative research, research, cultural sensitivity, general health and wellness, HIV/AIDS, physiological and endocrine disorders, sexually transmitted diseases/infections, physiological and endocrine disorders

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The HIV/AIDS epidemic is not over. The epidemic's almost 40-year history, shift from acute to chronic condition, and displacement from media coverage by more urgent health alarms such as the novel coronavirus, all combine to connote that the HIV/AIDS epidemic is a concern of the past. For Black men in the United States, however, the group most disproportionately affected by HIV/AIDS, the epidemic remains a serious and present reality. Black men represent just 6% of the U.S. population, but in 2018 accounted for 39% of HIV diagnoses among all U.S. men (Centers for Disease Control and Prevention [CDC], 2019).

Notably, HIV prevalence is considerably lower among Black heterosexual men compared with their counterparts

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who are gay, bisexual, and other men who have sex with men (GBMSM). In 2018, Black men reporting heterosexual contact as their primary mode of exposure accounted for 14% of HIV diagnoses among Black men, compared with 80% of Black GBMSM (Centers for Disease Control and Prevention, 2019). This notwithstanding, Black men accounted for 61% of all HIV diagnoses among all men reporting heterosexual exposure in 2018. Moreover, the fact that the virus is more efficiently transmitted from men to women during heterosexual contact—combined with the reality that Black women who reported heterosexual exposure as their primary mode of HIV exposure accounted for 55% of HIV diagnoses in 2018—underscores a critical need for more HIV prevention interventions for Black heterosexual men. And yet, HIV prevention research and interventions focused specifically on Black heterosexual men are still relatively rare compared with those tailored for Black GBMSM and women (Bowleg & Raj, 2012; Dworkin et al., 2009; Exner et al., 1999; Frye et al., 2012; Higgins et al., 2010; Raj & Bowleg, 2012).

A 2012 meta-analysis of HIV/STI interventions for Black heterosexual men identified 44 interventions that effectively reduced sexual HIV/STI risk, albeit with slightly lower effect sizes (assessed by odds ratio) in Black heterosexual men compared with those for Black women (Henny et al., 2012). Underscoring the stringent evaluation criteria for evidenced-based interventions, the CDC's compendium of risk reduction interventions lists just nine interventions designed expressly for Black heterosexual men or male adolescents (Centers for Disease Control and Prevention, 2020).

Responsive to the considerable gaps in HIV prevention interventions for Black heterosexual men, the senior author and her team developed *M*aking *E*mployment *N*eeds Count (MEN Count), an HIV/STI risk reduction and healthy relationship intervention with employment and housing stability case management services for Black heterosexual men (Raj et al., 2014). Building on the success of the pilot study, which showed significant reductions in condomless sex over the past 30 days and increases in employment, we scaled up the intervention to evaluate its effectiveness for reducing HIV/STI risk, housing instability, and unemployment, using a two-armed quasi-experimental design with a predominantly low-income sample of Black heterosexual men in Washington, DC (Raj et al., 2019).

Judged solely by well-established evaluation criteria for the effectiveness of interventions—namely, the demonstration of significant effects in HIV-related outcomes and tests with a comparison group (Centers for Disease Control and Prevention, 2020)—MEN Count failed to achieve its primary objective of reducing HIV/STI incidence. Specifically, although we found statistically significant improvements over time for participants in both the intervention and attention comparison (i.e., stress reduction) conditions for all of the study's outcomes (i.e., reductions in HIV/STI incidence, unemployment, and homelessness), we found no significant differences in the HIV/STI incidence by treatment group (Raj et al., 2019). Results did show, however, that participants in the study's treatment arm were significantly less likely than those in the attention comparison condition to report unemployment and that those who received all intervention sessions were significantly less likely to report recent homelessness. In light of empirical evidence that unemployment and homelessness are linked to both sexual HIV risk (e.g., Adimora et al., 2006; German & Latkin, 2012) and intimate partner violence (e.g., Bhalotra et al., 2019; Cunradi et al., 2008), these outcomes are obvious successes. The implications of these outcomes extend beyond improving just the participants' economic conditions to improving Black men's health outcomes and relationships. Furthermore, even though the MEN Count curriculum did not lead to significantly lower HIV/STI incidence than the attention comparison condition, it is notable that participants in both conditions showed reductions in HIV/STI incidence over the length of the study. There are very few HIV/STI prevention interventions tailored specifically for Black men, and these findings affirm the value of case management provided by peer counselors (i.e., counselors who share participants' race and gender) to reduce Black men's HIV/STI risk.

For most public health intervention research, results such as these would signal the end of the story or, at the very least, the commencement of methodological forensics to assess why the intervention did not produce the expected outcomes. There are a host of quantitative evaluation criteria—level of evidence, design issues such as whether or not the intervention met the gold standard of using a randomized control design, and the magnitude of the intervention's effects, for example (Flay et al., 2005; Gottfredson et al., 2015)—that exceed the scope of the present study. Often understudied, however, is the question of how participants in interventions—rather than the researchers who designed the study or funders who financed it—might define its success (Rychetnik et al., 2002).

Informed by long-standing advocacy to expand the criteria used to evaluate the success of interventions beyond just desired or anticipated outcomes (Israel et al., 1995; Rychetnik et al., 2002) and recommendations that health interventions designed for Black men assess the "unique characteristics" that improved health for Black men (Watkins et al., 2017), we designed this qualitative study to gain a participant-grounded understanding of how a subsample of participants in the MEN Count intervention's treatment arm evaluated the intervention's success. In light of a plethora of evidence that documents

that Black men's health ranks among the worst in the United States (Bonhomme & Young, 2009; Hudson et al., 2019; Murray et al., 2006), understanding success from the perspective of Black men has vital implications for future interventions designed to promote Black men's health equity. In the sections that follow, we detail the MEN Count intervention, review critiques of conventional evaluation criteria, and present the research questions that guided our analyses.

MEN Count in Detail

The MEN Count intervention is designed to provide counseling on HIV/STI risk reduction, gender equity, and healthy relationships. The individual-level (as compared with small group) intervention is designed to be delivered by peer counselors, who also provide case management to promote housing stability and employment for Black urban heterosexual men. The intervention is theoretically supported by the Social Cognitive Theory (SCT) and the Theory of Gender and Power (TGP). The SCT posits that individuals can reduce their HIV risk through understanding their personal risk for HIV/STIs, believing they can reduce this risk, and reducing "triggers" (e.g., substance use) that impede desired behavioral changes (Bandura, 1989). The TGP considers important structural and gendered aspects of HIV risk, noting that gender-based labor imbalances, power dynamics in heterosexual relationships, and traditional gender ideologies all lead to poorer health outcomes (Connell, 1987; Wingood & DiClemente, 2000).

MEN Count was empirically supported by a pilot study with 50 Black heterosexual men that documented that housing and employment instability, conflictual dynamics in heterosexual relationships, and endorsement of conventional masculinity hypersexuality norms were associated with increased sexual risk (Raj et al., 2014). The intervention was implemented in a men's health and social service community health center with a sample of predominantly poor, unemployed, and unstably housed Black men in Boston, Massachusetts, many of whom had histories of incarceration and/or were participants in a post-incarceration community reintegration program. The pilot intervention design used a one-armed assessment conducted at baseline and 6-month follow-up. Feasibility analyses demonstrated significant reductions in reports of condomless sex and homelessness and significant increases in employment.

Informed by these preliminary results (Raj et al., 2014) and findings from the Henny et al. (2012) meta-analysis, the scaled-up MEN Count intervention (Raj et al., 2019) included several of the elements deemed to be most efficacious for reducing HIV/STI risk behaviors in Black heterosexual men. Namely, it focused specifically on Black men, including those with a history of incarceration, included male facilitators, had short follow-up periods, and emphasized the importance of protecting significant others and family members (Henny et al., 2012). Of note, MEN Count did not provide or refer participants to medical services, the intervention component that results from the Henny et al. (2012) meta-analysis found to be the most robust, but it did share several other components such as being set within an STI clinic and having the intervention delivered by trained facilitators. We conducted a larger and more rigorous two-armed controlled trial evaluation of MEN Count with a sample of 454 Black heterosexual men in Washington, DC—227 each in the intervention and attention comparison condition—the majority of whom were recruited from an STI clinic (Raj et al., 2019). All participants completed computer surveys and were tested for STIs and HIV at baseline, 6-, and 12-month follow-up. The study's design provided for all participants to receive three roughly 45-min in-person counseling sessions in which trained peer counselors—all Black men—would deliver the intervention or attention comparison content. The treatment arm sessions included content about healthy relationships and reducing sexual risk behaviors, whereas the control condition sessions focused exclusively on stress management. All sessions (treatment and control) included referrals and case manager services relevant to housing stability and employment.

Expanding the Criteria for Success for Public Health Interventions

Advocacy for broadening the criteria by which interventions are evaluated is hardly new. For example, 25 years ago, Israel et al. (1995) acknowledged the limitations of "goal-oriented quantitative outcome evaluation" (p. 374), noting that it often excluded other types of goals or outcomes, ignored unanticipated effects, and relied too heavily on randomized quantitative experiments and data. Critics of conventional evaluation approaches have noted that these limitations are heightened when applied to community-level interventions and/or those that are heavily influenced by contextual elements such as "cultural, political, social, economic or geographic factors that may influence project activities or outcomes" (Israel et al., 1995, p. 368). Building on this important foundation, critics highlight a need to expand evaluation criteria to include (a) a range of outcomes, not just the desired or anticipated ones, and (b) assessments of contextual factors that shape the intervention's activities and outcomes (Israel et al., 1995; Rychetnik et al., 2002).

Relevant to broadening the range of intervention outcomes, Rychetnik et al. (2002) proposed two evaluation criteria relevant to our work on MEN Count. The first

criterion centers on the extent to which the outcome variables address the interests of "important stakeholders not just those who conduct or appraise evaluative research" (p. 123). Of particular relevance to our work is Rychetnik et al.'s acknowledgment that when stakeholders are members of marginalized and disenfranchised groups—as were the predominantly poor, unemployed, and unstably housed urban Black men in the MEN Count intervention—it is not always apparent whose interests are considered in evaluation research: those of the participants, the researchers, or the funders.

The second criterion spotlights anticipated and unanticipated effects. In noting that it is possible for unintended effects to be more desirable than the intended effects of the intervention, Rychetnik et al. (2002) advise that evaluation research that focuses only on an intervention's intended effects may miss other positive or negative effects. Applied to MEN Count, in line with the funding from the National Institute of Mental Health's (NIMH's) HIV prevention initiatives, HIV/STI reduction was the primary intended outcome. However, reducing housing instability and unemployment were also desired outcomes.

As for context, this criterion includes numerous factors that may influence an intervention's outcome, including but not limited to information about (a) the social, organizational, or political context in which the intervention took place (Rychetnik et al., 2002); (b) interactions between the intervention such as the background, skills, and experience of the people—in the case of MEN Count, the peer counselor—delivering the intervention and/or contextual factors such as the cultural or social–structural context of the community at whom the intervention was directed (Rychetnik et al., 2002); (c) naturally occurring events and changes in the environment (Israel et al., 1995)—in the case of MEN Count, numerous unforeseen events prompted us to change the project's site four times; and (d) the needs of the people for whom the intervention was tailored (Israel et al., 1995).

Informed by our quantitative evaluation of the intervention's effectiveness—namely, that participants in the study's treatment arm were significantly less likely to report unemployment than those in the control condition and that those who received all intervention sessions were significantly less likely to report unemployment and recent homelessness (Raj et al., 2019)—advocacy to examine how participants define an intervention's success (Rychetnik et al., 2002), and encouragement to assess how the intervention's context may have shaped its outcomes (Israel et al., 1995; Rychetnik et al., 2002), we designed this qualitative study to gain a culturally grounded understanding of MEN Count's success from the vantage point of a subsample of its treatment arm participants. Using narratives from brief structured qualitative individual interviews, we examined two research questions: (a) What were the intervention's most successful elements?, and (b) What do participants' narratives highlight about the role of context in participation in MEN Count's peer counseling sessions?

Method

Participants

Participants were 38 self-identified Black/African American heterosexual men who participated in the treatment arm of the intervention. All participants provided written informed consent prior to being enrolled in the study. Participants ranged in age from 18 to 60 years ($M = 31.1$, $SD = 9.3$). Twenty-four (63%) of the interviewed participants completed all three peer counseling sessions. The remaining 14 participants either completed two sessions ($n = 6$) or one session ($n = 8$). The average age of participants who completed two or three sessions was 32.7 years, compared with 25.6 years for those who completed just one session. This 7-year mean age difference suggests that older men may have perceived the intervention to be more valuable than younger men. The sample's demographic characteristics are shown in Table 1.

Procedures

We used a multi-method recruitment approach that involved community and street outreach: flyers placed at community-based organizations, libraries, and local businesses; Craigslist, a website that hosts free classified advertisements for studies seeking participants; on-site recruitment at a large publicly funded STI clinic; and participant referrals. To be eligible to participate, participants had to identify as cisgender Black/African American men; be at least 18 years old; report heterosexual HIV/STI risk behaviors, which we operationalized as sex with two or more women *and* reports of condomless sex in the past 12 months; and either report housing instability in the past 6 months *or* unemployment/underemployment in the past 12 months. Participants were screened over the phone and in person. As an incentive, participants received $30 at baseline and an additional $40 and $50 at 6- and 12-month follow-up, respectively. STI clinic and study staff provided standard of care HIV/STI counseling and testing, including support for follow-up and linkage to care or treatment for participants who tested positive for HIV/STIs.

We conducted brief structured interviews with treatment arm participants after their 6-month follow-up for assurances of quality control and implementation fidelity. Interviews lasted approximately 45 min, on average. Participants could elect to be interviewed on the day that

Table 1. Demographic Characteristics of Qualitative Individual Interview Participants (n = 38).

Pseudonym	Age[a]	Number of Intervention Sessions Completed[b]	Housing Instability in the Past 6 Months[a, c]	Unemployment/ Underemployment in the Past 12 Months[a, d]	Number of Sex Partners in the Past 12 Months[a, e]
Andre	28	1	Yes	Yes	3
Brandon	41	3	Yes	Yes	5
Carl	36	3	No	Yes	5
Curtis	37	3	Yes	Yes	3
Damien	30	3	Yes	No	2
Darrell	22	3	–	–	–
Dennis	18	1	Yes	Yes	8
Ethan	20	1	No	Yes	5
Frank	44	3	No	Yes	2
Gregory	27	2	Yes	Yes	5+
Harrison	28	3	Yes	Yes	20
Henry	27	2	Yes	No	3
Isaac	44	2	No	Yes	3
Jerome	60	3	–	–	
Kendrick	24	3	Yes	Yes	1
Kevin	29	3	Yes	Yes	3
Leon	37	2	Yes	Yes	10
Lewis	23	3	Yes	Yes	2
Marcel	29	3	Yes	Yes	10
Marcus	43	1	Yes	Yes	7
Maurice	36	2	Yes	Yes	5
Nathan	28	3	Yes	Yes	3
Neil	42	3	Yes	Yes	20
Omar	28	3	Yes	Yes	25
Paul	43	3	Yes	Yes	3
Reggie	21	3	Yes	Yes	2
Rick	22	1	No	Yes	8
Rodney	44	3	Yes	Yes	5
Roland	29	1	Yes	Yes	3
Sean	22	3	Yes	Yes	3
Sheldon	39	3	Yes	Yes	2
Stephen	20	1	Yes	No	3
Thomas	32	2	Yes	Yes	7
Tony	19	1	–	–	–
Tyrell	30	3	Yes	No	10
Vincent	25	3	No	Yes	2
Will	24	3	Yes	Yes	6
Xavier	30	3	No	Yes	3

Note. Housing stability, unemployment/underemployment, and number of sex partners data is missing for three participants.
[a]At the time of enrollment. [b]As documented by the peer counselor, Mr. Stroman. [c]Housing instability was defined as at least 1 night of staying on the streets or in a homeless shelter, or staying with friends or family because they had nowhere else to stay. [d]Unemployment/underemployment was defined as not having a full-time job (i.e., at least 40 hr per week at a single job). [e]Sex partner was defined as any woman with whom they had vaginal or anal sex.

they completed their 6-month follow-up or to complete it at a later date at their convenience. Interviews were conducted either in person at the clinic site or, to facilitate participation, by phone. The study's project director, a Black woman (the second author), conducted the majority of the interviews (n = 30). The remaining eight interviews were conducted by two of the peer counselors who delivered the attention comparison condition—both Black men—and a White female doctoral student (the third author). All interviews were digitally recorded and professionally transcribed. Interviewees received a $50 cash incentive.

We also interviewed Wayne Stroman—a 65-year-old Black man with a master's degree in Human Services and more than 15 years of experience providing professional counseling as a registered addiction counselor and certified anger management specialist—who was the only peer counselor to deliver the primary intervention content. A licensed clinical social worker, the study's seventh coauthor, monitored Mr. Stroman's sessions to assess quality and provide clinical supervision. All procedures were reviewed and approved by the Institutional Review Boards of the George Washington University (GW) and the University of California San Diego, and the DC Department of Health Institutional Review Board for Public Health.

Measures

We used a structured interview guide to elicit feedback about participants' experiences and perceptions of MEN Count, including its effectiveness in reducing their HIV/STI sexual risk behaviors and facilitating housing and employment. Sample questions that inform the present analyses included "What have you liked [most/least] about the MEN Count Program?"; "In your opinion, has the MEN Count program been successful?"; and "How would you describe the MEN Count program in terms of how helpful it has been to you personally?"

Data Analyses

Interviews were professionally transcribed and edited to remove identifiers. Our interview guide was fairly structured, that is, participants provided answers to specific questions about the intervention with limited opportunities to expound on other topics (Patton, 1987). We used the strategies from the Rigorous and Accelerated Data Reduction (RADaR) technique, a rigorous and accelerated strategy for reducing qualitative data (Watkins, 2017). The RADaR technique involves five analytical steps: (a) ensuring that all transcripts are similarly formatted, (b) copying and pasting the text from the transcripts into an all-inclusive Phase I Word-created table for data reduction, (c) reducing the Phase I data into a Phase 2 data table, a more concise table based on this study's research questions, (d) reducing the Phase 2 data table further so that it included only text relevant to the study's research questions, and (e) using the data obtained from the iterative data reduction stages to select the relevant quotes and themes that we present in the Results section. Analyses proceeded as follows. First, members of the analytical team—the second through fifth authors—read all of the transcripts thoroughly to familiarize themselves with the data. Then, coding independently, they used the aforementioned RADaR steps to reduce the data for analysis. Next, members of the analytical team—the first through third authors—reviewed the reduced data tables for relevance to our research questions and discussed any discrepancies until we arrived at consensus. To establish analytical rigor, we relied on three verification strategies; we: (a) checked and rechecked the data tables and our interpretations and discussed and revised them as needed, (b) abandoned any ideas that the data did not support, and (c) conducted a follow-up interview with Mr. Stroman (detailed in the Results section) to assess our interpretations of the data (Morse et al., 2002).

Results

We present the study's results by the research question: (a) How participants defined the intervention's success; and (b) what participants' narratives highlight about the role of context in participation in the peer counseling sessions. Because Mr. Stroman was such an instrumental component of the intervention's success, as the title of our article highlights, we include at the end of the results our findings from a brief interview that the second author conducted with Mr. Stroman about his interactions with participants, reflections on his role as a peer counselor with MEN Count, and implications of the study for future health interventions for Black men.

With the exception of minor edits to improve clarity, we provide verbatim quotes. We include quotes from 16 interviewees. To protect confidentiality, we provide pseudonyms for all respondents. The exception to this rule is Mr. Stroman, who provided his permission to be identified by name. In the interest of full disclosure, we acknowledge that we used the pseudonym Mr. Johnson for Mr. Stroman in the article in which we described the quantitative evaluation of MEN Count (Raj et al., 2019).

MEN Count's Success From the Perspective of Participants

Participants' assessment of the intervention's success coalesced around two key themes: (a) Mr. Stroman, the peer counselor, an effect that we dubbed "the Stroman Effect," and (b) the importance of gender matching and relatability for peer counselors.

Mr. Stroman, "OG"

Unequivocally, participants evaluated Mr. Stroman as the most successful component of MEN Count. Analyses of responses to questions about what interviewees liked most or considered to be the most successful part of MEN Count yielded a resounding response: Mr. Stroman. Twenty-five of the 38 interviewees (66%) highlighted their interactions with Mr. Stroman as their favorite part

of MEN Count. As a testament to their admiration, many used the term "OG" when they referenced Mr. Stroman. For instance, when talking about what made his sessions successful, 44-year-old Frank explained that "real recognizes real" and went on to say, "So, yeah, I mean it helped out that. . . he's an OG." "OG," an acronym for Original Gangster, is a slang term of respect and admiration in many Black urban communities. The term is typically assigned to older Black men who have survived many challenges such as incarceration, the drug trade, gang violence, and/or simply the act of surviving despite pervasive interpersonal and structural racism.

Participants recounted numerous positive interactions with Mr. Stroman and used words such as "respectful," "hospitable," and even "enjoyable" to describe their intervention sessions with him. Paul, a 43-year-old man noted, ". . . Mr. Stroman, he a good dude. I'm glad I met him." Neil, a 42-year-old man recalled: "It was just something about Mr. Stroman and he just got me. He just got me. He's so down to earth and, like, real." Our analyses highlighted three key subthemes about Mr. Stroman's role in the intervention: (a) how his candor about his own life challenges enhanced his relatability and the intervention's credibility, (b) participants' perception of Mr. Stroman as a mentor and a role model, and (c) the fact that he often exceeded the call of duty to show that he cared for and/or helped participants.

Mr. Stroman's Candor About His Own Challenges. Like many of the participants in the study, Mr. Stroman's life history has been characterized by bouts of substance use, incarceration, and homelessness. Mr. Stroman's willingness to share these experiences with participants during intervention sessions were invaluable to the rapport, respect, relatability and optimism, and ultimate success of the intervention. For example, to Jerome, a 60-year-old man with a history of homelessness, Mr. Stroman's disclosure that he too had previously lived in a housing shelter was "very encouraging." Damien, a 30-year-old man, acknowledged that although he was initially "skeptical" about the study, learning about Mr. Stroman's prior challenges—struggles that Damien also shared—was instrumental to his decision to participate in MEN Count. He observed: "When you have a person like Stroman who [has] actually been through the struggle. . . [with] a person like that, you'll have more people who want to actually . . . go through with [completing the program]."

Several respondents noted that Mr. Stroman's disclosures had garnered their respect in ways that a peer counselor who lacked these experiences might not have. Mr. Stroman's life history, they said, conferred legitimacy, credibility, and relatability, factors that in turn motivated participants to listen intently to him and learn from his experiences. They noted that they could relate to his struggles and likewise felt that he could relate to theirs. "Perfect" was the word that Henry, a 27-year-old participant, used to describe Mr. Stroman's role as a peer counselor. Henry summed up the issue this way:

> I think [Mr. Stroman's] the perfect fit for that job because he has been in a lot of . . . [the same struggles of] the people's that's coming through [this program]. He's been in they shoes, and he's been down that road, so that's the perfect person. Those kind of people that a program like this needs. Because they give the youth and the men out there a chance to feel where they coming from, because you seeing someone else telling you the same thing that you've been going through, so that'll give you more of a, you know, understanding, and you'll probably pay attention and listen and feel what they say more.

Echoing this theme, 29-year-old Kevin reflected, "And you know, me and Mr. Stroman, you know, we have similar the same background so we could relate to one another. . . . It played a role [in terms of the program helping me]." Others recounted how learning about Mr. Stroman's struggles had prompted them to feel comfortable enough to disclose their own challenges and/or inspired them to make positive changes. Paul reflected:

> I think talking to Mr. Stroman. He came from, kind of, like the same background I came from. He told me how he changed his life and it, kind of, inspired me even though I haven't stopped, like, drinking and stuff. He inspired me to do better.

Damien recounted that what he liked most about the program was ". . . having someone there [like Mr. Stroman who I could], personally, relate to."

Henry cited his peer counseling sessions with Mr. Stroman as his favorite part of the study:

> Basically, the counseling was the best part. Even though I didn't think I needed it. . . Mr. Stroman, my peer counselor, told me a lot of good stuff because he came from my shoes, and it was good to hear. You know, somebody that came from where I came from and to see him make it and stuff. I thought that was very valuable.

Finally, 36-year-old Maurice articulated the importance of Mr. Stroman's experiences in the "inner city" as a key factor in his relatability to the intervention's participants:

> Let me just put it like this. In the suburbs, it's different from the inner city. . .You know, it's different things you encounter, different things you see that you don't see out there. When you're raised in the inner city, it'll be better to talk to someone who's had a similar kind of background. . . Like, you know, somebody who's been locked up probably before or, you know, did a couple of bad things or maybe

> messed around with some drugs, plenty of girls. . . You know what I mean? . . . just the type of life that you don't want to live forever. . . And to see somebody change their life around gives you hope and makes you feel like, man, if they can do it, I can do it.

Mr. Stroman as a Mentor and a Role Model. Some participants referred to Mr. Stroman as a coach, uncle, and/or father figure; in other words, Mr. Stroman served as a mentor and a role model. Neil recounted how Mr. Stroman's mentorship was instrumental in prompting him to focus on his goals of getting a job. Unemployed when he first started participating in the study, Neil got a job at United Parcel Service (UPS) a month before his second intervention session. He reflected on the influence that Mr. Stroman had on his getting a job:

> . . . Mr. Stroman had me thinking and it's, like, you know, I need to get my priorities in order. He was, like, a mentor more than somebody to talk to, you know, for his job. He was really, you know [inspiring]. So, like I said, he got me thinking and I'm, like, I need to get my shit together.

When asked what was most helpful in terms of participating in MEN Count, Maurice replied, "the process of [Mr. Stroman] building me up". He went on to explain:

> As a Black young man. . . [you need] older men in your life to not exactly guide you, but like just to be there and [be] somebody to talk to about anything, and they don't judge you. You know what I'm saying? They don't judge you, but they'll. . . they'll suggest different ways to handle the situation.

Maurice described how, after his first counseling session with Mr. Stroman, he thought about some of the things Mr. Stroman said but wanted to talk with him more to ensure that they were still on the same page. He concluded by saying, "He felt like a coach and I was a player." Nathan, a 28-year-old participant, noted that Mr. Stroman reminded him of an uncle:

> Older guys, they're more experienced, you know? And I come up in a generation where it was cool to talk to your OG, you know, your older family members. So, he kind of reminded me of one of my uncles. I think they're in the same [age] range and, you know, . . . it was cool talking to him because he seemed like, you know, like I said, one of my uncles.

Going Beyond the Call of Duty. Mr. Stroman's primary duties involved delivering the intervention content—which involved assessments of participants' experiences with respect to relationships, housing, and employment; assessments of participants' alcohol and drug use, HIV risk, and HIV risk perceptions; identification of participants' barriers to HIV risk reduction; and conversations with participants around healthy relationships with female partners and the role of unstable housing and employment on HIV risk—via in-person or telephone sessions (as the study progressed, we decided to allow Mr. Stroman to complete sessions by phone to facilitate participation), scheduling intervention sessions and following up with participants, making himself available in between sessions as needed, and participating in supervision sessions with the study's licensed clinical social worker. As the aforementioned results highlight, Mr. Stroman excelled at his duties. He also exceeded them. Several participants praised Mr. Stroman for transcending the requirements of the job to support and assist them. Typical of these accounts was Jerome who stated:

> [Mr. Stroman] was always helpful, very informative. I mean, he even took the time. . . numerous times, you know, when we got through with our sessions, he would give me a ride back down to the shelter. He didn't have to do it. . . And you know. . . but he didn't mind doing it. He [would say] ". . . Just hang on and I'll give you a ride back over to the shelter."

Jerome also noted that Mr. Stroman encouraged him to "get in a good rapport with the director and people in management level [at the shelter at 2nd and D] so that I could, you know, better my situation." This facilitated Jerome getting a job at the shelter, which in turn meant that as a staff member he was then moved to an upstairs part of the shelter where he was ". . . not with the general population." He said that he considered that move to be ". . . a good thing because, you know, the areas are cleaner. We [staff] actually get perks as far as food, showers, things. . . there's more privacy."

Similarly, Damien, who said that he was homeless when he first participated in MEN Count, praised Mr. Stroman for following up with the information that he promised to send. Notably, Damien said that he found the information to be useful to finding him housing. He specifically recalled:

> [Mr. Stroman] gave me good, valuable information to, uh, better myself in life. . . um, like I said, I was homeless. He gave me. . . two places to go to. I went to one. I actually stayed there like two weeks. And saved a little bit of money and I actually got my own apartment.

Will, a 24-year-old respondent recalled another instance of Mr. Stroman going beyond the call of duty:

> When I stated that I needed clothes and things like that for a job, when I actually did get employment, he did take the time out to actually. . . well, he gave me a location to meet him at. I met him at that location, and he did give me a lot. I don't even know if you guys were aware of it, but, he did give me a lot of clothes. It went over the clothes amount that

> I was supposed to get, but, he saw that I was trying to get employed. I had a job and I was very thankful. . . I still am.

Peer Counselors: Demographics and Relatability Matter

After the "Stroman Effect," respondents cited the peer-counseling design of the intervention—specifically the component that provided for Black men to deliver the intervention content to other Black men—as one of the most successful elements of the intervention. In short, gender and, for some, the intersection of gender and race mattered. Damien was frank about how much the peer counselor's race and gender mattered to his participation:

> I'm gonna be honest with you, if I would have came through that session and it was a woman talking to me. . . I wouldn't have told her diddly squat. . . I would have kept my stuff to myself. . .I wouldn't've said nothing. . . Like, having someone there, personally, to relate to you. . . As a young Black male, is kinda good, when you going through something, period.

Unlike Damien, Neil did not mention race, but cited the peer counselor's gender as an important element. He noted that he valued "the one-on-one, being able to express yourself to another man and get some feedback."

Maurice cited his desire to bond with another man as pivotal to his decision to participate in MEN Count:

> Well, at the time I really needed to talk to another man. You know? Un. . . an older man or just. . . you know, 'cause I don't really talk to my brothers as much as I probably should, 'cause of my past and things that I've done. . . [MEN Count] just sounded like something that I could end up talking to a brother about some things, you know?

Age also mattered. Ten participants cited Mr. Stroman's age as essential to Men Count's success. They explained that his age provided him with the gravitas to be a mentor and gave him life experiences and wisdom that enhanced his credibility. Kevin summed up the age factor this way, ". . . you learn from the older guys. Guys my age, they can't teach me nothing but how to get into trouble. And I really appreciate what he was telling me that day because I could relate to pretty much everything that he was telling me."

Gregory, age 27 years, was one of the only participants to explicitly raise the issue of sexual minority status as a consideration when matching peer counselors. In response to a question about the project staff he had encountered throughout the MEN Count program, Gregory noted "Last time I think it was this little gay guy. . . I was a little uncomfortable." When asked to explain his discomfort he said, "It felt like, this is not, like, this is not your avenue, I mean, he must have just been a [GW] student or something but I don't know. I felt like, I don't know, funny, man." After being prompted, he noted that had his peer counselor been a Black gay male, he "wouldn't have talked to him."

The Role of Context and the Intervention's Outcomes

Our analyses of the interview data highlight a complex web of contextual factors that likely shaped participation in the intervention. These included: (a) four site changes for the intervention, (b) the impact of HIV/AIDS in Washington, DC, (c) participants' need for a safe place to disclose their challenges, (d) participants' need for employment and housing services, and (e) the role of absentee fathers.

Unforeseen Changes: Four Site Changes in 3 Years

Unforeseen at the time of implementation was the fact that we needed to move the site of the MEN Count intervention four times during the course of the study's data collection phase (which occurred between August 2014 and April 2017). MEN Count was not designed to be delivered in an STI clinic; we ended up in one out of sheer necessity. Originally, we planned to implement the intervention in a community-based organization that provided employment counseling to a predominantly Black clientele, most of them "returning citizens," with histories of incarceration. Within months, however, that organization closed, prompting us to find a new community partner. Next up was Calvary Healthcare Inc., a large church-based organization that provides health and social services to predominantly Black communities in Washington, DC. We housed MEN Count at Calvary until we realized that the number of eligible Black men would be insufficient for our study's recruitment quota and thus decided to move the study prior to the end of our 15-month contract. Thereafter, a local health official provided for us to move MEN Count to a publicly funded STI clinic in Southeast (SE) DC, a fortuitous arrangement that facilitated the bulk of the study's recruitment. Alas, after 2 years at the SE clinic, we learned that it would be rebranded as "The DC Health and Wellness Center" and we moved to a new location in Northeast DC. This resulted in our fourth and final move. As we noted in our quantitative evaluation of the intervention, the STI setting itself likely affected the intervention's outcomes because STI clinic attendees, by virtue of their presence at the clinic, already have high STI risk awareness (Raj et al., 2019). This may explain why the quantitative evaluation found no difference in HIV/STI reduction by

intervention condition. It is also likely that the stigma associated with visiting a STI clinic may have been a barrier to participation for other men not already seeking services from the clinic.

HIV Risk

The HIV/AIDS epidemic, as we noted in the introduction, remains an important contextual factor for Black men in the United States, particularly those who live in Washington, DC, where the rate of HIV infection exceeds that of any other region in the United States. The World Health Organization defines an epidemic as generalized when it exceeds 1% of the population. In 2014, the year that we initiated data collection for MEN Count, the estimated prevalence of HIV in Washington, DC was a staggering 2.5% (District of Columbia Department of Health [DCDOH], 2015). During that period, Black men had the highest prevalence of HIV in DC: 5.8% compared with 2.7% among Latino men, the group with the next highest HIV prevalence (District of Columbia Department of Health, 2015). Black men who have sex with men (MSM) and Black MSM who used injection drugs (MSM/IDU) accounted for the largest proportion (26%) of the cases of HIV diagnosed in DC in 2014, followed by Black heterosexual women (16%), White MSM and MSM/IDU (14%), and Black heterosexual men (10%). By 2017, when we ended data collection, the numbers remained roughly the same: Black MSM and MSM/IDU (27%), Black heterosexual women (16%), White MSM and MSM/IDU (14%), and Black heterosexual men (9%) (District of Columbia Department of Health, 2018). This HIV risk context likely shaped participation for a handful of interviewees, 11 of whom mentioned the program's free HIV/STI testing as their primary motivation for participation. For Omar, a 28-year-old man, MEN Count was attractive because "I wanted to know my current HIV status. . . because I had a lot of women I was dealing [having sex] with."

Housing and Employment Needs

Rooted in historical legacies of structural racism, unemployment, incarceration, poverty, and housing instability are intricately connected and formidable social–structural challenges for Black men in the United States. The Washington, DC, area offers no exception from these trends. Although the rates of unemployment shift through the years, one constant endures: The unemployment rate of Black men is always at least double that of their White counterparts. For example, in August 2014, the start of data collection for MEN Count, the overall unemployment rate was 6.1%. But whereas for White men 20 years and older, the seasonally adjusted unemployment rate was 4.9%, for Black men in the same age category, the unemployment rate was more than double: 10.8% (U.S. Bureau of Labor Statistics, 2014). By April 2017, when we ended data collection, the overall unemployment rate had decreased to 4.4%, but intersectional inequities persisted for Black men. Compared with White men 20 years and older for whom the unemployment rate was just 3.4%, the unemployment rate for Black men was 7.3% (U.S. Bureau of Labor Statistics, 2017). As such, this context was likely fundamental to several respondents' decision to participate in the intervention. Indeed, this was the case for seven participants who cited their need for housing and/or employment assistance as one of their motivations for participating in MEN Count. Carl, a 36-year-old man, typified this view, noting that he was motivated to participate in the study "to try to better myself as far as, like, getting me a counselor, try and get me some housing, try to get me a job. You know, see if it was going to work out for the best." Underscoring the importance of resources and access to information and networks in securing employment, 29-year-old Marcel praised the job referrals that he received from the program as ". . . great motivation, for real. That's actually what made me go get my part-time job."

Resources Specifically Tailored to Black Men

For other participants, the perception that MEN Count could be informative and/or helpful for Black men (n = 7) was the main draw. In general, responses centered around two key themes: (a) the need for Black men to have spaces to speak with other Black men about their issues and challenges and counteract conventional masculinity norms against discussing emotions, and (b) the lasting impact of absentee fathers.

MEN Count as a Space to "Get Stuff off of my Chest.". A handful of participants noted that they appreciated the outlet that MEN Count provided for Black men to discuss their challenges. Several noted that a space where Black men could express their feelings or "check-in" with themselves was vital because, as they noted, Black men rarely had opportunities to discuss these issues with other Black men. In line with conventional Black masculinity norms of restrictive emotionality (Anderson, 1999; Majors et al., 1994), several participants mentioned their tendency to "bottle up" or conceal their emotions. Brandon, a 41-year-old man, noted that the intervention content that Mr. Stroman delivered explicitly counteracted these norms: "[Mr. Stroman] also asked. . . just questions that you aren't normally asked. Not with African Americans. . . We call that kind of stuff, not only unimportant but too emotional. . ." Narratives of two participants revealed the role that conventional masculinity likely

plays in facilitating or hindering Black men from engaging in interventions or programs that emphasize talking about feelings. Kevin and 25-year-old Vincent, for example, emphasized that it was the fact that they lacked a "complex [about sharing their emotions]" and/or did not feel like "less of a man" for talking through things or "getting stuff off my chest" that shaped their participation in the intervention.

The MEN Count program was designed specifically to provide Black men with a safe space in which they could openly discuss their emotions and well-being during intervention sessions. Eighteen-year-old Dennis said that he relished having the opportunity to "[explore] the deeper part of yourself that you never knew existed." Participants, such as Paul, reflected on the salutary benefits of doing so:

> Just to be able to talk to people about my problems, because I keep a lot of stuff bottled up and usually, it turns out bad. . . if I get depressed. But, I think coming here. . . kind of, helped me. It was like a release.

Echoing Paul's sentiment, Ethan, a 20-year-old man observed:

> [Through] the MEN Count program, like, I could really speak my mind about what's going on with me or whatever I gotta say, or just be worrying about my body, and my health. That'd be the main focus 'cause, I know a lot of men don't be doing that as much. . . I don't really see a lot of my friends checking up on [themselves].

Absentee fathers. Fathers, their absence in particular, loomed large as another contextual factor that participants said shaped their willingness to participate in the study's peer counseling sessions. We found six accounts in which interviewees recounted how the MEN Count program had provided the guidance and structure that they had lacked most of their lives because they had grown up without fathers or father figures or had fathers who did not talk to them about what it meant to be a boy or man. Reflecting on his childhood, Brandon recalled:

> There was no talking to you [about] what it is to be a young boy growing up into a man. What you should do in school. How you should behave in the house and the neighborhood and community. . . My dad didn't do that. There was no conversation.

Similarly, Ethan said that it was because he did not have a father that he found his conversations with Mr. Stroman to be so helpful: "Listening to [Mr. Stroman]. . . so I don't got no father, so, listening to any male figure older than me, I learned."

Mr. Stroman's Reflections on His Role in MEN Count

Because Mr. Stroman was so instrumental to the intervention's success, we invited him to be a coauthor on this article and reflect on his role in the MEN Count study. His responses verify many of those that we highlighted in the Results section. For example, when asked what he considered to be the most successful part of the intervention, he cited his candor, "Guys seemed to take to me when they found out that I came from the same background that they did." His interview revealed that it was not accidental that some participants perceived his peer counseling sessions to be mentoring sessions instead of case management sessions. He attributed this to the fact that he had prioritized the sharing of his life experiences and not relied solely on his professional training. He explained that being with someone who has had your life experience "is a whole 'nother level [because] you're with someone that understand your plight." Indeed, Mr. Stroman noted that having mentors "that had been where I'd been" was invaluable to his own personal and professional growth as a peer counselor. Building on the lessons that he had learned from his mentors that you have to be "empathetic. . . not sympathetic," Mr. Stroman said that lessons such as this as well as the "intentional interviewing"—a counseling technique focused on positive interviewing with sensitivity to diversity, culture, and ethics and focused on "microskills"—methods that he had learned were instrumental to the success that participants described in their interviews.

As for going beyond the call of duty, Mr. Stroman elaborated on a host of things that he had done such as visiting participants at home, taking the initiative to check in with them between sessions, or taking them to McDonald's for a burger. Asked what motivated him to do these things, he offered: "I genuinely care about them and you have to care, to be successful. How can you go interview a guy and he tells you he's hungry, and you don't buy him a burger? It's just human." Mr. Stroman noted that he was also motivated by his own experience when he was still using substances and benefited from a mentor who chose to take a chance on him and give him a job as a program manager at Serenity, Inc., despite the fact that Mr. Stroman was still using drugs. He reflected:

> I thought that I was going to die a dope fiend on the streets or in jail. When I asked my counselor why he would choose me over more qualified people working in the office, he said, "Because I can trust you." I was strung out on drugs; no one could trust me. But my mentor did and took a chance on me.

During his peer counseling sessions, Mr. Stroman said that he summoned the same trust and commitment to

redemption with study participants that his mentor had shown him. He attributed the success of his peer counseling sessions to formal counseling training and techniques that he augmented with his personal experience and good listening skills. Notably, this affirms what many of the participants felt and observed as so valuable about their interactions with Mr. Stroman during their intervention sessions. Mr. Stroman also affirmed participants' sentiments about the importance of having Black men interact with and talk with other Black men. He recalled that many of the conversations that he had with participants about their relationships with women and HIV risk behaviors, such as having multiple sex partners or not using condoms, involved "two Black men having a real conversation about being responsible; conversations that need to be had between Black men."

Discussion

Black men in the United States bear the disproportionate brunt of health inequities such as HIV/AIDS, making interventions that promote health equity for Black men an urgent public health need. Informed by the social–structural contexts of unemployment and housing instability that constrain the ability of many Black men to engage in HIV/STI risk reduction behaviors and empirical evidence from a pilot intervention of MEN Count (Raj et al., 2014), we scaled up the intervention to test its effectiveness for reducing HIV/STI incidence, unemployment, and housing instability (Raj et al., 2019). From our vantage point as researchers, we had a vested interest in achieving three anticipated outcomes that we had proposed to our funder: a diminishment in HIV/STI incidence and increase in employment and housing stability. Although MEN Count did not produce the anticipated outcome in terms of significant reductions in HIV/STIs by treatment group, our findings of significant reductions in unemployment in the treatment group compared with the control, and dose analyses that demonstrated that participants who received all three of the intervention sessions were significantly less likely to have experienced homelessness in the previous 90 days or to be unemployed, were clear successes (Raj et al., 2019).

But as the present study shows, interviews from a subsample of treatment arm participants yielded an entirely different response about the intervention's most successful elements: Mr. Stroman, the main intervention provider, and the importance of having peers, namely, Black men deliver the intervention to other Black men. Learning how participants define an intervention's success has important considerations for future health interventions designed to promote health equity for poor urban Black men. Our study makes three important contributions to these endeavors. First, in line with advocacy to expand the criteria for success in interventions beyond just their intended outcomes and consider unanticipated outcomes (Israel et al., 1995; Rychetnik et al., 2002), participants' glowing evaluations of Mr. Stroman's work dispel widespread stereotypes that Black men are "hard to reach" for research. A key lesson from our study is that when Black men have the opportunity to participate in research in which they interact with peers such as Mr. Stroman, who look like them, share their life experiences, and respect them and whom they trust and feel like they can relate to, they are open and willing to discuss their lives, experiences, and challenges. Pursuant to community-based participatory action research principles applied to interventions, this finding has important implications for sustainability after a study ends (Wallerstein & Duran, 2010). Specifically, academic and community-based partnerships could collaborate to fund relatively inexpensive (e.g., costs might include meals and transportation reimbursement) peer-led initiatives held in easily accessible community-based settings to facilitate opportunities for former research participants and other Black men to meet regularly and informally discuss their challenges and receive social support from other Black men (Elligan & Utsey, 1999).

Without exception, every HIV prevention study that our team has conducted with Black men in which we have used qualitative methods, such as focus groups or interviews, has been characterized by research participants (a) remarking how rare but welcome it was to have the opportunity to talk about their lives or challenges with another Black man, and/or (b) asking about other opportunities to do so after the study ended. These anecdotal experiences, combined with the findings from the present study, suggest that providing opportunities for Black men to gather regularly to talk about their lives with other Black men may in and of itself constitute a health promotion intervention.

A second contribution of our study is what participants' interviews yielded about the importance of race and gender matching for peer counselors. Reinforcing results from other reviews of health interventions for Black men (Henny et al., 2012; Watkins et al., 2017), interventions that involve Black men as intervention content deliverers is fundamental. This noted, our study highlights an important nuance: the relatability of the peer match. Simply providing for Black men to deliver interventions to other Black men is just an initial step. Put another way, had Mr. Stroman not, as Henry noted, "[walked in the participants'] shoes and . . . been down that road," or as Damien observed, "had a similar kind of background" as many of the participants, he likely would not have been as successful. Black men are not a homogeneous group. As such, our study highlights the importance of researchers investing time to identify and support

the research staff who are likely the most demographically similar and have the most engaging and trustworthy rapport with participants.

This noted, our study also spotlights a troubling irony. Participants deemed Mr. Stroman, to quote Henry, as "perfect" primarily because they could relate to his life experiences with substance use, incarceration, and homelessness. And yet, these are the very experiences that prohibit many Black men from employment in general and, relevant to our work, the opportunity to support other Black men in health research and interventions. GW, under whose auspices the DC-based team conducted MEN Count, requires all prospective staff to undergo a "Standard Background Screening." The screening includes assessments of criminal history, education verification, and traces of social security number. Additional screenings could include those of motor vehicle records, drug screening, and depending on whether the position involves the handling of money, secure or hazardous equipment, or other security-sensitive data, other screenings relevant to those areas. The George Washington University (2017) policy on background screenings notes that a finding of a criminal record is "not an automatic bar to employment" and that

> . . . assessments will be made on an individual basis, taking into account factors including, but not limited to, the passage of time and the severity frequency, and nature of an adverse result, as well as its relationship to the position in question, information produced by the Finalist establishing rehabilitation or good character, and the implication for the general safety and security of the university community as well as the security of university assets. (pp. 3–4)

Mr. Stroman, whom we hired as a consultant for the study, sidestepped this barrier because the study's budget could not accommodate full-time employment for peer counselors. Presumably, had we hired him as an employee, we would have been able to convince Human Resources that Mr. Stroman had indeed "establish[ed] rehabilitation or good character" (pp. 3–4). Nonetheless, the fact that background-screening policies have a disproportionately negative impact on Black men has real implications for future research and interventions with Black men that rely on relatable peers.

Empirical evidence from audit studies that document that White men with criminal records (17%) are significantly more likely to receive callbacks for job interviews than Black men without criminal records are (14%) and that Black men with criminal records have a callback rate of 5% (Pager, 2003) underscores the stark inequality that Black men with criminal records face in the absence of powerful advocates. Background-screening policies provide yet another structural barrier to the ability of talented Black men with criminal records to be in positions of responsibility to improve the lives of their peers who participate in interventions and promote health equity for poor urban Black men.

Finally, as for the need to prioritize the role of context on the interventions' activities and outcomes (Israel et al., 1995; Rychetnik et al., 2002), a third contribution of our work is the need for more structural-level and multilevel (i.e., individual- and structural-level) interventions to improve the health and lives of Black men and, by extension, those of Black communities. At the individual level, an important finding—albeit one articulated by just a handful of participants—was the role of absentee fathers. One implication of this finding is that future interventions for Black men should ask about relationships with fathers, address the emotions associated with absentees fathers, educate about the effects of structural racism on Black fathers to counter racist and deficit-based myths about absentee Black fathers that compound suffering for many Black men (Roberts, 1998; Smith, 2017), and where possible, identify programs or role models to provide social support and coping strategies to Black men who struggle with the history of an absentee father.

As for the structural level, we echo the mounting advocacy of scholars for more structural interventions to improve health equity (Blankenship et al., 2000, 2006). Because most of the theoretical frameworks that inform health interventions are rooted in primarily individualistic and social cognitive perspectives that ignore the social–structural realities of Black people's lives (Cochran & Mays, 1993; Mays & Cochran, 1988), they are likely to have limited impact or fail entirely. This is because social–structural contextual factors such as unemployment and housing instability, to name just two, constrain the ability of individuals to engage in protective healthy behaviors (Blankenship et al., 2006). As findings from this study highlight, several of the study's participants struggled with homelessness, most with unemployment (often intertwined with their having a history of incarceration) and, as Mr. Stroman noted in his interview, hunger. The most promising and effective health interventions for poor urban Black men will likely be those that are gender, culturally, and intersectionally-specific and address the social–structural contexts and realities of what it means to be a poor Black man—especially one with a criminal record, a history of substance use, or experiencing unemployment or homelessness—in the United States (Griffith et al., 2011; Watkins et al., 2017).

Structural context is also likely relevant to the efficacy of interventions, not just the individual-level realities of participants. Evidence from a meta-analysis of 70 independent studies that examined the efficacy of sexual risk interventions for Black/African American people found two moderating indicators of structural stigma: White peoples' attitudes toward Black/African American

people and residential segregation in the communities where the interventions occurred (Reid et al., 2014). Specifically, results from the meta-analysis indicated that interventions improved condom use only when communities had both relatively positive attitudes toward Black people and lower levels of racial segregation. Moreover, these structural-level factors uniquely accounted for variance in condom use effect sizes over and above intervention-level features and community-level education and poverty. In line with the findings from the participants in the present study, Reid et al. found that tailoring the interventions to meet participants' values and needs buffered against the negative influence of White peoples' attitudes on condom use behaviors, potentially through the reduction of mistrust of the researchers and/or research process.

As for mistrust, this was not a focus of this present study, but Damien's acknowledgment that he was initially "skeptical" about participating in MEN Count until he interacted with Mr. Stroman implies that mistrust likely factored in decisions to participate in the study. A systematic review of studies on the barriers and facilitators to participating in health research with a multiracial/ethnic sample (i.e., African American, Latinx, Asian American, and Pacific Islander populations) documented mistrust and lack of access to information as key obstacles (George et al., 2014). For Black/African American participants, mistrust was frequently associated with the perception that the research would primarily benefit White people or the research institution, not its racial/ethnic minority participants. Black/African American participants also highlighted their fears about discrimination from health insurance companies to whom they may have disclosed information about their genetic health status and their fears of stigma relevant to disclosing their HIV-positive status in HIV-related research.

In line with the findings of the current study, George et al. (2014) highlighted specific facilitators to Black/African American people's participation in research, among which was the presence of Black/African American research staff members that showed a "personal touch" (p. e22) that was needed to encourage participation. George et al. (2014) also identified five distinct barriers for Black/African American participants that were not present for any of the other racial/ethnic groups: (a) the legacy of the Tuskegee Study, (b) lack of research integrity, (c) the legacy of racism and discrimination, (d) mistrust of the health-care system, and (e) concerns about the research process. These findings underscore the need for more research with participants like the Black men who participated in MEN Count to better understand how researchers can more respectfully and meaningfully engage with and design interventions for Black men to promote health equity.

Our study should be considered within the context of at least four limitations. First, the interviews were highly structured and brief, limiting opportunities for participants to elaborate about their experiences, life challenges, and the full breadth of their participation in the MEN Count study. Second, the fact that only 24 of the 38 interviewees represented here completed all three sessions with Mr. Stroman suggests that participants may have endured numerous obstacles to fully participating in the study's sessions. For example, findings from the quantitative evaluation documented very low study retention rates that we attributed to likely social–structural challenges such as recidivism and frequently disconnected cellphones—due to poverty and/or financial hardship—that thwarted follow-up for future sessions (Raj et al., 2019). Third, the interviewees in this study constitute just 17% of the entire treatment sample ($n = 227$) and were not randomly selected for the interviews. As such, the extent to which these findings might generalize to other participants in the treatment arm is unknown. Finally, social desirability concerns may have shaped reporting, prompting participants to provide more favorable evaluations of the program's success than they might have done if they had been given the opportunity to provide feedback anonymously.

These limitations notwithstanding, our study has important implications for future health interventions for poor urban Black men. Bolstering Rychetnik et al.'s (2002) poignant point that it is not always clear for whom interventions are designed—participants, researchers, or funders—findings from our study's qualitative interviews underscore the importance of asking participants before, during, and after an intervention about how they define an intervention's success. Such information can be invaluable to improving current and future interventions to increase the chances that interventions will actually promote health equity for men such as the participants of MEN Count. The other major takeaway from our study is patently obvious, albeit in the former case, not readily possible, and in the latter case, impossible: hire or clone Wayne Stroman.

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