

**Male Responsibility Network:
Office of Family Planning / Male Reproductive Health**

Denver, Colorado
May 4, 2006

Good morning,

I want to thank the organizers for inviting me to this gathering of leaders with responsibility for the health of many men. My association with the Office of Family Planning and examination of the work on male reproductive health has assured me of a willing and important partner in the work to engage men in the health system. My own values resonate with the directions of the program and it is these directions that acknowledge the totality of maleness and men's health that I want to explore with you this morning. But let us quickly revisit the past so that we can see that real progress is possible even in the midst of contradictory messages from various sectors in our social context. All of you have heard this information before: but let us review it just because as we all know, 'the past is prologue.'

- 1916 – First Birth Control Clinic
- 1929 – Birth Control Clinical research Bureau raided by NYC police
- 1960 – FDA Approves First Oral Contraceptive

(Somewhere along in these years the Congress passed the Medicare and Medicaid legislation, after much wrangling over race and poor people. The Medicaid legislation left men out of the picture and this started the precipitous drop in access to care. Then, there was Welfare which required that no man be in the home, essentially separating individuals who were trying to make it together. Now, we are saying 'get together' to people but it may take some time to turn things around. And we still have some laws that separate people who could be contributing members of a household. Extended family relationships make a difference. But policymakers seem not to understand this when working with the poor. Policies are not always well-informed and can set people and communities on a precipitous course.)

- 1966 – MLK Recipient Margaret Sanger Award
- 1970 – Title X Family Planning
- 1996 – Office of Family Planning Male Initiative

There were many ‘bumps’ along the road to 1996 but, we are now seeing ‘potholes’ that have shown us that our efforts are good but not sufficient. **We have seen rising rates of teen pregnancy in some communities and then declines when, in fact, declines in one racial or ethnic group have been replaced by growing rates in other communities. We have also seen deadly diseases reach epidemics (in communities and in prisons) that now threaten to devour the heart and soul of some communities.** We have ‘weathered’ from time to time those that ONLY support the ‘just say no’ mantra to young people who are inundated by a series of ‘yes’ trigger points and who have little or no social network to support them in simply making a decision. Often, these young people probably make no ‘decision’ but, rather, they just ‘do’ whatever is at hand.

We, who are scientifically and realistically informed know that simplistic a ‘yes’ or ‘no’ is not sufficient in many sectors of our society; life is often lived in ‘gray’ zones. We have learned that we must do more than just try to program the mind and we must indeed not try to program the health of men solely through their reproductive organs. **People are more than their sexual organs** and we, at Community Voices (www.communityvoices.org) - an initiative funded by the Kellogg Foundation and now operated by a program office at the National Center for Primary Care at the Morehouse School of Medicine, know this. We value all of humanness including the ability to reproduce.

Your programs have evolved. A sound male responsibility program today:

- Provides Family Planning and Reproductive Health services free or at sliding scale fee
- Learns what services are available to men at clinics, and which clinics are ‘male friendly’ (will not turn them around because they lack funds, do not know the right question to ask, are young, are homeless) (Older men and Viagra and HIV/AIDS)
- Establishes referral networks to send clients
- Collaborates with clinics on outreach

And, today we know that within the program there is a(n):

- Public policy focus on promoting responsible fatherhood & supporting healthy relationships and marriages
- Epidemic of STIs including HIV/AIDS
- High rate of unintended pregnancies
- Fatherless epidemic

There is a growing interest in involving males in building community support for pregnancy prevention.

It is well known that: 1) men want services from organizations that they trust and 2) that community based organizations that are known and trusted can improve the effectiveness of the delivery of clinical services. But we now need to know more about:

- Program utility
- Replicability
- Cost (cost accountability or perhaps cost effectiveness)

All of the things that we know and affirm are correct and laudable goals. **The Male Responsibility Program was virtually the first time in our nation's history that social or health related programming focused on men, particularly men of color and poor men.** The rationale for establishing the program was to engage men more in fatherhood or in not becoming fathers and not so much to bring attention to strategies to protect their overall health. But, on any level of rationalization, males were the focal point.

Today, as a result of the focus of programming (OR lack of focus on the total male body and psyche), we are still not reaching our goals of improving overall community wellness. We know that we are not there yet because of the continuing high rates of morbidity and mortality in communities of the poor and, particularly, in communities of color. **I want to have a conversation with you around the some of the facts of the matter today. I will speak in absolutes with data and about promising practices, based on the experiences in Community Voices and my 17 years as a program director at the Kellogg Foundation, a position I left in 2003.**

Who are we serving? Has anything changed in ten years? Who should we be serving today? Many of the young men (and women) the programs should target are less-educated and not enrolled in school. Marriage rates among less-educated non-enrolled young men have declined significantly since 1979, when more than a quarter (25.9 percent) were married. By 2001, the proportion of these young men that was married fell to just 13.3 percent.

This decline is a manifestation of the retreat from marriage, which has been especially important among the less educated. The decline in marriage does not indicate a decline in the number of less-educated non-enrolled young men responsible for children; increases in cohabitation have almost completely offset declines in marriage, and unwed births to cohabiting women account for nearly all the growth in unwed births since 1975. (Bumpass and Lu 2000; Bumpass, Sweet, and Cherlin 1991). Some suggest that as many as 25 percent of 18-24 year old, less-educated black males are fathers. It is notable that the proportions of less-educated men who are married or living with children have declined substantially among all racial and ethnic groups. Less-educated, non-enrolled young white men who were married fell from 27.4 percent in 1979 to 14.2 percent in 2001. The proportion of less-educated, non-enrolled young Hispanic men who were married fell from 28.8 percent in 1979 to 16.3 percent in 2001, a 43.4 percent drop.

What is happening to young men of color in education? In Georgia, consider the fact that 64,000 Georgia boys were part of the class of 2005 when high school began in 2001. Only 40,000 made it to their senior year, and some of them didn't last to graduation day. No one in the state really knows what happened to those 24,000-plus boys (Maureen Downey for the Atlanta Journal-Constitution, 4/23/06). Georgia graduates only 41 percent of its African-American males (51 percent of all boys graduate), compared to 60 percent of its white males. (The quality of education received by these groups is not equal.)

Marriage and living with children and the ability to parent (share values, instill ambition for achievement) is least likely for less-educated black men. Just 38.5 percent of black children

under 18 years of age live with both parents, compared with 76.9 percent of white children and 65.1 percent of Hispanic children. These trends are rapidly shifting in all groups. A recent study of African American men in the Overtown community of Miami reveals that 60 percent of homeless men are fathers and 60 percent of these have children under 18 years of age. The children, young males and females, are growing up without a father in the home and, most likely, with a full time working mother in a low wage position or on public benefits.

What about poverty? *Since 1979, the decline in poverty rates was greatest among white, less-educated non-enrolled young men, falling from 30.9 percent in 1979 to 10.4 percent in 1989 and 8.6 percent in 2001. The decline in poverty rates for black, less-educated non-enrolled young men was less dramatic; these rates fell from 44.5 percent in 1979 to 29.2 percent in 1989 and 26.1 percent in 2001. Less-educated Hispanic young men had their poverty rates cut almost in half from 1979 (48.4 percent) to 1989 (25.0 percent). By 2001, their poverty rate was well below the rate for black, at 20.1 percent.*

What about the criminal justice system? Perhaps we have found the ‘missing’ boys. Disproportionate poverty rates seem to lead without question to greater engagement with the juvenile justice and later with the criminal justice system. One of every nine African American males in his twenties or early thirties is now in prison or jail on any given day. And the impact of these policies threatens to spill over to the next generation as one of every 14 black children has a parent who is behind bars. (In a sample of detained youth, 35.3% were incarcerated 1 or more times in adult prisons within 7 years.-Linda Teplin, 2005). **In programming for children who live in risky settings and who therefore may have a past and predictable future without intervention, we must look backwards and forward to see where they have been and to anticipate what we need to do to avoid calamity.**

The system seems **predisposed to incarcerate the black offender.** While the rates of the offending varies little between blacks and whites (3:2), the arrest rate as measured by the FBI’s Uniform Crime Reports for serious violent offenses is 4:1. One clear measure of our

failure is seen if we examine the juvenile justice figures... The populations that we most need to reach are those involved in the criminal justice system, unless intervention occurs.

The Office of Juvenile Justice and Delinquency Prevention reported in 2002 that the juvenile population in the United States was more than 63 million (63,722,044). In that same year, nearly 2.3 million juveniles were arrested in the United States. Although Black youth represent 16 percent of the overall juvenile population, they are disproportionately involved in juvenile arrests. Of all juvenile arrests for violent crimes, 55% involved White youth and 43% involved Black youth.

Why am I spending all of this time developing a portrait of young men in our society since 1996? The reason is simple. **The children that are presented to Male Responsibility Programs today are perhaps at greater risk than in previous years to slip off of the track to upward mobility.** The message: We must do **population-based** programming if we want the program to succeed and make a difference. Serving those at less risk does little or nothing to justify your work or even the survival of the program that is providing funding to you.

According to a paper coauthored by the former Surgeon General, David Satcher, that appeared in Health Affairs last year, and Dr. David Williams in an accompanying article, University of Michigan sociology and epidemiology professor David Williams highlighted specific trends. Black and white death rates from heart disease were equal in 1950; by 2002, blacks died 30 percent more often. Blacks had a 10 percent lower cancer death rate than whites in 1950; currently, it is 25 percent higher. Additionally, the infant mortality gap doubled between 1950 and 2002.

The reasons for my **journey into obscure territory may be obvious** to most of you. The young people that we are serving today are different, far different from those that were to be served when the program was initiated. The challenges are greater: drugs, methamphetamine, crack cocaine, heroin, alcohol, and other drugs that are not strangers to our young children or

to their parents are pitting our children in a struggle to survive. Most of those in the juvenile justice system are there because of diagnosable mental illness, mainly depression or for acting out behavior that has its genesis in some form of child abuse. **We have a complex young person entering our offices today, far more complex than before.** IF we are to make a difference, we must open ourselves and our work to complex but meaningful relationships with other agencies in our communities. The health clinic, **the OFP clinic can be a wedge, a wedge that opens the door for the young person to other health, social, education and training, and employment resources that hold the greatest promise** for encouraging them to act responsibly sexually and with respect to their overall health. Pregnancy for young women coming out of juvenile justice institutions seems to be the only way that they are able to affirm themselves. Is fatherhood a need among young men reentering community? The data are not available but the numbers may be predictive. We have to give the individuals some options. These young people may not be in the school or active in the Boys and Girls Club. And the older men also reentering the community continue to father children. (Do not forget your Chamber of Commerce, your Rotary Club as members of your collaborative. As them to do something specific.)

The health clinic, family planning, and male responsibility clinics cannot improve sexual health/responsible behavior and general health alone. The Male Responsibility programs can give them coping skills, but not SURVIVAL skills so that they can THRIVE. **If we want them to thrive, and if our evaluation is to be meaningful, we should be able to see young people re-enrolling in school. This means that our programs are reaching out and finding those young people at greatest risk; those that are becoming disconnected, at risk of dropping out, have dropped out, have had encounters with the juvenile justice system** and finding real and meaningful connection points with them. Our **collaborators become other health clinics with full services, social workers, school systems and administrators, other educational programs, and criminal justice systems so that we create pathways to success.** Your program may need to include **outreach workers** who share the characteristics of those that you seek to reach in order to be successful in bringing the population at greatest need of your services. **Probation officers** may be your best sources

for names of potentially good outreach workers if you want to work with young people in reentry.

The greatest challenge to comprehensive programs is the work needed to reach **sustainability**. **So you have a grant: Congratulations.** What next? When the current funding ends, and it always ends, or is reduced, what next? We cannot raise the hopes of our young people and our families only to have them suffer yet another loss when traditional funds diminish and threaten to disappear. **When do you begin working to insure program sustainability?** We begin the work of sustainability as soon as the program is conceptualized. Key questions are:

- Who is interested in this work? (i.e. schools, criminal justice systems, employers)
- Who **should** be interested in this work?
- How can I establish a collaborative that gives meaning to a comprehensive framework of services?
- How can I effectively integrate program and budgets?
- How can I inform key informants or policy makers about the importance of this work?

Steps that must be taken include:

- Explain to the public what you are doing? This is done in personal appearances and more importantly in ‘fact sheets’ that lay out the problems in the communities that you are addressing and the importance of the work.
- Engage the media in any way that you can.
- Hold town hall meetings and community-briefings
- Work to become a part of the local municipality budget
- Propose matching funds schemes to your local government
- Work in partnership with community foundations. Engage them before you submit your proposal. You do not need to ask them for money. Just tell them what your

vision for change is and seek their advice. They may develop programs that can support you.

- Use high profile individuals in your community, unusual suspects, to make your case for you
- Expose your young people to a new world, one that they might dream about, aspire to for themselves and they can give you the success stories that generate funds
- Talk to decision makers every day, every month. Let your little light SHINE!
- Fundraise from the local government, the federal government, from philanthropy and from others. Make the program a part of the regular fabric of program services
- Without lobbying, help your community make its voice heard when there are discussions about public funding for health coverage. Medicaid, CHIP, SCHIP, and other programs ARE your issue, too.
- Make jobs available for young people who need the jobs MOST in your community. Give the young people a chance, an option as you can also decrease the numbers of those needing services.
- Braid funding streams to make your program work. Plan to work yourself out of business.

Remember the three P's: Program, Publicize, Policy. All three are required. You must pay attention to policy and tell decisionmakers what helps and what hurts, without lobbying. Remember, the scope of your work will be limited ONLY by the size of your dreams and your ability to imagine a different world.

In summary, you must plan your program carefully and identify the population at greatest risk, most likely to the cost your community if you do not intervene, and design comprehensive interventions with others (as a part of program development and implementation).

You must **evaluate your outcomes**. You need **numbers** and you need **stories**. A good story will move a policymaker whereas data is needed to guarantee long-term sustainable funds.

You must disseminate or publicize what you are doing so that community members, young people and decision makers know that you are there doing significant work.

You must communicate intentionally, purposefully, and regularly with policymakers, decision-makers. Let them know what works, what does not work, and why.

You must tell them precisely what you need for them to do in order to grow the program, to make it work, to sustain the activity. You must network with all who have access to resources.

Today, this morning, I have preached. I have sermonized. I know that these things work. I know that you can do these things, are doing these things. But I urge you to remember the following:

- Reach out to those young people in your community at greatest risk
- Engage the young people in comprehensive health services through the use of a strong collaborative
- Establish and nurture a strong collaborative that is multidisciplinary
- Use written materials to explain what you are doing, why, and your outcomes (a brochure is not sufficient)
- Communicate, communicate, communicate,
- Devise policy options.
- Have a 'campaign' strategy (evaluate, write, devise options, disseminate)

When I ask myself why I do this work, I remember a personal experience: I remember a young man that I met on an Atlanta street one evening at dusk. He came up to me as I was going into a store and asked me for money; he was hungry, he said. I did not immediately offer him money and he just about shouted that 'they' said" 'they told me that if I prayed and acted right, people would help me. But I am praying and I am trying to do right but no one is helping.'" When I came out of the store I gave him money to go buy something to eat. He stopped me and said: "Let me tell you my story." He kept me there and told me about his

mother's death and how he and his brother were separated and put into foster care and he was now out on his own. Fifteen minutes later I told him that I really had to go as he kept talking. I said: "I have given you some money; go get yourself some dinner. He thanked me again and said: **"The money is important but really, I just need somebody to talk to..."** I often wonder what happened to that handsome young man. I could not take him into a clinic at that time and I knew of none that would take him. He is likely a statistic. But, it is my hope that we will build stronger services throughout all of our communities so that our young people who are living without their parents, who are often set adrift by the winds of fate, will have someone to talk to, someone to believe in them, someone who sees not only their reproductive issues, but who also seeks to nurture and serve their body and their spirit.

This is not easy work. It is not for the feint of heart. I think often of the power in the story of the Wright brothers who were our nation's first aviators. The Wright brothers attempted many times to fly and failed many times. But the Wright brothers were ultimately successful because they not only **believed** that they could fly, they believed that they **SHOULD** fly. The work in which you are engaged is for those who not only believe that they can change the world of a child; they believe that they should, and **MUST** be the change that a child needs, **TODAY**.

Imagine what we can do for the brotherhood of man; for ourselves; for our nation!

Thank you!!

We are in a fight to the death for our children; a fight for what I believe is the very 'soul' of America. We cannot lose this battle for if we do, we may face the beginning of the end of our nation and of our democracy.

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