

“We Need Help in the Delta”: Barriers to Health Promotion Among Older African American Men in the Mississippi Delta

American Journal of Men's Health
2017, Vol. 11(2) 414–425
© The Author(s) 2017
Reprints and permissions:
sagepub.com/journalsPermissions.nav
DOI: 10.1177/1557988316684472
journals.sagepub.com/home/jmh


Sherry C. Wang, PhD¹, LaShaundra Crook, MS, RD, LD²,
Carol Connell, PhD, RD², and Kathy Yadrick, PhD, RD²

Abstract

The purpose of this study was to better understand the barriers to health promotion among African American older men living in the rural Mississippi Delta. A qualitative, intrinsic case study approach was used to explore the phenomenon of health and the barriers to promoting men's health within the unique context of the Delta. Data included one key informant interview and two focus group interviews with 14 men, with the majority between the ages of 41 and 55 years. Focus group participants were lay community members as well as members of a volunteer community health advisors men's group. Findings underscore the extensiveness of the term “health” and the importance of attending to structural barriers in addressing men's health. Three overarching themes emerged: “men don't talk about health,” “health care is not just the issue, everything is,” and “we need a strong male to lead.” Implications for future research and health promotion efforts are provided.

Keywords

cultural sensitivity, health promotion and disease prevention, health inequality/disparity, men of color, qualitative research

Received July 7, 2016; revised November 14, 2016; accepted November 22, 2016

African American men have the highest mortality rate (Roth, Skarupski, Crews, Howard, & Locher, 2016) and arguably the worst overall health status of any demographic subgroup in the United States (Centers for Disease Control, 2013). The 2013 life expectancy at birth, at 78.8 for the total U.S. population, was 71.8 for non-Hispanic African American males, the lowest of any gender–race/ethnicity group. The lower life expectancy is linked with higher death rates due to heart disease, homicide, cancer, and stroke (Kochanek, Arias, & Anderson, 2015). African American men also significantly underutilize health care services (National Center for Health Statistics, 2012; Sandman et al., 2000). The well-documented health disparities of African American men highlight the importance of understanding African American men's health-related beliefs and perceptions, given how essential it is to developing prevention and intervention services that build on their preexisting worldview as well as resources.

African American men in Mississippi are among those at highest risk for health disparities, given Mississippi's

typical ranking of 49th or 50th in overall health (United Health Foundation, 2015). Social determinants contribute to the poor standing of the state and its African American population, as determined by the American Human Development Index (Burd-Sharps, Lewis, & Martins, 2009), which builds on a human development, capabilities approach to assess well-being using health, education, and income indicators. The 2009 report of the American Human Development project suggests that African Americans in Mississippi are, “on average . . . worse off than African Americans in most other states” (Burd-Sharps et al., 2009, p. 5). African Americans in Mississippi are also less likely than their non-Hispanic White peers to have health coverage (Short, Gamble, &

¹Santa Clara University, Santa Clara, CA, USA

²University of Southern Mississippi, Hattiesburg, MS, USA

Corresponding Author:

Sherry C. Wang, Department of Counseling Psychology, Santa Clara University, 500 El Camino Real, Santa Clara, CA 95053-0201, USA.
Email: sherrycwang@gmail.com



Mendy, 2013) and more likely to describe poor access to health care as a contributor to health problems in the Mississippi Delta region (Yadrick et al., 2001). In 2014, 27% of low-income adults aged 19 to 64 years and 12% of nonelderly African Americans in Mississippi were uninsured, although there were decreases in the proportion of uninsured in both these categories from 2013 to 2014 (“KFF State Health Facts,” 2016).

The Delta region of Mississippi is most affected by these limitations. The Mississippi Delta is traditionally recognized to include 18 counties in the northwestern part of the state, along or near the Mississippi River. This region suffers from the highest poverty rates (average of 33%, range 9% to 48.8%; U.S. Department of Agriculture, Economic Research Service, 2015) as well as the lowest health rankings (University of Wisconsin Population Health Institute, 2016) in the state. These counties also are home to the highest percentage of African Americans, ranging in most counties from 37.4% to 85.3% (Delta Regional Authority, 2015). Community members in these counties suffer from low educational attainment, high unemployment (Delta Regional Authority, 2015), and a pervasive history of racism and segregation (Harvey, 2013). The rural nature of the Mississippi Delta further creates additional barriers to access to many health services (Delta Regional Authority, 2015).

The Mississippi Delta is characterized by poverty, limited employment opportunities, a “racialized social structure” (Harvey, 2013, p. 257) poor health status and health care access, and limitations in primary care and preventive services. As a result, grassroots efforts have been developed to empower community members for health promotion, as a means to improve the health of Mississippi Delta citizens. Health promotion and prevention efforts specific to cancer have been one priority, given that this disease is the second largest contributor to the deaths of African Americans, second to heart disease (Kochanek et al., 2015). Scholars such as Ekundayò and Tataw (2013) have thoroughly documented the prostate cancer burden among African American men in Mississippi, where crude death rates far exceed those for White men.

In 2012, a network of male African American community health advisors (CHA), Men in Black and Blue Fighting Prostate Cancer, was developed, specifically emerging from an expressed concern by a local prostate cancer sufferer who was troubled by the late stage diagnosis of the disease experienced by himself and his peers, and consequent higher mortality rates (Ekundayò & Tataw, 2013). The purpose of this CHA network is to focus on cancer awareness, education, research, advocacy, and on increasing utilization of empirically based, life-saving early detection screenings. The CHA network comprises volunteer men in the community who provide educational materials and speak individually and in

groups to community members about health care. A key emphasis of this network is the role of African American men to provide education, solidarity, and support to one another to promote health care utilization.

The male-specific nature of the CHA contributes to the extant literature on masculinity and health seeking. To date, the link between masculinity and mortality has been well-documented; delayed efforts to preventative health care can be attributed to men’s adherence to traditional concepts of masculinity such as self-reliance, stoicism, and health care avoidance (e.g., Courtenay, 2000). However, the intersection between masculinity and health-related attitudes and behaviors are unknown for African American men given that much of what is known is compared with White American experiences and constructions of masculinity (cf. Wade & Rochlen, 2013). Additionally, it remains unclear how middle-aged and older men of color “conceptualize, perform, and embody masculinity” as “there [are] no published studies of masculinity and health among men of color that had an average age of 40 years or older” (Griffith, Gunter, & Watkins, 2012, p. S192). Thus, little is known about the experiences of older African American men although benefits have been reported to emerge from having trusted fellow community members provide health information with each other (e.g., Griffith, Ellis, & Allen, 2012).

In recognizing the aforementioned gaps in the literature, the aim of this study was to understand how older African American men in the Mississippi Delta defined “health” and the barriers they faced when promoting men’s health in their local community. Additionally, the current study draws from the conceptual framework of Metzl (2013) to direct attention to the importance of attending to the structural health and politics of older African American masculinity. Metzl (2013) distinguished structural barriers from individual action by stating that “in certain instances, attempts to improve the morbidity and mortality of African American men come up against structures and institutions that afford, enable, and occasionally block attempts to achieve longevity and well-being” (p. 68S). Thus, an inherent assumption of this study was recognizing the existence of cultural, economic, and political influences of health for African American men.

Method

Researcher/Team Reflexivity

A major concern for researchers working with historically underserved and underrepresented populations is the community’s mistrust of outsiders who impose research ideas and projects in the community without consulting or collaborating with insiders. To address this concern, the research team partnered with local groups in

the region to understand men's perspectives on health through community members who were and were not volunteers of the local men's CHA network. This understanding could then be applied to future prevention and intervention programs built on the community's preexisting definitions, strengths, and experiences.

The research team for this study was composed of individuals from the disciplines of nutrition and psychology at a university located in the southeast region of the United States. For nine months, the research team met for 90 minutes weekly and designed, collected, analyzed, and wrote the findings of this study as part of a pilot study for a future grant-funded project. The racial composition of the group included individuals who identified as White non-Hispanic, Asian American, and African American. Because all of the members of the team were female, time was set aside to discuss how researchers' perspectives, worldviews, and biases would affect the project on working with older African American men. The University of Southern Mississippi's Institutional Review Board reviewed and approved this study.

Research Design

The research design for this study was a qualitative, intrinsic, case study. This design was selected for a number of reasons. To begin, qualitative research has been identified to contribute to research by providing marginalized groups with an opportunity to have their voices heard (Creswell, 2012). Even more specifically, Lyons et al. (2013) have emphasized the value of conducting more qualitative research with individuals of African descent due to several areas of confluence, including a shared value for human-to-human interactions, and recognition that people's experiences are embedded in their larger environments. In deciding on a specific qualitative approach, case study design was chosen for its emphasis on understanding a central phenomenon within a particular context. That is, case studies are meant to "understand a real-life phenomenon in-depth, but [knowing it is not possible to do so unless] such understanding encompassed important contextual conditions . . ." (Yin, 2009, p. 18). The phenomenon for this study was therefore focused on "health" and the barriers of health promotion, as it is situated in the unique sociocultural context of the rural Mississippi Delta. Finally, case study designs are unique for their characteristics of being bound by space and time (Creswell, 2012) and the current study was conducted over a 3-month time period and bound to Public Health District 3 in the Mississippi Delta.

Recruitment

Participants were recruited by a community advocate/gatekeeper known for her leadership role in starting the

CHA Men in Black and Blue Fighting Prostate Cancer program. This individual invited participants who represented formal and informal community outreach organizations. Additionally, given her important role in the community, she was interviewed as a key informant, providing the researchers with contextual, background information about the history of the CHA network. With regard to the focus group recruitment procedure, recruitment letters were sent to members of one of the county chapters of the CHA network, and to organizations in the community which provided outreach services such as churches, fraternities, and public health organizations, asking them to participate in a 90-minute focus group session. Participants had to fit the following two criteria which were to reside in the two Delta counties in which there were active Men in Black and Blue Fighting Prostate Cancer groups, and self-identify as African American. It was preferable (but not required) for participants to be within 35 to 60 years of age and for them to have had some formal or informal experience with community outreach, leadership, or programming. A total of 14 men were recruited with 8 men attending the first focus group session, and 6 attending the second session.

Procedures

Data Collection. The individual interview and the two focus groups were conducted by the first and second authors, both of whom identified as ethnic minorities (i.e., Asian American and African American). The moderator of African American descent grew up in the Mississippi Delta and visited family there frequently. Her family resided in a different county from where the study was conducted. The moderator of Asian American descent was not originally from Mississippi but was a resident of the state at the time of the study.

The individual interview was scheduled at a time and place convenient for the key informant. Focus group participants were scheduled to attend one of two focus group meetings and greeted with a sandwich buffet and drink station prior to beginning the interviews. Informed consent was obtained using an oral presentation and written consent. The focus group discussion was guided by a semistructured interview protocol consisting of six questions designed to explore participants' definition of health and their experiences of health promotion (see the appendix). Cultural mistrust was anticipated throughout the research process. Thus, in an effort to acknowledge the historical role of research in oppressing and inappropriately conceptualizing and interpreting the experiences of African American communities (for review, see Huang & Coker, 2010), the research team included a question to ask participants about their perceptions of researchers in the Delta, including the moderators.

Data Analysis

Data analysis for a case study consists of capturing a rich, descriptive understanding of the context and content of the case, followed by identifying the most salient themes that emerged throughout the interview process. The thematic analysis procedures of Braun and Clarke (2006) were followed so that the process consisted of gaining familiarity with the data by reviewing the transcripts repeatedly, generating codes, and continuing to reread the transcripts. Throughout the process, memos were also written in the margins of the documents to maintain a record of any ideas, phrases, or concepts that emerged when reviewing the materials (Creswell, 2012). As codes emerged from the data, they were then grouped into themes, which were the broader overarching umbrellas to capture the smaller codes. These larger themes were then defined, named, and reviewed. Whenever possible, the direct wording of the participants was used, via *in vivo* coding in order to stay as close as possible to the participant wording (King, 2008). In following this process, members of the research team first independently read and coded each of the transcripts to identify codes and themes. Next, they met to discuss areas of similarities and differences in the codes and themes that emerged. Last, members decided on a final list of themes and rereviewed the transcripts as a group to ensure that the themes best captured the data.

Validation

Validation strategies refer to the trustworthiness of the data, and in the current study, four strategies were employed, many of which have been frequently used and are recommended by qualitative researchers (Creswell & Miller, 2000; Morrow, 2005). The strategies used were prolonged engagement in the field, triangulation, researcher reflexivity, and using quotes of evidence. Members of the research team had spent extensive time working with communities in the Delta region, including the gatekeeper interviewed for this study, to learn the culture and build trust. In this way, rapport could be more easily established so that study participants were willing to disclose information. With regard to triangulation, researchers used different methods and sources of information (i.e., focus group data and key informant interview) to converge multiple data points and corroborate evidence from different people and perspectives. Thus, findings were based on multiple, overlapping data. In terms of researcher reflexivity, the first author maintained a detailed record of her experiences, prior knowledge, and subjectivity throughout the research process through journal entries as well as field notes. Last, the findings are presented using participants' direct quotes in order to stay as close to possible to their lived experiences. Known as *in vivo* coding (King, 2008),

adhering to participants' exact phrasing allows the codes and themes to emerge in ways that are true to participants' specific wording. Altogether, these four validation strategies were implemented to ensure the "accuracy" of the findings (Creswell, 2012, p. 250).

Results

The present study yielded three key themes to capture the definition of and barriers to men's health promotion based on the perspectives of older African Americans living in the rural Mississippi Delta region. These themes were "men don't talk about health," "health care is not just the issue, everything is," and "we need a strong male to lead." The key themes and subthemes are briefly summarized in Table 1.

Men Don't Talk About Health

The most salient theme across all of the interviews was the message that men do not talk about health because there are no opportunities to do so. "It's a subject that most men do not talk about. They don't talk about health . . . it's something that we rarely think about unless someone is ill or something goes on with them." One participant named the current research project as one of the only chances for focusing on men and their experiences.

This is the most I think, any of us in this room . . . have talked about health . . . and there's really no avenues or areas where we get together to discuss health issues. There are no focus groups or anything that's set up that deals with that . . . because like [another participant] said, there are so many things going on that we're focusing on trying to fix it till we ain't even, we're not even concerned with fixing us . . .

Thus, for these men, the topic of health was generally absent—except in the face of a critical incident requiring immediate "fixing." In spite of the absence of opportunities and likelihood for continued dialoguing about their own health, participants noted the value in coming together and sharing their personal experiences—both for their well-being and for others'.

I think just sitting here talking to these gentlemen is gonna open our eyes up and say, "hey, we do need to share"—if not personal experiences, share the fact that it is something going on and that others need to be checked, need to jump in. . . . Just from this group today . . . "hey if I can just share it with one person that might help that one person."

The notion of sharing to help one another was a motivating factor for individuals to talk about themselves: to disclose their own health in an effort to assist others. This issue dovetailed well with the men's beliefs that they had

Table 1. Themes and Subthemes.

Theme	Subtheme	Concept
Men Don't Talk About Health	Men and Masculinity: Being a Gladiator	Men do not have opportunities to talk about health. Men are not supposed to get sick, to have weakness, or to show weakness.
Health Care Is not Just the Issue, Everything Is	Structural Barriers	Healthy behavior, by itself, does not guarantee health or even safety. Larger issues such as poverty, unemployment, and overall lack of resources are greater priorities.
	Lack of Togetherness	People in the community do not unite for a common cause and instead have pulled each other down.
We Need a Strong Male to Lead	Lead by Example	In spite of the absence of role models, men are taking efforts to be exemplars of healthy living.
	"We Just Can't Get the Word to Them That We Need Help in the Delta."	People outside of the Delta do not know the needs of the community; collaboration from outsiders willing to understand these needs is necessary to improve the Delta.

to appear strong, masculine, like gladiators—which emerged as a subtheme.

Men and Masculinity: Being a Gladiator. Masculinity was a key theme in understanding men's definition of health, such that they emphasized the necessity of maintaining a façade of being sufficient and able to take care of themselves and provide for others. Having health problems therefore signified personal flaws in ways that led to feelings of shame.

You know, we look at it as being a crack in the shield, the armor: we're men, we got the armor on . . . and to admit that something's wrong or I got weakness, I don't want anybody else to know about that. And that's just the mindset that we have. We were brought up in an era where a man was considered a gladiator. You know he had to get out there and go get it . . .

Ignoring or denying physical ailments was considered a sign of strength and even described as a type of indestructibility. In turn, seeking health services was considered to be a form of weakness and one rendered acceptable only at critical junctures.

. . . We were brought up to think that a man is a person that is invincible. That, hey, you got to go to work regardless and you don't complain about aches, pains and whatever . . . most of us don't go to the doctor until it's time for that annual 50 physical . . . that's when we go. . . . Unless you sick, cold, flu, or something . . .

Attending to one's health was therefore considered to be a response to a critical incident rather than a preventative approach because of its connection to being perceived as weak. The stigmatizing nature of being unhealthy was described by participants in terms of how private health issues were, and how "embarrassing" it was to "let [anyone] know what's going on with

them." Several men disclosed that they would not share their health concerns with anyone *including* their family members. Furthermore, to highlight the ways in which masculinity encompassed hiding their experiences, the men contrasted their lack of disclosure with their perception of women openly discussing their health issues with one another.

[Health] is a subject that we don't talk about and never have. And we don't discuss it in the family either unless it happens to somebody in the family. . . . Now on the other hand, you know, Black women [*sic*] is different. You can hear them on the phone talking about stuff all day. What's going on in their lives. But you ain't gonna hear us on the phone talking about that. . . . That's just between me and that doctor.

Because of the need to maintain a façade of strength, participants talked about the ways in which getting sick had a greater impact on them compared with their female counterparts. They referred to the psychological pressures they put on themselves to be seen as invulnerable and unsusceptible to weakness. They further described physical sickness as a physical toll and psychological consequence from feeling defeated:

I see more men let their sickness get them down than the women, and that's one thing a lot of people tell you not to say . . . you can't let that be known and you always got to be all-strong and all that [laughing to himself].

One participant jokingly admitted that men would not even tell each other if they were overweight, whereas women might look out for each other to address issues related to body image. The contrast between masculinity and femininity was salient and also reflected in diet and nutrition. For example, one participant talked about his experience of being shamed when shopping for himself and his daughter because the yogurt he purchased was considered to be "feminine-like food."

Health Care Is not Just the Issue, Everything Is

Structural Barriers. The notion of “health” elicited a breadth of issues that extended beyond the traditional view of health and behaviors like nutrition intake that could affect health. One participant sarcastically joked about the futility of using diet to address health when there were larger concerns for safety and the stress of staying alive in the Mississippi Delta:

Well, I can eat right but it don't solve all the problems . . . see we can go home and eat good, but when I walk out the door I done got popped in the back. Well, at least I was eating good though, wasn't I? It's just a big contradiction, less stress.

Similarly, another participant talked about challenges beyond individual-level factors, such as problems confronting the community from the rates of incarceration to the rates of unemployment, to parenting problems, and, subsequently, teachers being overwhelmed by their responsibilities to socialize the children. The economy was a major concern given the high rate of unemployment in the region and for some, the need to work “three and four jobs” in order to make a living.

We got unwed mothers that's got five, six children in the house. . . . And the outside peoples that's not in the Delta don't realize how much suffering goes on in the Delta. . . . They [are] just about homeless because they [are] struggling so hard to try to make it from one day to the other one. So we don't have time to think about health issues and things like that. We so focused on trying to figure out where our next meal goin' come from. Poverty is killing the Delta and we can do all the research and all the whatever we want to do. Until we get some jobs to come to the Delta to help our people, then we still gonna be lost . . .

Thus, structural-level barriers such as poverty, homelessness, and unemployment were salient across the interviews. For example, when participants described the efforts they had seen to promote health in the Delta, there were mixed reactions toward those efforts. For example, while some regarded health fairs positively, others highlighted the inadequacy of addressing individual-level health when larger issues pertaining to unemployment loomed above them. “The next time you come here and want to do a health fair, bring 300 jobs.” Participants expressed feelings of frustration toward efforts to make individual change, and instead, called for macro-level changes, such as through federal intervention:

We got to bring some jobs here . . . we talk about the health issues, talk about the eating habits, goin' to be hard for the research to help in this area when we, you can come up with your research but the solution to the problem . . . the

government is goin' have to come in here to do something major for us to overcome this what we're living in in this area.

Across participants and interviews, the men consistently emphasized the need for large-scale changes that could be brought into the community. Although some expressed the value and need for continued health screenings and behavioral changes in diet and nutrition, all participants remarked that the Delta required funding and resources from outside of the Delta.

Lack of Togetherness. The dispersed nature of the African American community was a salient theme that emerged as individuals talked about the focus placed on individual needs instead of a shared collective agenda for community empowerment.

We're like crawfishes you know, you know . . . you'll never get out of this bucket, because every time you go up, one will pull you down. And we're our own enemy 'cause we're killing ourselves. . . . It goes back to what all these guys said earlier, one big word and that's togetherness. Until we can start trying to do things together, we gonna be the downfall in this. Health care is just not the issue, everything is the issue.

Racism was also described as one of the barriers that the community faced, not only in terms of African American and White relations but also within the African American community:

. . . I can go to a store and purchase anything, and the person at the end of the line, they'll say, “thank you” and “come back.” I don't get that from my sisters. They rude, real rude. I can be in line behind a white guy and they'll thank him [and say] “come back.” And when I get up there, they act like I did something to them. . . . Well don't I deserve that same courtesy you gave that White man? Is my money just as green as his?

It is important to note, however, that in discussing the impact of race and race relations, participants did not collectively perceive racism to be an “us versus them” issue, with one participant emphasizing “it's not always the White man, it's us,” which highlighted the responsibility of the African American community to unite together. Participants reflected mostly on their own disappointments and frustrations with their own community to fail to unite together. In discussing the lack of cohesiveness among community members, one participant aptly summed up the only two reasons for people to unite for a common cause.

Two things to get us to come together and its sad to say, but it happens every day: funerals and food. The funeral is death, and food is death cuz they ain't tak[ing] care of themselves.

Given that healthy nutrition was one of the major ways in which participants were able to improve their health, the juxtaposition of food, unity, and death reflected the bleak outlook that participants had for themselves and for their community.

We Need a Strong Male to Lead

Lead by Example. Several participants talked about the need for leadership in the community, reflecting on the absence of leadership in their own families and also in the larger community. They described incarceration as a major reason for a lack of male role models in the community. They also described the long-term consequences of teachers being overtaxed with parenting responsibilities because of the lack of parental role model figures in homes and in the larger community. Additionally, participants described the long-standing history and legacy of having African American children grow up without role models and father figures to teach them about health. For example, one participant stated,

. . . Being able to, you know, talk about health issues, talk about these things . . . I couldn't learn that from my father because he didn't know, and his parents. It goes back generations . . .

As a result of this historical context, participants stressed the need to provide role models, leaders, and exemplars to guide subsequent generations. Several participants remarked on their efforts to address the problem by actively being the positive example for their family members as well as for their larger community. One participant repeated throughout the interview that "I want to be a good example to my daughter . . ." and described his efforts to make salads more frequently in order to incorporate newly acquired information regarding health and nutrition. Another participant talked about his role of being an educator in a school setting and using himself as the role model for the students and seeing its success: "I've had to actually challenge myself to be a lil' bit more healthy, to be that prime example to my students. And it's working."

The men in this study expressed hope toward the future as they reflected on the possibility of having a community leader convey their needs to those living outside of the Delta. They stated that they "need a strong male to lead" and called on each other to engage in greater political activities to be able to actively vote for representatives who could voice: "we need help in the Delta." Of importance was having a community leader who shared the same race, gender, and age (i.e., older African American male) as the participants in the study. One individual gave the example noted previously of his interactions with

African American women in the Delta, in which he was treated differently than if he were a White man. Having a community leader who was African American and male were critical to the psychological experience of not having to justify their experiences. ". . . When I deal with my brothers . . . they understand when you go to a car dealership, where they are going to charge you an extra \$2,000 and charge that White person \$2,000 less . . ." The intersectionality of race, gender, and age was therefore noteworthy, to highlight the unique lived experiences of being an older African American man.

"We Just Can't Get the Word to Them That We Need Help in the Delta." Participants expressed a need to have a local representative advocate for the needs of the community to those outside of the Delta. They described difficulties with having one representative relay the needs of the community to the U.S. federal government. They felt that no one knew about the problems they faced from within the Delta. "We just can't get the word to [officials in Washington D.C.] that we need help in the Delta." In identifying existing leaders of the community, participants reflected on leaders who had self-serving agendas and who prioritized individual goals over the well-being of the collective community. For example, a number of churches existed within a short distance, and this was described as a way in which the community split into several small factions due to individual desires to become leaders.

In discussing the role of insiders and outsiders of the Delta, participants varied with regard to their perceptions of having to be culturally similar. Some were especially enthused about involvement of outsiders coming into the Delta to enact change. For example, when one participant clarified that the first author/moderator "hadn't been to the Delta before," he followed up by saying "this is who I need to be talking to," eliciting laughter from other focus group members as they shifted attention from the second author/moderator (who identifies as African American and is originally from the Delta region) to discuss how resources could be brought into the Delta. Therefore, an assumption was made that reviving the Delta required an outsider to bring in external resources.

Oh we been neglected, and for years. . . . With a lil' nourishment and. . . . The Delta can be changed. I mean, if you can change the Gulf Coast back better than where it was after Hurricane Katrina, you can't tell me you can't change the Delta.

Although the participants were open to inviting outsiders to help improve the rural Delta, they cautioned against outsiders who do not have the community's interest at heart. "[P]eople [in the community] know who's sincere,

who's not sincere . . . ” They added that if an outsider were to enter the community, it was critical to partner with a trusted individual in order to gain credibility with others. . . . “[Y]ou always try to get somebody from the community to work with you when you come in to help with the process . . . ” The emphasis on partnership was a stark contrast to their recounts of outsiders who tried to conduct research in the Delta with an attitude of “I’m coming to try to save you.” Thus, despite the community’s expressed need for outside intervention, they had expectations about how that help should be delivered in the Delta.

Discussion

The findings of this study highlight the complex challenges for promoting men’s health in the rural Mississippi Delta. Men’s health cannot be understood in isolation without recognizing the role and influence of masculinity, politics, economic conditions, and a long-standing history of oppression. Other scholars have documented that African American men’s perceptions of health extend beyond the definition of merely being free of physical distress (Griffith, Allen, & Gunter, 2011; Griffith et al., 2013; Ornelas et al., 2009) and also encompass emotional and mental well-being, spirituality, and economic stability (Ravenell, Johnson, & Whitaker, 2006). Additional aspects of health have been described as being able to provide for one’s family, protect and teach children, being part of a group/community, and being effective at managing one’s own level of stress (Affuso, Cox, Durant, & Allison, 2011; Wade & Rochlen, 2013). In building on this body of knowledge, the findings from this study support a broad definition of health to underscore the importance of attending to structural-level barriers in health and health promotion. Health can be understood as a comprehensive accumulation of life stressors for African American men (Ellis, Griffith, Allen, Thorpe, & Bruce, 2015), which include unemployment, poverty, violence, sexism, a lack of community, and a history of oppression. Similar barriers have been identified in Watkins’s (2012) framework on the social determinants influencing depression for African American men, underscoring the importance of understanding structural barriers for both positive and negative health outcomes.

The themes from this study demonstrate the gendered nature of health as a woman’s issue. Men’s health was described as largely invisible when compared with women’s experiences of health. Underlying men’s health was the assumption that being male meant focusing on other, more pressing concerns than “fixing” oneself. Men were generally ashamed to admit problems with their health and/or to attend to their own health until a critical incident emerged, usually when it was “too late” to take any

preventative measures. This process can help explain the abysmally low rates of health care utilization among African American men and the need to incorporate gender considerations to address health disparities (Gilbert et al., 2016). For example, prevention and intervention efforts would benefit by being grounded in male experiences and socialization, such as by drawing from strength-based approaches to highlight the resilience and perseverance necessary in being a “gladiator.” In this way, the concept of being a gladiator could be used to promote health rather than be a barrier to health care utilization.

The findings lend support for research that has suggested the importance of relationships among African American men (Bharmal et al., 2012) and the need for culturally competent services that focus on male relationships to promote health care utilization (Holden, McGregor, Blanks, & Mahaffey, 2012). Although prior research has recognized the value of African American male relationships in enhancing trust and health care utilization, the focus was on younger, college-attending African American males (Grande, Sherman, & Shaw-Ridley, 2013), with less known about the experiences of older African American men. Results support the importance of facilitating a brotherhood in a larger community setting and for older African American men living in a rural Mississippi Delta region, such as creating forums that facilitate men’s groups to talk about health issues with each other. This approach is in keeping with the intent and methods of Men in Black and Blue Fighting Prostate Cancer. Although there is a large body of research examining the use of and favorable outcomes associated with women as CHAs/community health workers engaged in health promotion in vulnerable communities, published accounts of men in the role of CHA or peer helper/mentor addressing African American men’s health, are limited; and largely based on urban settings or specific health conditions (Holt et al., 2015; Kim et al., 2016; Scott, 2009; Vines, Hunger, White, & Richmond, 2015). Lay health advisors may be an important means to engage men about their health in a setting like the Mississippi Delta, with the multitude of challenges and resource constraints that contribute to the poor health status of its population.

Contrary to broad generalizations about the collectivistic and communalistic nature of ethnic minority communities such as African Americans, the findings provide a contextualized understanding of the dispersed nature of the community. This information from this study provides a nuanced perspective to understanding the role of the African American church, such that churches are not necessarily the place that community members come together; and individual agendas must be considered rather than assuming there is a shared collective agenda.

The crawfish depiction in this study is a culture-specific metaphor that has been previously described as the “legendary crab-barrel metaphor of intraracial strife” (Dyson, 1993). Dyson (1993) notes that

this familiar black cultural metaphor compares the plight of African Americans to crabs in a barrel that, instead of pooling their resources to help free each other, prevent the successful escape of any member through the self-defeating activity of mutual clawing. (p. xix)

Thus, the findings underscore the importance of attending to within-community dynamics as part of the sociocultural determinants that influence health and health promotion. As there continues to be increased recognition about the need to understand racism and masculinity as structural-level barriers that affect the health and health seeking for African American men (Powell, Adams, Cole-Lewis, Agveming, & Upton, 2016), more attention is needed about within-group marginalization and its effect on the community's ability to advance together in unity and solidarity.

In the face of the challenges described above, it is important to highlight the themes identified in this study that reflect strengths and resources from the men that can be utilized and incorporated into culturally sensitive methods and processes of health promotion. The need for leadership was salient throughout the interviews, and the absence of male role models was both a limitation as well as a motivating factor for many of the men who took it on themselves to be the exemplars of health for their families and their communities. The findings support existing work highlighting the disparities that African American men face in having fewer role models due to the loss of their community members through racist practices such as higher rates of imprisonment, incarceration, and violence in contrast to White men (Alexander, 2012). However, it also highlights the ways in which participants embody resilience to improve the lives of their children and their community members. Participants' expressed need for African American male role models supports the recent work of Rogers, Sperry, and Levant (2015). These authors describe African American masculinity as an intersectional framework involving race and gender, including being role models, providers, and protectors. From this perspective, pride may be understood as a strength that can be brought to bear when taking action for health promotion. Despite participants' perceived need for outside collaboration to improve the Delta, they did not see the community as needing to be “saved” by outsiders. Efforts to improve the Delta should therefore be focused on capacity building so that insider–outsider collaborations work toward finding collective actions and solutions, rather than assuming a savior role for outsiders.

The dispersed nature of the community reflects not only a lack of solidarity for health promotion but a lack of unity toward a common goal.

Limitations of the Study

The Mississippi Delta region is an area that historically encompasses 18 counties, and therefore, the diversity within this region should not be overlooked. While the findings from this investigation can be transferrable to other areas, they should also be interpreted with an understanding that the interview process and findings may be different with a different set of researchers and relationships with the gatekeeper and the community. In the current study, two focus groups and one key informant interview were conducted as part of a pilot study for a grant-funded project. Although the data for this study reached saturation in the analysis, conducting more interviews might have shifted attention to other domains of men's health. Nevertheless, the findings from this study generate a descriptive and nuanced understanding of the ways in which structural barriers can intersect with notions of health and health promotion for older African American men living in the rural Mississippi Delta.

Implications for Research and Practice

Based on the results from this study, health service providers and researchers can recognize the ways in which structural-level barriers influence men's health promotion in Southern, rural, African American communities such as the one in this investigation. The definition of health can benefit by being expanded to include caretaking as part of a masculinity framework so that culturally sensitive approaches can incorporate African American men's perceptions of needing to be indestructible with motivation to assist others (e.g., “You need to take care of yourself before you can take care of others”). Including self-care as part of the definition of masculinity may contribute to minimizing the gender role strain that African American men may feel to provide, take care of, and be leaders and exemplars for their families and larger communities.

Researchers and providers should also recognize that isolated efforts to help the community are insufficient and that cross-disciplinary collaboration is needed in order to assist those living in the most underserved regions and communities. In the current investigation, structural barriers contextualized participants' definition of health; as such, attending to sociocultural determinants is essential in order to address the health process and outcomes of older, African American men. Future research goals might be broadened to incorporate structural-level

changes for communities. These opportunities include disseminating findings through policy changes, advocating for resource allocations and employment opportunities leading to jobs for community members, using data to support the possibility of building a male-specific health center, and codeveloping policies and practices to help community leaders unify their communities.

The “lack of togetherness” in this study also reflects the need and opportunity to engage in community capacity building. In order to do so, the history and dynamics of communities and community members must be better understood. Solidarity among community members is needed to promote messages of health; therefore, efforts to facilitate community cohesion must be incorporated into health promotion efforts. Relatedly, outsiders should refrain from assuming unity and cohesiveness of communities based on geographical location or skin color, particularly given the complexities of historical oppression in contexts such as the Mississippi Delta.

Finally, the findings suggest that communities may have differential expectations toward insiders and outsiders, and cultural similarity may not always be necessary. In the current study, the moderators’ identities did not correspond with the ethnic, racial, gender, or age background of the community members. However, an attitude of humility, openness to learning, and respect for community expertise facilitated participants’ openness to disclosing how they differentially regarded insiders and outsiders who conduct research in their community. Thus, future research might include community engagement which invites community members to share their perspectives about the research process and not just the content. Attending to community members’ perception of process during formative research can facilitate community members’ sense of power and agency related to the research process. At the same time, members of the research team should engage in reflexivity, given the benefit accruing as a result of the researchers in this study spending a significant amount of time discussing the ways in which their ethnic, racial, and gender identities might influence the research process. The research process in this investigation was particularly noteworthy in facilitating participants’ concerns as well as their hopes to collaborate with (rather than being dominated by) researchers to collectively improve health promotion efforts in the Mississippi Delta.

Conclusion

In order to understand the needs of African American older men in the Mississippi Delta, it is critical to recognize the expansiveness of the term “health” in order to recognize the intersectionality of individual with structural-level barriers that impede comprehensive well-being. Prevention and intervention services may

benefit by incorporating masculinity as strengths among African American men, by recognizing the value of the men as providers and gladiators of their families and communities. Understanding how outsiders and insiders can collaborate together to advocate for improved health also requires an in-depth understanding of the cultural and historical context of the Delta, as well as an attitude of humility, respect, and mutual learning and curiosity. To promote the health of the African American community, collaboration is needed within and outside of the Delta so that social change can be sustainable.

Appendix

Qualitative Interview Protocol for Focus Groups

1. What comes to mind when you think about African American men and health?
2. How have you been able to reach out to African American men living in the Delta?
3. What challenges have you experienced in trying to reach this community?
 - a. Probe: Examples
4. What challenges have you seen/heard others experience in trying to reach the community?
 - a. Probe: Example of failed experiences
 - b. Probe: Distinction between insider and outsider (open-ended question)
 - c. Probe: Interviewer status as insider/outsider (use self)
5. What advice do you have to those who want to reach out to the community?
6. Is there anything else you’d like to tell me that we haven’t already talked about?

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

References

- Affuso, O., Cox, T. L., Durant, N. H., & Allison, D. B. (2011). Attitudes and beliefs associated with leisure-time physical activity among African American adults. *Ethnicity & Disease, 21*, 63-67.
- Alexander, M. (2012). *The new Jim Crow: Mass incarceration in the age of colorblindness*. New York, NY: New Press.
- Bharmal, N., Kennedy, D., Jones, L., Lee-Johnson, C., Morris, D., Caldwell, B., . . . Brown, A. (2012). Through our eyes:

- Exploring African-American men's perspective on factors affecting transition to manhood. *Journal of General Internal Medicine*, 27, 153-159.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77-101.
- Burd-Sharps, S., Lewis, K., & Martins, E. B. (2009). *A portrait of Mississippi: Mississippi Human Development Report*. Brooklyn, NY: American Human Development Project.
- Centers for Disease Control. (2013, November 22). CDC Health Disparities and Inequalities Report—United States, 2013. *Morbidity and Mortality Weekly Report*, 62(3). Retrieved from <http://www.cdc.gov/mmwr/pdf/other/su6203.pdf>
- Courtenay, W. H. (2000). Constructions of masculinity and their influence on men's well-being: A theory of gender and health. *Social Science and Medicine*, 50 (2000). 1385-1401.
- Creswell, J. W. (2012). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). Thousand Oaks, CA: Sage.
- Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory Into Practice*, 39, 124-130. doi:10.1207/s15430421tip3903_2
- Delta Regional Authority. (2015). *Today's Delta: A research tool for the region*. Clarksdale, MS: Author.
- Dyson, M. E. (1993). *Reflecting Black: African-American cultural criticism*. Minneapolis: University of Minnesota Press.
- Ekundayo, O. T., & Tataw, D. B. (2013). Barriers to prostate cancer prevention and community recommended health education strategies in an urban African American community in Jackson, Mississippi. *Social Work in Public Health*, 28, 520-538. doi:10.1080/10911359.2013.763707
- Ellis, K. R., Griffith, D. M., Allen, J. O., Thorpe, R. J., Jr., & Bruce, M. A. (2015). "If you do nothing about stress, the next thing you know, you're shattered": Perspectives on African American men's stress, coping and health from African American men and key women in their lives. *Social Science & Medicine*, 139, 107-114.
- Gilbert, K. L., Ray, R., Siddiqi, A., Shetty, S., Baker, E. A., Elder, K., & Griffith, D. M. (2016). Visible and invisible trends in Black men's health: Pitfalls and promises for addressing racial, ethnic, and gender inequities in health. *Annual Review of Public Health*, 37, 295-311. doi:10.1146/annurev-publhealth-032315-021556
- Grande, S. W., Sherman, L., & Shaw-Ridley, M. (2013). A brotherhood perspective: How African American male relationships may improve trust and utilization of health care. *American Journal of Men's Health*, 7, 494-503. doi:10.1177/1557988313485783
- Griffith, D. M., Allen, J. O., & Gunter, K. (2011). Social and cultural factors influence African American men's medical help seeking. *Research on Social Work Practice*, 21, 337-347. doi:10.1177/1049731510388669
- Griffith, D. M., Ellis, K. R., & Allen, J. O. (2012). How does health information influence African American men's health behavior? *American Journal of Men's Health*, 6, 156-163. doi:10.1177/1557988311426910
- Griffith, D. M., Gunter, K., & Watkins, D. C. (2012). Measuring masculinity in research on men of color: Findings and future directions. *American Journal of Public Health*, 102, S187-S194. doi:10.2105/AJPH.2012.300715
- Griffith, D. M., Ellis, K. R., & Allen, J. O. (2013). An intersectional approach to social determinants of stress for African American men: Men's and women's perspectives. *American Journal of Public Health*, 7, 19S-30S. doi:10.1177/1557988313480227
- Harvey, M. A. (2013). Consensus-based community development, concentrated rural poverty, and local institutional structures: The obstacle of race in the lower Mississippi Delta. *Community Development*, 44, 257-273. doi:10.1080/15575330.2012.734840
- KFF State Health Facts. (2016). Retrieved from <http://kff.org/state-category/health-coverage-uninsured/?state=ms>
- Holden, K. B., McGregor, B. S., Blanks, S. H., & Mahaffey, C. (2012). Psychosocial, socio-cultural, and environmental influences on mental health help-seeking among African-American men. *Journal of Men's Health*, 9, 63-69. doi:10.1016/j.jomh.2012.03.002
- Holt, C. L., Le, D., Saunders, R., Wang, M. Q., Slade, J. L., Muwwakkil, B., . . . Naslund, M. (2015). Informed decision-making and satisfaction with a church-based men's health workshop series for African-American men: Men-only vs. mixed-gender format. *Journal of Cancer Education*, 30, 530-534. doi:10.1007/s13187-014-0731-x
- Huang, H-H., & Coker, A. D. (2010). Examining issues affecting African American participation in research studies. *Journal of Black Studies*, 40, 619-636. doi:10.1177/0021934708317749
- Kim, K., Choi, J. S., Choi, E., Nieman, C. L., Joo, J. H., Lin, F. R., . . . Han, H-R. (2016). Effects of community-based health worker interventions to improve chronic disease management and care among vulnerable populations: A systematic review. *American Journal of Public Health*, 106(4), e3-e28. doi:10.2105/AJPH.2015.302987
- King, A. (2008). In vivo coding. In L. Given (Ed.), *The SAGE encyclopedia of qualitative research methods* (pp. 473-474). Thousand Oaks, CA: Sage.
- Kochanek, K. D., Arias, E., & Anderson, R. N. (2015). Leading causes of death contributing to decrease in life expectancy gap between Black and White populations: United States, 1999-2013. *NCHS Data Brief*, 218, 1-8.
- Lyons, H. Z., Bike, D. H., Ojeda, L., Johnson, A., Rosales, R., & Flores, L. Y. (2013). Qualitative research as social justice practice with culturally diverse populations. *Journal for Social Action in Counseling and Psychology*, 5(2), 10-25.
- Metzl, J. M. (2013). Structural health and the politics of African American masculinity. *American Journal of Men's Health*, 7(4), 68S-72S. doi:10.1177/1557988313486512
- Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology*, 54, 250-260. doi:10.1037/00220167.52.2.250
- National Center for Health Statistics. (2012). *Health, United States, 2011: With special feature on socioeconomic status and health*. Hyattsville, MD: Author.
- Ornelas, I. J., Amell, J., Tran, A. N., Royster, M., Armstrong-Brown, J., & Eng, E. (2009). Understanding African American men's perceptions of racism, male gender socialization,

- and social capital through photovoice. *Qualitative Health Research*, 19, 552-565. doi:10.1177/1049732309332104
- Powell, W., Adams, L. B., Cole-Lewis, Y., Agyemang, A., & Upton, R. D. (2016). Masculinity and race-related factors as barriers to health help-seeking among African American men. *Behavioral Medicine*, 42, 150-163. doi:10.1080/08964289.2016.1165174
- Ravenell, J. E., Johnson, W. E., & Whitaker, E. E. (2006). African-American men's perceptions of health: A focus group study. *Journal of the National Medical Association*, 98, 544-550.
- Rogers, B. K., Sperry, H. A., & Levant, R. F. (2015). Masculinities among African American men: An intersectional perspective. *Psychology of Men & Masculinity*, 16, 416-425. doi:10.1037/a0039082
- Roth, D. L., Skarupski, K. A., Crews, D. C., Howard, V. J., & Locher, J. L. (2016). Distinct age and self-rated health crossover mortality effects for African Americans: Evidence from a national cohort study. *Social Science & Medicine*, 156, 12-20. doi:10.1016/j.socscimed.2016.03.019
- Sandman, D., Simantov, E., & An, C. (2000). *Out of touch: American men and the healthcare system*. New York, NY: Commonwealth Fund.
- Scott, T. N. (2009). Utilization of the natural helper model in health promotion targeting African American men. *Journal of Holistic Nursing*, 27, 282-292. doi:10.1177/0898010109339929
- Short, V. L., Gamble, A., & Mendy, V. (2013). Racial differences in ideal cardiovascular health metrics among Mississippi adults, 2009 Mississippi Behavioral Risk Factor Surveillance System. *Preventing Chronic Disease*, 10. doi:10.5888/pcd10.130201
- United Health Foundation. (2015). *America's Health Rankings Annual Report: Americans less sedentary; rising drug deaths, obesity pose challenges*. Retrieved from <http://www.unitedhealthfoundation.org/news/articles/feeds/2015/1210americashealthrankingsannualreport.aspx>
- University of Wisconsin Population Health Institute. (2016). *County Health Rankings*. Retrieved at http://www.countyhealthrankings.org/sites/default/files/state/downloads/CHR2016_MS.pdf
- U.S. Department of Agriculture, Economic Research Service. (2015). *Geography of poverty*. Retrieved from <http://www.ers.usda.gov/topics/rural-economy-population/rural-poverty-well-being/geography-of-poverty.aspx>
- Vines, A. I., Hunger, J. C., White, B. S., & Richmond, A. N. (2015). Building capacity in a rural North Carolina community to address prostate health using a lay health advisor model. *Health Promotion Practice*, 17, 364-372. doi:10.1177/1524839915598500
- Wade, J. C., & Rochlen, A. B. (2013). Introduction: Masculinity, identity, and the health and well-being of African American men. *Psychology of Men & Masculinity*, 14, 1-6. doi:10.1037/a0029612
- Watkins, D. C. (2012). Depression over the adult life course for African American men: Toward a framework for research and practice. *American Journal of Men's Health*, 6, 194-210. doi:10.1177/1557988311424072
- Yadrick, K., Horton, J., Stuff, J., McGee, B., Bogle, M., Davis, L., . . . Zaghoul, S. (2001). Perceptions of community nutrition and health needs in the lower Mississippi Delta: A key informant approach. *Journal of Nutrition Education*, 33, 266-277. doi:10.1016/S1499-4046(06)60291-1
- Yin, R. K. (2009). *Case study research: Design and methods* (4th ed.). Thousand Oaks, CA: Sage.