God's Will: Social Constructions of Health and Healing in the Mississippi Delta

by

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B.S. (Trinity College) 1995

A thesis submitted in partial satisfaction of the requirements for the degree of Master of Sciences in Health and Medical Sciences in the GRADUATE DIVISION of the UNIVERSITY OF CALIFORNIA, BERKELEY

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Spring 1998
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Spring 1998
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ACKNOWLEDGMENTS

There are a number of people to whom I am greatly indebted and I wish to acknowledge their role in this research. Starting with my initial experiences in Jonestown, I wish to thank the Sisters of the Holy Names for introducing me to this very special town through the SHARED MISSIONS program. Sisters Sylvia Horsich, Kay Burton, and Teresa Shields, in particular, have been truly inspirational. I admire their devotion to the people of this community, and I have been so blessed to know them. There are no words to articulate the ways in which they have shaped my views and values. And, I especially thank them for their encouragement over the last eight years, and support of this project during the inception and implementation.

I am grateful to the people of the Jonestown community for their friendship and willingness to be a part of this study. There are so many people to thank; hopefully, you know who you are. I do want to mention a few people. Ms. Liberty, thank you for letting me stay with you; I so enjoyed your hospitality and friendship. The Thompson and Johnson families, thank you for your friendship and kindness. The CSJs and staff at the Jonestown Health Center, thank you for welcoming me and letting me experience life at the center. Manette Durant and Victorine Long, thank you also for friendship and support of my work.

At Berkeley, I am grateful to Paul Newacheck and Henrik Blum for their support and encouragement of my evolving project during the first two years of thesis interest group. I also thank you both for extending your support beyond this bi-weekly meeting. For help advising my depth interview guide, I wish to thank Jewelle Gibbs, Denise Herd, Carol Stack, and Pat Morgan.

Carol Stack, thank you for your encouragement and suggestions. Your work on rural blacks has been inspirational, and it was a pleasure to work with you.

Pat Morgan, I am grateful for your countless hours of advisement and support. Your enthusiasm for my work always kept my spirits lifted at the moments I needed it most. Thank you.
I would also like to thank my JMP classmates for their friendship and encouragement.

I am deeply grateful to my family, friends, and boyfriend for their support, at times both financial and emotional. Your encouragement throughout the years, and especially during this work, has helped sustain me. Thank you.

This research was supported by a Graduate Research Grant from the University of California, Berkeley Human Rights Center, and a travel grant from the University of California, Berkeley Division of Health and Medical Sciences.
INTRODUCTION

You don’t prepare for the Delta, whether you’re black, white, Asian, or Hispanic. You can’t prepare, really, because there’s no other place like it in the South, in America. You don’t experience the Delta so much as the Delta experiences you.¹

As this quotation so eloquently states, the Mississippi Delta is a place unlike others. While I do not know the effects of my experiences on the Delta, the Delta has certainly influenced me over the last eight years. This research has resulted from of my initial acquaintance with the Delta community of Jonestown.

During and subsequent to that initial five week visit, I have become more interested in the health of rural black communities. In the search to find out more about this topic, it became increasingly obvious that limited attention has been given to the health experiences of blacks in specific rural areas. Due to this disappointing finding, this master’s thesis developed as a means to elucidate some of the gaps in the current understanding of health in a rural black community.

This project has been grounded in the cultural and social context of the Jonestown community since the complex web of cultural, social, and economic values have an enormous influence on the way health care needs are expressed as expectations or patterns of health seeking behavior (DeFriese & Ricketts, 1989). This research was undertaken to explore the ways in which such cultural norms, beliefs, values and social structures influence health conceptualization and behavior throughout the adult life-course. Within this framework, the following research questions guided this study:

1) How do adults take care of themselves?
2) What mitigating factors affect the ways in which adults take care of themselves?

¹ From “Delta is laden with history for an African American” by Larry Copeland in The Seattle Times Travel section from Sunday, November 10, 1996.
Thesis Overview

In chapter one, literature pertaining to the health of rural blacks is reviewed. Topics emphasized are the definition of health, health-protection, help seeking patterns, and illness behavior. Since most research in these areas has focused on older rural blacks, some comparative studies of urban blacks and also rural whites are also presented to provide some additional depth.

The theoretical framework of the study and research design are presented in the methodology chapter, chapter two. A detailed description of this ethnographic study is provided within the chapter. Procedures pertaining to data analysis are also reviewed.

Overview of historical background and demographics of Jonestown from its early settlers to the time at which the study was conducted is provided in chapter three. Texts, historical documents, and professional and citizen interviews and conversations were information sources for this review. This chapter provides the contextual background in which the reader should consider the research findings.

Chapters four through seven detail the ways in which health is conceptualized, people take care of themselves, and mitigating factors shape the ways in which people take care of themselves. In these discussions, I will try to give voice to the people of Jonestown through stories and quotations in their own words because too often those who have been marginalized have been silenced. In doing so, the pivotal roles of cultural norms, religiosity, and historical social structures are shown to affect health construction and behaviors to a greater degree than gender or income.

Health is defined in chapter four to show how health is conceived by study participants. The four inter-related meanings of health described by informants are presented. Additionally, a brief discussion of perceived health status and health control is provided within this chapter.

Chapter five details the ways in which informants took care of themselves throughout their adult life-course. A theoretical framework was devised to depict how illness affected the
ways in which informants took care of themselves. Religiosity, social structures, and health conception framed a number of complex factors that influenced health behavior, with illness and without.

Factors that influence the use of health professionals is the focus of chapter six. Even though medical care was briefly discussed in the prior chapter as a means of last resort when other healing modalities have failed, this chapter more thoroughly evaluates the effects of barriers to care, the Jonestown Health Center, and religiosity on health professional utilization.

Suffering was discussed by informants in terms of social injustices and physical ailments. Chapter seven gives voice to their experiences as a means to view suffering as a condition that has resulted from such hardships. Historical social structures, cultural factors, and religiosity are shown to be the important factors that mitigate the experience of suffering.

Discussion and concluding thoughts are presented in chapters eight and nine. Study findings are evaluated in relation to prior research of rural blacks. And, a brief discussion of reflexivity, researcher disclosure of preconceptions and assumptions that may have influenced this study, is provided. Concluding remarks and suggestions for future research directions are then presented.
CHAPTER ONE. LITERATURE REVIEW

Studies on lifestyle and health that account for contextual factors are needed (Bailey, 1987; Dean et al., 1995; Fleury, 1996; Weinert & Burman, 1994; Weinert & Long, 1987; Wilson-Ford, 1992). Despite these contentions, texts that portray blacks and black culture provide little discussion on health issues or how blacks take care of themselves (Levine, 1977; Smith, 1995; Staples & Boulin Johnson, 1993). Similarly, little discussion of health is contained in bodies of work strictly devoted to rural people (Castle [Ed.], 1995; Davidson, 1996) or black rural communities in the Mississippi Delta (Cosby et al., 1992; Doolittle & Davis, 1996; Lemann, 1991). Evaluation of how blacks take care of themselves would have been appropriate within these accounts because they provide the social, political, and economic context in which health factors can best be appreciated.

With regard to social science and public health research on black rural communities, previous attention has focused on older populations (Davis et al., 1991; Fleury, 1996; Parks, 1988; Powers, 1982; Snow, 1983; Weinert & Burman, 1994; Wilson-Ford, 1992). Of all research identified that explores health values and behavior in rural black communities, only one study has had a subject population that ranged throughout the life-course (Strickland & Strickland, 1996). This one study, however, limited its focus to preventive health barriers. Therefore, little is known about what factors influence health behaviors in rural black populations (Olmedo & Farron, 1981; Powers, 1982; Strickland & Strickland; Wilson-Ford, 1992).

A comprehensive review of health in rural communities has been provided by Weinert and Burman (1994) and Rowland and Lyons (1989). Their reviews are not specific to blacks, and little effort was made to identify literature that directly examined their issues. Similarly, Russell and Jewell (1992) and Snow (1983) review literature on health care practices of blacks, but they do not address issues that may be specific to blacks in rural communities.

What is known about rural blacks will thus be explored. In reading this, two caveats should be considered. First, as just stated, little is known about the health of rural blacks. And, the experience of all blacks is not adequately represented by what has been studied. Secondly,
rural communities are incredibly heterogeneous (DeFriese & Ricketts, 1989) and it is unlikely that findings from one particular community can be appropriately generalized to all others (Weinert & Burman, 1994).

Health Definition and Meaning

The World Health Organization (WHO) (1992) defines health as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity (p. 1).

Despite this broad definition provided by WHO, numerous studies have found health to have different meanings in various populations. Health has been defined as the ability to do what needs to be done in a study of rural white Montana farmers (Weinert & Long, 1987) and a study of white and black elders in six rural Alabama counties (Davis et al., 1991). This same study and others of black rural southerners (Dula, 1994; Stack, 1996) implicate that health for older rural blacks also involves freedom from dependence on others. Independence and autonomy were identified factors that determine health for older rural blacks in studies conducted by Blake (1977) and Dula. Additionally, the soul was been found to be an important component of how health is defined by lower class blacks (Snow, 1983).

Health status has also been described in generalized terms. Ware (1987) suggests that health status has multiple dimensions and is also a component of a broader quality of life concept that includes standard of living, quality of housing, job satisfaction, and other domains. Of all possible factors that influence health status, education has been determined to be the most consistent predictor (Kohrs & Mainous, 1996).

Taking Care of Oneself

Little research attention has been given to the ways in which rural blacks, or people in general, take care of themselves. Within this context, most research has focused on health care utilization patterns (Bailey, 1987; Blake, 1977; Davis et al., 1991; Dula, 1994; Millet et al.,
1996; Parks, 1988; Snow, 1983; Weinert & Long, 1987). Other research has considered factors of health maintenance (Powers, 1982), health-protection (Duelberg, 1992; Wilson-Ford, 1992), wellness motivation (Fleury, 1991; Fleury, 1996), and social support (Dula, 1994; Fleury, 1996; George, 1988; Semmes, 1996; Stack, 1970; Stack, 1974; Stack, 1996; Taylor, 1988; Tilden, 1985). None of these studies, however, thoroughly examine factors that influence the ways in which people take care of themselves throughout their adult life-course.

In a study of Detroit blacks, Bailey (1987) contends that health care seeking practices of blacks are affected by their continued use of practices adapted in earlier eras despite fewer present barriers to care. This study delineated a six step process in seeking help for one’s health: 1) illness appears; 2) wait; 3) allow body to self heal with use of prayer and traditional remedies; 4) evaluate daily activities; 5) seek advice from family or friends; 6) seek out health professional. Studies in rural populations also indicate that informal or self help (Davis et al., 1991; Fleury, 1996; Stack, 1974), prayer (Millet et al., 1996; Parks, 1988; Powers, 1982; Snow, 1983; Wilson-Ford, 1992), and home remedies (Blake, 1977; Dula, 1994; Parks, 1988; “Self-Treatment with herbal and other plant-derived remedies - rural Mississippi, 1993,” 1995) are frequently utilized before seeking help from health professionals.

Both traditional remedies and formal medical care have been used concurrently by some rural blacks to maintain health (Powers, 1982). This work and Clavon and Smith (1986) have also found that strong faith in God and living a good Christian life were believed to help older rural black woman to maintain health. This study, however, indicated the need to explore reasons why some people utilize both traditional remedies and the medical establishment.

A study of older rural black women found that they do not involve health care professionals or the formal health care system in their attempt to protect their health (Wilson-Ford, 1992). This claim has been challenged by a report that black Baptists commonly utilize regular medical check-ups (Spector, 1996) as a means of health protection. Rural or urban designation of the subject population was not designated in the report. Both researchers,
however, do suggest that blacks believe the following behaviors are health protective: eating right, prayer, home remedies, and rest.

Various barriers to care also influence rural black utilization of health care professionals (Beck et al., 1996; Fleury, 1996; Stack, 1974; Strickland & Strickland, 1996). Each of these studies identified that ability to pay or government assistance were circumstances that limited access to care and treatment. Health values and poverty were seen as interrelated rather than separate obstacles. Thus, inability to pay reinforced dependence on home remedies and self treatment. While these studies provide insight into the existing barriers to medical care, they do not describe what rural blacks do when encountered by such factors.

Factors influencing motivation to make lifestyle changes has been explored in older rural southern blacks attempting to make lifestyle changes (Fleury, 1996). This study substantiated a prior theory of empowering potential based on whites with coronary artery disease (Fleury, 1991). For older rural blacks, behavior change reflected an individualized definition of health that fulfilled personally relevant roles in family, social, and community activities. While this study found that various strategies were utilized to initiate and maintain health behavior change, three stages of change involved appraising readiness, changing, and integrating change. Health value orientation and social network affiliation were discussed as two cultural contexts in which change occurred. This study, however, did not discuss how its informants got to the point where they began to appraise their readiness for change.

Several health values acknowledged in this study (Fleury, 1996) are worth a brief discussion. Informants discussed the value of living in the present time rather than worrying about the future. In doing so, spirituality and religious beliefs were a emphasized. For many informants, healthy living was part of an effort to live according to personal values, religious beliefs, and community norms.

Such social factors have additionally been shown to affect the ways in which people take care of themselves in other studies. Within this context, family, church, and friends have
been most influential. The black family has been described as the primary care giving institution for kin and non-kin (Dula, 1994; Fleury, 1996; George, 1988; Semmes, 1996; Stack, 1970; Stack, 1974; Stack, 1996; Taylor, 1988). Semmes describes the role of families as pivotal to the goal of health as they provide and direct nutrition, caring and curing, and reduce stress. Families also serve to reinforce positive health influences, such as those from the church. These studies also indicate that older blacks frequently interact with family and community members and are part of reciprocal relationships with them as they both receive and provide social support. Such informal and interdependent support systems within the family and community are described as fluid, dynamic, responsive, and accommodating.

Response to Illness

Theories of illness behavior have been reviewed in various works (Chrisman, 1977; Kassebaum & Baumann, 1965; Kosa & Robertson, 1975; Loustaunau & Sobo, 1997; Mechanic, 1962; Suchman, 1965). Illness has been described to evoke a set of patterned expectations that define sickness status norms for appropriate behavior.

The concept of the sick role was introduced by Talcott Parsons in 1951. According to this social theory, sickness is legitimized under four conditions: a sick individual is exempt from normal social roles; 2) an ill individual is not at fault or responsible for the sickness condition; 3) an ill individual should try to get well; and 4) an ill individual should seek technically competent help and cooperate with the physician. Therefore, sickness produces a temporary disturbance in one’s ability to fulfill usual duties. As such, an ill person assumes a specific sick role that modifies one’s normal position and obligations when illness is legitimized. The sick role permits one to observe specific “norms” and let the sick role take priority over other social capacities.

Despite this theory, various other factors have been shown to affect illness behavior. Socio-cultural factors such as age, education, ethnicity, gender, disease, and social position
affect whether the dominant sick role is accepted or rejected (Chrisman, 1977; Kassebaum & Baumann, 1965; Kosa & Robertson, 1975; Mechanic, 1962; Suchman, 1965).

While no rural black specific studies of the sick role have were identified, rural whites (Lee, 1993) and urban blacks (Suchman, 1964) have rejected this dominant sick role. In the latter study, strong family orientation to tradition and authority were believed to important factors involved in sick role rejection.
CHAPTER TWO. METHODS

This community ethnography study explored health meanings, beliefs, and practices of a rural black population in the Jonestown, Mississippi area. In analysis of interview transcripts, participant observation, and ethnographic field notes, grounded theory was utilized to develop a framework that uncovers and describes: 1) how people take care of themselves and 2) what mitigating factors affect the ways in which people take care of themselves.

Design

This study was conducted between the months of May through August 1997 using a triangulated research design. The methodologies utilized consisted of depth interviews, professional interviews, participant observation field notes, and document reviews. Such qualitative methods are often employed to determine the story of a defined group's daily life, to identify meanings, patterns, and passions of a bounded cultural group (Miller & Crabtree, 1994).

Setting

This research was conducted in the greater Jonestown, Mississippi area. Located in the Mississippi Delta, this town’s population consists of approximately 1491 people (U.S. Bureau of Census, 1997). And, blacks comprise more than 95% of the residents.

Subjects

The target population were adults, over the age of 21, of African-American descent living in and around the area of Jonestown, Mississippi. All interview participants met this criteria. Discussions with non-black people and people below the age of 21 were a part of participant observation and were also included in field notes, when relevant.
Data Collection

Depth interviews of Jonestown residents were semi-structured, flexible, and in-depth. The twenty conducted interviews were audio-taped and varied in duration from forty-five minutes to two hours. These discussions provided a means for discovery and meaning understanding.

Professional interviews were unstructured, and were not audio-taped. Notes were either taken during the interviews, or immediately afterward. Interviews were conducted with town and surrounding area health practitioners, health services administrators, health educators, social workers, and government officials. These interviews provided the researcher information and reports about historical and present day community health issues in addition to particulars about service agencies and health initiatives.

Participant observation was unstructured and consisted of the researcher's day to day experiences of living and interacting in the Jonestown community during the study period. Within this capacity, the researcher participated in a number of community activities. Weekly Sunday church services were attended at various churches. Some church choir rehearsals and special church program services were attended. Various community meetings were attended, some of which included: a Head Start planning session for parents, volunteers, and workers, an HIV/STD education class for adolescents, and Clarksdale Medical Society meetings. The researcher shadowed the nurse practitioner in the Jonestown Health Center for more than twenty-two hours, and later spent around thirty-six hours working there in place of the registered nurse when she was on-leave. In all, approximately forty-five hours per week were devoted to such activities and other informal involvements with community members.

Principles discussed in Luborsky and Rubinstein (1995) and Bogdewic (1994) were incorporated into this aspect of the study. This process enabled the researcher to better understand how contextual factors influence the decisions and activities of people in the greater Jonestown community.
Ethnographic field notes were generated from experiences gained from living in the community. This documentation, typically daily, allowed for a flexible and open-ended process of inquiry. Even though such documentation cannot completely recapture all details of relevant discussion and activity, according to Atkinson (1992), it does allow for a number of important observations to be recaptured and analyzed.

Historical Documents were examined to provide for a thorough understanding of the cultural, political, and historical context of Jonestown. Texts, newspapers, organization literature and newsletters, U.S. Census Data, and other government databases were consulted.

Depth Interview Recruitment and Sampling Procedures

Interview participants were solicited through churches, posted signs, and word of mouth. Interviews were conducted in a location chosen at the discretion of the participant. Location suggestions made by the interviewer included: participant’s home, researcher’s residence, The Learning Center, and the Jonestown Health Center.

Churches were utilized for recruitment because the community is highly religious. Eleven churches were attended, they were chosen for being most proximally located to town. Going to various community churches provided the researcher a means to introduce herself to the community, and interviews were also solicited. Prior to attending a particular church, a pastor or church member was contacted. Arrangements were made to introduce the study during the time allowed for church announcements in the Sunday worship services. Interested individuals were encouraged to obtain an information sheet from the researcher following the service. The researcher made herself available to answer questions after the service. Adults interested in participating in the study were asked to contact the researcher in person or by phone. Scheduling arrangements were made with those interested in being an interview participant.

Posted signs were utilized to inform and solicit interview participants from the general public. Signs were, therefore, posted in highly visible locations. Locations of posted signs
included: the post office (townspeople have post office boxes and receive their mail at this location), stores, and the Jonestown Health Center. The researcher's phone number was on the sign so that prospective individuals could make contact and discuss their interest in discussing what health means to them. At that time of contact, the study was described as it was during the church announcement. If the individual was interested, arrangements were made to schedule a date, time, and location for the interview.

Interview participants and acquaintances in the community were asked to identify and introduce the researcher to additional potential interview participants and key informants. Such maximum variation and opportunistic sampling strategies and procedures enabled the researcher to become acquainted with a greater number and spectrum of the community than would have been otherwise possible. This approach also assisted in the process of gaining trust of new participants.

Twenty audio-taped depth interviews were conducted. This sample size is believed to be adequate as Kuzel (1994) states that approximately twelve to twenty participants are commonly needed in qualitative inquiry to achieve maximum variation while only six to eight data sources suffice for a homogenous sample.

Of those with whom interview arrangements were made, only one person changed her mind and declined to be interviewed. In this one case, after the researcher began to read the informed consent document the older woman decided that she would not be good for the researcher to interview and that others would be better. Although she refused the interview, she invited the researcher to stay and talk with her; the resultant informal conversation lasted more than an hour. Further visits were made at the request of the woman.

Depth Interview instrumentation

Qualitative Interview Guide

In-depth semi-structured individual interviews were carried out to obtain information about what health means to people and how people take care of themselves. All interviews
were conducted by the researcher using an interview guide (see Appendix A), rather than a questionnaire. Participants were audio-taped to document the interview.

Open ended, repeated, and probing questions were used to facilitate the flow of the discussions. The three categories of questions involved: general exploration, health care utilization, and health conceptualization. Sample questions from the three categories include: tell me some of the ways you take care of yourself?, if you have a health problem what do you do?, and what does health mean to you? Interview questions were developed with the assistance of several social scientists at the University of California at Berkeley. Some revisions were made after a pilot interview was conducted in Berkeley, CA. Questions were continuously revised during the interview process. Constant revision of interview questions allowed for a flexible approach to discussions that enabled the researcher to pursue topics and issues that were not anticipated during the pre-study development phase.

Interviews were conducted in various sites, and the decision was made by the interview participant. Ten interviews were conducted in the home of the participant. Three were held at the Jonestown Learning Center, and another three at the participant’s place of employment. Two were conducted at the researcher’s primary residence. One was held in a church, and another was conducted at the Jonestown Health Center.

Questionnaire Collected Demographics

After the audio-taped depth interview was completed, the participant was asked a series of demographic questions. Information about age, years lived in Jonestown, education, health insurance, and other factors were obtained to explore within-group generalizability and differences in addition to town generalizability.

Considerations

This study was reviewed by the Committee for Protection of Human Subjects at the University of California at Berkeley and approval was obtained prior to study initiation. Prior to interviews, signed informed consent was received from participants after reading aloud of
the document and discussion. Study participants were given the opportunity to decline the interview, and told that they could refuse any question or terminate the interview at any time.

Data Analysis

Using the grounded theory/editor analysis framework adapted from Miller and Crabtree (1994), all interview tapes were transcribed and analyzed as were field notes. This process was begun during the data collection period and continued after its completion. The applied framework is provided below:

```
editor → text → i.d. units → revise categories → interpretively → verify determine connections
```

The researcher was the editor. Within the text, meaningful segments were identified from which theme units were identified. These themes were then clumped into categories, and connections were determined. For verification, the researcher went back to the text and continued the process described above until determined meanings and variations were adequately verified. This approach provided for a process in which theory discovery was driven from the data, as opposed to utilizing a preconceived theoretical scheme with a priori assumptions to drive analysis.

The research tradition of grounded theory was developed by Glaser and Strauss in 1967. By being based on and connected to the context-dependent observations and perceptions of the social environment, this research approach was grounded. Theory was thus grounded in the examined social context. And, the researcher evaluated the core social, psychological, and structural processes within the investigated social environment. This was done by constant comparison checking of research interpretations against data, the text.

Using the grounded theory/editor analysis framework, two main models were utilized. Decontextualization-recontextualization as described by Atkinson (1992) was employed. It
involved fragmenting or “coding” (categories, instances) and then regrouping these fragments into thematic headings. Thick description was also utilized to make within-case generalization and to uncover conceptual structures, theory (Geertz, 1973). Thick description utilized narrative structures to give shape, coherence, noteworthiness, and passion to reported events. Both interview transcripts and field notes were analyzed in this narrative structure. Thus, stories that shaped events are presented.

The only statistical information of demographic data collected were number, frequency, and percentages. The statistical data was calculated by hand.

The criteria for rigor are based on trustworthiness and authenticity (Lincoln, 1992). In terms of trustworthiness, validity and reliability refer to the extent to which the results of a research study can be believed, trusted, and valued.

In the tradition of quantitative research, internal validity is the extent to which a researcher’s observations and measurements accurately describe a particular reality. External validity is believed to be the degree to which descriptions can be generalized or compared accurately with other groups. Reliability is substantiated by the consistency, stability, and repeatability of the research. Quantitative researchers assure that their studies are credible when the criteria for validity, both external and internal, and reliability are met (Miller & Crabtree, 1994).

While it is important in all research to use methods that assure a study can be believed, trusted, and valued, qualitative research uses a different set of criteria to achieve these principles. In qualitative research, trustworthiness can be accomplished through triangulation, thick description, and reflexivity (Brody, 1994).

Using multiple methods and various data sources to increase trustworthiness is a process called triangulation. Inquiry involves observation cross-checking among various divergent data sources.

Thick description gives shape, coherence, noteworthiness, and passion to reported events through thorough documentation of the investigation setting (Gilchrist, 1994). It is
utilized to make within-case generalization and to uncover conceptual structures, theory (Geertz, 1973). Trustworthiness is judged by the researcher’s ability to document and discuss similarities and differences within the study group and other similar groups.

Open disclosure of preconceptions and assumptions that may have influenced data gathering and analysis is called reflexivity. Research trustworthiness is gained as one is able to acknowledge bias and explore ways in which such predisposition may affect research findings and conclusions.
CHAPTER 3. THE LAND: JONESTOWN HISTORICAL
AND DEMOGRAPHIC BACKGROUND

Surrounded by fertile cotton fields, Jonestown, Mississippi is a rural community in Coahoma County. It is 70 miles south of Memphis, TN on highway 61. Today, Jonestown is a predominantly black community, and has a population of around 1500 people (Bureau of Census, 1997). The county seat, Clarksdale, is 14 miles south west of town at the junction of highways 61 and 49.

Background on Town

Over the years, this town has undergone many transformations. These major shifts in population, industry, and politics have occurred during significant historical periods for the United States. This timeline is, thus, used to get a snap-shot image of this town’s evolution to what it is today.

Early Settlers to World War I

Prior to the Reconstruction, the Delta was mostly quiescent. The Mississippi River seasonally flooded the area, and it was not until levees were built after the Civil War when the Delta became more developed as increasing numbers of white and black settlers came to the area. Prior to this, the land was mostly uncleared and undrained.

Native American settlement sites, however, date back to as early as 1700 BC along the eastern edge of the Mississippi Delta near the town of Greenwood which is about a one hour drive south west of Jonestown (Dennis, 1992). Whether Native Americans lived around the area now known as Jonestown at that early date is not known. The Tunica, Chickasaw, and Choctaw tribes, however, were known to be around the area of Jonestown in the sixteenth and seventeenth centuries. Less than a mile away from Jonestown lies an ancient Native American burial ground which is suggestive that Native Americans settled within close proximity to Jonestown. White explorers’ encroachment and diseases proved devastating to the Native
Americans and their populations dropped significantly from around 5,000 in 1700 to 1,600 in 1760. Tribal numbers then rebounded until their forceful removal in the 1830s.2

Around the 1840s, White settlers came to the Jonestown area to work in the mercantile industry. After the Civil War, whites began to cultivate the land and grow cotton. Blacks came to the area from the eastern Mississippi hills and other areas to fill the demand for field hands.

In these early days, this area was known as Swan Lake. It was later renamed Jonestown after one of its early white settlers, John Jones. In 1874, the Narrow Gauge Railroad, the Mobile and Northwestern, came through the area from Glendale, MS. Business in the village grew, and Jonestown was chartered on March 15, 1886.

A church housed the school and served as a place for general meetings. In these early days, Jonestown was active and bustling. Two large plantations were within close proximity, and this railroad town developed for the use of the white plantation residents along with their black sharecroppers and domestic workers. Political conventions were held in town, and local dances were held each time a new store was built.

Since the 1870s, Coahoma County has had a black majority. Immediately following the War in the early 1870s, Blacks voted and held political office within the county and state. After “race riots” in neighboring towns during 1875, many blacks were prevented from voting in the November election. This voting “black-out” became Mississippi tradition as Jim Crow laws were enacted in the late 1880s. For nearly one century after this, town leadership was white and the town was segregated.

Segregation was legally sanctioned after the Jim Crow Laws of etiquette were instituted. All aspects of life were separated. The whites had their Baptist churches and the blacks had theirs. The same was true for schools. Blacks, unlike whites did not receive much of a formal education because of the cotton industry. Black children of sharecroppers were only allowed to attend school when the cotton plants were not in the ground. Therefore, black

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children were able to attend school only from January to March. And, as many black boys and girls became more able bodied, they did not complete grammar school because they were needed to help their families tend to work and household needs.

During this time, the black community was close-knit through neighborly responsibilities, church, and circumstances that bound people together. Families helped others in time of need by making sure that others had enough food and supplies when others could not make ends meet. Blacks helped one another and knew that others would help them if times got rough.

Support was also provided by churches in times of need. During these early days, only a couple of black churches existed and they were central to the black community. These Missionary Baptist churches served as a place for worship and celebration. God was a priority in people’s lives. God was praised through prayer, word, and song. People lived by the word of God by following the teachings of the Bible. Comfort was found in the belief that God does not put more on someone than one can bear. This religious foundation provided blacks the strength to persevere.

World War I to World War II

This time period was marked the Great Migration of blacks to the North.

The demand for cotton was high during World War I. In 1919, the price of Delta cotton reached an all-time high, relative to inflation; it was priced at a dollar a pound. Hard times, however, struck hard and fast as the economic depression in the US began to be experienced in the Delta ten years early. Disaster struck in 1920 as the price of cotton fell to ten cents a pound. Times were rough for both the farm owners and their sharecroppers. Once the 1930s arrived, times got harder and the era was known as the “panic crash” by sharecroppers.

Prior to this cotton crash, blacks had begun to migrate North to make a new living. As a way out from the cycle of sharecropping, some men went into the military. Others, both men and women, took the train from Clarksdale directly north to Chicago, or found rides. Chicago
was a mecca for those seeking more education, nonagricultural employment, or reprieve from the legally enforced racial discrimination of the Delta. Many settled there and returned to Jonestown only for reunions, family celebrations, or funerals. Others found city life undesirable or too daunting; their stay in the big city was brief. The town’s connection to Chicago remains as many residents have family members there, and children frequently travel to and fro during school vacations. Other major areas of migration included: Detroit, Omaha, Kansas City, and Memphis.

Farm owners were vehemently opposed to this Great Migration. They needed blacks on their farms for their livelihood. The black school system was kept inferior, in part, because black children were not to have career options beyond sharecropping or domestic help (Lemann, 1991). White farm owners began to take steps to ensure their survival despite the black migration North.

Delta planters recruited blacks from the hill regions to sharecrop on their farms. Thus, the black migration was equalized by a movement of blacks within Mississippi to the Delta during the teens and 1920s. Predominantly, people came from the northern and central Mississippi hills.

In 1935, Aid to Dependent Children was established. This federal welfare program was devised to provide money to people, particularly widows, who were unable to earn a living. What effect this program had on the Jonestown community in these early days of its inception is not known. It’s later effects are paradoxical and will be explored.

What is known about black families during this era comes from discussions with older community members. During this time period, elders were active as primary care givers for many of their grandchildren or great nieces or nephews. Care provided by extended family enabled the passing on of core values. Parents were enabled to work without worrying about the care of their children. In turn, children learned the importance of God, respect, duties, education, and other fundamental values. This continues to be true, with some recent exceptions.
Post-World War II to the 1960s

This time period is noted for two major events. First, the era of sharecropping came to an end. Second, public school integration initiated a *white flight* and whites began to move out of Jonestown.

The widespread mechanization of the cotton industry in the late 1940s brought an end to the sharecropping system. Previously inexpensive sharecropping labor was replaced by a machine that could do the work of fifty people and cost a little more than one-eighth as much as hand picking a bale of cotton, $5.26 compared to $39.41 (Lemann, 1991). Most farm owners switched from a sharecropping farming system to an all-day-labor system. Blacks chopped cotton (weeded the fields) by hand while the machines picked the cotton.

In the late 1950s, chemicals were developed to kill weeds between cotton plants. With this, the need for hand chopping decreased significantly. While people were still needed to do adjunctive work, the all-day-labor system was no longer a viable source of income to provide for one’s family throughout the year. By the late 1960s, nearly all former sharecroppers had to find a new livelihood to sustain themselves.

The black migration continued, and white farmers changed their attitudes about it in the 1940s after the mechanized cotton picker was invented. Migration to the North actually became a resolution of the white farmer’s dilemma of what to do with all the black sharecroppers that they no longer needed.

As less field labor was needed due to mechanization, children of sharecroppers were allowed more formal education than previously. The impact of this change was tremendous as those able to obtain an education were provided skills that enabled some to break the cycle of sharecropper poverty. Despite this knowledge, blacks who remained in town had few career options. The few who were educated could teach in the black school system. Whites continued to need domestic help. Men could become preachers, get hired as farm help driving machinery, or establish a business in town. Despite these options, many were unemployed and could not find year-round work.
Other industries were slow to come to Jonestown, or it could be said that they did not come at all. Even though mechanization lessened the need for farm labor, white farmers opposed incoming industry because it would make it difficult for them to obtain the black labor force they needed. Incoming industry would offer higher wages than planters. Thus, other industries were met with resistance. As a result, the only industry to come to Jonestown was the cotton seed oil mill which remains operational throughout the year in the southwest corner of the town.

There were other barriers to economic development in the Jonestown community. It has been argued that the black migration contributed to create a brain drain that continues to present day as many young and educated people leave Jonestown (Gray-Ray, 1992). As these individuals have sought and achieved personal advancement, the community suffered economically and socially. With such an exodus, it has been difficult for an educated and skilled labor force to develop in Jonestown. These deficiencies in education and labor force are believed to be factors that deter industries from locating in the Jonestown area (Gray-Ray). Additionally, a thirty percent rule, where businesses avoid relocation to areas where the nonwhite population is greater than or equal to thirty percent, may have influenced industries to find Jonestown undesirable (Jones, Thornell, & Hamon, 1992).

The war on poverty was announced in a 1960 President Kennedy speech, however, it was not technically instituted until 1964 under President Johnson. Despite these Washington efforts to circumvent poverty, the urban ghetto was really the focus of that campaign. The particular problems of rural poverty, as experienced by people in Jonestown, were virtually ignored. The establishment of Head Start, however, reached Jonestown and it remains today as one of the governments attempts to acculturate the poor.

Schools were at the center of another big change for Jonestown. Despite the 1954 decision on Brown versus Board of Education, court ordered desegregation of schools was not actualized until the late 1960s and early 1970s. This decision had several effects. White academies were chartered to maintain racial segregation of schools; in Clarksdale, Lee
Academy was founded in 1969. Secondly, industrialization came to a near stand still as corporations seriously considered not relocating to the area due to racial concerns. And locally, a white migration was initiated; whites began to relocate to Clarksdale and other areas away from Jonestown.

The Civil Rights act of 1964 and the Voting Rights Act of 1965 were instrumental in enabling significant black electoral and general voting participation. Such freedom was last known prior to 1875. The white exodus continued as Mr. Shanks was elected the first black town mayor. As many whites left, so did their businesses and the town’s economic stability and livelihood. Many black descendants of sharecroppers and domestic workers remained in town, while most of the whites moved away.

Some blacks remained in their homes, others found new places to live as their homes were plowed down and more land was cleared for cotton. Others remain unoccupied.

Families became dispersed over many states, but most would travel and organize for family reunions in the summer. Most were held around the fourth of July weekend. Despite family separation, the family unit remained close. Extended family and friends, or kin networks, were especially important to the community. Family and kin continued to play a critical role in care giving for children and the aged.

As the town’s black population increased, more men received the call to preach. In turn, more churches were built. The once tight knit black community became more fragmented with this growth. The churches were no longer packed each Sunday. Church services began to alternate weeks at some churches while others were able to maintain weekly morning worship.

Church networks also became somewhat exclusive, often those who did not belong were disregarded; it's almost like they in they own little groups, and then the other people that's not in the groups, they just left out [interview #13 male].
1970s to Present

Today, Jonestown is a predominantly black community. Only seven white families live in town. Additionally, there are four white Catholic religious sisters whose work involves education and health care. A Chinese-American family own a food store in town and live above it. The rest of the residents are black.

Coahoma County remains a persistent poverty county as designated by the U.S. Department of Agriculture (1997). To receive this designation, more than 20% of the population must live below the poverty level in each of the years 1960, 1970, 1980, and 1990. Specifically in 1989, the Jonestown community had an overall poverty rate of 67.8%; see table 1.

This town is faced with urban problems that it does not have the resources to effectively address. Unemployment is high; there is great need for more jobs. Better education is needed. Public transportation is inadequate at best. There are few options for child care. Families are separated by state lines. The infrastructure is weak as roads are in dire need of repair, and some residents believe the water supply is contaminated. There are not enough social outlets. Homelessness exists; there are no shelters. Drugs, alcohol, and violence cause fear and safety concerns, among other things. And, the tight-knit community sustained through hard work and reciprocity has begun to change into a community in which helping others has decreased, but is still valued by many. And, racism still exists and its effects permeate through most aspects of daily life. These are some of the factors that make Jonestown unattractive to those seeking a “call to home” or remigration to the South.

Gone are the days of large dry good stores, a movie theater, and other commercial stores along main street. The gins in town no longer remain operational; they are now covered by lush greenery. Today, main street consists of the town hall, police station, two small mom & pop stores, a video rental store, a second hand store “The Treasure Spot,” a service station, a bank, a bar, a barbecue joint, a collapsed building, and several empty lots and store fronts. In other areas of town, there are a few more service stations and small mom & pop stores along with a

\(^3\) Determined through conversations with various community members.
post office, two schools, The Learning Center (a preschool and after-school center for children), The Durocher Service House (a religious sister’s house used for adolescent tutoring, mentoring, and social development), health center, and fire station.

Table 1. Jonestown Demographic Data from 1990 U.S. Census

<table>
<thead>
<tr>
<th>Population Characteristics</th>
<th>Overall N=1467</th>
<th>Whites N=62</th>
<th>Blacks N=1402</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age: &lt;18</td>
<td>(648) 44%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-20</td>
<td>(79) 5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21-29</td>
<td>(187) 13%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-39</td>
<td>(177) 12%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40-49</td>
<td>(101) 7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>50-59</td>
<td>(68) 5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>60-69</td>
<td>(91) 6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;70</td>
<td>(116) 8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education (≤18): &gt;9th grade</td>
<td>(222) 27%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9-12 (no diploma)</td>
<td>(275) 33%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H.S. graduate (or GED)</td>
<td>(80) 10%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some college</td>
<td>(116) 14%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A.A.</td>
<td>(80) 10%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B.A.</td>
<td>(43) 5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Graduate or Prof. degree</td>
<td>(13) 2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital Status: Married</td>
<td>(431) 47%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Divorced</td>
<td>(50) 6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Separated</td>
<td>(80) 9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never Married</td>
<td>(230) 25%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Widow</td>
<td>(124) 14%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Capital Income (1989)</td>
<td>$3046</td>
<td>$7405</td>
<td>$2859</td>
</tr>
<tr>
<td>Below Poverty Line</td>
<td>(986) 68%</td>
<td>(9) 14%</td>
<td>(977) 70%</td>
</tr>
<tr>
<td>Unemployment Rate</td>
<td>26.6%</td>
<td>5.7%</td>
<td>29.2%</td>
</tr>
<tr>
<td>Households</td>
<td>399</td>
<td></td>
<td></td>
</tr>
<tr>
<td># of People in Household</td>
<td>3.43</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Household Income: Mean</td>
<td>$7313.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;$5000</td>
<td>150</td>
<td>6</td>
<td>144</td>
</tr>
<tr>
<td>$5,000-9,999</td>
<td>107</td>
<td>2</td>
<td>105</td>
</tr>
<tr>
<td>$10,000-14,999</td>
<td>79</td>
<td>8</td>
<td>71</td>
</tr>
<tr>
<td>$15,000-22,499</td>
<td>59</td>
<td>2</td>
<td>57</td>
</tr>
<tr>
<td>$22,500-34,999</td>
<td>33</td>
<td>7</td>
<td>26</td>
</tr>
<tr>
<td>$≥35000</td>
<td>5</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Households Receiving:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Asst. (no designation)</td>
<td>(204) 47%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SSI</td>
<td>(123) 29%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

These remaining businesses do not fulfill the work force needs of this community of nearly 1500. Many do agricultural work in outlying fields of cotton, rice, pecans, or soybeans. Jonestown is predominantly dependent on this seasonal labor, the casino industry, and transfer
payments, the federal program monies which are designed to provide direct assistance to the needy. This dependence has resulted in high unemployment rates. Some work in nearby towns of Marks and Clarksdale, mostly in service jobs. With the advent of casinos along the Mississippi River in Tunica County, more jobs have become available since 1992. Those who commute to jobs at one of the ten casinos travel at least thirty minutes by car each way or take a commuter bus that takes more than an hour each way. Commuting to work is not uncommon to those in Jonestown as the nearest town is fifteen minutes away by car. Even with the new employment opportunities provided by the casinos, a job shortage remains for those in Jonestown. Thus, unemployment rates are high and dependence on government assistance is difficult to break.

Unlike Jonestown and most Delta counties, other communities in Mississippi and areas in the South are experiencing a remigration. The combined out-migration of blacks and whites in the county in which Jonestown is located has resulted in net population losses of more than 16,000 people since 1940 with continuing negative population changes into the 1990s (Doolittle & Davis, 1996; Howell, 1996; Saunders, 1992). Poor economic and education opportunities along with community deterioration play large roles in the continuation of out-migration despite the opposite current trend in other areas.

Unlike the sharecropping era when all adults were needed for field work, jobs are now not available to all. Without jobs, parents have increasingly taken the responsibility of child rearing upon themselves. Families have also become split between various states, and the role of the extended family and kin has changed. Now, elders are infrequently the care givers for their grandchildren. Additionally, the advent of Welfare enabled some parents to stay at home with their children instead of relying on elders.

Temporary Aid to Needy Families (TANF), formerly known as AFDC is viewed by many in the community as paradoxical. The working poor and unemployed poor who do not have children of their own do not qualify for assistance; some women feel that they are punished for not being able to bear children. Even though some of these women care for their nieces, nephews, and young cousins, they still are ineligible for benefits.
Additionally, the old system of AFDC was believed to enable people, mostly single mothers, to not help themselves. Some were not encouraged to work so they could receive benefits that would pay substantially more than a job. The issues of transportation and the unavailability of day care were also factors. Since TANF changes have been instituted, many people believe that they are being punished; once encouraged to be dependent, they are now being penalized for being just that. In the words of one woman, *why allow a person to get so used to, to being lazy, enable a person, where you gonna give him this and give him that, and then all of a sudden just snatch it, snatch it from him, snatch the bread out of his mouth. That’s not right* [interview #6].

Many community elders now believe that children are not being raised properly. It is believed that the stresses of daily living, working, transportation, health problems, racism, and poverty have resulted in such hard times and burdens that it has been difficult for some parents to pass on the values that they learned to their children. Frequently, parents have been too busy trying to provide for their family so that children have too often not been provided the guidance, encouragement, and positive reinforcement that they once received. Instead, television and the media have served as great influencers on these vulnerable youth.

An education is not as highly valued as it used to be when it was less obtainable, instead many view drugs and violence as attractive. Of course not all community members use cocaine, marijuana, or alcohol, but the problem is palpable. Some use these drugs out in the open. Most people can identify those that use and sell drugs. The issue is real and part of people’s daily lives.

Despite the available opportunity to receive an education, many continue to drop out of school. Early estimates of high school completion are not available, but town specific data as recent as 1989 are troubling (U.S. Bureau of Census, 1990). Only 40% of people eighteen or older (332 of 829) had graduated from high school or received their general education diploma (GED). Of the 60% who had not graduated from high school or received their GED, nearly one-half received less than a ninth grade education. In 1993, the county high school graduation rate
(there is no high school in town for a town specific graduation rate) was 58.6% (U.S. Bureau of Census, 1997). While a racial breakdown was not available, see table one for more specifics.

Drugs and alcohol are not just an issue for youth since adults are also users. Various community members discussed widespread effects of substance use; some of these concerns included: school drop-outs, unemployment, homelessness, violence, incarceration, and poor child rearing. Some extended families were said to have discontinued contact and support for the user. And, many community members and those from outside town fear for their safety in certain areas of Jonestown, especially at night.

Local government officials have been slow to respond to the pressing social issues affecting the community. Police officers are generally believed to be ineffective. One woman described them as Pickers and choosers ... them that they like, they don't do nothen to them. Them that they don't like, they throw them in jail or charge them a fine or something [interview #7]. Past mayors and alderman (elected town council) have also neglected to address the drug problem. Other town concerns such as lack of public transportation, road damage, inadequate school education, unemployment, homelessness, poor housing, and lack of social outlets have also not been adequately addressed.

Jonestown is still very much a town of religious black people, however, the number of church members has declined. Some estimate that only sixty percent of the town's 1500 residents are church members; previous percentages are believed to have been much higher. The contrast between the young and old is evident as few young people attend churches. Where have so many younger people gone? Most are still religious despite their uninvolved in a church. Times have changed. Employers no longer honor Sunday as a holy day and many must work. Others are disheartened by church divisiveness, and others must care for a young or elder family member. Some choose not to go for their own reasons.

Whether people go to church or not, the majority still believe in the word of the Lord. God is a guider that helps one lead their life. Religion is a panacea as God heals and promises
his followers an after-life that is a reprieve from one's human struggles and pains. Many do not believe that they could make it from day to day if it were not for God's help.

Today, there are more than twelve churches within three or four miles of town whose primary members are from Jonestown. Some churches hold weekly services and others alternate weeks. The establishment of the Swan Lake Baptist Association has brought some unity back to the community, but some still believe that the churches create divisiveness among blacks. These people contend that the community would be stronger if resources were pooled and there were one large church.

Much community mobilization is needed. Instead of the local government taking action, outsiders tend to be the ones to institute change. Outsiders, such as Catholic religious communities, have recently been the ones who identify needs and get resources. In 1984, the Washington Province of Holy Names Sisters began an education project in Jonestown. Of the two sisters currently living in town, one has been in town for fourteen years and the other for almost nine years. Their educational work provides remedial help and enrichment experiences for the community to achieve more academic and social success. Additionally, their programs have sought to increase self-esteem, adult skills, and volunteerism within the community.

In 1992, the Jonestown Learning Center was established under the sponsorship of the Holy Names Sisters because parents asked for after-school tutoring for their children. Programs are made possible by the sister who is the center director, and community members who are either Delta Service Corps (AmeriCorps) Volunteers or part-time employees. Current center programs include: a preschool, an after-school program for children below fifth grade, a “Girls to Women” class to prevent teen pregnancy, a “Parent as Teacher” parenting class, and summer school classes for children below fifth grade. In the past, GED classes, adult basic literacy, fitness classes, and loom weaving classes have been held at the center.

The Durocher Service House is overseen by another Holy Names sister, and was initially known as the Service House at its 1989 inception. Here, children in sixth grade and above receive after-school tutoring from other young adults from the community, piano lessons,
and get involved in projects. Some past projects include: carpentry and a chess tournament. The GED classes are now given here.

There are exceptions to this “outsider” involvement. One was the establishment of a club that provides money for people to buy groceries and pay their utility bills when times are tough. Their money is obtained through community fund raising and donations. This club was founded in 1984 by a group of ten black friends in their fifties and sixties.

Other exceptions include the recent completion of a softball field for the town’s youth under the direction of a black family. Other black families helped to relocate a family into a government housing project from a decrepit home. And, this summer two black women were preparing to open day care facilities in their homes to address the lack of day care available to working parents. So, change is coming.

**Interview Participant Characteristics**

Audio-taped interviews were conducted of twenty adults aged 30 to + 70 (one man did not give his exact age) from the greater Jonestown area. Ten were women and ten were men. Participants aged 30 to 54 were considered young while those 55 and older were classified as older (see table two). While this determination was made somewhat arbitrarily, it is only used here as a means to separate out those born during and after WWII from those born earlier.

The only striking differences from the interview population and available town demographics were in regard to household income and government assistance. While the interview participants had a higher mean household income than the general population in 1989, the interview respondents also received more government assistance. The men, both younger and older, earned significantly more than all women. The men also received less government assistance while all women received some form of government support.
<table>
<thead>
<tr>
<th>Participant Characteristics</th>
<th>Overall N=20</th>
<th>Women N=10</th>
<th>Men N=10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Young N=5</td>
<td>Older N=5</td>
<td>Young N=5</td>
</tr>
<tr>
<td>Age: Mean</td>
<td>52.1</td>
<td>35.4</td>
<td>40.8</td>
</tr>
<tr>
<td>30-39</td>
<td>(6) 30%</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>40-49</td>
<td>(4) 20%</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>50-59</td>
<td>(3) 15%</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>60-69</td>
<td>(1) 5%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>+70</td>
<td>(6) 30%</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Years in Jonestown (Mean):</td>
<td>31.9</td>
<td>20.6</td>
<td>21.8</td>
</tr>
<tr>
<td>Born in Jonestown</td>
<td>(3) 15%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Born in Delta Region</td>
<td>(18) 90%</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Education (Mean years):</td>
<td>11.75</td>
<td>12.8</td>
<td>7.8</td>
</tr>
<tr>
<td>0-6</td>
<td>(3) 15%</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>7-12</td>
<td>(8) 40%</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>&gt;12</td>
<td>(9) 45%</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Personal Income: Mean</td>
<td>17,009.11</td>
<td>4389.60</td>
<td>5748.00</td>
</tr>
<tr>
<td>$0 - 5,000</td>
<td>(4) 20%</td>
<td>3</td>
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<td>$5,001-10,000</td>
<td>(4) 20%</td>
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<td>3</td>
</tr>
<tr>
<td>$10,001-20,000</td>
<td>(7) 35%</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>≥$20,001</td>
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<td>5748.00</td>
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<tr>
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<td>3</td>
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<tr>
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<td>3</td>
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<td>5</td>
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<td>3</td>
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<tr>
<td>Housing</td>
<td>(3) 15%</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Food stamps</td>
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<td>4</td>
<td>1</td>
</tr>
<tr>
<td>TANF</td>
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<tr>
<td>WIC</td>
<td>(2) 10%</td>
<td>2</td>
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</table>

* Calculated mean reflects the refusal of a man at least 70-years-of-age to give his exact age.
Table 2 (Continued). Interview Participant Demographic Data

<table>
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<th>Participant Characteristics</th>
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<th>Men N=10</th>
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<td>Older N=5</td>
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<td>(Active members)</td>
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<td>Baptist</td>
<td>17 (12)</td>
<td>5 (4)</td>
<td>3 (2)</td>
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<td>Pentecostal</td>
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<td>0</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Catholic</td>
<td>1 (1)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>No Affiliation</td>
<td>1 (1)</td>
<td>0</td>
<td>1 (1)</td>
</tr>
</tbody>
</table>

= Overall percentage is greater than 100% since some people had multiple sources of health insurance or government assistance.
= Parentheses represents the number of those who were currently active in a church.

Background on Health

From discussions with people and review of literature, it is evident that people in the Jonestown community have used the allopathic medical system very little. Historically, they were denied due to their race. More recently, they have had limited financial and transportation access to care; see table three.

The tradition of home remedies developed as a means of self-care. According to Bushy (1992), health care, like other aspects of survival and social development, was an individual’s responsibility before the advent of specialized social functions. From topical turpentine and castor oil to ingested vinegar and teas, home remedy treatments have been passed on through women to younger generations. A more thorough discussion of home healing and medicinal remedies is provided in chapter five.

Racial politics have had a profound effect on the health of blacks. Although a detailed discussion cannot be provided here it is important to mention a few points.4

Public health crusades by black middle-class women in the early twentieth century probably did not involve the Jonestown community given its distant location from substantial

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black middle-class communities. Additionally, no evidence was found that would indicate that people from Jonestown community were involved in the health education and anti-segregation campaigns of the National Negro Health Movement from 1932 to the 1950s under the US Public Health Services. While the movement did not result in health facility integration, its legacy was surely instrumental in facilitating later changes providing greater access to care for blacks.

Coahoma County, in which Jonestown is located, has been designated a Health Professional Shortage Area and Medically Underserved Area by the U.S. Department of Human Services.

Prior to the 1991 reopening of the Jonestown Health Center, many people did not receive medical care. Cost and transportation were major factors. Instead, prayer and home remedies were utilized. Others went to medical offices in Clarksdale or Marks.

**Midwives**

The legacy of black lay midwives lasted nearly a century in the Jonestown area. From the Reconstruction to the late 1960s, black midwives delivered the majority of black babies in the area.

In Mississippi, they delivered 80% of black babies and a small percentage of white babies well into the 1940s (Smith, 1995). By 1982, the state stopped issuing permits to lay midwives, and only thirteen registered lay midwives remained in the state.

Accounts from the only living midwife in town provide the only town specific information available. At the age of 42 in 1948, this woman had finished having children and began her midwifery training. She trained by observing other midwives. Over time, she began to take on assisting responsibilities.

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Working nineteen years until 1967, this woman delivered a few thousand babies. Books of birth certificates still remain in her possession should anyone in the community need a copy of their record.

Table 3. Results from 1995 Jonestown Community Hearing

| Problems that Limit Access to Health Care | • funds not available for prescriptions if the physician is paid  
| | • limited knowledge of resources - where to find who and why  
| | • limited knowledge of surrounding communities  
| | • transportation to and from providers  
| Major Problems that Result in Health Care Problems | • unemployed, street people, causing filth/litter & frighten people in the community  
| | • alcohol and drug abuse  
| | • fear  
| | • sewage & stagnant water  
| | • inadequate housing  
| | • insufficient plumbing  
| | • pesticides & other chemicals  
| | • inadequate law enforcement  
| | • diseased animals allowed to run free  
| | • rodent infestations  
| | • no recreational facilities  
| Health Care Utilization Problems | • lack of funds for care  
| | • transportation to and from appropriate care  
| Transportation Problems | • lack of funds for transportation  
| | • lack of knowledge of location of providers in other communities  
| | • distance from emergency care  

Table contents are shown as presented in the Partner’s in Care summary document. Information was gathered at a 1995 Jonestown community hearing organized by administrators of the Partner’s in Care research project in Mississippi Delta communities. Approximately 20 adults from Jonestown attended this evening meeting held in the town’s community center.

Unlike some documented roles of black midwives as general community health educators (Smith, 1995), this woman was more focused on the birthing process. During the seventh month of pregnancy, she would make her first visit to make sure the mother had adequate supplies, ie. clean towels and a water. She would not return until she was called for, and would than attend to the mother and deliver the baby. Knowledge of the fetus’ position in
the womb was utilized to manipulate positioning. A woman’s discharge was also examined as an indicator for normal delivery. Blood was one such indicator. If the discharge was bloody, she tried to get the woman to the black hospital in Clarksdale or to a doctor when there was one in town. After the baby was born, the midwife would make three visits. The first was usually 12 hours after delivery. During these visits, she would check on the mother and baby’s well-being and bonding.

Patience and love for her work were the key to her success. She stopped practicing only after walking to people’s home became too much work at the age of 61. Many people lived outside of town on plantations and in the country, so she had to walk to people’s homes from hers in Jonestown.

The practice of midwifery in Jonestown ended soon after this woman stopped practicing. Interest in midwifery was fading as the Mississippi State Board of Health tried to eliminate midwives and people were encouraged to have hospital births.

Schools

Public school provided health education is taught in physical education classes. It was reported that these teachers are not interested in the health educational component of their courses. This disinterest is believed to effect the amount of time and effort put into the health curriculum.

Churches

Unlike some white churches in Clarksdale and some black churches in urban areas, black churches within the greater Jonestown area are not involved in formal health education programs.

Informally, however, churches do play a role in health. Pastors in various churches frequently told their congregations to turn your pains over to Jesus. God’s healing powers were emphasized in nearly all services that the researcher attended during the summer.
Some church networks also provide elders with free transportation to medical offices or the hospital. As many people have limited access to care due to transportation, church communities have begun to bridge this gap for some elders.

Additionally, Church Mothers and other older women in the church are frequently sought for health advice. Within this context, home remedy inquiries are common. Such knowledge is passed down through the generations in families and also through church networks, which some consider to be an extended family network.

Federal Funding

Federal health care funding outweighs other sources of revenue in Mississippi. Programmatic block grants that target particular services and populations are one major allocation of federal funds. Social Security along with the Medicare/Medicaid assistance is the second major provision of federal funds.

The program Women, Infants, and Children (WIC) is another source of federal funding. Mississippi does not provide state funds to supplement the program which is administered by the State Department of Health. Program participation is estimated to be 63% (95,060) of the 150,888 eligible. This participation percentage is higher than the national average of 45% eligible.

In 1993, 41.1% of Coahoma county residents (13,025 of 31,665) were eligible for Medicaid (Doolittle & Davis, 1996). This represents a 4.2% increase from the 1989 documented 35.9% (12,221 of 34,000).

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Community Health Centers

Mound Bayou was the pilot location for a federal authorized network of migrant and community health centers in medically underserved areas. This center opened in 1965. There are now more than 2,000 such health centers in the US.

In 1981, the Mound Bayou center also became part of the Aaron E. Henry Community Health Center consortium. Now, seven such sites exist in Mississippi. All are linked to the federal network of community health centers. The Mark’s DePorres Health Center and Clarksdale Aaron E. Henry Community Health Center are the two locations closest to Jonestown; Jonestown’s clinic is not a satellite site. These health centers are organized around the community oriented primary care approach. Of the seven sites, three are school based clinics located in Friars Point, Tunica, and Marks. Various primary care supportive services and educational programs serve the Delta community including: a perinatal high risk management and infant services program, HIV/AIDS/STD prevention activities, and public transportation.

Jonestown Health Center

The Jonestown Heath Center was built in 1962 under the Kennedy Administration during the movement for rural health center establishment. Since its opening, various doctors have provided services at the center a few days a week.

Most recently, the center was closed from 1988 to 1991. In June of 1991, it reopened under the direction of white Catholic Sisters of St. Joseph, a religious community based out of Minnesota. This federally qualified free standing center is now staffed by a family nurse practitioner, a registered nurse, a bookkeeper/microbiologist, and two administrative assistants. A physician from a nearby town serves as the center’s preceptor who reviews charts and sees patients one morning a week. Typical primary care services are provided by the center with the exception of: prenatal, mental health, surgical procedures (except stitch removal), and some laboratory work.
Initially after the center’s 1991 reopening, the community thought the center was a place for people with the disease (sexually transmitted diseases), like the Health Department. Over the years, this perception and attitude has changed. Those patients that were seen in the early years were mostly seeking acute care. Were it not for the center, these people would have gone to the emergency room at the hospital in Clarksdale.

From an initial average of 10.8 visits per day in 1991, client visits per day reached their peak in 1995 with 19.2 visits per day, see table four. During 1996, the center did not have a registered nurse. This is believed to be the reason why the average client visits per day dropped to 15.1 in 1996.

<table>
<thead>
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<tbody>
<tr>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td>0-4</td>
</tr>
<tr>
<td>5-12</td>
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<td>13-17</td>
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<td>Medicare</td>
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<td>New Clients per Month (avg.)</td>
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<tr>
<td>w/o Medicaid</td>
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</table>

Since the first few years of the center’s reopening, noted changes according to the family nurse practitioner have been: decreased number of children presenting with fever, decreased impetigo, decreased tinea (ring worm), better pneumonia management, and no presentation of epileptic episodes since 1994.

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Information from 1997 Jonestown Health Center Bi-annual Statistic Profile.
During an interview of the nurse practitioner and the bookkeeper/microbiologist, four major community health issues were identified. 1) Community poverty is associated with a high prevalence of chronic illness and disease. 2) Community health education is lacking. The public school system does not support the involvement of registered nurses as health educators. The curriculum is inflexible and does not allow for up to date and relevant lesson plan innovation. And, schools devote virtually no time to health education. 3) The community has limited access to medical care. Both transportation and medical expenses limit entry into the medical system. 4) People in the community have little or no time to think about or address health concerns. People are too busy trying to just survive which leaves little time or energy for secondary issues.

Agricultural issues for this community were also addressed. Lead poisoning continues to be a problem resulting from dirt ingestion. Both, young and old are affected. Farm accidents and work related disabilities are serious problems for men. Such injuries are believed to be the major contributing factor for the center’s equal patient population of men and women.

Mental illness is also believed to be a major community issue. The nurse practitioner said that the community has a high rate of mental health problems. Unfortunately, she believes that the community has not had the luxury to be able to deal with it. People do not know that medicines are available for nerve problems. Additionally, mental health issues are not discussed in school and have never been talked about, never really been dealt with because people are so busy with the physical demands of life, let alone their house is falling apart.

Some identified needs other than better school education, were home visiting, school clinic establishment, and cooking education. The former two needs would address access to care issues. The latter would help adults find ways to reduce fat and sodium from their diet.

**Hospitals**

The first area hospital was located in Clarksdale and built in 1903. It was a 5-bed wood-framed Delta Hospital of Kings Daughters. In the 1920s, the 19-bed Clarksdale Hospital
was constructed and replaced the previous hospital. Local, state, and federal funds financed the 100-bed Coahoma County Hospital which was built in 1952 to replace the Clarksdale Hospital. In 1973, the name was changed to Northwest Mississippi Regional Medical Center (NWMRMC) to more adequately reflect the dimension of its service area and provision. It is now a 174-bed general acute care hospital with twenty additional beds in an extended care unit.

Blacks were denied hospital admission up to 1940s\textsuperscript{7} and even later according to people in town. Blacks had their own ambulances because there were no municipal ambulances to take black people barred from the Clarksdale hospital to the Taborian Hospital in Mound Bayou. Mound Bayou is more than an hour's drive from Jonestown.

Currently, the NWMRMC is a teaching center for nursing students. Forty-six physicians staff the hospital. Of all medical specialties, there are no psychiatrists, neurology, or oncologists on staff or acting as consultants.\textsuperscript{8} Various other subspecialties are also not represented, i.e. hematology, endocrinology, pulmonology, urology, immunology, or infectious disease.

\textsuperscript{8} According to 1995 NWMRMC Medical Services Directory Bulletin.
CHAPTER FOUR. DEFINITION AND MEANING ASCRIBED TO HEALTH

This chapter examines the ways in which study participants ascribed meaning to health. Health was found to involve four complementary components, and informants placed ultimate control of their health in the hands of God. Even though God was discussed as having the ultimate power over their lives, study participants had their own means of authority. They control what they actually do with their bodies. Perceived health status is also briefly discussed as informants believed they were in good health despite disease.

Health Definition and Meaning

Study participants described four inter-related definitions of health. These definitions involve: 1) function, 2) autonomy, 3) freedom from dependence, and 4) mind and spirit. Meaningful physical function provides for independence as those interviewed fear dependence on others. The mind and spirit are also important components of health as they allow for independent functioning and determination, respectively.

Health was defined as the ability to function. Specifically, those interviewed discussed health in terms of being physically capable of performing meaningful duties. The following two quotations exemplify how interviewees defined health in terms of function:

Health. Well, to me it means being able to live a moderate life. Being able to do the things that you need to do. I didn’t say want. These are the things that you need to do [interview #18 male].

[Health is] being able to move, to work, to play [interview #19 male].

Autonomy is the reward of being healthy. Thus, health also means independence. Those interviewed want to be self-reliant. Being able bodied provides respondents with a source of well-being. Independence is highly valued and at the core of one’s ability to take care of one’s self.

Ultimately, participants fear dependence. By being able to take care of their own needs, help from others will not be necessary.
The issues of independence and dependence were discussed in relation to one another by those interviewed. The following quotations illustrate their inter-relatedness:

... health is one important thing to a person. Health, it means that you can, ah, do things not being dependent on other people, you can do things yourself. Oh, it means so much. ... Unhealthy ... it means inconvenience, it means that, ah, a lot of stuff you can't get going for yourself, it means that you might have to be dependent on somebody else and, ah, that someone else sometimes they don't mean no harm, I imagine, but they just ain't got time to fool with you [interview #12 female].

And, being able to see after yourself and not worrying your family about you. Because there's one thing I've learned, when you're taking care of yourself, your health is there. And then no one have to worry about you, when you start to do that [interview #18 male].

[Health means] I could depend on my own self and nobody else. That's what it means to me... I mean independence. ... Unhealthy mean you got to wait on the other fellow to do something for you if you can't do something for yourself. And, that gets on your nerves. That's what I think. I hate to depend on somebody to do something for me. I really do [interview #7 female].

A sound mind and vital spirit are considered important components to maintain health, independence. The mind enables people to execute functions and think autonomously while the spirit is what provides the will and determination to persevere. The spirit comes from within a person, and has a religious component that is believed to be connected to God. The following two quotations are representative of participants' views of health involving the mind and spirit:

I define health- health in its totality is having, um, a content mind, body, and spirit in its whole, in its totality, you know. Um, that's the way I feel it is [interview #5 male].

It all starts with God and then with mentality. I think that the mind controls the body in so many ways ... being religious or spiritual, being in touch with God [interview #1 female].

Perceived Health Status

The ways in which informants defined health influenced perceived health status. Despite illness or disease, all those interviewed believed that they were healthy. Their beliefs were based upon their ability to satisfy their varying needs to perform meaningful activities, have autonomy, be free from dependence, and have a sound mind and spirit.
For example, a 77-year-old woman who has difficulty walking due to an arthritic hip and has such poor vision that she cannot fix her hair to go to church regularly said *Nothing wrong with my health.* [interview #7]. Others with chronic disease believed that their illness did not make them unhealthy. Rather, comments such as *I didn’t just get sick because I had a sickness ... I don’t feel that I’m so unhealthy.* [interview #19 male] and *I just don’t give over to sickness ... So that is they way, that is the spirit I have toward keep on pushen.* [interview #12 female] were made.

**Health Control**

God is believed to be the controller of health. Those interviewed believe that God will take care of them, in good and ill health. Comments such as these were made by informants:

*... my health is not my health, it is God’s health.* [interview #15 female].

*I figure every time I works too much, I work too long, He can stop me and make me get rest. Now, that’s what I believe in. And whenever I get sick where I can’t go, it’s because He ready for me to rest a certain amount of time, and when He ready for me to go back to work, He turns me loose, you know, I don’t depend on a doctor there to say you ready, ‘cause I know they cannot do that. It’s only up to Him there. ... I cannot control it. No. I put it all in his hands. He’s the controller of my health and everything. Everything I own, I don’t own none of it. No, He give it, He can take it away.* [interview #2 male].

The above statements were similar to those made by others.

Upon further exploration, however, it is evident that respondents do not view themselves as powerless over their lives. God controls health, but study participants control what they do in response to God’s supremacy.

Personal authority is exerted by seeking God’s guidance through reading the Bible and prayer. The following quotations illustrate that informants actively involve themselves in their health despite believing that God is the controller of health.

*I deeply believe that God has been a control, a major control in my health. And, I do believe in prayers healing ... deeply.* [interview #19 male].
I have faith in my God that if, if he don’t want nothing to happen to me, it won’t happen. And so, I pray about things [interview #4 female].

Thus, those interviewed are able to influence their health by attempting to live according to the Word of God.

Many of those interviewed discussed others in the community who were thought to have disregarded the righteous path. The factors that determine why some have not accepted God’s role as the controller of their health remain unrevealed since many were unsure of the factors that influenced these people. Possibilities are discussed in the following two quotations.

Well, Michelle [researcher], some peoples got different minds about things, you know, different opinions, you know, and some people’s mind is, I would say, weak minded, don’t care about nothing [interview #20 male].

What control do you have over the flesh, you know? ... you’ve heard people say, “well there’s a war going on between your spirit and your body” you know. The body, the body, ah, is living off these things, it’s asking for these things ... These are the things that the body enjoys which is totally against, ah, those things that might be enjoyable to the spirit of a person, you know. This is part of my belief. And, so we feed the body those thing that it like, it request sometime, you know. Nobody- regardless of what nobody says. Regardless of what the doctor says, I’ve seen people go to the doctor and the doctor tell them, “You keep drinking, you ain’t going to live.” They come back out and the first thing they do is get them a drink, you know. Nobody thing, nobody going to tell them what to do. “When I die, I’m going to die the way I want to die. I’m ‘a live, I live the way I want to live,” you know. It just have a lot to do with- our tendency just not to listen to warnings and to do what we want to do [interview #5 male].

Thus, weak minds, self indulgence, and desires of the body were thought to over-ride the influence of God, the spirit, in some people. These individuals are the exception. They essentially beat to their own drum and are difficult to categorize or generalize.

In summary, study participants described four inter-related definitions of health, meaningful function, autonomy, freedom from dependence, and a sound mind and spirit. This construction of health influenced the ways in which informants perceived their health status. And, the ultimate control of health was placed in the hands of God.
The meaning ascribed to health, health status, and health control shaped health behavior in this rural community. Within this context, the next chapter begins to explore the ways in which study participants take care of themselves throughout the adult life-course.
CHAPTER FIVE. TAKING CARE OF ONESELF

Taking care of one's self was commonly reported as the primary way respondents could best sustain their health and preserve their independence. Their behavior, however, was shaped by a commonly reported belief that God controls their health. This belief played a major role in shaping respondents beliefs about health outcome and framed a number of complex factors influencing health behavior, how people take care of themselves. The ability to take care of one's self by adhering to principles of eating right, rest, and exercise, was mitigated by health experience, age, basic knowledge, historical, and environmental factors. The ways in which those interviewed responded to illness followed a common pattern: prayer, use of traditional home remedies, over-the-counter drugs, and finally professional health care.

This chapter explores a framework in which people tend to take their health for granted prior to being affected by illness. Although the importance of eating right, exercise, and rest is taught by families, people do not take care of themselves as they think they ought to until they are affected by an illness. Once people are affected by illness, they follow one of two paths. In the first, no lifestyle changes are made. In the second, people start to think more about their health and institute behavioral changes. While the onset of an illness may not be sufficient for lifestyle changes to be made, one's own illness or that of a family member does provide the eventual impetus for change. Most adults eventually make it to the second path. There is however, a group of people who are never influenced to start seriously thinking about their health and make lifestyle changes.

While Young

According to most respondents, young people tend to take their health for granted prior to being affected by illness. Although the importance of eating right, exercise, and rest is taught, people do not take care of themselves as they think they ought to until they are affected by an illness. Without conditions such as hypertension, diabetes, or arthritis, they
tend not to think about maintaining their independence through health protective measures. Rather, they take their health for granted.

While study participants were taught the importance of eating right, rest, and exercise, they often do not worry about how their behavior corresponds to what they were taught. Many older respondents believed that young people simply do not think about possible behavior ramifications until something happens to them. The following quotations illustrate this point.

_The health that the younger people have, they don't consider it an important thing because if it did they wouldn't do the stuff that touch their health. Such like, people that use cocaine. People says it cooks your brain. Well, the older person who tells me that, I'm not going to fool with that stuff. But a younger person, he going on and he don't think about it until it's too late. He just, he just ... and they say it kills some people - overdose or stuff. They say it kill some people. But that don't stop them from doing the same stuff, right on [interview #12 female]._

_Younger people don't seem like they even care, a lot of them, you know. A lot of them don't seem like they care about their health. And, the older people, you know, are very concerned. Old people are concerned about their health, you know, because they getting older. ... [when you are young, you] feel like nothing can happen to you [interview #5 male]._

Others, however, remembered the factors that influenced this in their own youth.

_... when I was your age, we didn't think about no sickness. And I, if I had a cold or something or cut on my foot or something, I didn't think about no sickness. You don't think about, you think about getting up and going on, you don't think about being sickness [interview #8 female]._

_Well, when I was younger, I didn't think about no health. All I did was working and try to make a living. Didn't think about no health because I didn't hardly be sick when I was young. Hardly ever was sick 'cause I was having babies so fast here, didn't look like there was no sick for me. ... I was around about 60-some years old when I started look like failing in health [interview #7 female]._

Even though respondents may not eat, exercise, or rest they way in which they think they should, they repeatedly discussed health in terms of the importance of a eating right, proper rest, and physical activity. The words of one woman are a reflection of the others interviewed as she said _health means taking care of yourself. To me, that's what it means._

_Eating right and exercising and making sure that your body get a lot of rest [interview #15]._
Most believed that the Bible outlines the proper way to live. While various lessons are to be learned from the teachings of God, those that affect lifestyle are particularly important to this religious community. One man describes a role in which God guides people to value eating right, rest, and exercise by saying:

...the Bible teaches us to avoid certain things that is harmful to our body, that would aétle our bodies, you know, we don't, we don't smoke and we don't drink liquor. We get the proper rest, you know, we don't, we don't allow anxieties to overwhelm us. Because we have faith in God, we put first thing first. We believe that we should follow the instruction that the Bible teaches us to how to live on this earth. ...by me being a believer in the scripture, I found these things to really work, you know, I seen that, that the lifestyle that you change, is even, can change a person physical appearance, that changes them emotionally, you know, it just that it sets some principles in your life [interview #11].

Not only does this man have strong conviction in the need to live a life as prescribed by the Bible, he believes that one's health is enhanced by living such a life.

The power and importance ascribed to God and the Bible by the people of Jonestown is truly remarkable. As a result, religious tenets are passed on from generation to generation. Family and kin play a key role in teaching their young these life principles. A 43-year-old man with twelve siblings believes that rearing has great effect on one's conceptualization of health as he says I think [health] influence has a lot to do with how you actually raised [interview #5]. The significance of a eating right, rest, and exercise has, thus, been emphasized in this community and taught to succeeding younger generations over time. Today, it remains a fundamental part of how people conceptualize health.

**Barriers to Healthy Behavior**

In order to maintain wellness, young and older people followed the basic principles of eating right, rest, and exercise to varying degrees despite acknowledgment of their importance. With few exceptions, those interviewed do not abide by the tenets prior to illness as they believe they ought to, despite their belief that they are important. The following quotations illustrate this point.
... our [her cousin and her] parents died very early and it could mean a
death for us. Like for my mother, she died when she was 48, and I will
be 44 this year. ... Hum, but both of us seem to think that it won’t
happen to us, but it might. It’s a possibility, we might die early, too, if
we don’t get our weight under control and start eating right and
exercising [interview #1 female].

I would say twenty years ago I was not as cautioned about what I eat,
twenty years ago. But today I am and I feel had I been a little more
cautions twenty years ago as I am today, probably health would have
been lots better [interview #18 male].

Despite discussing the importance of the three basic principles, both of these
individuals acknowledge that they have not always followed the tenets as they should. This
finding was supported by numerous other stories by nearly everyone with whom this topic was
discussed. Given the identified health consequences of not having a proper diet, exercise and
rest, why do people not adhere to their convictions? Some possible theories are forthcoming.

History

From community ethnography, it was evident that people try to eat right, but have
difficulty doing so. Not only do community members enjoy rich foods, but some are not able to
afford the fresh fruits and vegetables that their parents once grew in their gardens. Today, few
people have gardens; those who do tend to be older citizens.

The current public health view of prevention is not a widely embraced concept in the
Jonestown community. Even though eating right, exercise, and rest are believed to be
fundamental to sustain health, these practices are not viewed as preventive. Adults did not
receive routine medical check-ups during their younger years, nor do they now as a means of
learning preventive measures or early disease detection. The following statements articulate
this point.

... black people just don’t- in this area- just don’t get themselves
checked out a whole lot and they don’t believe in preventive anything.
I think it’s like, if I’m hurting and hurting bad enough, then I’m going to
the doctor. But then it’s almost too late [interview #11 male].

I don’t have to go [to the doctor] regularly. What do I’m going to go for
[interview #5 male]?
... there are those who don’t ever think about checking that health to see what’s going on even until they become ill. And in most cases it’s a little bit late to do so [interview #18 male].

Even though people value the importance of diet, exercise, and rest, there’s a lot of people who don’t even know how to take care of themselves [interview #12]. According to this 72-year-old grandmother with diabetes and hypertension, many people do not know how to eat a proper diet, exercise, rest, or find other ways to take care of themselves. Those who do not know how take care of themselves, and even those who do according to the above quotation [interview #11], do not think of what they do as preventive health.

In this respect, kin, schools, social services, and health providers have failed people. These educating institutions have not provided some with the essential tools to take care of themselves. Some people have not been taught what kinds of food and food preparation techniques are most healthy, and still appetizing. The lack of fitness facilities and decent housing are also factors that influence people’s ability to take care of themselves.

Data suggests that these deficiencies not only affect people today. If these factors go unchanged, the current lack of knowledge that exists will be passed on to future generations.

Environment

The concept of prevention is a luxury that people in the Jonestown community do not have. Commonly, respondents reported living in the moment and not looking ahead to the future. As one 58-year-old woman said, you can’t, you just can’t think ahead too fast and you, you just don’t [interview #8].

Many of those interviewed also do not have the time to think about their health. Frequently, there are more pressing matters that occupy one’s attention and concern. The following statements illustrate this point.

... most of them, they just don’t want to [do things to be healthy] and they work. They work a lot, and when they get off work they be tired. ...
... I guess their health, their health, is just not on their mind only until they become sick or something. Then they decide to worry about it, but other than that I don’t think, no, I don’t think that they worry about it [interview #15 female].
... health, you know, it's, I don't know, it's something really, it's in the back of a lot of people mind because you don't have time to really think about health. You got so many other problems, I'm talking about people I know. You got so many other problems, you trying to do this, you trying to take care of your family [interview #6 female].

With the stresses of life and just trying to survive despite hurdles, it is understandable that people focus on their primary needs while health prevention is an after-thought, at best.

God's Will

Not only do problems exist that inhibit people from thinking about preventive health, many people believe that there is no need for prevention because God will not put more on people than they can bear. The following quotations discuss this point.

_I don't have no worries [about my health in the future]. Um um. I, I'm, I'll have to accept whatever comes, you just don't worry about it. Just live one day at a time. Don't think about tomorrow, one day at a time. And, I asks God "what ever come, able me to stand it." And, he said he wouldn't put no more on me than you can bear. So whatever comes [interview #16 female]._

_... my health is not my health, it is God's health. And, if he has, if he has, say so over then I won't have to worry about my health because he will fix it. And, he will make it strong or he will make it weak, what ever he decides. [She sees her role in her health] by asking him what to do, by praying and asking how to help myself [interview #15 female]._

Since God controls health, there is no need for health prevention in the lives of those interviewed. As study participants believe that they have little control over there state of health other than doing God's will, they tend not to have concerns about their health or well-being. Comfort is derived from the belief that God will take care of them, in good health and ill health.

Through prayer, respondents may ask God to help guide them to assist in the healing process. While this may be viewed as prevention to the reader, it is not primary prevention to help prevent the act from happening in the first place. Rather it is an extension of God's authority over respondent's lives, as they find a way to be involved in the doing of God's will.

Those interviewed are consoled by the belief that God will not allow them to be in a situation that they cannot cope with or overcome. They live one day at a time as they cope
with life's struggles. Thus, it is not within their framework of life to look ahead and make plans for the future, let alone take action for the sake of their future health which they believe they do not control.

**Seeking Help for Health Concerns**

Despite beliefs that God controls health and illness, illness is a turning point in many participant's lives. Illness or a disease diagnosis, with few exceptions, is the catalyst for those interviewed to begin taking better care of themselves. In this way, severe illness or the diagnosis of a disease have been necessary for respondents to begin to seriously think about their health.

When people have an ailment, they find ways to deal with their condition. Study participants have developed ways to help themselves, and when necessary they seek help from others. A pattern of health seeking behavior emerged from interviews. According to respondents, one is likely to first turn to prayer, followed by traditional home remedies. Over-the-counter medicines are often used in conjunction with home remedies. With the use of these healing methods, aid from the medical establishment is often abated. If these home healing modalities are insufficient and great distress remains, then help from a health professional might be sought. Help from health professional is generally a last resort.

**Prayer**

Prayer is a powerful panacea. Reading the Bible and talking to God not only provides emotional consolation, but those interviewed believe that their symptoms are relieved. The following quotations illustrate this point.

*I have faith in my God that if, if he don't want nothing to happen to me, it won't happen. And so I pray about things and then, and rather, rather than to take medicine, I just pray and go to sleep and when I wake up I feel better. ... I don't normally take medicine unless it's real severe [interview #4 female].

*I believe the whole spirit, body, and soul is involved in your particular health. I don't think I'm strong enough to to to, and a lot of people aren't strong enough to- I believe we have the power to heal a lot of our
ailments ourselves but we're not just strong enough. I believe the power is within us, somewhere, we can [interview #5 male].

Believing that God has the power to heal and provide relief, many reported "tapping" into God's healing abilities through prayer and reading the Bible. It is through these means that people derive the strength to heal many of their afflictions.

Home Remedies

Notwithstanding the belief that God can cure ailments, most believe that adjuvant healing modalities are needed. Home remedies or over-the-counter medications are sometimes utilized in these situations. Seeking help from health professionals is another option that some respondents utilize. But in seeking medical attention, these interview participants acknowledge that God is the authentic and indisputable healer. A mother of three children articulates this point in the following quotation.

... even though you know you have to go to the doctor, there is a higher doctor than the ones here on earth that I can tell all my troubles to and that I can give him my health problems and he can, he will take care of it [interview #15].

Despite various available healing methods, some of those interviewed believe that prayer is a fundamental and necessary component of healing.

There are those, however, who believe that prayer alone is insufficient. Like the woman in the above quotation, the woman in the following quotation discusses the need for people to seek medical attention in addition to prayer alone.

A lot of folks say you pray to God, he'll heal you. I don't know how true that is ... they say that if you pray enough and you believe in God, he'll heal you. A lot of people die because of that. ... some people have to take medicine and I'm one of them. And, I know I have to take it 'cause I've been getting off and getting on for years and I always get sick. I know by now that I'm have to take it [interview #1].

This quotation speaks to the believed potential harm of prayer alone. From field study, other men and women made similar comments about the few people, mostly older women, who believe in solely using prayer to heal their ailments. These individuals believe that if one prays hard enough then one will be healed. Therefore, those who do not pray enough or have enough faith
in God remain ill. Those who have had their health problems cured or well controlled with
the aid of health professionals are those who tend to have the strongest feelings about the
potential detrimental effects of prayer alone.

The powers of prayer and home remedies have been passed down from generation to
generation, predominantly by women. These teachings have had a profound affect on those
interviewed as many today still rely on these healing methods. Medical care was not routinely
sought; it still is not sought by the general community unless there is a problem and it is severe.
Instead, respondents relied and continue to rely on God and their own methods of home
remedies. The following stories illustrate this point.

... you're not trained, it's not a part of your lifestyle, brought up to do
this, go to the doctor when something's bothering you. You just don't go.
... I know from my experience most of the people that I brought up
around, they parents and parent's grandparent's mother would just bear
pain and was just not educated to go to the doctor. You just didn't go
unless there was something really necessary like a broke something or
something that you couldn't fix. You just didn't go. You didn't go for
colds, whooping cough, and measles and ... mumps. If you went, you
went that one time. The doctor would tell you what's wrong with you
and that was it, you'd go home and treat it. I remember going to the
doctor once for chicken pox. He gave me a shot. And then grandma and
them, they would never. I think I went once. I didn't go for measles.
They ... looked at me and said I had measles so they didn't give me
nothing cold to drink. You know, everything was warm, they watched
what you did, made you stay in there. And mumps, when I caught the
mumps, I didn't go to a doctor. They gave me some candy and told me to
eat it. I couldn't eat the candy so they figured I had the mumps. Could
have been just sore glands. And they would take sardines, sardine juice,
caster oil, roll up the jowls and keep 'em warm. Put hot towels on me 'til
it passed. I never know nobody to die from it. It would just pass. ... [More
people go to the doctor today because] you forget the stuff that your
grandparents taught you to do for yourselves [interview #13 male].

... in this time, my parents was old and, ah, we didn't go to the doctors
much. People in back in that time didn't even believe in doctors. When
ever they went to the doctor they had to go. So my daddy, he had
diabetes. It wasn't taken care of like I take care of myself. Because if I
had known like I know now, he mighta woulda been well. They say,
you know, you live your time out; he lived a good age. But didn't
neither one of them understand what that complaint was. Ah, older
people back then, their time in that time, they was dumb to a lot of
stuff. They didn't know like we know. I am old, but I'm pretty sure that
I'm knowing better than they did. And, ah, so I said that the Lord took
care of us more, because they did not know like we know about these
things now. They didn't go to doctors and things now like we go to
doctors now. A sure lot of stuff they didn't do, whole lot of stuff what
they didn’t do it seemed to be healthy on them and so they just stayed, you know, that way [interview #12 Female].

Home remedies developed out of people’s need to heal themselves, much like other ancestral healing methods. Practiced and passed on through the generations, limited accessibility to health professionals and financial resources are factors that have sustained the utilization of these home remedies. Use of caster oil, turpentine, and hot or cold liquids are some of more widely applied substances used in home remedies. Older women continue to pass on this tradition as their advice is often sought by those seeking home remedy treatment. Wives, mothers, grandmothers, women friends, and church members often serve in this capacity.

In addition to the many traditional home remedies, there are times when those interviewed resort to new inventive home healing methods when they must find a way to deal with an ailment. An inability to pay for prescribed medicine is one factor in such home healing.

A story by 72-year-old woman with type II diabetes illustrates this point.

My diabetes had been 200 and 300. My daughter [was away for awhile], I ain’t going to tell her though. And um, her son-in, I mean my son-in-law he like beer. And he brought some beer back here every night while his wife was [away], he would give me a can of beer. That’s the time when my sugar went down to 45. Busch beer. Oh, you know I had been disabled to get my medicine at one time. The medicine what they give me they don’t even give out. And you know you have to have your medicine. Now, everything is not good, but you know what I did and it did me very well. I believe that I can, I believe, now its my belief that I can really keep myself in pretty good shape, myself ‘cause I know what I have. And, you know, [I] boil them and make a tea out of them. And drink that water and I- it did just what that pill I used to take. And it helped up until I could get my medicine. You have [to] do something when there’s some things you can’t get [interview #12].

During the times when she could not afford her medicine, this woman had to be resourceful to control her diabetic hypoglycemic episode. This story illustrates the point that people who have little access to care and few financial resources have developed home treatment modalities that sustain them.

Over-the-counter medications are also frequently used, primarily for analgesia. They are often bought only in times of need, although some people have a reserve supply.
While many believe that home remedies are an effective treatment modality, others are skeptical. A 71-year-old woman describes her misgivings in the following quotation.

*I was raised on home remedies. That’s how my mother-. They had different kind of things they would use in those days. But ah, like I before said, I don’t do that now. In those days they had to use home remedies for different things, you know, because, ah, the doctors weren’t plentiful as they are now. ... I never used too many home remedies. My mother did for her arthritis, but I never see where it did any good so I don’t fool with it* (interview #16).

Like the woman in the above quotation, the few who are particularly skeptical of home remedies have had personal experiences that cast a shadow of doubt on their efficacy.

Even though some who use remedies, such as turpentine, many develop severe skin burns or other complications, many continue to use home remedies. It appears that the decision to use or not use home remedies is largely based on one’s belief that remedies have some utility in treating particular ailments, despite possible undesirable side effects. The ability to pay for medical care is also a factor. Those who have financial resources have less barriers to overcome in seeking medical attention. Thus, those with adequate health coverage, beyond Medicare if they are eligible, are most likely to be less dependent on home remedies for their serious problems.

Health Professionals

With few exceptions, medical attention is sought when severe ailments are not alleviated by various means of home healing. Unless they have severe pains or problems or an already diagnosed disease, those interviewed do not seek health care. The following quotations represent the tendency to seek medical care after other healing methods have failed.

*Well, if something bothers me, I always will have some sort of something I start off with. And it don’t- Like my hips, I started rubbing on my hip and rubbing on my hip. Using hot bottles and things on there. And it didn’t no good, I went to on to the doctor* (interview #10 female).

*I ain’t do nothing [if something in her body starts to bother her] ‘cause I going to tell you the truth. Now if my knee or something hurt, I rub it in some Icy Hot or something. I rub in different Icy Hot. I have some Tylenol, take some Tylenol or something like that. But if it’s anything*
else, I don’t do nothen. ... Well, mostly I - I just don’t believe in running to the doctor every time you hurt. I really don’t. I just sit around and let it hurt if it don’t stop. If it just continue and it look like it getting worser, then I go to the doctor [interview #7 Female].

I immediately, if it’s a health problem, I, I, if it’s something common, you know, I usually try and do home remedies. If it’s something that is consistent then I will go to the doctor [interview #11 male].

[If something is bothering me, I] get that what I think might help me. Such as ... some kind of cough syrup or something that has Bills. I do that. And um, I try that then if it does pretty good, ah go ahead on [interview #12 female].

I don’t think any of them [family members] depended a lot on doctors. They just had that instinct of what was happening, that type of thing, and, I guess, somewhat as came on down through the line. Especially it was different between my twin and I, you know. But after I began, after I saw the need for doctors with being a diabetic and her [mother’s] sickness and friends, well, I thought it was best that I, you know, kind of stayed in contact with some doctors [interview #19 male].

... it’s not like I’m going to go get a check-up every year if I’m not sick. And I know it’s like that for people my, a lot of the people I know. I mean, you go to the doctor when you need to go, you don’t go ... if you’re not sick, if you’re not hurting, you don’t have the money to go, you don’t want to go. If you don’t- I mean, we don’t go, I don’t go to the doctor for regular check ups [interview #6 female].

These quotations illustrate that seeking medical attention from health professionals is really what most respondents resort to last in their process of help seeking.

There are a number of reasons why most those interviewed seek medical care only when other modalities are insufficient. First and foremost, adults in the community were not raised going to the doctor. Reliance on home healing methods is strong and it is now difficult for some to see the value in going to the doctor for conditions that they are either able to treat at home or believe that they must endure because it is not bad enough to warrant medical attention. The following statements reflect these beliefs.

... we weren’t raised up going to dentists or getting nothing checked like that, going to no doctor. [interview #1 female].

Fact is, I haven’t been to doctors too much, period [interview #20 male].

... you don’t want to, you don’t go to the doctor ‘cause you’re not used to going to him [interview #13 male].
In addition to believing that medical care from health professionals is only needed when there are severe pains or a diagnosed disease, there are numerous barriers that people must overcome to receive such medical care. This topic is discussed in the following chapter.

Despite various barriers to care, health professional interventions are sought for medications and other treatments after home healing methods have not adequately alleviated one’s health concern. This is explored in the following story.

*I had some symptoms that, you know, I was getting tired real quick, I would sweat and I get dry, you know, and sometime I feel fainted, you know, like light-headed. And that would just, you know, those kind of things was, made me want to go to the doctor or to find out, you know, what was happening with myself [interview #11 male].*

Since prayer and home remedies did not make this man feel better, he sought medical attention. This medical visit lead to this man’s diagnosis of type II diabetes.

While most respondents seek help from health professionals only after other methods of home healing have been insufficient, there are others who seek medical attention once they develop a specific problem. For these people, mostly older women, their past experience with their disease or an illness makes them know that they should seek immediate medical attention. In these cases, they suspect that something worse will happen to them if they wait.

*If I take with a cold, I better go to the doctor, really cold, I better get to the doctor because it’s gonna, I’m gonna wind up in the hospital. That’s where I usually wind up when I take with a cold [interview #7 female].*

*I go to the doctor when I know that my sugar ain’t right. I can tell when my sugar ain’t right. I can tell around there, something ain’t got no business. And, I can’t stand to be worried what my sugar will be [interview #8 female].*

In cases such as these, older women are more likely than others to seek immediate medical attention.

According to those interviewed, others are believed to wait too long before seeking medical help. In this sense, health professionals are seen as a necessary and integral role in people taking care of themselves. The following quotation discusses this.
I think we supposed to keep a check on our bodies before we get sick and then way the doctors can determine whatever is wrong and started it on- start on in time before it get too far in advance. A lot of us wait too late before we go, and sometime we expire. ... it's best to go to the doctor. That's what He [God] put them [doctors] here for [interview #16 female].

After Illness

... a disaster or something, some kind of disaster [influences one to start caring about their health from previous times of not caring]. Something has to happen to 'em. They're almost on the brink of death, they go to the doctor, the doctor explains he can't do too much to help them. They begin to care [interview #14 male].

... basically I think people just ignorant how important health care is until something happens to them, you know. Lot of people, they don't realize how important it is [interview #5 male].

As the above statements express, respondents believe that people only begin to think about their health once something happens to them. One's own illness or disease diagnosis or the illness of a loved one are the two factors that influence someone to begin to start thinking about their health and make lifestyle changes. Often times, however, one's first experience with illness is not disastrous enough to invoke change. So, people start to make health changes at varying stages of their life.

A theoretical framework was devised to depict how illness affects how one takes care of one's self. Once an individual is affected by illness, he or she follows one of two paths. In the first, one's health is not thought about, and no lifestyle changes are made. In the second, a person begins to seriously think about one's health and make lifestyle changes. People who follow the first path either continue to make no lifestyle changes, or they have an experience that influences them to think more about their health and move into the second pathway.

Of those interviewed, only one man had yet to have a major illness. Of those who have been affected by illness, two could be described as currently being within the first pathway. They are both women. Sixteen people could be described as currently being in the second pathway. Of these sixteen, seven began in the first pathway and later moved into the second
pathway either after their condition worsened or a family member had a severe illness. One person does not fit into this framework; she is discussed at the end of this chapter.

Well, some people don’t care, you know, about their health. Some of us really don’t care. This dude I know he had a stroke three weeks ago and went into the hospital. And, so I heard he act so bad, that, that, that, let him went. And so, he back home now and is drinking every day on it. Now that’s one, now, he don’t care about his health. ... they just don’t care. Whatever come, you know, let it come, I guess the way they think [interview #20 male].

According to people in town, the man referred to in the above story did not take good care of himself prior to his stroke. He was believed to use crack cocaine and drink too much. After having his stroke, this middle-aged man did not begin to institute lifestyle changes. Rather, he went back to his old ways of spending his days drinking and hanging out with other men.

Like this man, others who experience a major health issue are not immediately influenced to make behavior changes. The following story of an older woman with high blood pressure provides another example of someone who has not made lifestyle changes despite disease.

... my mother complained about high blood pressure and she went to this, ah, Senior Olympics thing and they out there taking blood pressure, you know, for the senior citizens. I think her blood pressure was up so she, ah, she comes home and she’s really worried about her blood pressure. My brother comes from Chicago the next day and he, she tells him that her blood pressure’s up, you know. And so I go through the house and show him what she’s been eating, you know at her age. She got a pack of pork chops, a new pack of bacon that she had. She has, ah, she has, ah, pigs feet. All these things that she want to eat and she knows that she has high blood pressure. She’s not taking her medicine now anyway. She’s not even taking her medicine that she has for her high blood pressure. And, first she’s eating all the wrong things. So what does she expect, you know, and yet, she want to make it seem, you know, like “well, I’m just eating a little bit.” But you know that once you have this problem, this disease, you have to put it on check [interview #5 male].

Why this woman has decided not to take her hypertension medications or follow her suggested salt-restricted diet is unclear. Even though she is concerned about her blood pressure, whatever
methods she has used to control her blood pressure apparently are not working and she has yet to utilize the other treatment modalities made available to her.

Various factors influence someone with an illness or disease to not institute behavior changes. While the factors for the man and woman in the above stories were not fully explored, those interviewed provided the following possible explanations for these two individuals and others which include: not caring, illness rationalization, denial, and not knowing the severity of one’s condition.

Without concern for one’s self or body, an individual tends not to take care of him or herself. This disregard may influence a person to not make health changes. The following quotations discuss not caring as a reason why some do not change their lifestyle after an illness.

... certain types of people look like they don’t want to take care of themselves. They just see how much can they do to themselves, you know [interview #17 male].

Now that’s one, now, he [reference to man discussed in an above quotation] don’t care about his health. ... [others] they don’t think of themselves, you know, if they behave like that. ... some people’s mind is, I would say, weak minded, don’t care about nothing [interview #20 male].

Some individuals who do not institute behavioral changes after an illness, however, do seem to care about their themselves and their health. These people often rationalize their ill fitness in such a way that no lifestyle changes are deemed necessary. This is discussed in the following story.

I was working that summer outside of the classroom, a summer job. And every morning when I got to work, my ankles would be of normal size. When I come in, in the evening, look like they had tripled or doubled, you know. And I’d get a good night’s sleep, and the next morning they were back. But I thought it was just a, wasn’t so much a diabetic, I didn’t think at that time, as it was weight and standing all day, and I didn’t think that was sugar and fluid causing that [interview #19 male].

Since this man’s diabetes complications were attributed to his job and weight, he did not seek ways to alleviate his swelling or better control his blood sugar. Instead, rationalization of his condition precluded him from thinking of making lifestyle changes. Many others react similarly when they find a way to excuse their predicament.
Denial of a health problem is another factor that has prevented some of those interviewed from making behavioral changes. In such a state, the very existence of one's condition is not acknowledged. Or if it is, the condition is not considered problematic. Thus, no lifestyle changes are instituted.

While some deny the actuality of their condition and do not make health changes, others do not make changes because they are unaware of the severity of their circumstances. The following story by woman with type II diabetes illustrates this point.

_I ate anything because, ah, say in 1970, I took this about this I had diabetes in 1966, but in that time I didn't know [what] that complaint was, I didn't know it was like that. So I am lucky. I took treatment for it one time, that was when I first went to that doctor. And, I didn't take no treatment no more until 1975. They say it a wonder I hadn't gone blind. ... I didn't care what I ate, and ah, it really- I didn't I didn't care what I ate or nothing I used to work in a store, down in the 1970s and I took sick one evening. I still didn't really pay no attention to it. I really didn't know what that the disease was, ah, is, ah, I didn't know that it was like that. So I didn't think anything of it, that's what I am try to say. I was larger. Ate anything [interview #12]._

Just knowing that a health problem exists is not enough to make some people institute behavioral changes if they do not understand what the condition is or what specific changes would be most beneficial.

Health education and good doctor - patient communication was influential in helping those interviewed to understand the importance of thinking about health and making lifestyle changes. In doing so, people can be inspired to move from pathway one, in which they do not think about their health and make behavior changes, to pathway two where health is seriously considered and lifestyle changes are instituted. This proved to be influential for the woman in the above quotation; her story continues as follows:

_And, ah, when I learned to about it I took sick and had to go back to the hospital [in 1975]. And, then that's that's when I begin to take care of myself in the 1970s ... when I found out that the diabetes was what it is, then I got more careful then about things, you know, that I would do. ... I mean I'm not a doctor, but I know the symptoms of it now and that's what make me so careful and everything. ... you got to take care of your feet, and ah, and you have to eat right [interview #12]._
Unlike the story of the woman quoted above, there may not be a factor that inspires other people with an illness to make lifestyle changes. Despite illness, some will continue to live without making behavioral changes or reconceptualizing their health. These people are the exceptions, but they exist.

The exceptions constitute two groups. The first group is composed of some older women who believe that God's control of health is so great that they do not need to think about their own health. The second group is made up of middle aged men, like the man who had a stroke and continues to drink and use drugs. It is unclear what specific factors influence them.

The illness of a loved one has provided some respondents with disease the impetus to start caring about their own illness and to make behavioral changes. In these cases, their own illness did not persuade them to care enough about their well-being to make changes prior to the affliction of a friend or family member. The following story illustrates this point.

But, you know, until I was truly totally swelling and tiredness began and higher sugar readings, I was not as careful twenty years ago because partly just I didn't know it and when I did, when it was found, you know, it just one of those things I accepted and I didn't break all of my regular habits. ... Well, swelling, swelling of joints and, and you know, and some sickness, and particularly the sight was getting dim and aches and pains and stiffness of joints from fluid build up and high sugar readings and following the doctor's orders [led him to break some of your regular habits]. ... I believe the first year that, it must have been about '74 that I was, you know, discovered to be a real diabetic. ... About '76 or '77, I made some major change because when my mother died in '75. I knew and then, you know, after taking care of her and watch her pass away. It changed my ideas on the condition that I had. Prior to that, you know, I didn't pay no basic attentions to it. And from those years on, I ... I began to watch and take more care of myself in regards to taking medications and reducing of the habits [interview #19 male].

For the man above and others, having an illness is not a sufficient stimulus to trigger people to better utilize the basic principles of eating right, rest, and exercise or to find other ways of taking better care of themselves. For these people, something else must affect them before they think that their poor health necessitates that they make lifestyle changes. What the factor, or factors, will be, no one knows.
Thinking about one's health in relation to a family member's, however, does not always lead to the institution of health modifications. In an earlier quotation, a woman expressed her concern that she may die early like her mother if she does not start eating right and exercising. Despite this concern, she has yet to take action. This is true of others, as well. These people are in the first pathway.

Sometimes, the illness of a family member has been sufficient to get study participants to start thinking about their own health prior to their own illness or onset of disease. In these cases, a family member's illness is enough to influence a person to make lifestyle changes and fully utilize the basic principles of eating right, rest, and exercise. The following story of the ailments of a man's father illustrates this point.

Well, my father mostly [influenced him to change his ways] because he was a, my father had a stroke when he was about fifty-seven years old, and then he had to go on dialysis and he stayed on dialysis about fifteen to sixteen years 'fore he died. And when he died, his brain started to die. But his body was still active. You know, his body was strong but he couldn't, didn't have no control over it. And I thought that was, that was kind of hard for him. It's like you were just going to die. He would live weeks without food or water and that to me was that, that cruel. So, I just started changing in the way I ate, you know, way I eat things and how much I eat and what I drink [interview #13].

Those in the second pathway, whether due to their own illness or that of another, were primarily concerned about not being unhealthy, sick, rather than maintaining good health.

This concern was reflected in the behavioral changes they make to avoid dependence. Lifestyle changes were not discussed as a means to maintain independence and the ability to do things.

Those who make changes because they have an ailment try not to worry about their condition. If it gonna happen, it gonna happen. So there's no, no point in worrying about it [interview #20 male]. The following quotation explores this belief.

I just don't worry about it. I go on cause I know, I know I got these complaints. There's no need of worrying about it, there's no need to take it to the heart because you know you got 'em so you just have 'em careful and do the best you can. Because there's nothing, you can't take the diabetes away. You can't take the heart trouble away. You can't take the high blood pressure away. And, you can't take the poor circulation away. So in your body you just got all those things to deal with. So you just take it one day at a time and do the best you can cause there's
nothing you can do about ‘em. ... I go to the doctor when I know that my sugar ain’t right. I can tell when my sugar ain’t right. I can tell around there, something ain’t got no business. And, I can’t stand to be worried what my sugar will be. The doctor told me to quit worrying about it, that my sugar goes up. ‘Cause when I was going to the doctor, I would stay in the hospital, so he asked me what was wrong, I said, “Well, I been worried all the time.” “About what?” I said, “About my children.” He said, “Well, long as you stay worried you won’t keep it down.” I stopped worrying. I have no problem. I don’t let stress, ‘cause stress is bad on sugar, and when I see myself going to get worried, I find something to do. Or anything get on my mind too heavy, I, I, I try to find something else to do [interview #8 female].

Even though respondents make changes in their diet, physical fitness, rest, and start using various healing methods, they do not let their condition consume them. Worrying is the result of such consumption, and worrying is believed to be harmful. Dwelling on an illness just making you go down faster. ... So you shouldn’t worry. I don’t think that you should worry about it [interview #15 female].

Religiosity also plays a role in study participant’s not worrying. The following quotation explains this relationship.

I sure don’t. I don’t worry. I figure, the Lord ain’t going to put no more on me than I can bear. That’s the way I figure. ... I feel just like that. The Lord ain’t put no more on me than I can bear. ... I believe he going to make a way for me. That’s my belief [interview #7 female].

As discussed previously in the context of preventive health, comfort is derived from the belief that God cares for those who are ill. Those interviewed believe that God will allow them to experience no more hardship than they can tolerate. Thus, they find a way to cope and not worry about their health.

**Exception to the Framework**

One exception to the above discussed framework was found. This deviation warrants some discussion.

For the sake of her children, one woman gets annual medical check-ups and wants to be healthy for her children. She says, I want my children to grow up and be healthy. ... So, I think that I would want to take care of myself and be healthy because I would want them to do
the same thing [interview #15]. Even though she thinks that most people in her community, including her women friends, do not think about their health until they get sick, she thinks that it is important.

This thirty-one-year-old woman has been getting annual check-ups since the birth of her first child. Before then, she never had them. After the birth of her son, she began to get annuals because they have, they send you letters and things and tell you to come in for your physical. While she could have disregarded these letters like most others do, she decided:


not to ignore them because I want them to check me out and make sure that everything was okay. ... I want to make sure that I don’t have any problems inside my body. And, I want- they check for cancer and AIDS and other diseases and I want to make sure that I am healthy and that I don’t have any of those diseases and that I don’t have no other kinds of problems.

Even after she lost her Medicaid benefits when she got married six years ago, this woman has continued to get annuals despite having no medical coverage.

What factors account for this woman starting to think about her health at such a young age and receive annual medical examinations and not other young mothers, is unclear. Two other young women with children were interviewed and many conversations with similar women took place during the course of this study. No others held this woman’s belief or sought regular health care without having a health problem.

In summary, religiosity framed a number of complex factors that influenced the ways in which study participants took care of themselves prior to and after illness. In turn, health experience, age, basic knowledge, historical, and environmental factors affected adherence to principles of eating right, rest, and exercise. Informant response to illness followed a common pattern: prayer, use of traditional home remedies, over-the-counter drugs, and finally professional health care. The next chapter more thoroughly examines the factors that influence the utilization of health professionals as a means of taking care of oneself.

Although the importance of eating right, exercise, and rest was taught by families, study participants did not take care of themselves as they thought they ought to until they
were affected by an illness. Once affected by illness, they followed one of two paths. In the first, no lifestyle changes were made. In the second, people started to think more about their health and institute behavioral changes. The one exception to this framework was discussed.
CHAPTER SIX. FACTORS INFLUENCING THE USE OF HEALTH PROFESSIONALS

Even though medical care is often sought last as study participants find ways to take care of themselves, health professionals are utilized in the healing process. When called upon, health professionals actually play an integral part in healing and are increasing called upon as years pass.

There are a number of factors that have historically influenced the Jonestown community's utilization of health professionals. Limited accessibility and availability are two barriers to care that are multi-faceted. Additionally, bad experiences with health care professionals have discouraged many from seeking medical attention. The reopening of the Jonestown Health Center (JHC) and religiosity are additional factors that influence the use of health professionals.

Financial Barriers

Jonestown is a poor community and many do not have health insurance or the money necessary for them to afford and receive medical care from health professionals. Not only do people have difficulty paying for their medical care, but medicines and other treatment options are often too expensive to afford. This is one reason why study participants seek medical care as a last resort.

From discussions, it was also evident that people often have difficulty adhering to medical advice because they don't have the money. The following quotations illustrate this point.

... we never did go to the doctor 'cause we never did have money. And now, going to the doctor is a strain because you just don't have the money. Because the doctor may tell you something [is] wrong with you and then you don't have the money to get it fixed, you have to live with it. You just have to live with it [interview #13 male].

... medicine is so high. One thing, and ah, if you go to the doctor he diagnosis your case and if you don't have insurance to get your medicine well no need in going to the doctor. Because without your medication,
you can’t feel better. And, I think that one of the main problem; medicine’s high. ... A hundred and some dollars, uh, is nothing for some people to pay for medicine. And that one of the main things- that bad on people that’s poor, poor people you know. If a person got all that to do that, well ah, naturally it’s no problem to them but it’s hard on a poor person [interview #16 female].

The working poor are especially hard hit. They face the paradox of being too poor to afford medical care, but not poor enough to receive government assisted health coverage. While some people receive medical coverage through their jobs, many employed people do not receive any job related health benefits. And, those who are self employed, often do not have any medical insurance. The following quotations illustrate the difficulties those without health insurance or government assistance face.

Most people that work, most people that work can’t get health [care]. People that was on government substance was more healthy than we were because, if I went to the doctor I had to pay ... They was in better shape than us, the people that was on Welfare and just government assistance. But it was a group of people out there that was working, like me and my wife, that can’t afford medical insurance but don’t have no other choice but to go to the doctor when you can [interview #13 male].

A lot of them can’t afford [health care]. A lot of them can’t afford it. That goes back to what we were talking about in the first place. You on minimum wage, you got to feed your family. What- and the company you work for don’t provide any kind of health care, any type of insurance, then how are you going to get it? How you going to afford it [interview #5 male]?

Even for those with medical coverage, deductibles are high and it is difficult to afford health care. In some cases, people with private health insurance also qualify for government assistance but they are not able to receive Medicaid benefits because their private insurance is the primary coverage. In the following quotation, a young woman discusses her frustration that her private insurance is not helping her.

I don’t go to the doctor, I go to the doctor when I’m really sick or when, when I really have to.

And because like, now even, even with me being eligible for Medicaid, to have, have this baby, it seems like to me such a double standard. If I’m eligible for Medicaid, then that should mean that, yes, I am under that level where Medicaid will kick in and pay for it. But because I’m working every day and I been working all life ever since I got out of
school, I'm working every day, and these people put a private insurance on me which benefits them, I guess, 'cause it, it really doesn't benefit me. But it's their, it's their insurance company because we've talked about it before. I've asked, because I know there are hundreds of other insurance companies out there that you could try. And dealing with the people, other people who come in with these private insurances, I know that there are private insurance companies who do pay more and who don't put all the burden, such a burden on their clients. Okay. I'm on private insurance through Blue Cross/Blue Sh-, Blue Cross/Blue Shield of Mississippi through the Jackson Diocese, whatever that mean. Okay. They will not drop this private insurance on me, but I am eligible for Medicaid. Me being eligible for Medicaid should say something. But instead, it's because I got a private insurance Medicaid is not going to help me anyway, whether I'm eligible or- Because even though I am eligible, Medicaid can't step in and help me pay my hospital bills which I'm getting close to being in default of, because my job got a private insurance on me that's not paying anything. So I, I just think that's so unfair. If the private insurance is not going to pay anything, evidently I need Medicaid for me to try to get it. If the private insurance is not going to pay anything, why not let Medicaid pay, help me pay?

Because before I had, before I could be seen in the hospital I had to pay $982 to have, have this baby. Okay, I paid that. Now, after I had the baby and really I didn't know- well, I didn't know a lot of stuff that happened, that was gonna happen. But now they're telling me I owe $581 more dollars and I just don't think that's fair. Medicaid was, I was Medicaid.

... And these people run around here talking about, like the lady in the meantime, "Don't they apply for Medicaid and this and this." Medicaid, they are, they are like, it's ... you can't, what did she ask me, "Aren't they eligible for Medicaid?" That's the same, yeah, they're, they should be eligible in my eyesight. But that don't mean that, that they got Medicaid.

I was eligible for Medicaid and, yeah, Medicaid wouldn't pay anything for me because the people are going to tell me they don't want to, they don't want to deal with Medicaid. She could get the money from Medicaid just as easy right now because I was eligible during that period of time. But because these people are dealing, are used to dealing with big time private insurance companies and not, and really not black people. Because the women's clinic that I had to go to with this baby, it's a women's clinic, where most people in my com-, in my community most call people call, "Oh, yeah, that's the white folks women's clinic." This is a, there were a time black people wasn't even allowed to go to that women's clinic and it wasn't that long ago. But now, the black people with a job, they make you go to that women's clinic because of your private insurance although that women's clinic can't do the paperwork to get Medicaid to help pay your medical bill's, even when, even though you are eligible [interview #6].
Additionally, full payments often must be settled in medical offices prior to receiving medical care. Paying for medical expenses before receiving medical attention poses a significant financial strain to those with and without insurance. The woman from the above story also discusses this point when she said:

... people are not gonna run to the doctor because they know that a lot of places, you can't go to the doctor without paying the money first up. ... If you go to a doctor, you better have some money with you. And it's not no little money [interview #6].

Location Barriers

As financial resources and the structure of government assistance programs make it difficult for the working poor and others to obtain health care, the rural town location posses an additional barrier.

While few people discussed the sentiment that they received a lower quality of medical care compared to other communities, this issue was addressed by some middle-aged men who had higher incomes and good medical insurance. The following quotation articulates this point.

I can't go to the best and get them good doctors up there, whatever. I have to settle with the rural doctor, and whatever he does to me, if he kills me, it's okay. And if I live, that's okay, too. Nothing to do with anybody. I'll tell you, Michelle, it's rough. And the only thing you got between you and life, when you're dealing with health care, is that that person is a good person and he wants you to be well. It's a lot of barriers out here, and like I say, everybody can't afford insurance and that golden green dollar is what drives everybody. The love of money is the root, I'm telling you [interview #9 male].

Those few who have adequate financial resources and have lived up north in cities such as Detroit and Chicago, like the man of the above quotation, are in a different position than those who have little money and little knowledge of the medical system in other parts of the country. While these men may believe that they are settling for the care that a rural health professional provides, they are resigned to continue getting health care in this setting.

The rural town location also limits one's health care treatment options. With few specialists in neighboring towns, people often must travel to Oxford, MS or Memphis, TN for
specialized medical care. The practice of such referrals is often done with little, if any, conversation with people about possible treatment options at nearby facilities. In fact, those interviewed were often not given the opportunity to make choices between receiving care twenty minutes away in Clarksdale versus traveling an hour or more each way to receive treatment from other specialty clinics. The below quotation expresses the frustration of a working woman with health insurance who was not told of her treatment location options and went to Oxford not knowing she could have received the same daily treatment in a neighboring town.

I barely got out of paying for that. I mean, I did. It put me in a strain paying all those hospital bills, but I, you know, because I'm in the market to try to find a house so I really wanted my credit to stay good and I didn't want that to be on my credit record. So I paid those hospital bills in Oxford, even though it was hard. And then, I was pregnant so I had more hospital bills which eventually caught up with me, and are probably gonna be on my credit now because I can't pay as I did with those other bills. ... I wish they had not me coming down there all of that time because that was very expensive, going to Oxford. I wish I had known that I could have gotten the same treatment here, closer to home [interview #6].

Transportation is another barrier to care that people must overcome. Not only was the woman from the above story upset about the lack of treatment options made available to her, she was also frustrated by the high cost and commute to Oxford, which is more than a two hour round trip car ride. While women, both young and old, tend to be more affected than men, the lack of public transportation affects the whole community as others are needed to drive those in need to medical offices and other places.

People pay others to receive transportation to nearby towns for medical appointments and to carry out other business needs. The current going rates are between five and fifteen dollars. Most people have little choice but to pay for their transportation if they do not get their care from the town's health clinic. (If people are unable to drive or walk to the Jonestown Health Clinic, one of the staff members will drive them.) The following quotations describe how some feel about their transportation issues.
I feel there is a lot of problems as far as transportation out here in this area. You got a lot of peoples that don’t have automobiles, you got some older people don’t have automobiles. ... transportation toward the casinos, all the emphasis has been put on that, picking folks up and carrying ’em, you know, the buses and the vans around. But I think there’s a, there’s a need for having some transportation design designated for doctor care [interview #11 male].

Every time I have to go down there [Clarksdale], I have to pay $7. To go to Marks, you have to pay $10 ... [a neighbor] will take me, I usually get her to carry me. Now that something else they need. They used to have a bus that would take you down to Clarksdale, would take a group of people down there. And they need some kind of bus since all these people is this high with their stuff they have in their store they should have a bus and everybody who wants to go to Clarksdale could get on there and go. You just don’t have no convenience, no convenience down here [interview #12 female].

Since there is no public transportation that will carry people to nearby towns for medical care or to run other errands, some churches have filled the role of providing rides to their older members. In these cases, either members of the church will drive a person free of charge or the church will pay for someone to carry the church member to the medical office.

The following quotation illustrates the role one woman’s church plays in her ability to get to her medical appointment.

... it’s like this ... I belongs to St. Luke’s Church and anytime I don’t have no money or nothing for somebody to carry me, I calls up there to the City Hall and tell them I have to get to the doctor and I don’t have no money. They always make, they get somebody down here to carry me to the doctor. [I would not be able to go to doctor as often as I need to if church members didn’t provide a way.] ... Um um, I wouldn’t be able. Um um. ... St. Luke’s they pay for it, they pay the transportation themselves, St. Luke Church. And if I have to go anywhere else - out of town, I had to go to the dentist over there ... They paid it. Girl charged forty some dollars to carry me. They paid it. They very nice, and when my husband was in the hospital they paid all the transportation. The pastor, he would, when he wasn’t able to get me, you know he would come get me. When ever he wasn’t able to come get me, they always got me a way [interview #7].

**Negative Experiences with Medical Care**

The discussed financial, location, and transportation obstacles to care are compounded by various bad experiences that people have with health care professionals. Many bad
doctoring stories were shared in discussions, both on and off tape. These negative experiences not only discourage the individual who experienced it from seeking future help from health professionals, but the whole community is effected by these experiences as others become offended and skeptical as a result of story sharing. Doctors implicated in these stories are not just white, some are also black.

People are dissatisfied with their medical visits when their doctors are impersonal. In these instances, doctors do not communicate well. Verbally, many are insensitive to people's needs for basic dignity and comfort. The following two stories illustrate this.

I wish the doctors would be ... more like humans than doctors. ... They, I don't know, doctors just don't treat people like they human, they treat 'em like they mannequins. When I got my leg amputated the doctors, they didn't, whatever they did, it was fast and right at the point. They would come in and clean my leg, they just cut it off, left it open at the end. It was just like a piece of meat that you see in the, in the, in the deli somewhere, you know. And then when they would come in and clean it, they would take it and pull it back at the end and take swabs and go around that bone, you could hear like a, like a tooth, like when you bite down on it, you know, you could hear it and I don't know. When they was, said, "Don't, don't move, be still." And if my grandmother had of did that she would say, "Oh, baby, hang on for your children" and be started what she doing. But you be listening to her and not thinking about what she doing. ... I don't know, I guess, I, I want the doctor to be more human than they is now. They used to be like that, they used to would touch you, put their hands on you, on your shoulder, on your knee, and sit there and talk to you [interview #13 male].

I never been to but one doctor, I didn't know him somebody recommend me to him, it's been a good while ago. That was Dr. Heal. I went there, I was disabled and I was trying to get on disability. And, when I went there and I had never heard a doctor do that. I don't think that he worked on Medicare and then he told me "Ms. C., you mean to tell me you brought Medicaid down here." He could have explained it to me, you know. I would have felt better if he had explained it to me. And, then you learned you don't go to just everybody somebody recommend you to. 'Cause I think that he's an independent doctor. So I never went back to him ... So I haven't been to Dr. Heal from that day to this one. I didn't know nothing about him ... I was trying to get on disability. So I had Medicaid, they send me the Medicaid card before they send me the money. I had a Medicaid card. He should have told me that he didn't take Medicare or something like that. Instead it look like he trying to make fun. And, so I don't even want to go back to him no more, under no kind of circumstances [interview #12 female].
Various stories were told about doctors who do not lay their hands on patients from the Jonestown community, and other communities as well, during their physical examinations. The following two stories illustrate dissatisfaction with doctors who do not touch them.

Uh, Dr., it was a doctor out of Memphis, who was a specialist doctor, I can't think of it, it was Dr. T-something, I think, I can't remember his name hardly. But a pole fell on my truck. And he told me to take my shirt off, he wanted to look at me because he wanted to make, he was a neurologist of some sort. And, and he walked in there, he told me to take my shirt off, bent over, the man never did touch me. He said, "Where do you hurt at?" I said, "I hurt right here." I said, "I hurt right here still." He said, "Move your head like so, move your head like so." Never did touch me. Never did put his hands on me. He said, "You could put your shirt back on now." I said, "Ah, yeah." I didn't stay in there, I didn't stay in there one minute. You come back and see me so-and-so and so-and-so and so-and, at the time. And that was it [interview #9 male].

Well, there's some nippy white doctors. 'Cause I went to one, one time. He ain't never put his hand on me. ... I, I didn't think it was fair 'cause he let me in there. If he didn't want to wait on me, about the color of my black skin, he should not let me in. Now that's right, you don't take that patient, you're the doctor. And you're gonna run into some hard folks. That patient, you let somebody handle 'em if you think you can't handle it. That's what you do. But this doctor, I was in the wrong place. He told me, "Ms. G., I want to send you to my doctor." "All right." He sent me down to his doctor. The man, if he asked me, I told the truth now. He go, "Ms. G., how you like him?" And I said, "I ain't going back to this man. He didn't even put his hand on me cause he thought some of my black skin is gonna come off on him. And there's some white people like that [interview #10 female].

From conversations, it was also evident that people are disturbed that some medical offices are so overbooked or that practices are full. Frequently when this happens, people in need are not able to receive medical attention. The following quotation explores this issue.

Well, some doctors tell me he's full, he's not taking anymore patients. That sends me up the river. I don't believe you took any kind of oath saying that you wanted to be a doctor and now you telling me you full? Well, the reason for that is because you can only see so many people and give them good, professional health care. I understand that. But I'm sick. Now, you gonna turn me away? Well, you know, I won't turn you away if, if you say you're hurting. I mean, I got to take you, and all this kind of thing. But, no, they usually don't, they ... if you, if you're a doctor, and you're committed to healing people or helping people, that's what you ought to do [interview #9 Male].
From the above quotations, it is clear that people have had bad experiences with their doctors who are not serving in their role as good healers to help people get well or stay well.

Despite the bad experiences discussed above, all of those individuals quoted above still seek medical attention for their health problems. While these people, and others, often do not return to the same doctor after a bad experience, they do seek out another health professional. In the voice of one woman these bad experiences *don't make you feel good, but you don't have no other choice but to go back and try to get help or maybe find you another doctor. Um hum, find another doctor* [interview #16].

**Jonestown Health Center**

As some people have sought better doctoring, some have turned to the JHC for medical care. Since the JHCs 1991 reopening, however, it has had its critics along with supporters among the Jonestown community. The center’s reopening was met with some excitement and much trepidation. Besides its location within the town as an attractive reason for study participants to seek care at the JHC, other incentives have been necessary for people to begin to trust the nurse practitioner and staff and seek care at the center.

With transportation issues and other barriers to care, many would not receive any health care if it were not for the JHC. Medicare and Medicaid (statewide managed care Medicaid was implemented July 1, 1997 and is now called Health Mecs) are accepted at the center, unlike some other medical offices in the area. Additionally, there is a sliding scale according to income that eases some of the financial burden of receiving health care. These are some of the reasons why some people have begun to seek medical attention at the center and others have transferred their care from other medical offices in neighboring towns to the JHC.

While the center’s clientele are mostly children and older adults, many middle-aged adults seek medical attention at the JHC. Of those interviewed, only six receive regular medical care at the JHC. The sexes were equally represented with three women (#01, 08, 12).
and three men (#13, 19, 20). The women ranged in age from 43 to 72 and the men from 47 to 63.

Four others had received care at the JHC at least once, but do not go there regularly for health concerns. All three women (#04, 06, 15) were in their thirties while the men (05, 18) ranged in age from 43 to 59. The nine others (#02, 03, 07, 09, 10, 11, 14, 16, 17) who have never received care at the JHC, represent the other half of the interview participants. These other nine who have never received health care at the JHC continue to see their doctors in outlying areas whom they were seeing prior to the reopening of the JHC.

Those who receive their care at the JHC believe that they get good treatment and are kindly regarded. They did not identify any problems with their medical care. One man said this about his experiences at the JHC.

... it’s good that they’re around now. ‘Cause I probably wouldn’t go to the doctor at all if I had to go to Clarksdale. You got to, they have a waiting list and the doctors don’t treat you like, you know, they just doctors, they’ll walk in and if you don’t tell ‘em everything that’s wrong with you, you might forget something, then they, they just blah, blah, blah, and see the next patient. Sister Manette and them, they’ll talk to you. It’s a whole lot better [interview #13].

The friendly staff and good nurse - patient communication are two components that make the JHC a place in which many people are comfortable receiving medical care.

Others have gained confidence in the care provided by the JHC and began to seek medical attention there after hearing about the good experiences of others. The following story about a man’s sister and friend illustrate this point.

Well, my sister was telling me, you know, what a job they did, you know, and I got a friend, he had a, he called it a, something on his brain, what you call that? A, tumor or whatever on his brain. And them doctors they couldn’t find his problem. So, the only time a Sister over here in Marks whose name- ... Aiello, yeah, okay. But he went to her and she’s the one that found his problem and sent him around to the hospital and had him operated on. She found this problem and he had been, so far the doctors in Clarksdale, they couldn’t find anything wrong with him. So that’s how, that gave me confidence in ‘em [interview #20].

While some like the treatment and care they receive at the JHC, others do not. The following quotation tells one woman’s story of why she does not go to the JHC and has little faith in the health center.
I’m just going to tell you the truth, I don’t like them up there, not at all ... I just don’t like their doctoring ... Don’t look like they do nobody no good. My daughter been going to them. She got sugar, she got heart trouble and all of that. She [nurse practitioner] ain’t trying to help her no way to get on disability or nothing. Um um. And, she stay sick. She ain’t able to work or nothing, they don’t try to help her no way shape or fact [interview #7].

In addition to this lady’s story about her daughter, there were other stories about people receiving the “wrong” medicine that raise some doubt within people who have not had enough good personal experiences with the JHC or heard enough encouraging stories to outweigh the negative ones.

Not only do experiences, direct or indirect, with the JHC influence whether one seeks medical care there, many people in the Jonestown community, especially elders, have some biases that they must contend against. The following two quotations articulate some of the dispositions that affect whether one goes to the JHC.

[At the JHC] because it’s not about the money, people say, “Hey, they ain’t no real doctors.” [But] Once they go get- they know they get good care. They get the best care, but before they go they so skeptical because they’ve been orientated to think the doctor want some money or the medicine going to cost you, you know, when they go in and they say, “All you got to pay is this, and the medicine going to be a few dollars,” you know. But that scares a lot of people, “cause I’ve been so used to paying a lot for medicine why your medicine so cheap, it must not be no good.” And, these are bigger issues. This is the way these people think [interview #5 male].

I’ve heard a lot of the older men, “Man, I just, I just can’t go up there,” them ladies, “I just can’t have them ladies looking up at my—” You know, that type of thing. Well, they just feel they’re white ladies, it’s I can’t, you know— And ... well, that’s basically the way they feel and some ladies, you know, just can’t accept the fact that they is ladies in medicine [interview #19 male].

While the two men quoted above have sought medical attention at the JHC on at least one occasion, they address some of the issues that must be overcome for people to feel comfortable getting care at the JHC.

The family nurse practitioner and bookkeeper/laboratory technician who were instrumental in reopening the center and now oversee the JHC are white Catholic religious sisters from the Community of Saint Joseph (CSJ) based in Minnesota. For this mostly black
community, it has taken time for people to trust the CSJs and feel comfortable enough to seek medical care from them as new community members, women, and European-Americans. From community ethnography, it was also evident that people must contend with the issue of receiving care from a nurse practitioner rather than a doctor. Most are accustomed to people receiving medical care from doctors and are somewhat apprehensive about the abilities of a nurse practitioner.

Many people within the black community acknowledge these issues as factors that influence their decision to receive health care at the JHC. Those with prior relationships with health care professionals in neighboring towns base their decisions on several factors which include: satisfaction with current doctor (if applicable), ability to pay, transportation, frequency of medical visits, and second-hand knowledge of other’s experiences at the JHC. For each individual, the importance of each factor varies and eventually determines whether care is sought from the JHC or not.

_God Works Through Health Professionals_

Whether medical care is sought at the JHC or from other doctors, those interviewed are comforted in the belief that God works through health professionals. So, not only do they believe that God can heal their pains through prayer, many believe that God intervenes through doctors to provide additional relief.

Previous bad experiences with health professionals have made some uneasy in seeking medical attention. When help is sought, comfort is derived from the belief that God has influence over the doctors and nurses during medical visits. The following quotation illustrates how respondents rely on God’s intervention to soothe fears concerning care from health professionals.

_A lot of them are prejudiced, hard core. When I had my surgery, I prayed to God, I didn’t ask nobody else. I said, “God, I know the man. He probably don’t care a lot for me. But would you guide his hand and his mind?” That’s all I could do. I was afraid [interview #9 male]._
Despite his prayer and belief that God influences doctors, this man was still afraid. Even though believing that God intervenes in health professionals does not provide total abatement of anxiety and uncertainty, such feelings are lessened to some degree.

Not only is some comfort provided during medical visits by the belief that God works through doctors, this belief also helps some people to better follow doctor recommendations. A woman articulates this point in the following quotation.

*A lot of people don’t have confidence in their doctors. ... a lot of people don’t have confidence in their doctors. Oh God would do this, but this is the thing about it, God knew all these things going to be and that’s why he’s preparing people to help us. And you supposed to take your medication. ... you supposed to take your medication. God works through the doctors. People got to realize that [interview #16]*.

Those interviewed in this religious community expressed the desire to live by the word of God. Therefore, viewing doctors as an extension of God serves as a means of validating doctors. Perhaps, the logic is that if God is working through doctors, then one should have confidence in doctors. Then, in turn, one should faithfully follow the advice of doctors.

While nearly all people with whom this was discussed believed they are comforted during medical visits by the belief that God works through doctors, few people are highly compliant with doctor recommendations despite God’s influence on doctors. Those who have been at the brink of death and are now stabilized on medications are the ones who are most likely to believe that adherence to medical advice is important. It appears that these believers have found God’s intervention to provide an extra motivation to comply with medication prescriptions and medical appointments as a vital part of taking care of themselves.

In summary, study participants discussed various factors that influence their utilization of health care professionals. In addition to limited accessibility and availability, negative experiences with practitioners have affected and continue to affect their health behavior. Health care utilization has been altered to varying degrees by the reopening of the
JHC. And, the continuing theme of religiosity also played a prominent role in mediating health care professional utilization and compliance.
CHAPTER SEVEN. SUFFERING: PULLED DOWN AND LIFTED UP

Through interviews and community ethnography, it was evident that people in the Jonestown community have endured a variety of hardships throughout their lifetime. From the agrarian sharecropping system to an inadequate public education system, the community has persevered. In the words of one man interviewed, I'm telling you, being black is rough. That's the first thing I mean that. It's not good [interview #9]. To understand this community, it is important to view suffering as a condition that has resulted from these experiences.

Not only have interview participants suffered because of social injustices, they have also suffered through their physical ailments. In terms of their health, they have withstood much hardship and pain. These pains are often unrelieved. Thus, they experience suffering.

The emotional suffering experienced through social injustice should not be viewed in isolation from the physical suffering that people experience. Even though some attempt has been made to evaluate these issues separately to more thoroughly examine each type of suffering discussed by interview participants, they are very much inter-related. Emotional suffering is believed to affect health and the body, and physical ailments are believed to affect the spirit. The two following quotations reflect this point.

*My health, oh sometimes I get worried about these bills when I don’t have the money to pay ‘em. That gets on my nerves. That mostly gets on my nerves. That’s mostly what bothers me. See, my check doesn’t cover my bills [interview #7 female].*

*Stress, you know, anxieties, those things can cause one to really just shoot up in a minute. And I don’t think enough emphasis is put on that. I think folks put a lot of emphasis on food [interview #11 male].*

Emotional and physical suffering is endured for a variety of reasons which will be examined in this chapter. Past experiences and foreseen future ones have necessitated that older interview participants be strong willed survivors what ever comes their way. Conversely, young and middle-aged adults suffer out of necessity, because they must. Not only have they learned how to suffer through their afflictions, this suffering may serve to enable them to gain entrance to the after-life with God. People interviewed are sustained during their difficulties.
by the belief that God will not let them experience more than they can manage. There are also institutional mitigating factors that have influenced people’s ability to utilize additional methods of coping or healing.

Social Injustices

Throughout life, people in the Jonestown community have faced adversity. The following story typifies those shared during interviews and community ethnography.

... like down here, I don’t know if you know but it’s not all, it’s not equal at all. No matter what, it’s unfair and, and it can be stressful. Like just the other day, dealing with a situation, the bank had sent me a check, I mean, people are prejudiced, I don’t know if you know it or not but people are prejudiced. And living in Mississippi, I know that probably more than a lot of other people. But I got a letter from the bank saying that I had written a bad check. I knew I hadn’t written a bad check, I don’t write bad checks because that’s the purpose of me getting a checking account is to know what I got in the bank. And I, and I’m just responsible enough not to write a check if I know I don’t have money there. So I called trying to explain, because I do have a black voice, people don’t treat you the same. ... And racism has never been gone, it’s always been here and there. ... you don’t have a fair chance. I mean, you know that the race didn’t start out equal to begin with. But you don’t have a fair chance. There’s hardly, well, we know education is the key but the Mississippi public school system, to me, I think—now this is the way I see it- if the education is the key then why not, why are so many public school system only giving the kids, barely giving them the key rings? They’re not, I mean, public school is not, it’s ridiculous. And if you know that that’s the key, why don’t we try to make it better for our children. We know the future is all, is what we’re gonna live the rest of our life in, what our children gonna live the rest of their life in, why don’t we try to make it better instead of just saying, “Well, education is the key, go out there and get it.” It’s not all that easy, when you’re in a school system that’s not, that doesn’t have you in its best interest [interview #6 female].

Life is unfair and stressful because the forces of prejudice and racism must be contended with constantly.

Public schools and banks are two institutions that hold the resources believed to be most powerful. Repeatedly, those questioned about the community’s needs said youth need to receive a better education. The above quotation addresses the need for education from the perspective
that even those who go to school do not receive the necessary keys that could open doors of opportunity.

As financial institutions, banks control resources that are often denied to those seeking to create their own opportunities. While the woman above spoke of her difficulty talking to a bank representative because she suspects that she will have difficulty disputing the bank's claim due to her black voice, others have also had problems with banks. A self-employed couple with a business that grosses more than $200,000 per year wanted a bank loan of $10,000 to make business improvements with newer equipment and some building renovations. Despite their good credit record and willingness to have a cosigner who had cash collateral, their application was denied. The reasoning they were given was that the couple was too high risk. This happened a second time when the couple wanted a $700 loan. The couple were in disbelief when they were refused again since a white farmer had just been approved for his loan of $150,000 and was behind in his payments for a prior loan. Racism was believed to be the reason why the couple was turned down, and they thought that there was nothing they could do about it. Nothing has been done, and they are unable to make their desired business upgrades.

Not only is it difficult to gain access to the resources that provide opportunities, but service agencies that were designed to assist those in need often deny dignity to those they assist. While they were not reported to withhold services from the community, those interviewed thought that service providers looked down on those in need. The following quotation illustrates this point.

_Unemployment is, is real bad, cause sometimes you have to then depend on people like the Health Department to give you whatever. Or you have to work, depend on some card or another, and then when you possess a certain card, people treat you like you're nothing. And then you have some professional people in that arena who feel like you're nothing and that's the way they treat you. I remember one time, I went to the Health Department down in Clarksdale, and I had some kind of little rash, and I walked up to the counter and I asked the lady, I said, "Ma'am," I said, "I need to see the doctor." "Do you have gonorrhea, syphilis or whatever?" I said, "I, I got a little rash." "Do you have so-and-so, so-and-so, so-and-so?" And there's a whole room full of people. Now I'm trying to be discreet and I said, "No, ma'am, I don't think so." I walked in a room just like this right here and this lady asked me to do, and she's a, I guess she's a doctor, she doesn't identify herself. She
said, "Pull your pants down, let me see what you're talking about." I'm in a big room! I just walked up to the desk. Hey, I pulled my pants down, I showed her what I was talking about. She said, "There ain't nothing wrong. Just put this right here on, there ain't nothing to that, just put this on like that and be gone." And I left. I didn't feel like I got healed and I said then, I don't ever, I never been back to that place again down in Clarksdale, to those places. And everybody else that goes there says the same story, that it's real sad the way you, you were treated at that time [interview #9 Male].

While this man is now fortunate to have a good job that provides excellent benefits and no longer needs to receive assistance from the Health Department or other social services, others must still depend on their services and face many indignities.

Such disrespect and humiliation are believed to take a toll on people. After a while, I just think, you know, people, you know, they feel the stress. They feel it, you know. It just gets to them after awhile [interview #5 male]. According to this same man and others, some people begin to internalize these struggles and bad experiences. I mean after you feel nobody else care, you actually don't care. The following story describes one woman's experience of thinking little of herself.

... when I was coming up, they didn't have black shows no more than "Amos and Andy" so I never got the black, uh, roles models that I needed. That would have helped me to believe, you know, would have helped me to think that blacks were important. ... I never thought that I was special when I was coming up [interview #1].

The easy life was not experienced by those interviewed, rather it was more like a struggle. Those interviewed expressed their feelings about the stresses the community faces by saying.

Well, poverty is bad. You don't have a decent place to live. That's bad. That's a strain on you when you can't get some of the things that you actually need, you know [interview #16 female].

A person overwork, under-rest, it cause just naturally that he's gonna have, have some problems. ... I think that's, that's a, does something for you, for you mentally and emotional. ... You know, you don't press your way on. You don't see that-, see other things that have been important [other] than what you're going through right now, you know [interview #11 male].
Thus, those interviewed believe that the injustices and stresses that they and others in their community deal with have a profound effect. According those interviewed, these experiences stay with an individual for one’s lifetime, they become a part of one’s core being.

**Physical Ailments**

*But now I am 77-years-old I don’t think I need no operation. I just suffer these few more years, or few more days I got here and just go on here and suffer. I done suffer with it all these years. I just go on and suffer with it. It don’t bother me all the time, just only sometime. Some time, I can walk just as good and sometime I can just hardly make a step. Sometime I have to call the children and tell them to bring me my walker before I can make ‘nera a step. And sometimes I can just get up and go on a walk [interview #7 female].*

As this mother of twenty-five children explains, people learn to accept their conditions. Being willing and able to cope with ailments is a part of life. Instead of looking to medical providers to relieve her hip pain and limitation of movement, this woman has decided to endure the pain and go on with her life.

Complaining is not a customary part of life. Even though people interviewed may live with great physical or emotional pains, they do not whine or gripe about them. And, they do not seek pity from others. Rather, they have a humble demeanor.

*I’m not, and I’m not the type of person who do a lot of complaining, you know. You have to accept diseases because when I watch television and see other children, I’m 71 years old, and there [are] kids, young, haven’t enjoyed any of their life. And they in bad shape. So, I’m just thankful that I can get around, you know, that’s a blessing, at my age and what I’ve gone through here, you know. Now there are people who been through worser things than I have, but still, I’m grateful that the good God has spared me, you know, it was his grace that did it [interview #16 female].*

*My mother never complained about no sickness. ... So she came out for Thanksgiving and then she went back again and she died in December. But she still wasn’t complaining and he [the doctor] said the cancer was so bad, you know, mostly into August, it was just- But she just, she never complained in all her life [interview #19 male].*

These quotations illustrate that complaining is simply not a part of their culture. Despite great distress or illness, respondents still do not complain. The first quotation is from a woman who has undergone triple bypass surgery following a massive heart attack; she also has
osteoarthritis, high blood pressure, and peptic ulcer disease. Like the mother of the man in the second quote, disease does not justify complaining.

It is important for community members to be able to endure suffering. In past times, older people interviewed knew that trials and tribulations often lay ahead. Thus, the importance of taking it one day at a time was emphasized. Despite this, respondents knew they would have to find a way to cope with forthcoming adversities. Starting as children and continuing into adulthood, older men and women learned that they needed to toughen up and live with pain to be able to deal with the greater difficulties that they would face in later life.

*We got to live with pain. There are thousands of people living with pain right now, some of them living in the hospital and they still ain't getting no relief. So you have to learn to live with pain. And, ask God to help you to endure pain (interview #16 female).*

This quotation illustrates the discussed opinion that people need to learn how to suffer to find a way to cope with pains that cannot be healed. There may be times when prayer, home remedies, and even allopathic medicine cannot relieve pain. Therefore, older people discussed the importance of finding a way to deal with their ailments. They now feel blessed and thankful that they have endured their hardships, and still have their autonomy (health).

The younger respondents, however, suffer out of necessity rather than as a means to gain endurance for future greater hardships. But, similar to the older respondents, they discussed approaching life one day at a time.

*Without health insurance or government assistance such as the Medicare that older citizens receive, many young and middle-aged adults have little access to health professionals to help them overcome their physical ailments. This is explored in the following quotation.*

*Most people that work, most people that work can't get health [care]. People that was on government substance was more healthy than we were because, if I went to the doctor I had to pay and ... if I couldn't pay then I just suffer through whatever was bothering me. Not knowing how to take care of myself, I just suffered through it and then would go on 'til it got better. I hoped it would get better. (interview #13 male).*
Similar to the belief held by older participants, young people believed that it was necessary to learn how to suffer in order to find a way to cope with pains that cannot be healed. In these times, prayer, home remedies, and even allopathic medicine have not relived pain.

Not everyone is able to suffer and cope with pain as well as others. From discussions, it was evident that these people do not get much pity. A woman expresses no sympathy for a friend who says that she cannot withstand pain by stating:

I have a friend who says, "Oh I can't stand no pain," I say, "Oh, yeah, you can stand pain. Don't tell me you can't stand pain. You can stand pain" [interview #16].

People are, thus, expected to live with pain and find a way to do so.

When people have physical ailments, they are expected to cope on their own, and with the help of God. People who go to the doctor early in their course of pain are not highly revered by those interviewed. Comments such as I came up the old way, you know, I don't go [to the doctor] for, ah, any ache and pain come up [interview #5 male] and I just don't believe in running to the doctor every time you hurt. I really don't. I just sit around and let it hurt if it don't stop [interview #7 female] and I came up the old way, you know, I don't go [to the doctor] for, ah, any ache and pain come up [interview #16 female] were commonly held by both men and women interviewed.

Most adults in the Jonestown community were not raised to go to the doctor as children and in later life. Despite having better access to medical care than previously, interviewed Jonestown community members still do not initially seek help from the medical establishment. Home healing is the first line of treatment. If this is not sufficient, then some seek help from health professionals. Seeking medical services for severe or persistent pain is viewed as acceptable. While help seeking is discussed in chapter five, the point being made here is that interview participants believed that pain must be endured for some time before it warrants seeking help from a health professional.

Even when those interviewed go to a nurse or doctor because of their pain, they do not always find relief. Thus, they have to find a way to cope with pain.
... we never did to the doctor cause we never did have money. And now, going to the doctor is a strain because you just don’t have the money. Because the doctor may tell you something wrong with you and then you don’t have the money to get it fixed, you have to live with it. You just have to live with it [interview #13 male].

You know, because I might end up suffering because I don’t have the money to receive the best health care in case something happen. Or I don’t have the policy where I can’t afford it, then what's going to happen to me [interview #5 male]?

These quotations, the first by a middle-aged self-employed husband and father of three grown children and the second by a divorced father of two, address yet another issue of suffering. People interviewed have learned to endure pain because they do not have resources for medical treatment. Despite the variable efficacy of current medical treatments, not having the option to receive such care or treatment leaves one to find other ways of healing. Most times, this involves coping with existing pain. Prayer and home remedies are often utilized, but pain often remains. People cope.

Suffering as a Means to Salvation?

During Sunday worship services, church pastors deliver their morning message to their congregation. These messages are a central part of the church service. Preachers often take thirty minutes to more than an hour to explore the meaning of a particular Bible passage or comment on observations of the Jonestown community from a religious point of view. Suffering became a recurrent theme of these homilies and Sunday services.

One particular Baptist preacher discussed the need to suffer by saying, we must be prepared and ready to suffer for Jesus. No pain, no gain. He went on to discuss how people do not want to suffer for salvation which is the problem with white religion because they don’t want to suffer. These preachings were typical of the churches in the Jonestown area.
In a different church, an old hymnal also insinuated that people need to suffer. *I had to learn how to suffer, so I can go to heaven* was one of the hymnal lines. The rest of the song's lyrics were quite similar.

Even though suffering was not discussed in a religiously motivated context by those interviewed, it is possible that some believe that the Bible states that suffering is a requisite and means to achieving eternal life. One could ask does life imitate what is preached or does preaching imitate life? It is possible that these values may reflect the beliefs of the community as many said *Amen* after suffering comments were made in church. Or conversely, pastors may be trying to impress this belief upon their congregations. Regardless, these church observations are worthy of some discussion.

While these Biblical passages were not identified during church services or conversations with people, such Biblical origination can neither be confirmed nor denied. But such verifying documentation need not be necessary if the belief persists.

Redemption may be the reward that those who suffer receive in the after-life. This belief may validate the past and present experiences of black people in the Jonestown community. Thus, the hardships that black people have endured becomes a means for empowerment once one explores the deep spiritual meanings that can be associated with these experiences. Believing that people must suffer to be saved serves as a confirmation that their hardships are and were necessary for people in the Jonestown community to find salvation with Christ. Suffering may then be endured as people see that their struggles have a higher purpose.

It may seem paradoxical that there is a community sense of needing to suffer to gain redemption while people also seek pain relief from prayer, home remedies, and health professionals. It is not unreasonable for people in pain to seek alleviation through any means possible. While it may be known that their suffering will be rewarded in the after-life, those interviewed live day to day and find ways to persevere and keep living. Pain management through various means, enables them to do this.

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9 The origins of the song were sought but could not be obtained. This black Baptist hymnal is believed to
Finding a Way to Make It

All those interviewed found a way to cope with their situations through God, and some used additional means. In doing so, it was emphasized that they not dwell on their problems and past experiences. In trying to move beyond their experiences and make it, those interviewed were able to protect their spirit from being pulled down. This is described in the following quotation.

Well, if you, if you look at [it] in a sad way, if you look at it in a sad way, it’ll pull you down. And, your health that goes down with it [interview #2 male].

In turn, God and spirituality are what keep you lifted up [interview #3 female] so one does not get pulled down and lose autonomy.

Those who are not able to call on God to help them are believed to have difficulty enduring their experiences. In one man’s words:

... poverty- when you’re poor and you’re trying to work two or three jobs and you don’t have a foundation at home or you yourself are not grounded, you know. I think, actually if you are not grounded in the word that you can depend on a higher being to give that spiritual upbringing you need, so you can be a leader for your family then you just, you so tossed by different ideas and different doctrines that you become confused [interview #5 male].

Such confusion or turmoil results from being pulled down.

In interviews, people discussed their ability “pull up” and find a way to live with their stress and experiences with injustice. God enables one to manage. The following three stories by a 59-year-old man, a 58-year-old woman, and a 76-year-old man explore the ways in which God was called upon to help deal with their experiences and make it.

When with all of that stress, when you hear of the hanging and lynching and this type of thing and you have to walk to school, with all of that stress, I made it. And there were a few others who made it. ... In most cases, I just tried to put it behind me, you know, and not even think about the lynchings, the mob and this type of thing, not even think about it, at least while I was in the classroom. Just put it behind me. ... it’s a difficult task. But I had learned that anything you really want to phrase out, you can do it. Anything that you want to phrase out, I guess that can phrase, put just about anything out of your mind. But

be quite old, but the approximate date in not know.
seeing your people going down to the train, you cannot phrase that out of your mind. Now that's one of the things you can never in a lifetime, you will never be able to phrase out. It's gonna be a thing that's gonna bother you... And I pray a great deal and I have great, great faith. I am a believer and once I pray, I don't pray wondering about it. When I pray, I pray knowing that it's gonna be done. That's my prayer. Knowing that it's gonna be done. And I just leave it there [interview #18].

I pull up... I just don't know how I pull up 'cause I had eight children. I pull up by God, that was my only way. 'Cause I was getting $180 a month. So it was a hard pull and it was stressful. It must a, I guess I did, that's all I know. 'Cause I didn't have no kind of help, no more than the help that I had of my own. I didn't have no husband so that was stressful. Wasn't getting no child support. It just was stressful. And it do something to the body. The mind. You got to be worried all the time with this, how you gonna do this, how you gonna do that? So that's the way it go... when you read the Bible, if, it just do something for you. It make your life more, when you go to getting you, you know, just going off too far, you get your Bible and bring yourself back together. When you go to church you can, I love to hear singing and I love to have... good preaching. And I just love, I just love everything about being in church, you know, cause I'm a mother of my church because I'm the only one there, you know. And you know, when you go, when you go to God and you'll feel better, you know. ... He can give you more understanding, you know, than you can—you just can't do without it. And just like when you sit down and read your Bible, you, you know what you got to do and you know what you want to do. And then you feel, you feel relaxed. 'Cause talking to God, we are relaxing and give you a better start [interview #8].

He [God] has played a major role. Because the way I cam up here in Jonestown, survival was a fact of life. ... The Lord help me find the way, a better way. You'd be surprised what exercise will do for stress, and then asking the Lord for guidance. They [past experiences] will build up stress. I'm telling you, and stress is really harmful to the body and mind and any other part of your body. ... See, I grew up, in my younger days, under stress. I didn't know what it was but, as I say, Uncle Sam [military service] opened my eyes. You had to walk right down the street, right here, passing kids, a white kid come by and sic the dog on you. And you'd better not, he'd tell you, you better not hit that kid. Better not hit his dog. You don't know what to do, you know what I mean? You don't know why. If a white boy want to slap you, he slap you. Now, that built up fear and plenty of stress, all of that. This is one of my— I keep thinking about these things but I try to get it out of my mind but I can't, I grew up with it, you know, I grew up with it. I guess I'll go to the grave with it, but I shouldn't do it. But I do. ... That's my biggest thing, fighting stress. Don't let no one get under my skin. Find a way to deal with it, such as walking away. Smile. Be sure you smile—and walk away, if you're permitted to. A lot of time they won't permit you, but you have to find some kind of way to deal with it [interview #14].
These quotations reflect the sentiments of others interviewed as God was relied on to help one find a way to persevere. Exercise was also discussed as a means to get one's mind off their condition and onto something else more constructive.

Those interviewed believe that they can endure what ever difficulties they may face since God will not give them more than they can handle. A 71-year-old woman articulates this belief.

*Just live one day at a time. Don't think about tomorrow, one day at a time. And, I asks God “what ever come, able me to stand it.” And, he said he wouldn’t put no more on me than you can bear. So whatever comes [interview #16].*

Believing that they can endure anything God will's them to experience is empowering and enabling. This belief provides much solace.

Helping others was another way in which those interviewed cope. By helping others, one can shift attention away from one's self and onto another. Additionally, those interviewed gained a sense of accomplishment and self-worth by helping others. The following quotations describe this.

*Making somebody else happy, working, and this type of thing and making somebody else feel good. If be it an adult or a child, I always worked as a boy and to make my grandma happy and she was a lovable person. And that’s trying to make other people, seeing other people’s happy. This has been one of my greatest things and this is one of the things that, that releases a great deal of my stress, doing something for somebody [interview #18 male].*

*I get out and I talk to the old people. I still see about the old people in my neighborhood. That keep me going because I look forward to going seeing about them, not sitting at home concentrating about my sickness and everything, that ain't good [interview #3 female].*

To cope, some of those interviewed found a way to transcend their emotional and physical ailments through meditation. The following stories of two men explores this.

*I meditate in the morning. When I go in, I try my best to not get stressed out. And when I don't get stressed out, I find a lot of people doing things to make me know that the day is going to be all right. And then when that level hits- Southern Bell is a good a company to work for- you're a good man, starting giving out good positive vibes and all this kind of thing. But some mornings you go in, you say, "Oh, God, Lee, this is going to be a tough morning." But through the meditation, I get the sweet communion, you know, of the Holy Spirit and all that other good stuff*
that goes along with it. It helps you, it helps my blood pressure, I guess, and it helps me from getting headaches. I haven’t had a headache in a long time. But then, I look back and I say, I guess it was the good Lord put me here for it to, to handle a lot of things. I might not ever get to the Promised Land, but I would have enjoyed this trip [interview #9].

‘Cause then, having pain is something that, that you just get used to. I’ve been in pain, when I was coming up I had headaches, I never knew about sinuses or nothing but my head would hurt all the time, you know, it wouldn’t be a week that went by, either I could be, I could get excited about something, have a headache. And I didn’t know that you had sinuses and different things that could have been treated. Or allergies or, didn’t know about nothing like that. ‘Cause all the pain, I was lived with, you know, you just live with it day-to-day. And then when my leg got, I lost my leg, that was another pain that I just lived with. Until I learned to treat it and find out that certain things that I could do to stop the pain. But you would just put your, if you have, if you would have pain, you would think about, I wouldn’t think about it. I’d just put myself somewhere else, my mind would drift on off and the pain would be there but it wouldn’t be there [interview #13].

Transcendental meditation was, thus, utilized as a means that provides spiritual healing of the body and soul. Not only was meditation believed to reduce stress, but it was utilized to control physical symptoms.

In summary, study participants have suffered emotionally and physically. Interviewed Jonestown community members have had limited access to resources for stress, illness, and pain management. And, some do not realize that they can do something about their suffering through health care. As a result, they cope to the best of their ability through prayer, meditation, and exercise. From discussions, it was evident that people found consolation in the belief that they can handle whatever God will’s them to experience. Being capable of coping with pain has enabled older people to be better prepared for future hardships and suffering. People’s experiences of adversity may gain meaning in the belief than they must suffer to gain salvation.
CHAPTER EIGHT. DISCUSSION

These findings contribute to a greater understanding of the beliefs, practices, and experiences that affect how rural blacks take care of themselves. Study participants indicated that health was mediated by the ways in which one takes care of one's self. God's control of health was the predominant factor that shaped the ways in which people took care of themselves. The historical importance of extended family networks and economics were also significant socio-cultural factors that influenced the process of taking care of one's self.

While previous attention has focused on older black rural adults (Davis et al., 1991; Fleury, 1996; Parks, 1988; Powers, 1982; Snow, 1983; Weinert & Burman, 1994; Wilson-Ford, 1992) this study examines health throughout the life-course of an adult rural population. Of all research identified that explores health values and behavior in rural black communities, only one study had a subject population that ranged throughout the life-course (Strickland & Strickland, 1996). This one study, however, limited its focus to preventive health barriers. Thus, the present study significantly contributes to what is known about health beliefs and practices of rural black adults.

Meaning of Health

Study participants described four interrelated definitions of health which involve: 1) ability to function, 2) degree of autonomy, 3) freedom from dependence, and 4) the mind and spirit. These findings are supported by other research on older rural blacks which indicates that other populations of rural blacks share similar values.

Specifically, health has been defined as the ability to do what needs to be done (Davis et al., 1991). Independence and autonomy have been emphasized as factors that determine health (Blake, 1977; Dula, 1994). The latter case study presentation also indicated that freedom from dependence on others was an integral part of the meaning of health. Stack (1996) and Davis et al. also stress the desire of older blacks to not be dependent on others. The soul has
also been found to be an important component of how health is defined in an older black rural population by Snow (1983).

A study of rural white farmers from Montana found that health was defined in functional terms (Weinert & Long, 1987). Health meant doing what needed to be done, being able to work, and being productive. This emphasis on being able to function was similar to findings of the present study of rural blacks. Their common agricultural history may play an important factor in how health is defined in these two different populations. Thus, environmental and cultural factors may be a stronger indicator of the meaning of health than ethnicity.

It is interesting, however, that these other studies of rural whites and blacks depict that health only has a one or two-dimensional meaning, while the present study found health to have four interrelated definitions. The more comprehensive exploration of health’s meanings provided by this research suggests that future health behavior studies needs to take into account the various meanings of health to provide a context in which behavior can be best understood.

Despite illness, disease, or education, this study found that rural blacks consider themselves healthy as long as the four meanings ascribed to health were met. Loustaunau and Sobo (1997) support this contention, however, studies of rural older blacks indicate otherwise (Davis et al., 1991; Kohrs & Mainous, 1996; Wilson-Ford, 1992). The former study indicated that one was not healthy if in pain. Participants in the present study believed differently as pain was an “accepted” part of life that did not necessarily limit or hinder one’s ability to function, autonomy, independence, or mind or spirit. The latter study of older women found that 60% perceived their health to be poor, 27% designated it fair, and only 13% said that it was good. The Kohrs and Mainous study found that education was the most consistent predictor of health status. In the present study, in depth interview participants, regardless of age, sex, disease, and education believed that they were healthy. Some said that they were not in perfect health, but they still felt healthy. Thus, the cultural ethos and socio-cultural
characteristics of the rural community may have dictated health perceptions despite illness or education which could be expected to affect such attitudes.

Differences in perceived health status may reflect differences in subject population or may have resulted from differences in determination. Informants in the present study and the Davis et al. (1991) study responded to open-ended questions while subjects in the Wilson-Ford (1992) and Kohrs and Mainous (1996) studies were asked to rate their health along various scales. The Wilson-Ford study also factored in the presence or absence of illness, disease, or physical disability to determine health status. So the results of the Wilson-Ford study were not purely based on self-perceptions.

Self perception of health is important because it can be an indicator of both health-protective behaviors and help seeking (Wilson-Ford, 1992). While this study found differences in the way those with poor, fair, and good health perceptions took care of themselves and sought help, perceived health status was not an identified variable that influenced such behavior in the present study. Rather, religiosity, cultural norms, economics, extended family networks, and presence of illness or disease were significant determinants of care taking and help seeking.

**Health Control**

This study found that God was believed to be an important mediator of health, and indeed one’s life. Informants believed that God controls health, yet they also had power to control what they did in response to God’s supremacy. While other research has found that rural black elders have strong faith in God’s ability to protect health and heal illness (Dula, 1994; Fleury, 1996; Parks, 1988; Wilson-Ford, 1992), no identified studies have explicitly explored the factors believed to control health for rural blacks. The present study indicates that health is believed to be both determined by fate and influenced by individual behavior. Thus, fatalism was not valued as some might erroneously surmise. More work is needed to explore the relationships among factors that influence health control.
A more thorough investigation of this topic will help determine ways to best influence health behavior for rural blacks. Findings from this study suggest that this issue of health control is complex, and it may affect how people take care of themselves throughout their life-course, seek help, and utilize available resources.

**General Health Factors Throughout The Life-Course**

While other studies have briefly discussed the strong religious faith of older rural black women in relation to their health (Dula, 1994; Wilson-Ford, 1992), few have included men (Fleury, 1996; Parks, 1988). Studies of urban blacks also indicate that religiosity plays a substantial role in taking care of one's self (Millet et al., 1996; Powers, 1982; Snow, 1983). Discussion in these studies was essentially limited to that of prayer as a frequently used healing modality. Only Snow and Wilson-Ford discussed religious faith as a health mediator without the presence of illness. Findings from the present study indicate that religiosity does indeed affect a myriad of health behavior throughout the life-course.

Similar to a study conducted by Fleury (1996), informants discussed the value of living in the present time rather than worrying about the future. In doing so, spirituality and religious beliefs were emphasized. Participants lived day to day, and did not think about the future. This perspective helped informants in the present study to persevere in spite of the hardships they faced. Both this study and Fleury's suggest that religious beliefs, community norms and personal values significantly contribute to this attitude.

Study informants looked to the Bible to outline the proper way to live. From this, participants incorporated the values of eating right, exercise, and rest into their lives. The principles of proper diet, exercise, and rest were also noted in Snow's (1983) review of health beliefs in lower class blacks, but the basis for such values were not explored. This study also discussed the use of magic as a means of protecting health. This finding was not substantiated by the present study. Such practices may be community specific, despite ethnicity.
Despite the reported value of eating right, exercise, and rest, few informants lived by these principles as they believed they should. A study of older urban black women has also found that adherence to healthy behavior is not always related to its perceived importance (Martin & Panicucci, 1996). While their study did not delineate reasons for such discordance, the present study identified important historical, environmental, and social factors that created barriers to valued healthy behaviors.

The present study also found that health was not thought of while one was young. This issue has not been explored in other research of rural blacks, probably because these studies examine the beliefs and practices of adults typically over the age of sixty. Family networks, economics, religiosity, and community norms were the most influential determinants of health conceptualization and cognition.

Informants did not receive wellness check-ups or screenings in part because health was taken for granted while young. This finding was not supported by previous reportings of regular medical check-ups and screenings in black women (Duelberg, 1992) and in both men and women (Spector, 1996).

One exception to this tendency, however, was noted. In this case, a 31-year-old mother of three began to get annual medical check-ups after the birth of her first child when she began to receive letters in the mail to receive a physical from the county Health Department. At the age of 19 after dropping out of high school, she has sought these yearly medical exams because she wants to be healthy for her children. Despite conversations with other young mothers, no other informants held this woman’s belief or sought regular health care without having a grave health concern. Specific factors that may have influenced this woman’s decision and not others remain unclear since they shared common demographic characteristics and religious beliefs. This finding suggests that further details need to be explored to explain what factors enable people to behave outside of cultural norms.
Response to Illness

With the exception of this woman, illness was the instigator for other informants to start thinking about health. One could then ask whether pregnancy should be considered an illness given the circumstances for the exception. I would argue otherwise because this woman sought annual medical visits while she was well, and others did not.

Empowering potential has been discussed as a process through which people make lifestyle changes (Fleury, 1991; Fleury 1996). While this theory takes into account health values and social factors, these studies did not assess factors that influence the desire to make changes in the first place. Rather, study participants had either made or were attempting to make health behavior changes. The present study found that one’s own illness or that of a family member were critical circumstances that instigated both cognitive and behavioral health changes. Health values and socio-cultural factors discussed in the latter study were also significant factors that determined whether informants in the present study began to think about their health differently or make lifestyle changes.

When ill or with disease, behavior followed cultural norms. No differences were found based on education or income. Wilson-Ford (1992) found similar results in her study of older rural black women. Mechanic (1992) argues, however, that educational differences should impact illness behavior. Findings from the present study suggest that a common social ethos is a stronger indicator of behavior than income or education.

The course of illness or disease was predominantly mediated by religious and socio-cultural factors. Regardless of whether informants instituted behavior changes, there were two common themes: rejection of the dominant sick role and pain endurance.

While limitations of the dominant sick role theory have been discussed (Chrisman, 1977; Kassebaum & Baumann, 1965; Kosa & Robertson, 1975; Loustaunau & Sobo, 1997; Mechanic, 1962; Suchman, 1965), prior research on rural white farmers (Lee, 1993) and urban blacks (Suchman, 1964) have rejected the sick role concept. Similar to the findings of Lee and Suchman, the following criticisms of the sick role resulted from the present research: 1) sick
rural blacks were not completely exempt from social roles; 2) some people were blamed for their own health conditions if they did not pray enough or were known to abuse their body; 3) some tried to get well, others did not. Who determines wellness?; and 4) initially, help from health professionals was not sought. These findings suggest that social and cultural values are indeed important determinants of response to illness.

Pain endurance was discussed in terms of both physical ailments and social injustices. Often, they were not distinguished from one another by study participants. Again, religious and socio-cultural factors determined the ways in which informants dealt with their pain. In addition to these factors, age influenced the meaning associated with pain endurance. Others support this finding (Bowker, 1997; Kleinman & Kleinman, 1997).

Stack (1996) portrays a black man whose pain was relieved once it was officialized and validated by receiving disability benefits. Findings from the present study, however, indicate that informants did not seek validation for pain and suffering from health professionals even though their help might have been sought. Historical denial of health care practitioner validation probably influenced informants to not seek such approval from the medical establishment. Rather, they were accustomed to pain, and suffering was endured. Otherwise, prior studies of rural blacks provide little insight into this finding.

**Seeking Help for Health Concerns**

Modalities sought for healing ailments were mediated by severity of health condition, prior health concerns, and experiences with various healing methods.

Prayer was a powerful panacea for participants in the present study. This finding is supported by numerous other studies of older rural blacks (Dula, 1994; Fleury, 1996; Parks, 1988; Wilson-Ford, 1992) and urban blacks (Bailey, 1987; Clavon & Smith, 1986; Millet et al., 1996; Powers, 1982; Snow, 1983; Spector, 1996). As described in most of these studies, prayer was the first line of treatment utilized by informants in the present study. Prayer was perceived as a
means to "tap" into God's healing abilities. Through prayer, study participants gained 
spiritual strength and ailment healing. Thus, religiosity was central to the healing process.

If prayer was not able to ameliorate a health concern, then informants utilized home 
remedies, and only sought medical attention with severe or persistent distress. Similar 
hierarchies of assistance have been substantiated (Bailey, 1987; Blake, 1977; Davis et al., 
1991; Dula, 1994; Fleury, 1996; Parks, 1988; Powers, 1982; Romanucci-Ross, 1977; Snow, 1983; 

Health care seeking practices of urban blacks has been described to involve six steps: 1) 
ilness appears; 2) wait; 3) allow body to self heal with use of prayer and traditional remedies; 
4) evaluate daily activities; 5) seek advice from family or friends; 6) seek out health 
professionals (Bailey, 1987). Findings from this study differ only with respect to steps three, 
four, and five. Informants in the present study were more likely to incorporate these components 
into one step as these three processes were interdependent. It is also important to note that the 
process of health seeking was very much dependent on one's health condition and prior 
experience with various healing modalities.

In terms of health professionals, seeking help from the medical establishment was 
determined by the following factors: cultural norms, financial resources, location, and prior 
negative experiences. Other studies of rural blacks support these reports (Beck et al., 1996; 
Fleury, 1996; Stack, 1974; Strickland & Strickland, 1996). Findings from the present study not 
only identifies barriers to medical care, but also provides some insight into what rural blacks 
do when encountered by such factors.

Despite informant perceived and possible theoretical expectations for gender 
differences, no differences were found in relation to use of various treatment modalities. These 
findings were not supported by Parks (1988), who found that older rural black men in Arkansas, 
Mississippi, and Tennessee were more likely than women to treat themselves when they got 
sick. Additionally, women were found to use more religious healing methods than the men. 
Findings of the present study suggest that gender may not be a strong indicator of help seeking in
specific rural communities. Rather, cultural factors such as religion, individual experience, and community norms seem to be the most important mediators of help seeking practices.

**Reflexivity**

Prior to this study, during it, and in analysis, I have tried to acknowledge my biases and explore the ways in which they may have affected my data collection, and in turn research findings. This important process proved to be both arduous and enriching.

Difficulty arose from the amount of soul searching that was required. I am a young, black, Catholic, middle-class, medical student who was raised in Seattle and went to college in Hartford, CT. As much as I would like to think that I have an open-mind, I have had to remind myself that my mind, as open as it my be, has been influenced by my upbringing and life experiences. As black as I may be, I have had to acknowledge that my education, worldliness, and upbringing have been a privilege that most people in this rural community have been denied. At times, it was difficult to force myself to acknowledge the ways my disposition affected my research. Often times, I would try to step out of my shoes and view things as I believed a Jonestown resident would, but even in doing this I was plagued by my perception of others which was still grounded in my life experiences.

This study took place during my third visit to Jonestown, seven years after I first became acquainted with the community. Undoubtedly, my two prior visits also affected my research approach, the questions I asked, and the ways in which I sought informants.

For field note documentation of participant observation, I chose not to carry a pad and pen on myself to take notes. Instead, I made daily computer entries from memory or from notes that I would write to myself in the privacy of my residence throughout the day. I wanted to be as accepted among the community as possible, and I thought that public note taking would put some people off and significantly impair my ability to participate in community activities if people truly felt their were subjects of a study. My counter-transference, may have affected my ability to recapture moments as they really occurred due to delayed notations. Additionally, it
was probably a fallacy to believe that I could minimize my perceived role as a researcher. I acknowledge that I wore an invisible hat of a researcher at all times, but there were many occasions when I wanted to take it off and slip into the community just as an individual.

My semi-structured interview guide and unstructured interviews with other community members and health professionals reflected my interest in how people take care of themselves. While I doubt that I probed too much, I may not have probed enough or asked questions in the most direct way. Nearly all of my inquiries were open-ended and non-judgmental in my desire to not influence informant responses. Many rich stories resulted from such freedom. Unfortunately, however, I did not begin to fully incorporate some of these findings into my initial working framework of how people take care of themselves until the end of the data collection period was fast approaching. Had I been able to recognize such inter-relationships earlier, my findings may have been more enriched.

For better or worse, I also had a somewhat established network of friends. They were my comfort zone, and at times I had to make a conscious effort to establish new acquaintances and spend greater amounts of time with others. The heterogeneity of those interviewed informally and audio-taped in-depth may have been affected by such bias.

Acknowledging my preconceptions and inclinations has provided me the opportunity to see that the process and products of my work have been shaped by me. It is possible that someone else could conduct a comparable study and deduce similar findings, but it would not be the same. This work is a reflection of me, my deficiencies, and my strengths.
CHAPTER NINE. CONCLUDING THOUGHTS

The results of this study have implications for health professionals in general, and in particular those that work in rural black communities. Hopefully, this research has demonstrated the need for clinicians to be aware of how their clients perceive health and take care of themselves. When health professionals begin to allow the context of their client's lives to come to the surface in patient-clinician interactions, rather than be objectified and decontextualized, client needs will be better addressed. Until this happens, some health concerns will remain unresolved and unacknowledged.

The results of this study also suggest the need for further research in rural black communities. In particular, adolescent attitudes and behaviors need to be researched. Study participants emphasized the effects of rearing on their behavior, i.e. they were not raised to go to the doctor, they learned the importance of God, and they were taught the importance of diet, exercise, and rest. Future research can determine whether adolescents are influenced by these factors. It is also important to explore whether young adults think about health since findings of this study suggests that they do not.

Additionally, the effects of managed care Medicaid, could play a significant role in medical service utilization, and thus how people take care of themselves. Current studies, such as this one, provide some baseline information about how rural blacks take care of themselves prior to and at the start of managed care Medicaid implementation. Future research is needed to assess the potential pending impact of these changes.
REFERENCES


APPENDIX A. INTERVIEW QUESTION GUIDE

I. Exploring Questions
Tell me about some ways you take care of yourself...
   - what about 10, 20 years ago, what is different now? what accounts for the change? how does it compare to your mother/father or sister/brother?

What emotional/spiritual experiences help you to be healthy?
   - kin & family support/social support.
   - what role does your family play? (keeping you healthy, adding to your problems)
   - who are the people you worry about? who worries about you? Who can you rely on?

What influences your health? (envir., living situation, jobs, poverty, community, discrimination)
   - Some people disagree about the effects of stress & unemployment, what do you think?

What are some things that you do to feel healthy or better about yourself?
   - what would you like to do, but you don’t get to do for yourself?

What do you do that may not be so good for you?

In what ways do you think that you are unhealthy?

What concerns you about being healthy? (in what ways do you worry about yourself?)

II. Health Care Utilization Questions
If you have a health problem what do you do? (ie. back pain, foot pain, cough, vision problem, stress)
   - who would you see? where do you go? how long do you wait to seek attention? what worries you?

How do you decide to use home remedies? For what uses do you utilize home remedies?

What influences your use of your health provider (ie. Jonestown Clinic, NWMRMC, dentist?)

What were your experiences with that provider?

What did you think about the care you received?

What are the problems or barriers to getting health care?

What needs does the community have (service gaps, access, etc.)?

III. Conceptual Questions
What does the word “health” mean to you? (mind/body distinction?)
   - in what ways does it change with illness?

How would you define being healthy today? (give specific examples, own or someone close to them)

What does the word “unhealthy” mean to you? (give specific examples, own or someone close to them)

Do you think men and women think of health differently?

Do you think that younger and older people have different attitudes about being healthy?

Is there anything else that you would like to share/discuss with me?