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Outreach Strategies to Recruit Low-Income African American Men to Participate in Health Promotion Programs and Research: Lessons From the Men of Color Health Awareness (MOCHA) Project

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Abstract

African American men continue to bear a disproportionate share of the burden of disease. Engaging these men in health research and health promotion programs—especially lower-income, African American men who are vulnerable to chronic disease conditions such as obesity and heart disease—has historically proven quite difficult for researchers and public health practitioners. The few effective outreach strategies identified in the literature to date are largely limited to recruiting through hospital clinics, churches, and barbershops. The Men of Color Health Awareness (MOCHA) project is a grassroots, community-driven initiative that has developed a number of innovative outreach strategies. After describing these strategies, we present data on the demographic and health characteristics of the population reached using these methods, which indicate that MOCHA has been highly effective in reaching this population of men.

Keywords

African American men, chronic disease, urban health, outreach, recruitment

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African American Men's Health Disparities

National news reports recently ran headlines trumpeting the shrinking gap in life expectancy between African Americans and other racial groups (Tavernise, 2016a). From such reports, one might conclude that current approaches to reducing health disparities are sufficient and that health professionals need simply stay the course to eliminate health disparities. The actual situation is more complicated and health disparities are not likely to be eliminated with currently available promotion and prevention tools and strategies. In fact, these reports should prompt concern rather than complacency.

While it is not the purpose of this article to present a detailed critique of the shortcomings of such newspaper accounts or the government reports behind the headlines (Fenelon, 2015; Kochanek, Murphy, Xu, & Tejada-Vera, 2016), it is important to be aware of some major flaws to appreciate the need for new approaches to promoting health equity, ones that can achieve more substantive results. Although there are areas where real progress is being made (such as the lower and declining rates of smoking among African Americans and, consequently, lower rates of lung cancer deaths), two areas that have made major contributions to gains in life expectancy for

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African Americans—but call for closer examination—are declines in AIDS deaths and homicides.

The decline in AIDS deaths is principally due to improvements in medical treatment regimens (not the successful redress of the fundamental causes of HIV infection disparities), which have greatly extended the life span of people infected with HIV, but may not have parallel effects on quality of life. However, although some African Americans who are HIV+ are living longer and the percentage drop in death rates has been similar for Blacks and Whites, declines in AIDS death rates have not been evenly distributed among various subpopulations (e.g., African American gay and bisexual men in Southern United States), and disparities in HIV infection rates continue to mount (Matthews et al., 2016).

Similarly, although the rate of homicide deaths for Blacks decreased by 40% from 1995 to 2013, compared to 28% for Whites (Fenelon, 2015), the cause of this decline is a matter of tense debate. The decline coincides with improvements in the socioeconomic status of African American families and the expansion of social services in urban centers at the local and state levels, but it also follows controversial, so-called tough-on-crime, war-on-drugs policies, which led to dramatic increases in the incarceration rates for African Americans and African American men in particular (Alexander, 2010). This increase in incarceration rates includes nonviolence offenses and, on the whole, constitutes state-sanctioned abduction of African American men from their communities and contributes to premature death rates.

Another factor contributing to the shrinking gap in life expectancy is rising mortality rates among Whites, in particular, opioid overdose deaths and suicide rates in White middle-aged men (Rudd, Seth, David, & Scholl, 2016; Tavernise, 2016b). On closer inspection, a recent study by Hunt and Whitman (2015), in fact, finds that disparities between Blacks and Whites actually increased on 8 of 17 major health indicators between 1990 and 2010. Among other reasons for the lack of more substantial progress in reducing health disparities is the lower rate of inclusion of African Americans in health research and prevention programs, still to this day, more than 30 years after the elimination of health disparities was declared a primary goal of the U.S. Public Health Service.

Underrepresentation of African Americans in Health Research

Less than 10% of all participants enrolled in clinical research trials today are minorities (Vickers & Fouad, 2014), and the underrepresentation of African Americans in health research is even more pronounced (Gansler et al., 2012; Ford et al., 2008; Williams, Beckmann-Mendez, & Turkheimer, 2013). An analysis of minority participation in 17 prostate cancer studies submitted to the U.S. Food and Drug Administration (FDA) between 1994 and 2011, for example, found that African Americans made up only 5.3% of the study populations, despite the fact that three trials had study cohorts with more than 20% minority individuals (Wissing et al., 2014). Disconcertingly, there was no trend toward increased minority enrollment over the 17-year period. The National Institutes of Health (NIH) Revitalization Act of 1993 mandated the commensurate inclusion of minorities in all NIH-funded research; 25 years after its passage, the proportion of minority participants enrolled in NIH-funded research remains persistently low (Nicholson, Schwirian, & Groner, 2015). Pointing to the slow pace of progress, the updated 2014 reauthorization report concludes that further policy changes are urgently needed to increase minority participation in health research (Chen, Lara, Dang, Paterniti, & Kelly, 2014).

Many factors contribute to the failure of investigators and health service providers to sufficiently recruit and enroll African Americans in health research and health promotion programs (Baquet, Commiskey, Mullins, & Mishra, 2006; Friedman, Corwin, Rose, & Dominick, 2009). Given the inherent conflict of interest in researchers investigating our own deficiencies in recruitment and enrollment of African Americans, it is unsurprising that most of the available research focuses on "perceptions" of African Americans rather than researcher shortcomings and inabilities. Oft cited is the Tuskegee Syphilis Experiment, the infamous U.S. Public Health Service study that ran for 40 years from 1932 to 1972, which fostered deep-seated distrust of the U.S. health-care system, misgivings that continue to reverberate in many African American communities today (Shavers, Lynch, & Burmeister, 2001, 2002; Shaya, Gbarayor, Yang, Agyeman-Duah, & Saunders, 2007). A survey of African American patients with prostate cancer in 2005, for example, found that one major reason for declining to participate was lingering suspicions left by the Tuskegee study (Hughes, Knight, Fraser, & Teague, 2005). Similarly, many studies report that fears of mistreatment and exploitation ("being treated as a guinea pig") and perceptions that the data will be used primarily to advance researchers' careers and portray communities in an unfavorable light leave many hesitant to volunteer (Quinn et al., 2007; Yancey, Ortega, & Kuminyika, 2006).

There are other significant social barriers that reinforce distrust of mainstream institutions (Branson, Davis, & Butler, 2007; Heller, 2015). Large portions of the Black population are denied access to diverse, mixed-use, and fully serviced neighborhoods, leaving many families isolated into pockets of urban centers (Shelby, 2015, 2016), marked by built environment degradation, high poverty

rates, and low rates of school completion. This deliberate exclusion and neglect have resulted in marked social disenfranchisement and alienation from publically supported institutions—save the criminal justice system—including health-care organizations and health research institutes.

Another factor contributing to the low rates of inclusion of African American men in health research is that, proportionately, there are far fewer Black men available for potential participation than men from other racial or ethnic backgrounds. While there are slightly fewer men than women (49% vs. 51%) in the total population, there are now only 83 African American men for every 100 African American women, a phenomenon referred to as "missing men" (Williams, 2006). In other words, 17% of Black men have been forcibly removed from their communities (Graham, Braithwaite, & Treadwell, 2008). The two major factors cited to account for this large discrepancy are incarceration and premature mortality. Nationwide, there should be 1.5 million more Black men in the age group of 25 to 54 years alone than are now present if Black men were present in the general population at the same rate as White men (Wolfers, Leonhardt, & Quealy, 2015).

Finally, only 5% of practicing physicians are Black, and only 2.2% of doctors are Black men, making it very difficult to structure a health-care system, which is culturally congruent with African American men that would facilitate routine check-ups or referrals to health studies. Hatchett and her colleagues (2000) report that another reason many African Americans report that they have not participated in health research is that no one has ever asked them.

Common Outreach Strategies

In a comprehensive review of outreach strategies used for recruiting minorities to participate in health research, Yancey et al. (2006) found that the most common methods of recruitment were physician referrals in clinical settings and direct mail solicitations, followed by follow-up telephone calls. Media strategies included public service announcements (PSAs) on radio and television, newspaper ads, posters on bulletin boards in clinics and social service agencies, and distributing flyers and brochures in targeted settings. More personalized recruitment strategies included providing screenings at health fairs, working with community-based organizations as intermediaries, and face-to-face recruitment, most commonly in churches. Although Yancey and colleagues report that face-to-face recruitment by ethnically matched staff conducting outreach in community-based organizations (such as churches) produced the highest yield, they note that the cost-effectiveness of this approach has yet to be determined.

In a more recent review of recruitment and retention strategies in 165 (69 focused on African Americans) clinical studies of low-income and minority populations between 2004 and 2014, language barriers and mistrust were identified as primary barriers to recruitment and retention (Nicholson et al., 2015). Overcoming mistrust is a focus of the Men of Color Health Awareness (MOCHA) project recruitment efforts elaborated in the following text. Most frequently used recruitment strategies identified in the review included face-to-face interactions, culturally tailored mass mailings, and use of participant incentives (e.g., monetary remuneration). Projects taking a community-engaged approach were more successful in retention.

Highlighting the effectiveness of community-engaged approaches, Sankare and colleagues (2015) used community-partnered participatory research to address low participation of racial and ethnic minorities in medical research and the lack of trust between underrepresented communities and researchers. In this study, residents of a large urban neighborhood were recruited using one of four strategies: word of mouth, community agencies, direct marketing, and exposure to study participants. Among 258 community members exposed to recruitment strategies, 80% completed the study (40% study participants, 31% community agencies, 18% word of mouth, and 12% direct marketing promotion). The authors conclude that African American levels of research participation and completion are higher when recruitment strategies emerge from the community itself.

A review of clinical trials conducted between 2001 and 2012 at an inner-city research center to determine the type, duration, anticipated enrollments, and actual enrollments of African Americans found an 88% median recruitment rate across 24 studies (Otado et al., 2015). Authors conclude that cultural competence is critical in order to design and implement successful recruitment strategies for African Americans. The aforementioned reviews and studies do not parse effective strategies for African American men specifically. Our article introduces a novel project using innovative recruitment strategies for African American men.

Since the pioneering studies by Hatch in the late 1980s (see, e.g., Hatch, Cunningham, Woods, & Snipes, 1986; Hatch & Derthick, 1992; Hatch, Moss, Saran, Presley-Cantrell, & Mallory, 1993), enlisting the support of Black churches has been recognized as one of the most promising strategies for enlisting Black populations in health research, an approach frequently used to this day. Although church attendance is higher among African Americans than other ethnic groups in the United States (Pew, 2007, n.d.), there are legitimate concerns to be raised about the degree to which regular church attenders are representative of the population as a whole and

whether or not such strategies reach the most vulnerable and marginalized. A number of studies, for example, have found that regular church attendance is associated with longer life expectancy—as much as 8 years—compared to nonattendance (*Powell, Shahabi, & Thoresen, 2003; Seeman, Dubin, & Seeman, 2003*). Also, African American men are less likely to attend church than African American women (Pew, 2007, n.d.).

Like outreach at Black churches, using barbershops to recruit Black men has been recommended for many years (NHLBI, 1987; Kong & Saunders, 1989; Robinson, Kimmel, & Yasko, 1995). Interest in working with Black barbershops grew out of needs for reaching out through trusted community organizations and for going to places that Black men frequent. Although this strategy is often cited in reports on health promotion projects these days (see, e.g., Releford, Frencher, Yancey, & Norris, 2010; Hart et al., 2008; Holt, Wynn, & Lewis, 2009), the main drawbacks are that it is relatively labor intensive (e.g., contact with 3–4 men per hour, 25–30 per day per barber), highly localized, draws men of a specific cultural orientation, and misses men who do not go to barbershops for a variety of reasons (e.g., do not have hair [e.g., bald], groom themselves, do not live near a Black barbershop, sexually marginalized and experience homophobia in barbershops).

The MOCHA Program, Outreach Strategies and Activities

Description of the MOCHA Program

Growing out of a series of community-initiated discussions, the mission of the MOCHA project is to become a movement for change for men of color and improve their physical, mental, emotional, and spiritual health. To fulfill its mission, MOCHA has five goals, to (a) reduce barriers to health care for men of color; (b) utilize the strengths inherent in cultural beliefs and norms regarding the role of men in caring for the health of their family; (c) enhance leadership among men of color in motivating change among their peers in behaviors that contribute to the onset of chronic diseases; (d) engage men of color in chronic disease self-management and wellness activities through peer-led activities; and (e) reduce poor health outcomes by building partnerships, implementing environmental strategies, and developing policies that create conditions for men of color to reach their full potential. These goals are reflected in the MOCHA pledge:

> *My community is in need. It is in need of me. It is in need of my fatherhood and brotherhood. I pledge to be present. My presence depends on my health. My community depends on me. I pledge to be healthier in mind, body, spirit and relationships. I will foster this in my family. I will carry this in my community.*

MOCHA was created to address the issues that men of color face, to enable them to learn strategies to improve mental and emotional health, and to build social support networks with other men. MOCHA addresses individual, social, and environmental barriers to health by (a) implementing targeted culturally relevant sessions on topics specific to the concerns of men of color, (b) generating social support, and (c) providing a physical space for meetings and fitness activities. The core program consists of an intensive 12-week program that integrates programming on physical, emotional, mental, and social health, including aerobic exercise; small group discussions on masculinity, stress, and other emotional health issues; and classes on disease prevention, such as nutrition, obesity, hypertension, and heart disease. Participants meet three times a week. They engage in structured exercise classes for 60 min of moderately intense aerobic exercise 2 days a week. At its core, there are 5 weeks of small group discussions on masculinity and gender role stereotypes, stress, violence, substance abuse, and coping strategies. Finally, there are 5 weeks of classes on health topics relevant to men of color, including nutrition, obesity, fitness, high blood pressure, and the social determinants of health.

Outreach Strategies

Unlike traditional clinical trials where participants are recruited through mailings or clinic waiting rooms, MOCHA employs four main strategies to overcome barriers to participation among low-income, African American men. These four strategies are (a) tapping into existing social networks; (b) capitalizing on established relationships of trust; (c) appealing to join a broader movement for social change; and (d) enlisting past participants to become MOCHA mentors, thus setting off a snowball effect in expanding the reach of social networks, trust, and movement building.

Social networks. Unlike most health research, which is conducted in large urban centers, MOCHA is based in a midsized city of roughly 150,000. The location of the MOCHA project is significant for several reasons. Small- and medium-sized cities house the majority of urban people in the world, and medium-sized cities are growing faster in the United States than larger cities, fueled principally by in-migration of people of color. Although a large part of the American population lives in such midsized cities, residents there face many different challenges than found in large urban centers. First and foremost, there is a less dynamic labor market, where many former small industries are closing and not being replaced, and unemployment runs high. There are also far fewer cultural amenities, such as professional (or semi-pro) sports, music venues, and museums or zoos. There is far less

public transportation than found in a bigger city. The limited employment, transportation, and recreational and cultural opportunities form the backdrop of the social structural determinants of stress for residents living here. These structural realities also increase the reliance of men on each other for job leads, opportunities, transportation, and other support, forming social networks MOCHA leverages for recruitment. MOCHA also offers cultural programming that fills a void in the city at large that facilitates retention.

On the other hand, midsize cities are different from large urban centers in ways that may facilitate outreach efforts. They are not large, impersonal, and anonymous, where research staff are left to approach strangers sitting in waiting rooms. MOCHA is based in a metropolitan area that is small enough that, if one grew up in the city, one would get to know many prominent public figures—politicians (city councilors, state representatives, etc.), community leaders, pastors, business owners, agency directors, and the like—through family, community ties, and social fraternities. Importantly, social networks are dense in the neighborhood where one grew up, which support follow-up efforts as it is easier to remain in contact with and locate participants.

Due to historic practices of redlining and patterns of urban development and renewal, neighborhoods across America continue to be highly segregated, perhaps even more so in small municipalities. For example, in the city where MOCHA operates, 97% of the residents of Brightwood are people of color, and 80.1% of McKnight is Black and only 13% White. As a result, neighborhoods tend to be visibly homogeneous with respect to race and ethnicity, which, positively, fosters a sense of community where neighbors tend to get to know one another well. Families attend the same church, their children go to the same school, they shop at the same grocery store, and they play ball at the same community center. Another major factor contributing to the density of social networks in low-income minority neighborhoods is that there is less social and geographic mobility than one sees in affluent suburbs, as fewer people go off to college and fewer heads of households relocate for career moves up the corporate ladder. It is commonplace for members of the Black community here to remark that they have known each other and their families for 40 years or more.

Capitalizing on established networks of trust. In broad terms, trust is the expectation and sense of confidence that others will not take unfair advantage of a situation to advance their own interests. We trust others to carry out their promises, for example, despite opportunities to renege. In the MOCHA outreach and recruitment context, this is sometimes reflected as potential recruits trusting that they will be given the lowdown or real scoop as opposed to the company line or official script, even if some information is unflattering to the organization. As noted earlier, one major barrier to participation in health research is that many minority residents do not trust representatives of dominant White mainstream institutions, including university researchers. They do not trust that "outsiders" have any idea what is in the best interest of the community or that they would prioritize the community's interest if they did. They are wary of promises that the community will be better off as a result of their cooperation, often unsure that the community will see any benefit at all.

In contrast, outreach by MOCHA is conducted by MOCHA mentors, men who grew up in the community and have gone through the program. These men come with wide-ranging social networks already established. They bring extensive extended family ties in the neighborhoods where the majority of the Black community lives. When the MOCHA mentors approach someone at some community event, during the course of the conversation, they frequently discover that they are somehow related or have friends in common (e.g., "The guy's brother used to date my sister and now he's married to my cousin"). The long-standing personal ties and connections enable MOCHA a head start in the arduous process of building trust, that most research projects face, and moving immediately into discussions about the benefits of participation.

Lest this sound simple, we want to be clear that this work is still hard. Even with well-established ties, there is a palpable sense of wariness in many low-income Black neighborhoods today. In the face of unconscionable rates of unemployment and poverty, many people have been left desperate, and scams and unsavory hustles are an inevitable part of the struggle for daily survival. Community members know they must be vigilant, and the MOCHA mentors know they will have to overcome the starting point of ingrained skepticism in almost every encounter. The MOCHA mentors know they must speak from the heart, to mean what they say, because community members have learned to be suspicious, as an almost reflex reaction to people offering quick cures and promises of a better life. Frank candor about their personal experience with MOCHA and how it has helped them to find purpose, to give back to the community, and to stay healthy is a major part of what gives MOCHA its credibility and provides potential recruits with sufficient hope that their participation will benefit themselves and their community.

MOCHA as movement. Black men know that their lives are not going to get substantially better until there has been a major social transformation in racial, social, and

economic relations in America. Telling these men that they will be better off if they lose 20 pounds and go jogging four to five times a week strikes most as being woefully shortsighted. They are sick of being out of work, sick of being targeted by the police. A big part of the appeal of joining MOCHA is to become part of a larger movement, one that recognizes the need for social change—change in the social determinants of health—to make a real difference. MOCHA is not just about getting a workout a couple days a week, even if the mentors emphasize the value of regular exercise, especially in coping with stress. MOCHA aims to serve the community by being politically active, for example, in struggles to increase Black entrepreneurship and gainful job opportunities, expunge Criminal Offender Record Information (CORI) records based on petty drug infractions and crimes of poverty, broader criminal justice system reform, advocate for affordable housing, and address other community concerns. A big part of the appeal of joining MOCHA is to become part of a larger social movement.

Recruiting new MOCHA mentors. MOCHA made a decision at the outset to seek out and recruit new MOCHA mentors consistently and conscientiously from the ranks of participants in each cohort. Men who get charged up, excited about seeing the larger vision, by the MOCHA training program are invited to become MOCHA mentors, which is a vital part of sustaining the organization and the movement. Men who show interest and enthusiasm are invited to participate in a daylong orientation session, designed to instill and reinforce the MOCHA philosophy of giving back to the community and to provide training on specific outreach strategies (described in the following text). Men who have gone through the mentor orientation are then enlisted to conduct outreach, join the weekly workouts, be part of the cohort discussions, and get active in the MOCHA committees and community projects.

Outreach Activities

While outreach and community education tend to become ingrained as a way of life for mentors, eight major outreach activities can be singled out for their importance and frequency of use. Because the MOCHA mentors always try to keep the broader goal of serving the community in mind, their intent in engaging community members is never strictly limited to recruiting men to join the next cohort. They usually start by talking to men about how they are doing, how they are feeling, and whether they need any information or referrals. Outreach begins as a conversation, about health but with an educational goal in mind, frequently drawing on their own experience in getting their blood pressure checked, having a prostate cancer screening, or commenting on how good they feel after a good workout. If someone seems interested, the mentors bring up the opportunity to join a cohort and hand him a color glossy brochure describing the sessions and expected commitment. It is not uncommon for the men to pick up the pamphlet, look at the pictures, and say, "Is that Hank? Hank Douglas? I know Hank, hey, how's he doing?"

Tabling at events. The mentors target events popular in the community: the Jazz Festival, the Stone Soul Picnic, the Juneteenth Celebration. (Juneteenth is a holiday commemorating the June 19, 1865 announcement of the abolition of slavery in Texas, and more generally, the emancipation of African American slaves throughout the Confederate South.) These events unfold in the African American tradition of the family reunion. There is a lot of mingling at these events, people catching up with each other, marveling over how big the kids have grown. The mentors see themselves as an integral part of the community: typically three to four men will sign up for tabling in 2-hr shifts, knowing that before or afterward they can just relax and enjoy the music, food, family, and friends. As mentioned earlier, there is no pressure to recruit participants, but rather an earnest desire to connect with others about the impact on the community when men go "missing," die too young, or get put behind bars.

Civic presence. The MOCHA mentors are well aware of the issues facing their community and are generous with their time and resources in supporting causes for which a health promotion organization may not have a direct stake but from which the community will benefit in the long term. The mentors proudly wear their MOCHA T-shirts, to show their presence and solidarity on other matters affecting the community. For example, many mentors are veterans and are active organizers and participants in the National Veterans Stand Down Day, an annual event designed to call attention to the need to provide a safe haven, food, and shelter for homeless veterans. MOCHA is there at the annual CORI Independence Day event, distributing information about how one can petition to have certain criminal offenses expunged from police records (a major impediment to employment). MOCHA is there at the local National Night Out event, designed to reduce and prevent crime in cities across the country. Likewise, they participate in the annual Back to School Celebration and work at polling stations to get out the vote. The men reach into their own pockets to support toy drives for families who cannot afford presents for the children over the holidays. Dressed in their T-shirts, the mentors like to talk about MOCHA, they want people to join the movement, but they are there to demonstrate their support for the many efforts striving to address issues facing the community.

Radio. The MOCHA men grew up with several of the local call-in radio hosts, stations housed at the community college, and often drop by to plug an upcoming event, put in a good word about getting an annual checkup, and take a few phone calls. Knowing which radio programs are listened to in the community and having that kind of access, where they can just drop in and say a few words, is another part of being members of the community. People listen when they recognize the voice of the speaker.

Rescue mission/homeless shelters. Another venue for MOCHA is outreach at the local homeless shelters. Two MOCHA mentors work at different shelters, giving back in appreciation for the assistance they received when they needed it. The men staying at the rescue missions face seemingly insurmountable barriers and most of society has given up on them, deaf to the cry to protect human dignity. The shelters serve as a major way station for men recently released from prison, many after many years of incarceration, struggling to get by outside the wall. MOCHA is there because men in need are there. Many mentors have walked in their shoes, and now they want to offer these men hope, giving them something positive and constructive to do, as they struggle to keep it together in the face of prolonged unemployment and homelessness.

After Incarceration Support System. In a similar vein, MOCHA has developed a strong collaboration with the After Incarceration Support System (AISS), a program designed to aid men in the transition from jail to life on the outside. Attendance at AISS programs is a mandatory part of the conditions of parole, and so, it is viewed by many as part of the state system of monitoring and control. To try to break through resistance and connect these men with some sense that they are not stuck in a revolving door, a couple of the mentors regularly stop in on Monday nights to join the AISS small group discussions, no agenda, just a willingness to share their experience and what helped them to endure after they were released.

As its reputation has grown, MOCHA has been invited to expand its outreach efforts to the prerelease program held in the county jail. Like most penal institutions across the country, the county jail has set up a 60-day program to prepare men immediately prior to being released, to provide them with information that the authorities believe will help reduce recidivism. MOCHA offers men in the program the chance to relate to men like themselves, men who have spent time behind bars and whom they can trust to talk straight about what awaits them on the outside. MOCHA now runs a 4-week, four-session cycle focusing on stress, anger management, stopping the violence, and rediscovering brotherhood. One important goal of these sessions is to introduce the men to MOCHA and letting them know they have a place to go when they get out.

Halfway houses. A couple of the mentors also work at halfway houses, drug rehabilitation facilities for men in recovery. MOCHA has built relationships with the counselors and they are often invited to lead small group discussions on the standard MOCHA topics. The mentors are role models of men who have found a way to get out of their own heads and channel their energy and effort toward positive change in their lives and communities. The presence of the MOCHA men enable men in recovery to see that there is life beyond drugs, there are things they can do that they can feel good about. Connecting with MOCHA helps them to see how they can regain their sense of self-respect.

Brothers Day celebration. As MOCHA strives to fulfill its mission—*My community is in need. It is in need of me. It is in need of my fatherhood and my brotherhood*—the men strive to forge the bonds of brotherhood. A central pillar of the MOCHA curriculum is the "Man Box," which examines notions of manhood centered on violence, competition, putting others down, to be a big man, and not be weak. By challenging these pillars of traditional and hegemonic notions of masculinity, the MOCHA men want to remind each other of the many ways that men value and celebrate the bonds of friendship and teamwork. To celebrate the strength that comes from standing together, MOCHA started a new annual gathering, Brothers Day. It is a major outreach event for the organization, with live music, horseshoes, face painting and balloons for the kids, and excellent barbeque, come rain or shine. MOCHA invites the many organizations that it has supported so that they can do their outreach and men can find and connect with the resources they need. It is a celebration of community, a celebration of brotherhood and the vital part that men must play in the overall health and well-being of the community. MOCHA had great media coverage this year, largely again due to the preexisting social networks that MOCHA has with local television, radio, and newspaper reporters.

Stipends. Another part of the success of MOCHA in recruiting participants is offering stipends. From its very beginnings, MOCHA has offered $100 in compensation, plus memberships at the local YMCA, for joining a cohort. With federal research grant funding now, MOCHA offers men $165 for participating in the 12-week program and completing pre-/post-survey questionnaires. Questions have come up about whether this is fair compensation, or perhaps, undue inducement. There is little question that getting stipends is part of the attraction for men enrolling in the program. This is largely because the men that MOCHA aims to reach are men most vulnerable to unemployment and underemployment. If MOCHA could not offer them a stipend, MOCHA would compete with any other earning potential activities. The men

appreciate any financial support, given that economic challenges are a constant part of the stress faced by men of color in the community. Thus, the stipends are fair, if still insufficient, in the context of poverty and unemployment; the notion that people should volunteer their time out of a sense of civic duty—to advance science or serve the common good—is a luxury that only people with steady incomes can afford to give. As reviewed in the preceding text, many explanations have been given for the low rates of participation of African Americans in health promotion programs and health research, especially men at high risk. The MOCHA project challenges currently existing standards for defining fair compensation, recognizing the need to set rates in a broader social context.

Summary of recruitment, retention, and follow-up approach. The MOCHA mentors who are responsible for recruitment, retention, and follow-up are active and visible in community, develop personal relationships with men in community, and work to support men in any way they can (e.g., food, employment, health care), which greatly facilitates recruitment when mentors are conducting outreach while tabling, on the radio, and at shelters, AISS, and halfway houses. During these interactions, mentors are not concerned principally with recruitment, but rather health education and involvement of men in a larger movement for social justice, which, along with stipends and cultural programming like "Brothers Day," keeps men motivated to complete the program. Once completing the program, the lasting experience of participation, the new networks of support built among men who go through the cohorts together, the dense networks throughout the city, and the potential to become a mentor keeps men connected throughout the follow-up period and beyond. While mentors pitch the MOCHA program, use pamphlets, direct potential participants to the MOCHA website, and distribute MOCHA paraphernalia at community events and institutional settings, it is the mentor as community leader, MOCHA's ability to connect men to needed resources throughout the community, and the experience of men who participate that most facilitate recruitment, retention, and follow-up.

Conclusion: MOCHA Moving Forward

While it is well established that affluent men with high levels of education are more likely to engage in health-promoting activities, low-income African American men experience higher levels of stress and often live in environments and settings that make it more difficult to find the means, space, time, and frame of mind to attend to their health. To make progress in reducing health disparities, officials at the NIH and the Centers for Disease Control and Prevention recommend renewed efforts to reach out and engage low-income African American men, but they have been hard pressed to identify effective strategies. MOCHA has developed a set of highly innovative strategies for reaching those most vulnerable. Data on the demographic and health characteristics of the population participating in MOCHA demonstrate the success of their efforts.

Between 2011 and 2015, a total of 245 men completed the MOCHA program, another 160 attended MOCHA events (e.g., community health screenings) and provided their contact information; 107 men took the MOCHA pledge (the first step in becoming MOCHA mentors), and another 150 men have indicated interest in participation but have not yet been engaged in any MOCHA activities. Of the 245 men who went through the program, 52% (n = 124) were over the age of 45 years and another 21% (n = 50) were aged 35 to 44 years. Overall, 92% were African American, 6% Latino, and 2% other.

Of these participants, 41% (n = 99) were obese, with body mass index (BMI) over 30, and another 29% (n = 70) were overweight, with BMI between 25 and 29.9. Only 30% of the participants were in the normal weight range, and there was a strong correlation with age, where only 12% of the participants under the age of 35 years were overweight or obese. Forty-two percent of the MOCHA participants had high or very high blood pressure, and another 45% were in the prehypertension range. Only 13% (n = 31) of the 245 men had blood pressure measures in the normal range. Based on the results of the Cohen's Perceived Stress Scale, 53% of the men had scores indicating high levels of stress, and only 10% had scores in the low level of stress range.

As these data demonstrate, there are many older African American men at high risk of chronic disease who are willing to join a health program under the right circumstances. The MOCHA mentors have created a number of novel strategies for successfully recruiting them to participate in health promotion activities and health research. In addition to a randomized controlled trial to evaluate the effectiveness of the MOCHA intervention, we are now also conducting semistructured individual interviews, collecting life histories, and collaborating with the men to create their digital stories on issues of concern to them. These formative research methods are being used to further refine and elaborate the Minority Stress Model (Graham, 2012), which has provided the fundamental theoretical framework guiding the generation of hypotheses for both the formative research and the outcome evaluation.

Because low-income, African American men are not being reached in the standard ways most widely used to recruit participants into health research projects and health promotion activities, MOCHA has developed alternative

strategies that seek to engage them where they live, to offer social support, and to join efforts to address the social and economic determinants that produce poor health outcomes. MOCHA is a movement to enlist men to be role models in improving quality of life for themselves, their families, and their community. Research and public health practice seeking to engage older, low-income African American men most vulnerable to high levels of stress and chronic disease should focus on connecting and working with men on social justice efforts to address structural issues facing their community. The appeal of joining a social movement can facilitate recruitment and retention of men in research and downstream interventions.

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