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Cynthia Newbille
Virginia Commonwealth University

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AFRICAN AMERICAN WOMEN'S HEALTH: AN EXAMINATION OF RESOURCE NEEDS, CONTEXT, AND POLICY OVER THE LIFE COURSE

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy at Virginia Commonwealth University.

By:

Cynthia Iris Newbille
Master's of Arts in Psychology, S.U.N.Y at Stony Brook, May, 1883
Bachelor's of Arts in Psychology and Linguistics, S.U.N.Y at Stony Brook, August, 1974

Director: Kevin W. Allison, Ph.D., Professor
Department of Psychology
L. Douglas Wilder School of Government and Public Affairs

Virginia Commonwealth University
Richmond, Virginia
December, 2010

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Abstract

AFRICAN AMERICAN WOMEN'S HEALTH: AN EXAMINATION OF RESOURCE NEEDS, CONTEXT, AND POLICY OVER THE LIFE COURSE

By: Cynthia Iris Newbille, Ph.D.

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Major Director: Kevin W. Allison, Ph.D., Professor
Department of Psychology, L. Douglas Wilder School of Government and Public Affairs

African American women die at an earlier age and at higher rates from preventable and/or treatable diseases than their European American counterparts. Notwithstanding epidemiology's successful identification of proximal, individually-based risk factors (such as diet, exercise, and smoking), and research supporting our understanding of differential rates of metabolic conditions (e.g., high blood pressure, stroke), African American women's poor health outcomes persist.

Grounded in an ecological and life course framework, the current study examined both proximal and distal contexts as a backdrop for understanding individual life course pathways that impact urban African American women's health outcomes, with a focused examination of Black women's experience of and risks for metabolic disorders (e.g., heart disease, diabetes and obesity).

This research study examined “lives” in context (i.e., physical and social environment) to delineate the mechanisms and factors underlying African American women’s health outcomes. The study compared the life course trajectories of African American women seeking health and non-health resources and services at a family resource center located in Richmond, Virginia, using both quantitative and qualitative (“Life Story” interviews) methods. This single generation inter-cohort comparison sought not only to clarify and examine the role of structural life-course factors in African American women’s health risks and outcomes, but also the critical roles and impact of other factors such as family of origin, gender, race, and health access.

The quantitative study results revealed a profile of the women accessing services that reflected the portrait of a single, older African American woman who is a high school graduate with some college education, unemployed, and without health insurance. Analyses also supported predictable relationships between African American women’s socio-demographic status and service needs. The qualitative study results revealed identifiable turning points in the lives of all of the women interviewed, and included experiences of abuse and loss. Notably the life courses of these women were characterized by resilience, and uncharacteristically for this population, many women accessed traditional counseling and mental health resources. Findings are discussed in the context of study limitations and policy implications.

Americans have a shorter life expectancy, greater mortality from conditions that are partially preventable or treatable, and more years of life with poor health and disability than many citizens of other Western nations (Schoen, 2006). In addition, there are wide between-group variations in life expectancy and mortality within the United States. African Americans have the shortest life expectancy compared to their European American counterparts. According to 2006 data, the life expectancy at birth for white women and white men was 80.6 years and 75.7 years respectively, compared to African American women and men of 76.5 and 69.7 years (U.S. Department of Health and Human Services, 2009).

Among US women, African American women experience a higher death rate for almost all causes compared to their European female counterparts (NCHS, 2008). The leading causes of early death, disease and disability among African American women include heart disease, cancer, stroke, diabetes and kidney disease (U.S. Department of Health and Human Services, 2009). State and local statistics reflect these same national mortality and morbidity trends for Black women (Gruss, 2006).

Despite epidemiology's identification of proximal, individually-based risk factors (such as diet, exercise, and smoking), African American women's poor health outcomes persist. For example, according to 2003-2006 National Health and Nutrition Examination Survey (NHANES) data, the age-adjusted prevalence of metabolic syndrome among US women is 31.5 percent for white, and 38.8 percent for Black women (American Heart Association, 2010). For Black women, this disproportionate representation is consistent with findings that metabolic syndrome increases the risk of cardiovascular disease, their leading cause of death (American Heart Association, 2010). Other risk factors associated with the metabolic syndrome, (i.e., smoking, obesity, alcohol consumption, physical inactivity, and diet) place some women at an

even higher risk for heart disease (NCCDPHP, 2010). Socioeconomic status and resources, and racial disparities also underlie many of these health status indicators and challenges (Centers for Disease Control, 2002).

Confronted with the magnitude and persistent nature of these disparities, the federal government identified one of its two Healthy People 2010 goals as the elimination of health disparities in disproportionately affected segments of the population by the end of the decade. The existence and persistence of racial disparities in health care was well documented in the landmark IOM (2002) report, *Unequal Treatment: Confronting Racial & Ethnic Disparities in Health Care,* which also highlighted historic and contemporary social and economic inequality, discrimination and fragmentation of the US health care system. A recent McArthur Foundation report further captures the magnitude of the racial and health disparities evidenced by African Americans:

> "On average, African Americans experience disability earlier in life and die sooner than others in our society. This distressing fact is a clear result of their relatively lower position on the socioeconomic ladder. African Americans are generally poorer, have less education, and are employed in lower status occupations than European Americans. Long-term discriminatory practices in housing, education, employment and health care contribute to these patterns. More troubling, though is that even when at the same level or higher on the socioeconomic ladder, Blacks have relatively worse health outcomes. This suggests that there is an added burden of race due in part to the stresses of encountering everyday discrimination" (Alder and Stewart, 2005).

Beyond race and other associated factors that impact health outcomes (e.g., neighborhood, employment conditions, personal health behaviors, health care, and experience of

toxic stress, research has established a clear association between socioeconomic resources and adult health outcomes (Alder and Stewart, 2005; Adler, Boyce, Chesney, Folkman, & Syme, 1993; House et al., 1990; Fryak et al., 2004). In addition, according to the US Census Bureau, 45.7 million (15.3%) Americans were uninsured in 2007 (US Census Bureau, 2007). The Institute on Health (IOM) issued six reports between 2001and 2004, each of which concluded that "being uninsured was hazardous to people's health". In fact, IOM evidence indicated that adults without health insurance: (1) are less likely to receive preventive services that could reduce unnecessary illnesses and premature death; (2) delay or forgo physician visits, effective therapies, and prescription medications; (3) are diagnosed with later stage cancers that are detectable by screening; and (4) suffer poorer outcomes, greater limitations in quality of life, and premature death associated with chronic health conditions (IOM, 2009). Although significant numbers of Americans are uninsured, notable racial and ethnic variations exist. In our current system, most Americans obtain insurance coverage through their jobs or their spouse's employer. African American women are almost twice as likely to be uninsured (23%) as compared to their white female counterparts (13%) (US Census Bureau, 2000).

In considering factors that contribute to the current health status of African American women, there is still a lack of clarity regarding: (1) the potential pathways through which experiences across the life course, including financial resource access, affect African American women's health outcomes; (2), the intervening mechanisms in the relationship between the physical and social environment experienced across the life course and Black women's adult health, particularly their risk for metabolic syndrome; and (3) potential policy implications of these associations. The current retrospective research study provides an inter-cohort comparison of African American women seeking health as compared to African American women seeking

individual or family resources at Richmond's East District Family Resource Center (FRC). Serving the community since 1998, FRC, one of Richmond's local individual and family resource and support programs, will provide a "lens" through which we can consider the current state of Richmond's African American women's health resource needs, care and status utilizing Bronfenbrenner's ecological model and Elder's life course framework.

Bronfenbrenner's ecological model views the interrelationship between the individual, their family, community and the larger society as the point of departure for understanding human development, and enables us to examine "lives" and human growth and development in social context. From this perspective, the significance of culture, racial and socioeconomic characteristics of the community, as well as national health policy, are factors to be included in considering the determinants of family functioning (Kagan & Weissbourd, 1994). To complement the ecological model, the study also employs Elder's life course perspective which views the socio-cultural environment as the point of departure, and places greater emphasis on the social pathways of human lives, transitions and turning points. Elder's Life course theory postulates that the "human life span can be best understood in terms of its four central principles - (1) historical time and place (i.e., being born in a different point in time exposes individuals to different historical circumstances), (2) the timing of lives, (3) linked or interdependent lives (i.e. human lives are embedded in family relationships, friendships, and other social relationships throughout the lifespan), and (4) human agency and social constraints (i.e., people are planful and make choices among options in constructing their life course)" (Bronfenbrenner 1979, 1986). Together, these paradigms facilitate a better understanding of the specific barriers that socio-contextual conditions such as the physical and social environment, family structure, and health insurance access pose for African American women.

The ecological and life course models also provide a sharp contrast to the individualistic conceptual models upon which many of our service delivery systems and related policy are often based. These models provide a perspective that may support further insight into the shortcomings of current and past policy efforts and clarify the limited effectiveness of individualistic models in adequately addressing the health needs of many African American women. Of critical significance is the potential utility of an integrated ecological and life course approach that informs policy efforts and work on the persistent health challenges and fragmentation of the healthcare system confronting African American women today. By examining the individual within the historical and policy context of their families, communities and larger society, we can acquire a deeper understanding of the nature and scope of the impact of environmental systems on African American women and their health outcomes.

Grounded in an ecological and life course framework, this retrospective study used both proximal and distal contexts as a backdrop for our understanding of African American women's life course pathways that impact their health outcomes, including metabolic conditions, and the implications for public policy. A better understanding of the life course of FRC clients and the socio-contextual factors that impact their health can assist us in reviewing the community and policy context which African American women have experienced across their childhood, adolescence and early adulthood, and allow us to understand their life experiences, health status, and resultant need of family support services.

The study is a two-phase qualitative and quantitative project. The quantitative study phase involved the compilation and analysis of secondary data collected by the East District Family Resource Center (FRC). Data was collected by the FRC staff as a part of the client screening and intake process for all individuals accessing services at the Center for calendar year

2009 and January through August of 2010. Over 600 individuals/families accessed FRC services during the study periods. Descriptive statistics on group characteristics and measurement metrics were utilized to answer the following questions:

1. Who are the African American women (i.e., age, marital status, education, annual household income, employment status, health insurance status, neighborhood) accessing FRC services?
2. What are the physical and/or emotional health needs of African American women accessing FRC services?

Service typologies were examined utilizing cluster analyses enabling us to identify underlying structure and patterns of relationship in the data, and thereby answer the following questions:

3. Are there specific clusters of needs?
4. Do health service needs differentiate these groups?
5. What are the individual characteristics related to these clusters of needs?

These data enable us to better understand today's African American women's health and service resource needs.

The qualitative study phase utilized a cross-sectional research design that is exploratory, descriptive and provides a retrospective perspective on the life course. Data was collected from the random samples of women identified in the quantitative study component, who accessed FRC for either health or non-health resources and services. Randomly selected samples of African American women were identified from each of the two categories. These two groups comprised the study population.

All qualitative study participants were asked to complete a "Life Story" interview protocol consisting of a structured component, including the completion of three short self-

administered surveys (i.e., Demographic Profile to collect relevant information such as age, race/ethnicity, socio-economic status, family composition, employment status; Health Status Survey focusing on their current health status; and the SF 36 Health Survey, an eight scale profile of functional health and well-being), as well as an unstructured component comprised of a list of interview questions from Harvard University's 1982 Intergenerational Studies Life Review (i.e., open-ended questions that query participants about their family composition, service needs, service agencies routinely accessed, and social supports).

This single generation inter-cohort comparison not only examined the role of structural factors within the life course relevant to African American women's health outcomes, including metabolic conditions, and associated risk factors, but also the critical roles and impact of other factors such as family structure, education, marital status, income, neighborhood, and health service access. This data enables us to better understand: (1) the role of health within the life course experiences, trajectories, transitions and turning points of African American women, that have led to or support their present level of service need and experience of metabolic disorders and associated risk factors; and (2) the health policy and program context experienced by African American women over their life course that support current adult health status and types of health care need.

The study focused on the following: (1) three aspects of adult health: (a) general physical health and well-being; (b) mental/emotional health and well-being; and (c) metabolic conditions and related risk factors); (2) two aspects of health care: (a) insurance access; and (b) health care service source; and (3) two aspects of family status/family factors across the life course: (a) Family Structure (i.e., household composition including parent marital status, and the number

and birth order of siblings); and (b) Family Resources including Family and Parental Economic Capital (i.e., income, education, employment, insurance coverage.

The mixed methods approach enabled the researcher to postulate what Neale and Holland 2005 refer to as “intensive (small scale) and extensive (large scale) views of the world into a common focus enabling an appreciation of broad trends . . . alongside insights into rich, detailed and dynamic meanings and contexts.” This “look through the quantitative and qualitative binoculars” afforded the researcher a more comprehensive “view” of the African American women accessing East District Family Resource Center health and other services. The study findings inform a gap in the literature linking life course trajectories, the relevant health policy context during African American women’s development and the impact of the life course and policy context on their health outcomes. Findings are discussed relative to implications for both program-level preventive health strategies and health policy.

Literature Review

Overview

In 2009, the American Human Development Project (AHDP) published "The Measure of America" which provides a comprehensive portrait of the health and well-being of the citizens across three dimensions: Health (e.g., life expectancy at birth); Education (e.g., degree attainment and school enrollment); and Standards of Living (e.g., median income). The Report findings reveal that America has experienced great progress in increasing life expectancy over the last century (Burd-Sharps, et al., 2008). However, among Western nations, Americans still have a shorter life expectancy, greater mortality from conditions that are partially preventable or treatable, and more years of life with poor health and disability (Schoen, et al., 2006). In 2008, the World Health Organization's annual comparison of nations revealed a disappointing picture of the United States' "health" status. For example, the US healthy life expectancy (HALE) measure, indicating the number of years that a newborn can expect to live a healthy and productive life is 69 years, a life expectancy score that is the same held by Portugal and Slovenia, and exceeded by 27 other countries (See Table 14). Further, the age-adjusted amenable mortality rate before age 75 for the United States was 109.7 deaths per 100,000 population in 2002, which meant it ranked last among the nineteen countries of the Organization for Economic Cooperation and Development (OECD) nations studied. The mortality rate in the U.S. is 50 percent higher than the rates in France, Japan, Spain, Italy, Canada and Australia.

Notwithstanding its international standing, America's health status has improved. While America's life expectancy indicator lags behind those in most other industrialized countries, this index has shown a long term upward trend. In addition, infant mortality shows a long term downward trend. In fact, from 1900 through 2005, life expectancy at birth increased

from 46 to 75 years for men and from 48 to 80 years for women (NCHS, 2008). Yet, despite this documented improvement in the health status of Americans, not all of America's citizens have shared in these overall health improvements.

Data from the AHDP Report indicates that women, on average, live five years longer (80.5 years) than men (75.4 years). There is also notable difference in life expectancy across racial/ethnic groups within the United States, with African Americans evidencing the shortest life expectancy comparatively. Within this context, African American women have a shorter life expectancy at birth than their European counterparts, and are dying more frequently from preventable and/or treatable diseases.

Although the gap in life expectancy between African Americans and Whites has narrowed since 1990, it still persists (NCHS, 2008). African American males and females born in 2004, have a significantly shorter life expectancy (i.e., 69 and 76.3 years respectively), than White males (75.7 years) and females (80.8 years) born in the same year (Arias, 2004).

The Report further reveals notable variations across the nation's regions and states, between women and men and among racial and ethnic groups. Among the country's four regions (Northeast, West, Midwest, South), the South ranked last (76.9 years). In state comparisons, Virginia ranked 13th (78.1 years). While the Report highlights the importance and impact of geography, gender, and race/ethnicity on the health of the nation, it is equally as clear in its identification of other critical factors such as education, income, individual behaviors, and access to health care that play important roles in health outcomes (Burd-Sharps, et al., 2008).

This American health portrait forms the backdrop against which we work to comprehend the socio-contextual and life course pathways that impact African American women's health

resource needs and outcomes, and the implications for public policies that might ensure them a healthier life and improved well-being.

This chapter provides an overview of the literature informing perspectives on: (1) the health status of America, African Americans, and African American women; (2) health disparities in the United States; (3) American health care and policies; (4) the ecological and life course models; and (5) factors that affect adult and African American women's health outcomes across the life course, with a focused examination of Black women's experience of and risks for metabolic disorders (e.g., heart disease, diabetes and obesity). For the purposes of this study, health is defined as the "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1948).

America's health. In 2007, America's top three leading causes of death were heart disease, cancer and stroke. Chronic diseases such as these account for approximately 70% of U.S. death. Studies reveal that the leading preventable risk factors and causes of death in the US are tobacco use (18.1% of the total deaths), obesity and overweight (4.6%–15.2% of the total deaths) and alcohol consumption (3.5% of the total deaths) (Haslam & James, 2005; Mokdad, et al., 2004). Further, according to a 2009 study led by researchers at the Harvard School of Public Health, smoking, high blood pressure and being overweight are the leading preventable risk factors for premature mortality in the United States (Goodarz, et al., 2009).

An examination of the 2.5 million U.S. deaths in 2005 revealed deaths from individual risk factors as follows:

- Smoking: 467,000 deaths
- High blood pressure: 395,000
- Overweight-obesity: 216,000

- Inadequate physical activity and inactivity: 191,000
- High blood sugar: 190,000
- High LDL cholesterol: 113,000
- High dietary salt: 102,000
- Low dietary omega-3 fatty acids (seafood): 84,000
- High dietary trans fatty acids: 82,000
- Alcohol use: 64,000

  (alcohol use averted a balance of 26,000 deaths from heart disease, stroke and diabetes, because moderate drinking reduces risk of these diseases. But these deaths were outweighed by 90,000 alcohol-related deaths from traffic and other injuries, violence, cancers and a range of other diseases).

- Low intake of fruits and vegetables: 58,000
- Low dietary poly-unsaturated fatty acids: 15,000

It is critical to note that "all of the deaths calculated in the study were considered premature or preventable in that the victims would not have died when they did if they had not been subject to the behaviors or activities linked to their deaths. All of these risk factors are modifiable through a range of public health and health system interventions" (Goodarz, et al., 2009).

Health and health disparities. The African American population has and continues to fare much worse with respect to health status than their European American counterparts. "On average, African Americans experience disability earlier and die sooner than others in our society." African American adults have disproportionately higher rates of chronic diseases (e.g.,

diabetes, hypertension) obesity, cancer, and HIV/AIDS than European Americans (Halle, et al., 2009). From 1950-2005, African Americans had the highest death rate for all causes of death, compared to other U.S. population.

These disparities are most often attributed to socioeconomic status; however, even at the same level or higher on the socioeconomic ladder, Blacks have relatively worse health outcomes. This suggests that there is an added burden of race due in part to the stresses of encountering everyday discrimination, which include "long-term discriminatory practices in housing, education, employment, and health care (insurance coverage and care) contribute to these patterns" (Alder & Steward, 2005).

Virginia and Richmond's health. The health of Virginia's population closely mirrors that of the nation, as reflected in data from the 2008 Virginia Health Equity Report, "Unequal Health across the Commonwealth". The life expectancy for Virginians of African decent (74.8 years) is lower than their European counterparts (79.2) (VDH, 2008). Nationally, Virginia ranks 11th based on the overall rating of 40.2 percent of adults in less than very good health. "Comparing Virginia's experience against the national benchmark (19%) for adult health status reveals that, at every education level and in every racial or ethnic group, adults in Virginia are not as healthy as they could be" (Burd-Sharps, et al., 2008; RWJF, 2009).

Cardiovascular disease (i.e., heart disease and stroke) is the number one killer of Virginians. In 2004, more Virginians died from cardiovascular disease (CVD) than from cancer, diabetes and injuries combined. The State's 2004 age-adjusted CVD mortality rates were significantly higher for all Blacks (361.0/100,000) than all whites (259.4/100,000). African Americans mortality rates from the three leading causes of death (heart disease, cancer, and cerebrovascular disease) in the Commonwealth, ranged from 23% to 150% higher than Whites.

These three causes of death accounted for approximately 70% of the deaths in the Commonwealth (VDH, 2008). Similar to national statics, the risk factors associated with CVD in Virginia are obesity, high cholesterol, hypertension, no physical activity and low consumption of fruits and vegetables. A review of Virginia's cardiovascular mortality rates by gender and race/ethnicity from 1995-2004, revealed that African American women had consistently higher cardiovascular disease mortality rates than their European counterparts (Gruss, 2006).

The City of Richmond's health portrait is equally, if not more daunting, than that of the nation's and the state's. Based upon a review of its mortality, morbidity and health outcomes rankings, Richmond's health is among the worst in the Commonwealth. In the 2010 Virginia County Health Rankings Report, Richmond's mortality rank was 128th out of 132 (i.e., based on a measure of premature death: the years of potential life lost prior to age 75), its morbidity rank was 107th out of 132 (based on measures that represent health-related quality of life and birth outcomes), and its health outcomes rank is 124th out of 132 (based on an equal weighting of mortality and morbidity measures) similar to the nation and the state, the City of Richmond's leading causes of death are heart disease, cancer and cerebrovascular disease (UWPHI, 2010; SCHS, 2007).

Statistics for the Richmond City Health District reveal a population profile that: (1) Has a citizen population that is 55.5% Black (with Black women representing 30.8% of the total population and Black men 24.9%) and 39.2% white (with White women accounting for 20% of the population and White men 19.2%); (2) Indicates mortality rates (per 100,000) that exceed the state's for heart disease (295 vs. 245), stroke (96 vs. 67), and cancer (274 vs. 208); (3) Reports the state's highest percentage of respondents with high blood pressure (35%), with the second highest percentage of adults who engage in binge drinking (18%), and third highest percentage

of adults who are current smokers (30%), and fifth highest percentage of adults who are obese (39%); and (4) Includes a significant percent of adults reporting having diabetes in comparison to the state (4.9% vs. 7.0%) (Gruss, 2006; VDH, 2004).

Review of the data reveals an alarming portrait of the City's health. This stark contrast of City versus state health statistics is indicative of the need to address health risks, including lifestyle strategies, in addition to policies that promote health and wellness throughout the City of Richmond.

Further, national and state data are reflecting higher rates of cardiovascular disease for African American women compared to their European counterparts, suggest similar local health trends for Black women, given their numerical status in the City of Richmond, combined with the City's high rate of mortality from heart disease. These data highlight the need for a greater understanding of the nature and scope of Black women's health status, with a particular focus on understanding health conditions, and risks specifically relevant to them. In the following section, literature on African American women, and African American women and metabolic conditions is reviewed.

African American women. African-American women represent 13.1% of all women in the US. However, their mortality rates are higher than women from any other racial/ethnic group for nearly every major cause of death including heart disease, cerebrovascular disease, and breast cancer (NWHC, 2000). The Minority Women's Health Report 2007 revealed that the leading causes of early death, disease and disability among African American women include heart disease, cancer, stroke, diabetes and kidney disease (USDHHS, 2007).

The 2001 Women's Health Data Book indicated the following health profile for African American women. "African American women are at high risk for CVD, in part due to a high

proportion with risk factors such as obesity and hypertension; Black women have lower rates of breast cancer, but have higher breast cancer mortality rates than white women; Among women ages 60 to 74, Black women (32.4%) are twice as likely to have diabetes as white women (16.0%)" (Misra, 2001).

Findings for women from the Third National Health and Nutrition Examination Survey, 1988-1994 note that the "higher mortality rates of heart disease in black women seem to be the result of a higher proportion of black women exhibiting the risk factors for increased mortality-cigarette smoking, hypertension, diabetes, high blood cholesterol, inadequate physical activity, and obesity" (Winkleby, et al., 1998).

A review of the 1999-2000 National Health and Nutrition Examination Survey revealed that 49% of African American women were obese in comparison to 30.7% of white women. This same trend is evidenced by more recent data (Health United States 2008), which reveals that 53% of African American women twenty years of age and older in comparison to 32% of white women experience obesity, a major risk factor for many chronic diseases (NCHS, 2008).

African American women and metabolic conditions. National, state and local health data have identified heart disease as the leading cause of death for African American women. Findings from the Third National Health and Nutrition Examination Survey, a study of more than 10,000 patients, revealed that the risk for heart disease, heart attack and stroke, doubled in women found to have a condition know as "the metabolic syndrome" (Ninomiva, et al., 2004).

The metabolic syndrome is defined as a group of risk factors that increase an individual's risk of developing heart disease, diabetes, and stroke. An individual is considered to have the metabolic syndrome if they have "3 out of the following 5 risk factors: (1) higher-than-

normal blood sugar, (2) blood pressure; (3) triglyceride levels; (4) a large waistline; and (5) low HDL (good) cholesterol" (NCEP, 2002).

A 2009 study of the prevalence of metabolic syndrome among a sample of U.S. adults 20 years of age and over revealed that approximately 34% of adults met the criteria for metabolic syndrome; and Black women were about 1.5 times as likely as white women to meet the criteria. The study further revealed the prevalence of the most frequently occurring risk factors for metabolic syndrome as follows: abdominal obesity (53%), hypertension (40%), and hyperglycemia (39%) (Ervin, 2009).

Two separate meta-analytic studies, Gami et al., (2007) and Motillo et al., (2010) involved systematic reviews of a total of 124 studies, and found that individuals with metabolic syndrome are at an increased risk of cardiovascular events. Equally as compelling is the finding by Motillo et al., (2010) that not only is the metabolic syndrome associated with a 2-fold increase in cardiovascular outcomes, but there is also a 1.5-fold increase in all causes of mortality.

These metabolic syndrome risk factors can be prevented and/or treated through positive lifestyle changes (i.e., weight control, exercise, and diet; and/or medication) (OWH, 2010). However, the large numbers of US residents with the metabolic syndrome underscores the importance of not only implementing effective intervention strategies, but effective policies, as well, that promote environmental strategies to create, facilitate, and enhance physical activity; access to healthier foods, health care and wellness resources.

The effectiveness of such strategies and policies will hinge on our increased understanding of Black women's health in general, as well as the types and scope of the metabolic conditions confronting African American women, and the associated risk factors. In the following section, a longitudinal study, the Black Women's Health Study, which provides a

comprehensive examination of the major causes of illnesses in Black women and the associated risk factors is presented.

Black women's health study. The 1995 Black Women's Health Study (BWHS) is the first large-scale prospective follow-up study of U.S. Black Women's health. The goal of the BWHS study is to provide information on the major causes of illnesses in Black women and to identify the associated risk factors. The primary health conditions targeted for study are breast cancer, high blood pressure, diabetes, uterine fibroids and lupus. Sixty-four-thousand-five-hundred participants aged 21–69 years enrolled in the BWHS by completing health questionnaires mailed to subscribers to *Essence* magazine, members of selected Black professional organizations, and friends and relatives of respondents.

BWHS respondents were almost equally proportionate in their representation from across the country, with the largest numbers from California, Georgia, Illinois, Indiana, Louisiana, Maryland, Massachusetts, Michigan, New Jersey, New York, South Carolina, Virginia, and the District of Columbia. There was a wide educational range, with more than half of the respondents having completed fewer than 16 years of education. The median age of the respondents was 38 years.

Questionnaires are mailed to BWHS participants every two years to obtain updated health information. Non-respondents are mailed up to six questionnaires at intervals of 2–3 months, and telephone calls are made after five mailings (Rosenberg, et al., 1995; Rosenberg, et al., 2001).

A brief summary of 25 of the BWHS research studies provides a profile of the nature and scope of metabolic conditions, and the associated risk factors among Black women. Consistent with national statistics, the BWHS identified heart disease, hypertension, diabetes, and cancer as the leading health conditions affecting Black women.

BWHS findings revealed that cigarette smoking, hypertension, diabetes, high cholesterol levels, family history of heart attack, and overweight were associated with a higher risk of heart attack and heart disease. Alcohol consumption was also found to be related to other chronic illnesses e.g., liver disease. Heavy alcohol consumption was strongly correlated with early age drinking, as well as increased mortality (Rosenberg et al., 2007; Rosenberg et al., 2002).

Further, overweight and/or obesity, diet, individual and neighborhood level socioeconomic status were found to be strongly associated with an increased risk of diabetes. Vigorous exercise was also found to be associated with a lower incidence of type 2 diabetes (Krishnan, et al., 2005; Palmer, et al., 2006).

Although a family history of breast cancer was found to pose the greatest risk for Black women for the development of breast cancer, postmenopausal weight was also found to be associated with an increased risk of breast cancer (Palmer, et al., 2007; Palmer, et al., 2006; Palmer, et al., 2009). Lower neighborhood socioeconomic levels, and physical inactivity were associated with weight gain (Coogan, et al., 2010; Kumanyika, et al., 2000; Palmer, et al., 2007).

Studies also suggested that physical activity is associated with reduced risks for certain chronic conditions (e.g., hypertension and depressive symptoms). Lower neighborhood socioeconomic status was associated with a higher occurrence of hypertension (Cozier, et al., 2004; Cozier, Palmer, & Rosenberg, 2006; Williams, et al., 2004; Wise, et al., 2005; Wise, et al., 2006).

BWHS data indicated that neighborhoods with high poverty levels had higher numbers of smokers. In fact, controlling for age, education, marital status, and occupation, it was found that the percent of women who were current smokers increased as the percent of residents below the poverty level increased (Datta, et al., 2006; Datta, Subramanian, & Rosenberg, 2004).

BWHS research findings firmly reinforce the need to address metabolic conditions and their associated risk factors, as it has been demonstrated that they can be prevented and/or treated through lifestyle changes. However, an equally as compelling case has been made via the data for the need to address neighborhood level socioeconomic, and other contextual factors in order to improve Black women's health. This highlights the need for a careful review and understanding of the implications of health care, health insurance coverage, and health disparities. In the next section, work on access, quality and racial disparities in health care will be reviewed.

Health care and health care disparities. Access to quality, affordable, culturally responsive health care is critical to the health of African Americans in the United States. However, the January 2008 U.S. Report to the U.N. Committee on the Elimination of Racial Discrimination summarizes our current state of affairs in this regard:

> "Health care disparities are not new—they are a relic of segregation and inadequate health care for communities of color. Like access to other opportunities, health care for minorities suffered from government inattention (and in some cases, government imposed inequality) for over 100 years after the end of the Civil War. Less than 40 years ago, minorities routinely received inequitable care in segregated settings, if care was received at all. Today, communities of color continue to experience significant disparities relative to whites in both access to care and in the quality of care received."

The existence and persistence of racial disparities in care was also well documented in the landmark 2003 Institute of Medicine report. The report documents the differential experiences of racial and ethnic minorities in terms of quality of care received. "Relative to whites, African Americans—are less likely to receive appropriate cardiac medication or to

undergo coronary artery bypass surgery; are less likely to receive peritoneal dialysis and kidney transplantation; and are likely to receive a lower quality of basic clinical services such as intensive care, even when variations in such factors as insurance status, income, age, co-morbid conditions, and symptom expression are taken into account". According to Bach et al. (1999) and Peterson et al. (1997), these differences in care and treatment are significantly correlated with greater mortality among African-Americans.

Health insurance coverage. Today, the US spends more on health care per capita than any other UN member nation (WHO, 2008). It also spends a greater fraction of its national budget on health care than Canada, Germany, France, or Japan. In 2007, an estimated $2.26 trillion was spent on health care in the United States, or $7,439 per person (OACMMS, 2008). Yet, according to the US Census Bureau, in 2007, 45.7 million (15.3%) Americans were uninsured (US Census Bureau, 2007). While this number has decreased slightly from 47 million in 2006, largely attributed to an increase in publicly sponsored coverage, it is estimated that the current economic crisis and rising unemployment rate likely resulted in a significant increase in the number of uninsured by at least 2 million in 2008 (Kaiser Commission, 2007).

The Institute on Health (IOM) has consistently concluded that "being uninsured was hazardous to people's health". In fact, IOM evidence indicated that adults without health insurance: (1) are less likely to receive preventive services that could reduce unnecessary illnesses and premature death; (2) delay or forgo physician visits, effective therapies, and prescription medications; (3) are diagnosed with later stage cancers that are detectable by screening; and (4) suffer poorer outcomes, greater limitations in quality of life, and premature death associated with chronic health conditions (IOM, 2009).

For over forty years, the US's primary source of health care coverage for its uninsured have been its Medicaid and Medicare public health insurance programs. Medicare, initiated in 1965, is a federal health insurance program for elderly workers and their dependents, individuals who are totally and permanently disabled, and end stage renal disease patients. Almost all adults 65 and older are covered by Medicare and Medicaid, also established in 1965, provides joint federal and state funded insurance for poor and very low income children and families. In addition, the State Children's Health Insurance Programs, established in 1997, provides joint federal and state funded insurance for children in families who earn too much money to qualify for Medicaid, but cannot afford to buy private insurance. Beyond these programs targeting American citizens with limited economic resources, Military Health Benefits are provided primarily to active duty service members, retired service members and their dependents by the Department of Defense Military Health System. These health access supports were established in 1930. Established in 1954, the Indian Health Services began providing health care assistance to eligible American Indians. Beyond these federal and collaborative federal-state programs, there are individual state sponsored health insurance plans (i.e., guaranteed-issuance risk pools) that enable the medically uninsurable to purchase health insurance plans (US Census Bureau, 2008).

The other health insurance options include private and individually purchased health care coverage. Private health insurance is typically received through an employer sponsored program (e.g., a business to cover its employees), although it may be purchased by an individual. "Most Americans with private health insurance receive it through an employer-sponsored program. A US Census Bureau report (2008) indicated that 60% of Americans are covered through an employer, while about 9% purchase health insurance directly. Individually purchased health insurance policies, generally include major medical, short-term medical, and student policies.

In 2007, 261.4 million nonelderly Americans were covered by health insurance. Data indicate that 61% were covered by employer sponsored programs, and 16% were covered by Medicaid, Medicare, SCHIP, Military or other state health programs. A little more than half of the participants in the employer sponsored programs were covered by their employer (52%), and 48% were covered as an employee's dependent. In 2005, SCHIP, the largest source of health insurance for children in the US, provided coverage for 29 million children. Medicaid covered more than 14% of the non-elderly US population, making it larger than any single private health insurer (Kaiser Foundation, 2008). Despite Medicaid's 2005 expenditures of $275 billion, for 59 million Americans, and Medicare's $330 billion expenditure for 42.5 million Americans, significant numbers of Americans remain uninsured (Kaiser Foundation, 2008; HHS, 2006). A 2008 Kaiser Family Foundation report revealed that African Americans experience an uninsured rate of 21% compared to their white counterpart's rate of 12%.

It is currently projected that these public health funds will be depleted in 2019, partially due to the current economic crisis and resultant escalating unemployment and loss of insurance coverage, the eroding job based employment, the projected number of aging "baby boomers" and the associated need for the financing of long term care (Kaiser Family Foundation, 2008). A 2009 Kaiser Family Foundation Health Tracking poll revealed that 62% of Americans indicated that health care reform was "more important than ever to take on given the serious economic problems facing the country". Similarly, a 2007 Gallup poll revealed that a "slight majority of Americans go so far as to favor a national healthcare plan run by the government, similar to the systems in Canada and Great Britain". Some recent studies however, indicate that "having insurance can also be hazardous to your health". A 2006 National Academy of Social Insurance study revealed the existence of racial disparities not only among the privately insured,

but among Medicare beneficiaries in fee for service managed care as well. Reaffirming that "even when they have equal insurance coverage and access to care, African Americans and some other ethnic groups, are less likely to receive life-saving treatments and preventive services than are non-Hispanic Whites" (Alder & Steward, 2005).

Given the existence of racial disparities (i.e., differential access to treatments based on race) among America's insured, it is evident, that while expansions in health insurance coverage are necessary, they will not be sufficient to address the nation's overall health care and health status challenges. Access to health coverage may be a control factor to consider and examine in identifying Black women's health status and needs. Beyond current health service access and insurance coverage, research has also suggested that a range of factors across an individual's life course can affect adult health outcomes. In the next section, research which examines a range of relevant contextual factors that impact adult health outcomes will be reviewed.

Factors that impact adult health outcomes. An enormous literature dating from the mid 19th century has posited and documented an association between adult health outcomes and several contextual factors that stage the life experiences of adults. These include socioeconomic status and access to financial capital. Socioeconomic status is generally measured by education, occupation or income. According to Mechanic (2000), "by the mid-19th century there were already careful, detailed inquiries in England, France, Germany and the United States on how the conditions of the poor cut life short".

Kosa, Antrononvsky & Zola's (1969) book, *Poverty and Health: A Sociological Analysis*, provided an exhaustive investigation of social inequalities in health and illness, concluded that "Whatever aspect of health, whatever stage of morbid episode is examined, the [less socioeconomically advantaged] are at a [greater] disadvantage."

Adler et al., found that individuals with lower socioeconomic status (SES) based on education, income, or occupation, have worse health than their counterparts with a higher SES. This relationship is often depicted as an inverse gradient between SES and poor health. Their research has also provided insights and evidence on the strong linkage between health and the individual's levels of education. Similarly, Anderson, et al. (1995) revealed that an inverse relationship between socioeconomic status and morbidity and mortality rates extends to a wide array of health problems, including heart disease, cancer, stroke, diabetes, hypertension, infant mortality, arthritis, back ailments, mental illness, and kidney diseases. In an examination of data from both the American's Changing Lives Survey (ACL) and the 1985 National Health Interview Survey (NHIS), House et al., (1990) found that: (1) the relationship between SES and health is stratified by age, such that lower SES individuals experience health problems earlier in life, shortly after adolescence, while their higher SES counterparts experience very little health decline until around retirement age; (2) "inequalities in health status by SES varied systematically over the life course; and (3) demonstrated differences by socioeconomic status in a number of health outcomes, including a number of chronic conditions, limitations of daily activities, and functional status. ACL and NHIS concluded that differential exposure to, and differential impact of, psychosocial risk factors, including social support, risky health behaviors, and mastery, were responsible for the inverse gradient in poor health over the life course".

Research has also demonstrated a clear impact of such factors as education, poverty and access to resources on mortality rates. An analysis of 1986 National Health Interview Survey data by Pappas, Queen and Hadden (1993) revealed that while controlling for educational attainment, mortality rates are higher among African American men and women compared with white Americans. In a study linking ecological measures of SES with individual outcomes,

Haan, Kaplanm, and Camach (1987) examined 9-year mortality rates as a function of poverty in a random sample of Oakland, CA residents 35 years of age and older, and found that poverty area was associated with all-cause mortality rates. According to Link and Phelan (1995) access to resources (e.g., "money, knowledge, power, prestige, and the kinds of interpersonal resources embodied in the concepts of social support and social network) determine the extent to which people are able to avoid risks for mortality and morbidity".

While research clearly demonstrates the impact of socioeconomic variables on health outcomes, literature equally as strongly posits the significance of additional factors across an individual's life course. In the following section, literature on adult health from a life course perspective is presented.

Adult health in life course perspective. A growing body of literature suggests that adult health outcomes are significantly shaped not only by co-occurring influences, but by a range of factors across the life course, including earlier childhood experiences and influences. For example, Johnson (2007) studied the influence of early life events on human capital, health status, and labor market outcomes over the life course. Results revealed that poor health at birth (e.g., low birth weight) combined with limited parental resources (including low incomes, lack of health insurance, unwanted pregnancy) to interfere with cognitive development and health capital in childhood. This reduced the educational attainment of study participants and resulted in worse labor market, as well as health outcomes in adulthood. Research findings also reflect linkages among earlier developmental circumstances and health behaviors. Smith and Hart (2002) demonstrated that childhood social circumstances (i.e., father's social class) were more likely to lead to cigarette smoking, and have high levels of alcohol consumption in later adulthood (Smith & Hart, 2002).

Further, Baltrus et al. (2005) in an investigation of socioeconomic position and racial differences in weight gain over 34 years from an analysis of data from the Alameda County, CA longitudinal study of adults that began in 1965, revealed that African American women gained more weight than their white counterparts, and were at the greatest weight related health risk, due to life course socioeconomic conditions. Similarly, a 2006 Pitt County, North Carolina study of obesity in African American women in relationship to their socioeconomic position (SEP) in childhood and adulthood, revealed that childhood SEP was a strong predictor of adulthood obesity.

Although this growing body of literature has established an association between adult health outcomes and experiences across the life course, there is still a lack of clarity regarding the multiple ways in which experiences across the life course have an effect on adult health outcomes in general, and African American women's health outcomes in particular. The ways in which life-course circumstances influence risk, as well as the intervening mechanisms in the relationship between the physical and social environment experienced across the life course and adult health, may have important policy implications. These linkages will be particularly important to explore among African American women, and a life course perspective may assist in supporting a more complex understanding of factors that undergird the greater compromise in their health status.

Theoretical underpinnings. The convergence of the ecological and life course paradigms provide the theoretical underpinnings for the current research study, enabling an examination of both proximal and distal contexts as the framework for our understanding of individual life course pathways that impact adulthood health outcomes.

Ecological Theory of Human Development

First articulated by Bronfenbrenner (1979), the ecological theory of human development, views the interrelationship between child/individual, family, community and the larger society as the point of departure for understanding human development. The model is comprised of environmental systems, most often depicted as concentric circles, is reminiscent of a set of nested structures – micro, meso, exo, and macro levels - each imbedded within the other, like a set of Russian dolls.

At the model's core or the inner most circle is the microsystem, which Bronfenbrenner indicates is the focus of most research on socio-cultural influences. The microsystem is the setting in which the individual lives in the context of their family, peers, school, and neighborhood. The individual is viewed as an active rather than passive recipient of experiences in this setting, such that their actions, roles and interpersonal relationships help construct the settings. The next ring, the mesosystem involves relations between microsystems and/or connections between settings. The third ring or exosystem contains one or more social settings in which the individual is not directly involved, but is nonetheless affected and/or influences what the individual experiences in an immediate setting. The outermost ring, the macrosystem, involves the culture in which people live, as well as economic trends and societal patterns. Lastly, Bronfenbrenner's chronosystem, involves the "patterning of environmental events and transitions over the life course and sociohistorical circumstances" (Bronfenbrenner 1979; 1986). While the theory contains the chronosysem component that involves historical time, it "does not have a strong life span developmental orientation" (Bronfenbrenner 1979; 1986).

Urie Bronfenbrenner's (1979) ecological model is predicated on the concept that an individual's or family's unique set of environmental systems affect their development and functioning. The model views the interrelationship between child, family, community and the

larger society as the point of departure for understanding human development. In this context, the significance of culture, racial and socioeconomic characteristics of the community, as well as the policies of the nation, are factors to be included in considering the determinants of individual and family functioning" (Kegan & Weissbourd, 1994).

While each individual is unique in their experience and response to ecological influences, efforts to better comprehend the nature and scope of the impact of environmental systems on individuals and families will enable us to work in a more comprehensive and collaborative manner to identify viable interventions that mitigate the negative conditions and stresses that individual's experience, which often result in negative health outcomes.

Life Course Theory

Elder's life course theory of human development views the socio-cultural environment as its starting point, placing greater emphasis on the social pathways/trajectories of human lives, transitions and turning points. Elder's (1974) landmark work, Children of the Great Depression was originally published in 1974, demonstrated the profound and lasting effects of historical change on human development throughout the life course. Elder postulates five central Life Course principles as key to our understanding of human development: "(1) Life Span Development: Human development and aging are life long processes; (2) Agency: Individuals construct their own life course through the choices and actions they take within the opportunities and constraints of history and social circumstance; (3) Timing: The developmental antecedents and consequences of life transitions,, events, and behavioral patterns vary according to their timing in a person's life; (4) Linked Lives: Lives are lived interdependently and socio-historical influences are expressed through this network of shared relationships; and (5) Time and Place: The life course of individuals is embedded and shaped by the historical times and places they

experience over their lifetime" (Mortimer & Shanahan, 2004). Elder's work was built upon a series of studies dating back to the late 1920's. "The Berkeley Guidance Study (GS) initiated in 1928 as a study of behavior problems of normal young children but soon evolved into a study of personality development.; The Berkeley Growth Study (BGS) initiated in 1928 was designed as a study of mental, motor, and physical development.; Oakland Growth Study (OGS) began in 1932 as a study of physiological, intellectual, and social development during adolescence" (IHD, 1994). Elder' expectations were borne out by the empirical realities of the lives he observed through time, instead of reproducing "hard times" in their adult years, most of these Depression children managed to surmount life's disadvantages. These youth frequently followed a developmental course characterized by resiliency. In fact, their trajectories of resiliency, provided insights into their key transitions and turning points out of disadvantage – higher education, a stable, quality marriage, and entry into the military.

The ecological and life course models also provide a sharp contrast to the individualistic conceptual models upon which many of our service delivery systems are often based, providing the opportunity for insight into their inability to remedy and why many have failed American adults, children, youth and families. Together, these paradigms will facilitate a better understanding of the specific socio-contextual conditions over the life course that impact adulthood health outcomes.

Of critical significance is the potential utility of an integrated ecological and life course approach that informs policy efforts and work on the persistent challenges and fragmentation confronting Americans today. By considering the individual within the historical and policy context of their families, communities and larger society, we acquire a profound understanding of the nature and scope of the impact of environmental systems on adults. This perspective can

potentially enhance our knowledge and enable us to develop programs and services predicated on the operationalization of the ecological and life course models that strengthen adults by offering information, resources, and emotional support based on their unique developmental experiences.

A review of several longitudinal studies supports the association of family and environmental contexts with adulthood outcomes. The Children of the Kauai study is one of the few longitudinal studies that have examined the phenomenon of resiliency over the life course, from infancy to adulthood. Initiated in 1955, the study explores the impact of biological and psychosocial risk factors, stressful life events, and protective factors on a multi-racial cohort of 698 children born on the Island of Kauai, Hawaii. A team comprised of mental health, health care and social workers monitored the study population's development at ages 1, 2, 10, 18, 32, and 40 years. These ages were chosen because they coincide with stages critical for the development of trust, industry, identity, autonomy, and intimacy.

Approximately 30% of the surviving sample population experienced biological and psychosocial risk factors, and stressful life events (e.g., born and raised in poverty, experienced pre-or perinatal complications; divorce, marital discord, parental psychopathology), two thirds of whom developed learning or behavioral problems by age 10 or became delinquent and/or showed mental health problems by age 18. However, the results also surprisingly showed that one out of three children matured into competent, confident, caring adults, the occurrence of which challenged the myth that high risk children are destined to experience compromised and negative life outcomes.

The researchers identified multiple protective factors within the individual, family and community that supported positive outcomes among individuals experiencing risk. These

protective factors included: child temperament (e.g., easygoing babies elicited support parents and other adults who could provide support and mentorship); values (i.e., optimism and faith that it was possible to overcome challenging circumstances); caregiving style of parents; strong surrogate parents who instilled hope for the future; and “second chance” opportunities at different points in life, supporting the phenomenon of resiliency, leading to positive adaptation in spite of challenging life circumstances. Notwithstanding the evidence to date, few studies focus on resiliency across the life course, which could serve to inform strategic interventions and public policy to improve adult outcomes (Werner, 1992).

While these two significant bodies of work - The Children of the Great Depression, and the Children of Kauai studies provide important empirical evidence that support and elucidate the “resiliency “phenomenon and the significant and the impact of family and environmental contexts over the life course, they do not provide significant insights into adult health outcomes and the role of health within and across the life course. The studies’ samples (i.e., White or Hawaiian), also limit the generalizability of the findings to other populations. However, this research does provide a framework for examining lives in context over the life course, as a well as a grounded theory approach to the research which allows the data to inform us about the factors that impact in our case adult health outcomes.

These research findings provides a framework that enables us to examine an individuals health status, not as we are oft tempted to do, solely focusing on the individual’s behaviors (e.g., alcohol and tobacco consumption, or diet and exercise), thereby simply allowing us to delineate the risks. If not more important, we also examine family and environmental circumstances, and the compounding key life experiences, transitions and turning points across the life course that

predisposed/placed the individual at risk. This will be critical to the development of effective programs, services and policies that do not blame the victim.

Richmond's East End community, a predominantly African American (55.5%), and African American female (30.8%) population, provides a setting in which the life course of African American women can be examined in relation to their health status. In the following section, an overview of the community that provides the setting for the current investigation is provided.

Richmond's East end community. The East End's health portrait mirrors the profoundly pervasive and persistent health challenges evidenced by the nation, state, and city. Upon review, the East End zip code (23223) had the highest number of cases per prevention quality indicator among all of the city's zip codes for the following conditions (VHI, 2006):

- Diabetes long term complications (81 cases)
- Hypertension (26 cases)
- Lower extremity amputation among patients with diabetes (25 cases)
- Congestive heart failure (246 cases)

This zip code comparison revealed that Richmond's East End community has the most negative health outcomes in the City of Richmond. This health portrait forms the basis for this study's focus on the East End community, to provide an increased understanding its community's health outcomes, and associated risk factors, in context over the life course, so as to promulgate programs, services and policies to improve its health.

Today, Richmond' East End community is home to several heath care providers including Bon Secours Richmond Community Hospital, Capital Area Health Network's (city's only federally qualified health care center serving the uninsured and underserved) two medical

centers, Edloe's Pharmacy established in 1945 (two locations), a chain pharmacy (i.e., CVS), a medical office building comprised of local physicians, as well as several other local physician's and dentists offices. The Medical College of Virginia located in close proximity to the East End community, is the community's other major health care provider.

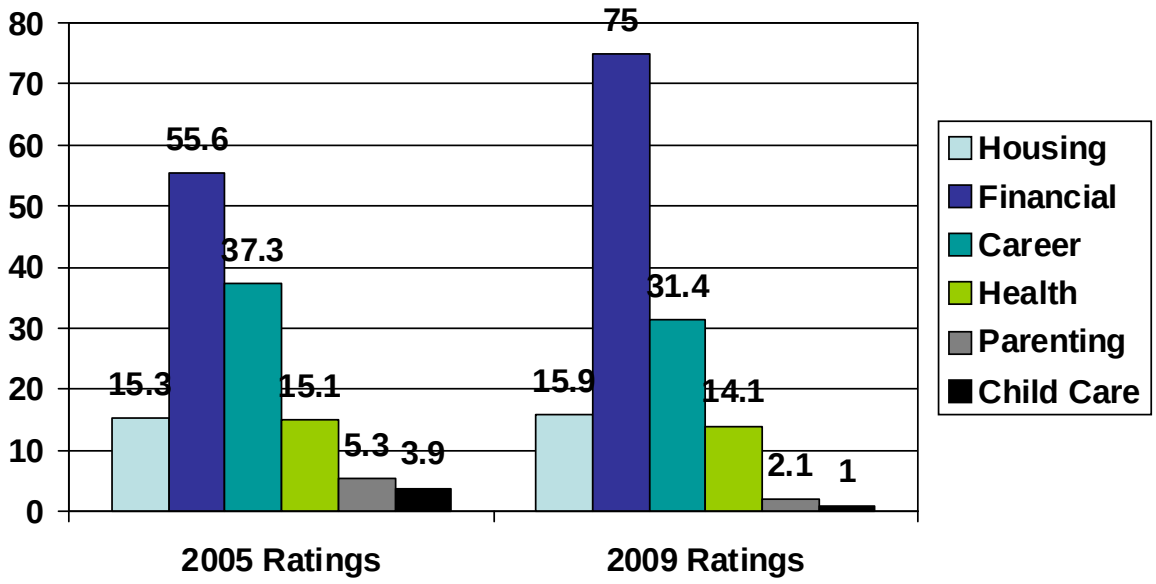
In addition, Richmond's East End community is home to the East District Family Resource Center *(FRC),* which opened its doors in 1998 at 2405 Jefferson Ave. FRC is unique in its collaborative interface with the community's health providers (i.e., formal memorandums of agreement for health service referrals), working to improve outcomes for individuals, children, youth and families. FRC is an outgrowth of the 1992 Annie E. Casey Foundation's Virginia/City of Richmond Urban Mental Health Initiative, the FRC was established based on the National Family Resource Center Coalition and Family Support America models designed to provide a full range of programs and services to improve outcomes for Richmond's children, youth, individuals and families in Richmond's East District community.

Today, FRC's mission is to provide family focused/family strengthening preventive and supportive community based, comprehensive and coordinated services to improve the quality of life for families and individuals in the City of Richmond. FRC's service menu includes: Basic Family Needs Services (including access to an Emergency Food Pantry, Clothing, and Heating Assistance); Education Programming (including GED Classes; Computer Classes; Tutoring etc.); Youth Programs: Summer Youth Technology Project; Peep THIS youth film camp etc.; Parent Support, Parenting Training and Senior Programs; Family/Community Activities & Events; Community Showcases & Performances; Information/Referrals; and Intake & Assessment. *FRC* operates 12 months per year, five days a week, Monday - Friday, from 10:00 am until 5:00 pm; and Saturdays as scheduled and/or requested by the community.

An analysis of 2005 and 2009 FRC client tracking system service data reveals that basic financial needs has consistently been the major need category, followed by career enhancement, housing resources, and access to health care (See Figure 1 below).

Figure 1.

FRC Client Brief Needs Assessment (2005 and 2009 Data)



Client Tracking System Data –Percent Indicating 'Not doing well' or 'Not doing well at all'.

In 2006, FRC effected a programmatic realignment based upon, and in response to its 2005 client service data and demonstrated community need, which resulted in the development of program and service enhancements designed to facilitate individual and family financial and economic self sufficiency and asset development.

The persistent nature and scope of the community's service needs (e.g., increases in financial needs reported by clients- 55.6% to 75%), combined with the negative health outcomes in the East End community is indicative of the need to better understand the connections between the life circumstances of community residents and their health status. FRC provides a setting that

can serve to assist in developing a better understanding of the connection of the life course and adult health outcomes for Black women who are experiencing economic challenges.

Research Goals

The study is a two-phase qualitative and quantitative project. The quantitative study phase involves the compilation and analysis of secondary data collected by the East District Family Resource Center (FRC). Data was collected by the FRC staff as a part of the client screening and intake process for all individuals accessing services at the Center for calendar year 2009 and January through November 17, 2010.

Five hundred –three (503) individuals accessed FRC services during the study periods. This population of service recipients was divided into two categories comprised of FRC health and non-health resources seekers. Randomly selected samples of African American women were identified from each of the two categories. These two groups comprised the study population. Descriptive statistics on group characteristics and measurement metrics were utilized to answer the following questions:

- Who are the African American women (i.e., age, marital status, education, annual household income, employment status, health insurance status, neighborhood) accessing FRC services?
- What are the physical and/or emotional health needs of African American women accessing FRC services?

Service typologies were examined utilizing cluster analyses enabling us to identify underlying structure and patterns of relationship in the data, and thereby answer the following questions:

- Are there specific clusters of needs?
- Do health service needs differentiate these groups?

- What are the individual characteristics related to these clusters of needs?

These data enable us to better understand today's African American women's health and service resource needs.

The qualitative study phase utilized a cross-sectional research design that is exploratory, descriptive and provides a retrospective perspective on the life course.

All qualitative study participants participated in a "Life Story" interview protocol consisting of a structured component, i.e. the completion of three short self-administered surveys (Demographic Profile to collect relevant information such as age, race/ethnicity, socio-economic status, family composition, employment status; Health Status Survey focusing on their current health status; and the SF 36 Health Survey, an eight scale profile of functional health and well-being), as well as an unstructured component comprised of a list of interview questions from Harvard University's 1982 Intergenerational Studies Life Review (i.e., open-ended questions that query participants about their family composition, service needs, service agencies routinely accessed, and social supports).

This current study enables us to better understand: (1) the role of health within the life course experiences, trajectories, transitions and turning points of African American women, that have led to or support their present level of service need and experience of metabolic disorders and associated risk factors; and (2) the health policy and program context experienced by African American women over their life course that support current adult health status and types of health care need.

The study specifically focused on the following: (1) three aspects of adult health: (a) physical health and well-being; (b) mental/emotional health and well-being; and (c) metabolic conditions and related risk factors); (2) three aspects of health care: (a) insurance access; (b)

health service utilization; and (c) health care source; and (3) three family factors across the life course: (a) Family Structure (i.e., household composition including parent marital status, and the number of siblings); (b) Family Resources including Family and Parental Economic Capital (i.e., income, education, employment, insurance coverage) and, Family Medical History and health behaviors (e.g., presence of maternal experience of health risks, maternal cooking choices during childhood).

A mixed-methods approach was utilized to execute the research project. According to Creswell et al. (2003), "a mixed methods study involves the collection or analysis of both quantitative and/or qualitative data in a single study in which the data are collected concurrently or sequentially, are given a priority, and involve the integration of the data at one or more stages in the process of research" (Creswell et al., 2003). While the mixed method approach has several weaknesses (e.g., multiple study phases, time consuming, costly), they are far outweighed by its strengths (i.e., comprehensiveness, opportunity for consumer involvement).

In this chapter, a description of the quantitative and qualitative study phases, including the research question, data collection method, and analyses, is provided.

Methods

Phase I – Quantitative Study

Goals. The primary goals of the quantitative study are the: (1) identification of the qualitative study population (i.e., African American women accessing FRC health resource and service needs); (2) random selection of the two groups of African American women accessing FRC for either health and or non-health resource and service needs); and (3) examination of the FRC data quality (e.g. variance in the data, missing data etc.).

The descriptive variables were selected based upon a review of the available FRC intake and assessment data variables and the desire to (1) develop a socio-demographic, economic, environmental and medical profile of each study participant; (2) identify African American women's health resource and service needs, and typologies; and (3) explore relationships, if any, between African American women's socio-demographic, economic, environmental and medical profile and their health resource needs.

Hypotheses.

I. There is a relationship between African American women's socio-demographic status (i.e., age, marital status, education, annual household income, employment status, health insurance status, neighborhood), and their health outcomes: (a) physical health and well-being; (b) mental/emotional health and well-being; and (c) metabolic conditions and related risk factors).

II. There is a relationship between African American women's socio-demographic status (i.e. age, marital status, education, annual household income, employment status, health insurance status, neighborhood), and their health resource and service needs.

III. African American women have identifiable clusters of service needs.

IV. There is a relationship between African American women's socio-demographic status (i.e., age, marital status, education, annual household income, employment status, health insurance status, neighborhood) and their service need clusters.

Data collection. The quantitative study phase involved the compilation and analysis of secondary data collected by the East District Family Resource Center (FRC). Data was collected by the FRC staff as a part of the client screening and intake process for all individuals accessing

services at the Center for calendar year 2009 and January through November 17, 2010. Five hundred and three (503) individuals accessed FRC services during the study periods.

Individuals and families seeking FRC services contact the center by telephone or walk-in. Telephone contacts are instructed to walk-in to the center during the normal hours of operation (Monday-Friday, 9:00am – 5:30pm during the study period) for screening and services. All individuals and families seeking FRC services are directed to the center's intake staff who:

(1) Provide an orientation to the individual seeking services on the Center's services, eligibility requirements, and waiting lists should they exist;

(2) Complete and/or enter information onto the East End Partnership with Families (EEPF) Client Intake Form which captures demographic information (See Appendix 1);

(3) Complete and/or enter information onto the EEPF Client Intake and Brief Assessment form which provides an assessment of service need(s) and goal(s) across 6 domains (See Appendix 2);

(4) Obtain client signatures on the consent to release information/authorization to share information with the EEPF forms (See Appendix 3);

(5) Discuss the client/family's service need(s) and determines whether the identified need(s) match the FRC service array; and,

(6) Refer clients as needed to the Community Care Coordinator for a Full Assessment, service plan development and intensive case management, as well as subsequent Full and Monitoring Assessments (See Appendix 4) at 3 and 6 month intervals to monitor progress towards goal accomplishment.

If the individual/family meet the eligibility requirements, and there is a match between the service need(s) and FRC service array, a client file is created and the client will be scheduled

for the receipt of services and/or participation in scheduled programs. When intake staff are unavailable to meet with prospective call-in or walk-in members, the receptionist collected their contact information (i.e., name, telephone number) and service request(s) and forwarded it to the appropriate staff member. Intake staff members return calls to the prospective clients before the close of the business day.

Individuals for whom there is not a match between the FRC service array and their service need(s) are referred to an appropriate agency/organization within the East End Partnership with Families (See Appendix 5) and/or other service providers in the East District or the greater Richmond metropolitan area.

Missing Data. Based on recommendations by Hair et al. (1998), the patterns of missing data were examined and in order to minimize bias, and inaccuracy, only observations with complete data were utilized in this study. There were 503 cases for the study period. After eliminating all males, 323 cases remained. After eliminating all non-African American females, and cases with females but no race, or African Americans, but no gender the number was 267.

Socio-demographic, economic, environmental, health description. The socio – demographic, economic, environmental, health variables collected from the FRC Family Information Sheets completed by the FRC Intake worker with clients accessing FRC services which included in this study are as follows:

(1) Age: This variable is defined as the respondent's actual age at intake.

(2) Marital Status- This variable is defined as the respondent's self reported marital status, and is coded such that 1=Married, 2=Single, 3=Divorced, 4=Separated, 5=Cohabitating (Never Married), 6=Unknown, and 7=Widowed.

(3) Annual Household Income – This variable is defined as the respondent's self-reported annual income on the date of the interview. The income ranges delineated on the family intake sheet utilized with the individual/family at intake will be utilized, and is coded such that 1=Under $10,000, 2=10,001-$19,999, 3=$20,000-$29,999, 4=$30,000-$39,999, 5=$40,000-$49,999, and 6=$50,000 or more.

(4) Employment Status: This variable is defined as the respondent's self-reported employment status and is measured such that 1=Employed full-time, 2= Employed part-time, 3=Unemployed, 4= Not in labor force, homemaker, 5= Not in labor force, student/job training, 6= Not in labor force, retired, 7= Not in labor force, disabled, 8= Not in labor force, resident, inmate of institution, 9=Not seeking employment, 10= Employment program, and 11= Unknown.

(5) Highest Grade Completed: This variable is defined as the respondent's reported highest grade completed, and is coded such that 1= Below 8^{th} Grade, 2= 8^{th} Grade, 3= 9^{th} Grade, 4= 10^{th} Grade, 5= 11^{th} Grade, 6= 12^{th} Grade, 7= Some College, 9= Graduate School, and 10= Other.

(6) Housing: This variable is defined as the respondent's self-report of home ownership or rental.

(7) Insurance: This variable is defined as the respondent's self-report of possessing insurance coverage.

Appendix 14 provides a summary of each of the seven variables above, along with their operational definition and coding.

The study's service needs assessment variables collected from the EEPF Family Brief Assessment forms completed by the FRC Intake worker with clients accessing FRC services were included in this study and examine the following 6 domains (See Appendix 2) as follows:

(1) Housing.

(2) Basic Financial Needs.

(3) Career and Employment

(4) Physical Health

(5) Parenting

(6) Child Care

Respondent ratings of their perceived level of functioning (i.e., "how they are doing") in each of the service need domains listed above are coded as follows: 0= Doing really or pretty well; No needs- Doesn't need attention; 1=Doing ok-getting by; Some minor needs; 2=Not doing well at all, not really making it; Serious need; clearly and definitely needs attention; 3=Not doing well at all—in very bad shape; Emergency; Needs immediate attention; 9= Staff rating: Not enough information.

Quantitative data analysis techniques were employed in this study. Data was coded and entered into SPSS-PASW 17.0.

Analysis and Results

In order to address Question #1, 'Who are the African American women accessing FRC services?' a series of descriptive statistics (i.e., basic frequencies) were conducted for each of the indicated demographic variables (i.e., age, marital status, education, annual household income, employment status, health insurance status, and housing).

Descriptive statistics revealed that 267 African American women accessed FRC services during the study period, out of the 503 individuals who received FRC services during the same period. The majority of the women were single (74.4%), and between the ages of 42 to 52 years (33.3%). Most of the women had completed the 12th grade (65 out of 170 respondents; 36.5%), and 22.9% had completed some college. Seventy-two percent (108 out of 150 respondents) of the women had an annual household income ranging from $0-10,000, and 38% were unemployed. The overwhelming majority of the women rent their homes (70.8%), and do not have health insurance (36%). Overall, the demographic portrait of women accessing services at the FRC paints a picture of a single, older African American woman high school graduate with some college education who is unemployed, with no health insurance. See Tables 1-7 below.

Table 1

Marital status

	Frequency	Percent
Cohabitating (never married)	1	.4
Divorced	23	9.7
Married	16	6.7
Separated	15	6.3
Single	177	74.4
Unknown	2	.8
Widowed	4	1.7
Total	238*	100.0

Note: *Excludes missing data (29).

Table 2

Age

	Frequency	Percent
20-30	53	22.6
31-41	56	23.9
42-52	78	33.3
53-63	37	15.8
64-74	9	3.8
75-85	1	.4
Total	234*	100.0

Note: *Excludes missing data (33)

Table 3

Highest grade completed

	Frequency	Percent
10th Grade	17	10.0
11th Grade	27	15.9
12th Grade	62	36.5
8th Grade	6	3.5
9th Grade	10	5.9
Below 8th Grade	4	2.4
Graduate School	1	.6
Other	4	2.4
Some College	39	22.9
Total	170*	100.0

Note: *Excludes missing data (97).

Table 4

Annual Income

	Frequency	Percent
0-10,000	108	72.0
10,000-19,999	37	24.7
20,000-29,999	3	2.0
30,000-39,999	1	.7
40,000-49,999	1	.7
Total	150*	100.0

Note: *Excludes missing data (117).

Table 5

Employment Status

	Frequency	Percent
Employed full-time	29	13.9
Employed part-time	30	14.4
Employment Program	3	1.4
Not in labor force, disabled	50	24.0
Not in labor force, homemaker	8	3.8
Not in labor force, retired	4	1.9
Not in labor force, student/job training	2	1.0
Not seeking employment	2	1.0
Unemployed	79	38.0
Unknown	1	.5
Total	208*	100.0

Note: *Excludes missing data (59).

Table 6

Residential Setting

	Frequency	Percent
Homeless	3	1.3
Own home	9	3.9
Renting	189	81.1
Subsidized	24	10.3
Unknown	8	3.4
Total	233*	100.0

Note: *Excludes missing data (34).

Table 7

Health Insurance

	Frequency	Percent
No	96	36.0
Yes	32	12.0
Total	267	100.0

Note: *Excludes missing data (139).

In order to respond to Question #2, 'What are the physical health and/or emotional health and well-being needs of African American women accessing FRC services?' descriptive statistics (frequencies) were conducted on the study's service needs assessment variables collected from the FRC Family Assessment forms completed by the FRC Intake worker with clients accessing FRC services. The six service need domains for which data was available

included the following: (1) housing; (2) basic financial needs; (3) career and employment; (4) physical health; (5) parenting; and (6) child care.

The data reveals that the overwhelming majority of African American women accessing FRC services report having basic financial needs (93.3%), followed by career and employment needs (26.6%); housing (15.7%), physical health (12.8%); parent briefing (1.2%), and child care (.7%) across all need categories (See Tables 8-13). It is notable that almost 70% more women report financial needs than any other service need category.

Table 8

Basic Financial Brief Rating

	Frequency	Percent
No needs	15	5.6
Some needs	47	17.6
Serious need	29	10.9
Needs immediate attention	173	64.8
Staff rating/not enough info.	3	1.1
Total	267	100.0

Table 9

Career Employment Brief Rating

	Frequency	Percent
No needs	193	72.3
Some needs	4	1.5
Serious need	28	10.5
Needs immediate attention	39	14.6
Staff rating/not enough info.	3	1.1
Total	267	100.0

Table 10

Housing Brief Rating

	Frequency	Percent
No needs	221	82.8
Some needs	5	1.9
Serious need	15	5.6
Needs immediate attention	22	8.2
Staff rating/not enough info.	4	1.5
Total	267	100.0

Table 11

Physical Health Brief Rating

	Frequency	Percent
No needs	231	86.5
Serious need	19	7.1
Needs immediate attention	15	5.6
Staff rating/not enough info.	2	.7
Total	267	100.0

Table 12

Parent Brief Rating

	Frequency	Percent
No needs	258	96.6
Needs immediate attention	3	1.1
Staff rating/not enough info.	6	2.2
Total	267	100.0

Table 13

Child Care Brief Rating

	Frequency	Percent
No needs	260	97.4
Some need	1	.4
Needs immediate attention	1	.4
Staff rating/not enough info.	5	1.9
Total	267	100.0

In order to respond to Question #3 –'Are there specific clusters of needs?' a hierarchical cluster analysis was performed utilizing the participant data, and the client ratings of six service needs domains (i.e., (1) housing; (2) basic financial needs; (3) career and employment; (4) physical health; (5) parenting; and (6) child care) for which data was available.

This technique allows us to group the FRC service population based on the similarity of their patterns of past service use so that we can ultimately tailor our program services to better meet their needs. The most distinct cluster formations are reflective of the greatest similarity (homogeneity) and the greatest difference between groups. Understanding these similarities will enable us to better serve and target services to the various subgroups who are most likely to be receptive to them.

Hierarchical clustering allows us to observe the underlying cluster structure i.e., whether and how the clusters are nested. Hierarchical clustering is most often displayed graphically in the form of a tree diagram i.e., dendrogram, displaying cluster/subcluster relationships and the order in which they were formed.

The dendrogram produced (See Figure 2) clearly delineates two (2) clusters across the six (6) domains. Basic financial needs and the other combined categories form the two clusters of need. As is evidenced in the dendrogram, and the agglomeration schedule (See Table 14), the greatest difference is between clusters 2 and 3. However, the distances between all clusters are summarized.

Figure 2

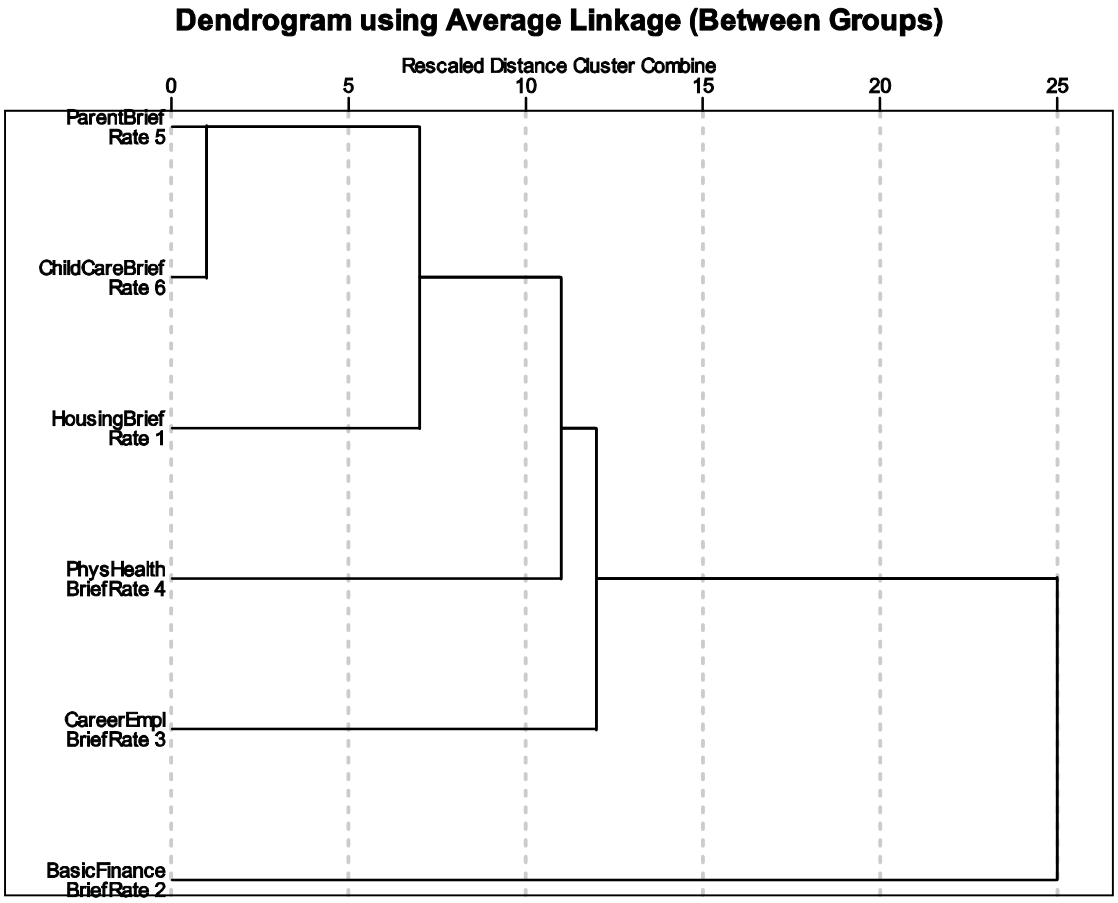

Dendrogram using Average Linkage (Between Groups)
Rescaled Distance Cluster Combine
0
5
10
15
20
25
ParentBrief Rate 5
ChildCareBrief Rate 6
HousingBrief Rate 1
PhysHealth BriefRate 4
CareerEmpl BriefRate 3
BasicFinance BriefRate 2

Table 14

Agglomeration Schedule

Stage	Cluster Combined		Coefficients	Stage Cluster First Appears		Next Stage
	Cluster 1	Cluster 2		Cluster 1	Cluster 2	
1	5	6	118.000	0	0	2
2	1	5	599.000	0	1	3
3	1	4	870.000	2	0	4
4	1	3	935.500	3	0	5
5	1	2	1864.600	4	0	0

In order to respond Question #4, 'What are the individual characteristics related to these clusters of needs?' correlations table were conducted. Five underlying clusters were identified among the six service domains based upon the hierarchical cluster analysis performed. In order to understand the characteristics related to theses clusters of needs, a correlation analysis was conducted. The results revealed significant correlations as follows: (1) health insurance was negatively correlated with physical health, housing, parent, and child care needs; (2) annual income (negative), marital status (positive), and highest grade (negative) completed were significantly correlated with basic financial needs; (3) highest grade completed was positively correlated with physical health needs; and (4) employment was positively correlated with career/employment needs (See Correlation Table 15). While one might anticipate many of the correlates revealed in the analysis (e.g., employment status and career/employment needs), others suggest a need for greater scrutiny to better understand the relationship (e.g., housing, parent, and child care needs and health insurance).

Table 15

Correlations

		Housing	Basic Finance	Phys Health	Parent	Child Care	Age	Annual Income	Marital	Highest Grade	Employ-ment	Health Insur.	Hous-ing	Career Employ-ment
Housing	Pearson Correlation	1	.284**	-.096	.415**	.401**	-.010	-.074	-.045	-.088	.071	.261**	.297**	.313**
	Sig. (2-tailed)		.000	.119	.000	.000	.874	.368	.494	.253	.309	.003	.000	.000
	N	267	267	267	267	267	234	150	238	170	208	128	233	267
Basic finance	Pearson Correlation	.284**	1	-.085	.061	.070	.031	-.201*	.201**	-.222**	-.038	-.013	.065	.100
	Sig. (2-tailed)	.000		.165	.321	.251	.641	.014	.002	.004	.586	.881	.325	.103
	N	267	267	267	267	267	234	150	238	170	208	128	233	267
Phys health	Pearson Correlation	-.096	-.085	1	-.058	-.050	.039	-.097	.043	.159*	-.015	-.205*	-.086	-.144*
	Sig. (2-tailed)	.119	.165		.342	.413	.550	.236	.510	.038	.832	.020	.189	.018
	N	267	267	267	267	267	234	150	238	170	208	128	233	267
Parent	Pearson Correlation	.415**	.061	-.058	1	.875**	-.042	-.056	.014	-.092	.023	.300**	.020	.108
	Sig. (2-tailed)	.000	.321	.342		.000	.522	.496	.830	.234	.744	.001	.759	.077
	N	267	267	267	267	267	234	150	238	170	208	128	233	267
Child care	Pearson Correlation	.401**	.070	-.050	.875**	1	-.061	-.060	.014	-.065	.068	.369**	-.002	.134*
	Sig. (2-tailed)	.000	.251	.413	.000		.357	.463	.829	.398	.331	.000	.977	.029
	N	267	267	267	267	267	234	150	238	170	208	128	233	267

Age	Pearson Correlation	-.010	.031	.039	-.042	-.061	1	.023	-.232**	.066	-.199**	-.008	-.063	-.125
	Sig. (2-tailed)	.874	.641	.550	.522	.357		.794	.001	.403	.006	.933	.371	.055
	N	234	234	234	234	234	234	137	220	164	190	117	207	234
Annual income	Pearson Correlation	-.074	-.201*	-.097	-.056	-.060	.023	1	-.254**	.128	-.274**	-.023	-.181*	-.113
	Sig. (2-tailed)	.368	.014	.236	.496	.463	.794		.003	.193	.001	.847	.037	.168
	N	150	150	150	150	150	137	150	139	105	133	76	133	150
Marital	Pearson Correlation	-.045	.201**	.043	.014	.014	-.232**	-.254**	1	-.260**	.151*	-.186*	.085	-.061
	Sig. (2-tailed)	.494	.002	.510	.830	.829	.001	.003		.001	.035	.043	.215	.349
	N	238	238	238	238	238	220	139	238	164	197	119	214	238
Highest grade	Pearson Correlation	-.088	-.222**	.159*	-.092	-.065	.066	.128	-.260**	1	-.083	-.150	-.076	-.137
	Sig. (2-tailed)	.253	.004	.038	.234	.398	.403	.193	.001		.325	.189	.351	.075
	N	170	170	170	170	170	164	105	164	170	144	78	153	170
Employment	Pearson Correlation	.071	-.038	-.015	.023	.068	-.199**	-.274**	.151*	-.083	1	.028	.101	.288**
	Sig. (2-tailed)	.309	.586	.832	.744	.331	.006	.001	.035	.325		.779	.162	.000
	N	208	208	208	208	208	190	133	197	144	208	105	193	208
Health insurance	Pearson Correlation	.261**	-.013	-.205*	.300**	.369**	-.008	-.023	-.186*	-.150	.028	1	.015	.060
	Sig. (2-tailed)	.003	.881	.020	.001	.000	.933	.847	.043	.189	.779		.873	.504
	N	128	128	128	128	128	117	76	119	78	105	128	109	128

Housing	Pearson Correlation	.297**	.065	-.086	.020	-.002	-.063	-.181*	.085	-.076	.101	.015	1	.029
	Sig. (2-tailed)	.000	.325	.189	.759	.977	.371	.037	.215	.351	.162	.873		.663
	N	233	233	233	233	233	207	133	214	153	193	109	233	233
Career employment	Pearson Correlation	.313**	.100	-.144*	.108	.134*	-.125	-.113	-.061	-.137	.288**	.060	.029	1
	Sig. (2-tailed)	.000	.103	.018	.077	.029	.055	.168	.349	.075	.000	.504	.663	
	N	267	267	267	267	267	234	150	238	170	208	128	233	267

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

In order to respond to Question #5, 'Are there predictors of FRC service type utilization?' a series of linear regressions were performed. Linear regressions were conducted for the six service need domains: (1) housing; (2) basic financial needs; (3) career and employment; (4) physical health; (5) parenting; and (6) child care. The predictor variables were age, income, marital status, highest grade completed, employment and health insurance coverage.

A review of the standardized B coefficients and associated significance levels reveal that annual household income makes the strongest and only significant contribution to explaining the dependent variable basic financial needs. Highest grade completed, employment, and health insurance are statistically significant contributions to explaining the career/employment dependent variable. Highest grade completed makes the strongest contribution, albeit not statistically significant, to explaining both the physical health and parent dependent variables. Health insurance makes the strongest contribution to explaining the child care variable, while

housing (e.g., rent own) makes the strongest contribution to explaining housing service needs. (See Tables 16 - 21).

Table 16

Regression Analysis: Basic Financial Needs

	Unstandardized Coefficients		Standardized Coefficients		
Model	B	Std. Error	Beta	t	Sig.
(Constant)	2.412	1.428		1.689	.100
Age	-.125	.156	-.140	-.801	.428
Annual income	-.653	.279	-.363	-2.341	.025
Marital	.161	.131	.216	1.224	.229
Highest grade	-.041	.049	-.129	-.842	.405
Employment	-.059	.044	-.197	-1.354	.184
Health insurance	.240	.306	.122	.784	.438
Housing	-.026	.277	-.014	-.094	.926

Note: R^2 = .313; F = 2.405; p = .039

Table 17

Regression Analysis: Career/Employment

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	3.346	1.777		1.883	.068
Age	.096	.195	.088	.496	.623
Annual income	-.297	.347	-.134	-.855	.398
Marital	-.161	.163	-.176	-.984	.331
Highest grade	-.125	.061	-.318	-2.050	.048
Employment	.116	.054	.313	2.126	.040
Health insurance	-1.017	.381	-.420	-2.668	.011
Housing	-.197	.345	-.089	-.571	.572

Note: R^2 = .292; F = 2.181; p = .059

Table 18

Regression Analysis: Physical Health

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	-.528	2.662		-.198	.844
Age	.167	.291	.113	.574	.569
Annual income	-.391	.520	-.131	-.752	.457
Marital	.155	.245	.125	.633	.531
Highest grade	.122	.091	.232	1.344	.187
Employment	.064	.081	.128	.781	.440
Health insurance	-.477	.571	-.146	-.836	.409
Housing	.095	.517	.032	.184	.855

Note: R^2 = .128; F = .777; p = .610

Table 19

Regression Analysis: Housing

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	-1.046	1.663		-.629	.533
Age	.216	.182	.224	1.185	.244
Annual income	-.318	.325	-.164	-.978	.334
Marital	.109	.153	.137	.716	.479
Highest grade	-.039	.057	-.114	-.686	.497
Employment	-.021	.051	-.066	-.420	.677
Health insurance	-.380	.357	-.179	-1.065	.294
Housing	.557	.323	.286	1.723	.093

Note: R^2 = .192; F = 1.257; p = .298

Table 20

Regression Analysis: Parenting

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	.154	.779		.197	.845
Age	.070	.085	.163	.817	.419
Annual income	.008	.152	.009	.051	.959
Marital	.045	.072	.127	.626	.535
Highest grade	-.036	.027	-.239	-1.361	.182
Employment	-.010	.024	-.073	-.440	.663
Health insurance	-.168	.167	-.179	-1.004	.322
Housing	-.002	.151	-.002	-.012	.990

Note: R^2 = .094; F = .551; p= .790

Table 21

Regression Analysis: Child Care

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	-.438	.739		-.593	.557
Age	-.098	.081	-.229	-1.208	.235
Annual income	-.056	.144	-.065	-.387	.701
Marital	-.008	.068	-.021	-.111	.912
Highest grade	-.003	.025	-.019	-.116	.908
Employment	.010	.023	.068	.427	.672
Health insurance	.265	.158	.283	1.675	.102
Housing	.157	.144	.182	1.091	.282

Note: R^2 = .185; F = 1.198; p = .328

Phase II - Qualitative Study

The current qualitative component of the study sought to examine the needs of African American women seeking FRC services by affording us an opportunity to better understand their lives, growth and development over time. African American women were asked to share information about their life history, that is, their perspectives on their childhood and family, experiences in their community, and their educational and work experiences.

The specific research questions are:

1- What is the relationship between African American women's life history (e.g., childhood and family, experiences in their community, educational and work experiences) and their health service and other service needs?
2- What is the relationship between African American women's life history (e.g., childhood and family, experiences in their community, educational and work experiences), metabolic conditions, associated risk factors, and their reported health status?

Hypotheses. The focal questions for this section were explored using qualitative analyses to explore the relationships between emergent themes that may link health status, life course descriptions and experiences and supports to access health services. Although there are not specific 'hypotheses' reflecting specific relationships, there is the anticipation that qualitative analyses would reflect relationships linking African American women's (a) physical health and well-being; (b) mental/emotional health and well-being; and (c) metabolic conditions and related risk factors); their health care including: (a) insurance access, and (b) health care service source; and family status/family factors structures and experiences across the life course including: (a) Family Structure (i.e., household composition including parent marital status, and the number of siblings); and (b) Family Resources including Family and Parental Economic Capital (i.e., income, education, employment, insurance coverage; and their health resource and service needs).

Setting. This research project was conducted at the East District Family Resource Center (FRC) located in Richmond, Virginia's East End community.

Design and Recruitment Sampling. This study utilized a cross-sectional research design that is exploratory, descriptive and retrospective. This study employed a probabilistic sampling

approach - simple random sampling which enabled us to (1) study a subset of the larger East District Family Resource Center population, which contains perspective participants who can be easily identified, and (2) generalize the results from the samples back to the entire population. A final sample of 12 African American female clients were recruited from among the five hundred and three (503) individuals who accessed East District Family Resource Center (FRC) services during the 2009 calendar year, and the period of January 1, 2010 through November 17, 2010.

Data collected by the FRC staff as a part of the client-screening and intake process for all individuals accessing services at the FRC Center were analyzed to identify African American female health and non-health resource seekers. Based upon client ratings of perceived levels of health functioning, a study population of 267 African American women who accessed FRC for physical health and other services (i.e., non-physical health seekers) were identified. The researcher/project coordinator identified a list of 96 potential African American female clients (17 health service seeking and 79 non-health service seeking) participants.

Given the small number of FRC physical health seekers identified during the study period, 100% of these individuals were included in the study. A randomly-selected sample (every 4^{th} individual) of non-physical health seekers was identified. Ninety-six letters were mailed to both sample populations, to inform them of the study, and that the researcher/project coordinator may be contacting them to determine their interest in participating in the study. The Research Project Coordinator mailed a letter (See Appendix 8) to the home of each woman on the list from the Project Investigator to inform her of the study, and that the research project coordinator may contact her to determine their interest in participating in the study. They were also informed that they could call the researcher/project coordinator and/or the principal investigator if they were interested in participating in the study.

The project coordinator contacted each client on the list and identified female clients who were amenable to participating in the project. There was no pressure to participate and there were no adverse effects in treatment based upon refusal to participate. The project coordinator thoroughly informed the client participant about the project, read and obtained their verbal consent to participate, and scheduled an interview.

The initial mailing and outreach resulted in the completion of eight first-round interviews. Due to the series of challenges identified in contacting individuals from the initial client list, FRC data for the September 1, 2010 through November 17, 2010 period was collected and analyzed to support recruitment of additional participants. Again, given the small number of FRC physical health seekers identified during this expanded study period, and consistent with the initial sample selection strategy, 100% of these individuals were included in the study. A randomly selected sample (every 2nd individual) of non-physical health seekers was identified. Eleven letters were mailed to both the health and non-health sample populations to inform them of the study. All clients interested in participating were scheduled for an interview at their convenience - days, evenings or weekends and interviews were conducted at the East District Family Resource Center site, located in Richmond's East End community, to ensure maximum convenience, comfort and accessibility for participants. After recruiting and conducting four (4) additional interviews for a total of twelve interviews, saturation - (the point at which no new information is revealed that could shed insight on the research study issues under investigation) was reached (Glaser & Strauss, 1967), and no additional participants were recruited for interviews.

Interview Protocol and Measures. All participants participated in a "Life Story" interview protocol consisting of a structured component, (i.e., the completion of three short self-

administered surveys: a Demographic Profile to collect relevant information such as age, race/ethnicity, socio-economic status, family composition, employment status; Health Status Survey focusing on their current health status; and the SF 36 Health Survey, an eight scale profile of functional health and well-being), as well as an unstructured component comprised of a list of interview questions from Harvard University's 1982 Intergenerational Studies Life Review (i.e., open-ended questions that query participants about their family composition, service needs, service agencies routinely accessed, and social supports), presented in Appendix 12.

SF (Short Form) 36 Health Survey. The SF (Short Form) 36 Health Survey was utilized to measure current health status. It is comprised of 36 questions which aggregate into an 8 scale (physical functioning, role-physical, bodily pain, general health, vitality, social functioning, role-emotional, mental health) profile of functional health and well-being, which further aggregates into physical and mental health summary measures. Thirty-five of the thirty-six SF36 questions are used to score the eight scales, and one question is a self reported health transition rating (i.e. a comparison of current general health status to the prior year).

In more than twenty-five studies, the reliability of SF 36's eight scales and two summary measures have been demonstrated to have exceeded the minimum standard of alpha equal or greater than 0.70, with most exceeding 0.80. Similarly, SF 36 studies of validity have yielded content, concurrent, criterion, construct, and predictive evidence of validity. The SF 36 is a generic measure, as opposed to one that targets a specific age, disease, or treatment group, which can be administered in 5-10 minutes. It was interviewer administered.

Health Status Survey. The Health Status Survey was utilized to measure study participant's current health status on several metabolic conditions. The survey is a compilation of

questions drawn from the Behavioral Risk Factor Surveillance System (BRFSS), established in 1984 by the Centers for Disease Control and Prevention (CDC). The BRFSS is the world's largest, on-going telephone health survey system, tracking health conditions and risk behaviors in the United States yearly since 1984. Currently, data are collected monthly in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam.

The survey questions were drawn from the BRFSS surveys administered in 1996, 2000, 2005, 2007 and 2010 BRFSS and focus on the following metabolic conditions and/or risk factors consistent with those most frequently evidenced by Black women: cardiovascular health, hypertension, diabetes, cancer, exercise, nutrition, weight control. In addition, the survey contains two questions from the 2010 Stony Brook University Center for Survey Research on prescription and/or medical non-compliance due to affordability, and perception of quality of care based on income level.

Harvard University's 1982 Intergenerational Studies Life Review Survey. The final part of the interview protocol consisted of open-ended questions that queried participants about their family composition, service needs, service agencies routinely accessed, and social supports drawn from the Harvard University 1982 Intergenerational Studies Life Review surveys (See Appendix 13).

The Intergenerational Studies (IGS) structured interview survey tool was selected because of the breadth of the domains addressed by the questions (i.e., questions regarding family of origin, family of procreation, spouse and marital relations, work and money), combined with the current and retrospective perceptions components (i.e., self, friendships, social involvement, and health) enabled the researcher to examine both proximal and distal contexts as a backdrop for our understanding of individual life course pathways that impact

adulthood health outcomes. The IGS tool was not utilized in total, questions were selected from it that would provide information on the study domains. We abbreviated the survey instrument to include questions from multiples IGS studies, which would enable us to collect information pertinent to the study domains (e.g., family status, structure and resources, respondent status, life course events and turning points).

The 1982 Intergenerational Studies (IGS) interview tool had been utilized with adult participants from three separate on-going longitudinal studies - the Berkeley Growth Study (GS - initiated in 1928 with healthy infants born 9/28 and 5/29), the Berkeley Guidance Study (BGS- initiated in 1929 with families with a 21 month old child), and the Oakland Growth Study (OGS- initiated in 1932 with 5th and 6th graders and their families), all designed to study normal development.

The purpose of the IGS longitudinal studies was to "study the course of adolescent personality development and change, and their relationship to adjustment in later life". The IGS goal was to "document age trends and individuals consistency, and illuminate factors associated with group and individual stability or change".

IGS data was collected in three waves - Adult Wave I (342 participants) in 1958-1959 & 1965, Adult Wave II (253 participants) in 1969-1971, and Adult Wave III (298 participants) in 1982. "Former BGS participants were 35-36 years of age during the first adult IGS follow-up, and were 54 years old when followed up a second time during Adult Wave III. Former GS participants were 30 years of age at Adult Wave I, participated in Adult Wave II at 41 years of age, and concluded their Adult Wave III interviewing at age 54. Former OGS participants began the IGS study between age 37 and 38. By Adult Wave II, participants had reached 48-49 years of age. Finally, former OGS participants were the oldest of the IGS participants during Adult Wave

III at 61-62 years of age. The IGS sample consisted of predominantly White Americans of varied socio-economic status."

While the IGS participant population is different from that of the proposed research study, the nature and scope of the interview tool is particularly appropriate for a life course study, and will provide further insight through a comparison of the study results with the IGS findings.

Interview Procedure. Both quantitative and qualitative data was collected from the sample of 12 African American women during November 2010. The researcher/project coordinator, an African American female, conducted all interviews. All qualitative study procedures were reviewed and approved by the Virginia Commonwealth University's Institutional Review Board. Prior to the interview, the project coordinator provided all client participants with, read and request the signing of a consent form explaining the purpose and importance of the project, participants' rights, how the data will be used, confidentiality and privacy protections, and the phone numbers and e-mail address of the principal investigator for questions and concerns about the study. Client participants were informed that their participation in the study was completely voluntary and that they could stop the interview process and refuse to participate at any time. Also, they were informed that their identity would be protected (i.e., use of identification code numbers rather than names) and all information would be kept confidential in a secure place with access available only to the researcher and principal investigator. The consent form was written at a 6^{th} grade reading level and was read to each participant prior to signing. A copy of the Research Participant Information and Consent Form is included in Appendix 9.

The researcher/project coordinator conducted 1.5 to 2 hour semi-structured interviews in a one-on-one, face-to-face format to ensure the maximum confidentiality of the participant. Audio taping of the interviews was requested and approved by all clients. A written record of observations and responses were be captured by the project coordinator.

All participants completed the self administered SF-36 Health Survey; and Demographic Profile (See Appendix 10), and the researcher/project coordinator administered the Health Status Survey (See Appendix 11), and interview protocol compiled from the Harvard University's 1982 Intergenerational Studies Life Review, presented in Appendix 13. The surveys took approximately 10-20 minutes to complete and the interview would took approximately 1.5 to 2 hours. However, additional time may have been required for the completion of the survey, if, due to literacy, the survey had to be read to the participant. As a result the maximum amount of time for the completion of both the survey and the interview was 1.5 to 2 hours.

As an incentive for participating in and completing the study, each participant received $40.00.

Data Analyses

Qualitative data was coded to allow the utilization of both quantitative and qualitative data analysis techniques. The self-administered survey data were coded and entered into SPSS. Descriptive and inferential statistics were utilized to examine relationships between variables and describe the data.

Audio tapes of the individual interviews were transcribed, and the data was coded and analyzed using the NVIVO9 software package (N9: QSR International, 2005) software designed for qualitative analysis. Each transcript was read and coded. In addition to the researcher/project

coordinator, three (3) coders trained in qualitative principles and methods, including coding and NVIVO 9 software utilization assisted with coding of the transcripts.

Level 1 initial coding categories were developed by the researcher/project coordinator based upon a review of all of the interviews conducted, juxtaposed against the research study focus areas in order to identify discrete themes, and define the larger domains they represent. These research study areas included: (1) the three targeted aspects of adult health: (a) physical health and well-being; (b) mental/emotional health and well-being; and (c) metabolic conditions and related risk factors); (2) two aspects of health care: (a) insurance access; and (b) health care service source; and (3) two aspects of family status/family factors across the life course: (a) Family Structure (i.e., household composition including parent marital status, and the number and birth order of siblings); and (b) Family Resources including Family and Parental Economic Capital (i.e., income, education, employment, insurance coverage). Next, the researcher/project coordinator reviewed the themes and domains with two members of the coding teams. Fifteen (15) domains were identified and defined (See the Qualitative Data Codes and Definitions attached).

First level coding was executed by the researcher/project coordinator and coding team members. Two member teams were established. Issues regarding the data coding were discussed by the researcher and the coders and decision rules were developed. All coders wrote analysis memos in the manner suggested by Erwin, Meyer, and McClain (2005) that discussed their rationale for coding or labeling text. Theme names that reflect coded text were developed, and definitions for the themes were written that were consistent with the text coded for that theme. Negative cases, or coded text that did not fit with the themes that emerged would be discussed

during the follow-up interviews, if warranted. Coding was refined through the process of constant comparison, recoding, and memos (Huberman & Miles, 2002).

Interviews were randomly assigned to each team for coding, such that each team member would first code the same interview; and have it checked for the level of agreement prior to proceeding to code the remaining three interviews assigned to them. This strategy was undertaken in order to reduce the likelihood of individual-level bias in producing results. Between-coder agreement on a random sample of 25% of the twelve (12) research study transcripts revealed an average coder agreement for each coding category of 92.45%.

Qualitative Study Results. Twelve qualitative interviews were conducted with African American women who accessed services at the Family Resource Center in order to provide a better understanding of the ecological and life course experiences that have led to and/or support the present level of African American women's health service needs, and reported health status; and the impact of health policies experienced by African American women over their life course that support their current levels of need and health status.

In the following section, a summary and descriptive overview of information from the life course review is presented, followed by analysis of the qualitative data.

Demographic Profile Data Summary. The majority of the twelve interview respondents were ages 22-44 years (63.6%), with the largest age group being 34 years of age (18.2%) (See Table 22 for a list of ages). The overwhelming majority of the respondents are single (58.3%), with 25% having completed some high school, 25% high school graduates, and 25% having completed some college. Fifty percent of the respondents are employed either full-time or part-time, and 41.7% are unemployed. One half of the respondents earn $200 to $11,200 annually, and the other half earn between $12,000 and $27,500 annually. The majority of the respondents

rent their homes (91.7%), with 58.3% having lived in the community from 1-5 years. Relatives reside with 41.7% of the respondents, while 66.7% of them have 1 to 4 children. A little over eighty-three percent of the respondents reported having good versus fair health. Twenty-five percent of the women have no health insurance, and fifty percent have Medicaid coverage (See Tables 22- 32).

Table 22

Age

	Frequency	Percent
22	1	9.1
27	1	9.1
29	1	9.1
34	2	18.2
40	1	9.1
43	1	9.1
44	1	9.1
46	1	9.1
48	1	9.1
50	1	9.1
Total	11*	100.0

Note: *Excludes missing data (1)

Table 23

Education

	Frequency	Percent
High School Graduate	3	25.0
GED	2	16.7
Some College	3	25.0
College Graduate	1	8.3
Total	12	100.0

Table 24

Martial Status

	Frequency	Percent
Single	7	58.3
Divorced	3	25.0
Separated	1	8.3
Cohabitating (Never Married)	1	8.3
Total	12	100.0

Table 25

Employment Status

	Frequency	Percent
Unemployed	5	41.7
Employed Full time	2	16.7
Employed Part time	4	33.3
Self-employed	1	8.3
Total	12	100.0

Table 26

Annual Income

	Frequency	Percent
$200	1	8.3
$1206	1	8.3
$1600	1	8.3
$8004	1	8.3
$8088	1	8.3
$11208	1	8.3
$12000	1	8.3
$16488	1	8.3
$21000	1	8.3
$23000	1	8.3
$26000	1	8.3
$27500	1	8.3
Total	12	100.0

Table 27

Health Status

	Frequency	Percent
Good	10	83.3
Fair	2	16.7
Total	12	100.0

Table 28

Health Care Coverage

	Frequency	Percent
Medicaid	6	50.0
Medicare	1	8.3
Private insurance	2	16.7
No insurance	3	25.0
Total	12	100.0

Table 29

Housing

	Frequency	Percent
Own	1	8.3
Rent	11	91.7
Total	12	100.0

Table 30

Length of Residency in Current Community

	Frequency	Percent
Less than one year	1	8.3
1-5 years	7	58.3
6-10 years	1	8.3
11-15 years	1	8.3
21-25 years	1	8.3
25-29 years	1	8.3
Total	12	100.0

Table 31

Number of Related Children

	Frequency	Percent
0	4	33.3
1	2	16.7
1.50	1	8.3
2	1	8.3
3	2	16.7
4	2	16.7
Total	12	100.0

Table 32

Relatives Living at Home

	Frequency	Percent
Yes	5	41.7
No	7	58.3
Total	12	100.0

A review comparing the demographics of the health-service-seeking in contrast to non-health service-seeking samples (5 health, 7 non-health respondents) drawn from the total population of 267 African American women who accessed FRC services during the study period reveal the demographic and health portrait outlined below.

The majority of the health sample (5 respondents) were single (40%), aged 22-40 (60%), had completed some college (40%), were unemployed (40%), rent their homes (100%) and have an annual income of $11,208 (60%). Comparatively, the majority of the non-health sample (7 respondents) was single (71.4%), aged 29-43 years (66.7%), has completed high school (42.9%), is unemployed (43.9%), rent their homes (85.7%), and has an annual income of $12,000 (57.1%) (See Tables 33 – 40 below). Comparatively, the larger FRC population and study samples, are primarily comprised of single unemployed women who have completed high school and some college, rent their homes, and have low annual household incomes. The majority of the larger population has no health insurance, while the majority of the sample respondents have Medicaid coverage.

Table 33a

Age

Health Sample	Frequency	Percent
22	1	20.0
27	1	20.0
40	1	20.0
46	1	20.0
50	1	20.0
Total	5	100.0

Table 33b

Age

Non-Health Sample	Frequency	Percent
29	1	16.7
34	2	33.3
43	1	16.7
44	1	16.7
48	1	16.7
Total	6*	100.0

Note: *Denotes missing data (1)

Table 34a

Education

Heath Sample	Frequency	Percent
Some High School	1	20.0
GED	1	20.0
Some College	2	40.0
College Graduate	1	20.0
Total	5	100.0

Table 34b

Education

Non-Heath Sample	Frequency	Percent
Some High School	2	28.6
GED	3	42.9
Some College	1	14.3
College Graduate	1	14.3
Total	7	100.0

Table 35a

Martial Status

Health Sample	Frequency	Percent
Single	2	40.0
Divorced	1	20.0
Separated	1	20.0
Cohabitating (Never Married)	1	20.0
Total	5	100.0

Table 35b

Marital Status

Non-Health Sample	Frequency	Percent
Single	5	71.4
Divorced	2	28.6
Total	7	100.0

Table 36a

Employment Status

Health Sample	Frequency	Percent
Unemployed	2	40.0
Employed Part time	3	60.0
Total	5	100.0

Table 36b

Employment Status

Non-Health Sample	Frequency	Percent
Unemployed	3	42.9
Employed full time	2	28.6
Employed part time	1	14.3
Self-employed	1	14.3
Total	7	100.0

Table 37a

Annual Income

Health Sample	Frequency	Percent
$200.00	1	20.0
$1600.00	1	20.0
$11208.00	1	20.0
$23000.00	1	20.0
$26000.00	1	20.0
Total	5	100.0

Table 37b

Annual Income

Non-Health Sample	Frequency	Percent
1206.00	1	14.3
8004.00	1	14.3
8088.00	1	14.3
12000.00	1	14.3
16488.00	1	14.3
21000.00	1	14.3
27500.00	1	14.3
Total	7	100.0

Table 38a

Housing

Health	Frequency	Percent
Rent	5	100.0

Table 38b

Housing

Non-Health Sample	Frequency	Percent
Own	1	14.3
Rent	6	85.7
Total	7	100.0

Table 39a

Health Care Coverage

Health Sample	Frequency	Percent
Medicaid	2	40.0
Private Insurance	1	20.0
No insurance	2	40.0
Total	5	100.0

Health Sample	Frequency	Percent
Medicaid	2	40.0
Private Insurance	1	20.0
No insurance	2	40.0

Table 39b

Health Care Coverage

Non-Health Sample	Frequency	Percent
Medicaid	4	57.1
Medicare	1	14.3
Private Insurance	1	14.3
No insurance	1	14.3
Total	7	100.0

Table 40a

Health Care

Health Sample	Frequency	Percent
Private Doctor	4	80.0
Other	1	20.0
Total	5	100.0

Table 40b

Health Care

Non-Health Sample	Frequency	Percent
Free Clinic	1	14.3
Private Doctor	5	71.4

A review of self-reports on perceived health status from the two samples revealed that the significant number of both samples rate their health as good (health=80%; non-health=57.1%). Respondents utilize Medicaid (health=40%; non-health=57.1%) for their health care to access private doctors (health=80%; non-health=85.7%). Neither sample reported having the following metabolic conditions: myocardial infarction, coronary heart disease, or stroke. None of the health sample and only one of the non health population reported having diabetes and cancer. However, forty-percent of the health sample, and twenty-eight percent of the non-health sample reported having high blood pressure, and one health sample member reported having cancer.

Of particular note is the fact that 100% of the health sample and 71.4% of the non-health sample participate in physical activities or exercises; and 100% of the health sample and the majority of the non-health sample (42.9%) are using physical activity or exercise to lose weight or keep from gaining weight. The overwhelming majority of the health sample (80%), and many of the non-health sample (42.9%) are trying to lose weight, and are eating either fewer calories or less fat to lose weight (health=80%; non-health=85.7%) to accomplish the goal.

Table 41a

General Health: What would you say that your general health is?

Health Sample	Frequency	Percent
Very Good	1	20.0
Good	3	60.0
Fair	1	20.0
Total	5	100.0

Table 41b

General Health: Would you say that your general health is?

Non-Health Sample	Frequency	Percent
Excellent	1	14.3
Good	3	42.9
Fair	3	42.9
Total	7	100.0

Table 42

Diabetes: How old were you when you were told you have diabetes?

Health Sample	Frequency	Percent
Not Diabetic	5	100.0

Table 43

Diabetes: Have you ever been told by a doctor that you have diabetes?

Non-Health Sample	Frequency	Percent
Yes	1	14.3
No	6	85.7
Total	7	100.0

Table 44a

Heart Attack/Myocardial Infraction: Has a doctor, nurse, or other health professional ever told you had a heart attack, also called a myocardial infraction?

Health Sample	Frequency	Percent
No	5	100.0

Table 44b

Heart Attack/Myocardial Infraction: Has a doctor, nurse, or other health professional ever told you had a heart attack, also called a myocardial infraction?

Non-Health Sample	Frequency	Percent
No	7	100.0

Table 45a

Coronary Heart Disease: Has a doctor, nurse, or other health professional ever told you angina or coronary heart disease.

Health Sample	Frequency	Percent
No	5	100.0

Table 45b

Coronary Heart Disease: Has a doctor, nurse, or other health professional ever told you angina or coronary heart disease.

Non-Health Sample	Frequency	Percent
No	5	100.0

Table 46a

Stroke: Has a doctor, nurse, or other health professional ever told you had a stroke? .

Health Sample	Frequency	Percent
No	5	100.0

Table 46b

Stroke: Has a doctor, nurse, or other health professional ever told you had a stroke?

Non-Health Sample	Frequency	Percent
No	6	85.7
Missing Data	1	14.3
Total	7	100.0

Table 47a

High Blood Pressure: Have you ever been told by a doctor, nurse, or other health professional that you have high blood pressure

Health Sample	Frequency	Percent
Yes	2	40.0
Yes (during pregnancy only)	1	20.0
No	2	40.0
Total	5	100.0

Table 47b

High Blood Pressure: Have you ever been told by a doctor, nurse, or other health professional that you have high blood pressure

Non-Health Sample	Frequency	Percent
Yes	2	28.6
No	4	57.1
Missing Data	1	14.3
Total	7	100.

Table 48a

Cancer: Have you ever been told by a doctor, nurse, or other health professional that you had cancer

Health Sample	Frequency	Percent
Yes	1	20.0
No	4	80.0
Total	5	100.

Table 48b

Cancer: Have you ever been told by a doctor, nurse, or other health professional that you had cancer

Non-Health Sample	Frequency	Percent
No	7	100.0

Table 49a

Physical Activity: During the past month, did you participate in any physical activities or exercises such as running, calisthenics, gold, gardening ,or walking for exercise?

Health Sample	Frequency	Percent
Yes	7	100.0

Table 49b

Physical Activity: During the past month, did you participate in any physical activities or exercises such as running, calisthenics, gold, gardening ,or walking for exercise?

Non-Health Sample	Frequency	Percent
Yes	5	71.4
No	2	28.6
Total	7	100.0

Table 50a

Weight Loss: Are you trying to lose weight?

Health Sample	Frequency	Percent
Yes	4	80.0
No	1	20.0
Total	5	100.0

Table 50b

Weight Loss: Are you trying to lose weight?

Non-Health Sample	Frequency	Percent
Yes	4	57.1
No	3	42.9
Total	7	100.0

Table 51a

Weight Loss: Are you using physical activity or exercise to lose weight or keep from gaining weight?

Health Sample	Frequency	Percent
Yes	4	100.0

Table 51a

Weight Loss: Are you using physical activity or exercise to lose weight or keep from gaining weight?

Non-Health Sample	Frequency	Percent
Yes	4	57.1
No	3	42.9
Total	7	100.0

Table 52a

Weight Loss: Are you eating few calories or less fat to lose weight or to keep from gaining weight?

Health Sample	Frequency	Percent
Yes, fewer calories	1	20.0
Yes, less fat	2	40.0
Yes, fewer calories and less fat	1	20.0
No	1	20.0
Total	5	100.0

Table 52b

Weight Loss: Are you eating few calories or less fat to lose weight or to keep from gaining weight?

Non-Health Sample	Frequency	Percent
Yes, fewer calories	2	28.6
Yes, less fat	3	42.9
Yes, fewer calories and less fat	1	14.3
No	1	14.3
Total	7	100.0

Qualitative Summary

The following section summarizes the qualitative information compiled from the twelve interviews. The section initially provides a brief overview of the coding approach, identified themes, with a specific focus and deeper description of themes relevant to 'clusters' of the study domains (i.e., groupings of related themes and qualitative coding nodes based upon the

theoretical relevance and preliminary linkages between these themes that are important to the central qualitative questions). The section further provides descriptive information examining respondent comments organized according to the study domains. The number of respondents who mentioned prominent themes, similar issues or perspectives are noted in parentheses within the text**.**

Coding

Level 1 initial coding categories were developed by the researcher/project coordinator based upon a review of all of the interviews conducted, juxtaposed against the research study focus areas in order to identify discrete themes, and define the larger domains they represent. These research initial study domains included: (1) the three targeted aspects of adult health: (a) physical health and well-being; (b) mental/emotional health and well-being; and (c) metabolic conditions and related risk factors; (2) two aspects of health care: (a) insurance access; and (b) health care service source; and (3) two aspects of family status/family factors across the life course; Structure (i.e., household composition including parent marital status, and the number and birth order of siblings); and (b) Family Resources including Family and Parental Economic Capital (i.e., income, education, employment, insurance coverage). Next, the researcher/project coordinator reviewed the themes and domains with two members of the coding teams. Fifteen final themes (i.e., first-level qualitative coding categories or nodes) were identified and defined as follows: parents and parenting relationship, siblings, family health history, family of procreation, family of origin resources, insurance access, respondent status, social and religion status, mental emotional health and well-being, health care access/service sources, physical well-being, metabolic conditions, development and life course review, and resilience (See Appendix 3: Qualitative Data Codes and Definitions).

Study Themes & Domains

Level-one themes were clustered into study domains in order to better facilitate the exploration of the relationships between construct and themes delineated within the study questions. The clustering of theoretically relevant coding themes will enable us to more accurately analyze and integrate findings pertinent to each question.

1. Family Status & Structure: This cluster brings together the set of basic coding themes to address, link and integrate respondents' descriptions of their parents and families of origin. The level one codes linked include: family structural and relational nodes including Parental Status (e.g., parents' marital status, parent/child relationship); Siblings (e.g., birth order, relationship with siblings); Family of Origin Resources (e.g., employment, education, and income). This clustering of themes is supported by an extensive body of research (e.g., Werner 1992, Elders 1974), that establishes and elucidates the association between childhood and developmental family contexts and adulthood outcomes.
2. Respondent Status: This cluster is comprised of basic coding themes that were designed to address, link and integrate respondents' descriptions of their lives. The level one codes linked include: Family of Procreation (e.g., offspring, marital/current relationship); Insurance Access (e.g., insurance coverage); Mental Emotional Health and Well-being, Physical Well-Being/Health, excluding metabolic conditions; Health Care Access (e.g., health resources routinely accessed); Social Status, Religion & Social). The development of this cluster is supported by research (e.g., Adler et al., 2005), that has identified an association between individual level socioeconomic demographics and adult health outcomes.

3. Development and Life Course Review**:** This cluster is comprised of basic coding themes that were designed to address, link and integrate respondents' descriptions of major turning points, stressful life events, abuse, and incarceration, and life periods of most and least satisfaction that they may have experienced in their lives. This cluster is supported by research (e.g. Werner, 1992; Elders 1974), that support and highlight the association between turning points, stressful life events, and adulthood outcomes.
4. Metabolic Conditions and Health: This cluster is comprised of basic coding themes that were designed to address, link and integrate respondents' descriptions of their parent's and family of origin's incidence of metabolic conditions; and respondent's mental and physical health status. This cluster is supported by research that supports and establishes associations between family history and health conditions (e.g., Palmer, et al., 2007), and incidence of metabolic conditions among Black women (Black Women's 1995-2009; Ervin, 2009).
5. Social Status & Religion: This cluster is comprised of basic coding themes that were designed to address, link and integrate respondents' descriptions of their perceptions of being Black and female with implications for life and health. The cluster also integrates perspectives on membership in social categories with religious participation and experience. .
6. Resilience: This cluster is comprised of basic coding themes that were designed to address, link and integrate respondents' articulation of positive attitudes, as well as hopes and plans for the future. This theme is supported by research that elucidates the resiliency phenomenon (i.e., individual's ability to surmount life's disadvantages; Elder

1974), challenging perceptions that high risk individuals are destined to experience compromised and negative life outcomes (Werner 1992).

In the following section, each cluster or group of themes (i.e., coding nodes) is presented to provide a basic understanding of data relevant to those themes. After each cluster is presented, data from those groups of themes are integrated to explicitly respond to the central qualitative study questions.

Family Status and Structure. Critical to our understanding of an individual's "life story," is our understanding of the unique set of factors that affect their development and functioning. From an ecological perspective (Brofenbrenner 1979), the interrelationship between child, family, community and the larger society, is a central factor in our understanding of human development and is the point of departure for understanding human development.

This section was designed to provide insight into the role of respondent's family status and structure and supports our examination of its relationship or linkage to adult health outcomes. In order to accomplish this, respondents were asked a series of questions about their family of origin, including the nature and scope of their relationship with their parents, and descriptions of their parents' health, marital status and respondents' perceptions of their socioeconomic status while growing up and living at home (e.g., parents employment status, income, education, insurance coverage for parents and children). In addition, sibling relationships were examined, including exploration of the number of children in the family of origin, their sibling birth order, the nature and scope of the respondents' relationships with their brothers and sisters, as well as the role she played relative to her siblings (e.g., caretaker). These questions were examined to consider and deepen understanding of the role of family factors on participants' lives and general well-being. Questions to support this exploration were taken from

Interview Survey Questions: family of origin survey questions 1-14; family of procreation questions 1, 1-4; family & parental economic survey sections – 5 questions; family interaction section -1.

Nature of Parental Relationship. Of the seven respondents whose mothers are living, six indicated that they currently have a positive relationship with their mothers, and one respondent indicated a negative relationship with her mother. Of the eight respondents who indicated that their fathers are living, four respondents described that they have positive relationships with their fathers and four respondents indicated that they currently have negative relationships with their father.

At times, parental relationships, whether positive or negative, appeared to provide a role model or a 'negative example' for strategies in dealing with life. In most instances, respondents described making choices as to which parental characteristics they choose to embrace or reject. For example, one respondent provides her perspective on her father, indicating that:

> " ..one thing, he was a go-getter. He somewhat made things happen. He wasn't afraid to do anything, which I get that from. But other parts of him, he was more like, somewhat a hustler. As far as making money, like this, I don't mind putting in extra hours, trying to get done what I need to get done. I don't mind working. You know, I don't wait for the bandwagon to come to me, sometimes I go to the bandwagon. He was, uh, he was not a good person as far as uh, moral wise. I'll put it that way. He was not, his morals sucked. And with me, I think about the decisions I make, so I'm more conscious about those, of what I want to do, of what I decide to do. I'm not gonna do anything that's gonna hurt anybody if I can help it."

In contrast, the same respondent shared a different perspective on her mother and perceptions of the ways in which she is different from her parent:

> "she's kinda scared to take risks. I'm a risk taker. I'll step out there and take my chances. Um, she's more, wanna be comfortable, wants to make sure she has a security blanket. But other than that, she's a hard worker, I'm a hard worker. You know, we pursue our goals. Anything we want we try our best to get them"

Marital Status. One half of the respondent's parent's were unmarried (n=6), with one of those six indicating that her parents were divorced. Four respondents indicated that their parents are married. In comparison, the overwhelming majority of the respondents themselves (i.e., 11 out of 12) were unmarried. This finding suggests the need for further examination of generational differences between parent and respondent marital status.

Parental Education. One half of the respondents' mothers had some and/or completed high school. A significant number of mothers had some college and/or graduated from college. Overall, the respondents' mothers' educational attainment was higher than that of the fathers. Fewer of the respondents' fathers had some and/or completed high school, and only one had some college.

Employment. The mother's of almost half of the respondents were consistently employed throughout their lives with employment in the areas of customer service, manufacturing, housekeeping, nursing, and baking. Two respondents mothers' were homemakers, and three were inconsistently employed. Similarly, the fathers of almost half of the respondents were consistently employed throughout their lives in the areas of manufacturing, carpentry, merchant seaman, hospital services.

Siblings. Most frequently respondents described being a part of where they had been the youngest (5) child. An almost equal number of respondents (4) had been the oldest child in their family. The average number of children per home was four. The respondents who were the oldest child discussed having greater responsibilities in general, but this was especially true relative to the care of their siblings (e.g., baby sitting), and the respondents who were the youngest described being spoiled, and feeling like they were raised by their siblings. Respondent descriptions of their relationships with their siblings varied from relationships wherein they fought with each other as children and felt that they served as the family's baby. For example, one respondent noted, "As far as my sister over me, we fussed a lot. As far as my brother they just like spoiled me. My next older brother used to spoil me, used to take me to the circus, stuff like that." One respondent shared that while she was the youngest sibling, she was treated like the oldest child by her siblings. This is expressed in her comment below:

> "You know, you would've thought that I was the oldest. Because me being the youngest, they'd always come to me. Girl, could you do this, could you do that? give me this, give me that. You know? I was thinking I was the oldest. And other people said, you know, you take more responsibility than they do. So, it's...it's still like that".

In some cases, respondents described liking each other, but having their own separate friends", I mean, um, we love each other, we just really didn't hang. We wasn't real tight. They had they own friends and associates, and I had my own" and cases in which siblings themselves were best friends: Everything I do is with my brothers, sisters, kids. That's, we just gather together."

The majority of respondents (7) described being close to their siblings, while three (3) indicated that they have poor or no relationships currently.

Metabolic Conditions and Health. One half of the respondents (6) sought and received mental health counseling services. Respondents sought and received mental health counseling services for diverse life events ranging from physical or sexual abuse and drug addiction, to the death of a child. One respondent discussed her mental health treatment services to address conditions associated with childhood abuse: “Like, physical, mental, emotional, verbal, sexual (by maternal boyfriends).Yeah. I was diagnosed with schizophrenia, because of the abuse I had as a child”. It should be noted here that the linkage made between childhood abuse and schizophrenia is the respondent’s perspective of her life events. The respondent discussed that she continues to receive treatment and medication for her mental illness, “Yes, I got counseling and I'm on medications,” which allows her to care for her son, work and be engaged in a personal relationship. The respondent accessed her mental services in childhood and currently though her Medicaid coverage. Another respondent sought and received mental health services to deal with the death of her 7 week old daughter, which credited with possibly saving:” Um, when my daughter died. Um, for about, almost two years. You know, basically, it helped me, you know, to move on. Cause I was stuck. And it helped me. I don't know if would be here or not, that's how bad it was. To be honest, It was bad.” As a child, this respondent accessed health services through her mother’s insurance plan. While the respondent discussed that she currently accesses her health care through a private doctor, the source of her insurance is unclear.

Health versus Non –Health Group Samples

To explore potential differences across the family/parental cluster, basic comparisons were made between the health and non-health samples. These comparisons provide important perspective on consideration of the role of the life course in relation to health status and experiences.

Parental relationships. Three of the health group described their relationships with their mothers as being very supportive or good (e.g., “Good. Not as good with my father.”). One respondent further described the nature of her relationship with her father as, “I'm my father's first, only daughter”, while two described their relationships as fair or “tricky” (e.g., “Um, it's pretty tricky with my mom, but it's pretty smooth once I keep my distance”). Two of the health group described their relationships with their fathers as excellent or good, and two described having fair or poor relationships with their fathers.

Marital Status. Two of the non-health group respondents reported that their parents were married and four reported that they were unmarried. Half of the health group respondents reported that their parents were married. Respondent descriptions of parental marital status were diverse. One respondent’s described her parents’ status as “My parents have been married for 51 years. Still together”, and the other half (2) reported their parents as being unmarried (e.g., “Not too much. My mom and dad got divorced when I was 6, and that's it. That's all I know”; “I never met my father, so ...I don't know anything about him. She never told me too much about him, so”).

Parental Education. More health-group respondents (3) had parents with some college or parents who were graduates in comparison to the non-health seekers (1). More of the non-health seekers (4) reported that their parents had attained a GED or completed high school than the health seekers. Although studies have linked individual level SES-based on education, income, or occupation, and adult health outcomes (Adler et al., 1993), it could be informative to further examine potential linkages between parental education and respondent health outcomes.

Parent Employment. The parents of one half of the health seeker (3) group, and one half of the non health seeker group (4) were employed either full-, or part-time or were self-employed.

Siblings. One half of the health respondents reported poor sibling relationships and one half reported good sibling relationships. The majority of the non-health respondent group (6) reported having good sibling relationships.

Health Group Sample

There does not appear to be a link between health respondent's reports of parental relationships and their health service needs (e.g., use of mental health counseling). Respondents rated parental relationships almost equally. The quality of parental relationships do appear to impact the frequency of the respondent's ongoing contact with the parent as described in this respondent's comment, "poor relationship, I haven't talked to my father in, I'd say, a year and a half, going on two years." Similarly, the existence or non-existence of a relationship was sometimes based on parental behavior towards the individual, "It's good, cause it was non-existent, because, I had...I was really, I had um..I had a hard time forgiving him for what he tried to do, you know, incest. He tried to have sex with me."

There appears to be some relationship between the health group respondent's parents educational level and their seeking of health services (e.g., accessing mental health counseling). Health group respondents' parents educational levels are slightly higher, and fewer health respondents accessed health service needs. There appears to be no link between health group respondents' parents' marital status and their seeking of health services. There does not appear to be a relationship between parent employment and non-health respondent's seeking of health services.

Non-Health Group Samples

There appears to be a relationship between respondent reports of parent relationships (e.g., quality of the relationships with their fathers) and their seeking ofhealth services. The majority of non-health group respondents reported poor father relationships, and also sought and received mental health counseling.

Non-health group respondents' parents educational levels were slightly lower than health group respondents. This supports potential links between higher parent educational levels and lower respondent health service needs.

Respondent Status

Respondents were asked to discuss and describe their current (or former) employment/career status (e.g., employment status, current job and income if applicable, savings, and rating of present financial status) or experiences supporting that employment (e.g., education and training) ; immediate family, current marital status and/or relationship with a significant other, as well as the number of and nature of her relationship with any children produced; and nature and type of their insurance access during childhood and adulthood (Interview Survey Questions: respondent questions 1-17; military service questions 1-2 and health care access 1-8).

Marital/Current Relationship Status. Eleven of the 12 respondents indicated that they are not married, seven are dating or in current relationships, three are single, and one is divorced. Some respondents expressed sentiments regarding their marital/current relationship status with experiences ranging from a sense of loss, excitement, to despair: "Greatest man I ever came across in life." The respondent attributes her failed marriage to her immaturity (e.g., thinking that she could find someone with greater financial means than her husband). The respondent

continues to describe her ex-husband as great husband, father and grandfather. In contrast another respondent summarized: “Ain’t no good men around”. The respondent is not married and not currently in a relationship. As might be expected, respondents’ marital/current relationships have impacted their lives significantly, up to and including some seeking and receiving mental health services.

Employment. Nine respondents indicated that they have worked for pay over the last ten years. Seven respondents are currently employed or self-employed in positions such as customer service representative, security guard, custodian/housekeeper, hair stylist, and street cleaner. One occurring theme among several of the respondents was the desire to return to school to obtain credentials to enable them to start their own businesses in such areas as childcare/senior care center, cleaning business, and/or enter other career areas (e.g., health field).

Income. Respondent’s income sources were not mutually exclusive. Some respondents had one or more sources of income. Paychecks, disability payments (3 respondents) and welfare (2 respondents) were also sources of income. Nine of the respondents rated their feelings about their financial status as fair or poor, with only two indicating that it is good. The majority of the respondents (6) indicating that they had not amassed any savings.

Overall respondents shared their desire to improve their financial circumstances, and thus their lives (e.g., a desire for improved housing, access to health insurance).

Offspring. Respondents had an average of two children. All of the respondent’s offspring reside in the City of Richmond. The majority of the respondent’s offspring still live at home and attend public schools. Two respondents also have custody of their grandchildren. Three of the respondents have offspring who attend college, one is in the armed services, and one is in the juvenile justice system. Overall, respondents appear to have good relationships with

their offspring. One respondent credited her offspring with inspiring her to change her life of drug use.

Health Insurance & Access. During childhood, Medicaid was reported as the primary source of health insurance for many of the respondents (5). A smaller number of respondents' parents (3) had health insurance through their workplace, and several respondent families had no insurance. During adulthood, Medicaid or Medicare continued to be the primary source of health insurance for half of the respondents, with a quarter of the respondents having no insurance.

Historically, almost all respondents accessed local hospitals and private doctors. Currently, more respondents (5) indicate that they access the health care resources in the community, Vernon Harris Health Clinic (5), local hospitals (e.g., Richmond Community, or MCV), and private doctors in comparison to prior usage. A respondent's comment on health care access follows.

> "As far as health wise, I mean, it's pretty good that they have like, hospitals and clinics that's nearby that we can get easy access to, even without catching the bus. That's good, that's a good thing".

Education. Almost even numbers of respondents completed some high school, graduated high school, completed their GED (2), and some college. Only one respondent completed college.

Health versus Non-Health Group Samples and Implications

The largest number of health group respondents is single, range in age from 22-40, have completed some college or graduate school, are employed, and have an annual income of $11,208. In comparison, the majority of the non-health sample is also single, slightly older

(ranging in age from 29-43 years), appear to have lower levels of education (e.g., completed high school or GED), are also employed, and have similar annual incomes (average of $12,000).

The majority of both sample groups report their health status as being good. This may speak to the homogeneity of the sample groups, and perhaps a sample bias, as one would expect a significant variation between the groups. A larger number of the health group report having no health insurance in comparison to the non-health group. The majority of the non-health group respondents rely upon Medicaid to access their health care. The majority of respondents in both groups access their health care with private doctors. Both sample groups have approximately the same range of numbers of offspring, i.e. health, 1-4 children and non-health, 0-4 to offspring.

There does not appear to be a link between respondent's number of offspring, marital status, health status, health care access, or income and respondent's health service needs for either sample group.

There may be a relationship between respondent's education level and health insurance, health service needs for the non-health sample group. The majority of the women seeking health services such as mental health counseling are non-health respondents, and have a lower educational levels than the health sample group. The majority of the non-health group respondents utilize Medicaid for their insurance coverage, and are the majority of the sample population accessing health services.

Development and Life Course Review

Respondents were asked to discuss their overall growth and development throughout different developmental periods of their lives, including a description of each of those specific periods (e.g., childhood, adolescent years, ages 20 to 30, ages 30 to 40, their years since age 40). In addition, the women interviewed were asked to discuss: (a) the age periods in their lives that

brought them the most and least satisfaction; (b) any "turning points," where their lives took a different direction than expected, including discussions of the type, impact and timing of these significant changes in their lives; (c) any challenges (e.g., abuse, incarceration) that they have experienced; (d) changes that they would make if they could live their lives over; and, (e) any social, cultural or other factors that contributed to their accomplishments, success or failure . These questions were taken from the Interview Survey Questions: Life review questions 1-5; and 1-16.

Summary. This set of questions was posed to support a better and deeper understanding of the respondent's perspective and construction of key transitions and turning points they had experienced across their life span (Elders, 1974) as well as to provide specific insight into significant "stressful life events e.g., born and raised in poverty, experienced pre-or perinatal complications; divorce, marital discord, parental psychopathology" (Werner, 1992) that these women experienced. The goal of the questions was to provide insight into the respondent's experience of these events, the ways in which these events affected their development and their health, whether the participants managed to surmount life's challenges, and how these experiences may have affected the physical and emotional health of the study respondents.

All of the women interviewed were able to identify and describe some "turning points" in their lives, or some sort of major life event, that is, one or more experiences where their lives took a different direction than expected, and/or major challenges that significantly impacted their lives. The type of events varied, but seemed to cluster in two groups: (a) experiences reflecting significant changes in family composition or structure. These included: birth of a child (3 respondents), death of a child or parent (3 respondents), or separation/divorce (2 respondents). A second broad set of turning points involved traumas or personal challenges. These included: drug

abuse/addiction (3 respondents), abuse/incest (3 respondents), incarceration (3 respondents), and personal health/ illness (2 respondents). One respondent described the restoration of their religious and spiritual faith as a key life transition.

In the following section, each group of turning points is presented.

Birth of a Child. The participants described the birth of a child as a major life event that had both positive and negative effects on their lives. Four respondents articulated giving birth to a child as a turning point in their lives. While one respondent indicated that she didn't know that she was pregnant until her mother commented on her swelling stomach, she considered this to be a positive turning point in her life, especially in light of her current health condition, which probably would have precluded her having a child. The respondent considered her daughter's birth to have been an intervention by God, as she had taken precautions attempting to prevent a pregnancy. In her words, "I didn't even know I was pregnant with her. My mother told me. I wasn't expecting it at all, because me and her dad took every precaution. Or, we thought we did. Actually, God just wanted her here."

For another respondent, becoming pregnant before the death of her grandmother was a proud moment, because her grandmother could see her "become a woman" before she passed. After her grandmother's passing, this respondent was motivated to be a great mother, in the hopes of not letting anyone down.

In both instances, having a child was a positive turning point in the respondent's life. The births were a source of pride and inspiration for both respondents: providing inspiration for better parenting for one, and inspiration in the face of a lifelong debilitating illness (neurofibromatosis) for the other respondent. These respondent comments serve as examples and insights into diverse nature and impact of a "child birth" turning point.

Death of a Parent or Child. Three respondents described deaths in their families as a major turning point in their lives, with responses indicating that these losses resulted in responses that set in motion sequences of life course experiences that linked rebelliousness and drug use to treatment and seeking therapy. One respondent who experienced the death of her mother at the age of 17, connected this experience to a life trajectory that included drug usage and ultimately entering a treatment center.

> "I didn't care about nothing or nobody, after that. I just, became rebellious. Then I had to move with my father, so I became rebellious against him, so then I had to leave out of his home at the age of 18, because he wasn't gonna put up with me like that. So, after then, I was just, you know, running the streets. Did all kinds of things, tried different kinds of drugs, and, um, after that, a couple years down the line, I went into a treatment center, and got myself together."

A second respondent described the loss of her infant child

> "When I was...40, 41. When my daughter died, things just changed. You know.....she was doing really really good. And she was 7 weeks of age. And then you know, I had just left from seeing her, and MCV called me that night and told me to come back to the hospital. She had caught the intestinal disease. And I was so upset. I was, because I felt that this hospital is dirty. Why is this hospital the only one that's having this disease?"

In both instances, the death of a loved one had devastating and debilitating impact on the respondent. In the first instance, the loss of a parent, it is important to note the age of the respondent (17) at the death of her mother, and her perception of her mother as having been very supportive of her. The respondent commented that "I didn't care about nothing or nobody, after that (i.e., the death of her mother). She also described having a poor relationship with her father.

The respondent's parental relationship is a key factor to be considered in understanding her life trajectory of drug use and treatment. The respondent's father's response to her rebelliousness after the death of her mother was to put her out of the house at 18. More reflective consideration of the impact of this significant life event on his daughter, and the seeking of mental health services for her, might have resulted in a different trajectory for her.

In the second instance, the death also resulted in the respondent seeking therapy. She described her situation as follow: "Um, when my daughter died. Um, for about, almost two years (therapy). You know, basically, it helped me, you know, to move on. Cause I was stuck. I don't know if would be here or not, that's how bad it was. To be honest. It was bad". In this case, the respondent clearly conveys the role of mental health services in possibly saving her life, and enabling her to continue to life a productive and meaningful life.

Abuse/Incest. Four respondents indicated the experience of some form of abuse or incest, which they identified as a turning point in their lives. These respondents did not discuss the abuse, experienced during their childhood, while they were children. Each respondent waited until she reached adulthood to share her experiences, either with family or a counselor. Abuse/incest was experienced and reported by respondents in both sample groups (i.e., health and non-health).

Drug Use/Addiction. Three respondents attributed abuse of and addiction to illicit drugs as a turning point. In all three cases, there was an acknowledgement that they turned to drugs as a means of dealing with their personal life circumstances (e.g., break up of a marriage, death of a parent). Respondent comments describe the nature and scope of their drug/addiction and the resultant impact as follows: crime and incarceration,"..my addiction. First it was the embezzlement, cause I needed some money. Then it started with the stealing...thing I would

never do out of the norm. I went to the penitentiary. I bypassed the jail." Another described a 15-year heroin addiction, as resulting from a loveless 26-year marriage, "I turned to that as a support, because it didn't allow me to feel anything."; and the demise of relationships i.e., marriage - "I left my husband for this other man. You understand, I had the drugs, yes. Yeah, that was a major break up, a blow".

Incarceration. Three (3) respondents attribute incarceration as a turning point in their lives. One respondent was incarcerated for drugs, and at the time she "wasn't taking care of myself. [She] wasn't being a good parent. That was like a really turning point." She is glad for her incarceration, because she attributes it to the reason she is alive today. Another was incarcerated due to check fraud, a symptom of her personal drug use. In her own words, "I wasn't clearly thinking, because of the drug use, but if I was thinking clearly they would have never put my name on the check, therefore I would have never went to jail for that. So they kind of coincide with each other to shut it down to get my attention."

A review revealed that most cases of incarceration were linked to drug usage, present in both the health and non-health groups. In the several of the cases, the respondent's drug usage resulted in a trajectory including criminal activity that often led to incarceration. Further, respondent's reported that their drug usage sometimes negatively impacted their family relationships, characterized by respondent's comment: "yeah, I was like the black sheep", about her families' perception of her during her period of drug usage.

Personal Health/Illness. The two respondent's comments in this section provide us with insight into the impact of biological and psychological turning points, and the associated outcomes. Here, the two respondents viewed their personal health and/or illness as a turning point in their life course. According to one respondent, her health was a "big turning point" at

age 12, when was diagnosed with schizophrenia…because of the abuse [she] had as a child." Another respondent described her health as a turning point, beginning at age one, when was diagnosed with neurofibromatosis. Since her diagnosis, she has spent her entire life enduring hospital visits and surgeries.

Separation/Divorce. Two health and two non-health group members described separation or divorce as a major tuning point in their lives. It is also important to note here that the majority of the sample population was unmarried, while more of their parents were married. One respondent attributes one turning point to her parents' divorce, while another attributed the catalyst of her turning point to her own separation. In the words of the first respondent, her parents' divorce meant loss of both stability and income, "I think that really took me in a different direction from when my mother and my father was together, we had more stability because my father had most of the income." Following the divorce, this respondent and her family struggled economically and she felt as if she carried more responsibility than she could handle at her age:

> And, um, when that happened, it...I guess it was a turning point because we were here, we were there. We had to help our mom a lot more. Um, and just, me acting out. And, the environment we lived in. So, it took me, instead of, what I see myself as being, or could have been. I mean it just took me out of school, instead of graduating from high school, I'm getting a GED. Um, you know...being locked up.

Restored Faith/Life Change. One non-health group respondent describes, and attributes the effectuation of her turning point, restored faith and a changed life, to her 11 year old son, as evidenced by her comment

> "Yeah, I said September 10, 2006, me and my son we got baptized together, and my life hasn't been the same since then" (drug usage, broken marriage). "You know, I was baptized as a child and I never was sure. So I said, well of course it was. I got everything they promised the baptism would do. It renewed, it just changed me inside and as I started changing on the inside, I started changing on the outside".

This respondent's life event is noteworthy, due to the association between faith and spirituality and one's overall mental well-being. All of the study participants described themselves as being Christians, but only one respondent raised the issue of faith in any significant way. Considering the literature on the role of religion in the well-being and coping of African Americans, the lack of voice to issues of religion and spirituality in this sample may warrant further attention.

Health versus Non-Health Sample Groups

A comparative review of life course events and turning points among the health and non-health groups revealed that respondents in both groups described significant life course events/turning points in their lives.

Three of the health and one of the non-health group respondents described the birth of a child as a significant turning point in their lives. Three of the health group respondents and six of the non-health group respondents discussed the death of a parent or child.

Three of the health group respondents and one non-health group members described drug use a major turning point in their lives. One of the health group respondents and two of the non-health group respondents described incarceration as a major turning point in their lives. One of the health group respondents and one of the non-health group respondents identified personal illnesses as major turning points in their lives. Two health group respondents and two non-health group respondents described separation and/or divorce as turning points in their lives.

Among the respondents, there does not appear to be a relationship between the birth of a child and the respondent's health service needs; however, it is important to note here that low income women are particularly vulnerable to depression following the delivery of a child. In addition, study respondents may be doing what most women of color who suffer with depression do, is turn first to friends and families and secondly to their health care providers.

The death of a child can be a devastating and debilitating life event. The current examination does not clarify a relationship between the death of a child birth turning point event and the sample respondents' health service needs although one respondent sought and received mental health services due to the death of her child, which credits with saving her life.

Metabolic Conditions and Health

This cluster examined respondents' descriptions and discussion of any current (or past) metabolic conditions (e.g., diabetes, high blood pressure, high cholesterol, obesity) that they have, as well as any family history of metabolic conditions. Included nodes also considered current (or past) physical health status; discussion of how well she believes that she is able to take care of her health, and what if anything gets in the way of her taking care of her health; and mental and emotional health and well-being including abuse, drug abuse and treatment (Interview Survey Questions: health section 1-6).

This question was selected to support the development of responses to address the study question: What is the relationship between African American women's life history (e.g., childhood and family, experiences in their community, educational and work experiences), metabolic conditions, associated risk factors, and their reported health status?

Summary. Given the higher incidence of metabolic conditions within the African American community, it was not surprising to hear that ten out of the twelve respondents discussed having family histories of metabolic (e.g., diabetes, stroke, high blood pressure, and heart disease), as well other health

conditions (including cancer, Parkinson's disease, asthma, cystic fibrosis) within their immediate families, and/or on one or both sides of their families i.e., paternal and maternal. The respondent's comment below provides insight regarding these health challenges:

> "Um, I know diabetes runs in the family, in both sides of my family. My father's side, diabetes, and I know his father, my granddad had heart problems. Um, and that's pretty much it for his side. …So, I know that her family has, um, like I said diabetes. Anything else major, I don't know. Except women, women problems. Uh, I know my mom had cystic fibrosis, stuff like that"

In addition, African Americans often suffer from multiple chronic health conditions simultaneously, which increases their morbidity and mortality rates (NCHS, 2008). The following respondent comment describes this frequent occurrence within the African American population.

> "She has high blood pressure. She had three hernias in her stomach. I think, my brother, the last time I talked to my brother, he said she had cancer, but I don't know what degree her cancer is...because she didn't tell me that. Because, I feel, while he telling me that, the last time I saw her it looked like she had cancer, and she got diabetes real bad".

Mental Health Services

Half of the respondents (2 health; 4 non-health) shared that they had received counseling from a therapist, psychologist, psychiatrist or social worker to address a range of life challenges and/or conditions including, depression, anger, incest, death of a child, schizophrenia, marital breakup.

> "Depression, stress, anxiety, cause other things, I'm pretty good with me and my son, I kinda lose touch with myself because I want to make sure he's ok, so um, like maybe a year ago, it was his birthday, 2009. I did not, no 2008, I went into a state of depression and I didn't even know it. For 10 months I did not comb hair, I did not touch my hair, I

> didn't do anything. I don't even know what happened to me. I honestly don't. And um, and I had hair down almost to my butt."

One respondent specifically expressed the desire to have the opportunity to meet with other Black women on an on-going basis to talk about their life experiences. She stated:

> "Probably if African American women were given a chance, maybe, to meet once a week and to almost talk like you and I are talking now, it would probably make me more conscious about my decisions".

Most respondents indicated that the therapy was beneficial to them, as reflected in the comment below.

> "I've learned to let things go. Don't meditate on a whole lot of things because if you don't it will runaway with you. Sometimes you just have to release the person and let them go. I had to learn that through my spirituality, you have to let them go. In spite of what you feel, cause, obedience is a decision, a choice. You can't always go on your emotions, because sometimes your emotions will get you in trouble. … I might be sitting in someone's jail cell for murder right now".

Only two of the respondents indicated that they were exhibiting premenopausal symptoms. One respondent indicated that her doctor did not concur with her assessment of premenopausal; however, in both instances the women felt that their health care provider was not accurately diagnosing them.

> " it's difficult for me because these are major changes for me, and I'm not being heard on it. so it's been difficult. with me having medical insurance, I went to the doctor many times, because I had, actually, an ovary removed. so you put that with not having your periods, it's bound to have an affect on you emotionally and physically. and so I'm trying

to work through all of that. and even with sex, my desire is not as it was, but you kinda know why, and you don't know what to do. And people look at me, because I look so young, and I'm not being paid attention to by my ob/gyn has not been what I expect, and I try to pick the best. I try to pick the one I'm comfortable with, so it's a difficult time for me now, because I know I'm going through menopause. I was tested in January and they say no, you're not there yet".

Social Status and Religion

Respondents' discussed their perceptions of how being Black and female growing up in Richmond or the East End affected their lives and health (Interview Survey questions: religion and social 1-4; and health care access 7-9).

This question was intended to address the study question pertaining to the relationship between African American women's life histories (e.g., childhood and family, experiences in their community, educational and work experiences) and their health service and other service needs?,

Seven of the respondents believed that being Black and female growing up in Richmond or the East End did affect their lives. Several prominent themes that emerged during the interviews include the following categories with examples of respondents' comments:

Race, Gender and Color Caste. Three (3) respondents addressed issues of gender, race and/or color caste. These comments included:

"It's kinda rough. Yeah, because the black, African American can have it rougher than, pardon my saying, the white women. Cause they have it a lil better. Because black men in our race, honestly, they treat the white women so much better than a black one. Black ones,

we right for dating, for college, but don't let them hit the pros, here come the trophy. That's the white woman."

Another respondent noted:

"..the woman and the black is a double standard. So it's like, you have to work extra hard, plus extra hard, to get anything done and to prove a point. "

Also considering race, one respondent commented:

> "Now, me being biracial, which gives me a lighter color skin, I feel like I have an advantage over dark-skin, black women and I do't feel that tha's fair. My mother is a dark-skinned woman um, 'm the lightest one in my whole family. No one is as light as me, and I kinda felt that it was saddening to me. It was saddening to me because I felt like they didn't get the opportunities that I would get."

Similarly another interviewee noted:

> "Um, any time I go out here to look for a job, I get a job. I have family members that look for a job for months and months and don't get a job. And I know that it has something to do with my skin color, I know that. And maybe the way that I talk, you know, sometimes -I just honestly feel that, that's why I want to continue my education to help out people. That's why, because it's not fair, it's not at all."

Role Models. In the words of one respondent, Richmond did not provide adequate role models for her to follow: "I didn't see a lot of strong women growing up. Um, which kinda cuts it down on the motivation or, um, just as, you know, what you can achieve as a woman. A black woman."

Adaptability. One respondent attributes her growing up in the East End as a positive occurrence that makes her adaptable to many life situations:

"Growing up in the east end has probably made me more able to adapt in my adult life, just through the experiences of living within an east end community versus a short pump community."

Religion. All of the respondents expressed that they were Christians, with the overwhelming majority expressing their denominational affiliation as Baptist (8). Many respondents expressed that they attended church in their childhood/youth, left, and have returned. Half of the respondents (6) indicated that they attend church every Sunday. However, respondents discussed the importance of faith in their lives, notwithstanding their attendance. Respondent comments include:

"Used to go all the time as a child"

"I was going and then I got a relationship with him, things got a little rough there and I left, then I came back. So, I appreciate Him so much more now."

One respondent's described her restored faith as a major factor in her positive life changes (i.e., . drug recovery).

While many faith based organizations routinely offer health screenings, none of the respondents reported accessing health services in this setting.

The qualitative analyses revealed that the identified turning points and "most/least satisfaction" periods in the lives of the overwhelming majority of the women interviewed revolved around family dynamics, either their family of origin or procreation. Respondent's descriptions of their substance abuse, and incarceration were related to family dynamics. This would seem to support the hypothesis that there is a correlation between family history (i.e. family of origin and procreation) and adult outcomes.

It is noteworthy that, one half of the group (2 health; 4 non-health) indicated that they have and/or are participating in therapy.

Research Questions

The next section presents the two research study questions, with a description of respondent information by coding theme/study domains, a highlight of the health versus non-health group respondent responses for each theme/domain, and an analysis of the findings.

In order to address research question #1: What is the relationship between African American women's life history (e.g., childhood and family, experiences in their community, educational and work experiences) and their health service and other service needs?, descriptions of respondent comments relative to their life histories (i.e., Family Status & Structure (Parental Status; Family of Origin Resources; Siblings); (2) Respondent Status (Family of procreation; Insurance Access; Mental Emotional Health and Well-being, Physical Well-Being/Health, excluding metabolic conditions; Health Care Access; (3) Social Status & Religion; and (4) Development and Life Course Review), and associated health and health service needs (Metabolic Conditions and Health i.e. mental health services – mental health counseling and/or substance abuse counseling) will be reviewed and presented.

Based on the review of the clusters, and the themes therein, the single most compelling relationship found between a cluster and service needs, was that between the Development and Life Course Review cluster and women's mental health and substance abuse service needs. The majority of the life events described (e.g., incest, death of a child, schizophrenia, marital breakup), resulted in the respondent's seeking of health services. Respondents discussed the importance of the mental health and/or substance abuse services received, and attribute their current well-being to their receipt of these services.

In order to address research question #2: 'What is the relationship between African American women's life history (e.g., childhood and family, experiences in their community, educational and work experiences) and metabolic conditions, associated risk factors, and their reported health status?' descriptions of respondent comments relative to their life histories (i.e., Family Status & Structure (Parental Status; Family of Origin Resources; Siblings), and metabolic conditions (i.e., respondents reports of metabolic conditions) and reported health status (i.e., respondent reported health status) have been reviewed and are presented

Based upon a review of the clusters, and the themes therein, the single most compelling relationship found between a cluster and metabolic conditions is that between the Family Status & Structure **(**i.e., Sibling status) and metabolic conditions. The findings revealed that 83% of the non-health respondent's families' (e.g., parents, paternal and/or maternal grandparents) exhibited metabolic conditions (i.e., hypertension, diabetes, heart disease, stroke, cancer), and 33% of the respondents exhibited metabolic conditions (i.e., hypertension). In comparison, 80% of the health respondent's families' exhibited metabolic conditions (e.g., hypertension, diabetes; cancer; heart disease), with the same percentage of respondents exhibiting metabolic conditions (e.g., hypertension). It was noteworthy, that while both the health and non-health groups' families exhibited approximately the same rates of metabolic conditions, there was a significant difference between the rates for the respondents of both groups (with the health having 80% experiencing metabolic conditions and among the non-health group, only 33%).

Upon further examination of the possible causes of such a significant disparity between the two respondents groups in the occurrence of metabolic conditions, sibling birth order was reviewed. Findings revealed that four out of the five health group respondents were the oldest sibling, in comparison to none of the non-health group respondents. This finding may suggest

that being an older sibling further increases your risk and predisposes you to metabolic condition. While noteworthy, this hypothesis requires further examination.

Resilience

Although there were no explicit questions designed to specifically explore the phenomenon of resiliency, participant responses suggested that they chose or engaged in a series of behaviors leading to positive adaptation in spite of challenging life circumstances. As a result, resiliency was the most notable and unexpected finding of the study.

Despite describing lives that contained significant challenges, all of the respondents held hopeful positive perspectives on their lives, reflective of resilience. Respondents described and discussed their life experiences to date, and their adaptive responses to major negative life events as evidenced by their accomplishments, as well as their ability to articulate positive attitudes and plans for their future.

Summary. The "Life Stories" of the 12 women interviewed are compelling in reflecting resiliency. All twelve women, regardless of sample group (i.e., health or non-health), were able to identify and share their constructions of turning points in their lives. Examples of some of the varied turning points and life course experiences described by the sample population are captured by category below through the women's "Life Stories", with daunting, but familiar scenarios. Further, these "Life Stories" demonstrate and support the phenomenon of resiliency, leading to positive adaptation in spite of challenging life circumstances.

Abuse. Respondent A describes her story of physical, mental, emotional, and verbal abuse by her mother at an early age, who also allowed her boyfriends to sexually abuse them. She described feeling alone, hated, and that no one cared for her. She was the oldest child and had a great deal of responsibility for the care of her siblings. She felt that she didn't have a good

social life at school, nor a good support system at home. The pressure of feeling responsible for everybody, and tasked by her mother to have to do everything resulted in her hospitalization and diagnosis of schizophrenia at 12 years of age. Even after the hospitalization, her mother persisted with her verbal and emotional abuse and demands. At age 18, Respondent A graduated from high school, had a son and moved into her own apartment, all in the same year. Respondent A continues to take medicine for her mental health condition and sees a doctor monthly, but is raising her son, has a boyfriend, and has been employed in a nursing home. Respondent A aspires to return to school to obtain a certificate which would enable her to seek and retain stable employment.

Death of a Parent. Respondent B describes her story of the death of her mother and her resultant drug use and treatment. Respondent B's mother died when she was 17, which began her downward spiral. She describes her rebelliousness, and being put out of her father's home because of her behavior at age 18. Now in the streets, Respondent B did all kinds of things, including trying and becoming addicted to drugs. She eventually went into treatment and subsequently as she described "got her life together" (i.e., kicked her drug addiction).

Death of a Child. Respondent C describes her story of the devastating loss of her 7 week old daughter due to a hospital acquired illness. Respondent C's daughter's death led to her seeking therapy, which she attributes to saving her life, and helping her to move on with her life. Respondent C works as a security guard, even though she would prefer being able to return to being a chef, but is precluded by her health (due to high blood pressure).

Drug Use and Incarceration. Respondent D describes her story of her drug use, which she reports led her writing bad checks and ultimately resulted in her incarceration. Respondent D went into a drug rehabilitation program, which she attributes to helping her to better understand

her life and develop positive strategies for dealing with life's problems. Respondent D secured a custodian/housekeeper job at the airport, is preparing herself to be able to be considered for advancement, and is looking forward to one day owning her own cleaning business, and becoming a motivational speaker for other women to provide encouragement and direction.

Break-up of a Relationship and Drug Use. Respondent E describes her story of the break-up of her 26 year marriage, which says led to her fifteen year heroin addiction. Before the break-up of her marriage, Respondent E described herself as being happy even though they didn't have a whole lot, being in love, raising her children, and mimicking her parents' lives. Respondent E's parents with whom she has a good relationship and sees several times a week, have been married for 51 years, and served as her role models.. Respondent E described the drugs as her way of dealing with the break up of her relationship, preventing her from feeling anything. Respondent E is now drug free, and is employed as a hairstylist and housekeeper. Respondent E also does volunteer work at the school in her community

The women's "Life Stories" describe a developmental course characterized by resiliency, notwithstanding their challenging life circumstances, they report creating positive lives for themselves and their families with definite hopes and plans for the future.

Further, emergent areas were most prominent among the stories, reflecting a sense of resilience reflected in terms of respondents' discussions of (a) employment, career and/or business aspirations; (b) educational aspirations; and (c) a desire to motivate others. Some respondents also shared their hopes for the future for family stability and/or opportunities and improved health.

Below is a summary of each of these emergent themes.

Education, Employment, Career and/or Business Aspirations. Two (2) respondents reflected resilience in terms of marketplace aspirations. According to one respondent, her hopes were to:

> "Hopefully get another job. But hopefully it'll be something I can maintain and keep over a period of time so that I can establish a good work history."

This respondent indicated that she enjoyed working at a nursing home, but she found the work to be very hard because of the number of patients she was responsible for managing. She articulated her plans to return to school to obtain a certificate as a nurse's assistant to enable her to get another job possibly as a certified nurse's assistant. This is significant for this respondent as she discussed being diagnosed at 12 and currently receives medication for schizophrenia. She attributed her illness to the abuse she experienced as a child caused by her mother and her mother's boyfriends.

Another respondent described "... going back to school, getting my certificate, buying me a home, then maybe one day, later on eventually, owning my own business (i.e. cleaning, eventually being my own boss)".

Many respondents wanted to return to school in the hopes of working better jobs with better pay. In the words of respondent, she is going back to school to "get a supervisor certificate. So I can take that because I know one of the ladies, she's gonna be retiring in another, 6 or 7 years. So when that door opens up I can".

These respondent comments are reflective of the protective factors identified by researchers (Werner, 1992), and reflect positive values (i.e., optimism and faith that it was possible to overcome challenging circumstances), that are characteristic of the phenomenon of resiliency, which leads to positive adaptation in spite of challenging life circumstances.

Motivate/Help Others. Some respondents want to motivate/help others. One respondent expressed desire to be a motivational speaker: “I would say for women, because sometimes women go through a lot in life where they need that extra push for, like, say the underclass women or single moms, or women who went through abusive relationships. That type of thing”. Some respondents expressed hopes for themselves and their families for the future.
Some respondents hold aspirations for their families. According to one respondent, “My hopes for the future is, just to um, be stable. And um, have my family. You know, just to take care of my family and to be able to support them comfortably”.

Improved health. In the words of one respondent, “I hope that my health could improve. That I could do what I really wanna do. You know, I want, I want to go back into cooking cause that's what's my, that's something I love. And, just being able to take care of myself better, you know?”

Discussion

The current study investigated the association between African American women’s experiences across the life course and their health outcomes. The study involved two phases. Phase I was a quantitative study, designed to: (1) identify the qualitative study population (i.e., African American women accessing FRC health resource and service needs); (2) randomly select two groups of African American women accessing FRC for either health and or non-health resource and service needs); (3) develop a socio-demographic, economic, environmental and health profile of the FRC service population and the study participants; (4) identify African American women’s health resource and service needs, and typologies; and (5) explore relationships, if any, between African American women’s socio-demographic, economic, environmental and medical profile and their health resource needs. Phase II was a qualitative study designed to investigate

the needs of African American women seeking FRC services through an examination of their lives, growth and development over time. African American women were recruited to share information about their life history, that is, their perspectives on their childhood and family, experiences in their community, and their educational and work experiences.

Quantitative

The literature has linked individual level SES-based on education, income, or occupation, and adult health outcomes (Adler et al 1993). Further, their research has also provided insights and evidence on the strong linkage between health and the individual's levels of education. House et al. (1990) found that: (1) the relationship between SES and health is stratified by age, such that lower SES individuals experience health problems earlier in life, shortly after adolescence, while their higher SES counterparts experience very little health decline until around retirement age. Research has also clearly identified higher risk for major metabolic conditions affecting African American women (BWHS, 1995).

In light of these research findings, several questions were posed by the quantitative study, and the findings are outlined below in response the research question posed.

The first question investigated was: Who are the African American women (i.e., age, marital status, education, annual household income, employment status, health insurance status, neighborhood) accessing FRC services? The descriptive statistical analyses conducted revealed that African American women who accessed FRC services during the study period were primarily single, older women, who are high school graduates with some college education, and who are unemployed, with no health insurance.

This profile is not surprising in light of the current economic crisis, resultant unemployment rates in the nation, City of Richmond and the East End community. Older adults

are experiencing a more difficult time in securing employment during this period. Further, the persistent nature and scope of the community's service needs (e.g., increases in financial needs), combined with the negative health outcomes in the East End community is indicative of the need to better understand the connections between the life circumstances of community residents their health status.

The second question posed by the current study was: What are the physical and/or emotional health needs of African American women accessing FRC services?

The descriptive statistics conducted revealed that the overwhelming majority of African American women accessing FRC services were seeking assistance with their basic financial needs, followed by career and employment needs, housing, physical health parenting and child care in that order. This finding is consistent with FRC's 2005 client data, and is compounded by the fact that for the last forty years, nine out of ten East End census tracts have evidenced poverty levels equal to 20% below the federal standards. There would appear to be a definite link between the economic downturn, and the population service needs (i.e., basic financial assistance).

The third question posed by the study was: Are there specific clusters of needs? The hierarchical cluster analysis conducted revealed that the 6 domains examined, clustered into two categories of need. Basic financial needs and the other combined categories form the two clusters. Based on the results of this analysis, we would accept the hypothesis developed prior to the study that, African American women have identifiable clusters of service needs. In fact, the most pervasive and persistent needs for individuals accessing FRC services, and women in both the quantitative study and qualitative studies is basic financial needs, followed closely by career/employment needs. Further, these findings generated on the basis of an examination of the

similarity of the patterns of FRC clients past service utilization will enable FRC to tailor its program services to better meet their needs e.g. possible expansion of basic financial services and elimination of others.

The fourth question posed by the study was: 'What are the individual characteristics related to these clusters of needs?' The correlation analysis conducted of the six service needs domains revealed significant correlations between the domains and socio-demographic variables as follows: (1) health insurance, and physical health, housing, parent, and child care needs; (2) annual income, marital status, and highest grade completed, and basic financial needs; (3) highest grade completed and physical health needs; and (4) employment and career/employment needs. While one might anticipate many of the correlates revealed in the analysis (i.e., employment status and career/employment needs), others suggest a need for greater scrutiny to better understand the relationship (e.g., housing, parent, and child care needs and health insurance). Based on the results of this analysis, we would accept the hypothesis developed prior to the study that there is a relationship between African American women's socio-demographic status (i.e., age, marital status, education, annual household income, employment status, health insurance status, and neighborhood) and their service needs. While the FRC client tracking system did not contain client data that would enable us to accept or reject the hypothesis that, there is a relationship between African American women's socio-demographic status (i.e., age, marital status, education, annual household income, employment status, health insurance status, neighborhood), and metabolic conditions and related risk factors, it does enable us to accept the hypothesis of the relationship between socio demographic variables and health outcomes: (a) physical health and well-being; (b) mental/emotional health and well-being.

The fifth question posed by the study was: 'Are there predictors of FRC service type utilization?' The linear regression analyses conducted to explore the possible predictors of the six service need domains revealed that annual household income is a predictor of basic financial needs, suggesting that basic household income level determines financial need; highest grade completed, employment, health insurance are predictors of career/employment needs, suggesting that increased education, may lead to better employment opportunities with possible health benefits. Highest grade completed is a predictor of physical health and parent needs, suggesting that education level, access to knowledge and information can impact health and parenting needs.

Qualitative

The literature suggests that there is a link between adult health outcomes and several contextual factors such as socioeconomic status and access to financial capital (e.g., education, income, occupation) (Mechanic, 2000). Similar research also establishes a clear association between socioeconomic resources and adult health outcomes (Adler, Boyce, Chesney, Folkman, & Syme, 1993; Fryak et al., 2004; House et al., 1990), and other associated factors that impact health outcomes such as neighborhood, employment conditions, personal health behaviors, race, health care, and toxic stress. (McArthur Foundation Report, 2005).

The literature also provides important empirical evidence that support and elucidate the association of family and environmental contexts with adulthood outcomes; and the resiliency phenomenon and the significant impact of family and environmental contexts over the life course (Elder 1974; Werner 1992). However, this work does not provide significant insights into adult health outcomes and the role of health within and across the life course. In addition, the primary sample populations used within these studies were white or Hawaiian, and may limit the

generalizability of the findings to other populations. The current research provides an opportunity to examine lives in context over the life course, as a well as a grounded theory approach to the research which allows the data to inform us about the factors that impact adult health outcomes.

The twelve African American women interviewed were primarily single, younger women with an equal number having completed some high school, high school, or some college, half of whom are employed full or part-time, with a significant percentage being unemployed. The women were in good health, with half of them utilizing Medicaid to access health care, and approximately one fourth of them have no health insurance. The women's annual income ranges from $200 to $11,200 for half of the population to $12,000 - $27,500 for the other half.

The participant sample was comprised of 5 women who sought FRC health services and 7 women who sought non-health services. A comparison of the two groups revealed that the majority of the health sample were single, younger, had completed some college, were unemployed, rent their homes, and have an annual income of $11,208.

The majority of both groups rated their health as good, with the primary metabolic condition for both groups being high blood pressure (5 out of 12 respondents). One health group member reported having cancer. The majority of the women in both groups are participating in physical activities or exercises. This single factor alone may account for the fact that fewer women reported metabolic conditions, as studies suggest that physical activity is associated with reduced risks for chronic conditions like hypertension (Cozier et al., 2006).

Comparatively, the quantitative study population and the samples are primarily comprised of single unemployed women who have completed high school and some college, rent their homes, and have low annual household incomes. The majority of the larger population has

no health insurance, while the majority of the sample respondents have Medicaid coverage. Within the sample, the majority of the non-health group had Medicaid in comparison to the health group.

Respondent resiliency was in fact, the most profound, pervasive, persistent, and unexpected finding of the study. The lives of the women interviewed were compelling. All twelve women, regardless of sample group (i.e., health or non-health), described significant turning points in their lives (e.g., death of parent and/or child, abuse, incest, drug addition, incarceration, divorce). The most salient factor throughout all of their stories was the impact of family (origin and procreation) over the life course.

While the nature of the turning points described led to devastating trajectories for several of the women for periods in their lives, like the youth of Elder's Children of the Great Depression, and Werner's Children of Kauai, instead of reproducing "hard times" throughout the entirety of their adult years, all of the women have managed to surmount life's disadvantages and challenges.

Each of the women have followed a developmental course characterized by resiliency, which is largely attributable to what Elder's refers to as agency (i.e., individuals construct their own life course through the choices and actions they take within the opportunities and constraints of history and social circumstance); and linked lives (--linked lives are lived interdependently and socio-historical influences are expressed through this network of shared relationships). Each woman without fail, notwithstanding their life circumstances, has created positive lives for themselves and their families with definite hopes and plans for the future.

Research Questions

The interview protocol was designed to enable us to answer two research questions, outlined below with the associated findings.

The first question considered 'the relationship between African American women's life history (e.g., childhood and family, experiences in their community, educational and work experiences) and their health service and other service needs?'

The most compelling relationship revealed relative to metabolic conditions was that between the respondents' reported development and life course turning points and events, and their mental health and substance abuse service needs. The majority of the respondents described turning points and life events (e.g., incest, death of a child, schizophrenia, marital breakup), which resulted in them seeking health services (e.g., mental health, substance abuse counseling). Respondents discussed the importance of the mental health and/or substance abuse services received, and attribute their current state of well-being to their receipt of these services. These findings suggest that there is a positive association between African American women's life history and their health service and other service needs.

The second question examined 'the relationship between African American women's life history (e.g., childhood and family, experiences in their community, educational and work experiences), metabolic conditions, associated risk factors, and their reported health status?'

The single most compelling finding relative to metabolic conditions was the relationship found between the family status and structure (i.e. sibling status) and metabolic conditions. The findings revealed that the overwhelming majority of the non-health respondent's families' (e.g., parents, paternal and/or maternal grandparents) exhibited metabolic conditions (i.e., hypertension, diabetes, heart disease, stroke, cancer), while only about a third of the respondents exhibited metabolic conditions (i.e., hypertension). In comparison, the overwhelming majority of

the health respondent's families' exhibited metabolic conditions (e.g., hypertension, diabetes; cancer; heart disease), as did the overwhelming majority of the respondents (e.g., hypertension, cancer). It was noteworthy, that while both the health and non-health groups' families exhibited approximately the same rates of metabolic conditions, there was a significant difference between the rates for the respondents for the two sample groups (health at 80%, and non-health at 33%).Upon further examination of the possible causes of such a significant disparity between the two sample groups, sibling birth order was reviewed. Findings revealed that four out of the five health group respondents were the oldest sibling, in comparison to none of the non-health group respondents. This finding may suggest that being an older sibling further increases your risk and predisposes women to metabolic condition. While an absolutely noteworthy finding, this hypothesis requires further examination due the sample sizes.

The qualitative analyses revealed that the identified turning points and "most/least satisfaction" periods in the lives of the overwhelming majority of the women interviewed revolved around family dynamics, either their family of origin or procreation. These evaluations were related to perspectives on the experience of family, both negative or positive. Respondent descriptions of their substance abuse and incarceration were related to family dynamics. This would seem to support the hypothesis that there is an association between family history (i.e., family of origin and procreation) and adult outcomes. For example, positive parental relationships provide role models for dealing with life as was evidenced in comments by respondents regarding their similarities to their parent, in terms of their approaches to dealing with life, their work and work ethic.

The implications of the study findings for public policy are twofold. First, the existence of significant numbers of uninsured women among the sample group, and the broader

community, warrant support of the national health care reform. Barriers to accessing health care (e.g., health insurance) must be removed if the health of African American women and the broader community is to improve. Second, given the study findings, and the persistent nature of African American women's poor health outcomes, a life course perspective may assist in supporting a more complex understanding of factors that undergird the greater compromise in their health status. More specifically, proposed policies designed to address and/or improve African American women's health must be undergirded by an examination of both proximal and distal contexts and associated social conditions, so as to ensure that they don't "blame the victim", as opposed to addressing the major underlying and contributing factors. Failure to do so, may result in the continued, persistent and pervasive health disparities that currently exist for African American women.

While compelling, the study has limitations. The small sample sizes (e.g., health group n=5; non-health group n=7); the socioeconomic homogeneity of the group, including education and income; the lack of prior data on clients metabolic conditions, that would inform recruitment, warrant a more extensive examination within the target population.

Future studies should be designed to engage study participants in a more detailed and methodical delineation of the turning points across their life course and the impact in their lives. A "life course" tool could be designed that enables the researcher to engage the study participants in the construction of their "lives" graphically, to facilitate a better understanding of critical issues (e.g., timing, turning points, linked lives that impact adult health outcomes). The tool could also be modified to complement the "life course" measure. Next steps would include enhancing the current qualitative study design consistent with the recommendations to address the study limitations.

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Appendix 1

EEPF Client Intake Form

Date of Intake: Edit Date: Staff Member Making Edit:

Date Consent Form Signed:

Family Information

		Type of Household		Relationship to HOH?
First Household	Family ID:		TO FAMILY LIST	Self
Second Household	Family ID:		TO FAMILY LIST	
Third Household	Family ID:		TO FAMILY LIST	

Client ID:

Agency Specific ID1:

Agency Specific ID2:

Agency Specific ID3:

Is Client Receiving Services in EEPF?

Basic Demographics

First Name Last Name

Middle Name Maiden Name

Also Known As

Social Security Date of Birth Age:

Home Phone: Cell: Pager:

Work/Other Phone: E-mail:

Address:

City: State: Zip:

Mailing Address if different from above:

Address:

City: State: Zip:

Neighborhood:

Census Track:

Are you a Richmond East End Resident?

Background

Marital Status: Sex:

Race:

Are you a Veteran? Disabled: Health Insurance:

Type of Health Insurance none

Housing: Current School:

Employment Status: Highest Grade Completed:

Annual Household Income: Special Education:

Income source: TANF, Food Stamps, Earned Income High School Diploma:

Chosen Values for Income Source: Earned Income

GED:

Other Certification Received:

Emergency Contact

Emergency Contact Name:

Relationship to Client:

Emergency Address:

Emergency Home Phone: Emergency Work Phone:

Emergency Cell: Emergency Pager:

Appendix 2

EEPF Brief Assessment Form

To get a sense of what kinds of services might be helpful for you (or your family), I am going to ask you to tell me a little about how
things are going in some different areas of your life and whether you have any needs in this area and how quickly would you need support.

(how you're doing in each overall category and Check/Tell me all specific issues that apply).

0=Doing really or pretty well; No needs-Doesn't need attention
1=Doing ok-getting by; Some minor needs
2=Not doing well at all, not really making it; Serious need; clearly and definitely needs attention
3=Not doing well at all--in very bad shape; Emergency: Needs immediate attention
[9=Staff rating: Not enough information]

1) Housing RATE 0

- ☐ Need housing
- ☐ Homeless evicted
- ☐ Housing in poor condition, unsafe
- ☐ Can't make housing/apt. costs

2) Basic Financial Needs: RATE 0

- ☐ Need food, clothes, help with utilities
- ☐ Utilities cut off
- ☐ No transportation

3) Career & Employments: RATE 0

- ☐ Unemployment/Need job
- ☐ Dislike job/'under'-employment
- ☐ Need job/career training

4) Physical Health: RATE 0

- ☐ Health emergency
- ☐ Promoting health /"wellness"
- ☐ Minor to moderate health problems
- ☐ Chronic illness
- ☐ No access to health care
- ☐ Child immunizations
- (Health ed., exercise, prayer, meditation)
- ☐ Dental care

5) Parenting: RATE 0

- ☐ Parenting stress
- ☐ Need Info on child/adolescent development
- ☐ Child/adolescent behavior problem
- ☐ Problem with discipline

6) Child Care: RATE 0

- ☐ Problems finding child care
- ☐ Problems affording child care

Qualitative Data Initial Codes

Parental Status
- Knowledge of father/mother
- Relationship with father/mother
- Health of father/mother
- Parents marital status

Number and birth order of siblings
- Historic and Current Relationship with siblings
- Positive or negative nature of relationship
- Role relative to siblings (e.g., sibling caretaking)

Family of Procreation
- Number of and relationship with offspring
- Marital/Current Relationship status

Family Resources
- Employment
- Income
- Education
- Insurance Coverage (Mother/Father/Children/Family)

Respondent Status
- Current employment status
- Income

Religion & Social
- Religious and social participation?
- Link to health?
- Access to health care services?

Mental Emotional Health and Well-being
- Experiences of depression?
- Treatment?
- Timing relative to developmental stage (Childhood? Adult? Current?)

Health Care Access/Service Sources

Physical Well-Being/Health
- Descriptions
- Status and level

Metabolic Conditions

- Type?
- Family History?

Turning Points
- Type
- Impact
- Timing

Insurance Access
- Childhood?
- Adult?

Social Status

African American
Female
Living in East End
Their education and employment

Emerging Themes
- Resilience?
- Intergenerational family living?

Appendix 4

Full and Monitoring Assessment Form

To get a sense of what kinds of services might be helpful for you (or your family), I am going to ask you to tell me a little about how
things are going in some different areas of your life and whether you have any needs in this area and how quickly would you need support.

(how you're doing in each overall category and Check/Tell me all specific issues that apply).

0=Doing really or pretty well; No needs-Doesn't need attention
1=Doing ok-getting by; Some minor needs
2=Not doing well at all, not really making it; Serious need; clearly and definitely needs attention
3=Not doing well at all--in very bad shape; Emergency: Needs immediate attention
[9=Staff rating: Not enough information]

1) Housing RATE 0

- ☐ Need housing
- ☐ Homeless evicted
- ☐ Housing in poor condition, unsafe
- ☐ Can't make housing/apt. costs

How satisfied are you with your current situation in this area? Completely Satisfied

What do you want to happen? What is your goal?

- ☐ Locate housing
- ☐ Home ownership
- ☐ Improve condition/Safety of housing
- ☐ Afford Housing

When you need(ed) it, how easy has it been to find out about or get resources to help with this issue in the East End? Very Easy

2) Basic Financial Needs: RATE 0

- ☐ Need food, clothes, help with utilities
- ☐ Utilities cut off
- ☐ No transportation

How satisfied are you with your current situation in this area? Completely Satisfied

What do you want to happen? What is your goal?

- ☐ Increase access to food
- ☐ Improve food quality and nutritional value
- ☐ Increase access to work clothing
- ☐ Increase access to everyday clothing
- ☐ Increase access to warm clothing
- ☐ Utilities established or Reestablished
- ☐ transportation

When you need(ed) it, how easy has it been to find out about or get resources to help with this issue in the East End? Very Easy

3) Career & Employments: RATE 0

- ☐ Unemployment/Need job
- ☐ Dislike job/'under'-employment
- ☐ Need job/career training

4) Physical Health: RATE 0

- ☐ Health emergency
- ☐ Promoting health /"wellness"
- ☐ Minor to moderate health problems
- ☐ Chronic illness
- ☐ No access to health care
- ☐ Child immunizations

	(Health ed., exercise, prayer, meditation) ☐ Dental care
How satisfied are you with your current situation in this area? Completely Satisfied	How satisfied are you with your current situation in this area? Completely Satisfied
What do you want to happen? What is your goal? ☐ Increase job readiness ☐ Search: look for new job ☐ Career: specific skills training	What do you want to happen? What is your goal? ☐ Improve healthy lifestyle ☐ Access insurance ☐ Access and treatment services ☐ Access treatment compliance and follow through
When you need(ed) it, how easy has it been to find out about or get resources to help with this issue in the East End? Very Easy	When you need(ed) it, how easy has it been to find out about or get resources to help with this issue in the East End? Very Easy

5) Parenting: RATE 0	**6) Child Care:** RATE 0
☐ Parenting stress ☐ Need Info on child/adolescent development ☐ Child/adolescent behavior problem ☐ Problem with discipline	☐ Problems finding child care ☐ Problems affording child care
How satisfied are you with your current situation in this area? Completely Satisfied	How satisfied are you with your current situation in this area? Completely Satisfied
What do you want to happen? What is your goal? ☐ Reduce parenting stress ☐ Improve parenting skills ☐ Increase knowledge of child development ☐ Improve child behavior	What do you want to happen? What is your goal? ☐ Access child care ☐ Afford child care
When you need(ed) it, how easy has it been to find out about or get resources to help with this issue in the East End? Very Easy	When you need(ed) it, how easy has it been to find out about or get resources to help with this issue in the East End? Very Easy

Appendix 5

Referral form

Referral for: Emergency Food Clothing Administrative Assistance (Fax, copy, etc)
Employment Services/Job Search

Other (Please Describe) _____

Agency Referred by: _____

Person Making Referral: _____

Contact Number: _____

Date/Time Called: _____ _____

Client Information

Name: _____

Address: _____

City: _____ Zip Code: _____

Social Security Number: _____

Phone#: _____

Number in Household: _____

Call Taken By: Rhonda Acholes Keisha Walker

Other Staff _____

Appendix 6

IRB Approval

VCU Memo

Virginia Commonwealth University

Office of Research Subjects Protection
Biotechnology Research Park
BioTech One, 800 E. Leigh Street, #114
P.O. Box 980568
Richmond, Virginia 23298-0568
(804) 828-0992
(804) 827-1448 (fax)

DATE: May 27, 2010

TO: Kevin W. Allison, PhD
College of Humanities and Sciences
Box 842019

FROM: Lisa M. Abrams, PhD
Chairperson, VCU IRB Panel B
Box 980568

RE: **VCU IRB #: 2180**
Title: Evaluation of the East End Partnership with Families

On May 12, 2010, this research study was ***approved for continuation*** by expedited review according to 45 CFR 46.108(b) and 45 CFR 46.109(e) and 45 CFR 46.110 Categories 5 and 7. This research involves children and is approved under 45 CFR 46.404.

PROTOCOL: Evaluation of the East End Partnership with Families, version 5/29/09, received 4/23/10

VCU IRB APPROVED CONSENT/ASSENT FORM (attached):
- Research Subject Information and Consent Form, version 6/8/07, 4 pages, received 4/23/10

This approval expires on April 30, 2011. Federal Regulations/VCU Policy and Procedures require continuing review prior to continuation of approval past that date. Continuing Review report forms will be mailed to you prior to the scheduled review.

The Primary Reviewer assigned to your research study is Cornelia Ramsey, PhD. If you have any questions, please contact Dr. Ramsey at caramsey@vcu.edu and 827-1513; or you may contact Donna Gross, IRB Coordinator, VCU Office of Research Subjects Protection, at dsgross@vcu.edu or 827-2261.

Attachment Conditions of Approval

Appendix 7

Description of EEPF Description EEPF

Overview of the Partnership

The East End Partnership with Families (EEPF) is a collaboration of human service agencies working to improve the quality of life for families in the East End of the City of Richmond, Virginia. The agencies making up the partnership provide a variety of resources including healthcare, parenting education and support, social services, and mental health care.

The overall mission of the partnership is, *Working together to improve the lives of the East End children and families with respect, with equality, and with hope.* The goals of the EEPF include supporting family functioning and self sufficiency through improved client assess to services, increasing service coordination, and strengthening the community through advocacy and the development of community infrastructure and resources.

Partnership Agencies

The agencies that make up the EEPF include:

- **Child Savers**, a mental healthcare service provider for children and their families (www.childdsavers.org).
- **Challenge Discovery, Virginia Health Department,** a counseling and drug treatment service provider for adolescents.
- **Community Voice** building on representation from community bodies such as the East District Roundtable or the East Team Board (a neighborhood governing body).
- **The East District Family Resource Center**, a community-based center that provides core family support services.
- **Families First/Healthy Families Richmond**, a community-based program that provides parent support services to expectant families and families with newborns.
- **Capital Area Health Network**, a community-based comprehensive healthcare provider (www.cahealthnet.org).
- **Parent Resource Network**, a community-based support and advocacy resource for parents.
- **Virginia Commonwealth University College of Humanities and Sciences,** Department of Psychology, provides facilitation, evaluation and administrative support (www.has.vcu.edu).

Appendix 8

Recruitment Letter

[date]

EDFRC Client
2405 Jefferson Ave.
Richmond, VA 23223

RE: East District Family Resource Center

Dear Ms. EDFRC Client:

The East District Family Resource Center (EDFRC) is interested in better understanding today's ever changing and challenging African American women's needs, the African American women who use their services, as well as the nature and types of resources and supports that African American women need.

The compiled information will be used by EDFRC in the development of more responsive and effective services and programs for African American women. This effort will also increase EDFRC's ability to become a more effective service provider to the African American women accessing coordinated services through the East End Partnership with Families. The study and its results will also be used for a VCU research project by Cynthia Newbille, VCU Project Coordinator.

Client interviews and self-administered survey tools will be used as the primary method to collect information from current and past EDFRC clients.

We would like to ask you to participate in an in-depth interview, and to complete a self-administered health survey. The interviews will be conducted by Ms. Cynthia Newbille, VCU Project Coordinator. The survey and interview will last approximately 1.5 to 2 hours, with the health survey taking approximately 10 minutes to complete. A written record of responses will be captured by the project coordinator. If you approve, we will also audiotape the interview.

As an incentive for participating in the project, you will receive $40.00

I will contact you within the next two weeks to determine your interest and availability to participate in this project.

Please feel free to contact me at (804) 828-1674 or kallison@vcu.edu or Cynthia Newbille, VCU Project Coordinator at (804) 321-3807 or s2cinewb@vcu.edu for additional information regarding this project.

Sincerely,

Dr. Kevin W. Allison
Principal Investigator

Cc: Cynthia Newbille

Appendix 9

Research Subject Information and Consent Form

Title: Evaluation of the East District Family Resource Center (EDFRC)

VCU IRB PROTOCOL NUMBER: 2180

SPONSOR: Casey Foundation

Investigator: Kevin W. Allison, Ph.D.

PURPOSE OF THE STUDY:
This study is being done to better understand the services provided by an EEPF agency, the East District Family Resource Center (EDFRC). The results will be used to improve EDFRC's ability to better plan and provide services to African American women, the majority service population. The study will also help us make sure that our measures help us understand your family's needs. The study and its results will also be used for a VCU research project by Cynthia Newbille, the VCU Project Coordinator and 7th District Richmond City Council representative.

DESCRIPTION OF THE STUDY:
The current study will help us better serve the needs of African American women seeking EDFRC services by allowing us to better understand their lives, growth and development. This will involve asking African American women questions about their childhood and family; experiences in their community; their educational and work experiences; and personal health information and behavior measures in an attempt to better understand African American women's lives, growth and development and the full magnitude and scope of the challenges confronting them, in order to develop more responsive and effective services and programs. In addition to an interview, they will be asked to complete a short health survey about their health status.

PROCEDURES:
If you decide to be part of this study, you will be asked to sign this consent form. You may ask any questions about the study. Sign the consent form only after you have had all your questions answered.

As part of your regular intake, an agency staff has already asked you questions about you and your family. This assessment was done to help your agency provide the best and most appropriate services. This intake covered a lot of areas including health, financial needs, and childcare. This was done at the agency even if you are not part of the study. We ask you to give

permission to use this information so we can study how well the services the agencies you use are working.

We would like to ask you to complete an interview session that will last about one and a half to two hours. The interview will be conducted by Ms. Cynthia Newbille, VCU Project Coordinator and 7th District Richmond City Council representative.

During this session we would ask you questions that will help us better serve the needs of African American women seeking EDFRC services by allowing us to better understand their lives, growth and development. This will involve asking you questions about your childhood and family, experiences in your community, your educational and work experiences, your personal health status and health behaviors. The interview will consist of open-ended questions that query participants about their family composition, service needs, service agencies routinely accessed, and social supports, as well as the administration of the EDFRC health status survey by the interviewer. You will also be asked to complete a short health survey about how you are doing, which will take about 10 -15 minutes. The maximum expected completion time for the interview and surveys is 1.5 to two hours.

RISKS AND DISCOMFORTS:
We do not expect risk or discomfort from your being in this study. Some agencies might be concerned if they felt community residents were not using their services. Neighborhoods might also be concerned about information being made public that might not cast their community in a positive light.

BENEFITS:
There is no guarantee that you or your community will benefit from being in this study.

COSTS
There are no charges for taking part in this study.

PAYMENT FOR PARTICIPATION
You will receive $40.00 for being interviewed and completing the surveys.

CONFIDENTIALITY
Information on the overall study will be given to the agency funding the study. The information that is provided will be confidential. Research records and the consent form signed by you may be examined and/or copied by the sponsor or an agent for the sponsor or investigator, the Department of Health and Human Services or Virginia Commonwealth University.

Absolute confidentiality cannot be guaranteed because of the need to give information to these parties. This research may be presented at meetings or in papers. This information will also be used as part of a research project being done by Ms. Cynthia Newbille, VCU Project Coordinator and 7th District Richmond City Council representative. Your name will not be used in those presentations.

VOLUNTARY PARTICIPATION AND WITHDRAWAL

Being part of this study is voluntary. You may decide not to be in this study. If you do decide to participate, you may freely decide to stop your part at any time. Your decision not to be past of the study will involve no penalty or loss of benefits or services. If you have concerns about pressure to participate, please contact Dr. Allison or VCU's Office for Research Subjects Protection (Contact information provided below).

QUESTIONS
In the future you may have questions about your part in this study. If you have any questions contact:

Dr. Kevin W. Allison
816 W. Franklin Street
Richmond, VA
Phone: 828-1203

If you have any questions about your rights as a participant in this research, you may contact:

Office for Research Subjects Protection
Virginia Commonwealth University

800 East Leigh Street, Suite 111
Box 980568
Richmond VA 23298
Phone: (804) 828-0868

Do not sign this consent form unless you have had a chance to ask questions and have received answers to all your questions.

CONSENT
I have read this consent form. I understand the information about this study. All my questions about the study and my part in the study have been answered. I freely consent to take part in this study.

I understand that I will receive a signed dated copy of this consent form for my records.

By signing this consent for I have not waived any of the legal rights which I would otherwise have as a subject in a research study.

_____
Name, Printed

_____ _____
Signature Date

ASSENT (For individuals under age 18.
NOTE: PARENT'S OR GUARDIAN'S CONSENT IS REQUIRED)

I have read this consent form. I understand the information about this study. All my questions about the study and my part in it have been answered. I agree to take part in this study.

_____
Name, Printed

_____ _____
Signature Date

_____ _____
Signature of Person Conducting Informed Consent Date

_____ _____
Investigator Signature Date

Appendix 10

Demographic Profile

DIRECTIONS: Please fill in the blanks below and/or place a "X" beside the category or item that applies to you.

1. Name: First_____ Middle Initial ___ Last_____
2. Age:_____
3. Gender: Male_____ Female_____
4. Race/Ethnicity:
   ___Black/African American ___Asian/Pacific Islander
   ___White ___American Indian/Native American
   ___ Latino/Hispanic ___Biracial
   ___Other (Please indicate)_____
5. Education: (Please indicate the highest grade completed.)
   ___Some High School ___ High School Graduate ___GED ___ Some College
   ___ College Graduate ___ Some Graduate School ___ Graduate Degree
6. Marital Status:
   ___Single ___Separated
   ___Married ___Cohabitating (Never Married)
   ___Divorced ___Widowed
   ___Other
7. Employment Status:
   ____Unemployed ___Employed full-time ___Employed part-time
   ____Not in labor force, retired ___ Not in labor force, disabled
   ____Not in labor force, primary caregiver ___ Not in labor force, student
   ____Employment/job training program
8. Annual Income: $_____
9. Current Community of residence: _____
10. Length of residency in current community (How long have you lived in this community?):
    ____Less than 1 year ___16-20 years
    ____1-5 years ___21-25 years
    ____ 6-10 years ___25-29 years
    ____11-15 years ___30+ years
13. Housing: ___ Own ___Rent

14. Household:
    Number of related children: _____ Number of related adults: _____

15. Relatives living at Home?: ____Yes ____No
    If yes, who are they?_____

15. Friends of the family living at Home?: ____Yes ____No
    If yes, who are they?_____

16. Health Status: (How would you describe your current health?) ___Excellent ___Good __Fair ___Poor

17. Health care: (Where do you and your family get health care?)
    __Public Health Clinic __Free Clinics __Emergency Room __Private Doctor __ Hospital
    __Other __

18. Health Care Coverage: (What type of health insurance do you and your family have?)
    ____Medicaid ____Medicare ____Private Insurance ____ No Insurance

Appendix 11

Health Status Survey

Section 1: Health Status

1. Would you say that in general your health is —
Please read:

1 Excellent
2 Very good
3 Good
4 Fair

Or

5 Poor

Do not read:

7 Don't know / Not sure
9 Refused

Section 2: Diabetes

1. Have you ever been told by a doctor that you have diabetes?

If "Yes" and respondent is female, ask: "Was this only when you were pregnant?"

If respondent says pre-diabetes or borderline diabetes, use response code 4.

1 Yes
2 Yes, but female told only during pregnancy
3 No
4 No, pre-diabetes or borderline diabetes
7 Don't know / Not sure
9 Refused

Module 2: Diabetes

To be asked following Core Q4.1; if response is "Yes" (code = 1)

1. How old were you when you were told you have diabetes?

_ _ Code age in years **[97 = 97 and older]**
9 8 Don't know / Not sure
9 9 Refused

2. Are you now taking insulin?

1 Yes
2 No
9 Refused

3. About how often do you check your blood for glucose or sugar? Include times when checked by a family member or friend, but do NOT include times when checked by a health professional.

1 _ _ Times per day
2 _ _ Times per week
3 _ _ Times per month
4 _ _ Times per year
8 8 8 Never
7 7 7 Don't know / Not sure
9 9 9 Refused

4. About how often do you check your feet for any sores or irritations? Include times when checked by a family member or friend, but do NOT include times when checked by a health professional.

1 _ _ Times per day
2 _ _ Times per week
3 _ _ Times per month
4 _ _ Times per year
5 5 5 No feet
8 8 8 Never
7 7 7 Don't know / Not sure
9 9 9 Refused

5. About how many times in the past 12 months have you seen a doctor, nurse, or other health professional for your diabetes?

_ _ Number of times
8 8 None
7 7 Don't know / Not sure
9 9 Refused

6. A test for "A one C" measures the average level of blood sugar over the past three months. About how many times in the past 12 months has a doctor, nurse, or other health professional checked you for "A one C"?

_ _ Number of times
8 8 None
9 8 Never heard of "A one C" test
7 7 Don't know / Not sure
9 9 Refused

7. About how many times in the past 12 months has a health professional checked your feet for any sores or irritations?

_ _	Number of times
8 8	None
7 7	Don't know / Not sure
9 9	Refused

8. When was the last time you had an eye exam in which the pupils were dilated? This would have made you temporarily sensitive to bright light.

Read only if necessary:

1	Within the past month (anytime less than 1 month ago)
2	Within the past year (1 month but less than 12 months ago)
3	Within the past 2 years (1 year but less than 2 years ago)
4	2 or more years ago

Do not read:

7	Don't know / Not sure
8	Never
9	Refused

9. Has a doctor ever told you that diabetes has affected your eyes or that you had retinopathy?

1	Yes
2	No
7	Don't know / Not sure
9	Refused

10. Have you ever taken a course or class in how to manage your diabetes yourself?

1	Yes
2	No
7	Don't know / Not sure
9	Refused

Section 3: Cardiovascular Disease Prevalence

Now I would like to ask you some questions about cardiovascular disease.

Has a doctor, nurse, or other health professional EVER told you that you had any of the following? For each, tell me "Yes," "No," or you're "Not sure."

1. (Ever told) you had a heart attack, also called a myocardial infarction?

1	Yes
2	No
7	Don't know / Not sure
9	Refused

2. (Ever told) you had angina or coronary heart disease?
1 Yes
2 No
7 Don't know / Not sure
9 Refused

3. (Ever told) you had a stroke?

1 Yes
2 No
7 Don't know / Not sure
9 Refused

Module 3: Cardiovascular Health

I would like to ask you a few more questions about your cardiovascular or heart heath.

1. After you left the hospital following your heart attack did you go to any kind of outpatient rehabilitation? This is sometimes called "rehab."
1 Yes
2 No
7 Don't know / Not sure
9 Refused

2. After you left the hospital following your stroke did you go to any kind of outpatient rehabilitation? This is sometimes called "rehab."
1 Yes
2 No
7 Don't know / Not sure
9 Refused

3. Do you take aspirin daily or every other day?
1 Yes
2 No
7 Don't know / Not sure
9 Refused

4. Do you have a health problem or condition that makes taking aspirin unsafe for you?
If "Yes," ask *"Is this a stomach condition*?" Code upset stomach as stomach problems.
1 Yes, not stomach related
2 Yes, stomach problems
3 No
7 Don't know / Not sure
9 Refused

Section 4: Hypertension Awareness

1. Have you EVER been told by a doctor, nurse, or other health professional that you have high blood pressure?

If "Yes" and respondent is female, ask: "Was this only when you were pregnant?"

1 Yes
2 Yes, but female told only during pregnancy
3 No
4 Told borderline high or pre-hypertensive
7 Don't know / Not sure
9 Refused

2. Are you currently taking medicine for your high blood pressure?

1 Yes
2 No
7 Don't know / Not sure
9 Refused

Module 4: Actions to Control High Blood Pressure

Are you now doing any of the following to help lower or control your high blood pressure?

1. (Are you) changing your eating habits (to help lower or control your high blood pressure)?

1 Yes
2 No
7 Don't know / Not sure
9 Refused

2. (Are you) cutting down on salt (to help lower or control your high blood pressure)?

1 Yes
2 No
3 Do not use salt
7 Don't know / Not sure
9 Refused

3. (Are you) reducing alcohol use (to help lower or control your high blood pressure)?

1 Yes
[1]2 No
3 Do not drink
7 Don't know / Not sure
9 Refused

Section 5: Cancer

Now I am going to ask you about cancer.

1. Have you EVER been told by a doctor, nurse, or other health professional that you had cancer?
Read only if necessary: By "other health professional" we mean a nurse practitioner, a physician's assistant, social worker, or some other licensed professional.

1 Yes
2 No
7 Don't know / Not sure

9 Refused

2. How many different types of cancer have you had?

1 Only one
2 Two
3 Three or more
7 Don't know / Not sure
9 Refused

3. At what age were you told that you had cancer?
_ _ Code age in years
9 8 Don't know / Not sure
9 9 Refused

INTERVIEWER NOTE: This question refers to the first time they were told about their first cancer.

4. What type of cancer was it? "With your most recent diagnoses of cancer, what type of cancer was it?"

INTERVIEWER NOTE: Please read list only if respondent needs prompting for cancer type (i.e., name of cancer

Breast
0 1 Breast cancer

Female reproductive (Gynecologic)
0 2 Cervical cancer (cancer of the cervix)
0 3 Endometrial cancer (cancer of the uterus)
0 4 Ovarian cancer (cancer of the ovary)

Head/Neck
0 5 Head and neck cancer
0 6 Oral cancer
0 7 Pharyngeal (throat) cancer
0 8 Thyroid

Gastrointestinal
0 9 Colon (intestine) cancer
1 0 Esophageal (esophagus)
1 1 Liver cancer
1 2 Pancreatic (pancreas) cancer
1 3 Rectal (rectum) cancer
1 4 Stomach

Leukemia/Lymphoma (lymph nodes and bone marrow)
1 5 Hodgkin's Lymphoma (Hodgkin's disease)
1 6 Leukemia (blood) cancer
1 7 Non-Hodgkin's Lymphoma

Skin
18 Melanoma

19 Other skin cancer

Thoracic
2 0 Heart
2 1 Lung

Urinary cancer:
2 2 Bladder cancer
2 3 Renal (kidney) cancer

Others
2 4 Bone
2 5 Brain
2 6 Neuroblastoma
2 7 Other

Do not read:

7 7 Don't know / Not sure
9 9 Refused

5. Are you currently receiving treatment for cancer? By treatment, we mean surgery, radiation therapy, chemotherapy, or chemotherapy pills.

1 Yes
2 No
7 Don't know / Not sure
9 Refused

6. What type of doctor provides the majority of your health care?

INTERVIEWER NOTE: If the respondent requests clarification of this question, say: "We want to know which type of doctor provides the majority of your health care."

Please read [1-10]:

0 1 Cancer Surgeon
0 2 Family Practitioner
0 3 General Surgeon
0 4 Gynecologic Oncologist
0 5 Internist
0 6 Plastic Surgeon, Reconstructive Surgeon
0 7 Medical Oncologist
0 8 Radiation Oncologist
0 9 Urologist
1 0 Other

Do not read:

7 7 Don't know / Not sure
9 9 Refused

Section 6: Exercise

The next few questions are about exercise, recreation, or physical activities other than your regular job duties.

1. During the past month, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?

a. Yes 1
b. No
Don't know/Not sure
Refused

2. What type of physical activity or exercise did you spend the most time doing during the past month?

Activity **[specify]**:
Refused

3.. How far did you usually walk/run/jog/swim?

Miles and tenths .
Don't know/Not sure

4. How many times per week or per month did you take part in this activity during the past month?

a. Times per week
b. Times per month
Don't know/Not sure
Refused

5. And when you took part in this activity, for how many minutes or hours did you usually keep at it?

Hours and minutes:
Don't know/Not sure
Refused

6. Was there another physical activity or exercise that you participated in during the last month?

a. Yes
b. No
Don't know/Not sure
Refused

7. What other type of physical activity gave you the next most exercise during the past month?

Activity **[specify]**:
Refused

8. How far did you usually walk/run/jog/swim?

Miles and tenths .
Don't know/Not sure
Refused

9. How many times per week or per month did you take part in this activity?

a. Times per week
b. Times per month
Don't know/Not sure
Refused

10. And when you took part in this activity, for how many minutes or hours did you usually keep at it?

Hours and minutes:
Don't know/Not sure
Refused

Section 7: Nutrition

These next questions are about the foods you usually eat or drink. Please tell me how often you eat or drink each one, for example, twice a week, three times a month, and so forth. Remember, I am only interested in the foods you eat. Include all foods you eat, both at home and away from home.

1. How often do you drink fruit juices such as orange, grapefruit, or tomato?
   a. Per day . . . . . .
   b. Per week . . . . . .
   c. Per month . . . . . .
   d. Per year . . . . . .
   e. Never . . . . . .
   Don’t know/Not sure . . . . . .
   Refused . . . . . .
2. Not counting juice, how often do you eat fruit?
   a. Per day . . . . . .
   b. Per week . . . . . .
   c. Per month . . . . . .
   d. Per year . . . . . .
   e. Never . . . . . .
   Don’t know/Not sure . . . . . .
   Refused . . . . . .

3. How often do you eat green salad?
   a. Per day . . . . . .
   b. Per week . . . . . .
   c. Per month . . . . . .
   d. Per year . . . . . .
   e. Never . . . . . .
   Don’t know/Not sure . . . . . .
   Refused . . . . . .
4. How often do you eat potatoes not including french fries, fried potatoes, or potato chips?
   a. Per day . . . . . .
   b. Per week . . . . . .
   c. Per month . . . . . .
   d. Per year . . . . . .
   e. Never . . . . . .
   Don’t know/Not sure . . . . . .
   Refused . . . . . .

5. How often do you eat carrots?
   a. Per day . . . . . .
   b. Per week . . . . . .
   c. Per month . . . . . .
   d. Per year . . . . . .
   e. Never . . . . . .
   Don't know/Not sure . . . . . .
   Refused . . . . . .

6. Not counting carrots, potatoes, or salad, how many servings of vegetables do you usually eat?
   a. Per day . . . . . .
   b. Per week . . . . . .
   c. Per month . . . . . .
   d. Per year . . . . . .
   e. Never . . . . . .
   Don't know/Not sure . . . . . .
   Refused . . . . . .

Example: a serving of vegetables at both lunch and dinner would be two servings.

Section 8: Weight Control

1. Are you now trying to lose weight?
   a. Yes. . . . . .
   b. No . . . . . .
   Don't know/Not sure . . . . . .
   Refused . . . . . .

2. Are you now trying to maintain your current weight, that is, to keep from gaining weight? (105)
   a. Yes . . . . . .
   b. No. . . . . .
   Don't know/Not sure . . . . . .
   Refused. . . . . .

3. Are you eating either fewer calories or less fat to . . .
lose weight?
keep from gaining weight?
   a. Yes, fewer calories . . . . . .
   b. Yes, less fat . . . . . .
   c. Yes, fewer calories and less fat . . . . . .
   d. No . . . . . .
   Don't know/Not sure . . . . . .
   Refused . . . . . .

4. Are you using physical activity or exercise to . . . lose weight?
keep from gaining weight?
   a. Yes . . . . . .
   b. No . . . . . .
   Don't know/Not sure . . . .

Refused . . . .

5. In the past 12 months, has a doctor, nurse, or other health professional given you advice about your weight?

a. Yes, lose weight . . . . . .
b. Yes, gain weight . . . . . .
c. Yes, maintain current weight . . . . . .
d. No . . . . . .
Don't know/Not sure . . . .
Refused . . . .

Section 9: Other

1. In the last 12 months, was there ever a time when you DID NOT fill a prescription, take a diagnostic test, or follow medical treatment because you could not afford it?

Yes
No
Don't know
Refused

2. Do you think that a patient from a low income family has access to medical care of the same, better or worse QUALITY as someone from a high income family with the same medical problem? Would you say it is

The same
Better
Worse
Don't know
Refused

Appendix 12

Harvard University's 1982 Intergenerational Studies Life Survey

Today we are going to ask you to participate in an interview where we will ask you about your life history. The information you provide will enable us to better understand African American women, their needs, the African American women who utilize EDFRC services, as well as the nature and types of resources and supports necessary to meet the needs of African American women. The findings will be used by EDFRC in the development of more responsive and effective family services and programs. This effort will increase the East District Family Resource Center's (EDFRC) ability to become a more effective and responsive service provider to African American women accessing their services, as well as coordinated services through the East End Partnership with Families.

Family Structure

Family of Origin

1. Are your parents living?

2. About how often do you see your parents these days?

3. Describe your father as a person.
   a. health (or what died of)
   b. nature of S's present relationship to him
   c. recent changes in the father
   d. recent changes in the relationship

4. Describe your mother as a person.
   a. health (or what died of)
   b. nature of S's present relationship to her
   c. recent changes in the mother
   d. recent changes in the relationship

5. Parents' present marital status; relationship (suggested way of finding out the nature of relationship—how they balanced and complemented each other)?

6. Similarities and differences between yourself and your parents.

7. Did any adult you know other than your parents have an important influence on your life? (If yes) In what way?

8. (Outline sibling position) What effect did this have on you?

9. How did you get along with your siblings?

10. Has this influence you? How important has it been?

11. What do you know of your family tree?

12. Anything unusual in your family history?

13. How important is family to you? (background; size; closeness are all important; pull for them)

14. Could you tell me who, if any, relatives or others lived with you and your family? What kind of relations do you have with them?

Family of Procreation:

1. Tell Me about _____(names of offspring).
   Where are they? What are they doing?

Spouse:

1. Are you currently married? [If multiple marriages, identify most recent]

2.. Would you tell me now about_____(wife/husband)? [Use most recent marriage if multiple marriages]

What is he/she doing?

3.. What kind of relationship do you have with each other these days?

4.. In general, how satisfactory and happy is your marriage? Check the point on the following scale which best describes your marriage.

0_____1____2_____3____4_____5_____6_____7_____8_____9_____10____				
Very Unhappy	**Somewhat unhappy**	**Fairly happy**	**Very happy**	**Almost perfect**

Family Resources: Family & Parental Economic Capital

Please tell me about your family's economic status when you were growing up and living at home.

- Employment Status
    i. Father _____Employed ____Unemployed
    ii. What type of work did your father do?
    iii. Was your father employed consistently during your childhood?
    iv. Mother _____Employed ___Unemployed
    v. What type of work did your mother do?
    vi. Was your mother employed consistently during your childhood?

- Did your parents have the financial resources to take care of you and your family when you were growing up?

- How would you describe your family's level of resources when you were growing up?
    i. Upper income (Doing very well)
    ii. Middle Income (doing well)
    iii. Low income (Having some difficulty making it)
    iv. Very low income (Having serious difficulty making it)

- Education (Highest degree attained)
    vii. Mother _____
    viii. Father _____

- Insurance Coverage [When you were growing up and living at home]
    ix. Mother _____
    x. Father _____
    xi. Children _____
    xii. Family _____

Family Interactions including parental support

How supportive would you say your parents have been of you over your life time?

	Mother	**Father**
Very supportive		
Supportive		
Fairly supportive		
Not very supportive		
Not supportive at all		

Respondent Status

Employment/Career

1. Are you working for pay or have you worked for pay in the last 10 years.
   1.___Yes, now working for pay
   2.___Not now working but have in the past 10 years
   3.___No, not working and haven't in the past 10 years

IF YOU HAVE WORKED FOR PAY IN THE PAST 10 YEARS, PLEASE ANSWER QUESTOINS 2 BELOW. OTHERWISE SKIP TO QUESTION 3.

2. Please list and describe the jobs you have held in the past 10 years, starting with the first job you had in that period.

Dates	Name of Job	What did you do?

3. What do you do in your work? (Details)
4. How do you feel about your work?
5. What do you like about it?
6. Are there things you don't like about it?
7. When did you first make your choice of your present work?
8. How did you come to this choice? What basis?
9. How do you feel you have made out compared with what you hoped to be in your teens?
10. Would you choose this work again if you could start over? What would you do?
11. What are your hopes for the future?
12. Are you doing any planning for this?
13. Which would you say is more important to you, a job with security and a reasonable income or a less certain job with the possibility of greater reward?
14. If you could have a really good income without working, what would you do?
15. Do you mind telling me something about your financial situation? (Salary; Total Income; Savings?)
16. How do you feel about your present financial situation?
17. How do you think that you will make out financially in the future?

Military Service

1. Did (you/your husband) ever serve in the Armed Forces?
   a. Yes __ b. No__
2. Looking back over the years, do you believe that military service made any difference, good or bad, in (your/your husband's) life?

Religion & Social

1. How about religion?
2. Do you go to church often? How often? Has any of this changed over the years?

3. How about your family? Were they religious people?
4. Do you belong to any social clubs, lodges, recreational, church or service organizations?
   _____yes _____no

If you do, please list them below and check the appropriate box indicating degree of activity.

		Degree of Activity		
Name of Organization	Years Belonged	1=High	2= Medium	3= Low

Life Review

1. Where did you grow up? What neighborhood/community did you grow up in? [Describe where, street location, area, address, physical or geographical markers.—Capture moves and multiple locations?
2. Think back to when you were growing up in your neighborhood/community. [IF multiple neighborhoods, the neighborhood that you think influenced you the most or where you lived for the longest (?).]
   a. Tell me how where you grew up affected your
      i. life in general, including educational attainment, employment, relationships etc.?
      ii. health?
      iii. diet e.g. access to fresh fruits and vegetables
      iv. exercise, recreational, sports activities?
   b. What are the most important changes that have occurred in the neighborhood/community since your days growing up there?
3. What, if any community resources e.g. resource centers, church programs, community services activities etc. were available in your community when you were growing up? How did you or your family connect to or use these resources?

4. Where do you live today? What neighborhood/community?
   a. Tell me how where you live today has affected your
      i. life in general, including educational attainment, employment, relationships etc.?
      ii. health?
      iii. diet e.g. access to fresh fruits and vegetables
      iv. exercise, recreational, sports activities?
      v. access to health care
      vi. access to employment opportunities
      vii. access to transportation
5. How do you feel about yourself at this time in your life (good points, bad points)?
6. What are your earliest memories?
7. What were you like as a child?

Review of your life

1. Looking back over your life, which period below would you say brought you the ;most satisfaction? (please choose only one) …the least satisfaction? (please choose only one) Mark the appropriate space below.

	Most Satisfaction	Least Satisfaction
Childhood		
Adolescent years		
20 to 30		
30 to 40		
over 40		

Indicate briefly what made this particular period most or least satisfactory:
Most_____
_____

Least_____
_____

2.. As you look back over your life, can you pick out any point or points along your life course that you would call "turning points"-where your life really took a different direction than you had expected? (IF NO, SKIP TO QUESTION 9

(Let's start with the most important)

- Tell me about the turn. What was the change? What caused it?
- (IF APPROPRIATE) Who was most important in influencing you in the direction you took at that time?
- (IF APPROPRIATE) As you look back, do you wish you had gone a different way or would you make the same choice again?

1. Did you have any particular problems as a child? (If yes) What was done about them?
2. How was your health? How was this handled? Up to what age?

3. Did your parents have health insurance coverage for you and/or themselves when you were a child? 4. What type of health insurance coverage did your parents have when you were a child?
5. Where did you routinely access health care in your community when you were growing up e.g. doctor, health clinic, emergency room, naturapath etc.
6.What was your daily diet like as a child? How often did you eat fruits and vegetables, fried foods, "fast foods" etc.
7. What was your family's daily diet like? How often did they eat fruits and vegetables, fried foods, "fast foods" etc.?
8. Did you participate in any recreational or sports activities as a child? If yes, which ones? Were these individual, family, or organized activities?
9.Were your parents, siblings actively involved in any recreational or sports activities while your were growing up?

Health

Now I'd like to ask you some questions about your current health.

Menopause

1. Started? If not when anticipated?
2. Do you expect difficulty?
3. How will or has change affected health, behavior, appearance, sex life?

Psychotherapy

4. Have you ever considered seeing someone for psychotherapy?
    a. Yes
    b. No
    c. Thought about it but did not actually seek treatment

    (If answer yes, proceed with questions 2-5; if answer id "thought about it", proceed with question 6 only)
5. a. Over what period of time did you see someone?
    b. Who did you see? (psychiatrist, psychologist, psychiatric social worker, or other)
    c. How often did you see the therapist? (weekly, monthly etc.)
6. What seemed to be the basic problem for which you sought help?
7. What do you feel you got out of this experience?
8. If you hadn't sought psychotherapy, in what ways do you think your life might be different?
9. What was the problem at the time you considered seeking psychotherapy?
    What seemed to prevent you from pursuing treatment?

Health Care Access

1. What community health services do you currently access and where?

2. How do you generally receive information about health issues and/or resources available in your community?

3. Indicate the locations below that you routinely access for your health services
    a. Church
    b. Vernon Harris Health Center
    c. MCV
    d. Bon Secours Richmond Community Hospital
    e. Local Private Doctors
    f. Natural Healers
    g. Other _____

4. How well do you believe that you are able to take of your health?
5. What, if anything, gets in the way of your taking care of your health? What would be helpful in this regard? Does your work or your husband's work provide health insurance coverage?
6. What is your opinion about health care reform? How do you think that it will impact your health, life and overall well-being?

Now I'd have just a few questions to wrap up our interview.

7. On the whole, what kind of life have you had?
8. What would you change if you could live your life over?
9. Final question, please share your thoughts and perceptions on how being Black and female growing up in Richmond or the East End community has affected your life and health?

Appendix 13

International Comparisons

Location	Healthy life expectancy (HALE) at birth (years) both sexes	Infant mortality rate (per 1K live births) both sexes	Age-standardized mortality rate for cancer (per 100K population)	Age-standardized mortality rate for cardiovascular diseases (per 100K population)	Prevalence of adults (>=15 years) who are obese (%) female	Prevalence of adults (>=15 years) who are obese (%) male	Prevalence of current tobacco use among adults (>=15 years) (%) both sexes
Japan	75	3	119	106	3.3	2.9	29.4
Iceland	73	2	136	164	12.3	12.4	26.3
Italy	73	3	134	174	8.9	7.4	26.1
Monaco	73	3	120	115			
San Marino	73	3	140	223			
Spain	73	4	131	137	13.5	13.0	33.7
Sweden	73	3	116	176	9.5	10.4	22.0
Switzerland	73	4	116	142	7.5	7.9	26.5
Australia	73	5	127	140			24.8
Canada	72	5	138	141	13.9	15.9	21.6
Andorra	72	3	126	125			32.9
France	72	4	142	118			31.7
Germany	72	4	141	211	12.3	13.6	31.6
Luxembourg	72	3	134	177			34.7
Norway	72	3	137	181	5.9	6.4	32.0
Austria	71	4	127	204			43.3

Belgium	71	4	148	162	13.4	11.9	27.1
Finland	71	3	115	201	13.5	14.9	28.1
Greece	71	4	132	258	18.2	26.0	51.8
Israel	71	4	133	136			24.6
Malta	71	5	124	214	21.3	25.0	28.7
Netherlands	71	4	155	171			34.3
United Kingdom	71	5	143	182	23.0	22.3	35.7
New Zealand	71	5	139	175	23.2	21.9	28.6
Denmark	70	3	167	182	9.1	9.8	33.4
Ireland	70	4	151	214	12.0	14.0	26.3
Singapore	70	3	128	171	7.3	6.4	
United States of America	69	7	134	188	33.2	31.1	23.9
Portugal	69	3	140	208			35.8
Slovenia	69	3	160	228	13.8	16.5	26.5
Czech Republic	68	3	177	315	16.3	13.7	31.0

Source: Various years of data, *World Health Statistics, 2008*, World Health Organization, Geneva, Switzerland.

Appendix 14

Intake Variables

Variable Name	Operational Definition	Metric or Non-Metric	Code
MARITAL	Respondent's marital status	Non-metric (Nominal Categorical)	1=Married 2=Single 3=Divorced 4=Separated 5=Cohabitating (Never Married) 6=Unknown 7=Widowed
AGE	Respondent's age/Date of Birth recoded/recomputed to age at intake	Metric (Interval Continuous)	1= 17 years and under 2= 18 to 20 3= 21 to 24 4= 25 to 44 5= 45 to 54 6= 55 to 59 7= 60 to 64 8= 65 to 74 9= 75 to 84 10 = 85 years and over.
INCOME	Respondent's annual household income	Metric (Interval, Continuous)	1=Under $10,000 2=10,001-$19,999 3=$20,000-$29,999 4=$30,000-$39,999 5=$40,000-$49,999 6=$50,000 or more
EMPLOYMENT	Respondent's employment status	Non-metric (Nominal Categorical)	1=Employed full-time 2= Employed part-time 3=Unemployed 4= Not in labor force, homemaker 5= Not in labor force, student/job training 6= Not in labor force, retired 7= Not in labor force, disabled 8= Not in labor force, resident, inmate of institution

			9=Not seeking employment 10= Employment program 11= Unknown.
HIGHEST GRADE COMPLETED	Respondent's highest grade completed	Metric (Interval Continuous)	1= Below 8th Grade 2= 8th Grade 3= 9th Grade 4= 10th Grade 5= 11th Grade 6= 12th Grade 7= Some College 9= Graduate School 10= Other
CENSUS TRACT	Respondent's address recoded/matched to their census tract	Non-metric (Nominal Categorical)	1= Census tract 201 2= Census tract 202 3= Census tract 204 4= Census tract 204 5= Census tract 205 6= Census tract 206 7= Census tract 207 8= Census tract 208 9= Census tract 209 10= Census tract 210 11= Census tract 211 12 = Census tract 212

Appendix 15

Assessment Variables

Variable Name	Operational Definition	Need(s)	Need(s) = Code 1		Satisfaction with current situation = Code 2	Goal = Code 3
HOUSING	Respondents current needs (Code 1), level of satisfaction with the current situation (Code 2), and goal (Code 3) in this area	• Need Housing, • Homeless, Evicted • Housing in poor condition, Unsafe • Can't make housing/apt. costs	0= Doing really or pretty well, No needs-Doesn't need attention 1= Doing Ok-getting by; Some minor needs 2= Not doing well, not really making it; Serious need; clearly or definitely needs attention 3= Not doing well at all—in very bad shape; Emergency; Needs immediate attention 9= Staff rating; Not enough information		1=Completely Satisfied 2=Somewhat Satisfied 3=Somewhat Dissatisfied 4=Completely Dissatisfied	1. Locate Housing 2. Home Ownership 3. Improve condition/Safety of Housing 4. Afford Housing
BASIC FINANCIAL NEEDS		• Need Food, Clothes, Help with Utilities • Utilities Cut off • No Transportation			1=Completely Satisfied 2=Somewhat Satisfied 3=Somewhat Dissatisfied 4=Completely Dissatisfied	5. Increase access to food 6. Improve food quality and nutritional value 7. Increase access to work clothing 8. Increase access to everyday clothing 9. Increase access to warm clothing 10. Utilities established or

						re-established 11. Transportation
CAREER AND EMPLOYMENT		• Unemployment/Need Job • Dislike Job/'under'-employment • Need Job/Career Training			1=Completely Satisfied 2=Somewhat Satisfied 3=Somewhat Dissatisfied 4=Completely Dissatisfied	12. Increase job readiness 13. Search: look for new job 14. 14. Career: Specific skills training
PHYSICAL HEALTH		• Health Emergency • Chronic Illness • Minor to moderate health problems • No access to health insurance • No access to Health care • Child Immunizations • Promoting Health/"Wellness" • (Health Ed.,			1=Completely Satisfied 2=Somewhat Satisfied 3=Somewhat Dissatisfied 4=Completely Dissatisfied	15. Improve healthy lifestyle 16. Access Insurance 17. Access and treatment services 18. Access treatment compliance and follow-through

		Exercise, Prayer, • Meditation) • Dental Care				
PARENTING		• Parenting Stress • Need info on child/adolescent development • Child/adolescent behavior problem • Problems with discipline			1=Completely Satisfied 2=Somewhat Satisfied 3=Somewhat Dissatisfied 4=Completely Dissatisfied	18. Reduce parenting Stress 19. Improve parenting skills 20. Increase knowledge of child development 22. Improve child behavior
CHILD CARE		• Problems finding child Care • Problem affording child Care			1=Completely Satisfied 2=Somewhat Satisfied 3=Somewhat Dissatisfied 4=Completely Dissatisfied	23. Access child Care 24. Afford child Care
EDUCATION		• Poor School Attendance/Truancy • Poor School Performance • School Behavior problems • Want to			1=Completely Satisfied 2=Somewhat Satisfied 3=Somewhat Dissatisfied 4=Completely Dissatisfied	25. Improve attendance 26. Improve grades 27. Improve school behavior 28. Complete HS or GED 29. Complete vocational/technical training 30. Complete college 31. Complete professional or graduate training

		complete/return to school • Want to seek training/higher ed.				
RECREATION		• Don't know of local resources • No outlet/access to recreation			1=Completely Satisfied 2=Somewhat Satisfied 3=Somewhat Dissatisfied 4=Completely Dissatisfied	32. Explore and identify interest 33. Explore and identify resources (outlets and equipment)
EMOTIONAL HEALTH AND WELL-BEING		• "Bad Nerves" • Problems with Handling Anger • Depression/Feeling Sad, Low, Blue • Other Emotional Problems • Drug/Alcohol Problem (Substance Misuse/Abuse) • Grief Work (Death or Other Loss) • Need Social			1=Completely Satisfied 2=Somewhat Satisfied 3=Somewhat Dissatisfied 4=Completely Dissatisfied	34. Reduce stressors 35. Improve coping skills (e.g. social support) 36. Seek and complete treatment (SA &MH)

		Support/Access to Peers • (People to talk to/hang out with)				
COURT INVOLVEMENT		• Arrest • Probation • Need Legal Assistance • CPS Involvement • CHINS			1=Completely Satisfied 2=Somewhat Satisfied 3=Somewhat Dissatisfied 4=Completely Dissatisfied	37. Follow through with legal requirements 38. Locate legal assistance
FAMILY ISSUES		• Out of home placement (child) • Family Conflict • Family Violence (Fights, Spouse Beating, Abuse) • Separation/Divorce/Absent parent • Unwanted/Unexpected Pregnancy • Caring for			1=Completely Satisfied 2=Somewhat Satisfied 3=Somewhat Dissatisfied 4=Completely Dissatisfied	23. Cope with family transitions 24. Reduce conflict/violence 25. Locate family support resource 26. Separation/divorce/absent 27. Unwanted/Unexpected pregnancy 28. Caring for elder 45. Moving/People living in household

		• Elder Moving/People living in household			

Vita

CYNTHIA I. NEWBILLE

1601 North 27th Street, Richmond, Virginia 23223
(804) 788-6872 Phone 804-321-3807 Cell (804) 788-0433 Fax E-mail: s2cinewb@vcu.edu
United States Citizen, Place of Birth: Richmond, Virginia, Date of Birth: 11-07-51

EDUCATION:

MA – Psychology – May 1983
S.U.N.Y. at Stony Brook, Stony Brook, L.I., New York

BA – Psychology and Linguistics – August 1974
S.U.N.Y. at Stony Brook, Stony Brook, L.I., New York

PROFESSIONAL EXPERIENCE:

Ms. Newbille has a more than 25-years experience as a public servant and has earned a reputation as a dynamic consensus builder and catalyst for community development, health and education. Ms. Newbille holds a Bachelors and Masters Degree in Psychology from the State University of New York; and, is a 2010 Ph.D. Candidate for Public Policy and Administration from Virginia Commonwealth University. Her career includes progressive senior level positions such as Consultant for the Annie E. Casey Foundation, Administrator of the Richmond East District Initiative and Chief of Staff to the Richmond City Manager. Ms. Newbille works as a consultant for organizational management and administration and lives in Richmond's historic Church Hill Neighborhood. Ms. Newbille was elected in 2009 to represent Richmond's East End 7th District community on the Richmond City Council.