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Promoting the Health Needs of Homeless Women Residing in an Urban Community: A Participatory Action Research Study

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PROMOTING THE HEALTH NEEDS OF HOMELESS WOMEN RESIDING IN A SHELTER IN AN URBAN COMMUNITY: A PARTICIPATORY ACTION RSEARCH STUDY

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ABSTRACT

PROMOTING THE HEALTH NEEDS OF HOMELESS WOMEN RESIDING IN A SHELTER IN AN URBAN COMMUNITY: A PARTICIPATORY ACTION RESEARCH STUDY

Shirley Ann Powe Smith

The purpose of this study was to discover the health promoting needs of homeless women, residing in a shelter. A qualitative participatory action research (PAR) approach was used to solicit a deeper understanding of the women's health promoting needs. PAR is designed as a systematic inquiry, including collaboration with those affected by the issue being studied for purposes of taking action, empowerment, and effecting change. The specific aims for this study were 1) describe the health promoting needs of homeless women in the context of their lives as homeless women; 2) develop and implement a plan for meeting the health promoting needs of homeless women in the context of their lives as homeless women. The research questions for this study were 1) What are the health promoting needs of homeless women?; 2) What does the homeless woman need in order to maintain or improve her health and well-being?; 3) What are the health promoting activities identified by homeless women that promote their health and well being within the context of living in a shelter for homeless women?; and, 4) What is the process developed and adopted by homeless women living in a shelter to promote their health and well being?

Participation in this study was voluntary, totaling twenty-one (21) women who were recruited at various stages of the study. All women residing in the shelter met the inclusion criteria. The research team consisted of the homeless women and the researcher in the roles of co-researchers and co-participants.

The PAR approach consisted of four (4) phases, planning, acting, observing and reflecting, and evaluating. The data were collected through group and individual interviews. Each interview was audio taped and documented. Open-ended questions were utilized to elicit a deeper and comprehensive view of the women's health promoting needs and solutions to identified problems. The management of the data was completed manually by the researcher by entering data in to a computerized Word document. The analysis and interpretations of the data were presented to the research team who then validated the accuracy of the analysis and interpretation of the researcher. The team selected the activity to develop as an intervention.

The findings from this study indicated that a group of homeless women who resided in a shelter identified exercise as their health promoting need. They planned and developed a six (6) week walking class to meet self determine group outcomes. The concept of commitment emerged from the data. The women began to understand how this concept impacted on their likelihood of participating in the walking classes. They took leadership roles throughout the study period. The findings of this study will be utilized to guide the development of culturally appropriate, community-based education/health promotion programs for homeless women at this shelter currently and in the future.

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Very special thanks go to my husband, Robert. The completion of this research project could not have been accomplished without his unconditional loving support and understanding. His joy and pride in my accomplishments have been an inspiration. My children, Craig, Stephanie, and Jimmy have always been there for me. Thanks to all my family members who have been a support to me as a life-long learner. They have nurtured and encouraged me through years of study.

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I. INTRODUCTION

This qualitative participative action research study explored the health promoting needs of homeless women who resided in a homeless shelter for women located in a large northeastern metropolitan area. By approaching this group from a participatory action research (PAR) perspective the researcher engaged the group to determine significant issues and problems related to health promotion, plan actions to resolve these issues, and evaluate the outcomes of these actions. Stringer (1999) describes action research as a "collaborative approach to investigation that seeks to engage subjects as equal and full participants in the research process" (p.9). It involves inquiry whereby the participants take responsibility for devising plans to solve issues and problems regarding their health. The intention of PAR is for the homeless women to take responsibility for improving their health and well-being and, as a result, become more empowered. The women will hopefully feel a sense of empowerment due to their inclusion in all phases of the research plan. Choudhry, Jandu, Mahal, Singh, Sohi-Pabla, et al. (2002) conducted a PAR study of twelve South Asian Women immigrants to discover their health promotion issues. Their study concluded that self-understanding and self-confidence empowered individuals and empowerment in turn enhanced health promotion.

Homeless persons in general do not have access to health care (O'Toole & Withers, 1998) or regular consistent sources of healthcare (Gallagher, Andersen, Koegel, & Gelberg, 1997). The homeless have been found to seek care for an illness in the

emergency room, which is the most expensive point of entry for health care (Kushel, Vittinghoff, & Haas, 2001; O'Toole & Withers, 1998). According to these authors, homeless persons often delay help until their illnesses have reached life-threatening stages. O'Toole and Withers (1998) further stated that conditions such as diabetes and hypertension tend to become more severe for individuals who live on the streets. Health promotion and prevention are more difficult when one's health status has deteriorated. More intensive and expensive interventions may be required at this point of severity. The homeless tend to be more occupied with basic survival than with health care (Flynn, 1997; Gelberg, Gallagher, Andersen, & Kogel, 1997; Hwang, 2001; O'Toole & Withers, 1998). Due to these identified characteristics, the homeless may not engage in health promoting behaviors.

Utilizing a participative action research approach, the homeless women and the researcher collaborated to identify the health promoting needs and developed a plan of action that was implemented in the setting by the specific group of homeless women. The outcomes of the action plan was reviewed and evaluated by the women in order to develop and enhance the health promoting needs of the homeless women.

Prevalence of Homelessness

Homelessness in the United States has increased over the last two decades (Rosenhack, 1994; Watt, 2000). According to the U.S. Department of Health and Human Services (2002) 2 to 3 million people each year will experience homelessness. Some of these individuals will experience homelessness for only a short period of time, while approximately 200,000 will be chronically homeless. According to Rosenhack, the number of homeless has been estimated to be as many as 600,000 individuals in the United States (1994).

Accurately enumerating the homeless population is a difficult endeavor (Fitzgerald, Shelley, & Dail, 2001). Homeless persons move in and out of homelessness frequently and at random. This makes it difficult to obtain an accurate count. Point in time or the prevalence count method is one means of counting the homeless (Allegheny County, 2001). This method counts the number of homeless persons at a particular point in time and place. A point in time survey was conducted to determine the number of homeless on any day in Allegheny County, Pennsylvania (Allegheny County, 2001), where this current study was conducted. The count was taken on two dates in 2000, July 26 and December 6. The data were collected from housing shelters, outreach/drop-in centers, and supportive services and prevention programs. The findings indicated that 1808 were homeless on July 26 and 1919 were counted as homeless on December 6. Prevalence counting provides information only on those who are in the shelters at the time of the count (Phelan, & Link, 1999). The homeless persons who remain on the streets, who do not frequent those particular shelters, or who do not frequent the selected shelter on the day of the count are not included. Their responses are not solicited and therefore some important information may not be included in the data analysis of the study. These types of survey results present problems if they are generalized to the broader population of homeless persons. The information obtained might skew the picture of homelessness and certain characteristics might be overestimated. According to Phelan and Link (1999), if homeless persons with mental illness reside in the shelters for a longer period of time than those without mental illness, then the prevalence of those with mental illness will be overestimated if this information is generalized to the larger population. Therefore, the data gathered in this research study only described the perceptions of those homeless women who resided in the shelter at the time of the data

collection. However the data were utilized to plan and develop a specific health promoting activity for the shelter in which the information was collected.

Demographics of the Homeless

The demographics of homeless persons have changed. A prominent perception was that the homeless population consisted of hobos, vagrants, and skid row drunks who were usually white males (North & Smith, 1994; Strasser, Damrosch, & Gaines, 1991). Findings in a study of homelessness in 25 cities in the United States indicated that the homeless population at that time was comprised of 44% men, 36% families with children, 13% single women, and 7% unaccompanied minors (Mayor's, 2000). This report also described the homeless population to be estimated to be 50% African American.

The National Survey of Homeless Assistance Providers and Clients (NSHAPC) study was conducted to collect current information on providers of assistance to homeless clients and to identify the characteristics of those who used those services (Burt, et al, 1996). The survey investigators interviewed 4,207 randomly selected recipients representing all of the clients who used these programs nationwide. Some of these recipients were not homeless but used the services of these agencies for one reason or the other. The study reported that most homeless clients (85%) were single, 77% were male, 23% female, 41% white non-Hispanic, 40% black non-Hispanic, 10% Hispanic, 8% Native American and 1% other races This study also found that homeless families made up 34% of the sample. Sixty percent (60%) of these women had children under 18 years old. According to the Allegheny County Department of Human Services Bureau of Hunger and Housing Services' Annual Report (2000-2001) the single

females and single females with children each made up 28% (2,406 & 2,412, respectively) of the homeless population.

Study Background

This researcher has volunteered in homeless shelters for a number of years. As a member of a voluntary advisory board this researcher provided input in the development of a comprehensive and collaborative health clinic in the selected local shelter for homeless women. As part of a team of nurses this researcher prepared and served lunch while providing health education on a variety of topics to the residents of another local shelter for homeless women. During and after lunch the nurses interacted with the homeless women to solicit information on their health education interests as well as other health issues and concerns. These health promotion sessions were well received by the women and the shelter staff as evidenced by their questions and words of gratitude and thankfulness. On other occasions this researcher visited the selected shelter for homeless women and discussed their needs for health education and health promotion in relation to the breast self-examination (BSE). Individual interviews and a focus group on topics of health education needs were held. This researcher found that the women had a basic understanding of the BSE as a result of the media and previous contacts with the health care system. Some misconceptions about the BSE were noted as well as some pieces of information were missing as they discussed their perceptions. However, they expressed the convictions that performing the BSE was important and a topic about which they would be interested in learning more. Their exposure to the media blips on the necessity of the BSE and mammography may have been sporadic in nature, but provided evidence that this method of awareness might initially result in positive outcomes. At least it is important as a method of stimulating interest and awareness. The women also expressed interest in other health care

issues. These issues included hygiene, menopause, gynecologic problems (infections), diabetes and relationships (letting go of significant others in negative relationships).

One of the reasons for making contact in a timely manner was to develop trusting relationships with the homeless women who resided in and utilized the shelter. According to Carter, Cuvar, McSweeney, Storey, and Stockman (2001) rapport and trust that is developed early in the relationship with the prospective participants will impact on the development of mutual interactions and openness toward health care providers.

Impact of Racial Discrimination

There is a scarcity of information describing the perceptions of the homeless experience of African American women (Alley, & Macnee, 1998; North, & Smith, 1994). Although the reported sample in the Allegheny County study consisted of 63% African Americans, there was no gender specific breakdown of the participants (Allegheny County, 2001).

African American women, with a history of racial discrimination and bias, may face more barriers when attempting to take advantage of educational and employment opportunities that would ensure incomes to adequately support themselves and maintain suitable housing. Combining gender and race may make for a more difficult situation coupled with inadequate opportunities and support. North and Smith (1994) found that nonwhite homeless individuals seem to have more external issues that present socioeconomic barriers and increase minority women's vulnerability to become homeless

Orientational Definitions of Terms

In conducting any research study it is important that terms are specifically defined within the context of the study. To that end several terms are defined as orientation definitions. An

orientational definition is one that is "derived from the people and environmental contexts" (Leininger, 1995, p. 416). Other emic perspectives of definitions of terms may emerge as this study progresses.

Definitions will include:

1. Homeless person

   > "individual who lacks a fixed, regular, and adequate nighttime residence, or an individual who has a primary nighttime residence that is: (a) a supervised publicly or privately operated shelter
   > supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill); (b) a public or private place that provides a temporary residence for individuals intended to be institutionalized; or a public or private place not designed for, or ordinarily used as, regular sleeping accommodations for human beings" (Stewart B. Kinney Homeless Assistance Act of 1987 pp. 21-22).

2. Health promoting needs

   Those resources that may be utilized to assist the client to make behavioral changes in their lifestyle to impact positively on their health

3. Culture

   > "the learned and shared beliefs, values, and lifeways of a designated or particular group which are generally transmitted intergenenrationally and influence ones thinking and action modes" (Leininger, 1995, p. 9)

A. Significance of the Study

The homeless population is a medically underserved group (O'Toole, & Withers, 1998). This lack of health services has resulted in disparities in health between homeless people and the larger population (Hwang, 2001; O'Toole & Withers, 1998). It has also been well documented in Healthy People 2010 that a disparity in health status remains between African Americans and the majority population (Healthy People, 2000). Hunte, Bangs, and Thompson (2001)

investigated the leading causes of death among African Americans in Allegheny County and compared these rates to Whites in Allegheny County. They found that the death rates of heart disease in African American females ages 44-55 were three times those of Whites; the diabetes death rates among African American females and males were nearly two times greater than the White rates; and the death rates from stroke for African American females and males were about 1.5 times greater than rates for Whites ages 65-74.

These disparities may often be worsened when one is homeless with decreased opportunities for seeking appropriate healthcare. According to Carter, Cuvar, McSweeney, Storey, and Stockman (2001) access to health care includes the use of health services and the outcomes of using these health services. Lack of transportation, inability to navigate the health care system, lack of health insurance to pay for services, as well as the perceived unfriendliness of some health care facilities toward homeless people might account for some of the reasons for lack of access to health care (Griffin, 1994; Hwang, 2001; Mayor's Study, 2000; Smith, 1999). The health promoting needs of the homeless population are the same as their housed counterparts, but because of their homelessness they may be unable to take advantage of the resources that are available (Smith, 1999). In order to better serve African American homeless women it is necessary to understand what their health promoting needs are and how those needs can best be addressed. Soliciting this information from African American homeless women and encouraging them to devise methods of addressing their health promoting needs might result in an empowered future to further improve their personal health and well-being. Adequate health care for homeless women may include health promotion and health education. Programs that include health promotion, health education and disease prevention strategies may assist the homeless in making life-style changes appropriate to the population (Ahijevych, & Bernhard,

1994; Alley, Macnee, Aurora, Alley, & Hollifield, 1998). Utilizing the PAR approach will assist the researcher in understanding the health promoting needs of homeless women from their perspective, with a focus on African American women,. This is imperative, as appropriate and culturally competent care most likely would evolve from this information. What effect does their culture and ethnicity along with their homeless status have on how homeless women view their health promoting needs? What barriers to health promotion exist for them? How best to provide interventions that will address the health promoting needs of homeless women will come from the homeless women themselves.

According to Leigh (1995), African Americans received less health education regarding the danger signs for cancer. They were also more pessimistic about treatment for cancer than were Whites. The death rates for heart disease, cerebrovascular diseases, cancers, and diabetes were significantly higher for African American women than for White women.

Breton (2000) stated in her article on minority women in general that Acquired Immune Deficiency Syndrome (AIDS) is the "leading cause of death for black women ages 25-44" (p. 65). The author indicated that minority women experience more disabilities, diseases and premature death. This state of affairs may be due to any number of reasons, one of which may be the social and financial inequities that prevent minority women from obtaining the financial assistance or insurance necessary in maintaining a positive health status. Effective strategies must be developed that will resolve the housing and employment issues and health care problems of the homeless. If the objectives of Healthy People 2010 (2000) addressing access to care and elimination of racial and ethnic disparities are to be met, the homeless population must be afforded adequate and competent health care. This care cannot be achieved without knowledge of the beliefs, needs, and values of the identified recipients of that care. The development of

health promotion and health educational interventions based on these values, beliefs and worldviews of African American homeless women may more likely result in positive behavioral outcomes (Leininger, 1995). Discovering how African American homeless women perceive their situation may provide health care professionals with important information upon which to base needed changes. The perceptions that homeless women hold about their health hopefully and health-promoting needs are of interest to this researcher. This research discovered what some of the needs were and implemented an activity to address one of the needs. The findings were utilized to guide the development of a culturally appropriate, population-based nursing intervention for the homeless women residing in this shelter.

The more that is known about the health promoting needs of African American homeless women and how they perceive that these needs can be met, the better equipped nurses can be to meet these needs. Encouraging low-income women to discuss their experiences and perspectives is crucial in the attempt to address the problems of homelessness (Rollins, Saris, & Johnston-Robledo, 2001). Nurses are able to facilitate, assist, enable, and support homeless women with meeting their health promoting needs. They are able to create environments that are conducive to homeless women promoting their own health. This can only be accomplished if knowledge of what homeless women perceive about their health promoting needs is explored and documented.

B. Purpose and Specific Aims

The purpose of this study was to discover what homeless women perceived their health promoting needs to be and how these needs could best be met. It was important to understand the beliefs, values, and worldviews of groups and subgroups within the context of their environment and how these concepts impact on promoting their health. Their needs, as

articulated by them, provided the basis on which a health promoting activity was built. This activity was culturally congruent and sensitive in order to be effective. Therefore, the specific aims were:

1. describe the health promoting needs of homeless women in the context of their lives as homeless women
2. develop a plan for meeting the health promoting needs of homeless women in the context of their lives as homeless women

Findings from this study may enable health care providers to develop effective strategies to support, facilitate, enable, empower, and assist homeless women in a culturally appropriate and culturally congruent manner (Leininger, 1995). Health promotion and disease prevention services may be provided in a culturally appropriate manner if the health care providers have a more holistic understanding of the needs and ways of thinking of the client group. In addition, the homeless women participating in this study may be empowered to promote their own health.

C. Research Questions

The research questions for this study were developed to elicit the perceptions of homeless women residing in an urban shelter for homeless women. The shelter residents consisted of members of a variety of ethnic and racial groups. All residents of the shelter had the opportunity to participate in the study and all of the data was analyzed, interpreted, documented, and reported.

The research questions for this study investigated the following:

1. What are the health promoting needs of homeless women?

2. What does the homeless woman need in order to maintain or improve her health and well-being?
3. What are the health promoting activities identified by homeless women that promote their health and well being within the context of living in a shelter for homeless women?
4. What is the process developed and adopted by homeless women living in a shelter to promote their health and well being?

D. Assumptions of the Study

The assumptions of this study were that the women in the study would:

1) understand and articulate their health promoting needs
2) express interest in promoting their health
3) willingly participate in the study group
4) willingly discuss their health promoting needs
5) be willing to devise methods and act in promoting their health

It was the desire of this researcher that by utilizing the PAR method the research team would articulate methods of gathering information from the larger population in the shelter on their health promoting needs. It was further desired that the residents would develop strategies and interventions to meet those needs. Health care providers can best facilitate changes and institute new programs only if they are aware of the health promoting needs of the recipients of these programs.

E. Limitations of the Study

Only those women who volunteered and who were residing in the shelter for homeless women at the time of the data collection were included in the study. Therefore the limitation of this study is that the findings cannot be generalized to other homeless shelters and populations of homeless women on the streets.

F. Summary

Homeless women are in need of health care and health promotion to maintain and attain optimal health. African American homeless women as a population are also in need of health care and health promotion as evidenced by the Healthy People 2010 document describing the disparities in health status between African American and White populations. Some probable reasons for these disparities in health status were provided earlier in this paper. How homeless women remain healthy, what part they play in remaining healthy, and what their health promoting needs were was the primary focus of this research. Through the participatory action research (PAR) approach, the researcher was able to assist, enable, facilitate, and support the homeless women to promote their own health. This approach to research was intended to empower the participants because of their inclusion in all phases of the research. It resulted in the homeless women having ownership of the health promoting program.

II. REVIEW OF THE LITERATURE

Homelessness is a blight on American society. It destroys lives, traumatizes children, reduces human potential, and increases disparities in health status (Johnson, & Kreuger, 1989; Walters, & East, 2001). Gelberg and Linn (1989) state that homelessness damages the physical and mental health of those so afflicted. There is documentation in professional and non-professional sources on this state of affairs. A review of the literature found studies on the causes of homelessness, the health status of the homeless, homeless women in general, and homeless African American women in particular. However, a dearth of research studies on the health promoting needs of homeless women was found.

A. Causes of Homelessness

Some authors addressed the causes of homelessness. According to Montgomery (1994) the causes of homelessness in the United States, although complex, may be found in the socioeconomic conditions and trends in the distribution of wealth. Some conservatives in society today believe that homelessness is a personal rather than a structural problem (Phelan & Link, 1999). However, the root causes of homelessness are a complex group of risk factors that must be further identified and studied. Urban renewal without the availability of adequate low cost housing, lack of jobs, sexual and physical abuse of women and children, mental illness and drug and alcohol abuse are among some of these causes found in the homeless community

(Montgomery, 1994; Watt, 2000). Society must identify methods to assist homeless persons to maximize their potential regardless of their reasons for being homeless. Those marginalized against their will and who find it difficult to live within the constraints placed upon individuals to conform, must be allowed to exist with dignity (Montgomery, 1994). The providers of health care must be involved in ensuring that all groups in society receive appropriate and culturally congruent health services that are acceptable to the recipients of that care. Before these health services can be offered the health promoting needs of these groups must be discovered and documented.

B. Health Status of the Homeless

The health status of the recipients of services for the homeless was identified in the National Survey of Homeless Assistance Providers and Clients (NSHAPC) (Burt, et al., 1996). The researchers interviewed 4207 individual recipients of service. The findings indicated that 46% of the homeless clients reported having chronic health conditions, such as arthritis, high blood pressure, diabetes, or cancer. Twenty-six (26%) percent reported having acute infectious conditions, such as cough, cold, bronchitis, pneumonia, tuberculosis, or sexually transmitted diseases other than Acquired Immune Deficiency Syndrome (AIDS). Self-reports of alcohol abuse (38%), drug use (26%), and mental health problems (39%) were made. Many of these conditions are amenable to preventative and self care strategies, including lifestyle changes, through interventions provided and supported by healthcare providers. Furthermore, the homeless person's health status remains a problem because of competing priorities. These priorities are thought to be barriers to healthcare for them. Homeless people are so involved in

subsistence concerns, that participating in health care and health promotion and disease prevention programs has been relegated to a low priority when addressing their needs (Gelberg, Gallagher, Andersen, & Koegel, 1997; Gillis, & Singer, 1997; Hwang, 2001).

C. Homeless Women in General

Rollins, Saris, and Johnston-Robledo (2001), after completing a review of the literature on homelessness, concluded that even though quantitative studies on the topic were common, qualitative studies asking homeless women to share their experiences and perceptions were scarce. Other studies reviewed described homelessness in general and the need for "innovative approaches…to provide the homeless with affordable, quality health care" (Watt, 2000, p. 84); the need for services developed by the women themselves (Walters, & East, 2001); utilization of healthcare services (Kushel, Vittinghoff, & Hass, 2001); and the sources of strength in homeless women (Montgomery, 1994).

Perceptions regarding risk factors for homelessness included mothering responsibilities, types of victimization such as child abuse and rape, substance abuse, and mental health issues. The feminization of poverty and gender socialization, teenage pregnancy, and domestic violence are other factors that relate to the homelessness of women (Alley, Macnee, Aurora, Alley, & Hollifield, 1998; Johnson & Kreuger, 1989; Wardhaugh, 1999). Because of the multifaceted roles that women perform such as wives, mothers, widows, single, childless women, single parent to name a few, they are vulnerable to being without health insurance and access to health care. Some of these roles might result from divorce or separation, death of a spouse, interruption in employment histories, or employer cut back or elimination of dependent coverage (Leigh,

1995). These women may not possess the education needed to perform financially suitable work. Or they may not have access to employment that pays a living wage enabling them to support both themselves and their children. Since women are usually the caregivers for the family and of the children, they may not work outside the home. If they do, they may not be the main breadwinners of the families. When separation or divorce occurs, women tend to suffer more losses both financially and in their ability to find suitable employment. These factors assist in explaining the concept of the feminization of poverty.

Smith and Maurer (2000) list two types of women who are homeless. The first group is comprised of single women with histories of drug and alcohol abuse. According to Caton, et al (2000) "homeless women were almost twice as likely as never-homeless poor women to have a lifetime diagnosis of drug use disorder" (p. 10). The second group includes women who are psychologically and socially decompensated. This group includes "bag" ladies that are alienated from the mainstream of society and use few resources. Bag ladies were first recognized in 1973 (North & Smith, 1994; Smith & Maurer, 2000). These persons carry all of their possessions with them and usually live on the streets. Wardhaugh (1999) noted that there was no male counterpart to the "bag" lady and "bag" ladies were usually older women.

According to Caton, et al (2000), there is a certain group of people with internal problems such as substance abuse and psychiatric disorders for which living in this society is more difficult. This results in this group being more vulnerable to homelessness. Mental illness and substance abuse have been found to be highly prevalent among homeless women navigating society (Flynn, 1997).

Warren, Clement, and Wagner (1992) stated that homeless women are at a greater risk for

"crisis development and physiological and psychological dysfunction" (30). Future generations may be at risk as these women have decreased capacities to nurture themselves or their families. This factor has implications for the costs to society as a whole because of the resultant loss in human potential.

D. Homeless African American Women

There was a dearth of studies describing the perceptions of homeless African American women (Alley, & Macnee, 1998; North, & Smith, 1994). Studies have been conducted which have included African American women in varying proportions of the total population. Flynn (1997) conducted a study of 122 homeless women and of that group 75.4% were African American. The percentages of other ethnic groups included Whites (9.8%), Hispanics (6.5%); and others (4.4%). Another 4.1% failed to respond to the question. This study was conducted to identify the effects of learned helplessness, self-esteem, and depression on the health practices of homeless women. The results of the study indicated that learned helplessness and diminished self-esteem had negative effects on the health practices of the homeless women in the study. Health practices were categorized under "exercise, nutrition, relaxation, safety, substance use, and prevention" (p.73). These results were not broken down into ethnicity or race factors.

Ahijevych and Gernhard (1994) conducted a study of the health promoting behaviors of African American women. Utilizing the Health Promotion Lifestyle Profile (HPLP) developed by Walker, Seachrist, and Pender in 1987 the authors surveyed a group of 187 housed women, 60% of whom reported annual incomes of less than $15,000. Housed women were those women who had a place to live and were not considered homeless. African American women scored lower than White women on their likelihood to engage in exercise. However, they scored higher

than other groups on the health responsibility subscale. This subscale measured their intention to pay attention to their own health and to take responsibility and seek help when needed. The study did not indicate if there were differences related to age, sex, education, or income.

In a study by Warren, et al (1992) it was found that a large number of the homeless African American women were on a lower socioeconomic level than other ethnic groups. For this reason, among others, African American women were more vulnerable to physical and psychological illness and their vulnerability is linked to health and health problems (Rogers, 1997). This report goes on to state that because African American women were most often the family member providing the economic support and nurturing, they also suffered from increased levels of stress. These risk factors that impact on poverty contribute to the homeless status of some women (Rollins, et al, 2001, p. 284). And they "suffer from the increased exposure to most of them" (Geronimus, 2000, p. 867). Thus poverty becomes intertwined with femininity.

North and Smith (1994) and Caton, et al. (2000) found that African American homeless women were more often mothers, had their children less than 15 years of age with them, depended more on welfare for income, and were younger than their White counterparts. North and Smith's (1994) research also showed that non-white homeless women had less mental health disorders than did their White counterparts. Non-white women also had less often received both in-patient and outpatient psychiatric care for their mental disorders. Johnson and Kreuger (1989) and North and Smith (1994) found that homelessness in African American women was more often externally related to such issues as socioeconomic problems rather than internally related to drug-abuse and psychiatric problems. The non-white women were found to be more psychologically intact, but were experiencing the impact and disadvantages of racial status and poverty. They encountered external societal barriers and disadvantages on the basis of racial

status that tended to impact on their homeless status. These externally imposed barriers to housing are targets for change with providers focusing on social justice and racial inequality.

Pettaway and Frank (1999) conducted a study on the health promoting behaviors of urban African American housed women who were the heads of their households. In this study the 198 women of which 72.7% were African American, were administered the Health Promoting Lifestyle Profile to identify their health promoting behaviors. The study concluded that religiosity and education had positive relationships with health promoting behaviors. This finding might be useful when developing interventions to assist African American women to make lifestyle changes.

Dietary intake patterns of low income White and African American women were studied by Liu, Soong, Wang, Wilson, and Craig (1996). The sample included 726 women with 61% African American and 39% White. All of the participants had diets
that were high in fats and low in fiber foods. The authors concluded that the differences between the two groups were due to low levels of education and income rather than racial background.

E. Summary

In reviewing the literature on the health promoting needs of homeless women in general and African American homeless women in particular, it is evident that a gap exists in the availability of qualitative documentation on what homeless women perceive as their health promoting needs (Acosta & Toro, 2000). The literature reviewed indicated that there is an interest in the health, health status, and health care of the homeless. Quantitative research studies have documented health promoting behaviors by utilizing a health promotion model developed for that purpose. However, no qualitative studies utilizing a participatory action

research approach on the health promoting needs of homeless women were found in the reviewed studies. The scarcity of data indicates a need for more research in this area of concern. An attempt to fill that gap with the knowledge gained by discovering these health promoting needs of homeless women was made. This qualitative research study discovered the health promoting needs of women through the use of a research method and a research approach that addressed the unique needs of the participants and empowered them to make lifestyle changes based upon culturally congruent information. The findings from this study might be utilized to assist nurses to develop interventions and strategies for providing appropriate and culturally congruent nursing care for this target population. More studies need to be conducted on this population of homeless women regarding their health promoting needs as perceived by them. An approach asking the women themselves what they perceived to be their health promoting needs is lacking and is one that must be addressed.

III. METHODOLOGY

A. Methodology

A qualitative research methodology utilizing a participatory action research (PAR) approach was used to elicit the perceptions and health promoting needs of homeless women residing in a shelter for homeless women. According to Leininger (1995) researchers are "needed to learn from the people about their particular lifeways, values, beliefs, and practices with a focus on human caring, health, and well-being" (p. 37). An emic perspective, or how these selected homeless women view their world in relation to their health promoting needs, was solicited (Polit & Hungler, 1999). There was a transient nature to the women residing in the shelter and several women interviewed were unable to continue in the study because of being discharged or leaving the Shelter on their own. However, other women were solicited and replaced those who left the shelter during the duration of the study.

Participatory action research is defined as "systematic inquiry, with the collaboration of those affected by the issue being studied, for purposes of education and taking action or effecting change" (McNicoll, 1999, p. 51). The goal of participatory action research is to devise a method of resolving the issues as identified by those who will benefit from the resolution of those issues (Wadsworth, 1998). According to Seng (1998), the people have the knowledge about their own bodies, their particular needs, and their health beliefs and usually are aware of what is needed to make appropriate changes.

O'Brien (1998) describes action research as having dual purposes. The first purpose is to identify and study issues and problems that impact adversely on the group. Secondly, the group collaborates with affected members to make appropriate changes that result in the group moving towards its goals.

The process in this PAR study was a collaborative effort that involved the researcher and the participants as co-researchers and co-participants in all phases of the process. By identifying issues, developing plans, implementing actions, and evaluating outcomes, the women become empowered in that they played a major role in addressing and solving an issue that they identified as important to them. McNicoll (1999) further states that PAR utilizes a "non-oppressive method of gathering information" and is "social change-oriented" (p. 51). This method is consistent with emancipation and equity. The solution to the identified issue was developed by those who were experiencing the problems through full participation of the affected group and were not imposed from without (Lindsey, Shields, & Stajduhar, 1999; McCormack, & MacIntosh, 2001; McNicoll, 1999). Participatory action research may also be described as involving the participants in all phases from problem identification to evaluation of outcomes. This approach "offers a framework within which the investigator can work with and for rather than on" the identified group (Walters & East, 2001, p. 171). The problems, issues, and concerns of the participants were identified by the participants. They developed outcomes, devised actions, implemented an action plan, and evaluated the outcomes in collaboration with the researcher.

Walters and East (2001) further described action research as a reflective cycle utilizing planning, action, observing, reflecting and re-planning, opposed to a single problem-solving

process. PAR has also been described as strengthening research findings (Kock, McQueen, & Scott, 1997). This was believed to be the case because of the repetitiveness or iterations, of the cyclical process. This allows previous knowledge and findings to provide the basis for new knowledge.

B. Setting

The homeless shelter, located in a large northeastern urban, metropolitan area, is part of a partnership and collaborative effort of thirteen other health care and social agencies in the metropolitan area. They provide a variety of health, mental health, dental health, emergency housing, psychosocial and support services, recreational activities and meals to homeless women. The shelter houses two other residential programs of which the women leaving the emergency housing section of the shelter may take advantage. Both are housing and supportive services programs offering counseling, drug and alcohol group therapy, referrals, on-site outpatient medical, dental, mental health treatment, and meals to homeless women. Women may remain in one of the programs for a maximum of four (4) months and reside in semi-private rooms. The second program provides housing for up to twelve (12) months and private rooms. Although there is no fee for the first program, women residing in the second program must pay 30% of their net income for the services.

The women in the study may reside temporarily in the emergency shelter up to (60) days. The annual report from the selected shelter utilized for this investigation indicates that out of 342 women who left the shelter 234 remained in the shelter less than two weeks (Annual Report, 2000-2001). This shelter serviced 429 unduplicated single adult females in fiscal year 2000-2001. There were 260 African American women, 147 White, 7 Hispanic, 3 Asian American, and 12 other. The ages ranged from 18 to 76 or older with the average age served being 42.27 years.

In this shelter 48.3% of the women have mental health problems, 42% have drug/alcohol problems, and 28.2 have both mental health and drug/alcohol problems (Bureau of Housing Services and Hunger Homeless Assistance Program Annual Report, 2000-20001).

C. Planning for Data Collection

After Institutional Review Board (IRB) approval had been granted from Duquesne University and permission from the shelter administration had been obtained, the data collection began. The research team meeting was scheduled at the convenience of the participants. After the dinner hour was found to be the most appropriate time for this event as the women were not in the shelter during the day time hours. Each research team meeting and individual interview was audio taped as well as documented through the use of field notes written by a research assistant or the researcher. None of the participants voiced any concerns around being audio taped. Open-ended questions were utilized, such as, "How do you feel we can best discover what the homeless women in this shelter need to help them take care of their health?" "What do the homeless women in this shelter do to take care of their health?" This researcher maintained the role of facilitator, resource person, and expert in the research process to guide the action group in their decision-making.

D. Preparing for Data Collection

This researcher has a history of involvement in the selected shelter for homeless women as previously described. To further familiarize the researcher with the setting and the residents, this researcher volunteered during the dinner hour to assist in the preparation and serving of meals. Immersion in the culture and current activities of the shelter to become more familiar with the residents prior to collecting data from the residents was the goal of this activity and continued until the researcher was satisfied that the goal had been attained. During these

visits the residents and the researcher interacted on a regular basis and, in general, got to know each other.

After the researcher was sufficiently familiarized with the setting and the residents, a voluntary convenience sample of homeless women residents of the shelter was solicited to participate in the process of a qualitative participatory action research study. The residents participating in this part of the study were described as the research team. Their purpose was to determine the best method of collecting data on the health promoting needs of the homeless women residing in the shelter. They were solicited through the posting of flyers in the shelter (See in Appendix F). These flyers served as invitations to prospective participants to join the researcher in discussions on the health and the health promoting needs of the sheltered homeless women and what they needed to become and remain healthy. The printed materials indicated a date, time, and place that the initial meeting would be held. The name of a contact person along with contact information was included on the printed material if further information was needed. The size of the group was determined by the spontaneous needs of the group.

E. Co-Participants/Co-Researchers

Flyers were posted in the Shelter inviting the women to join the researcher in a discussion on the health promoting needs of homeless women. The flyer listed the day, date, time, and place of the first meeting. It was also noted on the flyer that refreshments would be served. At the time of the meeting a voluntary convenience sample attended the meeting. This initial research team consisted of homeless women and the researcher in the roles of co-researchers and co-participants. In this format the researcher was a part of the group, interacting in a similar manner as all group participants. The researcher also was in the role of participant-as-observer.

This role required that the researcher participate as a member of the group as well as that of researcher. According to Morse and Field (1995) observations provide the researcher with an objective view of the group being studied and assist with interpreting and validating the information provided by the informants. Both of the roles of the researcher were disclosed to the group with clarifications as needed.

Inclusion Criteria

A total of twenty-one (21) homeless women were interviewed and participated at various stages of the PAR process of planning, acting, observing and reflecting, and evaluation. The size of the research group was difficult to establish early in the research process. It depended on the number of residents who agreed to participate during each session. A full description of the composition of the various groups will be disclosed in the Findings section of this study. The inclusion criteria for participating in the study were that the participant must be female, 18 years of age or over, a resident of the selected shelter, and must agree to voluntarily participate in the study.

The shelter utilized in this study serves women of various races and ethnicities. They were all invited to participate in the roles of co-participants/co-researchers. This was necessary in view of the fact that a PAR study is being utilized, which requires the building of community and all who may be affected must be provided the opportunity to participate in all steps of the process. All resulting data was analyzed, interpreted, and reported.

F. Protection of Human Participants Used for Research

During the initial meeting of the research team the study was explained to potential participants by the researcher who answered questions, emphasized voluntary participation, assured confidentiality and obtained an informed consent (See Consent to Participate in a Research

Study, Appendix A). If written informed consent had not been acceptable to the potential participant, verbal informed consent would have been accepted. Verbal consent is appropriate for this population due to the high level of suspicion and their hesitancy to provide their names and information to those that they may initially perceive as a stranger. All participants agreed to written informed consent. The researcher explained the purpose of the research study, the methods of inquiry, and the significance to the residents and to the researcher. The residents were asked to complete a demographic information form after agreeing to participate in the study. This form included questions related to age, gender, education, and economic levels (See Demographic Form, Appendix B).

Data collected during the study was coded using numbers for each participant so that there would be no need to use their full name and to enable the researcher to return to the data for confirmation of data. The researcher maintained a master file with all research materials stored in a locked cabinet within the home of the researcher, accessible only to the investigator, and possibly the dissertation committee. The data will be retained for seven (7) years after the completion of the study and then discarded.

It was explained to the prospective participants that there should be no risk to those who participated in this research study. The benefits inherent in this methodological approach include a sense of empowerment and emancipation for those who participated in the study. This is brought about due to the sense of ownership that comes when the participants are involved in all parts of the PAR process from planning the actions to evaluating the results of their actions.

The topic of compensation arose early in the discussions during the meetings with individuals and groups. The participants felt that they should be compensated for their time. This was agreed to by the researcher. IRB permission was requested at that time and granted.

The researcher paid each participant a sum of twenty-five dollars ($25.00) at the completion of the study for their full participation, time, and any inconvenience.

G. The Cycle of Participatory Action Research

After the researcher completed the identification of the research team members, the tasks of initiating the first cycle of the PAR process began (O'Brien, 1998; Parsons, & Warner-Robbins, 2002). This research team along with the researcher determined the best method of collecting data from the population of the shelter. Each cycle of the PAR process has four phases. These phases have been identified as planning, acting, observing and reflecting, and evaluating the results of the plan with feedback utilized to revise the plan as appropriate (Gabel, 1995). The scope of knowledge gained during the first cycle in this research study will be broadened and may result in new actions (Wadsworth, 1998). During each cycle patterns may emerge which may enhance the generalizability of the PAR approach. Even though only one cycle has been reported on for this research study, the research will continue the collaboration begun with the homeless women through other cycles.

Planning Phase of the PAR Process

The first phase, planning, involved identifying and prioritizing the problems or issues and was exploratory in nature. The purpose of the planning phase of PAR was for the co-researchers and co-participants to be introduced to the research questions, determine the best method of collecting data from the women of the Shelter, respond to the research questions, and plan the action phase of the PAR process. The semi-structured interview questions may be found in Appendix D. This phase involved open and free-flowing dialogue between the co-participants

and co-researchers to elicit issues and problems of concern and propose solutions. During the first phase this researcher introduced and discussed the purpose of the study. An emphasis during this discussion was placed on the importance of discovering the health promoting needs of homeless women. Dialogue was encouraged to determine how best the research questions of the study could be answered. All ideas were heard, reflected upon, and critiqued by the team members to determine clear meanings and interpretations. A multiplicity of views, commentaries, and ideas came forth through thoughtful discussion and discourse. The sharing of ideas, beliefs, and values was the focus of this planning phase which ensured an emic perspective to the research questions proposed by the researcher.

During this phase the action plan was developed. The co-participants and co-researchers determined the best method for eliciting responses to the research questions from the shelter population. That is, how could the co-researchers elicit information on the health promoting needs of homeless women residing within this shelter? Alternative courses of action were considered. Focus groups and individual interviews were discussed as possible methods of data collection. It was determined by this group that individual interviews of the homeless women residing in the Shelter was the best method to collect the data. The researcher then proceeded to collect data from homeless women solicited for that purpose. When saturation of data occurred the researcher analyzed the data utilizing Leininger's Phases of Analysis for Qualitative Data (See Table 1.). The analysis included four (4) phases:

1) Collecting, Describing, and Documenting Raw Data
2) Identification and Categorization of Descriptors and Components
3) Pattern and Contextual Analysis
4) Major Themes, Research Findings, Theoretical Formulations

Table 1 Leininger's Phases of Analysis for Qualitative Data.

Table 1. Leininger's Phases of Analysis for Qualitative Data
Fourth Phase Major Themes, Research Findings, Theoretical Formulations, and Recommendations. The patterns were reviewed and the emergence of a theme was identified that covered the full perspective of the phenomena experienced by the homeless women.
Third Phase Search for Pattern and Contextual Features. In this phase the researcher searched for recurrent similarities and differences in the data from Phases 1 and 2. Patterns related to the issues and concerns of the homeless women within the context of the homeless shelter emerged out of this data.
Second Phase Identifying and Categorizing Components. The data was reviewed for similarities and differences and their meanings. It was coded and then placed in appropriate categories of concerns and issues.
First Phase Collecting, Describing, and Documenting Raw Data (Use of Field Journal and Computer). This phase included collecting and documenting all of the data from the interviews of homeless residents of the shelter, the staff and administration. Also included were observations made in the field by the participants and the researcher.
Leininger, M. M., 1995.

The process of data collection, transcription, and analysis was ongoing through all phases of the PAR process. The plans were that the researcher would utilize the method of data analysis and interpretation that was consistent with the method of data collection decided upon by the co-researchers. Since the group and interview techniques of data collection were selected, the management of the data was completed manually by the researcher utilizing a computerized Word document. First the raw data were audio recorded and captured in field notes. The researcher transcribed these notes as recorded after each meeting. This transcription was documented in a three (3) column form developed by the researcher. The first column remained blank initially and later was used to record the categories. The second column included the first name of each participant as they spoke. Included in the third column were the transcribed notes of each participant. The transcribed notes were then reviewed for similarities, differences, and meanings of the responses to the research questions by the participants. Categories were

developed which included similar data. These categories were recorded in the first column designated for this purpose. Listed under each main heading of a category were all of the items pertaining to that category. For instance, many of the women talked about how nutrition was important to their health and well-being. Their comments in this area were placed in the category entitled nutrition. Data were collected and recorded on a separate sheet for each interviewing session. The sheet contained the title of the research project, the date and time of the interview and the number of participants. The date and location of the data collection was also provided (Wolf, 2003). It was during this coding and categorizing phase that the researcher continually analyzed and interpreted the data which resulted in the creation of concepts. This is an important phase as it provides the basis for the first draft of the results of the study (Wolf, 2003). A full description of the analysis will be reported in the chapter on Findings.

The patterns and major themes emerging from the data were taken back to the research team. At this point the original women participating in the study has been discharged or had left the Shelter on their own. A new team of homeless women residing in the Shelter was solicited through the posting of flyers in the dining area and by encouragement of the Shelter staff. Four (4) homeless women attended this meeting. The team was asked to validate the analysis and interpretations of the researcher. They identified the issue that was most important to them. This team then developed and implemented the intervention carried out during the second phase of the PAR process, the acting phase.

Acting Phase of the PAR Process

In the acting phase of the PAR process the selected action plan which was developed, was presented to the Shelter administration for approval, and implemented according to the directions of the team. A walking class was selected as the activity to promote the health of the

homeless women in the Shelter. It was advertised and promoted throughout the Shelter. In this phase other women residing in the Shelter joined the team and took advantage of the intervention. Some homeless women participated for only one walking session; others participated until the end of the sessions.

Observing and Reflecting Phase of the PAR Process

During the observing and reflecting phase of the PAR process the co-researchers and co-participants observed, monitored, and reflected upon the action plan and the progress that they were accomplishing. The acting phase and observing and reflecting phase actually were occurring concurrently. Modifications in the plan were made as the plan was being implemented. These modifications were then incorporated into and carried out in the current cycle prior to the evaluating phase of the PAR process. Observations made by the co-researchers and co-participants were mutually validated. The participants described how they felt as they walked, discussed their activities and accomplishments in the structured programs in the Shelter, and their future plans and aspirations.

Evaluating Phase of the PAR Process

Evaluation took place after all the classes in the intervention were completed and the researcher compiled the data for presentation to the research team. This phase included evaluating the action plan and the actual action taken. Was the action taken appropriate for the purpose of the research, was it effective? Were the identified outcomes met? What was learned from the process of PAR? Was the process of eliciting data clear and appropriate? Such questions, among others, were asked and the responses will be utilized to improve, strengthen, and refine future actions. The new information that became evident at this point will form the basis for revising the initial plan and beginning a new cycle (McNicoll, 1999; O'Brien, 1998).

Each phase of the cycle was monitored and facilitated by the researcher to ensure a systematic process that adhered to the rigors of scientific research. Even though the researcher will continue participation with the team through several cycles of PAR, only the first cycle has been utilized for this research study. The intention of the researcher is to leave the homeless women residents with a process that they can operationalize independently due to their empowerment and the knowledge gained by participating in the collaborative process of participatory action research.

H. Summary

Qualitative inquiry with a PAR approach sought to discover the deeper insights on health promotion held by homeless women residing in a shelter. The PAR process empowered the homeless women as evidenced by their taking on leadership of the team and responsibilities for investigating resources to continue the work of the team. This finding confirms the results of research studies found in the literature conducted with a variety of similar groups.

This study is one of few that use qualitative inquiry with a PAR approach. Rollins, Saris, and Johnston-Robledo (2001) indicated that qualitative studies asking the homeless women about their perceptions were scarce. Their study found the health promotion needs of the homeless women categorized under nutrition and exercise. This finding is comparable to the findings of Flynn (1997) who also found the health practices of homeless women to include exercise and nutrition. The Flynn study did not break these findings down into race. However just under seventy-six (76) percent of the homeless women in this study were African American. This current study found that the homeless women of this Shelter had great faith in God as a source of hope and support. This bears some similarity to research conducted by Pettaway and Frank (1999) in which religiosity was one of the factors found to have a positive relationship on

the health behaviors of the women in their study, just under seventy-three (73) percent being African American. Although the women in their study were housed they were heads of households which tends to give some indication of their income status.

IV. FINDINGS

A. Introduction

The findings of this research study support the purpose of discovering what homeless women perceived their health promoting needs to be and how these needs could best be met through the process of participatory action research. It was important to understand the beliefs, values, and worldviews of the women of the Shelter within the context of their environment and how these concepts impacted health promotion. Their articulated needs provided a meaningful basis for health promoting activities. The activity identified was culturally congruent and sensitive as it was planned and developed by the women themselves. In addition to the initial research team, other women residing in the shelter joined in the selected activity to promote their health. The following research questions guided the study and will be discussed in the context of the findings:

1) What are the health promoting needs of homeless women?
2) What does the homeless woman need in order to maintain or improve her health and well being?
3) What are the health promoting activities identified by homeless women that promote their health and well-being within the context of living in a shelter for homeless women?
4) What is the process developed and adopted by homeless women living in a shelter to promote their health and well being?

The research questions listed above guided the process of data collection, analysis, and evaluation, utilizing the participatory action research (PAR) approach as described and initiated by the researcher and co-researchers. The PAR process was utilized as the method for conducting systematic inquiry into the identified needs of the co-participants for this study. One cycle of the PAR process was utilized in this study and included planning, acting, observing and reflecting, and evaluating. Since the PAR process is cyclical in nature, the researcher plans to continue the collaboration and involvement in the Shelter with the homeless women to further define the identified issue as well as explore and resolve other issues. The findings of this study will be presented according to the cyclical phases of the PAR process, which includes planning, acting , observing and reflecting, and evaluating.

B. Context of the Study

Programming Within the Shelter

Some of the co-participants in this study were in a structured program within the Shelter aimed at recovery from substance abuse. While in this program they were required to attend scheduled meetings for group therapy and were afforded semi-private living conditions. During the time spent completing the study, two (2) co-participants graduated to the next program level in which they had private rooms and were required to pay thirty percent (30%) of their income for room and board. Some of the women had families and children with whom they visited and who visited them from time to time in the shelter. Others spent time with their children in agencies set up for this time of family reunification. Two (2) of the participants in the study were either in an internship program or employed.

Background of Researcher

The researcher's background and interest in the health promoting needs of homeless women were described to the co-researchers. This background included participating as a member of the advisory board to establish the health clinic and as volunteering as a member of the kitchen staff providing and serving meals. The researcher began the process of inquiry by meeting with an administrator in the Shelter to gain approval to complete the research on site and to gain entrance into the Shelter. The purpose of the research and how the information solicited would be utilized were discussed. The idea was acceptable to administration and discussion ensued on how the researcher would make entrance into the Shelter. Although the researcher had a long history of volunteerism with this Shelter time had passed since the last contact. It was decided that the researcher would again volunteer within the Shelter to become familiar with it at this time. The researcher volunteered during the dinner hours by providing food and serving dinner to the residents. After a few weeks of volunteering it was decided that participants could be solicited for the research study. A flyer inviting participants to the meeting was reviewed by administration and approved (See the flyer in Appendix E). It listed the purpose, date, time, and place for the meeting and that refreshments would be served. The flyer was posted in the dining area of the Shelter. Staff was requested to direct the women's attention to the poster. Four residents attended the first meeting.

C. Characteristics of the Informants

The research team, while changing in members due to attrition as the PAR process progressed, was involved throughout the entire process. A total of twenty-one (21) or 43.8%, homeless women out of a maximum total of forth-eight (48) residing in the Shelter participated in this study. Thirteen (13) of these were responsible for providing the raw data collected during the planning phase of the PAR process. When the researcher returned to the research team with the analyzed and interpreted raw data for validation, another four (4) homeless women joined the

research team bringing the total of homeless women residents participating to seventeen (17). The total number of homeless women participating became twenty-one (21) during the acting phase of the PAR process when four (4) new homeless women participated in the selected activity developed by the research group. Table 2 provides a description of the PAR phase when new participants joined the team. The data describing the twenty-one women who participated in all phases of the PAR process may be found in Table 2, Demographic Data of Study Participants.

Table 2. Number of New Participants Per Phase of PAR Process

Phase of PAR	Activity	Number New Participants
Planning	Raw Data Collection	13
	Validation of Researcher's Interpretation	4
Acting	Walking Class	4
Total Participants		21
Shelter Capacity		48

Age of Participants

The ages of all of the women who participated in the study were within three age-ranges. The majority, N=10, forty-eight (48) percent were within the age range of 25-44 years. Thirty eight (38) percent, N=8, were in the 45-64 year range and the remainder, ten percent (10 %), N=2, were in the 18-24 year range (See Table 3).

Race/Ethnicity of the Participants

African American women represented seventy-one percent (71%), N=15, of the participants. Caucasian participants represented nineteen percent (19%), N=4. Five percent (5%), N=1, self-reported as Black/Indian, and five percent (5%), N=1, were non-specified.

Table 3. Demographic Data of Study Participants			
Age		Income (per month)*	
18-24	2 (10%)	$750 and under	15
25-44	10 (48%)	$751-$940	4
45-64	8 (38%)	$941 and over	1
65-74	0	No response	1
75 and above	0		
No response	1 (4%)		
Race/Ethnicity/Cultural Heritage		Income Source	
African American/Black	15 (71%)	Employment	1
Hispanic/Latino	0	Spouse/family	1
Pacific Islander/Alaskan	0	Welfare	2
Native American	0	Other:	
Caucasian	4 (19%)	SSI	7
Black/Indian	1 (5%)	Unemployment	2
No response	1 (5%)	Compensation	1
		Survivor's Benefits	1
		Unspecified	6
Length of Time Homeless		Have Health Insurance	
Weeks	3	Yes	16
Under 1 month	2	No	4
2-6 months	5	If yes, what type?: VA.	
6-12 months	4	UPMC, Gateway, Med	
over 12 months	5	Plus, Medicare/Section65	
over 1 month, less than 2 months	2	No response	1
Number of Times Homeless		Number of Children	
1-5	19	None	4
6-10	1	1-3	12
over 10	1	4-6	2
		Over 6	2
		No response	1
Educational Level		Children Under 15 live with	
Less than high school	3	You	0
High school diploma (GED)	8	Spouse	0
Some college/post secondary school	8	Children's Grandparents	4
College degree		Other family member	6
Associates	2	Friend	1
Bachelors	0	Non-applicable	10
Masters	0		
Doctoral	0		
Marital Status: Married	2		
Separated	2		
Divorced	4		
Single	11		
Widow	1		
Lived with Partner	0		
No response	1		

*Federal poverty guidelines (2003)

D. Presentation of the Findings According to Participatory Action Research Approach

Planning Phase of PAR.

The purpose of the planning phase of PAR was for the co-researchers and co-participants to

1) be introduced to the research questions

2) determine the best method of collecting data from the women of the Shelter

3) respond to the research questions

4) plan the action phase of the PAR process

This phase began with the first meeting held with the co-participants consisting of four (4) women who had volunteered to attend. They had many questions about the purpose of the meeting, including the reasons for the study and how the information would be used. The study and purpose were explained to them. Since this was a PAR approach it was made clear that the researcher would include the women of the research team in the entire process. The women were informed that they would be co-researchers and co-participants, as would be the researcher. This meant that the team members would identify issues that were of concern to them and determine methods of resolving those issues that would enhance their lives. It was explained that the researcher would also act in the role of participant observer and as such would be making observations and recording notes throughout the process. The researcher indicated to the team that their initial purpose was to determine how best to obtain information about the health promoting needs of the residents in the Shelter from those women residing in the Shelter. They agreed to form a team to discuss how the health promoting needs of homeless women could best be explored.

Each participant completed a demographic form (See Demographic Form, Appendix B). Consent forms were reviewed and signed by all participants (See Consent Form, Appendix A). The research questions were discussed at this initial meeting as well as during the subsequent group and individual interviews. The interviews were audio recorded and field notes were documented by the researcher. These audio recordings and field notes were transcribed after each meeting.

Three (3) women attended the second meeting, none of whom had attended the first meeting. All of the previous women had been relocated or had left the Shelter. With this new group of women the researcher explained the purpose and process of the study, took demographic information, and had consent forms signed. The nature of the PAR approach was also explained. This group of co-participants recommended that the best method of collecting data from the other women in the Shelter was for the researcher to complete one-on-one interviews. It was believed

that the women would not participate in a group format because of shyness and unwillingness to share before others. One woman stated, referring to the group format, "I don't think going up with pad and pencil and asking questions the way you asked me would work". At this point the researcher changed strategies to reflect the needs of the homeless women. It is important to mention here that flexibility on the part of the researcher is necessary when using the PAR approach. It is an approach that enlists the collaboration and cooperation of the participants and as such must take their needs into consideration. A total of seven (7) data collection meetings took place. The first three (3) were group meetings. The last four (4) meetings were one-on-one interviews. The women were quite willing to discuss their feelings and behaviors regarding taking care of their health in this format. This collection of homeless women were responsible for determining the best method of collecting data from the women of the Shelter, for answering the research questions, and for planning the action phase of the PAR process.

It had been suggested by various interviewees that the researcher would get increased participation if compensation for the time and convenience of the participants was provided. One of the participants stated "Some didn't come down here because no money, or they weren't getting anything". Some sort of gift or financial incentive was thought to be appropriate. Another woman stated "it doesn't have to be expensive, something from the Dollar Store". The researcher took this under consideration and agreed that compensation would be awarded. This is another example of how the researcher in a PAR study must respond to the needs and desires of the participants. This change in protocol required that the researcher return to the Institutional Review Board (IRB) at the University and request that compensation be permitted. A request to award a sum of $25.00 for attendance at four (4) meetings, which represented the four phases of the PAR process, was submitted. Permission was granted by the IRB and the planning phase of the PAR process continued.

Data collected during the interviews included concepts such as access to health care, time management, religious faith, health-promoting behaviors practiced, barriers to health promoting activities, and self-care. The group discussed how they improved their health and remained healthy. There were questions on the part of the research team members regarding their health that were posed such as where they could go for health care other than the on-site facility, how could the amount of paper work required be reduced, and how could communication within the Shelter be improved. After several weeks of individual interviews the data reached saturation. The interviewees were describing similar issues and situations. They articulated and defined common issues of importance to a number of them within the context of residing in a shelter for the homeless. Analysis of the data took place at this time.

Analysis of Data During the PAR Planning Phase

Leininger's Four Phases of Analysis for Qualitative Data. The PAR process requires that data collected initially from the research team be analyzed and brought back to the research group for validation. For the analysis of the data collected during the planning phase in the PAR process the researcher chose Leininger's Four Phases of Analysis for Qualitative Data (See Table 1, Chapter IV). The raw data collected from the individual and group interviews were then analyzed utilizing the four phases of Leininger's qualitative analysis as a guide. This raw data collected was in response to the researcher's questions such as "What do you do to become and remain healthy while living in this homeless shelter"?; "What are your health promoting needs"?; and "What do you need in the shelter to help you remain healthy"?.

Phase one began with the collection and documentation of raw data relevant to the research questions collected during the interviews. Both emic and etic data were considered in focusing on the data collected. It utilized all of the raw data collected to this point in time. During this phase the women discussed what it meant to be healthy, what they did to remain healthy, and what prevented them from promoting their health. Some responses to the interview questions included

"Taking my medication is what helps me stay stable". Another woman spoke of nutrition related to avoiding salts and caffeine and "eating plenty of fruits and vegetables" and getting plenty of exercise as important ways of taking care of her health. One woman stated that "One of the biggest components of my general well-being is the amount of walking that I do, every day". In response to the researcher's question, are there any things that you feel you need other than what you already have to remain healthy, one woman responded "the Bible". She went on to state that she "needed to be spiritually inclined". Another women speaking about the influence of religion stated "I know that when I leave here that I need to be thankful and grateful for everything because it was God who took me through this experience". One woman mentioned that the Shelter provided all the resources for them to get their lives together. All they had to do was take advantage of what was being offered to them. She put it succinctly "You can stay this way or you can use the resources and change the whole structure of your life". In response to what keeps you from being healthy one woman mentioned that the lack of staff development in medication administration made her uneasy. She stated that "lay people are dispensing medications without being licensed and without any knowledge of the side effects or the contraindications of the medications" and "That bothers me". Their perceptions of health were feeling good, being able to go about their daily activities, and possessing a positive attitude within the context of being homeless.

In the second phase of Leininger's qualitative analysis the raw data were coded and categorized as they related to the research questions. They were reviewed for saturation of ideas and for similarities and differences in perceptions in this phase of Leininger's Phases of Ethnonursing Analysis of Qualitative Data. Meanings were then attached to recurring components. The women shared many of the same concerns regarding how they remained healthy, how they prevented diseases, and what their needs were to continue these endeavors. "Obtaining the proper food and proper sleep" was of importance to one of the women. Some of the women discussed remaining healthy within the context of being homeless. "God is putting me through this" was

voiced by one of the women in response to what helps her remain healthy in a homeless shelter. Having a place to consistently exercise was another concern of the women. One woman noted that having her "own place, privacy, and a better relationship with people" would enhance her health. Another woman stated that "This is probably the best health care that I have had for quite some time" referring to the health care services provided in the Shelter. They also discussed the barriers that prevented them from promoting their health on a consistent basis. Such barriers as no space or time to exercise consistently and possible exposure to undiagnosed communicable diseases that other residents may have were seen as important issues that needed resolution. One of the women saw as a barrier the inability to access drinking water during the day due to the fact that the women had to vacate the Shelter daily for several hours during the day. She stated that "Just because of some of the rules that they enforce about where you can carry beverages, I don't actually get enough water". Others also had no place to go and found it difficult to drink water as needed. Some of the women reported attempting to eat healthy foods and drinking more fluids, practicing good body hygiene, maintaining their faith in God, exercising when and where they could, and having access to health care that was available, acceptable, and accessible. Categories of concerns that emerged from the dialogue included nutrition, religious faith, health promoting behaviors, and access to health care.

The Third Phase saw the emergence of patterns. The following patterns were derived from the data:

(1) Pattern of barriers to health promoting activities and behaviors .

Barriers to health promoting behaviors were seen as not having access to well balanced diets consistently. They felt that most of the foods served in the Shelter were high in calories, fats, and cholesterol. Although the Shelter offered a variety of foods so that the women could make choices, it was still perceived to be quite difficult to

access well-balance meals consistently. The inability to exercise due to the requirement to attend mandatory meetings and to the lack of an organized method of exercising was perceived as a barrier to promoting their health. Some women felt that their safety was compromised in that new admissions to the Shelter were not screened for the presence of communicable diseases in a consistent manner. They further discussed the need for Shelter staff to be trained in the recognition of the signs and symptoms of common diseases and when to refer for more advanced medical assessment. One woman stated "It bothers me that lay people are dispensing medications without being licensed and without any knowledge of the side effects or the contraindications of the medications".

(2) Pattern of behaviors and actions that promote health.

Actions and behaviors that promote health was the second pattern identified. The women reported a whole host of activities that they practiced in order to remain healthy. "I try to get fresh fruits and vegetables in me", "Walking helps me with depression", "When I go out I take only 2-3 cigarettes and I try to come back with one" were some of the statements made by the women. The behaviors that they reported participating in to promote their health included smoking cessation, personal cleanliness, walking, drinking water, avoiding stress, making healthy food choices, and prayer.

(3) Pattern of faith in God to get through adversity.

The third major pattern was one that described the faith in God exhibited and discussed by the majority of the women. There was an ever present sense of a belief in God throughout the interviews which was perceived as a means to sustain the homeless women in their hours of need and adversity. One woman exemplified this thought by saying "You know, God is putting me through this"

referring to the hard times she was experiencing by being homeless. This faith provided them with the strength, support, and hope necessary to work toward their recovery and progress toward independent living. Many of the women displayed positive attitudes about their homeless situation. This attitude was attributed directly to a belief in God and all that He could help them attain.

In the fourth and last phase major themes that emanated from the patterns were presented. This task "requires synthesis of thinking …analysis, interpreting findings, and creative formulations from data of previous phases" (Leininger, 2002, p. 95). After the researcher analyzed the data, identified categories, and noted patterns an emergence of a theme was recognized. This commenced the Fourth Phase of Leininger's Phases of Analysis of Qualitative Data. The theme that emerged was:

Women in the homeless shelter experienced a sense of hope based upon their faith in God while maintaining health and identifying barriers to their health promotion. This theme indicated that although the homeless women were constrained in their ability to act freely and consistently in terms of promoting their health, they did manage to find ways of doing so. They did what they could, when they could, but felt the need to be more organized and consistent in their endeavors to promote their health.

Reconvening the Research Group

After this brief break in the planning phase of the PAR process to allow the researcher to analyze and interpret the findings according to Leininger's Phases of Qualitative Analysis, the research team was reconvened. The purpose of this meeting was for the researcher to report the findings and interpretations that resulted from the analysis utilizing Leininger's Phases of Qualitative Data Analysis. The team was convened by sending messages to the initial research team, all of whom had moved out of the shelter. This turn of events meant that new participants had to be solicited from the women in the Shelter. A date and time convenient to the Shelter schedule

was set and posted in the Shelter. Participants were solicited through one on one request by Staff and through a convenience sampling at the time of the meeting. Four (4) women attended this meeting and assumed the role of co-participants and co-researchers. The

addition of these four homeless women brought the total number of women participating in the PAR planning phase of the study to date to seventeen (17). Only this last team of four (4) homeless women remained intact to the conclusion of the study. The planning phase of the PAR process begun with the initial research team was now continued with new team members. The purpose of this meeting was for the women to validate the researcher's analysis and interpretation of the data collected to date. The purpose of the study and an update on the progress to date was provided to the women. Demographic information was recorded and consents to participate were signed by the new members.

During this continuation of the planning phase of PAR the results of the analyzed data were presented to the group. The researcher asked the co-participants if the researcher's analysis and interpretations were accurate. They were asked to validate the interpretations and to decide which avenue to follow from this point. The women agree that the issues identified by the original group represented a wide and broad perspective of concerns and that they were accurate. After discussion of the findings, the research group identified the lack of physical activity expressed by the women and their need to be physically and mentally active in order to facilitate the promotion of their health as the most pressing issue. These women were aware of the part that healthy life-styles played in the prevention of disease and disability. They had been exposed to the print and visual media that espoused the importance of making life-style changes to reduce one's risk factor for any number of preventable conditions. The fact that good nutrition, optimum weight, decreased stress, and exercise were important in attaining and maintaining a positive health status was known to them. Their rationale for selecting exercise included their recognition that being physically active

was important to one's health and well-being. They described life in the Shelter as a sedentary one. There was basically nothing physical to do. They attended meetings and consumed their meals while sitting. The foods usually served in the Shelter were those high in starches, cholesterol, fats, and calories. It stood to reason that exercising on a regular basis could assist them in promoting their health. Through the process of working with these four (4) homeless women, a plan of action was developed and submitted to administration of the Shelter for approval to implement the plan.

There were now administrative and procedural tasks to be accomplished. First, two (2) members of the research team accompanied the researcher to a meeting with two (2) Shelter administrators to describe the plans and to secure permission to conduct exercise classes on site. Issues of confidentiality and supervision of the women when off site were discussed as some of the residents required staff supervision when off site. Space within the shelter was discussed. A possible site was one that was subcontracted to another community agency and would require legal clearance to use. Legal clearance would also be required from the Shelter in case some untoward event occurred while the women were exercising. Due to these restraints and the amount of time it would take to resolve them, it was decided to explore other sites for exercising.

The results of the meeting with administration were reported at the next meeting of the research team by one of the women who assumed a leadership position. Walking was eventually identified as the means of exercising as it could be accomplished on or off site. Off site courses were identified. Since the University was in close proximity to the Shelter it was decided to utilize the campus as a site for walking. Several sites on campus were explored such as the athletic center, the football/soccer fields, and the perimeter of the campus. The perimeter of the campus was agreed upon as the most convenient.

Specific responsibilities were identified to put the plan into action. Again the women assumed leadership responsibilities. One woman volunteered to develop and post a flyer announcing the walking sessions. She developed a sign-up sheet to post along with the flyer so that

others would sign-up if they intended to participate. The researcher accepted an invitation to attend a Staff meeting to describe the walking project to Staff and solicit their support. The Staff received the project positively with one Staff person volunteering to walk with the group each week. One of the members of the research team suggested that we all keep a positive attitude toward the walking so as to encourage others in the Shelter to join the class.

In the final analysis the women decided on conducting walking classes two evenings a week for a six (6) week period. They identified five outcomes to be measured for the walking classes. These outcomes included: 1) increase in stamina, 2) increased well-being,
3) increased self-esteem, 4) a healthy heart, and 5) weight loss.
The first three outcomes were measured by having the participants record their subjective feelings on a Likert-like scale with ratings from one to four with (1) poor, (2) fair, (3) good and (4) excellent. A healthy heart was gauged by normotensive measurements of their blood pressures. The revised scale of the American Heart Association on blood pressures was used to indicate pre-hypertensive to hypertensive readings (7th Joint Commission, 2004). Weight was monitored by measuring the participant's weight each week. At week three during the six week walking sessions heights were reported in order to record each participant's body mass index (BMI).

Acting Phase of the PAR Process

The plan was put into action and eight (8) homeless women and the researcher participated during the first walking session. This group of eight (8) women included the four (4) women of the research team. This meant that four (4) new women joined the team. Again the purpose of the study was explained, demographic forms were completed, consent forms were reviewed and signed, and how compensation would be earned and distributed was described. Each participant completed an Initial Survey (Appendix F) which documented their subjective feelings, their blood pressures and weights at this time. There were questions related to the presence of a preexisting diagnosis of hypertension and treatment, whether they exercised on a regular basis, and if they were on a weight

reduction diet at this time. A Weekly Survey (Appendix G) was completed to chart the progress of each walker. This form was an abbreviated form of the Initial Survey and asked the participant to reflect on their subjective feelings about their stamina, well being, and self-esteem. Their blood pressure, weight, and distance walked were also documented. In each subsequent week a Weekly Survey was completed by each participant. If elevated blood pressures were found, based on the American Heart Association (AHA) blood pressure guidelines, the woman was counseled regarding appropriate follow-up medical supervision. Beside the researcher, a registered nurse and a nursing student assisted in the collection of data.

A Staff person from the Shelter accompanied the researcher and the group on the walk each week. The women were usually waiting at the front entrance to the Shelter for the researcher to begin the walks on the second evening of the week. The directions for walking led from the Shelter to campus, around the perimeter of the campus and then returned to the Shelter (See Appendix H for Protocol). This was approximately 1.35 miles. The first walk was completed in approximately 35 minutes. Subsequent walks took approximately twenty-eight (28) minutes to complete

Observing and Reflecting Phase of the PAR Process

Throughout the six (6) weeks of walking and during two (2) focus groups, observations and reflections on those observations were carried out by the co-researcher, co-participants, other participants in the walking classes, and Staff. The women described how they felt within the context of being able to walk during the early evening hours in an environment that was conducive to quiet, serenity, and convenience. The Security Guard spoke of how anxious the women were for the walking class to begin as evidenced by them always being at the door waiting for the researcher to arrive.

Focus Groups

Two focus groups were held during the action phase of PAR where the participants reflected on their behaviors and feelings. One focus group was held after the first walking class, the second after the last walking class. The questions and responses during the first focus group were (See Focus Group Questions, Appendix I):

(1) How do you feel about what you did today? The women responded by stating That they felt "motivated, energized", "achy, tired", and "refreshed"

(2) Overall, what has this experience been like for you today? The responses included "Was a good experience", "relieves stress, anxiety", "Worry-free mind" "Mind not on food", "Feel less guilty about the food previously eaten", and "Glad that idea was put into action"

(3) How has walking in this class affected your personal life? Responses elicited included "Builds self-esteem" and "motivated to lose weight"

(4) Is there anything else that you would like to talk about today? There were no suggestions of other topics at this time.

Two (2) women attended the focus group held after the last walking session. Others had commitments that took them away from the Shelter and the weekly walk. The focus group discussion was on commitment as an important trait to continue participating in the walking sessions. One of the women who had previously expressed anger at those less committed stated "I don't always feel like walking but I'm committed to do what I said I would do" felt differently now. She stated that "I no longer am concerned about how others keep their word. I'm only concerned about what I can do". She was now more focused on self and felt that she must do what is best for her and not worry about what others did or did not do.

The researcher accompanied the women on the walks each week and observed that after time the walking of the participants became easier and took less time twenty-eight (28) minutes to

walk the distance, after originally taking thirty-five (35) minutes. This observation by the researcher was validated by the homeless women. Comments from the participants included that the walks were "refreshing" and "cleared the head". Discussion on several occasions reflected on the commitment of members of the group. The attitudes and values of those who participated consistently were that one must commit to an action and persist in it. This topic arose because several members of the group only participated periodically. They had various reasons for not participating such as body aches and pains, tiredness, other commitments. Some members were involved in other activities that interfered with them walking. Eventually the Shelter administration made sure that no other activities were scheduled during the time that the walking was to take place. This freed up the necessary time for all to participate freely. However there did not appear to be any increase in the participation by those who had indicated that this was an issue.

Walkers reflected upon how blessed they were to have been led to the Shelter and to the researcher. Some reported that they had access to and were welcome to stay in the homes of relatives and friends, but they felt that they never would have been exposed to the services and programs, the caring people, and their fellow residents found in the Shelter.

The researcher observed that a couple of the group members assumed leadership positions. The issue involving a conflict of times between walking and meetings was addressed by a Staff member and was resolved. One of the women felt that this issue should have been referred to and handled by the research group. She took it upon herself to discuss this with the Staff person and resolved this potential area of conflict. These behaviors indicated that the group members felt ownership for the walking sessions and that they should handle issues and seek resolutions for them.

Some of the women walked at different speeds as they progressed in the sessions. Others would walk an additional time around the perimeter of the campus. At the end all would wait for each other until all were ready to return to the Shelter. Some of the women would report if they did

not plan on attending the walk due to special events that they were to attend. As previously mentioned Administration made sure that the time allotted for the walking sessions was now a scheduled activity in the lives of the shelter residents. No other meetings would be scheduled for this time.

The women showed compassion and caring for each other during the walks. Some felt that they were role models for others in the Shelter. They encouraged each other to continue their efforts and provided needed support when appropriate.

In general the health promoting activity identified and implemented, walking, was a minor one that was somewhat easy to implement. In time and with continuation of the group meetings, it is hoped that other issues of a more complex nature may arise. However, being that the exercise issue was resolved, the increase in confidence and self-efficacy of the team resulting from the PAR process will assist them in future problem solving and decision making.

Role modeling was a topic brought up by the women during the walks and in the second focus group. One woman noted about another woman, "She has been such a great role model for others in the Shelter". Members congratulated this member who had exhibited exemplary behaviors that could influence others. The women felt that it was important for those in the group to encourage newer residents in the Shelter to become involved in the group and in the activities. To this end others will be invited to attend the next meeting of the research team which will mark the evaluating and last phase of the first cycle of the PAR process. The group felt that the outcomes of the walking sessions had been met and that the walks had been therapeutic.

Evaluating Phase of the PAR Process

The overall evaluating phase of PAR meeting was held approximately a week after the conclusion of the walking classes. The research team decided upon the day and time. There were four homeless women in attendance. Three of the women were members of the research team that

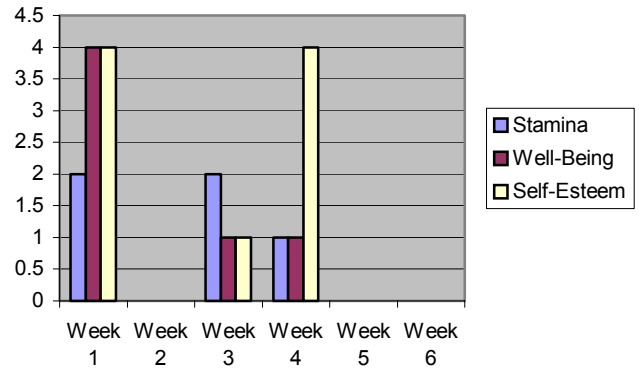
was convened to validate the interpretation and analysis of the raw data by the researcher. The fourth woman had walked consistently with the group from the beginning. The researcher reported on the outcomes of the walking sessions as determined previously by the research group. Even though twenty-one (21) homeless women completed demographic forms and signed consent forms, the aggregate data for the acting phase of the PAR process was based on only six (6) participants, as they represented those who consistently participated in the measurements and walking sessions. These twenty-one (21) women represented those who participated in the research study from its inception. According to the self-reported data collected and measured perimeters of six (6) participants, the walking exercises resulted in the outcomes listed in Tables 4 and 5. The data in each graph is that of each participant in the walking classes. Since the women attended sporadically, there are weeks when no data were recorded. This is because the participant may have been absent or arrived too late to complete the Weekly Survey form. There was an overall slight increase in stamina. Only two (2) women reported an increase in well being while the others remained the same or had a slight decrease. By the end of the walking classes three (3) women reported their self-esteem to be the same, two (2) indicated an increase, and one (1) felt that their self-esteem had decreased.

All six (6) walkers showed a decrease in systolic blood pressure representing a total decrease of 41 mm/hg (Table 5. Diastolic blood pressure had a net decrease of 31 mm/hg., with four (4) women lowering their diastolic pressure, one (1) increasing it, and one (1) remaining the same.

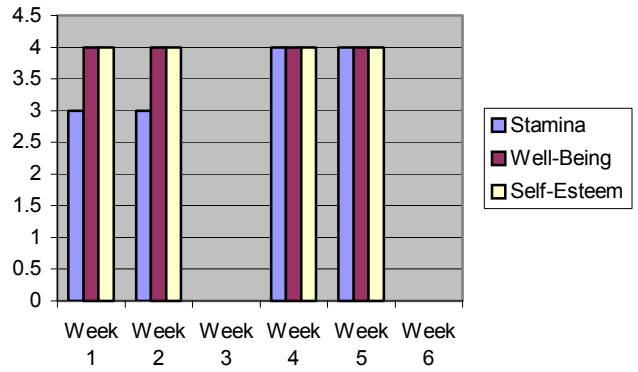
Only weight showed a negative result with a net increase of one (1) pound (Table 5). Three (3) women increased in weight, two (2) lost, and one (1) remained the same.

Table 4: Outcomes of Walker Exercises

Participant #20



Participant #17



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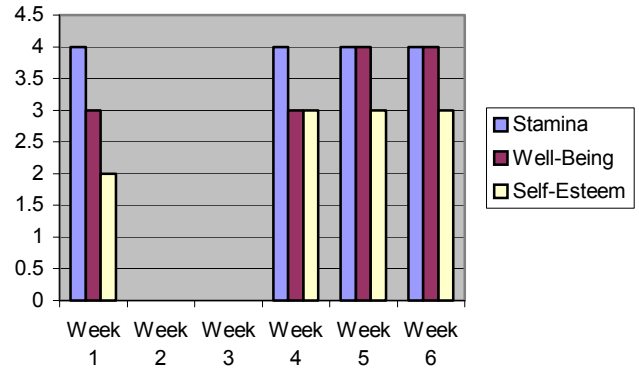
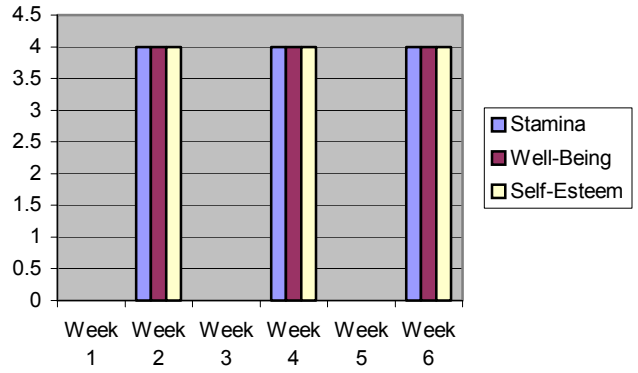
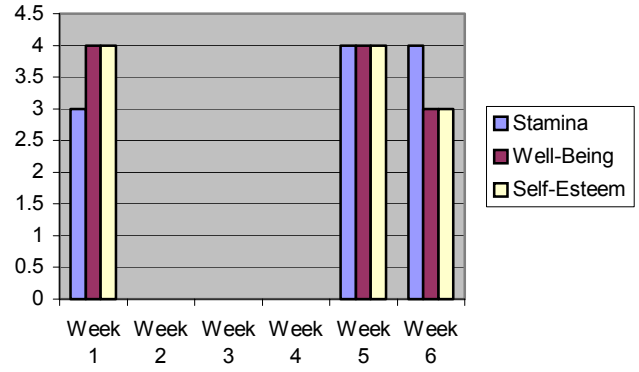


Participant #14



Participant #18



Participant #16

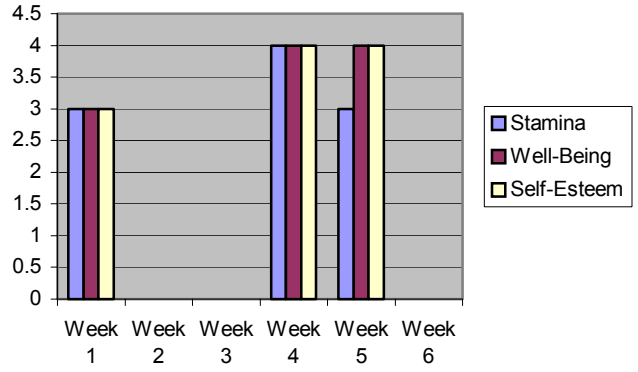
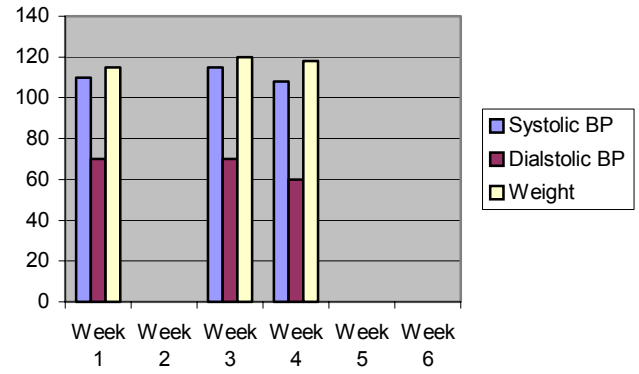


Table 5: Blood Pressure and Weights

Participant #20



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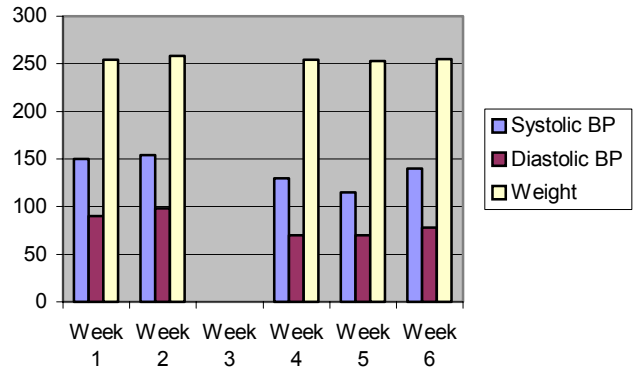

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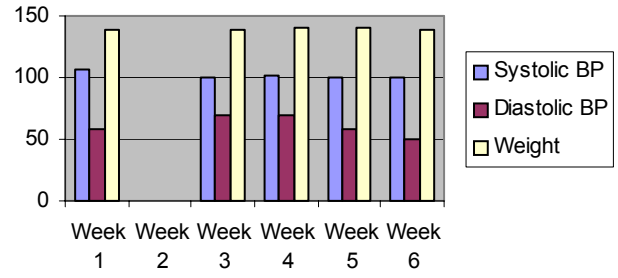

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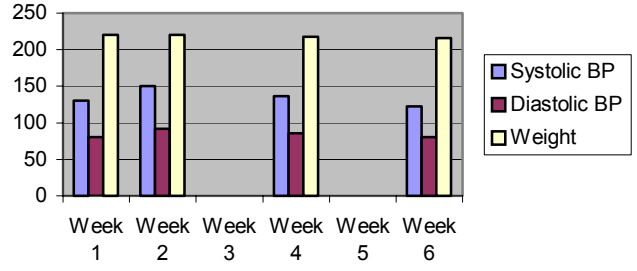

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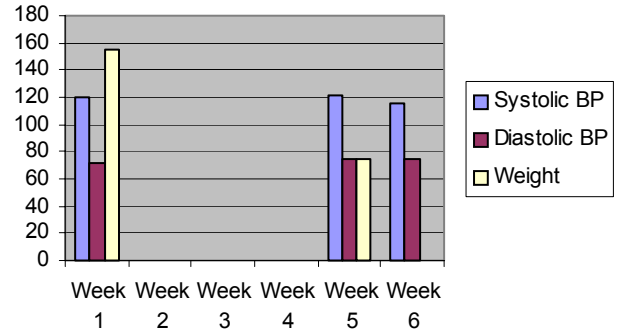
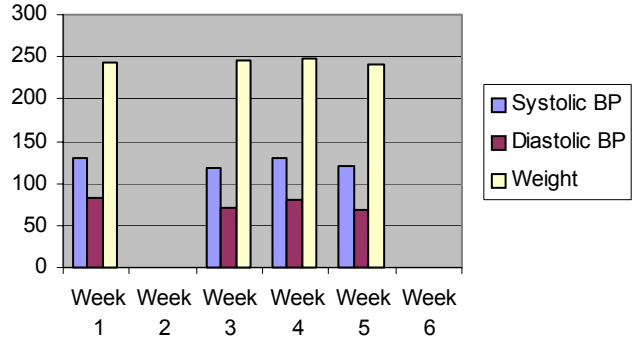


Participant #16



Other outcomes were noted that the women felt were significant. One member felt that she "slept better after walking". Her sleep was more comfortable. Others felt more motivation and were "eager to do something physical". Discussion ensued again around the concept of commitment. They felt that being committed to the walking sessions carried over into other activities in their lives. The act of just being there, getting themselves together motivated them to make improvements in other areas of their lives. One woman stated, "If I can push myself to do that (referring to the walking), I can push myself to do other things". She continued, "If you really don't do anything you get real lazy". "I think it helps if you are committed to something". Another woman stated:

> "I never committed myself to do; I started something and never finished it. So it gave me a feeling of something that I did and I could pat myself on the back because I started it, and I didn't want to walk all the time, but it was a commitment that I made. And ultimately after the walk it made me feel good. It was something accomplished".

One woman stated that walking made her " breathing better". She also had difficulty walking because of arthritis and only participated in the walking once.

Other comments from the homeless women on the walking sessions included that the walking location was a good one because "it had hills, flat stretches", "was scenic, not boring" and "overall it was a good walk". It was also observed that the walking time was perceived by the researcher and co-researcher to go by so quickly. In the beginning it seemed to take a long time to walk the 1.35 miles representing the distance from the Shelter and back. But after a couple of weeks the walking time seemed shorter. It was also noted by the researcher that the some of the women were slow during the first weeks and in subsequent weeks gained more speed.

Future Plans. Discussion ensued regarding future plans for the residents of the Shelter. Swimming was suggested by one of the women. She felt that it was the best exercise because "you moved all parts of your body". Twice a week was felt to be sufficient time for swimming. Swimwear and where to secure it was a concern. Some did not want to wear a bathing suit due to issues around exposing their bodies at this time. They thought that one could wear boxer shorts and a shirt instead of a swimming suit. Several places to swim were suggested. They included the local YWCA, the University pool both of which were within walking distance, and a community center, which would require a short bus ride to get access. Being a member of the "Y" was thought to be a barrier. One of the women suggested that perhaps something could be worked out between the "Y" and the Shelter that would allow them to swim in their pool. The women volunteered to further investigate each task. They were responsible for gathering information on each of the suggested sites. It was suggested that all report to a designated research team member who in turn will report to the researcher. Then the when, what, how, where will be determined.

Aerobics was the second suggestion as to a method to continue exercising. This could be conducted on-site at the Shelter. Video exercise tapes could be used to exercise. A television set and video player are available for use. There are two possible spaces within the Shelter to be considered. One of the women volunteered to discuss this matter with administration of the Shelter.

Recruitment: There was some discussion of recruiting others into the group. One woman said that she knew of two new members who would be interested in swimming. All were encouraged to ask others to join the group. The women were complimented by the researcher on being great role models for the other women within the shelter. Compensations and gifts were

distributed by the researcher. The group expressed their thanks to the researcher for giving of her time and energy because "no one else took the time".

E. Summary of the Findings

In summary, the findings of the PAR study indicated how a systematic approach to change may be integrated in the area of making lifestyle changes to promote the health of homeless women residing in a shelter for homeless women. Using an organizing framework that was consistent with the needs of the participants resulted in a more empowered and knowledgeable group of homeless women. The process of data collection was completed through a systematic process that took time, persistence, and patience. Approximately one (1) year transpired from the time that the researcher sought approval from the Shelter staff, to the end of the evaluation phase of PAR. The agency used in this study was one known to the researcher. Time had passed since the research last visited the shelter on a regular basis. The researcher had to again build a relationship of trust with the staff and homeless women. Several visits and phone calls were made to the agency in preparation to begin to collect the data. The purpose of the study and the process of the initial data collection were explained. Approval to conduct the research was granted. Entrance and approaching the women was carefully planned prior to data collection. Each step was communicated to all of those involved. For instance, the date and time of each visit that the researcher made to the Shelter was scheduled and communicated to the staff and security guard. Even with this careful planning there were times when someone in the communication chain was unaware of the researcher's visit. However, careful explanation usually cleared up the issue at the time of arrival of the researcher. Forming relationships with staff and security employed by the agency facilitated entry and built a sense of community.

The PAR process used in this study encouraged the input and collaboration of all members of the team through all phases of the process. Each participant was allowed the opportunity to fully act in her best interest and make changes deemed appropriate. A catalyst, in this case the researcher, is sometimes needed to assist clients to work towards making those changes. This researcher became a trusted ally, was flexible and consistent, and collaborated fully with the participants. Ensuring that the participants feel ownership in the project was important and basic to the plans for improving life conditions. These findings will add to the scarce amount of research using qualitative inquiry with a participatory action approach that has been found in the literature by this researcher.

V. DISCUSSION OF THE FINDINGS

A. Discussion

The health promoting needs of homeless women may be the same as or different from their housed counterparts. However, homeless women carry the added burden of being homeless in their pursuit to satisfy their health promoting needs. Strategies and interventions are required to assist homeless women in realizing and satisfying these needs. Through the systematic planning, acting, observing and reflecting, and evaluating phases of the participatory action research (PAR) process and guided by the research questions in this study, a strategy was developed and implemented that was aimed at the promotion of health of this group of homeless women.

There were four (4) research questions addressed in this study. The first research question asked "What are the health promoting needs of homeless women?" This study found the health promoting needs of the homeless women were for balanced nutrition, access to drinking water, and to be able to exercise. Even though the shelter provided a variety of foods each day, it was difficult to consistently maintain a well-balanced diet of food and drink. Some of the foods were found to be high in fats, cholesterol, and calories. This finding is comparable to the findings of Flynn (1997) who found the health practices of homeless women to included exercise and nutrition. The Flynn study did not break these findings down into race. However just under seventy-six (76) percent of the homeless women in the Flynn study were African American. This compares to the

seventy-one (71%) percent of African American women participating in the current study.

Access to drinking water was limited. The women were required to vacate the Shelter for several hours during the day. Most of them found it quite difficult to obtain drinking water while on the streets. They indicated that they were not permitted to bring food or drink back into the shelter and felt that this further limited their access to a variety of fluids. No comparable studies were found in the literature on the topic of hydration and the homeless.

The homeless women in this current study self-reported a sedentary life-style of sitting for most of the day. These findings indicated that lack of exercising was a major concern of the women. A study by Ahijevych and Bernhard (1994) in which African American women received the lowest score for exercising on the Health Promotion Lifestyle Profile scale supports the findings of this current study. Although the results in the current study were not broken down into race/ethnicity, African American homeless women represented 71% of the total participants. A need for exercise to promote their health was felt by the homeless women. Although they did exercise in the form of walking during the day, there was no consistency in this activity. The women were unable to consistently participate on a daily basis in exercise activities. Lack of a structured program of exercise within the Shelter fostered the lack of consistent exercising. Time, resources, and space might be provided for exercising in the Shelter to assist in satisfying this health promoting need. Alley, Macnee, Aurora, Alley, and Hollifield (1998) found in their study of women in crisis, 49% of whom were homeless, that during the crisis period the women did not exercise or adhere to other health

promoting activities. It was suggested by these authors that health care providers could encourage and guide clients in these situations to continue to promote their health. One might wonder why nutrition and exercise were so important to the homeless women in promoting their health. Perhaps the enormous amount of health information found in newsprint and television might account for this phenomenon. There is so much public education on the health advantages of maintaining good nutrition and participating in a daily exercise program. It could be inferred that homeless women have access to this information and internalize it as a part of their health promoting needs.

These responses reported above indicate that there are barriers to promoting the health of the homeless women in this shelter that could be addressed by the Shelter's administration through recognizing and addressing the identified needs of the women. The consistent provision of a forum that encouraged the homeless women to voice their concerns created an environment of open communication and dialogue. Throughout the group and individual interviews the women opened up to discuss their needs and concerns. They were quite open and articulate when provided the opportunity to talk about issues important to them. One of the women commented that it was therapeutic to be able to talk about her concerns. This type of format may be instrumental in providing an environment conducive to identifying and solving issues in a constructive manner.

The second research question that guided this study was "What does the homeless woman need in order to maintain or improve her health and well-being?". Here again, the women indicated that they needed access to a well-balanced diet, to water during the day, and to a place and time to consistently exercise. It was also noted by the women that the lack of staff education on medications and signs and symptoms of common diseases

put the promotion of their health at risk. No references to this issue were found in the literature by this researcher. Such a situation as described by the women frightened them in that they felt that there was no other recourse for them except to depend on staff that they did not trust, to have the necessary preparation to handle medical issues. The emotional implications of such a situation may impact negatively on one's health. A program of staff development could be implemented which would provide the staff with the knowledge and skills necessary to provide competent and sensitive care. The Shelter in this study does provide staff development. Perhaps this study might provide suggestions for future topics.

The third research question was "What are the health promoting activities identified by homeless women that promote their health and well-being within the context of living in a shelter for homeless. The women spoke of their spiritual beliefs and values and prayer that sustained them through adversity. A firm belief in God gave them hope, support, strength, and inspired them to move on toward improving their physical and emotional health. The belief in a higher power may give one the necessary confidence and strength to move on toward empowerment and taking responsibility and charge of one's life. Being empowered enables one to focus on problems and the situation, determine goals, and institute positive changes. This finding bears some similarity to that found by Pettaway and Frank (1999). They conducted research with homeless women in which religiosity was one of the factors found to have a positive relationship on the health behaviors of the women in their study. Just under seventy-three (73) percent of the women in the Pettaway and Frank study were African American. Although the women in their study were housed they were heads of households which

tends to give some indication of their income status. In the Shelter in this current study, religious groups visit regularly to provide services for those who are interested. The homeless women are free to attend churches of their choice in the area.

The fourth and last research question was "What is the process developed and adopted by homeless women living in a shelter to promote their health and well-being?". The process adopted was to follow the framework of the PAR process. During the first phase, planning, issues were identified and prioritized. A need for exercise was selected as the issue to address at this time. Through subsequent meetings during the planning phase, the women developed a walking class. They decided how often to walk, where to walk, and what outcomes to expect from the walking classes. The second phase, acting, of PAR commenced on the first day of the walking class. Participation by the homeless women was not consistent in the beginning. However several women did continue to participate on a regular basis to the end of the classes. During this phase the women participated in two (2) focus groups where they described their perceptions and feelings related to how the walking classes were affecting their lives. The third phase of PAR, observing and reflecting, occurred concurrently with the acting phase. Discussions took place on the advantages of their walking and on the activities in which they were involved to improve themselves. Several women expressed their appreciation of what the Shelter meant to them in terms of making lifestyle changes. One woman mentioned that the Shelter provided all the resources for them to get their lives together. All they had to do was take advantage of what was being offered to them. She put it succinctly "you can stay this way or you can use the resources and change the whole structure of your life". Another woman spoke of how she had other resources, such as the homes of family and

friends, where she could live. But the best place for her was in this Shelter as she would not have received the support and therapy in someone's home that she has received in the Shelter. This was quite insightful. This woman was able to understand and appreciate the positiveness of being placed in a shelter with supportive strangers rather than in the home of loved ones. With loved ones, because of the emotional involvements, this woman may not have been able to heal and progress in her recovery.

The fourth and last phase of PAR, evaluation, resulted in the women having a renewed confidence in what could be achieved by being committed to an action, in this case walking. Discussions ensued around the need to make a decision to change a behavior and then commit to it. A feeling a pride in accomplishment was observed by the researcher when the women spoke of being committed. It was as if by continuing their participation in the walking group they began to realize what they could do. They found that they could adhere to a lifestyle change and be positively affected by the behavior.

A Focus on African American Homeless Women

The researcher was particularly interested in the health promotion of African American homeless women residing in a shelter. The racial mix in the study found that seventy-one (71) per cent was African American. What, if any, effect did their race/ethnicity have on their ability to promote their health within the context of homelessness? No differences were found in this study in how the women promoted their health based on race/ethnicity. There was very little discussion on racism and discrimination from the women. One (1) woman out of twenty-one (21) interviewed spoke of being discriminated against in local hospitals based on her color. Another woman talked about being discriminated against in local health care agencies because she

was homeless. Perhaps if the researcher had broached the question of racism and discrimination specifically, there may have been more dialogue in this area. But that topic was not a focus of this research study.

A question that arose in the mind of the researcher was whether the African American women felt more at ease with the researcher, who was also African American, and therefore agreed to participate in the study. This was difficult to assess and there were no indications that the race/ethnicity of the researcher had any impact on the women's participation in the study. This may have been the case because the majority of women in the shelter and the staff were women of color. And another woman of color joining their ranks did not make much of an impact in the area of willingness to participate in the study. The only reference to the race/ethnicity of the researcher came from one participant. She expressed how proud she was to see a Black woman pursuing higher education. No discussions on the relationship between the race and ethnicity of the participants and the researcher were found in the literature by this researcher.

Johnson and Kreuger (1989) and North and Smith (1999) found that homelessness in African American women was more externally imposed related to socioeconomic issues rather than psychiatric problems. African American homeless women were found to be experiencing the impact and disadvantages of racial status and poverty. In the current study not much discussion ensued around what caused their homelessness. However from observations by the researcher there was a mix of reasons including drug and alcohol abuse as well as socioeconomic issues.

B. Implications

The findings in this research study have implications for nursing practice, education, and theory. In the domain of theory development certain concepts emerged from the discussions and observations during this first cycle of the PAR process. These concepts included commitment, empowerment, and collaboration. They were noted early on as behaviors that assisted the women in achieving their goals of becoming physically active and have implications for practice, education, and theory,

Implications for Nursing Practice

Nurses can use the PAR process for assisting individuals, groups, and communities in instituting self-described changes in their behaviors based on the needs and culture of those being changed. Rather than focusing on the preconceived notions of the provider about the needs and desires of the people and how they should be met, this process allows one to investigate issues and explore solutions in collaboration with those who will be the recipients of any programs or interventions to improve their health (Stringer, 1999). By the people being thoroughly involved in a planning, action, observation and reflection, and the evaluation process that is seen as democratic and equitable, they will be more likely to participate, be liberated and empowered to accomplish other goals, and work toward life-enhancing activities. Enhancement of one's spirit occurs—I will survive. I did this so I can do other things.

Implications for Nursing Education

Nurse educators can integrate the principles of PAR in curriculum development and in course content in the area of community outreach. The community is where health and wellness should begin. People must be aware of prevention, promotion, and risk

factor reduction. This awareness and methods to deal with health issues will assist them in promoting their health. Nursing students must understand that collaborating with communities whether at the individual, family, or group level must include these communities in the entire process of problem solving. Emphasizing the teacher role as one of facilitator and resource person rather than director is key to teaching students to effectively and efficiently work in the community. The findings in this study clearly indicate that the PAR process can be taught to nursing students as a framework for providing care to patients/clients. It emphasizes the importance of including the clients of care in their care. This process should ultimately result in fuller participation by the clients. Nursing education emphasizes the assessment of clients to discover their needs, validation of the nursing diagnosis by the client, and including the client in the development of their goals and objectives. These same principles are utilized in the PAR process. In this way the client is fully invested in their care and share the responsibility for carrying out the selected interventions. Nursing students can be taught this process which can be used in a number of settings.

Implications for Nursing Theory

Generation of Knowledge

One of the purposes of nursing research is to create knowledge to improve nursing practice and enhance the status of nursing (Polit & Hungler, 1999). Nursing researchers conduct research to increase the scientific knowledge base of nursing. They investigate phenomena to discover innovative and evidenced-based methods of providing

care to individuals, groups, and communities, to educate nursing students, and to define and discover administrative strategies to enhance the implementation of nursing.

According to Park (1999) there are three forms of knowledge that are generated through participatory research. Note here that the author Park (1999) refers to the process as participatory research with no mention of action. He explains this by noting that action is a key component in most participatory research activities. However, there are some participatory research projects conducted in organizations and corporations that include little participation or action by the people who should ultimately benefit for any changes brought about due to the findings of the research. The action is from a top-down perspective with the ultimate policies, procedures, and needs of the organization taking precedence over those of the lower level workers.

The categories of knowledge devised by Park included representational, relational, and reflective knowledge. Representational knowledge is knowledge that "depicts and explains" the reality of the person (p. 146). Within the context of this research study representational knowledge was brought forth. The homeless women throughout the process of PAR continued to describe and explain their reality in the area of health promoting activities and their needs. This was evidenced in the dialectic dialogue which included discussions, questions and self-reflection. This process ultimately brought about clarification of ideas, definitions, actions, and processes. It tended to generate self-knowledge as well as knowledge about the other co-participants. Out of these discussions emerged the idea of participating in physical activity to promote their health.

Relational and reflective forms of knowledge were beyond the context of this research study. They represent the basis of topics for further research which will be addressed in the section on Recommendations for Future Research.

Emerging Concepts

The concept of commitment emerged during the initial cycle of the PAR process. Commitment is defined as "a pledge to do something; being bound emotionally or intellectually to an ideal or course of action" (Webster, 1995). Fahrenwald and Walker (2003) in their discussion of the behavioral processes of change posited that self-liberation represented making a commitment to change. And commitment to change involves making realistic behavioral goals. In the current study the participants determined outcomes to be achieved during the acting phase of the PAR process which were realistic and reasonable. Overall the outcomes of the acting phase were satisfactorily attained.

The participants discussed commitment as an important factor in making changes in their health promoting behaviors. When discussing the elements of time and commitment consideration was given to other responsibilities of the residents of the Shelter. Many residents were involved in mandatory meetings during the day. Some had other responsibilities outside of the Shelter. However, in spite of these commitments, the group felt that once the commitment was made to participate in the physical activity that it should consistently be honored. The women commented on how commitment to the walking sessions might impact on their ability to participate in other life-enhancing activities. The more they extended themselves to attend the walking sessions, the more they began to internalize that physical activity on a regular basis was an attainable goal.

Hence their self-efficacy, or their belief that they could accomplish a particular task, was enhanced. According to Bandura (1977) one must have increased self-efficacy prior to actually participating in activities that lead to behavior changes. The women indicated a "belief in self-responsibility" (C. M., Personal Communication, May 15, 2004). They found that they must "take control of themselves in order to get what they needed from shelter" (G. S., Personal Communication, May 22, 2004). She continued by stating that the women should "take advantage of the opportunities and what's available".

During the walking sessions discussion ensued regarding the well-being and self-esteem of the participants due to their willingness to commit to a task. Changes were noted by the women, although small, in their lives. According to Stringer (1999) there is some change in the lives of the participants who participate in action research.

The women experienced the PAR process by providing input and making decisions. This, in turn, led to a commitment to improve themselves. Commitment to a goal might play a part in their becoming self-determined to resolving their substance abuse problems, receiving job training, finding employment, and moving on to conquer new goals.

Empowerment as a concept has been noted to be an outcome of the PAR process by several authors (Koch, Selim, & Kralik, 2002; Lindsey, & McGuinness, 1998; Walters, & East, 2001; Yuen, & Owens, 1996). Empowerment was observed in several ways. Two group members assumed the role as leader. They made decisions and guided other members in the processes and procedures. Women volunteered to investigate issues to ensure that the walking classes would be carried out in a systematic and organized manner. Discussions focusing on resources available, time and space,

administrative support, and liability issues were put forth by team members. Feelings of empowerment provided the leaders with the ability to make decisions about their role in the progress of the walking activity. This probably evolved because the women were provided the opportunity to voice their opinions, explore their ideas, values and beliefs, make decisions, and to act on those decisions. According to Meyer (2000) the democratic nature of the PAR process assures that the participants have equal say in decisions. Meyer (2000) continues by indicating that this democratic process makes the outcomes more meaningful to the participants as they are rooted in the reality of day to day practice. They experienced an environment, set up through the cooperation and collaboration of the Shelter administration that was conducive to taking charge of and making decisions. The PAR process empowered the homeless women as evidenced by their taking on leadership of the team and responsibilities for investigating resources to continue the work of the team.

The third and last concept was collaboration. During the meetings the women collaborated as co-participants and co-researchers in the decision-making activities of the group. According to Webster (1995) collaboration may be defined as working together with others. The homeless women collaborated with each other in the following manner:

1) determined the best methods of collecting data from the women residing in the shelter
2) agreed upon the health promoting needs of the group
3) selected a specific health promoting activity to initiate the process
4) developed a program to meet the identified health promoting needs
5) determined the outcomes of the activity selected.

Their participation in the meetings afforded them opportunities to provide input into the development of the activity and the process of conducting the activity. The women were involved throughout the entire process and as such owned it. According to Park (1999) this indicates a collaborative process within the research process. Ownership in the project was also indicated by the desire of the women to continue the cyclical process of PAR. Administration and Staff of the Shelter collaborated with the research group, the researcher, and the other participants by providing an environment that was conducive to accomplishing the identified outcomes and by making administrative decisions that avoided time conflicts

C. Limitations of the Study

One limitation of this study was in the small numbers in the groups. With larger numbers more interaction between the participants with increase exposure to a variety of ideas could have occurred. The second limitation was that only those women who volunteered and who were residing in the shelter for homeless women at the time of the data collection were included in the study. Therefore the findings cannot be generalized to other homeless shelters or to homeless women living on the streets. Another limitation was the transient nature of the homeless women residing in the Shelter. This resulted in new team members joining the team, replacing those who had left, throughout the entire PAR process. Women residing in the Shelter, but not in a structured program, had an average stay of two (2) weeks. A more stable group did evolve during the action phase of the PAR process. This group consisted of those homeless women who were in structured programs within the Shelter with a minimum stay of sixty (60) days.

D. Recommendations for Future Research

Further research should be conducted to investigate the concept of commitment as it relates to making lifestyle and health behavioral changes to promote the health of homeless women. What is the role of commitment in making improvement in the lives of homeless women? How is commitment defined within this context? How does it evolve? What are the characteristics of commitment? Can commitment be taught? If yes, how is it taught? What is commitment's relation to self-efficacy and self-determination within the context of a homeless shelter for women? What is the meaning of commitment in relation to the context of homelessness for women? How is it interpreted?

Park (1999) also discusses interpretive knowledge which may be classified as a component of representational knowledge. This component deals with the meanings put to the phenomena experienced by the homeless women and how those meanings are interpreted. The interpretive division is an option for further study. Perhaps a hermeneutic study which is one of the sciences of interpretation might be conducted to delve more deeply into these areas. To understand the nature of issues presented they must be interpreted and meanings attached (Park, 1999).

Other forms of knowledge as addressed by Park (1999) which included relational and reflective knowledge might be further researched within the context of a shelter for homeless women. The author states that relationships are the backbone of community life and relational knowledge can be augmented through participatory research.

Continuing the PAR process long-term might delve deeper into the health promoting needs of homeless women residing in the Shelter. The PAR process will be continued by this researcher in other initiatives identified by the homeless women.

This current study is one of few that used qualitative inquiry with a PAR approach. Rollins, Saris, and Johnston-Robledo (2001) indicated that qualitative studies asking the homeless women about their perceptions were scarce. This scarcity of qualitative studies indicates that there is a need for more research into the health promoting needs of homeless women utilizing this method.

E. Conclusions

Stakeholders

When there is discussion of nursing practice the benefits to stakeholders must be addressed. In this first cycle of a PAR process it became quite evident as to who the stakeholders were and what benefits they experienced and could experience in future cycles. These stakeholders may be identified as the homeless women, the Shelter Administration and Staff, and society as a whole.

The Homeless Women as Stakeholders

The first stakeholders, of course, were the women themselves. Leadership abilities and empowerment shone throughout the process. Decisions that needed quick solutions were handled as the group progressed. Increases in self-efficacy and commitment were evident in their self-reported subjective feelings. According to Parsons and Warner-Robbins (2002) the PAR as a methodology "empowers individuals

and groups to take action and builds confidence that the individuals and groups can accomplish goals" (p. 48).

The Shelter Administration and Staff as Stakeholders

The Shelter administration and staff were stakeholders. Now that the women have experienced a process whereby their opinions were sought and they were included in the entire process of self-determination, they might continue to use these skills in other areas within the homeless shelter. This should benefit administration and staff in that they might work in collaboration with women who are more self aware of their needs and strategies for satisfying those needs. These women have been involved in experiences that may have left them feeling more empowered to make decisions in a more organized manner

Society as a Stakeholder

Last, but not least, society as a whole is a stakeholder. It will benefit by having law abiding, contributing citizens rejoining society. People who have experienced a process that empowers and emancipates them might move on to further enhance their lives. They may possibly engage in other endeavors that allow them to participate in and give back to their communities.

F. Summary

In summary, the implications of this study are just the tip of the iceberg. The development of the walking sessions, although a minor and easily implemented solution to the issue of physical inactivity, served only as the beginning of an on-going process. This process could in the long run involve more residents and deal with more complex

issues affecting their lives within the context of a shelter for homeless women. According to Park (1999) PAR "does not easily ignite in spontaneous combustion regardless of how dire people's objective conditions are" (pp. 143-144). The author continues to explain that sometimes a catalyst is needed to encourage people to come together and discuss their issues in a non-threatening forum. This catalyst he sees as the researcher who has the ability to assist the group to work in a systematic, collaborative, and organized manner to identify issues, determine solutions, and act upon these solutions. As one participant in the study stated "God brought you (the researcher) here to help us".

Nurses are the providers of health care to diverse and vulnerable populations. They are able to facilitate the planning and development of appropriate health promoting interventions that can be delivered in homeless settings. Interventions aimed at enhancing the health of homeless women by enabling them to make appropriate health choices and lifestyle changes are of utmost importance. The intervention in this study was based on a strategy that had a high probability of improving the health behaviors and was culturally congruent within the context of homelessness. The intervention was based on an understanding of the health promoting needs of the target population. The women themselves best described their needs. The findings of this study will be utilized to guide the development of other culturally appropriate, community-based health education/health promotion programs for homeless women.

APPENDICES

APPENDIX A

DUQUESNE UNIVERSITY

600 FORBES AVENUE ♦ PITTSBURGH, PA 15282

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

TITLE: Promoting the Health Needs of Homeless Women Residing in a Shelter in an Urban Community: A A Participatory Action Research Study

INVESTIGATOR: Shirley Ann Powe Smith, MNEd, RN, CRNP
7000 Meade Place
Pittsburgh, PA 15208
412-396-6535 (W) 412-242-1956 (H)

ADVISOR: (if applicable :) Dr. Rick Zoucha
School of Nursing
412-396-6545 (W)

SOURCE OF SUPPORT: This study is being performed as partial fulfillment of the requirements for the doctoral degree in nursing at Duquesne University.

PURPOSE: You are being asked to participate in a research project that seeks to investigate the health promoting needs of homeless women. In addition you may be asked to allow me to interview you. The interviews will be taped and transcribed.

These are the only requests that will be made of you.

RISKS AND BENEFITS: There will be no risks to you. You may benefit from this study by being able to take advantage of any improvements in health care delivery that might come about because of this study.

COMPENSATION: You will receive a monetary compensation of twenty-five dollars ($25.00) at the completion of the study for your full participation, time, and any inconvenience. Participation in the project will require no monetary cost to you.

CONFIDENTIALITY: Your name will never appear on any survey or research instruments. No identity will be made in the data analysis. All written materials and consent forms will be stored in a locked file in the researcher's home. Your response(s) will only appear in statistical data summaries. All materials will be destroyed at the completion of the research.

RIGHT TO WITHDRAW: You are under no obligation to participate in this study. You are free to withdraw your consent to participate at any time.

SUMMARY OF RESULTS: A summary of the results of this research will be supplied to you, at no cost, upon request.

VOLUNTARY CONSENT: I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason. On these terms, I certify that I am willing to participate in this research project.

I understand that should I have any further questions about my participation in this study, I may call Dr. Paul Richer, Chair of the Duquesne University Institutional Review Board (412-396-6326).

_____ _____

Participant's Signature Date

_____ _____

Researcher's Signature Date

APPENDIX B

DEMOGRAPHIC FORM

DIRECTIONS:

1. Age:

    1.1 __18-24 years

    1.2 __25-44 years

    1.3 __45-64 years

    1.4 __65-74 years

    1.5 __75 years and above

2. Race /Ethnicity/Cultural Heritage:
    - 2.1 __ African American/Black
    - 2.2 __ Asian/American
    - 2.3 __ Hispanic/Latino
    - 2.4 __ Pacific Islander/Alaskan
    - 2.5 __ Native American
    - 2.6 __ Other _____

3. Length of time homeless at this time:
    - 3.1 __ weeks
    - 3.2 __ under 1 month
    - 3.3 __ 2-6 months
    - 3.4 __ 6-12 months
    - 3.5 __ over 12 months

4. Number of times you have been homeless:
    - 4.1 __ 1-5
    - 4.2 __ 6-10
    - 4.3 __ over 10

5. Educational level:
    - 5.1 __ less than high school
    - 5.2 __ high school diploma/GED
    - 5.3 __ some college/post secondary school
    - 5.4 __ college degree
        - 5.40 __Bachelor
        - 5.41 __Masters
        - 5.42 __ Doctoral
        - 5.43 __Other _____

6. Marital Status:

    6.1 __ Married
    6.2 __ Separated
    6.3 __ Divorced
    6.4 __ Single
    6.5 __ Widow
    6.6 __ Lived with Partner

7. Income (per month):
    7.1 __ $750 and under
    7.2 __ $751 - 940
    7.3 __ $941 and over

8. Income source:
    8.1 __ employment
    8.2 __ spouse/family
    8.3 __ welfare
    8.3 __ Other, Type? _____

9. Do you have health insurance?
    9.1 __ Yes
    9.2 __ No
    9.3 __ If yes, What type? _____

10. Number of children:
    10.1 __ 1-3
    10.2 __ 4-6
    10.3 __ over 6

11. If you have children under age 15 with whom do they live?:
    11.1 __ You
    11.2 __ Spouse
    11.3 __ Children's Grandparents
    11.4 __ Other family member
    11.5 __ Friend

APPENDIX C

Duquesne University Institutional Review Board Approval

DUQUESNE UNIVERSITY
INSTITUTIONAL REVIEW BOARD
403 ADMINISTRATION BUILDING ♦ PITTSBURGH, PA 15282-0202

Dr. Paul Richer
Chair, Institutional Review Board
Phone (412) 396-6326 Fax (412) 396-5176
e-mail: richer@duq.edu
web site: http://www2.duq.edu/research/policies.cfm#human

March 2, 2004

Ms. Shirley Ann Powe Smith
7000 Meade Place
Pittsburgh, PA 15282

Re: "Utilizing participatory action research to discover the health promoting needs of homeless women with a focus on African-American women, residing in a shelter in an urban community"

Dear Ms. Smith:

Thank you for submitting your research proposal.

Based upon the recommendation of IRB members, Dr. Linda Goodfellow and Dr. Kathleen Sekula, along with my own review, I have determined that your research proposal is consistent with the requirements of the appropriate sections of the 45-Code of Federal Regulations-46, known as the federal Common Rule. The intended research poses no greater than minimal risk to human subjects. Consequently, under rules 46.101 and 46.110, your proposed research is approved on an **expedited** basis.

In accordance with federal guidelines, the IRB stamps consent forms with an approval date and one year expiration date. This stamp appears on the front page of the consent form, which is enclosed with this letter. You should use it as the original for your copies. Please remember that there should be two copies of each consent form with original signatures, one for you and one for the subject.

This approval must be renewed in one year as part of the IRB's continuing review. You will need to submit a progress report to the IRB in response to a questionnaire that we will send. In addition, if you are still utilizing your consent form, you will need to have it approved for another year's use.

If, prior to the annual review, you propose any changes in your procedure or consent process, you must inform the IRB of those changes and wait for approval before implementing them. In addition, if any

procedural complications or adverse effects on subjects are discovered before the annual review, they immediately must be reported to the IRB Chair before proceeding with the study.
When the study is complete, please provide us with a summary, approximately one page. Often the completed study's Abstract suffices. Please keep a copy of your research records, other than those you have agreed to destroy for confidentiality, over a period of three years after the study's completion.

Thank you for contributing to Duquesne's research endeavors.

If you have any questions, feel free to contact me at any time.

Sincerely yours,

Paul Richer, Ph.D.
Chair, IRB

C: Dr. Rick Zoucha
Dr. Linda Goodfellow
Dr. Kathleen Sekula
IRB Records

DUQUESNE UNIVERSITY

INSTITUTIONAL REVIEW BOARD

424 RANGOS BUILDING ♦ PITTSBURGH, PA 15282-0202

Dr. Paul Richer
Chair, Institutional Review Board
Duquesne University
email: richer@duq.edu
web site: http://www2.duq.edu/research/policies.cfm#human

October 22, 2004

Ms. Shirley Powe Smith
7000 Meade Place
Pittsburgh, PA 15208

Re Amendment: **"Utilizing participatory action research to health promoting needs of homeless women with a focus on African American women, residing in a shelter in an urban community"**
Protocol #04/19

Dear Ms. Smith:

Thank you for following appropriate procedure in seeking approval of your proposed change in procedure.

Based upon the recommendation of IRB members who reviewed the original proposal, Dr. Linda Goodfellow and Dr. Kathleen Sekula, along with my own review, your amendment is approved. The amended procedure adds no risk for subjects in comparison to the original. Consequently the study remains approved under 45CFR46.101 and 46.110.

Annual review will remain on the cycle established by the original approval.

If you have any questions, feel free to get in touch.

Sincerely yours,

Paul Richer, Ph.D.
Chair, IRB

C: Dr. Linda Goodfellow
Dr. Kathleen Sekula
Dr. Rick Zoucha
IRB Records

APPENDIX D

Semi-Structured Interview Questions

Questions used during the group and individual interviews included:

1) How can we get information about how the women of this shelter take care of their health?
2) How do you as a homeless woman living in this shelter keep yourself healthy?
3) What kinds of things do you feel that you need to keep yourself healthy or to get healthy?
4) What are some things that keep you from being healthy?
5) Are there any other things that you will do or can do to improve your health?

APPENDIX E

Flyer to Solicit Participants

RESIDENTS OF BETHLEHEM HAVEN

COME PARTICIPATE IN A RESEARCH STUDY TO DISCUSS THE HEALTH AND HEALTH NEEDS OF WOMEN LIVING IN BETHLEHEM HAVEN

DATE: **Saturday, _____, 2004**

TIME: **9AM-10:00AM**

PLACE: **Conference Room, 1st Floor**

FOR MORE INFORMATION CONTACT:

Shirley Smith, MNEd, RN, CRNP
Doctoral Student
Duquesne University School of Nursing
412-396-6535

Refreshments and beverages will be served

Rev4/24/04/sps

APPENDIX F

EXERCISE SURVEY 2004
INITIAL SURVEY

NAME/ID# _____WEEK # ____ DATE/TIME _____

Release: ___Physician

Age: __18-24 __25-44 __45-64 __65-74 __75 & above

Race /Ethnicity/Cultural Heritage: __African American/Black __ Asian/American
__ Hispanic/Latino __ Pacific Islander/Alaskan
__ Native American __ White (Caucasian)
__Other _____

Are you being treated for high blood Pressure? If yes, how? _____

Program: __Shelter __STEP-UP __STAR

Resident of BH Shelter: __Yes __No

Do you perform aerobic exercises regularly? __Yes __No Last time exercised _____

Are you on a weight reduction diet? __Yes __No

Directions: Please complete this Exercise Survey for each walking/exercise session. The information collected will show your progress during the six (6) weeks of the walking/exercise program. Use the scale of 1-4 to rate your responses to the questions.

1=Poor 2-Moderate 3=Good 4=Excellent

OUTCOMES	WEEK #1/DATE 11/5&6	WEEK #2/DATE 11/12&13	WEEK #3/DATE 11/19&20	WEEK #4/DATE 12/3&4	WEEK #5/DATE 12 10&11	WEEK #6/DATE 12/17&18	SUMMARY OF OUTCOMES
Rate your ability to walk/exercise (stamina)	1 2 3 4 1 2 3 4	1 2 3 4 1 2 3 4	1 2 3 4 1 2 3 4	1 2 3 4 1 2 3 4	1 2 3 4 1 2 3 4	1 2 3 4 1 2 3 4	
Rate your well-being, (how well you feel)	1 2 3 4 1 2 3 4	1 2 3 4 1 2 3 4	1 2 3 4 1 2 3 4	1 2 3 4 1 2 3 4	1 2 3 4 1 2 3 4	1 2 3 4 1 2 3 4	
Rate your self-esteem (how you feel about yourself)	1 2 3 4 1 2 3 4	1 2 3 4 1 2 3 4	1 2 3 4 1 2 3 4	1 2 3 4 1 2 3 4	1 2 3 4 1 2 3 4	1 2 3 4 1 2 3 4	
Blood Pressure	/	/	/	/	/	/	
Weight	/	/	/	/	/	/	
Distance Walked/time Exercised							
Comments:							

These values and information are all considered to be confidential and will not be discussed or displayed to identify any of the participants. Your participation in the exercises is taken as your consent to provide this information.

Exercisesurvey/10/04/sps

APPENDIX G

EXERCISE SURVEY
WEEKLY SURVEY

NAME/ID# _____WEEK # ____ DATE/TIME _____

Directions: Please complete this Exercise Survey at the beginning of the first walking session of each week in which you participate. The information collected will show your progress during the six (6) weeks of the walking sessions. Use the scale of 1-4 to rate your responses to the questions.

1= Poor 2= Moderate 3=Good 4=Excellent

Do you exercise outside of class? __Yes __No If, yes last time exercised _____
Are you on a weight reduction diet?__Yes __No

OUTCOMES	WEEK #1/DATE 11/5 /04	WEEK #2/DATE 11/12/04	WEEK #3/DATE 11/19/04	WEEK #4/DATE 12/3/04	WEEK #5/DATE 12/10/04	WEEK #6/DATE 12/17/04	
Rate your ability to walk/exercise (stamina)	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	
Rate your well-being, (how well you feel)	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	
Rate your self-esteem (how you feel about yourself)	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	
Blood Pressure							
Weight Height							
Distance Walked/time exercised							

These values and information are all considered to be confidential and will not be discussed or displayed to identify any of the participants. Your participation in the exercises is taken as your consent to provide this information.

APPENDIX H

WALKING CLASSES PROGRAM PROTOCOL

DIRECTIONS:

- Assist each participant to complete the following:
  -Walking survey [Initial (yellow) and Weekly (blue)]
  -Demographic Form
  --assign a number and record participants name on the Those in Attendance Sheet next to that number
  -Consent Form—have participant read and sign
- Take and record:
  1. Blood pressures
     -- no caffeine or smoking 30" prior to taking BP
     --seated with (right) arm bared, supported at heart level
     --counsel according to the American Heart Association revised guidelines
  2. Weights
  3. Ask and Record Heights
- Walk: Start at BH; Go to Forbes Avenue Garage elevator; Take elevator to 8th floor; walk over to Academic Walk; proceed down Academic Walk to McAnulty to Bluff to Stephenson to Academic Walk (approximately one (1) mile); note those who may be having trouble walking and suggest that they stop and rest or end the session completely;
- Assist with recording during the focus group session (first and last sessions)

APPENDIX I

WALKING CLASSES

FOCUS GROUP QUESTIONS

1. How do you feel about what you did today?

2. Overall, what has this experience been for you today?

3. How has walking in this class affected your personal life?

4. Is there anything else that you would like to talk about today?

REFERENCES

REFERENCES

Acosta, O., & Toro, P. A. (2000). Let's ask the homeless people themselves: A needs assessment based on a probability sample of adults. *American Journal of Community Psychology, 28*(3), 343. Retrieved August 12, 2003 from http://proquest.umi.co/pqdlink?index=206&sid=1&srchmode=1&vinst=PROD&fmt=4&sta

Ahijevych, K., & Bernhard, L. (1994). Health-promoting behaviors of African American women. *Nursing Research, 43(2),* 86-89.

Allegheny County Department of Human Services, *Bureau of Hunger and Housing Services, Annual Report*. (2000-2001).

Alley, N., Macnee, C., Aurora, S., Alley, A., & Hollifield, M. (1998). Health promotion lifestyles of women experiencing crises. *Journal of Community Health Nursing, 15*(2), 91-99.

Annual Report. (2000-2001). Bethlehem Haven. *Bureau of Housing Services and Hunger Homeless Assistance Program.*

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavior change. *Psychological Review, 84, 191-215.*

Breton, J. H. (2000 November). Treating Beyond Color: Health issues in minority women. *Advance for Nurse Practitioners*, 65-101.

Burt, M. R., Aron, L. Y., Douglas, T. Valente, J., Lee, E., & Iwen, B. Homelessness: Programs and the People they serve, summary Report [On-line], Available: http://www.urban.org/housing/homelss/homeless.html

Carter, J. H., Cuvar, K., McSweeney, M. Storey, P. J., & Stockman, C. (2001). Health-seeking behavior as an outcome of a homeless population. *Outcomes Management for Nursing Practice, 5*(3), 140-144.

Caton, C. L. M., Hasin, D., Shrout, P. E., Opler, L. A., Hirshfield, S., Dominguez, B., et al. (2000). Risk factors for homelessness among indigent urban adults with no history of psychotic illness: A case-control study. [On-line]. Available: http://gatewayLovid.com:80/ovidweb.cgi

Choudhry, U. K., Jandu, S., Mahal, J., Singh, R., Sohi-Pabla, H., & Mutta, B. (2002). Health promotion and participatory action research with south asian women. *Journal of Nursing Scholarship,34*(1), 75-81.

References (continued)

Fahrenwald, N. L., & Walker, S. N. (2003). Application of the transtheoretical model of behavior change to the physical activity behavior of wic mothers. *Public Health Nursing, 20(4), p. 307-317*. Retrieved March 18, 2005, from http://gateway.ut.ovid.com.authenticate.library.duq.edu/gw2/ovidweb.cgi

Fitzgerald, S. T. Shelley, M. C., & Dail, P. W. (2001). Research on homelessness. *American Behavioral Scientist, 45*(1), 121-148.

Flynn, L. (1997). The health practices of homeless women: A causal model. *Nursing Research, 46*(2), 72-77.

Gallagher, Anderson, Koegel, & Gilbert. (1997). Determinants of regular source of care among homeless adults in los angeles. *Medical Care. 35*(8), 814-830. [On-line]. Available: http://gateway1.ovid.com:80/ovidweb.cgi.

Gelberg, L., Gallagher, T. C., Andersen, R. M., & Koegel, P. Competing priorities as a barrier to medical care among homeless adults in Los Angeles. *American Journal of Public Health, 87*(2), pp. 217-220.

Gelberg, L., & Linn, L. S. (1989). Assessing the physical health of homeless adults. *AMA, 262*, 1973-1979.

Geronimus, A. T. (2000). To mitigate, resist, or undo: Addressing structural influences in the health of urban populations. *American Journal of Public Health, 90*(6), 67-871.

Gillis, L. M., & Singer, J. (1997). Breaking through the barriers: Healthcare for the homeless. *Journal of Nursing Administration, 27(6),* 30-34.

Griffin, F. N. U. (1994). Perceptions of African American Women Regarding Health Care. *Journal of cultural Diversity, 1*(2), 32-35.

Healthy People 2010. (USDHHS, 2000). [On-line]. Available: http://www.health.gov/healthypeople/prevagenda/default.htm

Homelessness: Programs and the people they serve. (1999). *National Survey of Homeless Assistance Providers and Clients*. [On-line]. Available: http://www.urban.org/housing/homeless/homeless.html

Hunte, H., Bangs, R., & Thompson, K. (2001). The health status of African Americans in allegheny county: *A Black Paper for the Urban League of Pittsburgh.* Pittsburgh: University of Pittsburgh.

References (continued)

Hwang, S. W. (2001). Homelessness and health. *Canadian Medical Association Journal, 16*4(2), 229-233.

Johnson, A., & Kreuger, L. W. (1989 November). Toward a better understanding of homeless women. *Social Work*, 537-540.

Koch, T., Selim, P., & Kralik, D. (2002). Enhancing lives through the development of a community-based participatory action research programme. *Journal of Clinical Nursing,* 11(1), pp. 109-117.

Kock, N. F., McQueen, R. J., & Scott, J. L. (1997). Can action research be made more rigorous in a positivist sense?: The contribution of an iterative approach. *Action Research Electronic Reader,* more *Journal of Systems and Information Technology* 1(1), 1-24. Retrieved September 24, 2002, from *http://casino.cchs.usyd.edu.au/arow/reader/kms.htm*

Kushel, M. B., Vittinghoff, E, & Hass, J. S. (2001). Factors associated with the health care utilization of homeless persons. JAMA, 285 (2), 200. Retrieved August 12, 2003 from http://proquest.umi.com/pqdlink?index=153&srchmode=1&sid=1&vinst=PROD&fmt=3&sta

Leigh, W. A. (1995). The health of African American Women. In Adams. K (editor), *Health Issues for Women of Color: A Cultural Diversity Perspective.* California: Sage Publications, Inc.

Leininger, M. (1995). *Transcultural nursing: Concepts, theories, research & practices, (2nd ed.).* New York: McGraw-Hill

Leininger, M. (2002). The theory of culture care and the Ethnonursing research method. In, M. Leininger, & M. R. McFarland., *Transcultural Nursing: Concepts, Theories, Research & Practice, (3rd Ed. (pp. 71-98).* New York: McGraw-Hill Companies, Inc.

Lindsey, E., & McGuinness, L. (1998). Significant elements of community involvement in participatory action research: Evidence from a community project [Electronic version]. *Journal of Advanced Nursing.* 28(5), pp. 1106-1114.

Lindsey, R., Shields, L., & Stajduhar, K. (1999). Creating effective nursing partnerships: relating community development to participatory action research. *Journal of Advanced Nursing, 29 (5),* pp. 1238-1245.

References (continued)

Liu, T., Soong, S, Wang, X, Wilson, N. P., & Craig, C. B. (1996). African american and white differences in nutritional status among low-income women attending public health clinics. *Journal of Health Care for the Poor and Underserved, 7* (4), 323-337.

Mayors' 16th annual survey on "hunger and homelessness in America's cities" finds increased levels of hunger, increased capacity to meet demand. (2000). *A Status Report on Hunger and Homelessness in America's Cities.*

McCormack, D., & MacIntosh, J. (2001). Research with homeless people uncovers a model of health [Electronic version]. *Western Journal of Nursing Research, 23(7),* 679-697.

McNicoll, P. (1999). Issues in teaching participatory action research. *Journal of Social Work Education, 35* (1), 51-62)

Meyer, J. (2000). Qualitative research in health care: Using qualitative methods in health related action research. *Qualitative Research in Health Care,* 320, pp.178-181.

Montgomery, C. (1994). Swimming upstream: The strengths of women who survive homelessness. *Advanced Nursing Science, 16*(3), 34-35.

Morison, M., & Moir, J. (1998). The role of computer software in the analysis of qualitative date: efficient clerk, research assistant or Trojan horse? *Journal of Advanced Nursing, 28*(1), 106-116.

Morse, J. M., & Field, P. A. (1995). *Qualitative Research Methods for Health Professionals* (2nd ed.). Thousand Oaks, California: Sage.

North, C. S., & Smith, E. M. (1994). Comparison of white and nonwhite homeless men and women. *Social Work, 39* (6), 639-647.

O'Brien, R. (1998). An overview of the methodological approach of action research. [On-line]. Available: http://www.web.net/robiren/papers/artinal.html

O'Toole, S. M., & Withers, J.S. (1998). From the streets, to the emergency department, and back: A model of emergency care for the homeless. *Emergency Med, 20* (4), 12-20.

Park, P. People, knowledge, and change in participatory research. (1999). *Management Learning,* 30(2), 141-157.

References (continued)

Parsons, M. L, & Warner-Robbins, C. (2002). Formerly incarcerated women create healthy lives through participatory action research. *Holistic Nursing Practice, 16*(2), 40-49.

Pettaway, L., & Frank, D. (1999). Health promoting behaviors of urban African American female heads of household. *Association of Black Nursing Faculty Journal,* January/February, p. 14-19.

Phelan, J. C., & Link, B. G. (1999). Who are "the homeless?" Reconsidering the stability and composition of the homeless population. [On-line]. Available: *American Journal of Public Health, 89*(9), 1334-1338.

Polit, D. F. & Hungler, B. P. (1997). Qualitative research traditions in *Essentials of Nursing Research: Methods, Appraisal, and Utilization (4th ed.*). p.202). Philadelphia: Lippincott.

Polit, D. F. & Hungler, B. P. (1999). *Essentials of nursing research: Methods, Appraisal, and utilization (6th ed.)* Philadelphia: Lippincott, p. 284.

Rogers, A. C. (1997) Vulnerability, health and health care. *Journal of Advanced Nursing, 26*(1), 65-77.

Rollins, J. H., Saris, R. N., & Johnston-Robledo, I. (2001). Low-income women speak out about housing: A high-stakes game of musical chairs. *Journal of Social Issues, 57(*2), 277-298.

Rosenhack, R (1994). Homelessness in American. *American Journal of Public Health, 84*, 1885.

Seng, J. S. (1998). Praxis as a conceptual framework for participatory research in nursing. *Advances in Nursing Science, 20(4),* pp. 37-48.

Smith, C. M., & Maurer, F. A. (2000). *Community Health Nursing: Theory and Practice, (2nd ed).* Philadelphia: W.B. Saunders Company.

Smith, S. P. (1999). Homelessness as a lifestyle: A risk factor. *Nursing & Healthcare Management,* 43-48.

Stringer, E. T. (1999). Action Research: A handbook for practitioners. Newbury Park, CA: Sage Publisher.

The 2003 hhs poverty guidelines: One version of the federal poverty measure. (2003). Retrieved January 27, 2004, from http://aspe.hhs.gov/poverty/03poverty.htm

References (continued)

The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure. Retrieved March 20, 2005, from http://www.nhlbi.nih.gov/guidelines/hypertension/jnc7full.pdf

United States Department of Health and Human Services. (2002). Health and Human Services programs and initiatives to combat homelessness. [On-line]. Available: http://www.hhs.gov/news/press/2002pres/homeless.html

Wadsworth, Y. (1998). What is participatory action research? [On-line] Available: http://www.scu.edu.au/schools/sawd/ari/ari-wadsworth.html

Walters, S., & East, L. (2001). The cycle of homelessness in the lives of young mothers: The diagnostic phase of an action research project. [On-line]. Available: http://gateway1.ovid.com:80/ovidweb.cgi

Wardhaugh, J. (1999). The unaccommodated woman: Home, homelessness and identity. *The Editorial Board of The Sociological Review*. Massachusetts: Blackwell Publishers.

Warren, B. J., Menke, E. M., Clement, J., & Wagner, J. (1992). Mental health of African American and Caucasian American women who are homeless. *Journal of Psychosocial Nursing, 30* (11), 27-30.

Watt, A. H. (2000, February). Improving health care for the homeless. *Physician Assistant*, pp. 77-84.

Webster's II New College Dictionary. (1995). Boston: Houghton Mifflin Company

Wolf, Z. R. (2003). Exploring the audit trail for qualitative investigations. *Nurse Educator, 28*(4), 175-178.

Yuen, F., & Owens, J. (1996). Power in partnership [Electronic version]. *International Journal of Nursing Practice,* 2(3), pp. 138-141.