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UNIVERSITY OF MIAMI

STRUCTURAL VIOLENCE AND VULNERABLE POPULATIONS: HEALTH AND HEALTH CARE UTILIZATION AMONG BLACK, FEMALE SEX WORKERS IN MIAMI, FLORIDA

By

Leah Marlene Varga

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Vulnerable populations are affected by social ills resulting from unjust social, political, and economic systems. The consequences of these structural inequalities may affect health care utilization patterns. I examined the health needs, barriers, and utilization of health care services among a sample of Black, female street-based sex workers in Miami, Florida, while exploring the impact of violence, both physical and structural, on utilization of health care services. To do this, both quantitative and qualitative methods were applied. I used focus group data and a grounded theory approach to illuminate health care experiences and the relationship between structural violence and health care utilization for this group of women. For the quantitative portion, I used Andersen's Behavioral Model for Vulnerable Populations to test which variables were most efficient in predicting utilization, as well as to test the effect of victimization on utilization. Overall, results indicated that having a consistent and meaningful link or resource for accessing health care facilitates utilization for this group of women and determines future utilization behaviors. Vulnerable and traditional domains in Andersen's model contributed to predicting health care utilization behaviors, particularly enabling and need variables; however, victimization had no effect on utilization. From the qualitative data, the Experiential Model of Health and Health Care Utilization was constructed linking health definitions, goals, and experiences of seeking health care at one level, all of these to structural violence at a more abstract level and the general ideology that maintains a repressive system. Recommendations for future research are included.

This dissertation is dedicated to the participants and staff of Women Protecting Women who gave their time and their stories to this project.

In Memory of Mamita, Papi, and Ulo

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CHAPTER 1: INTRODUCTION

For this dissertation, I examined health needs, barriers and access, and utilization of health care services among a sample of Black, street-based sex workers in Miami, Florida, while exploring the effect of violence, both physical and structural, on utilization of health care services. To do this, I tested Andersen's Behavioral Model for Vulnerable Populations among these sex workers. Also, I used focus groups to illuminate health care experiences and the relationship between physical and structural violence and health care utilization for this group of vulnerable women. Above all, I attempted to elucidate the way this sample of women may suffer due to structural violence.

Before continuing, a point of clarification is needed regarding the use of racial terms. When referring to the research questions for this dissertation, the word "Black" will be used rather than "African-American" for reasons of inclusiveness. The sample included a small number of Haitian Blacks and Hispanic Blacks, neither of which typically identifies as African-American. Also, the outcome variable of health care utilization may be affected more by the social construction and interpretation of race, which hinges on skin color rather than ethnicity. Black is capitalized because it refers not only to race but also to ethnicity.

Unjust social, political, and economic systems manifest as unequal power and unequal life chances and leave some populations quite vulnerable. These social organizational hierarchies that end up causing harm are conceptualized as producing structural violence (Galtung 1969). Vulnerable populations are highly affected by social ills resulting from structural inequalities, such as suffering higher rates of poverty, homelessness, and violence. The interaction of these structural factors, many covertly embedded in racist and sexist ideology, and the consequences these factors have on minority communities may affect health care utilization patterns of marginalized populations. Thus, patterns of structural violence experienced by minority populations may negatively affect their willingness and ability to seek out health care services, and ultimately, their health.

Low income, Black women overall are particularly vulnerable as a doubly marginalized population, due to gender and race, experiencing lower life expectancies, higher age-adjusted death rates, and higher rates of a host of diseases, including diabetes, stroke, heart disease, obesity and cancer than women of other ethnicities (Institute of Medicine 2002). Drug-using, street-based, sex workers are particularly vulnerable for health problems and often neglect their health, seeking care only when at advanced stages of morbidity. Trauma, drug use, homelessness, poverty, and violence are some of the experiences that significantly impact the well-being of sex workers and contribute to the state of their physical and mental health. However, these factors are sometimes the very reason sex workers do not seek help. Sex workers use health services inconsistently, with low rates of preventive care. They lack a regular doctor, health insurance, identification, transportation, and safety, and are at higher risk for being homeless and victims of violence. This combination of social/political/economic issues perpetuates inequality and may affect the way these women view their health and health practices.

Andersen's Behavioral Model for Vulnerable Populations (1968, 1995) has been used as a framework to examine whether the factors that make a population vulnerable might also affect use of health services and health status. Although the model does not directly address structural violence, it does contain components that are the result of structural violence. Thus, the model can be conceptualized as not excluding the context of structural violence. The model suggests that health care utilization is a function of a predisposition by people to use health services, factors that enable or impede use, and people's need for care (Andersen 1968, 1995). The additional vulnerable domains focus on social structure and enabling resources. Problems typically encountered by vulnerable populations may include: mental health needs, substance use, physical health needs, victimization/violence, social isolation, inadequate housing, lack of insurance/ regular health care provider and competing needs.

Using the Behavioral Model for Vulnerable Populations as a framework, there are traditional and vulnerable predisposing, enabling, and need factors that may serve as predictors of health care utilization among Black, drug using sex workers. In addition, a clearer understanding of what the general health care needs are for this population would also be valuable. Finally, the role of violence might play a critical yet relatively unexamined role in the health and health seeking behaviors of this population.

Research questions and hypotheses

This dissertation examined the following research questions and tested the associated hypotheses:

1. a. How do Black, female, drug using, sex workers construct their health care needs?

Because this research question is exploratory, there is no hypothesis.

b. How does this vulnerable population of women experience health problems and accessing health care?

Because this research question is exploratory, there is no hypothesis. Questions 1a and 1b were answered using a grounded theory approach with data from focus groups.

2. What are the patterns and independent contributions of predisposing, enabling, and need factors for this sample as described by the Andersen Behavioral Model for Vulnerable Populations (1968, 1995) of health services utilization?

Hypothesis 2.1: Traditional Predisposing factors will be positively associated with having visited a doctor in the past 12 months.

Hypothesis 2.2: Vulnerable Predisposing factors will be negatively associated with the use of health care services by Black, female, drug using sex workers.

Hypothesis 2.3: Traditional Enabling factors will be positively associated with having visited a doctor in the past 12 months.

Hypothesis 2.4: Vulnerable Enabling variables will be negatively associated with the use of health care services.

Hypothesis 2.5: Traditional Needs factors will be positively associated with having visited a doctor in the past 12 months.

Hypothesis 2.6: Vulnerable Needs variables will be negatively associated with the use of health care services.

Research question 2 was answered using the quantitative data.

3. How is health care seeking influenced by interpersonal violence?

Hypothesis 3: The experience of interpersonal violence will have a negative effect on health care utilization among Black, female, drug using sex workers.

Research question 3 was answered using the quantitative data.

4. How is health care seeking influenced by structural violence?

This research question was examined using data from focus groups. The goal of this research question is to identify the processes and relevant factors that this population encounter when seeking health care services.

Predisposing variables are meant to represent and account for biological imperatives, age and gender, as well as social structural factors, education and ethnicity. Enabling variables represent personal and community provisions for access to health services. In other words, services, as well as the means to obtain those services, must be available. Need variables represent perceived and evaluated need of health care services. Perceived need of utilization is believed to provide a better understanding than evaluated need (Andersen, 1995). Predisposing and enabling vulnerable domains have been found to be important supplements to traditional predisposing and enabling variables in predicting health care utilization for vulnerable populations (Gelberg, Andersen, and Leake 2000). The enabling and need variables usually explain most of the variation in health care utilization (Andersen 1995). However, there is support in the literature stating that need variables are the most important factors, over predisposing and enabling, in motivating health care utilization (Elhai et al. 2007; Solorio et al. 2006). Andersen interpreted the results of whether access is equitable or inequitable depending on which set of predictors were significantly related to health care utilization. Based on his original model, Andersen (1968) considered access inequitable if the social structural and enabling variables determined utilization and access as equitable if demographic and need variables determined utilization.

Review of the Literature and Theoretical Orientation

Mainstream research on health indicators finds that the health of minorities is poorer than the health of the population in general. Research consistently reports that relative to whites, racial and ethnic minorities have disproportionately higher mortality rates, higher rates of disease, reduced access to health care, fewer treatment options, a greater likelihood of being publicly insured or uninsured, and are less likely to have a regular source of care. These differences generally have been attributed to variations in socioeconomic status, with those reporting lower income having higher rates of disease and less access to health care services. However, socioeconomic status and lack of access do not account for all the variations in health disparities (Mead et al. 2008). In addition to poorer health outcomes, Blacks have higher poverty rates, are more likely to be homeless, and are less likely to receive health care than members of other ethnic groups (Susser, Moore and Link 1993; Bassuk et al. 1997; U.S. Census Bureau 2000).

In attempting to account for these diminished life chances, a broader explanation claims that racial injustice does harm (Krieger 2005). Life chances are diminished when people are socially dominated, politically oppressed, or economically exploited, and the adverse effect of an disadvantaged social status impairs health and perhaps health care use. Minority groups are labeled as such due to their social position of being the dominated, oppressed, and exploited victims of a social order that keeps some groups from meeting their basic needs. Structural violence is a term used to describe any constraint on human potential and the harm resulting from social exclusion, a limited social welfare state, institutional racism, and lack of access to social goods and resources (Galtung 1969, Maynard 2007). Therefore, structural violence provides a useful framework to examine the way social, economic, and political factors affect a vulnerable population's use of health care.

Structural violence

Systemic barriers that legitimize disparities and inhibit marginalized populations from accessing health care, and all else that contributes to health and well being, ultimately lead to physical harm. Structural violence is related to the concept of symbolic violence. Bourdieu and Wacquant (1992) first introduced the notion of symbolic violence as a form of social control implemented through the belief in universal judgments. Through the acceptance and use of all-encompassing meta-narratives, control appears as a rational, necessary part of society. Symbolic violence exists at all levels of social interaction, usually in a covert, and sometimes overt, manner. This does not entail a physical force to the human as much as a virtual force to the human, a “gentle, invisible violence . . . chosen as much as undergone” (127), chosen because the dominated are complicit yet not recognizing the domination. For Bourdieu, this power to impose ways of comprehending and adapting to the social world is disguised in taken-for-granted forms. We accept these forms, which are offered as legitimate, immune from critique, and transcending human construction and interpretation. This leads to the strengthening and reinforcing of imposed norms and social roles. Humans become alienated, not realizing that the very structure they created is now in control. Such legitimating power elicits the consent of both the dominant and the dominated (Bourdieu and Wacquant 1992). Social norms that prevent the poor, downtrodden, or any marginalized group, from living a healthful life and receiving necessary health care and the group’s social participation in those norms, becomes a form of symbolic violence.

Structural violence is a term for the social forces that exist and create conditions of harm that would otherwise be avoidable. Structural violence occurs when it is born of policies within the system itself, such as those that affect life chances, and describes the way socially constructed institutions stop individuals, groups, and societies from realizing their full potential, where the violence is built into the structure, perpetuated and manifested by unequal power and ultimately unequal life chances (Galtung 1969). Violence in this sense represents the avoidable denial of fundamental human needs or impairment of human life and reveals the way habits, norms, and policies embedded in our everyday activities are harmful. This violence causes injury, not always in the usual obvious physical sense, but perhaps more dangerously, because it is indirect and accepted as a societal norm. For instance, Valentic (2008) argued that this violence is not limited to a direct deed or activity, but we must consider that "passivity can also be violent." Considering violence in a restricted context blinds us to passive violence in a world where we are at risk of being "perpetrators and not just innocent victims" (Zizek 2008).

In this regard, bureaucratic impediments plaguing the health care system can be said to cause injury by denying necessary, sometimes life-saving care. In addition to bureaucracy, the medical institution, with all its components, has become a source of unquestionable authority that transcends human interpretation and provides society with a set of universal expectations surrounding health and health behaviors (Farmer 2005; Farmer et al. 2006). As Schubert (2002) stated, categories are never innocent. They imply oppression and exclusion that result from and lead to legitimizing dominant groups. Anything impeding necessary health care access is a way dominant groups reinforce other's subservient positions. However, the structural violence experienced by vulnerable populations goes beyond limited access to health care services. Theirs is likely a lifetime of limited life chances.

Galtung (1969) argues a fundamental relationship between personal and structural violence in that structural violence can manifest in personal violence, as the daily stressors of oppression and poverty erase any sense of power and control and are therefore manifested in physical violence or abuse. The other relationship posited is that personal violence can amplify an environment of structural violence. For instance, the violence experienced can potentially affect health- seeking behaviors due to shame, guilt, stigma, fear, and distrust of discriminatory health care systems (Bent-Goodley 2007). Either way, this theory may help elucidate the pathways, processes, and relationships between structural violence and health care seeking behaviors for vulnerable populations. Although interpersonal and structural violence may be related, I do not intend for interpersonal violence or structural violence to represent each other in this work. These two concepts were examined separately. The effect of interpersonal violence on health care utilization was measured in quantitative analyses. The role of structural violence in health care utilization was an exploratory analysis using the qualitative data.

Vulnerable Populations

With slight variations, vulnerable populations are populations typically low on the social status hierarchy, ethnic minority groups, children, the poor, and women. From a research perspective, vulnerable populations also include institutionalized populations or those who might be especially susceptible to coercion, such as prisoners, the terminally ill, and children. Populations are defined as vulnerable when they are at heightened risk of poor physical, psychological, and/or social health and for whom this has or is likely to become a reality (Aday 2001). Healthy People 2000 and 2010 (US Department of Health and Human Services 1991, 2001) were national prevention initiatives by the federal government to improve health in the United States and reduce health disparities experienced by vulnerable populations identified as low income, the disabled, or minority groups. The government effort specifically targeted the health conditions primarily affecting racially and ethnically vulnerable populations: infant mortality, cancer screening, cardiovascular disease, diabetes, immunizations, and HIV/AIDS (US Department of Health and Human Services 1998, 1999). A goal of this effort was to level the playing field for those at high risk for poor health yet who lack the material and nonmaterial resources to meet their health needs.

Health risks for vulnerable populations are a function of the accessibility to the resources that improve health. These are typically linked to poverty and homelessness, both forms of structural violence. Poverty constrains choices. It constrains education, employment, living arrangements, health, and power arrangements, particularly for women. Homelessness, substance use, and sex work are bleak results for some who are in potentially desperate circumstances due to lack of choice. Poor health outcomes are associated with each of these social ills. Common physical problems among the homeless are skin problems, skeletal/muscular issues, respiratory problems, gastrointestinal problems, sexually transmitted disease, hypertension, and diabetes. In addition, homeless women rate their physical health at lower levels compared to women in general and one-third of homeless women report suffering with a chronic condition (Bassuk et al. 1996; Hatton 2001). In a qualitative study with women from two women's shelters, Hatton (2001) found that homeless women rarely had a direct route to health services. Typically, a first tier of access, usually in the form of shelter or outreach program, provided the needed entry into necessary care.

For many, substance use is a coping response that magnifies their vulnerability to homelessness, violence, and social isolation. This combination of vulnerable statuses creates an even higher risk of having both poor health, and fewer resources, leading to high vulnerability for contracting or failing to recover from illness. According to Andersen (1968; 1995) vulnerability of health status is a function of predisposing, enabling, and need domains at individual and structural levels. Predisposing characteristics represent the susceptibility to becoming ill, enabling characteristics represent the resources available to access services, and need characteristics are actual health status, perceived and evaluated. Populations are more vulnerable the more these domains converge in inequity at both the individual and structural levels of each domain. The convergence of these domains ultimately affects access and utilization of health care. Poor health along one domain would be magnified by poor access in another domain resulting in greater health needs for those with multiple problems in multiple domains. Andersen's health model will be described in more detail in the following chapter.

The vulnerable population that is the focus for this dissertation consists of Black, female, drug using, sex workers who suffer, or likely will suffer, poor physical health. Drug-using, street-based female sex workers are immersed in complex social situations that increase their need for health services, while limiting their access to care (Jeal and Salisbury 2004a). In this regard, Black sex workers suffer unique disadvantages. As a group, Black women have lower life expectancies, higher age-adjusted death rates, and higher rates of a host of diseases, including diabetes, stroke, heart disease, obesity and cancer than women of other ethnicities (Institute of Medicine 2002). Black women have a fifty percent higher incidence of breast cancer before the age of 35, a greater likelihood of developing aggressive tumors, and the highest incidence of pre-menopausal cancer (Satel 2002). Minority groups have been cited to be at higher risk for alcoholism and sexually transmitted diseases (Osborne and Feit 1992).

Perhaps no other health issue has burdened the Black community in general, and women in particular, as dramatically as HIV/AIDS. HIV/AIDS is a disease that worldwide, has fed off the social inequalities of gender, race, social status, and sexuality. Consensual or forced heterosexual sex is the most significant risk factor for HIV/AIDS among women. As rates of newly reported cases in the United States are stabilizing, the proportion of new cases among women is increasing (Centers for Disease Control 2010). In 2007, the national HIV incidence rate for Black women was 56.2 per 100,000, and Blacks account for 64% of cases among women. The Centers for Disease Control has designated rates of HIV/AIDS in Miami to be at state-of-emergency levels, particularly among Black women. In Miami-Dade County, Black women account for a full 70% of female HIV cases. Further, a recent study found that Black HIV-positive women who have been recommended to be on highly active antiretroviral therapy (HAART) are less likely to be taking HAART than white or Latina women (Cohen et al. 2004). Much of the AIDS prevention research has focused on behavior modification at the individual level without considering the social and economic factors and constraints on women. According to Conners (1996), structural factors such as social class and socioeconomic status rather than individual behaviors explain why HIV is increasingly affecting women.

Utilization

Just as structural factors have affected Black women's vulnerability to health problems, they also influence health care access and utilization. For example, with the exception of emergency room services, minorities use less health care than Whites overall, regardless of health status (Zheng and Zimmer 2009). According to the 1996 to 2003 wave of the Medical Expenditure Panel Study, on average, Whites visit a physician 4.5 annually compared to 3.47 visits for Blacks yet Blacks have significantly more ER visits than Whites. One possible reason for these racial differences is that Blacks have less private insurance coverage than Whites, so are more likely to use the emergency room rather than a private doctor (Zheng and Zimmer 2009). General statistics show that 20% of Blacks lack a usual source of health care and 16% rely on hospitals or clinics as their usual source of health care (Agency for Healthcare Research and Quality 2000). Over 25% of Blacks do not have a primary health care provider and approximately one in five (18%) are uninsured. (Mead et al. 2008).

Hargraves and Hadley (2003) compared whites to Blacks in three markers of primary care: unmet needs, having a regular health care provider, and having seen a physician in the past year. Blacks were 16% more likely to report unmet needs, 25% less likely to have a regular health care provider, and 9.5% less likely to have visited a doctor than Whites. When controlling for demographic factors between Whites and Blacks, disparities in access to health care persisted. The authors offer possible explanations from previous literature to their finding of persistent disparities as lack of trust among minority groups and discrimination.

Literature on Black women's experience with accessing the health care system is scarce and centers mostly on health care disparities and experiences of racial discrimination. However, literature on health care disparities is dense, and a great deal has focused on lack of access to care as a primary barrier to health care utilization for minority populations. Access to health care has been a variable consistently examined and identified as a potential predictor of poor health outcomes among minorities (Ross and Mirowsky 2000, 2010). In order to decrease health care disparities, improving access to and utilization of health care services is imperative.

Previous literature examining barriers to utilization for minorities addresses various structural barriers to health care. Lack of transportation, lack of insurance, lack of a regular provider, long waiting times, and inconvenient locations have all been cited as posing barriers to utilizing care (Agency for Healthcare Research and Quality 2009, Anderson 1995; Beal 2004, Frist 2005, Kennedy 2005, Owens et al 2002). However, even when access is available, the quality of care that Blacks experience also becomes a barrier to care (Copeland 2005).

Patient experience has been cited as an important indicator of health care quality and research suggests minority groups often receive lower quality health care than whites (Mead et al. 2008). In addition, the quality of care the poor receive is inferior compared to those who have higher income (Kaplan 2009). The AHRQ 2008 National Healthcare Disparities Report suggests that properly addressing health care disparities requires attention to cultural attitudes and perceptions that affect health behaviors and patterns of health care access and utilization (Agency for Healthcare Research and Quality 2009). “Patient centeredness” has been listed as a main component of quality health care by the AHRQ as a National Health Quality initiative. The patient perspective is increasingly becoming recognized as a vital indicator of quality. If access is not as significant to health disparities as once posited, perhaps the patient’s experience in the health care system for minorities is worth considering when evaluating their health utilization patterns and outcomes. Receiving lower quality care not only directly impacts health disparities but also impacts the experience of the patient. If the experience a patient has while seeking health care depends on the quality of care received or the patient perception of the quality of care, this will in turn affect future utilization.

Research has shown that minority groups suffer worse quality of care than whites. In 2007, colorectal cancer screening was offered to 57% of whites and

49% of Blacks. This lack of preventive medicine contributed to a later diagnosis of colorectal cancer among a higher percentage of Blacks leading to a higher mortality rate than any other race or ethnic group (Mead et al. 2008).. Black women are less likely to get breast cancer than white women but more likely to die from the disease than their white peers likely due to less access and lower rates of screening. Low-income women are 26% less likely than higher income women to receive a mammogram. The problem may start as early childhood in pediatric care when Black children are at lower odds than whites of receiving any counseling or screening during well child visits (Hambidge et al. 2007; Selden 2006) and are less likely to receive needed medical care (Weech-Maldonado et al. 2001) and primary care comprehensiveness (Seid, Stevens, and Varni 2003).

These patterns of health care quality that are present so early in life suggest that by adulthood, minority groups have accumulated experiences of poorer quality care as compared to their white counterparts, and this inevitably will come into play when considering future utilization. Furthermore, Blacks recognize the policies and practices that are embedded in social structures, which lead to unfair treatment and ultimately institutional racial discrimination, and they perceive the poor quality of care to be based on race (Nazroo 1998). For example, Penner et al. (2009) conducted a longitudinal analysis of 156 individuals to examine how perceived discrimination affected Black patient's responses to received health care. They found that frequent experiences with racial discrimination in the health care system affect adherence to physician recommendations, which leads to subsequent poorer health.

Possible barriers that have not been given as much attention in the literature are patient's perceptions of utilization experiences, as well as their perceptions and ideas on health. A qualitative study with poor Mexican women and their experiences with health care identified various barriers to health care utilization including: "not having money to pay for a specialist or see a general physician," "not to be able to have money to buy medicine or special treatment," "not to be able to carry out continuous treatment," and "not to be able to be attended to immediately" (Hernandez, Arenas, Trevino-Siller 2005: 629). The perception was that these were all consequences of being poor rather than race or ethnicity per se, and that there was a certain type of health care and quality of care for the poor. The authors describe that this outlook among the poor women has become a "sense of conformity." These women associated their lack of economic resources with a lack of accessible quality health care (Hernandez, Arenas, Trevino-Siller 2005). Abrums (2000) used an ethnographic approach to examine the meaning of health and experiences in health care situations among a group of poor Black women from a church in Seattle. Fear and distrust were the two most common descriptions of their experiences with the health care system. When speaking specifically about the interactions with health care providers, the women felt that providers were judging them. An underlying stigma or shame exists in these examples. Women are either placing it on themselves due to their position in society or are perceiving from others because of racial and economic stratification or discrimination.

Such narratives of the experience of health and health care are crucial in providing insight to access to health care and utilization patterns. However, listening to women's personal thoughts and words on how they conceptualize health may also be useful in determining why and when they seek health care. When studying health utilization patterns of vulnerable women, as well as their barriers to health care utilization, it is of interest to question how they define health and their health care needs. Traditionally, definitions and studies of women's health focused on reproductive capabilities. Even when definitions of health were being expanded beyond such basic gendered functions, the biomedical model reigned in describing diseases and conditions unique to women rather than describing wellness (Weisman 1997). In 1993, Ann Oakley delivered a call for a new understanding of women's health, not based on biomedical models, on studies with men, or on the researcher's a priori notions of categories and questions related to health. Instead, she insisted that we listen to the voices, experiences, and explanations of women themselves. Women's health is bound in these daily lived experiences, the context of their living conditions, and the resources they have and use, and the sources of their struggles (Oakley 1993). McDonald and McIntyre (2002) encouraged researchers to access discursive realities, which are the way in which life or a certain aspect of life is talked about and constructed.

In an early French study on conceptions of health, 11,000 people were asked to indicate among eighteen different factors, how they conceived health. The most common items noted in defining health were hygiene, living and working conditions, and feeling well psychologically (D’Houtaud and Field 1986). Only two-thirds of the sample described health as the absence of illness. The socially disadvantaged were more likely to perceive health and its absence as a matter of luck. The socially disadvantaged constructed health and their experiences from a context of oppression where hygiene, living and working conditions, and mental well-being may be luxuries. This early work provided insight into the different perspectives of the health experience.

Women should be the informants in efforts to understand the experiences of women. Kasle, Wilhelm, and Reed (2002) conducted focus groups asking Arizona women about their views on optimal health and well-being. Participants discussed optimal health in terms of : 1. balance and integration of physical, social, emotional, and spiritual elements of life; 2. harmony and stability within family and close relationships; 3. support, empathy, and connection with friends and community; 4. equality, power, and respect; and, 5. living within a society that values people, relationships, and diversity. The authors highlighted that almost every definition offered by this group of women was relational and that for women to feel healthy, it was important that their relationships and their community also be healthy. Out of the 62 women in the study, only two were Black. Additionally, while informative, the women represented in this sample were those who had been receiving community services, working in agencies, and involved in health policy.

Another study specifically asked Black women to define health and explore perceptions on obesity. Rowe (2010) conducted focus groups with 67

Black women between the ages of 40-65. Women had a multilayered description of health as combining physical and metaphysical aspects of life, body type, and environmental factors out of individual control. Again, psychological well-being and the holistic view of mind, body, and spirit are important elements repeated in the attempts to define health in these studies. In vulnerable populations, where the experiences that contribute to forming a construct like health are very different than the experiences of the dominant population, notions of health and health care may be constructed from a more harsh and tumultuous reality. Female, Black, drug using sex workers comprise a group of women who are among some of the most marginalized in our society. The way these women define and experience health may be completely different from the above studies. However, understanding the way these most vulnerable members of society conceptualize and experience health can assist in making one aspect of their lives less cumbersome, specifically accessing and utilizing health care.

Studies of female drug users have reported a variety of barriers to health service utilization. Drug-using women confront multiple life problems that may limit their ability to seek and access needed services, including: 1) lack of socioeconomic resources; 2) medical problems due to poverty, violence, drug use, and other aspects of street life; 3) chronic depression, anxiety, and lack of self esteem; and 4) physical or psychological consequences related to a history of victimization (Luthar et al. 1996; Maher 1997; Mondanaro 1989; Nyamathi et al. 1998; Pottieger & Tressell 2000; Reed 1991; Rosenbaum & Murphy 1987). Female drug users who trade sex also face fear of discrimination, stigmatization, and experience social isolation and distrust of others due to their lifestyle, which may further hinder health care seeking behaviors (Flynn et al. 2000; Kurtz et al 2005; Shedlin 1990; Weiner 1996). Lack of transportation, lack of knowledge of where to go for services, difficulty gaining entry, lack of information, mental health status, lack of finances, frustration, poor communication, and generalized fear indicate a general lack of resources, knowledge and sense of defeat (Hatton 1997; Kurtz et al. 2005).

In addition to these individual level barriers (some of them arguably structural), numerous structural barriers keep these women from accessing care such as: the structure of care systems (Hatton 2001); provider resistance to serving marginalized populations (McCoy, Messiah & Zhao 2002; Weiner 1996); the immediate need of acute care over consistent primary care; long waits for appointments (Jeal and Salisbury 2004b), ineligibility of services and inconvenience of health care facility hours or location (Kurtz et al 2005). Studies have also documented the degrading treatment that indigent drug-using women receive when they do apply for services or medical care (McCoy 2004; Jeal and Salisbury 2004b; Nicolas & Jean-Baptiste 2001; Okwumabua et al. 2001; Oliva, Rienks & McDermid 1999; Seccombe, James & Walters 1998).

However, some of the barriers these women experience are not the typical factors of access and cost. Many of these women must juggle competing needs. In a 1992 study by Nyamathi and Flaskerud, homeless Black women in a drug treatment center identified psychosocial and economic issues rather than health as their primary concerns. Issues like financial insecurity, lack of social support, loneliness, and discrimination were among their salient problems. Another reported barrier is having to explain a stigmatized or embarrassing life history repeatedly to health professionals (Hatton 2001). These individual and structural barriers may affect women's perceptions of service availability, as well as their ability to successfully access and utilize health care providers. A lifetime of struggle with these individual and structural experiences of oppression, poverty, and inequality may lead to lower use or desire to use the health care system. In addition to these forms and consequences of structural violence, interpersonal violence is another lived reality for these vulnerable women and may also affect their desire to seek services.

Interpersonal Violence

In Galtung's (1969) typology of violence, in addition to structural violence, these women are vulnerable to what he labels “direct” violence, also known as “interpersonal” violence. This violence involves an identifiable actor causing intentional harm. Women are at higher risk than men for experiencing some form of interpersonal abuse during their lives, including rape, incest, and domestic abuse. In a national telephone survey conducted from 1995 and 1996 by the National Institute of Justice and the Centers for Disease Control and Prevention, women were asked about their experiences with physical assault and rape (Tjaden and Thoennes, 2000). Of the 8000 American women surveyed, 52% of women reported being physically assaulted at some point in their lives and 1.9% reported being physically assaulted in the previous 12 months. Regarding sexual assault, 18% of the women had been victims of a completed or attempted rape at some time in their lives, and 0.3% reported being a victim of a completed or attempted rape in the previous 12 months.

Women living in impoverished neighborhoods, the disabled, or less educated tend to experience high rates of physical violence (Cunradi et al. 2000; Plichta 2007). The experience of interpersonal violence has been found to be significantly associated with poor health, acute injuries, chronic health problems, and mental health problems, including drug and alcohol abuse (Bent-Goodley 2007; Rieker and Bird 2000). Women who were unemployed, had no health insurance or had government subsidized insurance were significantly more likely to be victims of intimate partner violence (Lipsky and Caetano 2007). The experience is compounded when accounting for race. For instance, Black women who have been victimized experience higher rates of victimization, more severe injuries (Sullivan and Rumptz, 1994) and are more likely to have weapons used against them (Gondolf et al., 1988).

Despite their higher risk of victimization and injuries, many Black women may not be able to access necessary medical care (Lee, Thompson, and Mechanic 2002). A report by Kaiser (2007) reviewed the results of the 2005 National Healthcare Disparities Report examining insurance coverage, having a usual source of care, problems obtaining health care, and patient-provider communication. The report revealed that despite some improvement, overall, Blacks fare worse than Whites when measuring access to health care. The report also revealed that Blacks still received lower quality health care compared to Whites. The 2003 National Healthcare Disparities Report stated that women of color received less quality care, substandard care, less follow up, and fewer referrals (Kaiser 2003). These experiences may affect the health seeking behaviors of Black women.

Literature is mixed regarding victimization and use of health care services. Several early studies showed that women who are victims of violence use health care services more often likely due to possible physical injuries sustained when victimized. (Bergman, Brismar, and Nordin 1992; Liebschutz, Mulvey, Samet 1997; Plichta 1996). Data from the 2002 National Survey on Drug Use and Health found that after controlling for race and substance use, female victims of intimate partner violence were 15 times more likely than those not such victims to have used an emergency room in the previous 12 months (Lipsky and Caetano 2007). In a 2007 review of the literature on intimate partner violence, Plichta states that victims of intimate partner violence are as likely as other women to use health care services, but if the victimization is not detected, health care service use will be inefficient. Plichta also found that victims of intimate partner violence were well represented in primary care settings, emergency rooms, and inpatient services, but are also more likely than other women to have unmet needs for care (Plichta 2004).

However, other studies have shown that many women do not seek services after being victimized (Coben, Forjuoh, and Gondolf, 1999; Keilitz, Hannaford, and Efkeman 1997). According to the National Institute of Justice and CDC study (Tjaden and Thoennes 2000), an injury is sustained in approximately one in three of all rapes and physical assaults against women.

The victim receives some type of medical care in only one third of these injuries from violent acts. Of women injured during their most recent rape since age 18, 36% received medical treatment. Of women women injured during their most recent physical assault since 18, only 30% received some type of medical treatment. A 1997 study by Keilitz et al. examined a group of women who had sought protective orders and found that when victimized, only a small portion of women sought formal services and only 6% sought medical services. In 1999, a study conducted in Denver, Dallas, Pittsburgh, and Houston interviewed women whose male partners were enrolled in batterer intervention programs (Coben et al. 1999). Of the 488 women enrolled, only 39.3% reported ever seeking medical help for injuries caused by their partner's behavior.

In order to identify barriers to health services utilization for women with victimization experiences Logan, Stevenson, Evans, and Leukefeld (2004) conducted eight focus groups with rural and urban women. Affordability, availability, accessibility, and acceptability were identified as the main barriers in seeking health care services. While these are barriers that many women face, acceptability may be particularly salient for women who have been victimized. Embarrassment/stigma, lack of efficacy, confidentiality concerns, lack of perceived need for help, and gender/power issues were themes of acceptability mentioned as concerns for women seeking care. Negative experiences due to discrimination and perceived stereotypical notions of the victims by service providers and hospital staff may affect any future use of formal services by these women (Bent-Goodley 2007; Campbell et al. 2002). These experiences may partially explain why victimized Black women are more likely to seek informal services through family or the community rather than formal medical services (Bent-Goodley 2007; El-Khoury et al. 2004).

Although there has been significant research with interpersonal violence and health, little work has been done with violence among sex workers and health care utilization. If similar victimization and violence happens to vulnerable and marginalized women involved in illicit and illegal activity and who may not have easy access to health care, there may be additional barriers faced and even less of a chance that health care services would be utilized. For example, although victimized women of color may turn to informal services like family and the community, these may not exist for women involved in substance abuse and sex work. In addition, most of the literature on victimization refers to intimate partner violence, or domestic violence. Although similar issues may still apply, the sample examined for this dissertation has high risk of violence from other sources.

Street based female sex workers are particularly at risk for assault, rape, and other forms of physical violence from a variety of different perpetrators. However, most of the violence experienced by female sex workers comes from their customers (Church et al. 2001; Farley & Barkan 1998; Inciardi, Lockwood & Pottieger 1993; Kurtz et al. 2004; Silbert & Pines 1983; Surratt et al. 2004b). Because of the stigma attached to sex work, sex workers become culturally legitimate targets of violence so that their victimization is often overlooked because of their ostracized and culpable social status (Fattah 2003). As victims of violence, sex workers also may not access necessary medical care for fear of revealing their participation in an illegal activity. They become doubly victimized, on an individual and structural level. Thus, due to their degraded social standing, street sex workers are perceived by themselves and by their victimizers to be outside of the protections of the legal system (Boyle 1994; Karen 1998; Lowman 2000; Miller & Schwartz 1995). Such attitudes may carry over into their perception of, and treatment at the hands of, the health care system.

Poverty, homelessness, oppression, and victimization are forms of structural violence that create conditions that put women at risk for health problems as well as possibly keeping them from accessing health care for health problems. As Nancy Krieger (2005, p. 350) states, “patterns of health, including social disparities in health, are to be found chiefly in the dynamic social, material, and ecological contexts into which we are born develop, interact, and endeavor.” She argues that these social influences become embodied, such that personal histories become part of expressed physiological responses as evidence of the way people inhabit their bodies and embody their world (Krieger 2005; Krieger and Smith 2004).

If these have always been present as dynamics of structural violence, what would be the effect on health care utilization? In this dissertation, I examined the health needs of a population of vulnerable women and use Andersen’s Behavioral Model for Vulnerable Populations to examine the way individual and structural components described above converge and predict health care utilization. I also collect qualitative data via focus groups to learn how these women define their health needs, as well as understand their utilization behaviors in the context of structural violence. Chapter 2 addresses the research methods used to examine these issues.

CHAPTER 2: RESEARCH METHODS

Quantitative and qualitative methodological approaches were used to examine and better understand health care utilization among especially vulnerable women. Quantitative data were collected first as part of a larger study while qualitative data were collected subsequently via focus groups with women who participated in the larger study. Although quantitative data had been collected first, qualitative analyses were conducted prior to the quantitative analyses to minimize any bias during the use of grounded theory methodology. Both methodologies were given equal priority in the collection, analysis, and interpretation of the data.

The purpose of the mixed methods approach was complementarity and expansion (Greene, Caracelli, and Graham 1989) as I sought to expand on and enhance the quantitative data with the voices of the women, describing in their words what the barriers to health care utilization were for them and why these were considered barriers. To expand the range of inquiry, different methods were necessary as the quantitative data provided more generalizable findings using a large sample to empirically test hypotheses, while the qualitative data gave meaning through real world experiences of the women from the sample. Meaning is a phenomenon that cannot easily or effectively be quantified; using grounded theory and qualitative research methods produced results that the quantitative analysis cannot produce. The qualitative data illuminated the quantitative findings by providing an avenue of awareness to the underlying processes of the quantitative relationships among variables. The synergy between the two analyses is discussed further in the conclusion.

Quantitative Methods

Data

Quantitative data were drawn from baseline interviews originally conducted as part of a randomized intervention trial designed to test two case management approaches for increasing health services linkages among the target population (Surratt 2006). The research was supported by a grant from the National Institute on Drug Abuse (grant number 7R01DA013131-11). Data collection was initiated in May 2007 and concluded in June 2010. The intervention trial tested two conditions using a five session case management approach: 1) a Strengths-Based / Professional-Only (PO) Condition in which participants participated in a case management approach where an experienced, credentialed, professional case manager partners with the participant to set, plan and achieve goals from a strengths perspective; and, 2) a Strengths-Based / Professional Peer (PP) Condition in which a team composed of an experienced, credentialed, professional case manager, and a recovering addict/former sex worker peer facilitator, both trained in “strengths-based” case management techniques, work with the participant to develop service goals, facilitate implementation of the case plan, and assist the participant in overcoming obstacles to service linkage and engagement. Participants were randomly assigned by a computer program into one of the case management intervention conditions, and case management sessions ideally commenced the week after the baseline interview, one session a week, over a period of five weeks.

Recruitment and Data Collection

The sample of drug using, Black, female, sex workers were recruited into the study using targeted and snowball sampling strategies (Watters and Biernacki 1989). Participants were recruited in Miami from the community by peer outreach workers who were former drug using, sex workers trained in project recruitment procedures. Women were also recruited using participant referrals. Eligible women were: self-identified as Black, 18-54 years of age, had used heroin and/or cocaine 3 or more times a week in the last 30 days, and had traded sex for money or drugs at least 3 times in the past 30 days. Potential participants were approached by outreach workers and were given a brief discussion of the purposes of the project, emphasizing that it is designed to assist women working on the street in obtaining drug abuse treatment and other health and social services. Interested women were told to call the project field office to be screened for eligibility over the phone. Once initial eligibility was determined via the phone screen, women were given an appointment to visit the project field office, where a trained research interviewer further explained the project and what was expected with participation, confirmed participant eligibility by administering a second screening, and if the woman was still interested, obtained informed consent. Because the target population was expected to have low literacy, interviewers read informed consent forms with participants. An application for a Confidentiality Certificate under section 502C of Part E, Title II of the Comprehensive Drug Abuse and Control Act of 1970, Public Law 91-513 was obtained. A copy of the certificate of confidentiality was available for participants. All participants were informed of its provisions, and its impact on their participation during the informed consent process. Self reported drug use data were confirmed with oral swabs tested for opiates and cocaine (although the results were not used to determine eligibility, but only as validation of self-reports).

Data collection commenced in May 2007 and 562 women were enrolled at the project enrollment end date of June 2010. All enrolled participants were interviewed face-to-face, using structured questionnaires. Interviews were conducted using CAPI (Computer Assisted Personal Interviewing) at baseline, three months after the initial interview, and six months after the initial interview. All participants were paid $25 for each interview and $25 for each intervention visit. Baseline interviews were designed to capture historical and recent data on health service needs, service utilization history, as well as predisposing, enabling and need factors that facilitate or inhibit health service seeking. Only data from the baseline interviews were utilized in this dissertation. Focus groups interviews were also conducted as needed to pursue related issues of interest to the larger study.

Conceptual Model

A model of health services utilization was used to guide the quantitative analysis (see Figure 1, page 36). The Behavioral Model for Vulnerable Populations was adapted from Andersen's Behavioral Model and was designed to identify the challenges faced by vulnerable populations and to understand their seeking, accessing and utilizing health care (Andersen 1968,1995). The model suggests that the use of health services is a result of the predisposition of the individual to use services, the person's ability to obtain services, and the person's illness level or the urgency or "need" for services. This theoretical model uses predisposing, enabling, and need components to predict personal health behaviors. Each component is divided into traditional and vulnerable domains that are especially important to examine in understanding the health needs and behaviors of vulnerable populations. Included in the vulnerable domains are characteristics that would affect or are experienced by vulnerable populations of: minorities, undocumented immigrants, mentally ill, chronically ill, elderly, disabled, impoverished, and homeless (Aday 2001). Examples of characteristics in the vulnerable domain are physical illness, mental illness, substance use, unstable housing/homelessness, social isolation, and victimization (including physical and sexual abuse).

Data were collected using the Global Appraisal of Individual Needs Initial (GAIN-I). The GAIN-I is a comprehensive instrument that has eight core sections: Background; Substance Use; Physical Health; Risk Behaviors and Disease Prevention; Mental and Emotional Health; Environment and Living Situation; Legal; and Vocational (Dennis et al. 2002). There are over 100 scales and subscales included in the GAIN-I and the scales have shown good test/retest reliability (*r*=.7 to .8). Alphas for the scales used in the current study range between .66 to .97. The Women Protecting Women (WPW) Questionnaire was developed specifically for use with sex workers in the parent grant (Inciardi

2000). The sexual risk behavior section was used as a supplement to the GAIN. There is no psychometric information available on this instrument. All data were based on respondents' self-reports.

Variables:

One purpose of this dissertation was to test the usefulness of Andersen's Behavioral Model for Vulnerable Populations for this sample of women. The strategy for accomplishing this is using quantitative data represented by the items listed below. The outcome variable was receipt of physical health care in the past year. The independent variables were organized into the predisposing, enabling, and need factors that may affect health care utilization using the framework from Andersen's model. Within each of these constructs, variables were further divided into the Traditional Domain or Vulnerable Domain. The operationalization of each concept is presented below.

Dependent Variable

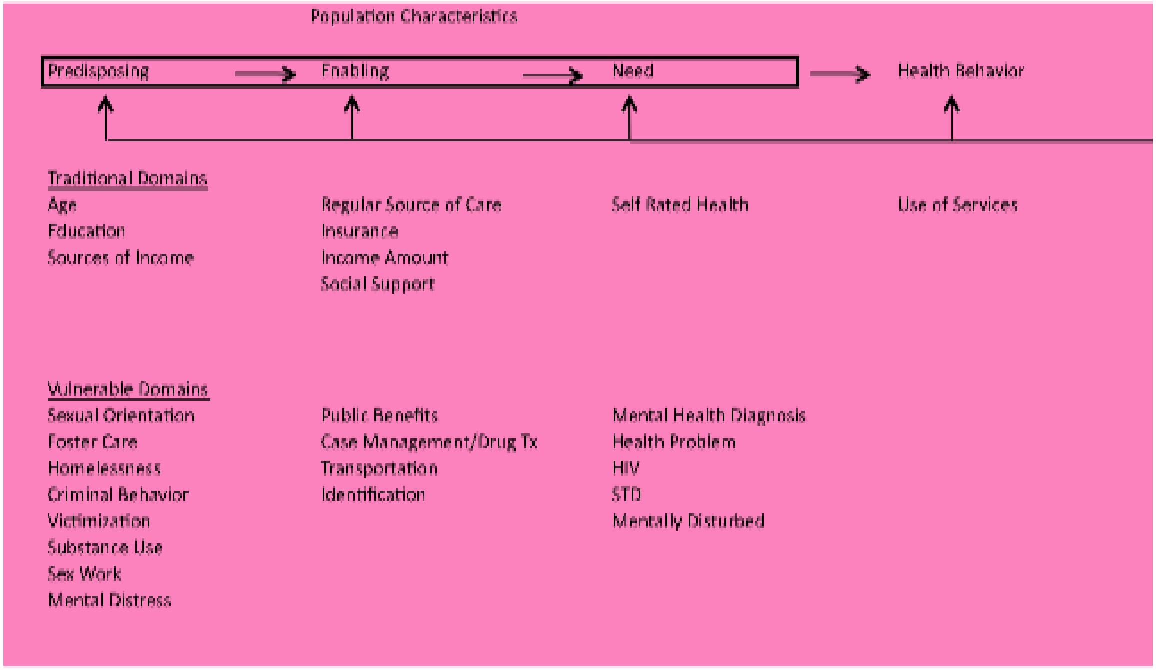
Physical Health

The dependent variable is utilization of physical health care services in the past year. Participants were asked, "Have you received any care from a doctor in the past year?" Responses were "no" (0), "yes" (1), and "unsure" (7).

Independent Variables

The independent variables are organized below using Andersen's framework from the Behavioral Model for Vulnerable Populations (1968, 1995).

Figure 1: The Behavioral Model for Vulnerable Populations



Predisposing Predictors

Traditional variables are age, education, and sources of income. Additional predisposing variables measured as part of the vulnerable domain and include sexual orientation, foster care history, homelessness, criminal behavior, victimization, mental distress, substance abuse, and sex work history. Age was determined by asking the women "How old are you?" For the purposes of analysis, age was collapsed and recoded into 18-39 (coded as "0") and 40 and older (coded as "1"). The categories were determined using the mean age, 39.29 years, of the sample. Education level was determined by the question, "What is the highest level of education you've completed?" Respondents chose between: No formal schooling, Eighth grade or less, Less than high school graduation, GED, High school graduation, Some college, College graduation, Unsure, or Refused. Categories were collapsed and coded as: no high school diploma (coded as “0”) and high school diploma or equivalent or higher (coded as “1”). Since steady employment is precarious in this population, sources of income, rather than employment status, were asked. Sources of income were based on no (=0) and yes (=1) responses to the following options: paid job, salary or business; welfare, public assistance, aid to families with dependent children (AFDC), food stamps; social security, disability, workman’s compensation; unemployment compensation; spouse, family, or friend; sell or trade goods, barter; alimony or child support; illegal or possibly illegal activity (including drug dealing, but not prostitution); prostitution; and other. Two categories had fewer than ten cases, unemployment compensation (n=4) and alimony or child support (n=9), and were removed from the analysis. Participants could indicate more than one income source.

The predisposing variables in the vulnerable domain represent potential marginalized statuses. For sexual orientation, “Do you consider yourself to be? Heterosexual (straight), Lesbian, Bisexual, Other, and Unsure”. For the purpose of this analysis: lesbian, bisexual, other or unsure was coded “0” and heterosexual was coded “1”. Participants were asked, “Were you ever placed in foster care before you were 18?” where “no” was “0” and “yes” was “1”. Current homelessness was measured with the question, “When was the last time, if ever, you considered yourself to be homeless?”. Response categories were: within the past two days, 3-7 days ago, 1-4 weeks ago, 1-3 months ago, 4-12 months ago, more than 12 months ago, or never. In order to compare time of homelessness with visiting a doctor in the past year, categories were collapsed and recoded into whether a participant considered themselves homeless within the twelve months prior to the interview “1,” otherwise “0.” Criminal history is a continuous variable and is measured by number of arrests. Participants were asked, “In your lifetime, how many times have you been arrested, charged with a crime and booked?” Substance use was measured with various questions quantifying the use of different substances in the past 90 days. The items were part of a scale determining whether participants met the DSM -IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition), diagnosis for substance abuse.

A series of questions were asked in order to measure lifetime participant victimization in this sample and was scored as part of a victimization scale (α=.86). Questions asked were whether the women had ever been: attacked with a gun, knife, stick, bottle, or other weapon; hurt by a strike or beating; forced to participate in sexual acts; and abused emotionally. Information on age at when any of these first happened, duration of abuse, number of persons involved, family member involvement, fear for life, resulted in sex, and whether others believed or helped were also collected as part of the scale. Number of years involved in sex work is a continuous variable: “Altogether, how many years have you been doing sex work?” Participant’s mental state was evaluated using the General Mental Distress Scale (Appendix A)based on DSM-IV symptom criteria for depression, anxiety disorders, and somatic symptoms (Dennis, Chan, and Funk 2006) in addition to a Traumatic Stress Index. This index assesses the presence of symptoms of stress disorders related to trauma over the past 12 months. Higher scores on these scales signify more severe problems (α=.97).

Enabling Predictors

Traditional enabling predictors included whether participants had a regular source of health care, insurance status, income amount, social support, receipt of public benefits, receipt of case management or drug treatment services, transportation, and identification. In order to determine a regular source of care, women were asked, "Do you have a physician who you consider to be 'your doctor' or a clinic you consider your 'regular source of care'?" Response options were: "no"= 0 and "yes" =1. Insurance status was measured by the question, "Do you currently have any public or private health insurance?" Response options were: "no" (0), "yes" (1), and "unsure." Only one woman selected "unsure" and was not included in the analysis. Income amount was treated as a continuous variable in the analysis and was determined by the question: "How much money did you receive from all sources of income in the last 90 days?" Response categories were: Less than $1000; $1000-$1999; $2000-$3999; $4000-$5999; $6000 or more; and Unsure. Only one woman selected "unsure" and was not included in the analysis. Social support data were collected via the Medical Outcomes Study (MOS) Social Support Survey (Sherbourne and Stewart 1991). The MOS Social Support Survey was developed from a study of patients with chronic conditions. There are four separate social support scales totaling eighteen items: emotional/informational, tangible, affectionate, and positive social interaction (Appendix B). Respondents were asked, "How often is each of the following kind of social support available to you if you need it?" Response options were a Likert scale and ranged from "None of the time" (1) to "All of the time" (5). Examples of some of the items are:

Emotional/informational:	Someone to give you information to help you understand a situation
Tangible:	Someone to take you to the doctor if you needed it
Affectionate:	Someone who hugs you
Positive Social Interaction:	Someone to do something enjoyable with

A higher score for a scale or for the overall support index indicates a higher level of support. Response categories are: none of the time; a little of the time; some of the time; most of the time; and, all of the time. The subscales have shown strong reliability over time. Alphas for the individual subscales are: emotional/Informational=0.96; tangible=0.92; affectionate=0.94; positive social interaction=0.91; overall general index=0.97.

Perceived barriers to care consist of information on perceived need for and barriers to having a regular source of care. This instrument listed open-ended reasons for barriers to care in order to examine participant perceptions of internal and external barriers to health services. The interviewer selected the answer that best matched the participant's response when asked the reason for lack of a regular source of care. The options were: do not need one, do not like to go to doctors, do not trust doctors, can't afford one, can't find one I like, not treated well, none located near me, no transportation, or other reasons not specified in the list. These were grouped and recoded into: did not need one, do not like/trust doctors, can't afford one, not convenient, not treated well, and other. These were analyzed using frequencies to determine the most common barriers for this sample. While notably many of the variables being analyzed can be interpreted as a barrier, these are the reasons that care was not accessed when needed, according to participants.

Vulnerable enabling predictors included variables that may assist or hinder access to health care for vulnerable populations. Receipt of public benefits was determined using the sources of income variables for welfare, public assistance, aid to families with dependent children (AFDC), food stamps, social security, disability, or workman's compensation. A "yes" was coded as "1" to receiving any of these benefits and "no" was coded as "0". Receipt of case management and drug treatment services was collected by asking, "When was the last time you received treatment, counseling, medication, case management, or aftercare for your use of alcohol of any drug?" Response categories were: within the past two days, 3-7 days ago, 1-4 weeks ago, 1-3 months ago, 4-12 months ago, more than 12 months ago, or never. For the purposes of analyses, the responses were collapsed and recoded into "never" (0) and "at least once" (1) since any amount of intervention could potentially lead to health care utilization. Transportation was determined by asking, "What form of transportation do you usually use to get from place to place?" Responses were: personal car, ride with family/friend, public transportation, taxi, bicycle, walk, or other. Since not having one's own transportation may be a barrier, items were collapsed and recoded into, “my own car” as “1” and “relying on others or public transportation” coded as “0”. Having a valid state government identification card is often necessary for accessing health services. Women were asked, “Do you have a valid Florida driver’s license or state ID card?” where “no” was coded as “0” and “yes” as “1.”

Need Predictors

Need predictors are divided into perceived health and evaluated health. Measures of perceived health include self-rated health. To collect self-rated health data, women were asked, “During the past 12 months, how would you say your health in general was?” Response categories were: excellent, very good, good, fair, or poor. After reviewing frequency distributions, the responses were recoded into two dummy variables (yes=1) for good health and fair/poor health with “excellent/very good” serving as the comparison category. To evaluate perceived physical health, women were asked, “When was the last time that you were bothered by health or medical problems that kept you from meeting your responsibilities or interfered with your daily activities?” Response options were: within the past two days, 3-7 days ago, 1-4 weeks ago, 1-3 months ago, 4-12 months ago, more than 12 months ago, never. In order to determine perceived need in the past 12 months, responses were recoded into: never or more than 12 months ago (0) or within the past 12 months (1). This element of perceived need was included in the vulnerable domain since self-reported health was already in the traditional domain, and the daily challenges that make these women vulnerable may affect the way they perceive health needs.

To evaluate perceived mental health, women were asked, “When was the last time, if ever, your life was significantly disturbed by nerve, mental, or psychological problems that you felt you could not go on?” Response options were: never, more than twelve months ago, 4-12 months ago, 1-3 months ago, 1-4 weeks ago, 3-7 days ago, and within the past two days. In order to evaluate perceived need with health care utilization in the past year, responses were recoded into: never or more than twelve months ago (0) or within the past twelve months (1).

The markers available for evaluated health were: diagnosis of a mental, emotional, or psychological problem; HIV status; and sexually transmitted disease history. Women were asked, “Has a doctor, nurse or counselor ever told you that you have a mental, emotional, or psychological problem or told you the name of a particular condition you have/had?” Responses were open-ended. For analytic purposes, “no” or “not applicable” responses were coded as “0” and responses that named specific diagnoses were coded as “1.” Information on HIV status was collected by asking women, “What was the result of your last HIV test?” Reponses were: negative, positive, indeterminate, don’t know, refuse to answer, or not applicable (because they had never been tested). Responses were recoded into two dummy variables (yes=1) for HIV positive and unknown HIV status with HIV negative as the comparison. An unknown HIV status included women who responded indeterminate, don’t know, refuse to answer, or not applicable when asked their HIV status. Finally, information on sexually transmitted disease (STD) diagnosis in the previous twelve months was collected by asking, “Have you had any of the following diseases or conditions at any time in the last twelve months?”. Respondents answered yes, no, or unsure to each of the conditions: Syphilis, Gonorrhea, Chlamydia, HPV or genital warts, Herpes, Hepatitis B, Hepatitis C. The STD variables were combined, and a new variable was created with the responses yes (1) and no (0) if diagnosed with any STD in the twelve months prior to the interview.

Victimization Variables

To determine the effect victimization has on health care utilization, lifetime victimization (part of the victimization scale discussed above), as well as additional items capturing recent victimization and date violence were included in a logistic regression model in order to examine the independent effects of each on physical health care utilization. The additional questions included, “When was the last time you were attacked with a weapon, beaten, sexually abused, or emotionally abused?” Reponses were categorized into: within the past 2 days; 3-7 days ago; 1-4 weeks ago; 1-3 months ago; 4-12 months ago, more than 12 months ago; and never. This variable was then recoded into “within the past 12 months (1) and “more than 12 months ago or never” (0). To capture recent victimization, participants were asked, “During the past 90 days, did someone other than a date or client: attack you with a gun, knife, stick, bottle, or other weapon, hurt you by striking or beating or otherwise physically abusing you, pressure or force you to participate in sexual acts against your will, or abuse you emotionally?” Reponses to these items were yes (1) or no (0). Finally, “How many times in the past 90 days have you: been hit or beaten by a date, been raped by a date, been threatened by a date with a weapon, been cut or shot by a date, been ripped off by a date, or other violence by a date. Reponses were open-ended and each violent situation was recoded into no (0) and yes (1), if the participant reported at least one incident in the past 90 days.

Analysis

Research questions 2 and 3 are analyzed using similar quantitative research methods. Research Question 2 is: What are the patterns and independent contributions of predisposing, enabling, and illness/need factors for this sample as described by the Andersen Behavioral Model for Vulnerable Populations (1968, 1995) of health services utilization? Research Question 3 is: How is health care seeking influenced by interpersonal violence? A variety of statistical methods were used to describe, summarize and analyze the baseline data. Frequency distributions were calculated to provide a description of the sample characteristics. Included in these is the distribution of the most common health care needs and barriers as reported by these women.

The sample size for the analyses was 546 due to missing data. Listwise deletion was used to exclude any participant data with missing data. There were only 16 (2.8% of the original sample size) of the 562 such cases, which were removed from all the logistic regression models for consistency across models.

Bivariate analyses were conducted with each of the predisposing, enabling, and need factors for research question 2, as well as the lifetime, past 90 days, and date victimization questions for research question 3, to test the association between each variable with the dependent variable, health care utilization. Pearson chi-square tests were calculated for categorical variables and independent sample t-tests were used for continuous variables. Since the Behavioral Model for Vulnerable Populations is a model that has been designed specifically with certain factors for measurement, all variables were included in the logistic regression model, regardless of bivariate significance.

Prior to conducting multivariate analyses, collinearity diagnostics were examined for both research questions by evaluating variance inflation factors (VIF), condition indexes, and variance proportions obtained using ordinary least squared (OLS) regression. The VIF is an indicator of the impact of collinearity on the precision of the estimates (Fox 1997). Multicollinearity occurs when there is a near perfect correlation between two or more explanatory variables, making it difficult to estimate the variable's separate effect on the dependent variable and increasing the standard error. A large standard error could result in a high chance of failing to reject the null (Type II error) or lead to a statistically insignificant finding for a variable that may in fact be significant. For these diagnostics, a VIF cutoff of 4 and a variance proportion cutoff of .8 were used and the condition indexes were reviewed for any large jumps in values. For research question 2, only two variables had VIFs that were potentially problematic at 4.022 for affectionate social support and 6.052 for internal mental distress. However, after evaluating the variance proportions for these items, it was determined that there were no significant issues of multicollinearity. For research question 3, the same two variables had high VIFs, affectionate social support (4.131) and internal mental distress (5.373). However, condition indexes and variance proportions showed no indications of multicollinearity.

Logistic regression is the analytical method of choice when using a dichotomous dependent variable. Independent variables can be dichotomous, discrete, or continuous. The logistic regression model predicts probabilities between 0 and 1 of an event taking place using variable values (the dependent variable, seeing a doctor in the past 12 months), and the results of the analysis are in the form of a log odds or odds ratio. These are estimated using maximum likelihood estimation (MLE), which finds the parameter estimates that are most likely to have produced the observed data, maximizing the likelihood that the estimated parameters are equal to the true parameters. Logistic regression analysis assumes that individual observations are independent of each other but makes no assumptions regarding the distribution of the errors, the variance in the error term does not have to be normally distributed (accounting for heteroskedasticity), or linearly related (Wooldridge 2006).

Logistic regression was used to examine the independent contributions of each of the variables on health care utilization. The first set of models are in response to research question 2, and focus on the predisposing, enabling, and need components of the traditional and vulnerable domains that predict utilization of physical health care services in the past year. Domains were included in the analysis using the traditional items first and then with the vulnerable domain items to evaluate the effect of the vulnerable domains on the dependent variable. This modeling approach will allow evaluation of the impact each domain might have on predicting health care utilization. In the final model, variables that are significant at p<.05 are determined to have significant independent effects on the dependent variable of utilization.

Model 1-	Traditional Domain Predisposing
Model 2-	Traditional Domain and Vulnerable Domain Predisposing
Model 3-	Traditional Domain Enabling
Model 4-	Traditional Domain and Vulnerable Domain Enabling
Model 5-	Traditional Domain Need
Model 6-	Traditional Domain and Vulnerable Domain Need
Model 7-	All domains and variables

For research question 3, lifetime victimization items, victimization in the past 90 days items, and date victimization items are included in a logistic regression model in order to examine the independent effects of each on physical health care utilization. Variables that are significant at p<.05 are determined to have significant independent effects on the dependent variable of health care utilization in the past 12 months. In addition, the lifetime, last 90 days, and date violence items are included in the Behavioral Model for Vulnerable Populations in the Predisposing Vulnerable domain, replacing the Victimization Scale item to determine if there any independent effects on health care utilization. The sample size for the victimization logistic regression models was 541 due to missing values. Listwise deletion was used to exclude any participant data with missing values. There were only 21 such cases, which were removed from all the logistic regression models for consistency across models.

Qualitative Methods

How do Black, female, drug using, sex workers construct their health care needs? How does this vulnerable population of women experience health problems and accessing health care? How is health care seeking influenced by structural violence? These questions are addressed in the qualitative portion of this dissertation. Rich data on life experiences was collected using qualitative research methods. Qualitative research focuses on meaning and allows the researcher to gain perspective and explore research questions using the experiences, interpretations, and narratives of those studied, usually in their own words. Understanding subjective experiences of the population of interest is an objective of qualitative research. To achieve this goal, grounded theory guided this component of the dissertation, using a series of focus groups with women from the larger baseline sample.

Grounded theory uses an inductive approach starting with specific observations that lead to broader theories. Data gathering begins with a broad lens that is refined during the data collection process and generates categories, themes and eventually theory (Charmaz 2006). Theories are "grounded" in the social research and are constructed from the data. Simultaneous data collection and analysis, constructing codes and categories from the data, constant comparative analysis, and memo writing, combined with theoretical sampling, represent the hallmarks of grounded theory research (Charmaz 2006).

FOCUS GROUPS AND STUDY DESIGN

Participants

Women who were already recruited and enrolled in the parent study participated in the focus groups. Participants were divided into two groups of health service utilization: those with no use of health care services in the twelve months prior to the quantitative interview and those who used health care services at least once in the 12 months prior to the quantitative interview. In grounded theory, ongoing analysis determines the needs of data collection, which made it difficult to anticipate how many women would be needed for the focus groups; however, following principles of theoretical sampling led to a total of thirteen women being recruited to participate in five focus groups with 2-4 women per group. Theoretical sampling is sampling directed by the collected and analyzed data, with the goal of developing, elaborating, and refining any emerging categories (Charmaz 2006). Preliminary analysis of focus group data guided the subsequent phases of sampling. Participants who reported characteristics that might elucidate emerging categories were identified using data from the structured baseline interviews and were recruited for the next focus groups. This was the first line of synergy between the quantitative and the qualitative phases of this study.

Participant files from the parent study contained locator forms with telephone numbers for contacting the women. Every listed contact number in the file was used to call the women. At successful contact, the purpose, location, date, and time of the focus group were provided to potential participants. Two focus groups were held at the project field office of the parent study on Biscayne Boulevard in Miami, and three focus groups were held at another project field office in Miami Beach.

Women completed the informed consent process before participating in focus groups. The informed consent form provided a clear, simple, and concise description of the purpose of the groups, a brief description of the risks and possible benefits of participation, and information on the time commitment. Participants acknowledged understanding of their rights as human subjects, including the voluntary nature of participation and the right to withdraw at any time, prior to signing the form. Participants received a copy of the informed consent form to keep. Participants received $25 for their participation at the conclusion of the focus group.

Data Collection

Although the process of grounded theory requires simultaneous involvement in data collection and analysis, for purposes of clarity, the methodology will be reviewed separately in the following sections. Participant discussion of health and health care was the primary purpose of the focus groups. Open ended questions (Appendix C) were used to address topics such as: how the women thought about health; how they described health; their health goals; barriers to health goals that they faced; and perceptions or observed differences in access to, and type of health care received between Black women and white women. As the focus group facilitator, my goal was to encourage exploring and conversational flow, and avoid leading the participants by unintentional bias through the language or format of the questions. Questions began as general and exploratory, but were changed as the groups progressed, adjusting to emerging concepts and focusing the research lens. The use of probes assured that necessary topics were covered and discussions redirected if too far off topic. Any secondary topics the women mentioned were noted and reviewed with them for clarification or further exploration.

A digital recorder audio-recorded focus groups. Audio files were transferred from the recorder to a computer, transcribed verbatim, entered into standard word-processing files and verified. Randomly selected numbers were used for participant identification on the audio file and the transcripts to ensure confidentiality. Audio files were deleted from the digital recorder immediately after successful download, and transcripts were saved on a password-protected computer. No participant identifiers appeared on the focus group transcripts. The decision to use focus groups was based on removing participant burden of responding to potentially uncomfortable or sensitive topics. In addition, focus groups have proven valuable when collecting data from minority group members or other groups involving a significant gap between researchers and participants (Charmaz 2006).

Categories of interest were identified from the emerging data of the focus groups, and additional data were gathered to further examine these and their components. Emergent categories guided sampling efforts and data collection for subsequent groups. If a category led to more questions or needed refining, theoretical sampling was employed to seek participants with characteristics that would help elucidate these categories.

Analysis

Qualitative analyses were conducted prior to quantitative analyses to prevent any potential bias of the qualitative results. For research questions 1 and 4, the analytic process followed a grounded theory approach (Charmaz 2006; Glaser and Strauss 1967). Research question 1 has two parts: a. “How do Black, female, drug using, sex workers construct their health care needs?”; b. “How does this vulnerable population of women experience health problems and accessing health care?” The analytic process for research question 1 is detailed in the following paragraphs. Research question 4 is, “How is health care seeking influenced by structural violence?” For research question 4, the analysis does not come directly from grounded theory, but rather structural violence is used as a sensitizing concept guiding the analysis. Sensitizing concepts are the underlying premises that provide a framework or reference point to guide qualitative study (Blumer 1969, Charmaz 2006). These provide a direction for data collection and interpretation. In essence, sensitizing concepts acknowledge and state the point of view that directs the evolution of my analytic process in answering research question 4.

For research question 1, after data were collected via the first focus group, analysis commenced with the initial coding of transcribed focus group data. Codes were created representing ideas that were emerging from the data. Coding continued with each focus group building upon what was learned from the previous group. At each stage of data collection and analysis, comparisons of the codes were made using the constant comparative method. Memo writing was a helpful tool used for recording notes: examining patterns and relationships among the codes or for noting insights during the focus groups. These memos helped to develop, define, and organize codes into analytic categories. Each step of data collection and analysis contributes to theory development. This method is interpretive rather than standardized and is described below in more detail.

Initial open coding of transcripts (Strauss and Corbin, 1998) from the first focus group was the beginning step of analysis. The process of initial open coding avoids preconceived ideas and aims to be explorative. At this level of coding, codes are close to, or grounded in, the data. Coding involved assigning descriptive words or phrases as labels to portions of the data. Initial coding was done on paper transcripts, looking for similarities and patterns within the focus group discussions with no preconceived coding scheme and remaining open to the narrative of the data, developing codes closely tied to the data. After noting the codes on the paper transcripts of the focus groups, they were transferred into Nvivo for help with organization of the emerging codes. Nvivo software is used for the storage, coding, retrieval and analysis of text. Initial codes are open and flexible and are changed when needed to best fit the data. As codes evolved during analysis, questions related to the emerging codes were developed and presented to new focus group participants for elaboration and confirmation or rejection of categories. As data analysis progressed, existing codes were constantly compared to new emerging codes. Data analysis continued exploring and developing these new codes, looking for relationships between all codes, and how the codes fit together to potentially represent larger categories.

While conducting the constant comparative method, I used memo writing to help analyze and record codes and any ideas about the codes or the way they fit together (Charmaz 2006). Early memos provided a way to explore the codes and processes taking place in the focus groups assisting the direction of further data collection. As memo writing developed, certain codes and patterns represented preliminary theoretical categories; codes were changed, were confirmed, or disconfirmed; and categories were defined and supported with raw data. Memos were useful in providing a record of the analytic process and were reviewed closely as analysis and writing continued.

Following initial coding of all focus group transcripts, advanced levels of coding were conducted. Focused coding is a more conceptual approach to the data that focuses on the codes that appear most often or are the most significant in making sense of the data. For example, while coding one of the focus groups, I coded the following participant quote as “having your own doctor”: “[women with health insurance] got a folder. They got a primary doctor. If something were to happen to you, if you get hurt out on the streets and having to go to the emergency room, your doctor would be able to go find you and fix you.” After initial coding of all focus groups, I realized that this concept came up often in different ways throughout the groups. I kept this code and made a category “reliable links to care”. Any participant language referring to having or not having a regular clinic, physician, or link to care was included in this category.

Once major categories were identified, axial coding was done, in order to organize and specify categories and subcategories. Axial coding focuses on the content of the categories or the pieces that make up the categories. Charmaz (2006) describes the initial coding process as fracturing the data, whereas axial coding brings all the codes and the data back together (Strauss and Corbin 1998). The focus was on separating, sorting, and synthesizing the data using coding to identify themes that relate to health care utilization, including individual and structural barriers. The formation of broad categories resulted from axial coding. These categories include: health defined, health goals, links and resources to care, utilization, and no links or resources to care. Sub-categories contained more detail about the way the categories were constructed and what additional concepts existed within each category. For example, the following codes were grouped into the category “links and resources to care”: received disability, Medicaid, has a Jackson card (for access at Jackson Memorial Hospital), and receives health care at treatment center.

From this process, as well as using the memos and constant analysis of the corresponding quotes from the women, two underlying themes were constructed: 1. Experiencing health, illness, and care; and 2. Talking health. The two themes were compared across all of the focus groups and verified with focus group data to help answer research questions 1 and 4. To organize themes and corresponding categories, diagrams were developed and re-developed for a visual representation of the relationships between the categories and themes. My engagement in the diagramming process continued until one diagram seemed best to embody the women’s experience of health, illness, and care and the way the women talked about health (see page 64). While the goal of this method is not representativeness, this method does require saturation of the data being analyzed before concluding the analysis. Data saturation was accomplished when the gathering of new data no longer offered new insights or revealed new categories (Glaser and Strauss 1967). Categories relevant to the research questions were saturated for the purposes of this dissertation.

Focus Group Process

As stated earlier, a total of thirteen women participated in five focus groups. Details on each focus group, including the progression of grounded theory methods and personal observations made during the groups, appear below. Originally, the recruitment plan for the focus groups was to evenly target women who had not been to see a doctor in the past twelve months, and those who had seen a doctor in the past 12 months. The plan for the first group was to contact women who, during the quantitative portion of the study, reported not having seen a doctor in the previous twelve months. However, several problems became obvious and immediately evident:

1. For some women, particularly the ones that reported no doctor visit in the previous twelve months, their utilization status changed between their quantitative interview and the focus group. Therefore, although initially contacted because they fell into the “no health care visit in the previous twelve months” category, the grouping was no longer accurate at the time of the focus group.

2. The instability of these women’s lives made it very difficult to contact most of them, as their contact numbers had been disconnected, the telephone number now belonged to someone else, or personal contacts no longer knew how to find them. Therefore, it is likely the case that those women who were successfully contacted and attended a focus group were the women who were currently more stable.
3. Another result of the difficulty in contacting women was that the focus groups were small. Three of the groups had two participants although at least five women were always invited and confirmed, and usually more than five. One group had three participants, and one group had four participants. Although larger focus groups are recommended, the smaller groups may have made it easier for the women to share openly, and from a facilitator perspective, the smaller groups were easier to conduct.

Focus groups were conducted between January 13 and April 22, 2011. Focus groups lasted approximately one and a half hours and included two to four participants per group. In total, twenty-nine women were invited to participate in the focus groups, thirteen were enrolled, one attended the group, but changed her mind and left before the group started, and fifteen did not attend the focus group appointment. For focus group 1, the intent was to involve participants who did not have a regular source of care or had not recently seen a physician. Three of the participants were either currently in drug treatment programs or recently had completed a drug treatment program. The status of these women’s sobriety was noted because of the similar responses between participants 1-3 when describing health goals and definitions. These three women seemed to be very affected by public health messages of diet and exercise. This same pattern was also seen in the following group with a woman who had just completed drug treatment. Recent treatment was successful and seemed to influence most of her opinions regarding health care. For instance, Katrina, who was still living at a treatment center, stated:

> My attitude towards doctors, when I was in my addiction, I never liked the male doctors to give me pap smears, but I was using. Kind of cuckoo, I just thought they were down there playing or something. Today I think different. I think a doctor is a doctor and if its in his heart to be the best that he can be that he's not gonna lead you wrong or astray. See I, my mind is clear, ain't no smoke clouding up this, my mind or nothing so I feel better about it. Um, I'm not as, I'm scared. I'm scared when I don't know what's going on with me, but I'm not scared enough not to go.

Because of the unique perspective shared by women in recent treatment, I employed theoretical sampling and recruited women who had reported no recent drug treatment for the remaining focus groups.

When participant answers revealed a new concept that needed further exploration, focus group questions were adjusted and new questions were added. Typically, questions were only reworded for clarity. Questions were added covering the following topics: the affect of addiction on health care utilization, experiences with an influential health care worker, whether discrimination experiences are a result of insurance status or race, feelings about always having a different doctor, and the availability of mental health services outside institutional settings.

At one point, I feared the sequence of questions was influencing participant's responses. Initially, focus group questions almost immediately went into topics on health. One of the first questions asked was, "Do you think about your health?" It seemed that once that question was discussed, participants would stay in a health mindset and answer all question with health related responses. In order to assure the possibility of a less influenced response to potentially non-health related questions like, "What is important to you? What are your daily priorities?", in later groups, these questions were asked before, "Do you think about your health?". Although the women still knew the focus group was about health, the responses were not health related. For instance, women answered the question, "What are your daily priorities?" with: "First, I pray, that's my first priority, I pray. Then my second priority is to get me some sleep cause I work at night" (Juanita).

In the first two focus groups, there was a distinction between women who had recent drug treatment histories, and those who did not or did not reveal their current drug use. The women who were not vocal about their current use were often quiet compared to those who were sharing their treatment experiences. Every attempt was made to engage these participants by trying to make them feel comfortable, reminding them that all opinions and stories were important, gently probing them directly for opinions.

Per grounded theory methodology, all groups were transcribed and coded immediately after completion. A subsequent group was not conducted until the previous group was coded and questions were reviewed again for relevance.

The following chapter presents the results of the qualitative analyses.

CHAPTER 3: QUALITATIVE RESULTS

Results of the qualitative analysis using grounded theory revealed that these women, no matter how vulnerable, have similar views to women in general on health and health care ideals. Where they differ is in their experience of health and health care. Most notably, the women seemed well informed by public health messages, were introspective when evaluating themselves and their beliefs when thinking about health, and were guided by health ideals. When discussing health goals, the women's language was similar to their definitions and opinions; however, the lack of resources became enmeshed with goals the women had for their health. Their experience with their health and the health care system is a narrative guided by their available links to resources for health care and lack thereof. This is what proved vital to the women's experience of health and influenced their utilization practices. These concepts are detailed below and appear in the following diagram.

Many of the quotes from the women are short and may seem disjointed. This may have been the first time many of these women have been asked to talk about health and describe their experiences, the first time their voice was sought, or that someone listened. It is possible that they had a difficult time articulating their thoughts in anything more than a few words at a time.

Profile of Sample

A total of five focus groups were conducted with a total of thirteen women. Surprisingly, given their life circumstances, nine of the women rated their health as good or excellent. Even though only one woman reported having some type of health insurance, nine had been to a health care provider in the past year, and eight reported having a regular doctor or clinic. The current health problems mentioned by the women were mostly chronic conditions and included high blood pressure, back pain, asthma, menstrual problems, and acid reflux. Additional, perhaps more current, health concerns mentioned during the focus groups were diabetes, knee pain, anemia, pancreatic cancer, migraines, heart problems, and HIV. This level of chronic illness both reflects and contributes to their vulnerability. One would not see this rate of illness among women their age living in better circumstances.

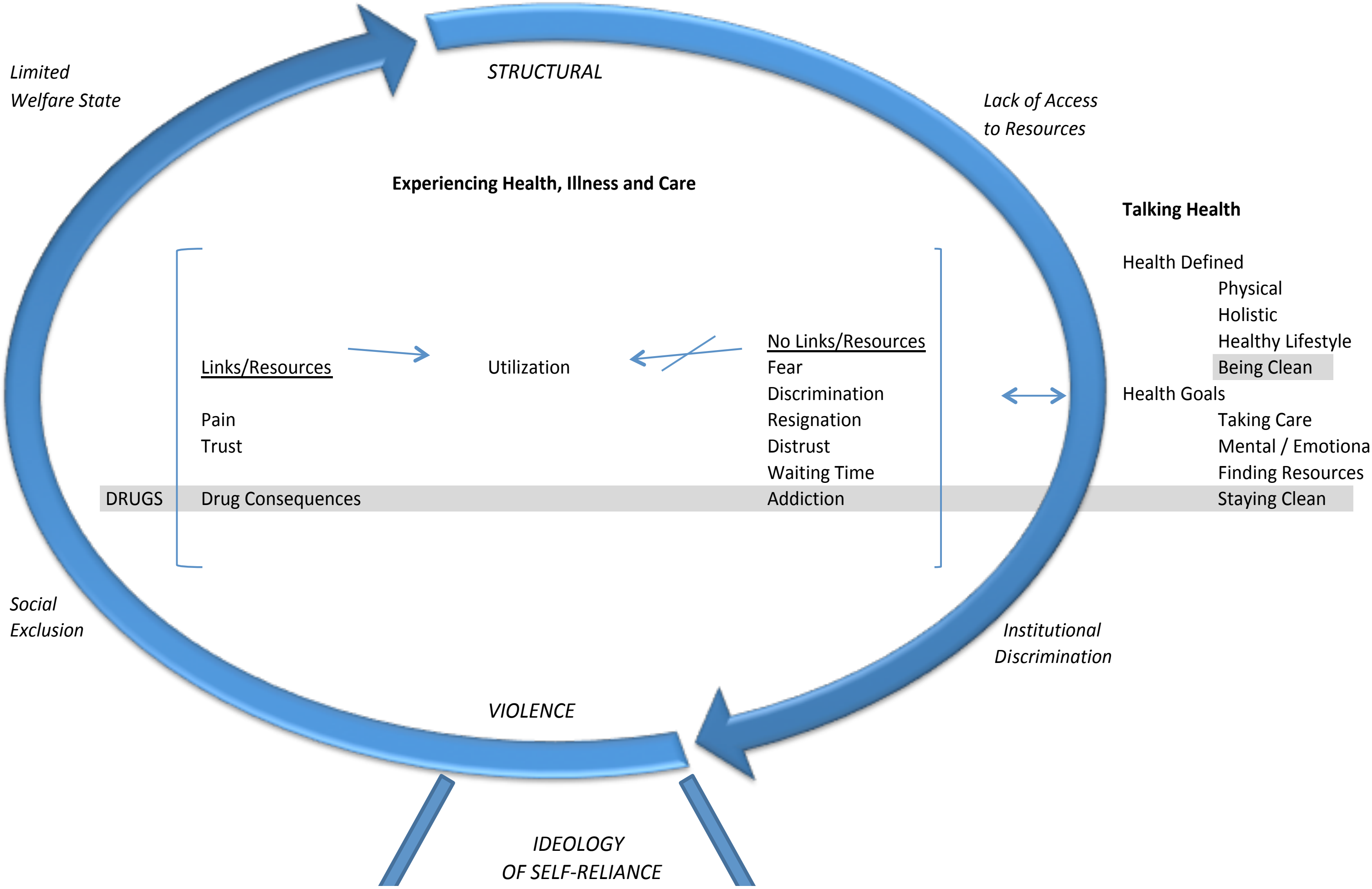
The age range of the participants was 20 to 53 with the mean age at 43.5 years. These are not uneducated women. Eleven of them had graduated from high school or received a General Educational Development credential. Seven of the women had never been in any type of drug treatment program. Four had been in an inpatient treatment program and two were in some other type of drug treatment. The women had spent from 2 to 33 total years in sex work, and 15.5 was the average number of years involved in sex work. Housing was severely unstable for these women. Eleven women reported having been homeless within twelve months of the quantitative interview, with ten homeless within two days of the interview, and four women living on the streets. Interestingly, these four women were the same ones who had been most recently in an inpatient drug treatment program and as of the focus group were sober, had access to health care, and had a place to stay.

As a result of their difficult life situations or marginalization due to drug use and sex work, the concept of good health may be very different for these women, and affected by the daily situations they endure. Research question 1 focused on how these women define and experience health. How do women of this population construct their health care needs? How does this vulnerable population of women experience health problems and accessing health care?

These research questions are exploratory, and there were no hypotheses. These questions address the lived experiences with health care by these women. A grounded theory approach was used to examine the way these women construct their health and health care needs. Two overall themes regarding health and health care were constructed through simultaneous data collection and analysis: 1. Talking health, and 2. Experiencing health, illness, and care (Figure 2, page 64). These themes and the factors that construct them are represented in Figure 2 and discussed in more detail below.

Before describing the components of the themes, the role of drug use in the model should be noted. At the level most of these women were using crack, it is an understatement to say that drugs have permeated every aspect of their lives. The women's history with substance use was evident in every section of these themes and is represented in the shaded portion in Figure 2. However the way drugs were represented took on different forms. When talking about their conceptions of health and their health goals, the women spoke of drug use in terms of sobriety. When speaking to their experiences with health, illness, and the health care system, the women referred to the consequences of drug use

Figure 2: An Experiential Model of Health and Health Care Utilization



as a motivator to seek care and the way addiction acts as a barrier to health care utilization. These will all be discussed in more detail in this chapter.

Talking Health

Talking Health included the way women conceptualized health, how they defined it for themselves, and what they considered as goals for their health. Essentially, "Talking Health" comprises how these women constructed their health. Their definitions represented broad ideals that were straightforward and removed from their personal experience or to the existence or absence of links to care. The women's conceptions and definitions of health seemed similar to women who are not part of a vulnerable group. The real difference is revealed in their experience of health, illness, and care. This will be discussed after reviewing "Talking health"; however, it is worth mentioning that perhaps negative experiences do not affect ideals.

Health Defined

Women were asked how they defined health and what being healthy meant to them. Women's personal definitions of health generally fell into four main categories: physical definitions, holistic definitions, health lifestyles, and being clean. Functional/physical definitions were those referring to functioning and physical parts of the body, including any reference to illness or health issues. Holistic definitions were definitions where the women described, and at times connected, the mental, emotional, and spiritual aspects of health. Initially, when women talked about their personal definitions of health, they were generally about physical functioning. However, as the women talked, they revealed definitions describing a more holistic approach to health. Health lifestyle definitions focused on diet and exercise. Being clean definitions were discussions regarding drugs and health. All four are discussed below.

Physical Definitions

Women's physical definitions of health included definitions related to daily functioning, the absence of pain, and the absence of illness. These dimensions of physical health were at times entwined with each other and reinforced each other. Overall, the most common definition of health for these women was tied to physical functioning, which was often described using general references to the body. For instance, Caroline expressed the meaning of health as: "It means having your body doing fine." While not attributing health to any specific function, she speaks about the state of her body in general. Other women were more specific. Direct references to working limbs, body parts, being able to move and walk were equated with health as Katrina stated, "Having, to be able to use all your limbs." Lucinda talked about the use of her senses to describe health; "I still have my eyes, I still can smell, still can hear, and still can walk around." Some definitions were as simple as seeing another day, "Getting up in the morning, I can move" (Katrina). For these women and given the level of risk they experience daily, Katrina's statement is not merely a cliché. Literally, getting up in the morning is not taken for granted. Being able to carry out general daily activities seemed a critical part of defining health for these women.

A connection between health and the ability to work was also made where work was mentioned as both a definition of health and a way of keeping healthy.

"You know being healthy really matters to me because it allows me to get up. It allows me to function, it allows me to work." (Katrina) For Janice, work was the reason she was healthy, inactivity made her feel she was no longer healthy. "I might look healthy, but I ain't healthy. No, no, no, no, no. I walk two blocks and I be tired. I guess cause I ain't working. When I was working, I didn't get tired. I didn't." (Janice)

"Being free of aches and pains" was another common way health was defined among these women. For Michelle, this went with functional health, "I could be functional and I don't have any problems or aches or anything like that." Not having pain is then attributed to being healthy, "If I don't feel pain, I don't feel like nothing's wrong" (JJ). The absence of pain may be related to being able to function, in that pain can impair function, causing women to no longer feel healthy. Caroline aludes to this connection, "Your body's not feeling any pain or any aches, and you can get up." (Caroline)

The absence of illness was another way these women defined health. Caroline states, "Healthy is when there's nothing wrong, you know, and everything is on track, you know." Although for Caroline, the absence of illness alone is not enough, as she also needs "everything" to be "on track". Some women take this description of health in a different direction. It is not only the absence of illness that determines health, but also the absence of worrying about illness. For instance, Michelle, a woman who was very concerned about a diagnosis she received years earlier stated, "Not having to worry about the ins and outs of sickness". Also, Lucinda, an HIV positive woman defines health as, "Not being scared of being sick". The absence of illness and the absence of fear of illness are closely related. However, for these vulnerable women, the fear of illness may be more salient if they do not have the resources to seek health care when needed.

Holistic Definitions

While the women often used definitions about the physical body to describe health, a more holistic view of health also came through in their responses. Remaining spiritual and keeping a positive attitude were mentioned several times as components of good health. Regarding attitude, one woman expressed just being able to be herself felt healthy. Juliette stated: "If I still can fuss at everybody, whether I'm right or whether I'm wrong. You know, and be sad, or be happy, that's healthy for me. That's my healthy." Health isn't always about a positive attitude. It might be the ability to maintain one's own attitude, vitality, soul, whether positive or otherwise.

A number of women made the link between mental, spiritual, and physical health. JJ had this explanation of health, "As far as health go, when you mention the word, I think of just like wellness. Not only physical, but mental, as well as spiritual." The way these different components of health actually affect each other was noted as well. Katrina talked from personal experience about how mental health, as well as spiritual health, actually affected physical health:

> I just want to say that when I was mentally and emotionally, you know, unstable, I remember that it kept me sick as well. It kept my blood pressure up, it kept me, that's why I, I desire and continue to try to keep healthy because when something's bottling in my head and on my mind and in my heart, it really makes me sick...For me, good health for me, is uh, for my inner self, remaining spiritual,

> having a relationship with who, your higher power, my higher power. You know, having good relationships, having uh, learning who to um talk, you know, being involved with things that are important.

Given that these women have difficult life circumstances, their mental and spiritual health are likely always being challenged. Life on the streets, poverty, substance use, and prostitution are all well-known factors that negatively impact their mental, spiritual, and physical health. However, past trauma is another salient experience. Being able to move beyond traumatic experiences, particularly for these women, was another perspective on health. Katrina describes this:

> Its so many things I don't remember. I don't want to remember because they're so painful. They, they, and that's why I don't go to meetings like I should because everybody has a story they can tell you. You can say, you don't say it out loud, but you say to yourself, or you cry, or tears drop on your face because I could still feel that pain. But, it doesn't stay there, you know. I was told its ok for me to feel it but I have to be able to move. And now, I could do that. I think that's very healthy.

The women who made this connection between emotional, spiritual, and physical health are women who were currently in, or had recently completed a drug treatment program. Perhaps these connections are part of the messages they are receiving from these programs on their paths to sobriety.

Life itself, for these women and their situations, the simplicity of life, living to see another day, constituted health. When expressing her definition of health, Katrina started with, “Getting up, looking in the mirror, thank you God for letting me see another day.” Similarly, Donna said, “Health is life, long life”. When life is as difficult as it is for these women, sometimes the challenges might lead to the most straightforward and poignant perspectives.

Healthy Lifestyle

Most of the time when women used language about healthy lifestyles or health behaviors they were describing their health goals. However, several women did include health behaviors in their definitions of health. Caroline succinctly stated her definition of health was, “Taking care of yourself like you supposed to.” The other women who talked about healthy behaviors had both recently completed drug treatment at the time of the focus group. Katrina had a long definition of health. Within her description, she included, “I, I practice a healthy lifestyle, you know. Its some things I have to work on but I’m better. I’m better, you know. I’m better.” Although she never clarified what she meant by “practice a healthy lifestyle”, her definition overall seemed to communicate a holistic practice of mind, body, and spirit. Donna’s definition of health was influenced by public health messages of diet and exercise, “I used to be a fanatic for exercise, but I never been a fanatic for eating healthy, you know. And, I’m older now and I’m trying to drink more water cause I have thick blood. I’m anemic. I need to take my vitamins, things of that nature I haven’t been exercising. I need to practice the medicated parts, not just the exercise part.” She never actually defined health, but clearly exercise, diet, and vitamins are part of what she wants and considers healthy.

Being Clean

With substance abuse a significant part of these women's day-to-day lives, health definitions were tied to being drug free for many of these women. The connection between health, drug use, and the effects of drug use on the body were most salient among women who were currently clean and sober. For Katrina, being clean was all she needed to feel healthy, "Even if I were to get sick, I'm healthy. I'm clean, you know, I'm clean." She seems to insinuate that getting sick is not a health problem; however, addiction is a health problem. This is a powerful definition of health, tied to sobriety rather than any physical illness.

Caroline connected her drug use to physical health. She has Hepatitis C, which she attributes to her years of drinking; the drinking led to crack use. She still uses both and says her goal is, "not to drink and use drugs no more. That's the main thing, try to get off of them." The consequences of the years of use have become obvious to her. She states:

> Healthy is when there's nothing wrong, you know, and everything is on track, you know. With me, everything's not on track. Goes off track, comes back and after years of using drugs and drinking, it takes a toll on you.

The irony of knowing the close connection between drug use and health, yet still using can be seen in Lucinda's comment about smoking crack, "If somebody tell me that I had to stop smoking crack or else I die, there won't be no more smoking, not for my health. It's not worth my life".

While analyzing the women's definitions of health, initially, I thought I was not really looking for a process with these definitions but rather how a concept like health is constructed among these women. While construction is a process, I was more interested in the result, the description the women provided. I thought within the construction would be the women's process of forming their definitions most likely based on their experiences. However, this was not the case. No matter how difficult their life circumstances, these women's definitions seemed to come from ideals about life and health, as well as from public health messages. Any negative experiences did not seem to impact their view of health.

Health Goals

Women's health goals were for the most part, also about ideals, although some did suggest that experience influenced their goals. Women were directly asked about what their health goals were or what they wanted for their health. This is where the ideals began to collide with experience. The women's health goals fell into four categories: 1. taking care, 2. mental/emotional, 3. finding resources, and 4. staying clean. Goals mentioned were "watching my diet", "living a long life", to "getting a job that offered health care benefits". It is within these goals that seeking care without resources intensifies. The women whose goals were insurance and resource related were those who expressed several barriers in linking to care.

Taking Care

Women want to take care of themselves, their lives, and their bodies. Their ability to take care of themselves might be a challenge, but the desire to do so was unanimous. To "live a long time" was Lucinda's goal; Lucinda still uses and is HIV positive. **"**Trying to get my body together**"** was Caroline's goal; she still has a problem with alcohol use. Again, although hurdles existed for these women, they were clear about what they wanted for themselves, and that they needed to take care of themselves.

For some, this came in the form of nutrition and exercise. Many of these women, no matter how socially isolated they may be because of their life situations, are getting the public health messages of exercise and proper nutrition. However, nutrition and exercise were only mentioned by women who were currently sober or in treatment. For instance, Donna, who was currently in drug treatment:

> I've always been a freak for keeping the weight down, but I ain't never want to put the right food in the body. I just go and burn off what I put in. And it seemed to be working for me but you know, cholesterol, things now. I had a physical and I was just reading over some of this stuff and uh, they tell you what high is and they tell you what normal is, and average and some of the numbers, they didn't look so good, cholesterol. So I know I need to, need to kind of work on that and, um that's why I'm gonna go. I was just telling them the other day, I'm starting my diet again.

JJ had only recently completed drug treatment:

> I would like to exercise more. I would like to be more fit, more in shape, and I also would like to eat healthier, and don't know if none of that is gonna happen, but I would like.

Both these women were in the same focus group. It is possible that these goals were mentioned more than once out of social desirability. However, the first one to mention it was in current treatment and the other recently completed treatment. Perhaps this is a message the women get in treatment. The fact that they are getting these messages could be the important part, regardless of whether these goals are their honest health goals. A complaint of the active users is that they do not care about anything but getting high. Their health and everything else is secondary to their drug use. Now, with treatment, these women are in line with what would be considered more mainstream healthy thinking. This is not to qualify mainstream thinking as better or worse, but it is more conducive to health than focusing on one's next drug fix. Perhaps that is the real health goal coming through their response: I am focusing on taking care of myself instead of getting high.

Mental/emotional

Women's goals were infused with statements like "staying positive", "remaining stress free", and "remaining sober". In fact, mental/emotional goals were mentioned more often overall than physical. Although the women considered their mental state as well as physical when asked about health goals, I did not make this distinction in my questioning. For these women, mental and emotional goals might be more immediately salient, particularly within the context of substance use. Katrina talks about her health goals in this context:

> Try to maintain um, my inner peace just as well as, in my mind, so it won't fight out bad, fight things too, because I know it plays a big part. I learned that in my addiction. You know, that when I wasn't at peace with myself, nothing went right, you know. And that's my goal, yes to just stay focused, to stay positive, even when I have a bad moment, cause that's all its gonna be, a bad moment, cause I'm not gonna stay there.

"Staying focused," "staying positive," these words, her goals, go beyond just simple words of encouragement. She is talking about staying clean, staying on a healthy path, staying off the streets, and healing from past trauma. These are issues that most of these women are dealing with on a daily basis. Even the ones that are currently sober discussed how beating substance use, and the corresponding lifestyle, is a daily struggle.

Finding Resources

Some of the women link their health goals directly to accessing stable health care coverage. Michelle shares, “Actually, that’s my primary goal is to actually find me a secure job with benefits on it so I can take care of my health.” She mentions finding a job in order to get health care, because she knows that is the only way to access stable care. Kira also talks about finding stable health care. However, for her, this means her own doctor:

> I hope to find a good health care doctor, like my own special doctor. Somebody that I can go to whenever I have a situation. That would [be], my main goal I hope for. A regular doctor would already know what’s going on with me.

Women who were in either drug treatment or jail facilities had temporary access to health services as long as they remained institutionalized. Katrina was in drug treatment at the time of the focus group. Her drug treatment center has a health clinic where volunteer doctors provide health care on certain days of the week. Katrina states, “Continue to go to my doctor as long as we have the clinic and we’re allowed to go there because I don’t have insurance on my job.”

Lack of resources (money, insurance) is an undercurrent when these women think about health and health care. It defines health goals for some women and is embedded in their health experience. Each time they need to access care without any resources, it might change their view of health and health care again, solidifying their barriers. This will be discussed in the following section.

Staying Clean

As with their definitions of health, many of these women link their health goals to their past drug use. For example, staying clean, remaining positive, stress free, and at peace were important elements of some of the women's health goals. When asked about her health goals, JJ immediately stated, "It definitely, most definitely to remain clean and sober."   Caroline again made the connection between her drug use and the effects on her body when expressing her goals:

> Not to drink and use drugs no more. That's the main thing, try to get off of them, you know, that thing there, because that's a big problem with my health because I'm getting older and as you get older, things start wearing and tearing and you know, you can't do the things you used to do when you were younger. It just tears your body down quicker, you know.

She definitely associates health with her physical body, but also links it to drug use and its consequences. She also does refer to the mental/spiritual process of staying clean.

Experiencing Health, Illness, and Care

This theme encompasses the experience of feeling ill and seeking care for this group of women, and the issues that come into play when attempting to do so. The purpose of this theme develops into understanding how experience is driven by links to and resources for care, as well as the intricacies of how these women access, or do not access, health care services and what they experience while trying. Within this, conditions that contribute to women successfully accessing and utilizing care are included as well as those that present barriers. Conditions that led to utilization were only important if secure links to care existed. These included: pain, trust, and drug consequences. Barriers to utilization are due almost entirely to lack of money/insurance. Negative experiences with fear, discrimination, resignation, distrust, waiting times, and addiction are all linked to lack of links and resources.

In attempting to conceptualize and understand the way illness and health care were experienced by these women, it became evident early on how deeply embedded lack of insurance was within many of these categories. It appeared in the way health goals were conceptualized for some women and was even more prevalent when examining these women's experience of health care. Lack of money or insurance basically meant lack of resources or reliable health care links. Almost every single barrier to care discussed by the women was linked in some way to lack of money and insurance. Therefore, insurance or lack of insurance is a critical component in the way these women experience health, illness and care.

Utilization

Having no consistent or secure link to or resource for care seemed to be the primary basis of utilization for these women. Even the smallest amount of access like having a regular place to go or doctor to see, seemed to help these women utilize care as the women with no type of link, coverage, or resources were the ones who were most worried and least likely to access care. Two of the women stated that their primary health care goal was having a regular source of care, and women who felt they did not have an assured link to care were less trusting, expressed fear, feelings of rejection, feelings of discrimination based on lack of insurance, and reported negative experiences when they did utilize care.

Most of the women did talk about existing available access to health care services, and most agreed that Jackson Memorial Hospital is an available place for care. These women defined access to health care at Jackson as, if a person was sick enough, Jackson would provide care. However, the wait might be for hours in the emergency room or clinic, or months for an appointment. Furthermore, Jackson will send a bill for the care received, and unless stringent residency requirements and payment arrangements have been made, the bill for service must be paid. Jackson requires a state issued identification, proof of county residency for at least six months (rent receipt or utility bills for six months), and proof of income (last four consecutive pay stubs, most recent income tax return), which are used to decide the payment amount that is the patient's responsibility. Without these documents, the patient will be responsible for the entire payment. These requirements themselves become a barrier to care as homeless women do not have utility bills and sex workers do not have pay stubs. Those who are able to provide the required documentation receive a "clinic card" with the payment requirements that have been determined. As Donna, described, "If I was in dire need of, of medicine right now, then hey, I take this and do it. I got a card. I could do it [go to the clinic]. You know what I mean? Well, it'd have to be a situation but I have something to help me financially or something physically that push me". Having the Jackson clinic card opens up her options to seek health care if she really needed. As Michelle stated, "When [health care] coverage is available, you go to the doctor".

A link to health care resources also exists through institutionalized settings such as a treatment facility, a shelter, or jail. This is especially true for any mental health services. Those with criminal histories or those who are consistently homeless may actually report more health care utilization because of this structure (Butters and Erickson 2003; Padgett et al, 1995). Several women spoke about available health care services through a clinic at a well-known women's shelter. This shelter has set up their own health care clinic, with a volunteer doctor from Jackson Memorial Hospital, to serve the women who are at their shelter. As Katrina describes, even when you have "graduated" from their programs, there are instances you can still use their clinic:

> I lived at the shelter for eleven months, and now they have a clinic. I also work at the thrift store. So, since I work part time, and I don't have insurance, they have a clinic where we are allowed to go get seen by a doctor and then we get out, he is able to give us prescriptions and stuff like that.

Recipients of Medicaid communicated that this safety net system gives them the access to care they need. Donna shared how things changed for her once she received Medicaid, "Now that I got a Medicaid card, I think that's a great help because before I didn't want to spend the few dollars I got, you know [to go to the doctor], if its really not killing me, if I'm not dying." The fact that the Medicaid card opened up access to care for this woman is evident. However, even more critical is that with the card, she doesn't have to wait until her symptoms are more severe, more serious, and overall, more expensive. Kira talked about how when her family used to receive Medicaid, they used to see a doctor regularly for preventive care:

> When we [were] growing up, we had Medicaid, my mom, she had Medicaid for all three of her kids and herself. So back then it was totally different from now because she was like, we used to go to the doctor every six months. We was able to get our shots. We was able to get our shots record updated. It was totally different back then and then now, it's not like that no more. My little sister got two kids and she can't even get Medicaid for her two kids and herself.

Kira recognized that receiving Medicaid as a child allowed her family necessary health care. She also raises the unfortunate issue that it has gotten more difficult for families to qualify for Medicaid. Although Medicaid may be far from a sufficient system, it can provide access for individuals and families who would otherwise go without health care, especially preventive care.

Therefore, while some access exists through systems like Medicaid, treatment programs, and public hospitals, for those who do not meet the requirements to receive these resources, the space between feeling fine and being "sick enough" is where women seem to get lost and frustrated. However, any link, regardless of the source, seemed to facilitate the utilization of health services. The next section will review additional factors that motivated women to seek health care services, particularly among women who had resources to care.

Links to Resources

If a link to care exists, several other factors were motivators for seeking care when needed. Pain, trust, and drug use consequences were the main factors mentioned by the women that motivated care. Drug use consequences produced fear of illness because women stated their worry about the toll years of drug use had taken on their bodies. In addition, the women recognized that sex work has put them at higher risk for several health problems, particularly HIV.

Pain

Health care utilization was strongly linked to pain for these women, and pain often was mentioned as a primary reason to seek health care. When the women were asked what motivated them to seek care, these were several responses:

> Pain is a motivator for the doctor for me, that's it. (JJ)
>
> Well I have to be in a situation but I have something to help me financially or something physically that push me. Pain to push me…Excruciating pain. (Donna)

Many wait till they are "passed out and dying" to go (JJ). JJ, in particular, expressed how much pain played a role in her health care seeking behaviors. She associated the absence of pain with being healthy, and she went on to state that the only thing that might actually get her to seek care is pain.

> I have to feel pain to actually go and do something about it because if I don't feel that pain, I don't feel like nothing's wrong. So, if I don't feel the pain, than everything's cool, but if I feel the pain, I panic, and I have to see about it…I'm not one to just run to doctors and stuff like that. I literally, I think, I have to be passed out and dying before I go, but if the pain is bad enough or severe enough, I'll go.

The idea that pain is such an important motivator for seeking health care is especially significant among this population since, according to the quantitative data, the primary health concern these women reported was skeletal/muscular issues, or in other words, pain. If links to resources are non existent, these women either end up in an emergency room, ignore the pain as long as they can while the associated health issue worsens, or live in constant discomfort.

Trust

Women talked about trust in health care usually resulting from previous good experiences while utilizing health care and having their own regular doctor or source of care. After a good experience with a doctor at Jackson Memorial Hospital, Katrina changed her negative opinion on doctors. The doctor kept Katrina in the hospital eleven extra days in attempt to detoxify her body from the cocaine she had found in her system. The fact that this doctor took those steps to help her "changed my life" (Katrina). "She made me think, here's a doctor that loves me enough, don't even know me, that's trying to keep me alive. When she did that, ever since then, I started going to get help." After this experience, Katrina thinks favorably of the health care system and felt that women need to take any health complaints to the doctor rather than play doctor:

> Whatever's making me feel bad cause I'm not a doctor, I need to come to them and let them know about it, you know. We tend to go behind the counter, get some medication, 'oh that's for my stomach'. Who made you a doctor that you want to take all these things?

When asked why she had the negative attitude towards doctors in the past she blamed her drug use as influencing her opinion, "in my addiction, I didn't like doctors and all that but, you know, they don't know what they're doing, but today, no I don't feel that way."

Michelle discussed that having a regular doctor she trusted was important for her to feel comfortable utilizing health care. What was important to her was a compassionate doctor with a good bedside manner. It gives her confidence in the doctor and takes away her fear of going. Speaking of a doctor that she trusts and who is willing to work with her on paying for her health care:

> If I could go with him on limited coverage, it would be beneficial for me because I feel confident…I could deal with whatever situation because I know this doctor has a good bedside manner…if I have to take a different route, and meet another physician where I have to develop a relationship with him, its gonna be a little difficult for me.

She stated she is willing to pay money for health care that she trusts, even on her small income. Having a doctor to seek that she trusts is worth the financial sacrifice.

Consequences of Drug Use

Women acknowledged the negative affects years of drug use has on the body. The drug high from crack cocaine does not last very long so a person addicted to crack usually uses large amounts of the drug in order to stay or maintain that high. The negative effects on the body of high doses of the drug itself are not the only problem with heavy crack cocaine use, as addicts usually rely on sex work to sustain their addiction. Women connected their life situations with their bodies acknowledging the affects of drug use and sex work on the body, and the need to check "what I messed up" because "all the drinking and drugs after a while take a toll on your body and your body be going through some strange changes" (Caroline). Katrina talks about always being at risk once you have used drugs:

> One of my ovaries is gone. Ok, this is due to my addiction. When I was younger and so many things not going good down there, but the doctor says they're ok. I really need to pay attention to that because, because you never know. I never know…I think girls who use drugs, they always they, we're at risk. Even when we clean, we're still at risk because you don't know what's going on down there, you don't know.

Fear of illness in general from consequences of drug use, and particularly fear of HIV, was mentioned as motivation for seeking care. "Getting an HIV test" was a common response when women were asked for reasons to see a doctor. Women expressed so much fear of HIV that they were even being HIV tested various times for the same "exposure" even though it was unnecessary if they were found seronegative and have not had a new exposure. (Katrina, Carla)

No Links to Resources

When women were asked why did they not seek health care when needed, the most common response was lack of money, insurance, or any link to or resource for care. When there is no link to a resource for health care, it is not likely that care will be sought. As JJ stated, "Its, its, its, you better hope you don't get sick. It's just like that, you know. Just hope you don't get sick." Jackson Memorial Hospital, as discussed earlier, is a source for care, and the emergency room is the typical destination for health care for these women. According to Kira, in the past, the health department was also a no-hassle source for indigent care, but now requires a patient to have income, show proof of income, and it must be low to quality for free services. Some women will go to Jackson or the health department anyway and ignore any bills. When I asked Juliette what she did with the hospital bill from Jackson Memorial Hospital for care she had received, she said, "Goes in the trash."

However, without insurance, it is more likely that women will postpone seeing a doctor for a health problem as long as possible. Below are some of the quotes from women when they were asked about health care without insurance or minimal insurance:

> She had a little bit of insurance and she was at Cedars, no not

> Cedars, North Shore, and when her insurance ran out, they sent her home. She had a stroke and it was affect her mind. We were hurt. We were devastated. (Katrina, sharing about a relative)
>
> But the people without any health insurance, you don't even have a chart. You're just like a number. You're just probably number 80, da, da, da, da. You got insurance, they got a folder. They got a primary doctor. If something were to happen to you, if you get hurt out on the streets and having to go to the emergency room, your doctor would be able to go find you and fix you like, that's the health insurance, that's the health care. (Kira)

The frustration is evident in these women's words. While the experience of health care with insurance can be bewildering, for a person without insurance it can be devastating. Even if these statements are completely based on subjective definitions of the situation, these definitions are what guide behaviors. If these women think they get substandard care, this would likely affect the type of patient they are and whether they will utilize care in the future.

These perceptions, and sometimes misperceptions, play a significant role in the way these women experience and utilize health care. For instance, Kira mentioned that a lot of people she knows do not get tested for HIV because, if HIV positive, they would have to face the expense of receiving follow-up care. She also stated that some people actually cannot afford to even pay for the HIV test itself. Unfortunately, this is an example of lack of information and misperception guiding behavior. For years there have been government funded AIDS awareness campaigns with considerable efforts focused on HIV testing and treatment, particularly in low-income and minority communities. These campaigns provide funding for community agencies to offer free HIV tests. If a person receives a seropositive result, they are linked to community programs, mostly providing health care and medications for free or minimal costs. Apparently, the availability of these free services is not common knowledge resulting in hesitation to seek health care.

The same hesitation based on misconception may transfer to health care in general. Other participants also mentioned that follow-up care is a problem. For instance, if you seek care and are diagnosed with a condition that needs regular follow-up or medications, lack of insurance may become a larger issue and the expectation that it is necessary to pay for at least some of the health care services received may become overwhelming. Whether this is really the case with follow up care does not matter. The affect this has on health care seeking behaviors is still adverse. Some women choose to not even bother to get a check-up if there is a risk that something might be wrong and require follow-up care.

Fear

Fear was a barrier to utilizing health care that was mentioned by several women and meant different things for different women. These women discussed how fear is a barrier to health care utilization in terms of: the fear of finding out something is wrong with your health (especially if you don't go regularly or haven't been in a while); fear of having to change your lifestyle because something is wrong; fear of not having money or insurance to pay for care; and fear of the long wait to see a doctor. The fear that something is wrong with your body and yet not being able to conveniently go to a doctor, or fearing that a visit to a doctor will equal a large bill or long wait in the clinic/ER are all intertwined.

The fear seems to all initiate from the fundamental problem of “I have no insurance”. All the other resulting fears seem directly related to this one overarching concern.

Feeling badly is frightening and many people feel the desperation and fear that comes along with realizing something might be wrong. However, the fear is pronounced when you have nowhere to seek care and little trust in the system that exists as an uninsured patient. The result is that many women won’t go seek care, and the very problem that they have not been receiving health care for a long time because of a lack of insurance or link to care feeds into that fear. Michelle explains, “if you haven’t been to the doctor in awhile, you fear the outcome of that visit when you go there. And, a lot of people just don’t want to deal with the reality of something. They don’t, you know.”

An example of this type of fear and the culmination of various factors is Michelle. Michelle has a job, but the job does not provide insurance or benefits. If she were to take time off from work to seek health care, she would not get paid. People in this situation will likely not go a doctor unless a health problem become severe. Michelle was told she possibly had pancreatic cancer and needed to return to the doctor for follow-up tests. She did not get the tests done because she was feeling fine, was worried about the cost of care, and did not want to take the time off of work. As of the focus group, it had been over a year since she had received the news of possible cancer. Now, she is terrified to return for these tests, because she fears the cancer has advanced since she had not gotten care, and that doctors would give her a few months to live.

Discrimination

Incidents of discrimination were a significant part of the women's experience with health care. However, these women did not feel they experienced race-based discrimination, or at least not classic race based discrimination. Rather, they described discrimination by way of lack of insurance. The common opinion among this group of women is that the quality of health care and treatment one receives without insurance is considerably worse than that provided to those who have insurance. Noelle described what a doctor's visit is like without insurance:

> Because if you don't have insurance…they don't take the time to check you out thoroughly. They might check you out, but it won't be as through as person who has Blue Cross Blue Shield, you know what I mean? …They're not gonna give you 100%. (Noelle)

This was the common opinion among this group of women regarding the experience of health care without insurance. Michelle explains it similarly, but she adds a sense of shame in her words.

> It's a way that, you know they look at you, 'Oh how she gonna pay this?', and you know the lack of attention that's given to you or they think that this is like a common animal or something like that. 'Oh, we ain't getting paid for her, no way." You know, so what, go ahead, get her in here and get her out. They don't care about what your situation may be or what your health situation may be. You know it's probably the fact that they know that they're not getting paid, lets get her on up out of here.

She went on and described health care and treatment without insurance is like going to the grocery store and not being able to pay for all of the items you want to purchase. When you have to return the items you are unable to pay for, the cashier will likely look down on you. The cashier would think, "Now she no good, when she ain't putting, she had all these groceries up here and she ain't have enough money to pay for it." If this is the perception, those without insurance may actually be embarrassed to seek health care when they know they cannot pay. Women talked about the way "they look at you" and the "lack of attention that's given to you" or they treat you like a "common animal." There is pain in their words. As in Kira's, "We get treated wrong, we get treated like nothing, [be]cause we don't have no money to pay for the stuff."

One woman felt that drug use was a reason why she was discriminated against. "The drugs, the drugs. That's why that's a big a problem that it is. That's why they ain't, that's why they ain't helping, they ain't helping, everybody, everyone, that they, they, they, they think, they think that they all on drugs." (Janice) Discrimination is a problem because of the drug use, because they don't get treated right by health care providers if there is a history of drug use. If the participant goes to seek care, she feels that she is treated poorly based on her current or past drug use, and is being stigmatized by the health care provider. This becomes a barrier to her seeking care.

Women were asked if they perceive that white women receive better or different treatment in health care than Black women. This question was based on a quote from a woman in another set of focus groups conducted as part of the larger study. This quote came from a set of focus groups conducted to understand the barriers to HIV testing for this same sample of women. When a woman was asked why she does not get HIV tested:

> I think the information is out there, it's just how we perceive it. We've, well, I was brought up to get a mentality that Black folk are less than White folk, you know? You're not gonna always get what they get, so when you see all your newspapers, all your flyers saying Black women

> are dying of AIDS, they [Blacks] saying, ‘They just lie, fucking us up.’ Seriously, literally, this is how we think…Somewhere through all the red, yellow, green, tape, there’s a doctor that I can go to for a pap smear, but is he going to give me the best pap smear that I can get or is he just going to, you know, play around with me and not tell me the stuff I need to know? Do we get the same information other communities get the way they get it? In my opinion, no.

Using this same idea stated by this woman, I was interested in whether these women felt white women received better care than Black women and if this perception affected their utilization. Lack of insurance, not race, was the determining factor in how one is treated when seeking care. “It has nothing to do with color” stated Katrina, “being a Black woman and getting health care ain’t no different from being a white woman and getting health care…the criteria is insurance” (Juanita). Having insurance is having status when accessing health care, as Carla stated it, “[with insurance] You get the best of care. We ain’t talking about no color. You could be white or Black, but if you got insurance, they treat you like a king, a queen.” Regarding whether the poor treatment they receive due to lack of insurance affected their future utilization, the answer seems to be yes, and it is discussed in the “Resignation” section below.

Resignation

Repeated experiences of discrimination may change perceptions of health care and affect utilization. When I asked the women in the focus groups if and how their experiences of discrimination affected their view of the health care system and the likelihood of future health care utilization, the responses had a sense of resignation. Some examples of the women’s responses to the question, "How do these experiences (of discrimination) affect your use of doctors and clinics?"

> Sometimes you don't even go, you figure its going to be a waste of time. (Noelle)
>
> Sometimes you get frustrated and just leave. (JJ)
>
> You be dead by the time they get ready to see you, you ain't got no insurance. You might as well stay home. So I say, Lord just keep me, I don't go to the doctor. I don't go. (Juliette).

One woman shared what she felt was continuous rejection due to the environment of denial of services that exists for these women whenever they attempt to seek health care. Speaking about trying to access Medicaid, Juliette stated:

> You know the biggest barrier, you know, for me, I don't know. I really don't know, because its like, I'm 51 years old right, and its like when you go to sign up for these different things, they gonna tell you you gotta be this and you gotta be that, and its like, forget it. Like they be telling you about with Medicaid and all that, you know, they deny me so many times until I just get to like F you. You all keep that, I'll just have to wait till I get 65.

She made a similar comment when comparing treatment at clinics between those who do and do not have insurance. Her opinion, which was the same as several other women's, was that if you have insurance, you will be seen by the doctor before those who do not have insurance: "Them people over there ain't treating nobody right. I was here first…on my head, that's rejection" (Juliette). This type of substandard treatment at the clinics becomes personal for these women when they feel this sense of rejection. Because of these types of experiences, Juliette mentions that she does not trust doctors and thinks they will kill her. Clearly she has perceived the health care system, or perhaps “systems” in general, as something that will not help her and will likely hurt her.

Distrust

Distrust towards doctors and the health care system, particularly how these are linked to lack of insurance, were indicated as barriers to utilization. In essence, if a person does not have insurance, no one is really going to help. Again, money, or lack of it, is at the root of these attitudes, and these uninsured women think that money is all that some doctors care about. As Donna poignantly articulates, “It can be some strictly for the money, just go to work for the dollars and not for the souls.”

These women do not believe they are getting quality care from the doctors and clinics. Overall, they describe doctors as dismissive and unconcerned with taking the necessary time to evaluate the uninsured patient. It seems that even when there might have been legitimate reasons why care was handled a certain way, these women do not have faith in what the doctor says, and this perception might come from repeated experiences as a patient with no insurance. A woman speaking about the volunteer doctor at the shelter she stays at made the trust/insurance connection.

> And that’s not really even, I don’t really see that, I really don’t see that as being a real doctor… Because, by you not having no insurance, as I could go there, and I could be like, ‘my chest hurts’, cause I have. Sometimes I have like chest pains and I went there, and I was telling him about these chest pains and I kid you not, the man just basically told me, ‘yo, uh, there’s nothing wrong with you’. And, I’m like, well why is my chest bothering me like this? It’s got to be something wrong. I said, I got a heart murmur. I said and you know, I’m gasping for breath at times, and, and at times my chest is hurting. They told me the same thing when I went to Jackson one

> time before. They told me nothing wrong and they took all my blood, strapped me all up, put these, gave me an EKG, and, and nothing. Tell me ain't nothing wrong. And at that time, I was, I had that, I had like blood coming from out of my, like I would hock up phlegm and blood be in it.
>
> *And this is because you think that you didn't have insurance?*
>
> Mm, hmm. (Noelle)

This woman questioned the legitimacy of this doctor. She did not trust him or the hospital when they told her nothing was wrong. There are several possible reasons why: because he is volunteer, because he did not validate that something was wrong, because she doesn't have insurance she feels she is not really getting health care. She could be getting substandard care, or there may be a perception of substandard care because that is what this woman is accustomed to or expects from doctors as an uninsured patient.

Having a regular doctor that was familiar with their history and who was compassionate would help overcome the cynicism towards health care. Michelle's quote earlier about feeling comfortable with her doctor who had a good bedside manner made a significant difference in her approach to seeking care in the future. As Kira explained, being able to see the same doctor whenever she needed health care would help her trust that she was receiving proper care because she wouldn't have to go over everything all over again. Her regular doctor would "already know what's going on with me." She was frustrated that whenever she uses the emergency room or clinic, a different doctor examines her, and she has to go through her history again.

> I have to be specific with what's really wrong with me, and I have to tell them like, for instance, I had a cold last week. I have to explain to

> them exactly what's going on with my cold and how, if I don't, if I miss something, they be like, 'well, you didn't tell me this and that's not my problem. You have to reschedule another appointment.' So, it's like, I don't really trust the doctors. I have to have a tablet when I go. I have to show them this and this is what happened this day. I don't have health care. I've been in the emergency room this time, this time, this time. Like, I have paperwork like that, and it's like, I need some, a regular doctor that I could, he already know what's going on with me.

Lucinda expressed how much she did not like or trust doctors, "I didn't trust them, It's like they didn't care", until she was diagnosed with HIV. Once she started attending the Infectious Diseases clinic at Jackson Memorial Hospital, she was assigned a doctor who she describes as "thorough and caring", and she now attends all of her appointments. Speaking about her doctor, "He really, really cares. If there's a symptom, he gonna make sure that he do a check or something of what he think might not be right. I love my doctor, because he cares."

However, Katrina, who said she now trusts doctors, introduced the possibility that distrust might be a side effect of drug use. She explained that when she was in "her addiction":

> I didn't like doctors and all that, you know, they don't know what they're doing. For me, my attitude towards doctors, when I was in my addiction, while I never liked the male doctors to give me pap smears, but I was using. Kind of cuckoo, I just thought they were down there playing or something.

Perhaps for some women, trust is related to whether they are still using drugs. The drug use lifestyle may skew the ability to trust anyone.

Waiting Time

Long wait times in the clinic or emergency room were mentioned various times as a barrier to care. Many women forgo seeking care and just wait until they are severely ill and have little choice but to endure the wait. The exchange below elucidates this:

> *So you both mentioned that you have to be like passed out on the floor before you'll go to…why? Why do you think that is?*
>
> Because the long wait. (Donna)
>
> They just do you bad boy. They do you real bad. Just sitting there, dying. (JJ)

Again, for these women, this waiting time is linked to lack of insurance. It is not clear where this belief originated, from witnessing those with insurance being seen quicker, or just the perception that this is what happens. "Because if you have insurance, they, lets say she has insurance, and I don't, she's not gonna wait 12 hours. She'll probably wait 6" (JJ). The result of this is that many will leave before being seen by a health care provider, or they just will not go at all.

However, women with insurance are more likely to be using the emergency room for true emergencies rather than for non-emergency reasons. Women without insurance are forced to use the emergency room for any aches, pains, or flu symptoms when there is no other source of care. What the uninsured women are likely witnessing is triage based on the presenting problem, but that link between insurance and triage may be not be visible. The perception becomes that insured women get seen more quickly.

Addiction

Drug use was pervasive throughout every component of the women's experience with health care (as well as the way they defined health). Some women mentioned that their biggest barrier was drug use. "The drugs don't let you think about anything but one thing and that's that." (Katrina) "Cause every time I supposed to do something, I never do it. I supposed to go somewhere, if I'm high, I'm not going" (Caroline). While in active drug use, the drug becomes first priority over everything. Women talk about being in the hospital and walking to Overtown, with the IV still attached, to buy drugs. As soon as they get out of the hospital, and for all intents and purposes were "detoxed," the first thing they do is go buy drugs. They will lie to doctors, family, partners, and themselves.

> They kept me there for eleven days because the lady, my doctor said I was on drugs and she didn't want me to go back out there because she knew what I was gonna go do. I wasn't going to pay attention to me. I was going to go back out there and get high, and god forgive me, I did exactly that. I got, my ex-boyfriend gave me 50 dollars for my medication and you know what I went and did with it. I got high…sickness is not even stopping me, you know. (Katrina)
>
> I be sitting there smoking, with a headache but staying and smoking, staying there snorting, blood coming out of my nose, just wiping my nose, but steady doing it. (Carla)

Several women made the connection between their health and drug use, in most cases, completely avoiding health issues they knew they needed to face. When she was told of a mass in her ovaries, Katrina admitted to placing drugs before her health, "I have a mass on my ovary, I know that. In my addiction, I was supposed to go get surgery, I didn't go get it". The women talked about being too "busy" to get care for their health problems, and by "busy" they meant involved in activities related to their drug use whether it was hustling, sex work, or getting high.

Drug use served an additional purpose to just getting high. The women shared that drugs help in managing emotional and mental, as well as physical pain. Many of the women affirmed that getting high is cheaper than going to the doctor, and it is better at eliminating pain, “make the whole body feel good, not just whatever problem, it’s the whole body” (Lucinda). Basically, they self medicate with illegal drugs. “We’ll numb ourselves with a drug before going to the doctor”(Katrina). When speaking of a friend with AIDS who still smokes crack, Lucinda describes her theory, “Because that’s like her medication…I really do think if she was to quit smoking and get on [AIDS] medication, I believe she would leave here. It’s like preserving her to me. That [crack] is all that gives her any gumption to get up and move.”

The women also assert that they trust the illegal drugs more than the prescription drugs given to them by doctors, because they are more worried about addiction to prescription drugs. They feel they understand and have better control over the illegal drugs, whereas the prescription medication, with its complicated dosing, was more frightening, more expensive, and potentially more addicting. Juliette stated that she knew how to control her use of street drugs, but prescription drugs are designed for your body to need them because of the dosing schedule. She would rather listen to what her body is telling her to do than what a doctor is telling her to do. The fact that many prescription drugs are legal versions of some of the same illegal, street drugs was not lost on these women.

> Oxycontin is heroin. It ain’t nothing but heroin. I go to the street, I pay $5. Now I go to the doctor, I give the doctor $25 or $50 for a visit. He write me out a prescription. All he’s doing is writing me out a street drug but under a different name and different form. So what’s the difference than going to a doctor and going to the streets? Just one, they get paid more. (Juliette)

Experiences of discrimination, lack of trust in the health care system, feelings of resignation, and waiting times to see a doctor due to lack of insurance, in combination with ready access to street drugs potentially makes the choices available to these women relatively straightforward when presented with the decision of going to the doctor or self-medicating with illegal drugs. It is much easier to continue to self-medicate. While drug use may be a barrier to seeking out necessary health care services, it may also serve as a way to manage pain for vulnerable populations whose options are limited by lack of insurance. The fact that for these women, choosing a street drug over prescription medication can be a rational decision is an indictment of our health care system.

Structural Violence

Research Question 4 was: "How is health care seeking influenced by structural violence?"

This research question is exploratory, and there was no direct question that was asked during the focus groups about symbolic or structural violence. I hoped to be able to attain the answer within the responses the women gave about their experiences with the health care system. This analysis does not come directly out of grounded theory, but rather my interpretations of the findings in the context of structural violence as a sensitizing concept.

Many experiences of systemic discrimination were noted during the analysis. I used Galtung's (1969) definition of structural violence, which is a constraint on human potential and the harm resulting from social exclusion, a limited welfare state, institutional discrimination, and a lack of access to social goods and resources. The Experiential Model of Health and Health Care Utilization (Figure 2, page 65) displays how structural violence was the encompassing context in which the experience of health, illness, and care took place.

Using this definition and the women's shared perceptions, it is clear that these women are a case study for structural violence. There were examples of the effects of social exclusion and discrimination, as well as a limited welfare state and a lack of access to goods and resources in the telling of their health care seeking experiences. The structural violence they encounter when seeking care influences future utilization, and ultimately does harm to the women themselves. Due to their similarities and overlap, for this analysis, examples are combined into two categories: 1. a limited welfare state and lack of access to resources, and 2. social exclusion and institutional discrimination.

Limited Welfare State and Lack of Access to Resources

The intended purpose of a welfare state is to play a key role in its citizen's well-being. Although there is a limited welfare state to rely on, there are several services such as Medicaid, state health departments, and county hospitals that exist in order to assist low-income populations access health care. Jackson Memorial Hospital, as discussed earlier, provides care for indigent patients of Miami-Dade County, on the condition that the proper documentation is provided and can be verified. Jackson has also established eleven satellite clinics attempting to provide geographically accessible care. However, the coding system to determine patient's financial need is cumbersome and a barrier for those who cannot provide the necessary documentation. Six months of county residency can be determined with a utility bill, but many of these women have precarious living situations, staying in shelters, with friends, or on the streets. Household income requires some type of pay stub that is non-existent when sex-work is your main source of income. Such rules inflict violence upon patients and prevent a socially and economically vulnerable population from being able to meet basic, minimal, necessary health needs. While the state health department was at one point a source of refuge, particularly for preventive services, they now have the same requirements as Jackson.

Two places that were mentioned consistently as sites for health care access as well as counseling and a place to sleep were drug treatment facilities and jail. Ironically, women referred to jail as “R&R” for “rest and relaxation”. In jail they were safe, were given meals, had a place to sleep, a place to bathe and were provided with necessary physical or mental health services. Sadly, a little down time in jail is more appealing than being on the streets. At drug treatment centers, sometimes jobs are provided for the women who are successfully completing treatment. These two institutions may not necessarily be direct examples of structural violence, but the fact that these are the only places the women know they can get care is telling. Furthermore, these institutions may actually uphold the structural violence by promoting ideologies of self-reliance. The idea of self-reliance in the context of these women’s lives constitutes blaming the victim.

I observed, among the women in the focus groups, that those who had recently been in drug treatment had a different sense of health care. While most women still spoke of bad experiences with wait times and experiencing discrimination due to lack of insurance, there seemed to be more of an acceptance of health care providers, even if there was not complete trust. There was a certain connectedness, a normalcy, in their descriptions compared to the women who had never or not recently been in drug treatment. For instance:

> You know, it, its things out there, and there's options for us but people just don't use them. They don't utilize them. We're lazy. They don't want, ok, today's life, everything is a line. You gotta stand in line to go to the bank, you gotta stand in line, everything is a line. You just gotta get some patience and do whatever it takes to better yourself. You know what I'm saying. It's up to you. You don't have, ok, half of this world don't have insurance, so you got to work about that and take what you can. I think a little bit of medical assistance is better than none. Especially when you, when you're, when you can't make bills meet, when you can't pay this, when you can't pay that, you need to try to find you a free doctor somewhere, because that's enough right there. I can't afford it, and they don't have the, they don't take the resources. I don't say they not gonna have it, they don't take the resources that can help them to get things because they don't want to take the patience, and they don't want to take the time, and they don't want to take a whole day. Cause if you go to Jackson, you gonna be there a whole day. But if you go there, you gotta know its gonna take twelve hours before you can see the doctor. If you got that in mind, you gonna see somebody. (Katrina)

While Katrina's outlook was a positive way of handling the frustration of seeking health care, there is a sense of reifying the dominant ideology, excusing the difficulties involved with trying to get health care and blaming the most oppressed for their situations. Her words illustrate an individualism and self-reliance she likely gained in drug treatment. However, the victim blaming is evident. She has made excuses for the system, at one point saying, "that's the way it is, policies are policies". This type of acceptance of a severely stratified system is actually an example of Bourdieu's symbolic violence where the oppressed actually participate in their own oppression. Kira, who had never been in drug treatment, had a very different opinion on trying to get health care:

> I never use the Jackson card because the first time I did had to go to the doctor, they gave me an appointment like two months in advance, and I'm like then how can I remember the appointment time and then, you supposed to come an hour and 30 minutes before the time of your appointment. So, I'm like I got there on time and everything, but its like that waiting five, six hours, it was not worth it and I actually had to wait that long to get seen. Even if I was crying, they still did not care. I was the last person. I was the first person to walk in and the last person to leave. And, I had a Jackson card. I had all the qualities that they needed to show them that I have it but still, cause I had the Jackson card. I was just there for birth control, and I had to pay for that. I couldn't even get that. The Jackson card, the Jackson card only covers like half of medication and stuff like that. I can't get it for free so I had to pay for that. All my prescriptions, I have to pay for. So, the Jackson card is not nothing. It ain't helping me pay for the prescription. It ain't helping me.

These opposing views on care at Jackson may have nothing to do with the fact that one of these women had recently been in treatment. However, a pattern was noticed among all these women, those who were somehow connected to health care through an institution like drug treatment had better experiences with care. This could also be due to the simple fact that the institution provided the crucial link they needed to access care with fewer barriers. It also seemed to instill the ideology of individualism.

Social exclusion and Institutional discrimination

Female, Black, drug using sex workers are a population that are discriminated against for a variety of reasons. However, based on the women's responses in the focus group, the primary reason for the discrimination they receive in the health care system is due to a lack of insurance. Every single woman who participated in the focus group conveyed this notion. The health care system and its services are sold as commodities primarily available to those who can afford them, creating an atmosphere where lack of insurance is stigmatized. It affects health care access because health care providers are bound within these social forces and may internalize the ideologies, reinforcing the structural violence through their behaviors towards patients. In turn, this covert violence leads to the inferior treatment towards uninsured women who decide to stop seeking care because they feel it is not worth it. Caroline questions the tainted promise of the Hippocratic oath, ironically, and accidentally, calling it the "hypocritical oath."

> Someone with insurance, yeah, it shouldn't be that way but it is. I don't know if its because the pay that they get, cause I thought all doctors working in the hospital get about the same pay rate, you know. I didn't think, it has nothing to do with the pay, the insurance, that the, what's, what's the, they saying called? The hypocritical oath?

It is critical to note that the lack of insurance itself is not the barrier to health care. These women know of the various clinics and services that Jackson Memorial Hospital offers. The treatment and quality of care they get at these health care settings because of the lack of insurance operates as the barrier to health care. Michelle describes being treated like a "common animal". JJ states, "They just do you bad boy. They do you real bad. Just sitting there, dying." I asked Kira why she did not seek care more often, even with her Jackson card, she said, "We don't want to go because we get treated wrong, we get treated like nothing." When I asked Janice how it made her feel when she got treated differently due to not having insurance, she said, “Make you wanna be a mass murderer.” These words are powerful representations of what these women go through and solidify that the experience of seeking care can be a tireless challenge, and when one is likely already in a weakened state. Having to deal with such frustrations when the reason care is being sought already puts one in a vulnerable state truly seems a harmful act. This results in fear, distrust, and resignation of an institution intended to support, but ends up violating the weak, vulnerable, and ill.

Self-reliance

What cannot be overlooked is how embedded self-reliance is in American society, and how it is exemplified here in the policies and philosophies of the health care system by supporting structural violence in the experience of health care. Self-reliance, upheld by American ideology and institutions while seemingly internalized by health care providers, plays a significant role in the experience of health care for this vulnerable population. This was evident in the way the women talked about seeking health care without insurance as well as in the language used by women who recently attended drug treatment. Structural violence provided the context within which these women experienced health care, and was supported by the ideology of self-reliance.

Self-reliance, or individualism, claims that through liberty and free choice, we are responsible for ourselves and the choices we make, assuming we fully control our existence. Therefore, the ideology of individualism supports the notion that health is a personal matter involving personal choice. Individualism has been attributed to society’s motivation for achievement (Long, Ziller, and Henderson 1966) and as a justification for social stratification and inequality (Dewey 1984, Lukes 1971). It is an individual’s responsibility to make the right choices for themselves and their health. Not only does this concept of individualism affect our moral obligation of access to health care, but also the way health care is experienced, particularly when the pursuit of equity in health care is being hampered by the existing dominant ideology of self-reliance in our institutions, including drug treatment and health care. This ideology promotes health as an individual event, and the focus of the treatments and practice of health is shifted toward individual causes and treatment for health problems.

Currently, we participate in health care as consumers, and health care is a commodity for sale. Those who can pay receive better quality goods. Those who cannot pay do without. In this view, health care is seen as a reward for hard work, personal achievement, and for practicing control in abstaining from risky behaviors (Shin 1999). In turn, those who cannot afford access to health care, at some level, must be doing something wrong and are undeserving. This idea supports the notion that poverty is deserved and access to necessities like health care is based on individual personal effort (Priester 1992). This of course undermines and distracts us from the more serious examination of ever-present adversities of sociopolitical and economic structures that dictate and uphold oppression. Victim blaming becomes a strategy for diverting attention away from the social causes and the manufacturers of the social problems of disease.

In this sense, the ideology of self-reliance constitutes an example of symbolic violence. It represents an ideology created and sustained by society, one that is ultimately destructive to community, and one that the public and it's institutions have reinforced and perpetuated as a fundamental part of being a good American. Above all, it is an ideology that has been accepted as moral, superior, and unchangeable even when witnessing it's oppression. The next chapter presents the results of the quantitative analyses.

CHAPTER 4: QUANTITATIVE RESULTS

The results of the analyses and findings for the hypotheses that were tested are presented below. First, a description of the sample describing demographic and behavioral characteristics is provided. The results of the bivariate analyses are presented in the following section. Finally, the results are discussed for the various multivariate logistic regression models.

Description of the Sample

Of the 546 women included in these analyses, 68.5% had seen a doctor in the 12 months prior to being interviewed. The demographic and behavioral characteristics of the sample are summarized in Tables 1-3 (pages 109-111). All participants in the sample self-identified as female and Black. The frequencies for the predisposing variables appear in Table 1. The average age of the sample was 39.3 years with 56.6% of the women between the ages of 40 and 53. For 89.6% of the women, prostitution was their primary source of income and about half (51.3%) received some sort of public assistance. Most women had unstable living situations as 65.0% considered themselves homeless at some point in the 12 months prior to being interviewed. The mean for length of time involved in sex work was 14.5 years. Substance use was a serious problem for these women as the mean score for the DSM-IV scale of substance abuse was 1.89 with 2.00 being the maximum possible score. For the measure of general mental distress, there were particularly high scores on the internal mental distress and depressive symptoms components.

Table1: Characteristics of the Sample by Predisposing Variables

	%	Frequency N=546	Mean (SD)	Range Min, Max
Dependent Variable				
Doc Visit in 12 Months				
No	31.5	172		
Yes	68.5	374		
Independent Variables				
Predisposing Traditional				
Age				
18-39	43.4	237		
40-53	56.6	309		
Education				
No HS Diploma	51.5	281		
HS Diploma/GED	48.5	265		
Sources of Income				
Job	11.2	61		
Welfare, Public Assistance, AFDC, Food Stamps	51.3	280		
Social Security, Disability	19.8	108		
Spouse, Family, Friend	39.0	213		
Selling or Trading Goods	6.8	37		
Prostitution	89.6	489		
Other Illegal Activity	9.2	50		
Predisposing Vulnerable				
Sexual Orientation				
Heterosexual	65.0	355		
Lesbian/Bisexual	35.0	191		
Foster Care				
No	83.3	455		
Yes	16.7	91		
Homeless past 12 months				
No	35.0	191		
Yes	65.0	355		
Arrests			9.79 (16.98)	0, 153
Years in Sex Work			14.53 (9.21)	0, 38
Victimization Scale			6.85 (3.41)	0, 11
Substance Use (DSM)			1.89 (0.37)	0, 2
Internal Mental Distress			1.41 (0.70)	0, 2
Somatic Symptoms			1.09 (0.65)	0, 2
Depressive Symptoms			1.43 (0.70)	0, 2
Anxiety/Fear			1.19 (0.76)	0, 2
Trauma			1.35 (0.90)	0, 2

Table 2: Characteristics of the Sample by Enabling Variables

	%	**Frequency N=546**	**Mean (SD)**	**Range Min, Max**
Enabling Traditional				
Regular Source of Care				
No	42.5	232		
Yes	57.5	314		
Health Insurance				
No	66.7	364		
Yes	33.3	182		
Income Amount				
less than $1000	34.2	187		
$1,000-1,999	29.7	162		
$2,000-3,999	25.6	140		
$4,000-5,999	5.9	32		
$6,000 or more	4.6	25		
Enabling Vulnerable				
Drug Treatment				
No	45.8	250		
Yes	54.2	296		
Transportation				
Own Car	7.3	40		
Rely on Other Means	92.7	506		
Identification				
No	24.7	135		
Yes	75.3	411		
Social Support				
Emotional/Informational			3.11 (1.24)	1, 5
Tangible			3.20 (1.47)	1, 5
Affectionate			3.53 (1.42)	1, 5
Positive Interaction			3.38 (1.41)	1, 5

Table 3: Characteristics of the Sample by Need Variables

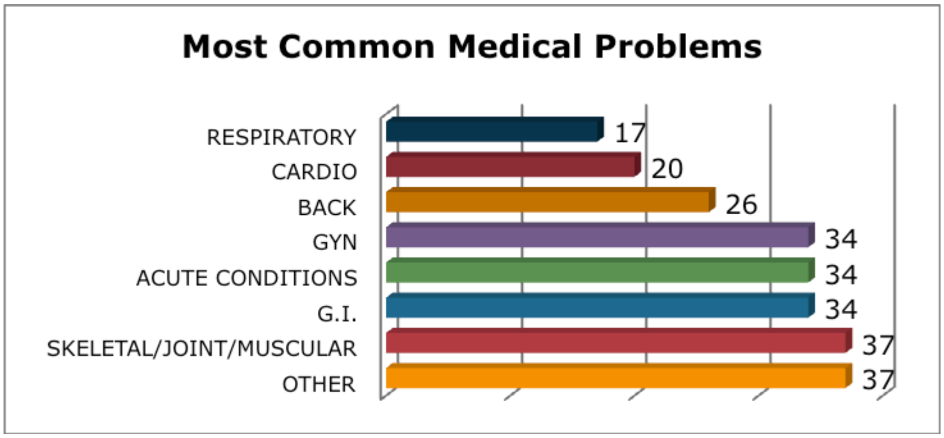
	%	**Frequency** N=546
Need Traditional		
Self Rated Health		
Excellent/Very Good	21.4	117
Good	35.3	193
Fair/Poor	43.2	236
Need Vulnerable		
Mental Health Dx		
No	55.9	305
Yes	44.1	241
Health Problem/ last 12 months		
No	39.2	214
Yes	60.6	332
HIV		
Negative	78.2	427
Positive	16.8	92
Unknown	4.9	27
STD/ last 12 months		
No	76.2	416
Yes	23.8	130
Mentally Disturbed/ last 12 months		
No	30.2	165
Yes	69.8	381

Table 2 shows the frequencies for the enabling variables. Among the enabling variables, 57.5% of women had a regular source of health care, but only 33.3% had any type of health insurance. A little more than half of the women (54.2%) had at least one experience with drug treatment in their lives. Only 7.3% had their own car for transportation, and 75.4% had a valid form of identification. The most common type of social support was affectionate, with a mean score of 3.53 out of 5.

In Table 3, need variables of special interest include self-rated health where 43.2% reported fair/poor health, 35.3% reported good health, and 21.4% reported excellent/very good health. A doctor had diagnosed approximately 44.1% with a mental health problem. Most women, (60.8%) were dealing with some sort of physical health problem in the 12 months prior to being interviewed. About 16.8% were HIV positive, 78.2% were negative, and 4.9% did not know their HIV status. Finally, 69.8% reported feeling mentally disturbed in the 12 months prior to being interviewed.

Reasons that women did not have regular doctors were: “can’t afford one” and “don’t like doctors”. Reasons given by those women who needed care and didn’t get it were: “couldn’t afford care”. In order to have a better understanding of the health care needs of these women, frequencies of the most prominent and pressing health care issues they were currently having are presented in Figure 3 below. Only 256 of the women responded to the question indicating a current problem with their health. Skeletal, joint, or muscular problems were the health complaints mentioned most often. These included complaints about arthritis and any complaint about pain in a muscle or joint but did not include back pain. Gastrointestinal and gynecological problems were also common among the women. Acute conditions were mostly colds and headaches. The “other” category consisted of a variety of ailments such as weight problems, infections from wounds, skin irritations, dizziness, and weakness.

Figure 3: Most Common Medical Problems



Bivariate Results for Andersen’s Behavioral Model for Vulnerable Populations

The results of the bivariate analyses of the predisposing, enabling, need, and victimization independent variables on health care utilization are displayed in Table 4 (page 114-116). These analyses were used to test the association between each individual independent variable with the dependent variable, health care utilization. Pearson chi-square tests were calculated for categorical variables and independent sample t-tests were used for continuous variables.

Of the predisposing independent categorical variables, homelessness in the last 12 months was the only one significantly associated with health care utilization in the last 12 months. Among the women who were homeless in the

Table 4: Bivariate Analysis: Percent Differences among Health Care Utilization by Categorical Variables

	Health Care Utilization in last 12 months		
	% Yes n=374	% No n=172	Total N=546
Predisposing Traditional			
Age			
18-39	71.3	28.7	237
40-53	66.3	33.7	309
	X^2=1.53 1df p=.216		
Education			
No HS Diploma	65.8	34.2	281
HS Diploma/GED	71.3	28.7	265
	X^2=1.90 1df p=.168		
Sources of Income			
Job			
No	68.9	31.1	485
Yes	65.6	34.4	61
	X^2= .272 1df p=.602		
Public Assist., Welfare, F. Stamps, AFDC			
No	60.5	39.5	266
Yes	76.1	23.9	280
	X^2= 15.28 1df p<.000		
Social Security, Disability			
No	63.7	36.3	438
Yes	88.0	12.0	108
	X^2=23.64 1df p<.000		
Spouse, Family, Friend			
No	66.4	33.6	333
Yes	71.8	28.2	213
	X^2= 1.80 1df p=.180		
Sell or Trade Goods			
No	69.0	31.0	509
Yes	62.2	37.8	37
	X^2=.738 1df p=.390		
Prostitution			
No	61.4	38.6	57
Yes	69.3	30.7	489
	X^2=1.49 1df p=.223		
Illegal Activity (except prostitution)			
No	68.8	31.2	496
Yes	66.7	34.0	50
	X^2=.159 1df p=.690		

	% Yes n=374	% No n=172	Total N=546
Predisposing Vulnerable			
Sexual Orientation			
Heterosexual	67.9	32.1	355
Lesbian/ Bisexual	69.6	30.4	191
		X^2=.175 1df p=.675	
Foster Care			
No	67.5	32.5	455
Yes	73.6	26.4	91
		X^2= 1.33 1df p=.249	
Homeless/ past 12 months			
No	75.4	24.6	191
Yes	64.8	35.2	355
		X^2= 6.47 1df p<.05	
Enabling Traditional			
Regular Source of Care			
No	47.0	53.0	232
Yes	84.4	15.6	314
		X^2=86.54 1df p<.000	
Health Insurance			
No	58.8	41.2	364
Yes	87.9	12.1	182
		X^2=47.68 1df p<.000	
Income Amount			
less than $1000	62.0	38.0	187
$1,000-1,999	69.8	30.2	162
$2,000-3,999	72.9	27.1	140
$4,000-5,999	78.1	21.9	32
$6,000 or more	72.0	28.0	25
		X^2=6.49 4df p=.165	
Enabling Vulnerable			
Drug Treatment			
No	62.0	38.0	250
Yes	74.0	26.0	296
		X^2=9.02 1df p<.003	
Transportation			
Own Car	87.5	12.5	40
Rely on other Means	67.0	33.0	506
		X^2=7.22 1df p<.007	

	% Yes n=374	% No n=172	Total N=546
Identification			
No	59.3	40.7	135
Yes	71.5	28.5	411
	X^2=7.09 1df p<.01		
Need Traditional			
Self Rated Health			
Excellent/Very Good	60.7	39.3	117
Good	74.1	25.9	193
Fair/Poor	67.8	32.2	236
	X^2=6.17 2df p<.05		
Need Vulnerable			
Mental Health Dx			
No	60.7	39.3	305
Yes	78.4	21.6	241
	X^2=19.70 1df p<.000		
Health Problem/ last 12 months			
No	63.1	36.9	214
Yes	72.0	28.0	332
	X^2=4.78 1df p<.05		
HIV			
Negative	64.2	35.8	427
Positive	85.9	14.1	92
Unknown	77.8	22.2	27
	X^2=17.65 2df p<.000		
STD/ last 12 months			
No	65.9	34.1	416
Yes	76.9	23.1	130
	X^2=5.61 1df p<.05		
Mentally Disturbed/last 12 months			
No	64.2	35.8	165
Yes	70.7	29.7	381
	X^2=1.99 1df p=.159		

previous 12 months, 64.8% had visited a doctor during the same time period, while of the women who did not consider themselves to be homeless during that time, 75.4% visited a doctor in the previous 12 months. This relationship was statistically significant as indicated by the chi-square test of independence (X^2=56.47, 1df, $p<.05$). Thus, women who were homeless in the previous 12 months were less likely than those who were not homeless to visit a doctor during that time period. Age, education, and source of income were not significantly associated with visiting a health care provider in the previous 12 months. Hypothesis 2.1 states, traditional predisposing factors will be positively associated with having visited a doctor in the past 12 months. This hypothesis was preliminarily rejected based on bivariate results because the traditional predisposing factors of age, education, and source of income were not significantly associated with health care utilization in the previous 12 months.

Table 5 (page 118) shows the results of the independent sample t-tests for the continuous and scaled item predisposing independent variables and health care utilization in the last 12 months. Only one variable, victimization ($p<.05$), showed a significant association with health care utilization in the past year. A higher score on the victimization scale indicates higher levels of victimization. Women who had higher reported levels of victimization were more likely to have visited a health care provider in the last 12 months. Years of sex work, arrest history, substance use, and mental health had no significant effect on health care utilization in the previous 12 months. Hypothesis 2.2 states that vulnerable predisposing factors will be an important element in explaining the use of health

Table 5: Bivariate Analysis: Mean Differences in Health Utilization by Continuous and Scaled Items

	Doctor Visit Past 12 Months		
	Yes Mean n=374	No Mean n=172	T-test
Independent Variables			
Predisposing Vulnerable			
Years in Sex Work	14.54	14.52	-0.017
Arrests	9.93	9.49	-0.279
Victimization Scale	7.07	6.38	-2.23*
Substance Use	1.88	1.89	0.385
Internal Mental Distress	1.44	1.36	-1.203
Somatic Symptoms	1.11	1.05	-1.091
Depressive Symptoms	1.47	1.36	-1.630
Anxiety/Fear	1.21	1.15	-0.945
Trauma	1.35	1.33	-0.261
Enabling Traditional			
Social Support			
Emotional/Informational	3.17	3.00	-1.457
Tangible	3.33	2.91	-3.098*
Affectionate	3.63	3.32	-2.372*
Positive Interaction	3.46	3.23	-1.780

care services by Black, female, drug using sex workers and specifically, variables that contribute to marginalized statuses will negatively affect use of services. This hypothesis preliminarily has mixed support based on bivariate findings as homelessness, a variable contributing to marginalized status, did negatively affect utilization. However, victimization positively affected health care utilization, and the other vulnerable characteristics were not significantly associated with health care utilization.

There were several enabling independent variables that were significantly associated with health care utilization. For the enabling traditional domain variables, among women who had a regular source of care, 84.4% visited a doctor in the previous 12 months compared to the women who did not have a regular source of care (47.0%). This relationship was statistically significant as indicated by the chi-square test of independence ($X^2=86.54$, 1df, $p<.000$). The relationship between insurance status and visiting a doctor was also statistically significant ($X^2=47.68$, 1df, $p<.000$). Approximately 87.9% of women who had insurance visited a doctor in the previous 12 months compared to 58.8% who did not have insurance.

Table 5 shows the results of the independent sample t-tests for social support variable and health care utilization in the last 12 months. Tangible social support ($p<.01$) and affectionate social support ($p<.05$) showed a significant association with health care utilization in the past year. Women who reported higher levels of affectionate and tangible social support were more likely to see a health care provider in the previous 12 months. Hypothesis 2.3 states that traditional enabling factors will be positively associated with having visited a doctor in the past 12 months. Based on preliminary bivariate results, this hypothesis is partially supported as having a regular source of care, having insurance, tangible social support, and affectionate social support were all positively associated with visiting a health care provider in the previous 12 months. However, income amount, emotional/informational social support, and positive interaction social support were not associated with health care utilization in the previous 12 months.

Several enabling independent variables in the vulnerable domain were also associated with visiting a doctor in the past 12 months and can be seen in Table 4. Recipients of public benefits were more likely to visit a doctor in the 12 months compared to those who do not receive public benefits. For instance, 76.1% of women who received welfare, food stamps, or AFDC visited a doctor compared to 60.5% who did not receive those benefits. The relationship was statistically significant according to chi-square test of independence (X^2=15.28, 1df, p<.000). Among women who received Social Security, disability, or workman’s compensation, 88.0% visited a doctor in the previous 12 months compared to 63.7% who did not receive those benefits. This relationship was also statistically significant (X^2=23.64, 1df, p<.000).

Women with at least one experience in drug treatment were more likely to visit a doctor than women who reported never receiving treatment. Among women who had received treatment, 74.0% had seen a doctor whereas of women who had never experienced treatment, 62.0% had seen a doctor in the previous 12 months. The relationship is statistically significant (X^2=9.02, 1df, p<.01). Transportation was associated with visiting a doctor in the past 12 months. Approximately 67.0% of women who did not have their own car visited a doctor compared to 87.5% of women who did have their own car. This relationship is statistically significant based on the chi-square test of independence (X^2=7.22, 1df, p<.01). Finally, having a valid form of identification was associated with visiting a doctor. Women who did have valid identification (71.5%) were more likely than those who did not (59.3%) to visit a doctor in the previous 12 months. This relationship is statistically significant (X^2=7.09, 1df, p<.01). All of the enabling vulnerable variables were significantly associated with having seen a health care provider in the previous 12 months. Hypothesis 2.4 states, vulnerable enabling variables that contribute to women's marginalized status will negatively affect their use of services. This hypothesis is preliminarily supported based on bivariate results. Variables that contributed to a marginalized status were associated with not visiting a health care provider in the previous 12 months. These variables were, not receiving any public benefits, no experiences with drug treatment, no transportation, and no valid identification.

Among the need independent variables, in the traditional domain, self-rated health was associated with visiting a doctor in the last 12 months. Among women who rated their health “excellent or very good”, 60.7% visited a doctor in the past 12 months compared to women who rated their health “good” (74.1%), and women who rated their health “fair or poor” (67.8%). Women who reported “good” health were more likely to see a doctor in the past 12 months, and these results are statistically significant according to chi-square test of independence (X^2=6.17, 2df, p<.05). A self-report of “excellent/very good” or “fair/poor” health was not significantly associated with having visited a health care provider in the previous 12 months. Hypothesis 2.5 stated, traditional needs factors will be positively associated with having visited a doctor in the past 12 months. This hypothesis is preliminarily rejected based on bivariate results. Women reporting “good” health were the only group significantly associated with visiting a health care provider in the 12 previous 12 months. Support for this hypothesis would have required the women who self-rated their health as “fair/poor” as more likely to have utilized health care as those are the women in highest need.

Need independent variables in the vulnerable domain were also significant. Women who received a mental health diagnosis by a doctor (78.4%) were more likely than those with no mental health diagnosis (60.7%) to have visited a doctor in the previous 12 months. This relationship was statistically significant (X^2=19.70, 1df, p<.000). Women who were HIV positive are more likely to have visited the doctor in the previous 12 months (85.9%) than women who are HIV negative (64.2%) or women who have an indeterminate HIV test or did not know their status (77.8%). This relationship is also statistically significant (X^2=17.65, 2df, p<.000). Similarly, women who reported diagnosis of an STD in the previous 12 months were more likely to have seen a doctor (76.9%) than women who reported no STD diagnosis (65.9%). This relationship was statistically significant as indicated by the chi-square test of independence (X^2=5.61, 1df, p<.05). Finally, among women who reported being bothered by a health problem, 72.0% visited a doctor compared to 63.1% who reported not being bothered by a health problem. This relationship was also statistically significant (X^2=4.78, 1df, p<.05). Feeling mentally disturbed in the previous 12 months was not associated with visiting a health care provider.

Hypothesis 2.6 stated, the vulnerable needs variables that contribute to women's marginalized status will negatively affect their use of services. This hypothesis was preliminarily rejected based on bivariate results, and the data are in favor of Andersen's need model. Having a mental health diagnosis, having a health problem, being HIV positive, and having a sexually transmitted disease were all associated with visiting a health care provider in the previous 12 months. The only variable not associated with health care utilization was feeling mentally disturbed in the previous 12 months.

Multivariate Results for testing Andersen's Behavioral Model for Vulnerable Populations

Tables 6-8 show logistic regression results for Models 1-7 using the variables from Andersen's Behavioral Model for Vulnerable Populations to predict health care utilization in the previous 12 months. The purpose of the modeling approach is to examine whether the vulnerable domain variables in combination with the traditional domain variables, better predict health care utilization for these vulnerable women. In addition, this modeling approach allows the comparison of predisposing, enabling, and need variables in order to distinguish which set of variables does a better job at predicting health care utilization. Model 1 included the set of independent variables labeled "Predisposing

Traditional” in Andersen’s model, which include, age, education, and sources of income. These independent variables are the basic demographic variables that are included in all of the models. In Model 2, “Predisposing Vulnerable” independent variables were added to the traditional variables. These included sexual orientation, history of foster care, homelessness, criminal history, years in sex work, victimization, substance use, and mental distress. Model 3 contains the independent variables that are part of the “Enabling Traditional” domain in Andersen’s model, which include: regular source of care, insurance status, income amount, and social support. For Model 4, “Enabling Vulnerable” variables are added to the “Enabling Traditional” variables. The variables for the vulnerable domain include: public benefits, drug treatment history, transportation, and identification. Model 5 includes the self-rated health variable from the “Need Traditional” domain. Model 6 adds the “Need Vulnerable” domain variables to the traditional variables. These variables are: evaluated mental health, perceived mental health, perceived health problem, HIV status, and 12 month history of sexually transmitted diseases. Model 7 represents the final logistic regression model and includes all variables from Andersen’s Behavioral Model for Vulnerable Populations. The coefficients, standard errors, and odds ratios are reported for all the models.

The results for Model 1 with health care utilization in the past 12 months regressed on predisposing traditional variables, are presented in the first three columns in Table 6 (page 125) . Age and education are both significantly associated with health care utilization. Women between the ages 40 and 53 are

Table 6: Logistic Regression- Predisposing Characteristics

Independent Variables	**Model 1**				**Model 2**			
N=546	**Coef.**		**S.E.**	**OR**	**Coef**		**S.E.**	**OR**
Predisposing Traditional								
Age	0.42	*	0.20	0.66	0.37		0.24	0.69
Education	0.44	*	0.20	1.55	0.47	*	0.20	1.60
Source of Income								
Job	0.12		0.31	0.885	0.18		0.31	0.83
Public Assist.,Welfare, etc.	0.62	**	0.20	1.854	0.60	**	0.20	1.83
S. Security, Disability, etc.	1.59	**	0.33	4.892	1.51	**	0.35	4.51
Spouse, Family, Friend	0.53	*	0.21	1.707	0.60	**	0.22	1.82
Sell/Trade Goods	0.45		0.39	0.635	0.56		0.40	0.57
Prostitution	0.79	*	0.33	2.20	0.00	*	0.34	2.02
Other Illegal Activity	0.06		0.34	1.06	0.70		0.35	1.00
Predisposing Vulnerable								
Sexual Orientation					0.13		0.22	0.88
Foster Care					0.15		0.29	1.16
Homeless past 12 months					0.40		0.24	1.49
Arrests					0.00		0.01	1.00
Years in Sex Work					0.00		0.01	1.00
Victimization					0.08	*	0.04	1.08
Substance Use (DSM)					0.04		0.30	0.96
Internal Mental Distress					0.04		0.34	0.96
Somatic Symptoms					0.05		0.19	0.95
Depressive Symptoms					0.36		0.24	1.44
Anxiety/Fear					0.07		0.22	0.93
Trauma					0.16		0.14	0.85
Enabling Traditional								
Regular Source of Care								
Health Insurance								
Income Amount								
Social Support								
Emotional/Information								
Tangible								
Affectionate								
Positive Interaction								
Enabling Vulnerable								
Drug Treatment								
Transportation								
Identification								
Need Traditional								
Good Self-Rated Health								
Fair/Poor Self-Rated Health								
Need Vulnerable								
Mental Health Dx								
Health Problem								
HIV Positive								
HIV Status Unknown								
STD/ last 12 months								
Mentally Disturbed								
X2	55.37, 9df, p<.01				67.81, 21df, p<.01			
Constant Coefficient	-0.59, p=.12				-1.10, p=.12			
-2 Log Likelihood	625.01				612.57			

less likely to have visited a health care provider than women younger than 40 (p<.05), and women who have a high school diploma or GED are more likely than those without a high school diploma to have visited a health care provider in the previous 12 months (p<.05). Certain sources of income are related to seeking health care. Women who receive public assistance, welfare, food stamps, or AFDC are 1.85 times as likely to have visited a health care provider (p<.01) and women who receive Social Security, disability, or workman's compensation (p<.01) are 4.89 times as likely to have visited a health care provider than women who do not receive these sources of income. Receiving income from a spouse, family, or friends is significantly associated with health care utilization such that women who have this source of income are 1.71 times as likely than those without such income to have visited a health care provider (p<.05). Women who rely on prostitution as a major source of income are 2.20 times more likely to have visited a health care provider than women who did not mention prostitution as a major source of income (p<.05).

Overall, the model is significant (X2=55.37, 9df, p<.01) and is better at predicting health care utilization than if these variables were not included. Hypothesis 2.1 stated, traditional predisposing factors will be positively associated with having visited a doctor in the past 12 months, and is partially supported since some of the traditional predisposing variables are associated with having visited a health care provider in the previous 12 months. However, certain sources of income that represent marginalized status were positively associated with health care utilization.

In Model 2, when controlling for predisposing vulnerable variables as well as predisposing traditional, education ($p<.05$) and income from public assistance ($p<.01$), Social Security ($p<.01$), family or friends ($p<.01$), and prostitution ($p<.05$) remain significantly associated with health care utilization. When accounting for all predisposing independent variables, women who reported more victimization were more likely to have seen a health care provider in the previous 12 months compared to women who reported lower levels of victimization ($p<.05$). The rest of the vulnerable domain predisposing variables, sexual orientation, foster care, homelessness, arrest history, years of sex work, substance use, and mental distress were not associated with health care utilization in the previous 12 months.

The chi-square for Model 2 was statistically significant ($X^2=67.81$, 21df, $p<.01$). This model is better at predicting health care utilization than a model without these variables. However, comparing the fit of model 2 to model 1, the change in chi-square and the associated change in the degrees of freedom (df) was not statistically significant ($\Delta X^2=12.44$, $\Delta df=12$, $p > .05$). As such, Model 2 did not represent a significant improvement in fit relative to Model 1. Hypothesis 2.2 stated, vulnerable predisposing factors will be an important element in explaining the use of health care services by Black, female, drug using sex workers specifically variables that contribute to marginalized statuses will negatively affect use of services. This hypothesis is not supported since victimization, a variable contributing to marginalized status, was actually found to positively predict use of health services.

Table 7: Logistic Regression- Enabling Characteristics

Independent Variables	**Model 3**				**Model 4**			
N=546	**Coef.**		**S.E.**	**OR**	**Coef.**		**S.E.**	**OR**
Predisposing Traditional								
Age	-0.55	*	0.22	0.58	-0.63	**	0.23	0.53
Education	0.47	*	0.21	1.60	0.43	*	0.22	1.53
Source of Income								
Job	-0.16		0.34	0.85	-0.32		0.34	0.73
Public Assist., Welfare	0.31		0.22	1.36	0.25		0.22	1.29
S. Security, Disability, etc.	0.77		0.42	2.16	0.66		0.43	1.94
Spouse, Family, Friend	0.45		0.24	1.57	0.41		0.24	1.51
Sell/Trade Goods	-0.25		0.42	0.78	-0.37		0.42	0.69
Prostitution	0.99	**	0.36	2.69	1.02	**	0.36	2.78
Other Illegal Activity	0.12		0.37	1.13	0.09		0.38	1.09
Predisposing Vulnerable								
Sexual Orientation								
Foster Care								
Homeless past 12 months								
Arrests								
Years in Sex Work								
Victimization								
Substance Use (DSM)								
Internal Mental Distress								
Somatic Symptoms								
Depressive Symptoms								
Anxiety/Fear								
Trauma								
Enabling Traditional								
Regular Source of Care	1.61	**	0.23	4.98	1.61	**	0.24	4.99
Health Insurance	0.72	*	0.33	2.04	0.74	*	0.33	2.09
Income Amount	-0.01		0.10	0.99	-0.02		0.10	0.98
Social Support								
Emotional/Information	-0.08		0.12	0.93	-0.03		0.13	0.97
Tangible	0.18		0.11	1.20	0.16		0.11	1.18
Affectionate	-0.10		0.14	0.90	-0.11		0.14	0.89
Positive Interaction	-0.02		0.13	0.98	-0.02		0.13	0.98
Enabling Vulnerable								
Drug Treatment					0.56	*	0.22	1.75
Transportation					1.03		0.55	2.79
Identification					0.27		0.24	1.31
Need Traditional								
Good Self-Rated Health								
Fair/Poor Self-Rated Health								
Need Vulnerable								
Mental Health Dx								
Health Problem								
HIV Positive								
HIV Status Unknown								
STD/ last 12 months								
Mentally Disturbed								
X2	130.93, 16df, p<.01				143.49, 19df, p<.01			
Constant Coefficient	-1.27, p<.05				-1.72, p<.01			
-2 Log Likelihood	549.44				536.89			

Model 3 regressed health care utilization on the enabling traditional variables of regular source of care, insurance status, income amount, and social support. The results, in Table 7 (page 128), show that women with a regular source of care ($p<.01$) were 4.98 times as likely to have seen a health care provider, and women with some type of health insurance ($p<.05$) were 2.04 times as likely than those without a regular source of care or health insurance, respectively, to have seen a health care provider in the previous 12 months. Income amount and social support were not associated with health care utilization. Hypothesis 2.3 stated, traditional enabling factors will be positively associated with having visited a doctor in the past 12 months, was partially supported since some traditional enabling factors were positively associated with having visited a health care provider in the past 12 months. Age ($p<.05$), education ($p<.05$), and prostitution as a major source on income are also significant ($p<.01$).

The chi-square for Model 3 was significant (X^2=130.93, 16df, $p<.01$). This model is better at predicting health care utilization than a model without these variables. Since the variables in Model 1 are nested in Model 3, Model 1 was compared to Model 3 to determine which model fit the data better. The change in chi-square value for the associated change in degrees of freedom (df) was statistically significant (ΔX^2=75.56, Δdf=7, $p<.01$). Thus, Model 3 fit the data better than Model 1; the inclusion of the enabling traditional variables enhanced the fit of the data.

In Model 4, the enabling vulnerable variables were added to the enabling traditional variables to predict health care utilization. Age ($p<.01$), education ($p<.05$), prostitution as a source of income ($p<.01$), a regular source of care ($p<.01$) and insurance status ($p<.05$) remained significant in predicting health care utilization for these women. In addition, women who had been in drug treatment at least once were 1.75 times as likely than women who had never been in drug treatment ($p<.05$) to have visited a health care provider in the previous 12 months. Of the newly added vulnerable domain variables, transportation and valid identification were not associated with health care utilization.

Hypothesis 2.4 stated that vulnerable enabling variables that contribute to women's marginalized status will negatively affect their use of services and was partially supported since only history of drug treatment was found to significantly predict health care utilization. The chi-square for this model was significant as well (X^2=143.49, 19df, $p<.01$). This model is better at predicting health care utilization than a model without these variables. To determine which model fit the data better, Model 4 was compared to Model 3. The change in chi-square value and the associated change in degrees of freedom was statistically significant (ΔX^2=12.56, Δdf=3, $p<.01$). Thus, Model 4, which included the vulnerable domain variables, fit the data better than the reduced Model 3, which only contained the traditional domain variables.

Model 5 included the need traditional self-reported health variable. The results appear in Table 8 (page 131). Women reporting good health were 1.95

Table 8: Logistic Regression- Need Characteristics and Full Model

Independent Variables	**Model 5**				**Model 6**				**Model 7**			
N=546	**Coef.**		**SE**	**OR**	**Coef.**		**SE**	**OR**	**Coef.**		**SE**	**OR**
Predisposing Traditional												
Age	-0.43	*	0.20	0.65	-0.44	*	0.21	0.64	-0.54		0.28	0.59
Education	0.42	*	0.20	1.52	0.48	*	0.21	1.61	0.44		0.23	1.55
Source of Income												
Job	-0.10		0.31	0.91	-0.11		0.32	0.90	-0.33		0.36	0.72
Public Assist. etc.	0.66	**	0.20	1.94	0.57	**	0.21	1.77	0.27		0.24	1.31
S. Security, Disability,	1.59	**	0.34	4.91	1.12	**	0.36	3.08	0.66		0.47	1.93
Spouse, Family, Friend	0.56	**	0.22	1.75	0.55	*	0.22	1.74	0.47		0.27	1.6
Sell/Trade Goods	-0.47		0.39	0.62	-0.55		0.40	0.58	-0.33		0.45	0.72
Prostitution	0.65		0.34	1.92	0.64		0.35	1.90	0.07		0.40	2.02
Other Illegal Activity	0.10		0.34	1.11	-0.06		0.35	0.95	0.18		0.41	1.19
Predisposing Vulnerable												
Sexual Orientation									-0.02		0.25	0.98
Foster Care									0.20		0.33	1.22
Homelessness									0.03		0.28	1.04
Arrests									0.00		0.01	1.00
Years in Sex Work									-0.01		0.02	0.99
Victimization									0.07		0.04	1.07
Substance Use (DSM)									-0.13		0.35	0.88
Internal Mental Distress									-0.21		0.38	0.81
Somatic Symptoms									-0.27		0.23	0.76
Depressive Symptoms									0.65	*	0.28	1.92
Anxiety/Fear									-0.09		0.26	0.92
Trauma									-0.18		0.17	0.83
Enabling Traditional												
Regular Source of Care									1.84	**	0.27	6.26
Health Insurance									0.57		0.35	1.76
Income Amount									-0.05		0.11	0.95
Social Support												
Emotional/Information									-0.03		0.14	0.97
Tangible									0.18		0.12	1.19
Affectionate									-0.04		0.15	0.96
Positive Interaction									0.00		0.13	1.00
Enabling Vulnerable												
Drug Treatment									0.14		0.26	1.15
Transportation									1.17	*	0.57	3.23
Identification									0.27		0.26	1.31
Need Traditional												
Good Self-Rated Health	0.67	*	0.27	1.95	0.56	*	0.28	1.76	0.84	**	0.32	2.32
Fair/Poor Self-Rated Health	0.47		0.26	1.60	0.18		0.28	1.20	0.51		0.34	1.66
Need Vulnerable												
Mental Health Dx					0.56	*	0.22	1.75	0.45		0.27	1.56
Health Problem					0.18		0.22	1.20	0.23		0.25	1.25
HIV Positive					0.92	**	0.35	2.52	0.22		0.42	1.25
HIV Status Unknown					0.53		0.50	1.70	1.08	*	0.55	2.94
STD/ last 12 months					0.18		0.26	0.72	0.06		0.29	1.06
Mentally Disturbed					0.16		0.26	1.17	0.31		0.30	1.36
X2	61.56 11df p<.01				81.65 17df p<.01				174.00 39df p<.01			
Constant Coefficient	-0.92, p<.05				-1.25, p<.01				-2.99, p<.01			
-2Log Likelihood	618.82				598.73				506.38			

times as likely to have seen a health care provider in the previous 12 months than women who reported “excellent/very good” health. Women reporting fair/poor health do not differ from those reporting excellent/very good health. Age ($p<.05$), education ($p<.05$), and income from public assistance ($p<.01$), Social Security ($p<.01$), and a spouse, family member, or friend ($p<.01$) are the demographic characteristics associated with health care utilization when accounting for self-rated health.

Hypothesis 2.5, traditional needs factors will be positively associated with having visited a doctor in the past 12 months, was not supported by the data. Self reported health was associated with having visited a health care provider in the past 12 months only for those women reporting “good” health. The chi-square for the model was significant ($X2=61.56$, 11df, $p<.01$). This model is better at predicting health care utilization than a model without these variables. Since the variables in Model 1 are nested in Model 5, Model 1 was compared to Model 5 to determine which model fit the data better. The change in chi-square value and the associated change in degrees of freedom was statistically significant ($\Delta X2=6.19$, $\Delta df=2$, $p<.05$). Thus, Model 5 fit the data better than Model 1.

In Model 6, the need vulnerable variables were added to the need traditional variable to predict health care utilization. In this model, self-reporting good health remains significant ($p<.05$). In addition, women who have been diagnosed with a mental condition by a doctor were 1.75 times as likely than women who have never been given a mental health diagnosis ($p<.05$) to have seen a health care provider in the previous 12 months. HIV status was significantly associated with seeing a health care provider. Women who are HIV positive were 2.52 times as likely than women who were HIV negative ($p<.01$) to have visited a health care provider in the previous 12 months. The demographic variables that are significant remain unchanged from the previous model.

Hypothesis 2.6 has mixed support. The hypothesis stated, vulnerable needs variables that contribute to women's marginalized status will negatively affect their use of services. Some vulnerable needs variables, including mental health diagnosis and HIV status, are important in explaining the use of health care services by Black, female, drug using sex workers. However, variables that contribute to their marginalized status, including being HIV positive and having a mental health diagnosis, actually increased the likelihood of visiting a health care provider.

Overall, the model is significant ($X^2=81.65$, 17df, $p<.01$). This model is better at predicting health care utilization than a model without these variables. To determine which model fits the data better, Model 6 was compared to Model 5. The change in chi-square values and the associated change in degrees of freedom was statistically significant ($\Delta X^2=20.09$, $\Delta df=6$, $p<.01$). Model 6, which included the vulnerable domain variables, fit the data better than the reduced Model 5, which contained only the traditional domain variables.

Results for the final model, Model 7, which includes all the independent variables from all domains, also are presented in Table 8. When controlling for all variables and domains, several significant relationships are revealed. In the predisposing vulnerable domain, depressive symptoms now are associated with health care utilization. Women who report more depressive symptoms are as likely as women who reported less depressive symptoms ($p<.05$) to have visited a health care provider in the previous 12 months. In the enabling traditional domain, having a regular source of care remains significant ($p<.01$). Women who have a regular source of care are 6.26 times as likely than those who do not to have visited a health care provider in the previous 12 months. In the enabling vulnerable domain, women who have their own car are 3.23 times as likely than women who do not have their own car ($p<.05$) to have visited a health care provider in the previous 12 months. In the need traditional domain, women who self- report having “good health” were 2.32 times as likely than other women to have seen a health care provider in the previous 12 months ($p<.01$). HIV status also continued to predict health care utilization, but this time, women who did not know their status were 2.94 times more likely to seek health care in the previous 12 months than HIV negative women ($p=.05$). The chi-square for this model was significant ($X^2=174.00$, 39df, $p<.01$). This model is better at predicting health care utilization than a model without these variables.

Since the variables in Models 2 (predisposing variables), 4 (enabling variables), and 6 (need variables) are all nested in Model 7, Models 2, 4, and 6 were compared each individually to Model 7 to determine if the full model fit the data better than the predisposing, enabling, and need variable models. Comparing Model 7 to Model 2, the predisposing variables, the change in chi-square value and the associated change in degrees of freedom (df) was statistically significant (ΔX^2=106.19, Δdf=18, p<.01). Thus, the full model, Model 7, fit the data better than Model 2. When comparing the full model to Model 4, the enabling variables, the change in the chi-square value and the change in degrees of freedom was not statistically significant (ΔX^2=30.51, Δdf=20, p>05). As such, Model 7 did not represent a significant improvement in fit relative to Model 4. Finally, when comparing the full model, Model 7, to Model 6, the need variables, the change in chi-square value along with the associated degrees of freedom was statistically significant (ΔX^2=92.35, Δdf=22, p<.01). Thus, the full model fit the data better than the reduced model, Model 6. The full model was a better fit for the data than most of the reduced models except for Model 4. Model 4 consists of the enabling variables which included having a regular source of care, having health insurance, and having been in drug treatment as significant predictors of health care utilization.

Transportation is a variable that was significant in the bivariate analyses and again only in Model 7, the model with all the variables. Prior to conducting multivariate analyses, collinearity diagnostics were examined for this model. Two variables had VIFs that were potentially problematic at 4.022 for affectionate social support and 6.052 for internal mental distress. However, after evaluating the variance proportions for these items, it was determined that there were no significant issues of multicollinearity. However, with such a large model, it is possible that some multicollinearity does exist.

In summary, research question 2 asked, “What are the patterns and independent contributions of predisposing, enabling, and illness/need factors for this sample as described by the Andersen Behavioral Model for Vulnerable Populations (1968, 1995) of health services utilization?" The logistic regression results showed that, although there are mixed findings, overall, vulnerable characteristics do seem to help predict health care utilization for this sample of women. However, some of the variables that represent marginalized or vulnerable statuses (depressive symptoms, mental health diagnosis, HIV) actually contribute to the likelihood of visiting a health care professional. Overall, the most consistent predictors of health care utilization were having a regular source of care and self-rated health. These traditional variables were significant in every model.

Descriptive Statistics- Victimization

To answer research question 3, "how is health care seeking influenced by interpersonal violence?," individual victimization items were analyzed using univariate, bivariate, and multivariate analyses to determine the relationships between interpersonal violence and health care utilization. The victimization variables were analyzed separately due to a smaller sample size of 543 cases after missing cases were removed. Table 9 (page 137) presents the frequencies for lifetime victimization, past ninety-day victimization, and date violence in the past ninety days. Most of these women had been victims of violence in their lifetime. Approximately 66.7% (362) had been attacked with some sort of weapon, 66.7% (359) had been attacked to the point of bruises or broken bones,

Table 9: Frequencies of Victimization

n=543	%	Frequency
Lifetime Victimization		
Attacked w/weapon		
No	33.3	181
Yes	66.7	362
Striked/beaten/physical abuse		
No	33.3	184
Yes	66.7	359
Pressured or forced into sex		
No	38.3	208
Yes	61.7	335
Emotional Abuse		
No	22.3	121
Yes	77.7	422
Ninety-day Non-date Violence		
Attacked w/weapon		
No	93.4	507
Yes	6.6	36
Striked/beaten/physical abuse		
No	91.2	495
Yes	8.8	48
Pressure or forced into sex		
No	95.8	520
Yes	4.2	23
Emotional Abuse		
No	86.0	467
Yes	14.0	76
Ninety-day Date Violence		
Beaten or hit		
No	84.3	458
Yes	15.7	85
Raped		
No	92.8	504
Yes	7.2	39
Threatened w/weapon		
No	86.9	472
Yes	13.1	71
Cut or shot		
No	98.7	536
Yes	1.3	7
Ripped off		
No	76.8	417
Yes	23.2	126
Any abuse past 12 months		
No	62.2	338
Yes	37.8	205

61.7% (335) had been pressured or forced into sex, and 77.7% (422) had been abused emotionally. More than one-third (37.8%) of women reported being a victim of abuse in the past 12 months. Victimization at the hands of a client or “date” was common with 15.7% (85) being beaten or hit by a date, 7.2% (39) being raped by a date, 13.1% (71) being threatened with a weapon, and 23.2% (126) being ripped off by a date in the past ninety days.

Bivariate Results for victimization and health care utilization

Bivariate relationships were examined between health care utilization in the past 12 months and lifetime victimization, past ninety-day victimization, and date violence in the past ninety days. Results are presented in Table 10 (page 139). These analyses were used to test the association between each type of victimization with the dependent variable, health care utilization. Pearson chi-square tests were calculated for the victimization variables.

None of the victimization that occurred in the past ninety days, whether from a date or non-date, was significantly associated with having visited a health care provider in the past year. Being a victim in the past 12 months was not associated with having visited a health care provider in the past 12 months. The only variable significantly associated at the bivariate level with visiting a health care provider in the past 12 months was having been pressured or forced to participate in sexual acts against your will at some point in your life. Women who had been forced into sex at some time in their lives were more likely to have visited a health care provider in the past 12 months (71.3%) than women who had not been forced into sex at some point in their lives (63.5%). This

Table 10: Bivariate Analysis: Health Care Utilization and Victimization

N=543	% Yes	% No	Total n
Lifetime Victimization	n=371	n=172	543
Attacked w/weapon			
No	65.7	34.3	181
Yes	69.6	30.4	362
	X^2=.83 1df p=.361		
Striked/beaten/physical abuse			
No	65.8	34.2	184
Yes	69.6	30.4	359
	X^2=.85 1df p=.358		
Pressured or forced into sex			
No	63.5	36.5	208
Yes	71.3	28.7	335
	X^2= 3.68 1df $p<.05$		
Emotional Abuse			
No	61.2	38.8	121
Yes	70.4	29.6	422
	X^2= 3.70 1df p=.055		
Ninety-day Non-date Violence			
Attacked w/weapon			
No	68.4	31.6	507
Yes	66.7	33.3	36
	X^2= .05 1df p=.825		
Striked/beaten/physical abuse			
No	67.9	32.1	495
Yes	72.9	27.1	48
	X^2=.51 1df p=.474		
Pressure or forced into sex			
No	68.1	31.9	520
Yes	73.9	26.1	23
	X^2=.35 1df p=.556		
Emotional Abuse			
No	67.7	32.3	467
Yes	72.4	27.6	76
	X^2=.67 1df p=.414		
Ninety-day Date Violence			
Beaten or hit			
No	67.7	32.3	473
Yes	71.9	28.1	89
	X^2= .63 1df p=.428		
Raped			
No	68.5	31.5	520
Yes	66.7	33.3	42
	X^2=.06 1df p=.810		
Threatened w/weapon			
No	68.2	31.8	487
Yes	69.3	30.7	75
	X^2=.04 1df p=.841		
Cut or shot			
No	68.7	31.3	553
Yes	44.4	55.6	9
	X^2= 2.41 1df p=.121		
Ripped off			
No	67.6	32.4	429
Yes	70.7	29.3	133
	X^2= .44 1df p=.505		
Any abuse past 12 months			
No	67.8	32.2	338
Yes	69.3	30.7	205
	X^2=.14 1df p=.713		

Table 11: Logistic Regression: Health Care Utilization and Victimization

N=543	**Coef.**		**S.E.**	**OR**
Demographics				
Age	-0.48	*	0.21	0.62
Education	0.44	*	0.20	1.56
Sources of Income				
Job	-0.19		0.32	0.83
Public Assistance, Welfare etc.	0.69	**	0.21	1.99
S. Security, Disabilitly	1.67	**	0.34	5.32
Spouse, Family, Friend	0.61	**	0.22	1.84
Sell/Trade Goods	-0.54		0.41	0.59
Prostitution	0.73	*	0.35	2.08
Other Illegal Activity	0.05		0.35	1.05
Lifetime Victimization				
Attacked w/weapon	0.04		0.25	1.04
Striked/beaten/physical abuse	-0.07		0.25	0.93
Pressured or forced into sex	0.44		0.25	1.55
Emotional Abuse	0.18		0.30	1.20
Ninety-day Non-date Violence				
Attacked w/weapon	-0.59		0.58	0.56
Striked/beaten/physical abuse	0.36		0.59	1.43
Pressure or forced into sex	0.27		0.69	1.3
Emotional Abuse	-0.01		0.4	0.99
Ninety-day Date Violence				
Beaten or hit	0.11		0.36	1.11
Raped	-0.48		0.49	0.62
Threatened w/weapon	0.15		0.40	1.16
Cut or shot	-1.28		0.91	0.28
Ripped off	0.03		0.29	1.03
Any abuse past 12 months	0.07		0.27	1.07
X2	69.65 23df p<.01			
Constant Coefficient	-0.99, p<.05			
-2 Log Likelihood	606.92			

relationship is statistically significant as indicated by the chi-square test of independence (X^2=3.68, 1df, p<.05).

Multivariate Results for Victimization and Health Care Utilization

The results of the logistic regression analyses for all victimization variables on health care utilization are presented in Table 11 (page 140). None of the victimization variables were significant predictors of health care utilization in the model. Demographic variables were significant. When controlling for lifetime, last ninety-day date and non-date violence, older women compared to younger women (p<.05) were less likely to have seen a doctor in the previous 12 months. Those with a high school diploma or GED were 1.56 times as likely than women with no high school diploma to have visited a health care provider (p<.05). Several main sources of income had positive significant effects on visiting a health care provider. Women who received income from welfare, public assistance, AFDC, or food stamps were 1.99 times as likely than those who did not receive income from these sources to have visited a health care provider (p<.01). Women who received Social Security, disability, or workman's compensation were 5.32 times as likely than women who did not receive income from these sources (p<.01) to have visited a health care provider. Women who received income from a spouse, family, or friend were 1.84 times as likely than women who did not have this source of income (p<.01) to have visited a health care provider. Women who stated that prostitution was a major source of income were 2.08 times as likely than women who did not consider prostitution a major source of income (p<.05) to have visited a health care provider in the previous 12

Table 12: Logistic Regression: Health Care Utilization and Victimization Variables, Full Model

N=543

	Coef.		S.E.	OR
Predisposing Traditional				
Age	-0.60	*	0.29	0.55
Education	0.47		0.24	1.59
Job	-0.39		0.38	0.68
Public Assistance, Welfare etc.	0.39		0.25	1.48
S. Security, Disabilitly	0.58		0.48	1.78
Spouse, Family, Friend	0.43		0.27	1.53
Sell/Trade Goods	-0.34		0.47	0.71
Prostitution	0.82	*	0.41	2.26
Other Illegal Activity	0.19		0.42	1.21
Predisposing Vulnerable				
Sexual Orientation	0.04		0.26	1.04
Foster Care	0.21		0.34	1.24
Homelessness	0.03		0.29	1.03
Arrests	0.00		0.01	1.00
Years in Sex Work	-0.01		0.02	0.99
Substance Use (DSM)	-0.20		0.36	0.82
Internal Mental Distress	-0.28		0.40	0.75
Somatic Symptoms	-0.25		0.23	0.78
Depressive Symptoms	0.70	*	0.29	2.01
Anxiety/Fear	-0.10		0.26	0.91
Trauma	-0.17		0.17	0.85
Lifetime Victimization				
Attacked w/weapon	0.01		0.30	1.37
Striked/beaten/physical abuse	-0.28		0.32	0.76
Pressured or forced into sex	0.32		0.29	1.38
Emotional Abuse	0.08		0.37	1.08
Ninety-day Non-date Violence				
Attacked w/weapon	-0.98		0.67	0.37
Striked/beaten/physical abuse	0.64		0.72	1.90
Pressure or forced into sex	0.46		0.82	1.59
Emotional Abuse	-0.01		0.50	0.99
Ninety-day Date Violence				
Beaten or hit	0.43		0.43	1.53
Raped	-0.36		0.59	0.70
Threatened w/weapon	-0.02		0.45	0.98
Cut or shot	-1.51		1.20	0.22
Ripped off	0.21		0.36	1.24
Any abuse past 12 months	0.04		0.31	1.04

	Coef.		S.E.	OR
Enabling Traditional				
Regular Source of Care	1.88	**	0.28	6.53
Health Insurance	0.64		0.36	1.91
Income Amount	-0.08		0.12	0.93
Social Support				
Emotional/Information	0.01		0.14	1.01
Tangible	0.20		0.13	1.23
Affectionate	-0.07		0.16	0.93
Positive Interaction	0.03		0.14	1.03
Enabling Vulnerable				
Drug Treatment	0.21		0.27	1.24
Transportation	1.23	*	0.59	3.44
Identification	0.36		0.27	1.43
Need Tradtional				
Self-Rated Health				
Good	0.89	**	0.33	2.44
Fair/Poor	0.50		0.35	1.65
Need Vulnerable				
Mental Health Dx	0.54		0.28	1.72
Health Problem past 12 months	0.19		0.26	1.21
HIV Positive	0.21		0.44	1.24
HIV Status Unknown	1.05		0.57	2.85
STD/ last 12 months	0.03		0.3	1.03
Mentally Disturbed past 12 months	0.38		0.31	1.46

X2	187.31 52df p<.01
Constant Coefficient	-3.25,p<.01
-2 Log Likelihood	489.27

months. The chi-square for this model was significant (X^2= 69.65, p<.01). This model does a better job at predicting health care utilization using these variables than a model without these variables.

Table 12 (page 142) presents all of the victimization variables included in Andersen's Behavioral Model for Vulnerable Populations. The victimization scale variable was removed and the individual lifetime, past ninety-day date and non-date violence variables were used in it's place. None of the victimization variables were significant in predicting health care utilization. Age was significant with older women less likely than younger women (p<.05) to have visited a health care provider in the previous 12 months. Women who reported prostitution as a major source of income were 2.26 times as likely than those who did not to have visited a health care provider (p<.05). Higher scores on the depressive symptoms scale predicted visiting a health care provider (p<.05) with women who scored higher being as likely to have visited a health care provider. Women who had a regular source of care were 6.53 times as likely than those who did not to visit a health care provider (p<.01). Women who had their own car were 3.44 times as likely than women who did not have their own source of transportation (p<.05) to have visited a health care provider. Finally, self-reported health was also significant, with women reporting good health to be 2.44 times as likely than women who reported excellent/very good or fair/poor health (p<.01) to visit a health care provider.

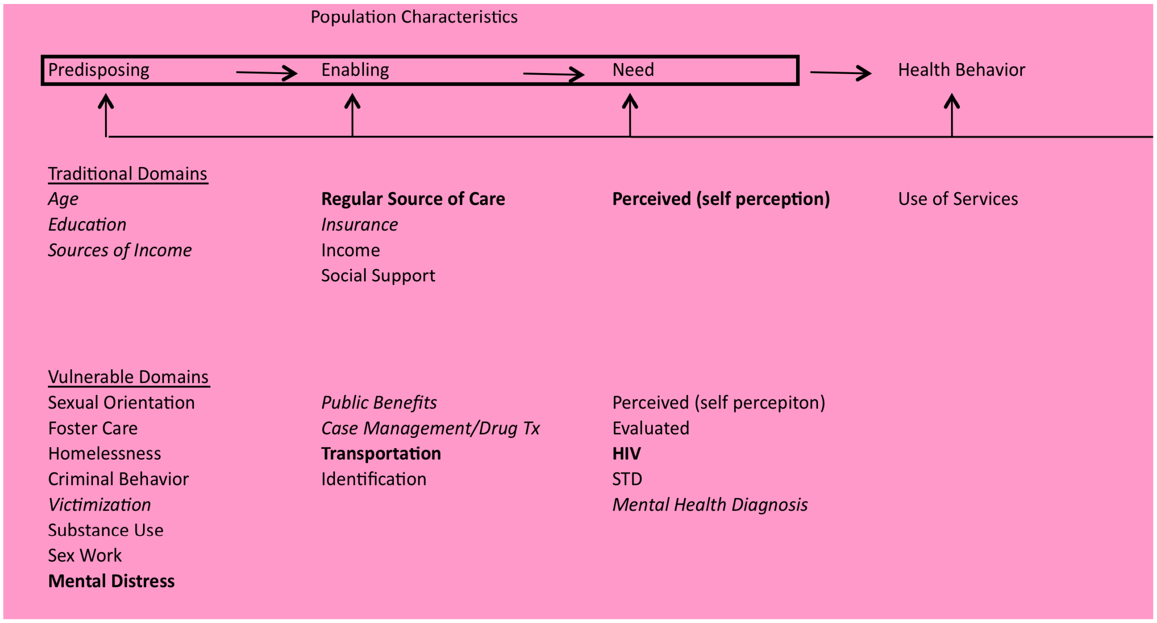
This model was significant (X^2=187.31, p<.01). It does a better job predicting health care utilization than a model without these variables. To determine which model fit the data better, the full model was compared to the reduced model that only contained demographic and victimization variables. The difference between the chi-square values with the associated changes in degrees of freedom (df) was significant (ΔX^2=117.36, Δdf=29, $p<.01$). The full model fit the data better than the reduced model. However, hypothesis 3 was not supported by the data, as interpersonal violence had no effect on health care utilization for this sample of Black, female, drug using sex workers.

Collinearity diagnostics were examined for this model. Affectionate social support (4.131) and internal mental distress (5.373) had high VIFs. However, condition indexes and variance proportions showed no indications of multicollinearity. Therefore, the results of these analyses are not due to collinearity issues.

Overall, victimization does not seem to have an effect on health care utilization for these women. Even in the bivariate analysis, the only variable that affected health care utilization in the previous 12 months was an experience of having been forced or pressured into sex at some time in your life. When controlling for other types of victimization occurring in different time periods, only demographic variables were significantly associated with health care utilization. When the individual victimization variables were included in Andersen’s model for Vulnerable Populations, victimization variables still did not significantly predict health care utilization.

Summary

Figure 4: Significant Variables- The Behavioral Model for Vulnerable Populations



Predisposing	Enabling	Need	Health Behavior
Traditional Domains			
Age	**Regular Source of Care**	**Perceived (self perception)**	Use of Services
Education	*Insurance*		
Sources of Income	Income		
	Social Support		
Vulnerable Domains			
Sexual Orientation	*Public Benefits*	Perceived (self percepiton)	
Foster Care	*Case Management/Drug Tx*	Evaluated	
Homelessness	**Transportation**	**HIV**	
Criminal Behavior	Identification	STD	
Victimization		*Mental Health Diagnosis*	
Substance Use			
Sex Work			
Mental Distress			

In Andersen's Behavioral Model for Vulnerable Populations (Figure 4) variables in bold were significantly associated with health care utilization in the previous 12 months in the full multivariate model, Model 7. The italicized variables were significantly associated with health care utilization in the previous 12 months at some point in multivariate Models 1-6. The modeling approach was designed to examine whether the vulnerable domain variables in combination with the traditional domain variables, better predicted health care utilization for these vulnerable women. This modeling approach also allowed for the comparison of predisposing, enabling, and need variables in order to distinguish which set of variables did a better job at predicting health care utilization.

Models 1 and 2 compared the ability of predisposing characteristics to predict health care utilization. Among the predisposing variables, the traditional variables alone fit the data better (Model 1). Model 2 that contained the predisposing vulnerable variables did not improve the relative fit of the model. The predisposing vulnerable factors did not significantly improve predicting health care utilization. Models 3 and 4 compared the enabling characteristics' ability to predict health care utilization. Model 4 included both traditional and vulnerable characteristics and fit the data better than Model 3, which only contained the traditional enabling variables. Here, the vulnerable enabling characteristics did improve the predictive ability of the variables. Models 5 and 6 compared the need characteristics and their ability to predict health care utilization. Model 6, which included the vulnerable domain variables, fit the data better than Model 5, which only had the traditional need variables. The vulnerable need variables improved the predictive capability of the model. Therefore, the only set of vulnerable variables that did not significantly improve the fit of the model were the predisposing characteristics, representing demographic and social structural variables.

Models 2, 4, and 6 were nested in Model 7, the full multivariate model, and were each compared to the full model to determine if the full model improved the fit of the data. Model 7 only was an improvement only for the predisposing and need characteristics. It did not improve the fit of Model 4, representing the enabling variables. It is worth emphasizing, the enabling variables that were significantly associated with health care utilization in Model 4 were, having a regular source of care, health insurance, experience in drug treatment, and the demographic variables that were included in every model, age, education, and prostitution as a source of income. Of these variables, having a regular source of care is the only variable that, when accounted for, is significant in every model. This result is consistent with the findings from the qualitative analyses.

CHAPTER 5: DISCUSSION AND CONCLUSIONS

Having a consistent and meaningful link or resource for accessing health care facilitates utilization among this group of vulnerable women and determines future utilization behaviors. This was supported by both the qualitative and quantitative data. In the qualitative analysis, women talked about their experiences in the health care system in the context of their links to care, and those without these links clearly had more negative experiences with utilizing care, as discrimination based on lack of insurance became their primary perception of accessing health care. Quantitative analysis revealed the variables in the model representing these links to resources that were instrumental in predicting utilization behaviors.

In the quantitative analysis, this association was represented by several enabling variables: having a regular source of care, insurance status, or having received any case management or drug treatment services. The model that included only these enabling variables (Model 4) was the most efficient model in predicting health care utilization in the previous 12 months. This model had fewer variables than the full model, yet was just as effective predicting health care utilization as the full model. This is due to the strength of the enabling variables in their relation to health care utilization. The variable that quantified whether the women had a regular source of care was the most consistent predictor of health care utilization in the quantitative data models. This variable was significant ($p<.01$) in every model where it was included (Models 3, 4, and 7).

Having a regular health care provider likely represents stability and trust, characteristics that may not be common in the lives of most of these women. However, when health is in question, this is what is important, perhaps even more so than having health insurance. I believe this was supported by the qualitative data as trust was mentioned throughout the focus groups. Common themes described by the women in the focus groups were the desire to have their own doctor, having someone they trust and who knows them rather than a difference doctor every visit, and the negative experiences of seeking care without health insurance. Most of the complaints were generated around being treated poorly, distrusting the quality of care, fearing having to pay for care, and resigned to frustrating experiences with seeking care, all of which would likely be tempered if a regular, trustworthy, stable source of care existed for these women. This may be the reason insurance status no longer predicted utilization in the full model, yet having a regular provider remained highly significant. A stable source of health care is more important.

Another example of the strength of this variable can be seen when examining the receipt of public benefits. Receiving social security, disability, welfare, public assistance or food stamps was significant in every model except when accounting for having a regular source of care. Having a regular source of care reduces the effect of receiving public assistance on health care utilization to non-significance. That is, the impact of public assistance for health care utilization is mediated by having a regular source of care.

Several need variables were associated with health care utilization in the quantitative models. Self-reported health was another consistent predictor of health care utilization whenever it was included in a model although not as hypothesized. Women in “good” health were more likely to use health care services than those in “excellent/very good” health. There were no significant differences in utilization between those in “fair/poor” health compared to women in “excellent/very good” health. Although women reporting “fair/poor” health are those in highest “need,” they might consider themselves in fair or poor health precisely because they have not been to see a health care provider recently and are not able to access care. These women may represent those with the fewest links to resources.

Significant need variables that also represented opportunities to be linked to care were HIV status and mental health diagnoses. Women who are HIV positive are more linked to services thanks to valiant public health efforts that exist to provide care for HIV positive patients. Mental health care diagnosis was also significant in the models, also likely representing a connection to an institution providing a link to care. Diagnosis of a mental health problem had to be identified by some type of health care provider. Since women were asked only whether a doctor ever diagnosed them with a mental health problem, there is no way to know whether the point of visiting a doctor in the previous 12 months was for mental health care, or the participant was diagnosed by a mental health practitioner who then opened up a link to health care utilization is unclear and cannot be determined with these data. What the data do show is that women who had been diagnosed with a mental health problem were more likely to have visited a health care provider supporting the idea that any contact with an institution may provide a resource or link to care.

The links to care through HIV diagnosis, mental health diagnosis, and drug treatment suggest that women who have hit a “bottom” are more likely to have accessed health care services than women who may be struggling but perhaps have not reached individual severe levels of substance use or sex work. This was supported by the quantitative enabling data on experiences with drug treatment. Women who had some connection to an institution via drug treatment or through a shelter were considered having a “resource” or “link” to care. Drug treatment provides case management services and is often inpatient. Many of these programs provide health care through onsite clinics and volunteer health care providers. Another example of this is jail or prison, a vulnerable predisposing variable. Several women in the focus groups mentioned access to health care through being incarcerated. This was not supported by the quantitative analysis in this data set, but there is something to be said for the women referring to jail time as “R&R”. Jail provides a bed, a meal, a shower, and according to the women, a possibility of receiving necessary medical attention. It is a shame that access to health care seems facilitated by, what most would consider, desperate situations.

When these resources were not present, experiences of discrimination based on lack of insurance became the primary barrier to health care utilization as women described the fear, resignation, distrust, and waiting times associated with trying to access health care without insurance. Much like the resignation these women spoke about, these experiences of perceived discrimination may inhibit health care seeking by creating situations where women feel powerless (Krieger 1999). Through these experiences, women construct expectations and beliefs about health care services and any negative experiences reinforce their constantly developing perceptions of discrimination. According to Sims (2010), a lifetime of these experiences influences current individual health behaviors. Perhaps this is the reason that older women were less likely to have visited a health care provider in the previous 12 months. Their longer lives provide more opportunity for these negative constructions of health care services to develop. Some research has suggested that poor women internalize belonging to a certain social class that are only allowed to access certain types of services along with a certain set of barriers suggesting that poor women expect less and may not even recognize quality care if they receive it because of these lowered expectations (Hernandez et al. 2005; Butters and Erickson 2003). While women may internalize discrimination, which affects future utilization, the findings among this sample of women portray an awareness of the quality of care they feel they should receive. Their expectations appeared to be in line with what any patient would want: thorough and quality treatment. Although one woman, Katrina, from the focus group did express lowered expectations, overall, this was not the common attitude held by the women.

While women’s experiences in the health care system were influenced by their vulnerable status, their definitions of health were in line with mainstream descriptions and goals. This is encouraging and does not fit with the idea of lowered expectations. Definitions of health focused on diet, exercise, being free of pain, and feeling mentally clear. The goals of the women were also similar to mainstream goals except for one goal that more fortunate women do not have to worry about-- accessing resources. This challenges some common notions of the health behaviors of these women. The culture of poverty is a popular theory describing a certain ideology that the poor adhere to based on their economic and social conditions. In 1969, Oscar Lewis wrote, "The subculture [of the poor] develops mechanisms that tend to perpetuate it, especially because of what happens to the world view, aspirations, and character of the children who grow up in it" (199). The culture of poverty suggests that those who are poor are disconnected from the world outside of their own troubled situations and, therefore, are not in tune with the mainstream (Lewis 1998). Following this line of thought, health definitions and health goals would evolve from low expectations, powerlessness, inferiority, and feelings of personal unworthiness. Of the thirteen women who participated in the focus groups, in hours of discussing ideas about health and health care, and in the weeks of qualitative analysis that followed, not once did these women's words support the ideas put forth by the culture of poverty.

Due to the population of interest, drugs also played a large role in the way these women talked about health. "Being clean" of drugs was mentioned throughout their discussions of health and health goals. While drug use is destructive to women's lives in countless ways, the way these women connect drug use to their health suggests using drugs is unhealthy and being clean is healthy. In a sense, these women have bought into the medicalization of drug use. They do not necessarily define drug use as a medical problem, but it most certainly is a health problem. This may also be influenced by the way drug addiction is treated, in many circles and treatment centers, as a biological and therefore health, problem. Addiction, for many of these women, has been identified at some point, as a disease. However, not all the women in the focus groups viewed addiction as a disease. Some women indicated that using drugs was the only viable way to self-medicate and cope with physical and mental health problems. Cheaper, and more readily available than prescription medication and containing the same pharmacological properties, apart from price, the women did not see a difference in taking street drugs or legal drugs.

Limitations

Certain limitations must be considered before drawing any final conclusions based on these findings. First, the quantitative data analyzed were cross-sectional data using targeted and snowball sampling. The study does not assume to be representative of all Black, substance using, sex workers in Miami. Also, there may be a sample bias due to the sampling strategies used to find this hidden population of women. The women included in this sample were women who were found in the “strolling” areas of Miami, where sex workers work on the streets. There are other sex workers found in more organized locations or under the control of a pimp that we were likely unable to include in this sample and would have required different sampling techniques. However, the sample size is large (n=546) which helps increase the potential for generalizability of the findings.

Similarly, the qualitative portion of the study cannot be considered generalizable to all female, Black sex workers, because the thirteen women who participated are not representative of all health definitions and experiences with the health care system. However, the goal of inductive work is exploration and theory construction, not generalizability. That said, the women who did participate in focus groups were women with consistent and functioning telephone numbers, who answered the phone when called, and who were willing to come to the field office to participate. The majority of the women who were contacted for the focus groups did not have operating telephone numbers, or the phone number no longer belonged to them. Therefore, the women in the focus groups most likely represented more stable sex workers, or former sex workers who were no longer using drugs.

All data on behaviors were self-reported increasing the possibility of reporting bias. Social desirability may have had a role in the responses during the interview. Additionally, some of the data collected were sensitive in nature and are therefore difficult to answer. To counteract this possibility, all interviewers were trained extensively and were taught the importance of being non-judgmental, of building rapport, and making the participants feel comfortable. Interviewers reinforced the importance of answering honestly and reminded participants of the voluntary nature of participation as well as the strict confidentiality of the data. Nonetheless, social desirability may have played a role.

Temporal sequence is an issue with cross-sectional studies. Women answered “yes” or “no” to whether they had seen a health care provider in the twelve months prior to being interviewed. Data were not available on exactly when the woman utilized health care within those 12 months. This would have been useful to know when examining certain relationships. For example, having a valid identification was significantly related to health care utilization in the bivariate analysis. However, knowing when a woman acquired or lost her valid identification and whether this was before or after having utilized care is not known.

Conclusions

Andersen’s Behavioral Model for Vulnerable Populations proved useful for examining the health utilization behaviors of this vulnerable group of women, Black, substance using, sex workers. The model is practical for large population studies due to appropriate generalizability of the findings and provides a framework for organizing considerable amounts of variables in a meaningful way. Vulnerable domains contributed to predicting health care utilization behaviors, particularly the variables within the enabling and need characteristics. The enabling characteristics in both the traditional and vulnerable domains were particularly efficient in predicting health care utilization for these women. Andersen (1995) defined the enabling variables as representing a measure of access to health care and a sign of inequitable access is when these variables determine who receives health care. Results of the multivariate models revealed that this access was the most significant predictor of utilization for this sample of women. The qualitative data verified the findings of the quantitative analyses, but even more valuable, told the story of why and how those enabling variables were so important. The qualitative data also provided the basis for constructing a model that further explains how the quantitative variables in Andersen's model actually play out in these women's lives. Without stable access to resources, negative experiences in the health care system influenced future utilization patterns. Without collecting both quantitative and qualitative data, the scope of these findings may have been overlooked or understated.

Andersen intended for the predisposing characteristics to measure structural factors in accessing care. Variables like ethnicity, education, and occupation were intended to determine the status of a person in the community. However, the status of these women, due to their ethnicity and primary source of income, was not represented in the conceptual model as they were all Black, female, sex workers. For this reason, the vulnerable domains were useful in measuring other variables representing possible structural issues. However, the qualitative data provided insight into structural elements that the behavioral model could not effectively capture since these women already had a set of characteristics making them vulnerable and were not compared to another group of women who did not have these challenges. If we do not take these structural elements into account and fully understand the exact way they affect health care utilization behaviors, we run the risk of continuing to perpetuate the idea that poor health and health care utilization behaviors are due to "individual shortcomings" (LaVeist 2002). The contribution of qualitative data showed that individual shortcomings are not the barrier to utilizing care for these women; the problem is negative experiences due to structural violence.

Although Andersen's model attempts to account for these structural elements by including variables that may represent structural inequities, the process of being a victim of structural violence and how it impacts utilizing care cannot be captured with his model. Additionally, there are limits to what the quantitative data can tell us about the variables. Andersen's model accounts for demographic, social, and economic quantifiable characteristics of health care utilization, but is unable to capture the actual process of seeking out health care or enlighten us on the meaning of the process. In other words, Andersen's model does not tell the whole story. To better understand the context in which these women seek health care, quantitative data are not adequate. Taking into account the position of these women in society and their daily challenges and stressors provides the social context within which they think about health and in which health care seeking occurs.

The primary contribution of the qualitative research is a newly developed model of health and health care utilization for vulnerable populations. Using the qualitative data from the focus groups, I constructed this model linking health definitions, health goals, and experiences of seeking health care at one level, all of these to structural violence at a more abstract level and the reinforced ideology that maintains a repressive system. The Experiential Model of Health and Health Care Utilization provides the meaning, experiences, context, process, structure, and ideology that effects health care utilization. It goes beyond the capability of Andersen's model. While Andersen's model results in predictions of utilization behaviors, the new model explicates women's attempts to seek care and the meaning of these attempts in their lives. The women's definitions of health and health goals embody what they believe to be good health, and what conditions would require care.

Qualitative data and the resulting model showed that utilization behaviors are affected by structural issues, upheld by individualistic ideologies and internalized through interactions with health care providers. Within this dynamic of structural violence, the model displays the factors that come into play when the women have resources that link them to health care as well as when those resources are nonexistent. It also reveals the way the women talk about health and their health goals, and how these have remained unaffected by their experiences. This model reveals a process model of health care utilization, within the context of structural violence, an active dissection of what is suffered when seeking health care without proper resources. It lays out the meaning of these in the lives of some of our most vulnerable women.

The new model displays how issues of structural violence were present throughout the experience of health care for these women. The qualitative data were necessary to understand the process of structural violence within the health care system, how exactly this type of violence occurred, under what circumstances, and for what reasons. This type of violence is created by ideology, policies, and institutions and is constantly reinforced by each, making it seem like it is a normal part of life. However, the social structures that create and continually reproduce a limited welfare state, lack of access to resources, social exclusion, and institutional discrimination are man-made phenomena set in place as a means of social control. These are supported by an individualistic ideology of self- reliance, and continually oppress the most vulnerable. This system is revealed when talking to these vulnerable groups. Through their words you discover elements of structural violence in how difficult it is to actually receive services for the indigent unless you have several items of proper documentation, how jail becomes a resting place, and how places that exist as sources of refuge only end up reinforcing the same vicious ideology that results in blaming the victim. The women's words also reveal how trust, a decisive component in seeking or not seeking care, is completely debilitated by structural violence when health care providers adhere to and reinforce these harmful ideas that lead to the belief that women without insurance are not deserving of proper quality treatment in health care settings.

The new model demonstrates how women's experience of health, illness, and care occurred in the context of this structural violence and affected the way they utilized care. Without the proper resources and a lack of health insurance, women expressed feelings of fear, discrimination, resignation, distrust, and unjust waiting times associated with trying to seek care. However, women's definitions of health and health goals are mostly untouched by these experiences. Their definitions are still primarily based on mainstream health ideals of physical, mental, spiritual and emotional well-being. This is hopeful. Knowing the way these women define health is beneficial to understanding how these women would determine their own need for seeking health care, were it available. These definitions of health are an attempt to distinguish at what point a health problem is dire enough that they would willingly seek care that they acknowledge as poor quality and treatment that they perceive as discriminatory.

Through the vulnerable women interviewed for this work, we learn about the real challenges of seeking health care, and the covert ideologies that sustain a troubled system and harm the most disadvantaged. We learn that even though disadvantaged, ideals remain in their definitions and goals for health. However, lack of insurance or links to resources eliminates following ideals and dictates future use due to the poor treatment received when attempting to access care without some validating symbol of self-reliance. In turn, many women use street drugs to self- medicate and justify doing so with rational arguments of attainable costs and access. This is the context of the experience of health and health care utilization for this group of vulnerable women, revealed and constructed using grounded theory with qualitative data and analyses and displayed in the my qualitative model.

Based on the findings of this dissertation, it is clear that this group of vulnerable women do not desire or expect less of the health care system than mainstream women, but they are very aware that they receive less. Their perceptions have been constructed and reinforced by their life experiences, and whether the discriminatory process due to lack of insurance is actually occurring does not matter. For these women, it is real and probably reinforced in other areas of their lives as well. The quantitative data showed that a regular source of care was critical to future utilization for these women. Resources, links, any type of connection to or with an institution or any consistent point of care play a primary role in these women's health care behaviors. The qualitative data showed why a stable source of care is so vital, because of their already difficult life situations, where issues of trust are always challenged. In order to feel confident they are receiving proper services, some type of stability in health care providers is critical for these women. Women experience discrimination in seeking care and need a provider they can trust. Trust, stability, reliability, these are the underlying factors involved in the way women seek health care. The synergy between the quantitative and qualitative research methods effectively captured this process. Neither model supplements or contradicts the other. Rather, they are complementary, each telling a different feature of the health and utilization story of vulnerable women.

Another contribution of this work is that these women may represent other vulnerable populations that likely experience similar struggles when trying to seek health care. Access to care is always a primary goal in efforts to reduce health care disparities. This research reveals the factors that define what access to care really means. The goal of access must reach beyond making health care formally available for everyone who needs it, because at some level, health care is available, if only through emergency departments. However, Andersen's model showed that access must be equitable and having a regular source for care would contribute significantly to health care utilization among vulnerable populations. For this sample of women, access meant having a link to a trusting source of care. These women are an example of other vulnerable populations with similar struggles and needs. This research provides information on how to better serve those in greatest need in society for the benefit of public health, and for the greater good of human decency.

Future Research

Future research should include assessing the Experiential Model for Health and Health Care Utilization with other vulnerable populations. The processes at work for these women may apply to other vulnerable groups and concomitant factors may be added to the model. For quantitative data, longitudinal studies with similar populations would be valuable in examining whether experiences in health care change after links to resources are introduced. Based on the current data, perception plays a large role in the women's behaviors. It would be helpful to examine how these would change or evolve. If trust, stability, and reliability of a health care provider could effectively be quantitatively measured, perhaps a large population study examining how these may affect health care seeking behaviors of vulnerable populations would be more widely disseminated. Finally, when considering health care utilization, the explicit role of structural violence, in conjunction with individual behavior, should always be accounted for in order to accurately examine equitable access to care, particularly for any marginalized population.

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APPENDIX A

Mental and Emotional Health

The next questions are about common nerve, mental or psychological problems that many people have. These problems are considered significant when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities or they make you feel like you cannot go on. **Please answer the next question using yes or no.**

M1a. During the last 12 months, have you had significant problems with…..

1. headaches, faintness, dizziness, tingling, numbness, sweating or hot or cold spells?
2. sleep trouble, such as bad dreams, sleeping restlessly or falling asleep during the day?
3. pain or heavy feeling in your heart, chest, lower back, arms, legs or other muscles?
4. having dry mouth, loose bowel movements, constipation, or trouble controlling your bladder?

M1b. During the last 12 months, have you had significant problems with…..

1. feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?
2. remembering, concentrating, making decisions, or having your mind go blank?
3. feeling very shy, self-conscious or uneasy about what people thought or were saying about you?
4. thoughts that other people did not understand you or appreciate your situation?
5. feeling easily annoyed, irritated, or having trouble controlling your temper?
6. feeling tired, having no energy or like you could not get things done?
7. losing interest or pleasure in work, school, friends, sex or other things you cared about?
8. losing or gaining 10 or more pounds when you were not trying to?
9. moving or talking much slower than usual?

M1c. During the last 12 months, have you had significant problems with…..

1. feeling very anxious, nervous, tense, scared, panicked or like something bad was going to happen?
2. having to repeat an action over and over, or having thoughts that kept running over in your mind?
3. trembling, having your heart race or feeling so restless that you could not sit still?

4. getting into a lot of arguments and feeling the urge to shout, throw things, beat, injure or harm someone?
5. feeling very afraid of open spaces, leaving your home, having to travel or being in a crowd?
6. feeling very afraid of the dark, being alone, elevators or other things?
7. thoughts that other people were taking advantage of you, not giving you enough credit or causing you problems?
8. thoughts that someone was watching you, following you or out to get you?
9. seeing or hearing things that no else could see or hear or feeling that someone else could control your thoughts.
10. thoughts that you should be punished for thinking about sex or other things too much?
11. having a lot of tension or muscle aches because you were worried?
12. being unable or finding it difficult to control your worries?

APPENDIX B

MOS Social Support

READ: People sometimes look to others for assistance. How often is each of the following kinds of support available to you if you need it?

Emotional/Informational support

1. Someone you can count on to listen to you when you need to talk
2. Someone to give you information to help you understand a situation.
3. Someone to give you good advise about a crisis.
4. Someone to confide in or talk to about yourself or your problems.
5. Someone whose advice you really want.
6. Someone to share your most private worries and fears with.
7. Someone to turn to for suggestions about how to deal with a personal problem.
8. Someone who understands your problems.

Tangible support

9. Someone to help you if you were confined to bed.
10. Someone to take you to the doctor if you needed it.
11. Someone to prepare your meals if you were unable to do it yourself.
12. Someone to help with daily chores if you were sick.

Affectionate support

13. Someone to show you love and affection.
14. Someone to love you and make you feel wanted.
15. Someone who hugs you.

Positive social interaction

16. Someone to have a good time with.
17. Someone to get together with for relaxation.
18. Someone to do something enjoyable with.
19. Someone to do things with you to help you get your mind off of things.

APPENDIX C

Focus Group Guide

How are you feeling today?

NEEDS

Do you think about your health? Is this a daily concern/thought for you*? If not, what is? What are daily priorities?*

How do you think about health? *What does being healthy mean to you? What is a healthy day like? What do you consider a good day/bad day?*

How would you describe your health? *How do you get health or good health? (probe) Does good health mean seeing a doctor?*

How important is health to you?

What are you goals for your health? *Is getting through the day a goal?*

How would you try to reach these health goals?
(probe) At what point do you seek care for a health problem?

(probe) What stands in the way of your health goals?

ACCESS

Do you think different races get treated differently?
(probe) How do you know about this?
(probe) Have you witnessed this? Can you share an example?

Studies show that black women don't use health care/ go to the doctor as often as white women. Why do you think that is?

Other women have told me that a lot of black women think they don't get the same kind of health care as white women. What do you think about this? Do you agree?

What do you see as the biggest problem to accessing health care for women here in Miami?