

# Appalachian Health Status in Greater Cincinnati: A Research Overview

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## Introduction

Migration from the Appalachian mountain region has been a constant, if little noted, feature of the American experience. Distinct migration streams from the Appalachians were identified as early as the 1820s. The early streams flowed west to rural and for the most part frontier destinations, while post-Civil War Appalachian migration streams took on a more urban focus. During the twentieth century, migrants from the Appalachian region settled in the heavily industrialized areas of the Midwest and Northeast; millions of mountain people moved into these areas between 1940 and 1960, an era known as the Great Appalachian Migration. Later these migration flows switched to metropolitan destinations in the South and West. Beginning in the 1970s cities in and bordering the federally-defined Appalachian Region have become the principal recipients of large Appalachian migration flows. Today Appalachian migrants and their descendants form a substantial population in and surrounding the city of Cincinnati, and migrants from Appalachia remain a significant portion of the area's newcomers.<sup>1</sup>

Health issues and service strategies in the Appalachian region are reasonably well documented, and new studies will undoubtedly be generated under the National Institutes of Health goal of reducing health disparities for minority populations, including "Appalachian residents."<sup>2</sup> Less is known, however, about the health status of Appalachians in metropolitan areas outside of the region.<sup>3</sup> Urban Appalachians may be residents of metropolitan areas in the federally-defined Appalachian region, while others live in urbanized areas outside of that region. For the purposes of this paper, the term "urban Appalachians" refers to migrants from the region or their descendants who live in metropolitan areas outside of the region.<sup>4</sup>

The purpose of this working paper is to summarize urban Appalachian health research with particular attention to three recent studies conducted in southwestern Ohio. While this working paper constitutes a general summary, the references provide information about relevant sources and data sets for those with more specific research interests. In addition, recommendations for future research are made in the conclusion.

## Early Studies

The few commentaries on urban Appalachian health that appeared in the 1960s through the 1980s are now quite dated, but still provide useful insights. In 1978 Virginia McCoy Watkins noted the key roles of home remedies, folk medicine, and faith healing in the migrants' background. Modern medicine was not unknown in the mountains but was relatively difficult to obtain. Few opportunities for nutritional education or preventive health care measures were available. Watkins pointed out that in the mountains, health care was often obtained on a crisis basis. Medical interventions done on an emergency basis were usually drastic, impersonal, and frequently ineffective. This unfortunate situation, usually accompanied by many bureaucratic forms and procedures, fostered a fear and a suspicion of health care providers that Appalachians brought with them into urban environments. These perceptions may still persist in some

parts of the urban Appalachian community.<sup>5</sup>

In 1983 John Friedl interviewed 51 health care providers and 106 Appalachian migrant families in Columbus, Ohio, about health-related topics. His findings were consistent with Watkins' in that the rural health care experiences of Appalachian migrants influenced their expectations of urban health care providers. The rural physician had fewer staff resources and therefore more direct contact with the patient. Because of cost and travel time, referrals to distant specialists were rare. For similar reasons, physicians in the Appalachian region were more likely to attempt a "one-shot" cure than a series of treatments, and drugs were distributed more frequently at the time of treatment than by prescription. Third party payments were less typical in rural areas, so fees were low and payment schedules flexible. The sharp contrast between the styles of health care service in rural and in urban settings often led to confusion, distrust, and negative stereotypes on the part of both the urban medical care providers as well as their new Appalachian patients.<sup>6</sup>

## Recent Research

Four studies appeared in the early 1990s, two using sample surveys and two others involving hospital records.<sup>7</sup> Data from a 1987 Greater Cincinnati Survey of 512 city residents were analyzed by Obermiller and Oldendick for insight on urban Appalachian health beliefs, health-related concerns, and health care behaviors.<sup>8</sup> Urban blacks and Appalachian whites showed similar levels of concern about their risk of heart attack, stroke, emotional or mental illness, or serious injury.<sup>9</sup> Two thirds of the white Appalachian respondents reported being smokers, as compared with less than one third of the blacks surveyed. White Appalachians were unlikely to believe their health status could be affected by behaviors such as exercise and good nutrition, but nearly two thirds did believe it was affected by God. The authors of the study indicated that the health concerns of urban blacks and Appalachian whites were not atypical for working-class groups constantly exposed to both physical and emotional hazards at their job sites. They pointed out that many of Cincinnati's white Appalachians came from eastern Kentucky where the use of tobacco products was not only socially acceptable but perceived as critical for economic survival. They also indicated that the strong association of health status with God's will is found throughout the Appalachian region and the rural South.

Obermiller and Handy used data from a 1989 Greater Cincinnati Survey to examine the health education needs of the African American and white Appalachian residents of Cincinnati.<sup>10</sup> The researchers found both black and white Appalachian respondents very concerned about their health status. The white Appalachians surveyed indicated lower utilization of hospital emergency services than the African Americans. A clear majority of both groups did not seek preventive care such as regular physical checkups. White Appalachians in the survey had fewer physician contacts than the black cohort. Family and kin were the most important sources of health information for urban Appalachian whites, while the urban blacks were more likely to gain similar information from their churches. Both groups indicated that television and radio provided more useful sources of health information for them than did newspapers and magazines.

In 1989 a task force was formed by the Urban Appalachian Council to study the health status of children in Cincinnati's heavily Appalachian neighborhood of Lower Price Hill (LPH). The Lower Price Hill Task Force issued its report, "Health, Education and Pollution in Lower Price Hill," in 1990.<sup>11</sup> The report included a historical review of the results of environmental pollution and contamination investigations of area industries and properties, the history of citations and permitting by regulatory agencies, and community efforts to stop polluting industries. Educational achievement test scores and school performance measures of Lower Price Hill students were compared with the Cincinnati Public

Schools district as a whole, and hospital discharge data of Lower Price Hill children were analyzed.

The primary health-related analysis presented in the task force report included four years of Children's Hospital Medical Center primary discharge diagnoses, grouped according to the Ninth Revision of the International Classification of Disease (ICD-9) subcategories. Standardized Morbidity Ratio (SMR) analyses were performed, comparing the discharge diagnoses of children (less than 18 years of age) from Lower Price Hill (zip code 45204) with those of patients from the city as a whole, as well as from zip codes of similar socioeconomic status with high numbers of Appalachian residents. The research showed that LPH children ages 5 to 11 were over four times more likely to be discharged with diagnoses of acute respiratory infections than children from the city as a whole. Younger children were even more adversely affected:

"Children under five years of age from the Lower Price Hill area are over two times more likely to be discharged from Children's Hospital with a diagnosis of intestinal infectious diseases, other diseases due to viruses and chlamydia, inflammatory diseases of the central nervous system, diseases of the ear and mastoid processes, or acute respiratory infections than children of the same ages from the city at large. This same group of children is over three times more likely to be discharged from Children's with a diagnosis of other non-arthropod-borne viral diseases of the central nervous system or the toxic effects of substances chiefly non medicinal, than children of the same ages from the city at large..."<sup>12</sup>

The report warned that Lower Price Hill children were growing up in a polluted community and that their impaired health might be compromising their ability to succeed at school.

In 1994 Brown and Obermiller compared the hospital admissions of children living in Cincinnati zip codes with a sizeable white Appalachian population with 1) the pediatric population of the City of Cincinnati and 2) children living in predominantly poor, African-American zip codes.<sup>13</sup> The SMR analyses were based on five years of primary discharge diagnoses from Children's Hospital Medical Center. Appalachian children in the under 5 and 5-11 year old age groups were hospitalized more frequently than children from the city as a whole with bacterial and viral infections, diseases of the ear and mastoid process, and injuries; other age-specific, statistically significant findings were reported. However, the health status of children living in the predominantly poor black zip codes was generally worse than their Appalachian counterparts. Both age groups of African-American children had higher rates of hospital discharge diagnoses - compared with children living in predominantly Appalachian zip codes - involving chronic obstructive pulmonary disease, other diseases of the respiratory system, diseases of skin and subcutaneous tissue, poisonings and toxic effects of non-medicinal substances.

## Contemporary Studies

In the past five years, one community-based health survey and two regional health surveys have been conducted in the Cincinnati area. The community-based survey focused on the health of children in a single neighborhood; of the two regional surveys, one addressed adult health issues and the other addressed children's health issues. All three surveys offer insights on Appalachian health which will be presented in this section.<sup>14</sup>

### 1. Community-based children's health survey

During the spring and summer of 1998, the Lower Price Hill Children's Health Survey was conducted by the Lower Price Hill Environmental Leadership Group (ELG).<sup>15</sup> This participatory research project was

a partnership between the Environmental Leadership Group, the Urban Appalachian Council and the University of Cincinnati, and sponsored by an environmental justice grant from the National Institute of Environmental Health Sciences. The ELG is an organization of neighborhood residents concerned about the impact of local industrial operations on the health of their families and friends.

The survey instrument was based on concerns expressed by neighborhood women in focus group discussions. The members of the Lower Price Hill Environmental Leadership Group, trained in interview techniques and survey procedures by University of Cincinnati personnel, conducted surveys in randomly-selected households where children less than 18 years of age lived. Interviews were conducted in 112 households representing 264 children; no households refused to participate in the survey. Sixty-three percent of the children in the survey were between ages one and ten; 72% had lived in the neighborhood all of their lives.

The results of the Lower Price Hill Children's Health Survey were summarized in six major findings:

- *Lead poisoning*: 72% of the households surveyed reported that a child had been tested for lead poisoning; 35% of these households reported at least one child had an elevated blood lead test result; and ten children were reported to have a blood test result indicative of lead poisoning.
- *Respiratory diseases*: 16% of the children in the survey had been diagnosed with asthma; 15% used a breathing machine or inhaler; 14% experienced bronchitis symptoms more than three times a year; and 14% experienced breathing problems other than asthma more than once a month.
- *Diseases of the ear*: 22% of the children in the survey had ear tubes; and 13% had visited a hearing specialist in the twelve months prior to the survey.
- *Developmental and learning problems*: 15% of the children in the survey had been treated for delayed speech development; and 9% had been diagnosed with or treated for attention deficit disorder (ADD) or attention deficit and hyperactivity disorder (ADHD).
- *Allergies and infectious diseases*: 42% of the children in the survey had colds more than four times a year; 40% had sinus problems or allergy symptoms more than twice a month; 39% had viral or bacterial infections more than four times a year; and 35% had ear aches or ear infections more than once a month.
- *Smoking and passive smoke inhalation*: 80% of the households surveyed had one or more adult smokers; and 10% of the households had one or more children who smoked.

In addition, parents interviewed in the survey were read a list of symptoms, asked whether they experienced each symptom, and whether they associated their symptoms with specific odors. The symptoms included watery eyes; burning eyes; dry, irritated throat; coughing; shortness of breath; gagging/dry heaves; sick-to-your-stomach feeling; metal taste in mouth; and headaches. The odors included readily recognized smells that are commonly used by regulators to characterize nuisance complaints: paint/chemical, rotten eggs, sickly sweet, burning, chlorine and sewage. Between 43% and 78% of the respondents reported experiencing the symptoms. The symptoms were most frequently associated with the paint/chemical, sewage and burning odors. Respondents consistently related their symptoms to multiple, concurrent odors.

The survey findings were presented in meetings, first with community residents and then with health care providers, researchers and other interested groups. The Environmental Leadership Group also described the genesis of the survey in a comic book it produced and circulated, as well as in a one-page flier detailing how the survey was conducted and outlining some of its major findings. In response to these findings, numerous educational outreach initiatives were developed and implemented by the Environmental Leadership Group and the Urban Appalachian Council. A survey of women's health is being prepared by the Environmental Leadership Group and the University of Cincinnati for

implementation in 2002.<sup>16</sup>

## 2. Regional adult health survey

In 1999 a Community Health Status Survey was initiated by the Health Improvement Collaborative of Greater Cincinnati and the Health Foundation of Greater Cincinnati. This telephone survey included 2,108 randomly selected adults living in a twenty-county region surrounding Cincinnati; the response rate was 53%.<sup>17</sup> Thirteen percent of the sample were first-generation white Appalachian adults; 9% were African Americans; 73% were white non-Appalachians; and 5% were of other ethnic backgrounds. Because only first-generation Appalachian adults were included in the sample, the Appalachian cohort was older than the other respondents. Age, therefore, became a key factor in interpreting the survey results.<sup>18</sup> However, when statistical controls were included for age, economic and demographic differences, as well as other social and health-related factors, the analysis produced the following conclusions:

- Low-income white Appalachians had lower overall perceived health status than did blacks or white non-Appalachians of similar economic status. No differences were found for this perception among high-income respondents from the three groups.
- Regardless of income level, white Appalachians over 45 have a perceived health status comparable to that of white non-Appalachians and better than that of blacks.
- White Appalachians were more likely to report chronic physical health conditions than non-Appalachian whites, and were equally likely as blacks to report multiple conditions. There were no differences among the three groups in having multiple chronic conditions after the age of 45.
- White Appalachians were more likely than non-Appalachian whites to report a professional diagnosis of allergies, cancer, and chronic digestive disease.
- White Appalachians over 45 were more likely than blacks and non-Appalachian whites over 45 to report a professional diagnosis of cancer, heart trouble/angina, and severe allergies.

This study also found that the overall mental health status of the white Appalachian respondents was on a par with, and in some instances slightly better than, that of the other two respondent groups.

## 3. Regional child health survey

In 2000 the Child Policy Research Center initiated a child well-being telephone survey, interviewing 2,287 primary care givers about children under 18 living in randomly-selected households located throughout 29 counties in the region surrounding Cincinnati.<sup>19</sup> Thirteen percent of the interviews produced information on first-generation white Appalachian children, while 12% produced information on second-generation white Appalachian children; another 11% involved African-American children, and 64% involved white, non-Appalachian children. Although the survey covered other topics relevant to child well-being, only those findings pertaining to child health status, access to health care and mental health are presented here.<sup>20</sup>

- Appalachian children of both generations had reported diagnoses of hearing problems at rates higher than those reported for African-American and non-Appalachian children.
- The preferred sources of health care and health information differed between the two Appalachian generations. First generation Appalachians were more likely to use a clinic, health center or emergency room; the second generation was more likely to use a doctor's office, HMO, or hospital outpatient department.
- First-generation Appalachian children were more likely to have a reported diagnosis of developmental delay than members of the second generation, African-Americans, and non-Appalachians.
- First-generation Appalachian children were more likely to have a reported diagnosis of mental

retardation than members of the second generation.

- First generation Appalachian children were more likely to have a reported diagnosis of asthma at a rate on a par with African American children, and at a rate much higher than that for second-generation Appalachian children and non-Appalachian children.
- Second generation Appalachian children were more likely than those of the first generation to have high problem level scores on the Child Behavioral and Emotional Problems Scale.

This study also includes comparative information on access to health and social services, child care, learning environments and school readiness.

## **Conclusion**

Studies done in the late 1970s and early 1980s indicate that experiences from a rural background may, to a certain degree, influence urban Appalachian behavior, attitudes, and expectations regarding their health and their utilization of medical services. The authors of these early studies also contend that health care providers should be aware of and adapt to their patients' Appalachian backgrounds at least as much as their Appalachian patients need to adjust to the urban health care system.<sup>21</sup>

Research published in the early 1990s indicates that the health status of white urban Appalachians is generally better than that of urban blacks, but not as good as non-Appalachian whites in the same area. When urban Appalachian adults and youth do fall ill, they are likely to see physicians more frequently and have more frequent and longer hospital stays than do their black and non-Appalachian counterparts, indicating severe illness. Hospital records and survey responses show that Appalachians have different health beliefs, practice different health behaviors, and utilize different sources of health care information and services than do African Americans and non-Appalachians in the greater Cincinnati area. Moreover, heavy environmental pollution in one Appalachian neighborhood appears to have a seriously detrimental effect on its children's health as well as their prospects for finishing high school. Comparative studies have shown that these effects cannot simply be attributed to poverty, poor nutrition, passive smoke inhalation or genetic defects because they do not occur at the same rate in Cincinnati's less polluted Appalachian neighborhoods of similar socioeconomic status.<sup>22</sup>

Survey research conducted between 1998 and 2001 indicates that asthma, hearing, and developmental problems continue to be among the chief health problems affecting Appalachian children in the greater Cincinnati area. Appalachian adults in the area are affected by allergies, cancer, and chronic digestive diseases at higher rates than non-Appalachians. Older Appalachians are more likely to be affected by allergies, cancer, and heart trouble/angina than blacks and non-Appalachians in their age group. Generational differences within the Appalachian cohort, although clouded by urban/rural distinctions, appear in terms of emotional and mental health, sources of health care, and the incidence of asthma.

In sum, white Appalachians have health-related behaviors that set them apart from their black and non-Appalachian white counterparts in the greater Cincinnati area. At each life stage -- childhood, adulthood, older adulthood -- urban Appalachians have health concerns specific to their cultural group. Similar to African-Americans living in industrialized areas, environmental pollution is a key factor affecting the health of some low-income urban Appalachians. Moreover, distinctions appear between the health status of first- and second-generation Appalachians. All of these findings should inform the training of health professionals, the care of their urban Appalachian patients and further health research in greater Cincinnati.

## **Research Recommendations**

These findings can be used to inform the training of health care professionals, the health promotion strategies of health care providers, the health outreach and education programs of public health agencies, health and environmental policy decisions, and the enforcement of environmental regulations. In addition, these findings highlight the gaps in the understanding of the health beliefs and health status of urban Appalachians. Since many of the prevailing health problems in greater Cincinnati's Appalachian communities appear to have an environmental basis and may be managed successfully with timely medical treatment, additional research should focus on that area. Finally, other questions remain outstanding:

- Which variable or set of variables best explains the differences in health status between first- and second-generation white Appalachians in the greater Cincinnati area: varying environmental exposures; changes in risk behavior and/or utilization of medical services; differences in treatment by health care providers?
- Which variable or set of variables best explains the differences in health status between white urban Appalachians and African Americans in greater Cincinnati, and between white urban Appalachians and white non-Appalachians in greater Cincinnati?
- What are the differences in the health status and health history of first-, second-, and third-generation white urban Appalachian adults? What are the differences for white Appalachians in urban and rural settings?
- What are the current health beliefs and behaviors of white Appalachians? Do they differ between urban and rural settings? Do they differ by age or generation?
- How should intervention and prevention initiatives be conducted to ensure the health of all generations of white urban Appalachian children? How should they be conducted for white urban Appalachian adults?
- How do successful intervention and prevention initiatives in white urban Appalachian communities differ from such programs in African-American communities and non-Appalachian white communities?

## Notes

1. For more on the size and direction of Appalachian migration flows see Phillip J. Obermiller and Steven R. Howe. 2001. "New Paths and Patterns of Appalachian Migration, 1975-1990," *Journal of Appalachian Studies*, 7:331-348. For more on urban Appalachians in Cincinnati and Hamilton County see: Michael E. Maloney and Janet R. Buelow. 1997. *The Social Areas of Cincinnati: An Analysis of Social Needs. Third Edition - Patterns for Three Census Decades 1970-1990*. University of Cincinnati, School of Planning; Phillip J. Obermiller and Steven J. Howe. 2000. "Urban Appalachian and Appalachian Migrant Research in Greater Cincinnati: A Status Report." (available at <http://www.uacvoice.org/wp/workingpaper16.html>); Phillip J. Obermiller, Michael E. Maloney and Thomas C. Shaw. 2001. "Urban Appalachians in Hamilton County: A Restrospective Analysis of Greater Cincinnati Survey Results." Urban Appalachian Council Working Paper No. 17, Cincinnati, OH. (available at <http://www.uacvoice.org/wp/workingpaper17.html>). For general information on urban Appalachians and Appalachian migrants see the bibliography on the Urban Appalachian Council's website (available at <http://www.uacvoice.org/bibliography.html>).

2. National Institutes of Health. 2002. "Press Release for the FY2003 President's Budget." (mimeo). Washington, D.C., Feb. 4. See also Appalachian Center. 1989. *Health in Appalachia: Proceedings from the 1988 Conference on Appalachia*. Lexington, KY: University of Kentucky; Sandra Barney. 1996. "Bringing Modern Medicine to the Mountains: Scientific Medicine and the Transformation of Health Care in Southern West Virginia, 1880-1910," *West Virginia History*, 55:111-126; Vern L. Bullough and Bonnie Bullough. 1982. *Health Care for the Other Americans*. New York: Appleton-Century-Crofts; Richard A. Couto, Nancy K. Simpson, and Gale Harris, eds. 1994. *Sowing Seeds in the Mountains*:

*Community-Based Conditions for Cancer Prevention and Control*. NIH Publication #94-3779, Washington, DC: Appalachian Leadership Initiative on Cancer, National Cancer Institute; Richard A. Couto. 1975. *Poverty Politics and Health Care: An Appalachian Experience*. New York: Praeger; Sharon A. Denham. 1996. "Family Health in a Rural Appalachian Ohio County," *Journal of Appalachian Studies*, 12: 229-310; Joellen B. Edwards, Patricia Shuman and L. Lee Glenn. 1996. "Relationships between health risk factors and objective physical findings in well rural Appalachian women," *Family & Community Health*, 18:67-80; Gilbert H. Fridell, et al. 2001. "Community Cancer Control in a Rural, Underserved Population: The Appalachian Leadership Initiative on Cancer Project," *Journal of Health Care for the Poor and Underserved*, 12:5-19; Susan E. Keefe, ed., *Appalachian Mental Health*. Lexington: University Press of Kentucky; Lonnie R. Helton. 1995. "Intervention with Appalachians: Strategies for a Culturally Specific Practice," *Journal of Cultural Diversity*, 2:20-26; David H. Loof. 1971. *Appalachia's Children: The Challenge of Mental Health*. Lexington: University Press of Kentucky; Kathleen McInnis-Ditrich. 1997. "An Empowerment-Oriented Mental Health Intervention with Elderly Appalachian Women: The Women's Club," *Journal of Women and Aging*, 9:91-105; Sally J. Reel. 2001. "The Meaning of Childbearing Among Rural Appalachian Adolescent Women Living in Eastern West Virginia," *Journal of Multicultural Nursing and Health*, 7:48-55; Barbara W. Reed, Jacquelyn Wineman and Gregory A. Bechtel. 1995. "Using a Health Risk Appraisal to Determine an Appalachian Community's Health Care Needs," *Journal of Cultural Diversity*, 2:131-135; Mary Ann Rosswurm, Debra M. Dent, Cynthia Armstrong-Persily, Paula Woodburn and Barbara Davis. 1996. "Illness Experiences and Health Recovery Behaviors of Patients in Southern Appalachia," *Western Journal of Nursing Research*, 18:441-459; Tuskegee Institute. 1955. *Report to the Council of the Southern Mountains on Health Care Services and Facilities in the Southern Appalachian Region*. Tuskegee, AL: Rural Life Council; For more information on health in Appalachia, see <http://www.arc.gov/index.do?nodeId=1283>.

3. See for example E.R. Porter. 1961. "Modern Medicine and the Migrated Mountaineer," *Cincinnati Journal of Medicine*, 42:433-44; E. R. Porter. 1963a. "When Cultures Meet - Mountain and Urban," *Nursing Outlook* 11:418-20; E.R. Porter. 1963b. "From Mountain Folk to City Dwellers," *Nursing Outlook* 11: 514-15; John Friedl. 1978. *Health Care Services and the Appalachian Migrant*. Columbus: The Ohio State University; John Friedl. 1983. "Health Care: The City Versus the Migrant," pp. 189-209 in Allen Batteau, ed., *Appalachia and America: Autonomy and Regional Dependence*. Lexington: University Press of Kentucky; Lonnie R. Helton. 1988. "Urban Appalachian Health Care: Attitudes and Practices," *Mountain Life & Work*, 64: 13-26; H.V.M. Watkins. 1973. "Considerations of Factors Relevant to the Development of Adequate Health Support Systems for Appalachian Migrants." M.A. thesis, University of Cincinnati.

4. The concept "urban Appalachian" involves a complex blend of regionalism, race, ethnicity, social class, degree of assimilation, and generational position. To see how this concept has been operationalized in a variety of quantitative studies, see notes 9 and 18 below as well as Obermiller, Maloney, and Shaw, *op.cit.*

5. Watkins, *op. cit.*

6. Friedl, *op. cit.*

7. The Greater Cincinnati Survey is a semi-annual telephone survey of the adult public (age 18 and over) in metropolitan Cincinnati conducted in May and November of each year by the University of Cincinnati's Behavioral Sciences Laboratory. See Phillip J. Obermiller, and Walter S. Handy, Jr. 1994. "Health Education Strategies for Urban Blacks and Appalachians," pp. 61-70 in Kathryn M. Borman and Phillip J. Obermiller, eds., *From Mountain to Metropolis: Appalachian Migrants in American Cities*. Westport, CT: Bergin & Garvey; Phillip J. Obermiller and Robert W. Oldendick. 1994. "Urban



Appalachian Health Concerns," pp. 51-60 in Borman and Obermiller, eds., *op. cit.* The two studies involving hospital records are: M. Kathryn Brown and Phillip J. Obermiller. 1994. "The Health Status of Children Living in Urban Appalachian Neighborhoods," pp. 71-82 in Borman and Obermiller, eds., *op. cit.*; Pauletta Hansel, Katie Brown, et.al. 1990. "Health, Education, and Pollution in Lower Price Hill." A Report by the Lower Price Hill Task Force. Cincinnati: Urban Appalachian Council.

8. Obermiller and Oldendick, *op. cit.*

9. Their low representation in most small-area survey samples normally makes the cohort of black Appalachian respondents too small for meaningful analysis in any given survey. In most comparative studies, including the ones cited in this working paper, they are either excluded from the analysis or included in the general African-American cohort. For more on black Appalachian migrants see William W. Philliber and Phillip J. Obermiller, 1987. "Black Appalachian Migrants: The Issue of Dual Minority Status," pp. 111-116 in Obermiller and Philliber, eds., *Too Few Tomorrows: Urban Appalachians in the 1980's*. Boone: NC: Appalachian Consortium Press. For other sources on black Appalachians see William H. Turner and Edward J. Cabbell, eds., 1985. *Blacks in Appalachia*. Lexington: University Press of Kentucky; John C. Inscoe, ed., 2001. *The Mountain South from Slavery to Segregation*. Lexington: University Press of Kentucky; J. Trent Alexander. 2001. "Great Migrations: Race and Community in the Southern Exodus, 1917 - 1970." Ph.D. dissertation at Carnegie Mellon University.

10. Obermiller and Handy, *op. cit.*

11. Hansel, Brown, *et. al.* 1990. "Report." *op. cit.* See also Anna Johnson and Amber Pleasant. 2001. "Lower Price Hill, Cincinnati: A Community Gaining Strength," *Community Journal*, 49:6-9

12. Hansel, Brown, *et. al.* 1990. "Executive Summary of the Lower Price Hill Task Force's Report on Health, Education, and Pollution in Lower Price Hill. (mimeo), p.7.

13. Brown and Obermiller, *op. cit.*; see also Johnson and Pleasant, *op.cit.*

14. See Edward F. Donovan and Barbara Rose. 2001. *The State of our Children: Report on the Well-Being of Children in the Tristate Region*. Volume II. Cincinnati, OH: Child Policy Research Center (available at <http://www.cprc-chmc.uc.edu>); Lower Price Hill Environmental Leadership Group. n.d. "Lower Price Hill Children's Health Survey." (document available from the Urban Appalachian Council, Cincinnati, OH). This environmental health survey was conducted as part of the Lower Price Hill Environmental Leadership Coalition Project funded by grant 1-R25 ESO7717 awarded by the National Institute of Environmental Health Sciences; Robert L. Ludke, and Terrance J. Wade. 2001. *Self-Reported Health Status of White Appalachian Adults in the Greater Cincinnati Area*. A report prepared for the Health Improvement Collaborative of Greater Cincinnati by the Center for Health Systems Research at the University of Cincinnati can be found at <http://www.the-collaborative.org/>.

15. Lower Price Hill Environmental Leadership Group, *op. cit.*; see also Johnson and Pleasant, *op. cit.*

16. As part of a second grant sponsored by the National Institute of Environmental Health Sciences (2-R25-ES-07717-05A1 Revised), the Lower Price Hill Leadership Group and the University of Cincinnati have developed a Lower Price Hill Women's Health Survey which will be conducted in the neighborhood during 2002. The survey questions are based on focus group discussions with neighborhood women, and the survey methods will be comparable to those used for the 1998 Lower Price Hill Children's Health Survey.

17. Ludke and Wade, *op.cit.*, see especially pages 22- 24. Although several of the counties in the survey geography are in the federally-designated Appalachian region, the controls used by the researchers mitigate the possibility of urban/rural differences confounding their findings concerning white Appalachians.
18. First-generation Appalachian migrants are those born in the Appalachian region as defined by the federal government's Appalachian Regional Commission; second-generation Appalachian migrants are those with at least one parent born in that region.
19. Edward F. Donovan and Barbara Rose. 2001. "Child Well-Being Survey Results by Ethnicity." Cincinnati, OH: Child Policy Research Center can be found at <http://www.cincinnatichildrens.org/research/cores/cprc/>; see also Donovan and Rose, *op.cit.*
20. Three points should be kept in mind when interpreting the results of this study: First, six of the 29 counties surveyed are in the federally-defined Appalachian region and each of these counties has a high percentage of rural residents: Adams (87.8%), Brown (89.6%), Clermont (46.9%), Highland (68.1%), and Scioto (57.5%) in Ohio, and Lewis (100%) in Kentucky. Second, by definition most of the children in these counties would be first-generation Appalachians; concentrations of second-generation Appalachian children would typically reside in households located in the urbanized portions of the non-Appalachian counties surveyed. Thus, the differences among outcomes between generations may, in part, be explained by urban/rural influences. Third, the smaller, weighted counts for subgroups such as first- and second-generation white Appalachians, African Americans, and white non-Appalachians make the margins of error quite large. Nevertheless, some broad indicators of Appalachian children's health concerns do emerge from the data in this study.
21. The benefits that accrue from culturally competent practices used by human service professionals are well established. See for example Linda S. Smith. 1998. "Concept Analysis: Cultural Competence," *Journal of Cultural Diversity*, 5:4-10; Dennis E. Chestnut. 2000. "Understanding Culture and Ethnicity: Basic Rudiments of an 'Anthropsychological' Perspective for Understanding Human Behavior," *Journal of Cultural Diversity*, 7:108-113.
22. See Hansel, Brown, *et. al.*, "Report." *op. cit.*; see also Johnson and Pleasant, *op. cit.*; Phillip J. Obermiller. 1999. "Paving the Way: Urban Organizations and the Image of Appalachians," pp. 251-266 in Billings, Norman, and Ledford, eds., *Confronting Appalachian Stereotypes: Back Talk from an American Region*. Lexington: University Press of Kentucky, especially page 261 and footnote 29.



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