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Keitra L. Thompson April 15, 2013

“It Just Ain’t Like It Used To Be”: The Relationship of Food, Culture, & Metabolic Disease in African American Senior Citizens of the South

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Abstract

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By Keitra L. Thompson

African American senior citizens, like any elderly group, have seen their fair share of personal, as well as public triumphs and defeats. As one of the fastest growing populations in America today, African American senior citizens are slowly becoming one of the largest groups dependent on state-funded health care programs and assisted living resources. They are also experiencing high rates of chronic disease and limited resources. Unfortunately, current literature has failed to critically examine the life trajectory of African American senior citizens in relation to dietary patterns, prevalence of chronic disease, and the impact of African American cultural values and traditions. This study has aimed to fulfill the current gap in research by exploring the intersection of food and culture and how it relates to the prevalence of metabolic disease in the African American senior citizen community, through appraising the health beliefs, life choices, dietary patterns, and food accessibility of African American senior citizens located in a low-income residential facility in the Old Fourth Ward of Atlanta, Georgia. Qualitative and quantitative data was collected on 39 African American senior citizens through surveys and life-history interviews. The results of the study indicate that African American senior citizens living in the Old Fourth Ward of Atlanta are experiencing limited access to nutrient dense foods due to economic constraints and food availability. They are also overwhelmingly affected by chronic metabolic conditions such as hypertension, high cholesterol, and diabetes. Nonetheless, while they are aware of the commonly defined association between diet and disease, there is a perceived disconnect of how such a relationship has and/or continues to play out in their own lives. Furthermore, the overall life-history of participants reveals that experiences resulting from societal discrimination are most pronounced as a result of age as an elderly member of society than as an African American. Such findings and others revealed throughout the paper, suggest that more analysis and research is crucial to the well-being of all senior citizens in America and particularly to issues of improving medical care, food access and quality, and economic resources for African American senior citizens living in Atlanta, Georgia.

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PREFACE

> "I want to eat healthy, I do, but it's just too expensive. Going over there to that organic market is a waste of my time when they want to charge $12.00 for two little baby squash. Everyone's in your ear saying eat this and don't eat that, but they act like we have a choice over here. I know food has changed cause it just don't taste the same…I can't even really explain it [to you], but you know…my greens don't cook right or taste like they used to, I have to cook them all day to try to even get them tender and then end up throw'n em out cause they don't taste good. Tomatoes don't even be right. My friend's husband that used to work for one of those tomato delivery companies told me they turn'em red now with chemicals or whatever when they're green still, so what we buy ain't even really ready to be eaten, and…. Peaches just taste like water, no flavor like they used to have. Honey, you wouldn't know it but even sugar don't taste like it used to! So it's real sad. Food just don't taste good no more, and it's more expensive than it used to be even for the regular [non-organic] stuff, but there's nothing we can do about it when the good stuff [organic] cost so much for just a little amount ya know. I'll eat anything they think I should eat if they gonna give me the money for it…"

This statement was made by a female attendee of a focus group held by other students and I in the spring of 2012 as we attempted to ascertain senior citizen food needs. We conducted the focus groups in hopes of encouraging residents at Wheat Street Towers to purchase fresh, local, and organic produce from the community supported agricultural center just two streets over. Her statement undoubtedly reflects the sentiments of many consumers in society as the push for organic, local, and sustainable foods has increased in recent years. However, her age, place, and perceived level of income had a great impact on the way I heard her words. While I, myself, can be found guilty of disregarding organic or simply healthier foods in an effort to save money, conserve time, and feed my "unseasonal" cravings, I am aware that my choices are more often than not to blame for my dietary practices than circumstance itself. Thus, through

considering her statement in tandem with observations of her surroundings I deeply understood the impact one's circumstance can have on their choices.

After thinking about her statement and current surroundings, which constituted limited grocery stores and an abundance of fast food restaurants and convenience stores, I began to wonder how this woman and other residents at Wheat Street were able to secure healthy food options. I then realized that based on what I hear many family and friends of older generations discuss about how things used to be "back in the day," it is possible that older generations are not eating the way they are eating out of habit. In other words, if history serves us right and the majority of the older individuals in the focus group "got everything from [their] farm or made it [themselves] growing up" as one woman in the focus group mentioned, then it is highly likely that the current dietary practices of senior citizens is more often than not a result of agricultural shifts in the U.S. food system, fluctuations in financial stability, and changes in their physical environment over the years. If so, older generations are not eating what or how they have always eaten. Unlike many members of my generation, trying to become healthier as we are told the horrors of McDonald's or trying not to eat those Oreos if we are not able to pronounce everything on the ingredient list, senior citizens of America are longing for the quality and taste of food as they had known it for the majority of their lives.

In making this realization and thinking about the fascination with homemade, from scratch food, within my own extended family and the role of my grandmothers in nurturing such an infatuation through "secret recipes" and family tradition, I began to understand the great significance of food to African American culture. Through the messages relayed in the focus groups and my own personal revelations, I also realized that although African Americans have

an intimate relationship with food as a result of both their rich culinary and cultural history, they also have an undesirable relationship with poverty and metabolic disease. Thus, the idea and research objectives of this study were born.

Chapter 1 introduces the research project and its foundation in cultural anthropology, including background information on the study location and population, and the methodology of the study. It also includes a review of current literature to better understand dietary traditions in African American culture, current rates of metabolic disease in African American communities, and issues affecting African American senior citizens in particular. After reading chapter 1, readers should have a firm grasp on the importance of this study, the validity of the study design, and how data collected throughout this study will fill gaps in previous areas of research.

Chapter 2 presents demographics of study participants and outlines their experiences of discrimination as a result of being born and raised in the Southeastern United States. Growing older and aging successfully are also key themes of chapter 2, as study participants reveal how their interpersonal and familial relationships have been impacted by growing older. Personal notions of and advice for successful aging and living a full life as explained by study participants is also presented.

In chapter 3 readers will gain a better understanding of the intersection of food and culture as it pertains to African American study participants. Shifts in food quality over the years, favorite foods, and the impact of community surroundings on one's regular diet will be explored in chapter 3 as we prepare to look at the relationship between diet and disease within the African American community in chapter 4.

The primary purpose of chapter 4 is to provide insight on the role of diet in the health beliefs of the study population that likely represent the majority of African Americans over the age of 65. In doing so, this chapter will expose the prevalence of certain metabolic conditions at Wheat Street Towers, compliance with health recommendations, and every day dietary habits that seemingly have a greater impact on the incidence and prevalence of metabolic disease rates within the African American community than cultural dietary practices known as "soul food."

Chapter 5 is the concluding chapter of this project and will discuss issues of food justice for the given study population. It will also reiterate key findings that have appeared throughout the previous chapters that may aid in the production of more culturally competent dietary recommendations for African Americans and limited-income senior citizens. Furthermore, this chapter will capture more interesting and revealing observations and stories from Wheat Street Towers regarding food insecurity. Chapter 5 will close with remarks on the ultimate findings of the study, providing recommendations for the ideal future of African American senior citizens living in the Old Fourth Ward of Atlanta at Wheat Street Towers and ideas for future research.

CHAPTER 1: INTRODUCTION & BACKGROUND

Introduction

African Americans have long comprised one of the largest ethnic minority groups in America, with a cultural history steeped in both oppression and resourcefulness that has resulted in lifestyle factors with unfavorable effects on health. Shedding light upon the intersection of diet and disease in the African American community, this research examines the relationship between ethnicity, socio-economic status, location, and dietary preferences. Dietary patterns and rates of chronic disease are heavily influenced by culture and ethnic identity. Today, "the African American community is experiencing nutritional deficiencies and increasing rates of hypertension, diabetes, and obesity, the largest of any ethnic group" (Peters, et.al., 2006:83). Therefore, in seeking to explain how collective African American dietary practices relate to oppression, food access, and metabolic disease, historical as well as contemporary analysis and research is needed. In order to frame the research and overarching arguments of this paper, an extensive view of socio-cultural historical food traditions, health disparities within the African American community, and contemporary dietary practices of African Americans will be explored through the lens of cultural anthropology and food studies. The health status and personal life-history narratives of low-income, urban African American senior citizens in relation to the aforementioned topics are central to understanding how dietary practices are shaped and how African American senior citizens fare in terms of successful aging. However, a review of current literature reveals that this has yet to be fully explored and taken into consideration in the face of metabolic disease, diet composition, and culture.

Goals of this Project

The overarching goals of this study were to gain a greater understanding of the intersection of food and culture, and how their intersection inform the relationship between food, physical and emotional contentment, and disease in African Americans located in Atlanta, GA. More specifically, through exploring life history narratives and surveys conducted with African American men and women 65 and older, I desired to discover the role socio-economic status, location, level of education, familial demands, and dietary preferences play in food choices and the prevention and management of chronic metabolic disease. Guiding research questions included the following:

- How have food access and the socio-economic status of African American senior citizens evolved over the course of their lives?
- How does the experience of chronic disease relate to oppression, health beliefs, food access, and dietary habits as observed in African American senior citizens?
- What is the significance of certain foods to African Americans?
- How have gender roles influenced lifestyle choices and familial relationships?
- What factors impact African Americans' ability to age successfully?

The Anthropological Connection & Study Rationale

This project is deeply rooted in anthropology and food studies, while taking an interdisciplinary approach to analyzing lived history, mechanisms of chronic disease, and societal determinants of health. In designing this project, it was essential to define my population, problem, and purpose. In doing so, I began to think of the potential for medical anthropology to reveal how certain popular health recommendations to prevent and manage chronic metabolic diseases, such as hypertension and type 2 diabetes, could be considered

culturally incompetent and thus ineffective, particularly for African Americans. I chose African American senior citizens, the most vulnerable population within the African American community, as my study population in order to better understand how notions of kinship, tradition, food insecurity, and social change are communicated through generations in relation to dietary practices and preferences, health beliefs, and lived experience. Their statements and stories surrounding food and health not only shed a great deal of light upon the intersection of food and culture, and how together they impact rising levels of chronic disease in African Americans, but they also illustrate the use of anthropology in creating social change.

The work and words of anthropologist Sidney Mintz and Christina Du Bois reinforce the anthropological lens of this project and its focus on ethnographical accounts of food, as they state:

> In-depth studies of food systems remind us of the pervasive role of food in human life. Next to breathing, eating is perhaps the most essential of all human activities, and one with which much of social life is entwined. It is hoped that more anthropologists will accord food the central place in their ethnographies that it occupies in human existence (Du Bois & Mintz, 2002:102).

I aim to incorporate what Mintz and Du Bois challenge of ethnographies. The data analysis of this study is centered on the physical and emotional sentiments of food that impact what one chooses or does not choose to put into their mouth based on health, economic, and/or socio-cultural factors. Furthermore, by incorporating an analysis of health behavior that is largely impacted by social structures as well as cultural heritage this project also includes a comprehensive view of medical anthropology. Ultimately, my chosen study population of African American senior citizens in a low-income area of Atlanta is a prime informant group for a study of this nature. As senior citizens, they are the only group of people able to give firsthand

accounts of how poverty, discrimination, and food access have evolved over the last 55 years within the African American community of the United States South. They also hold key information as to how food quality, dietary guidelines, and healthcare accessibility should be approached to aid in healthy lifestyles for subsequent generations.

Background

Community health and determinants of disease have always been of interest to me. During an environmental studies course taken Spring 2012, I had the opportunity to work with senior citizens in the Old Fourth Ward of Atlanta in an effort to ascertain their food needs and assess their low consumption of organic foods grown and sold at Truly Living Well, an urban center for fresh, natural foods also located in the Old Fourth Ward of Atlanta. This experience opened both my heart and eyes to the insightful but often forgotten opinions of senior citizens; their rich life experiences, and their need for improved access to quality, fresh foods. Thus, my research topic was born. Having developed previous relationships with senior citizens living at Wheat Street Towers apartment homes, I was intrigued to explore the health status of residents, their health beliefs, and what they could tell me about changes in the food system alongside socio-political shifts throughout history. In doing so, I have hoped to discover gaps in food accessibility, health care, and social services that are negatively impacting the health and well-being of one of the most vulnerable, yet deserving populations in the U.S.

Sweet Auburn Avenue

Atlanta, Georgia has long been considered home of some of the most prominent and well-known African Americans and notable for its instrumental role in the Civil Rights Movement. Coined “Sweet Auburn Avenue” by John Wesley Dobbs in 1880, Auburn Avenue

was thought to be "the richest Negro street in the world." (Grant 1993: 249). For many African Americans it was a place to live freely and establish businesses, schools, churches, and more without the threat of Jim Crow laws and segregation. Civil Rights leaders instrumental to Georgia and the world at large, such as Martin Luther King Jr. and Maynard Holbrook Jackson were also born and raised on Auburn Avenue, learning the value of social responsibility and education. However, in visiting the Old Fourth Ward of Atlanta today, where Auburn Avenue is located, visitors and residents alike witness a deep contrast from Dobbs' "Sweet Auburn Avenue." As a designated historical landmark, "Sweet Auburn" is now a visibly decaying memorial to a bygone era as a result of the dissolution of Jim Crow laws and city infrastructure development (Pomerantz 1996). Present day Auburn Avenue is mostly known for its tourist landmarks including Ebenezer Baptist Church and the King Memorial Center. It is at the crux of urban revitalization and poverty, with a number of restaurants and convenience stores. Nonetheless, many African American senior citizens still call it home and reminisce about how "sweet" it used to be.

Wheat Street Towers

Wheat Street Towers, formerly Wheat Street Gardens, was established in 1972 by then pastor of Wheat Street Baptist Church, Reverend William Holmes Borders, as a low-income retirement home for elderly residents of Auburn Avenue. Today, Wheat Street Towers continues to serve senior residents of Atlanta. With 207 apartment units, Wheat Street Towers is considered a subsidized, independent living facility for individuals 62 and older or that have been deemed physically disabled. As of February 13, 2013, there are currently 190 occupied units with a total of 270 residents living there. Of the 270 residents, 170 are male and 100 are

female. 160 residents are 65 and older, being classified as senior citizens. 268 of the current residents at Wheat Street Towers identify as African American, with the remaining two identifying as Caucasian. The annual household incomes for residents do not exceed $21, 000, with 96% of households with an annual income of less than $10,000.

Image 1: Main Entrance to Wheat Street Towers

Literature Review

In considering the intersection of food and culture and how their affiliation relates to the prevalence of metabolic disease within the African American community, the topics covered in this literature review and the research project at large have been heavily guided by the fields of medical anthropology and food studies. Medical anthropology is defined "as the study of human health and disease, health care systems, and bio-cultural adaptations that impact health" (Holt 1996:1). Thus, the role of medical anthropology is essential to fulfilling the research objectives of this project, which seek to emphasize the role of culture in the dietary patterns, health beliefs, and the ecological surroundings of African American study participants 65 and older that

ultimately influence their health behaviors, dietary patterns, and health beliefs. As interdisciplinary fields, both medical anthropology and food studies, which uses food as a lens into human experience, engage the physiological and social aspects of diet. Subsequently, both disciplines are not only fundamental to the core of this literature review, but also to the overarching goals of this project as:

> Behaviour in respect to food is assumed not to be random. First, it is a prior assumption of cultural anthropology that human behavior is patterned activity. Second, it is assumed that the tendency to fall into [certain] patterns is affected by economic and political concerns. Consequently, and thirdly, the patterns that are sufficiently stable to be identified in research are assumed to be adapted to an equally stable distribution of power in the social dimension. As the distribution of power changes so will the cultural patterns affected by it (Douglas 1986: 85).

As one reads what is to come in the following sections of this project, the preceding words by Mary Douglas will become clearer in the face of African American culture, traditional African American dietary practices known as "soul food," every day diets of low-income senior citizens, rising rates of chronic disease in the African American community, and the imprint of socio-economic status on lifestyle determinants of health.

Health Disparities and Metabolic Disease

As rates of obesity rise throughout the United States, the prevalence of chronic metabolic conditions steadily increases. Although obesity does not always correlate with poor health, the accumulation of excess body fat can pose detrimental effects on health. Thus, obesity is often a risk factor for developing a myriad of health conditions, including hypertension and type 2 diabetes. Physiological, social, genetic, and lifestyle factors influence the prevalence of diabetes in the United States, while also playing a key role in the management of chronic metabolic conditions. Therefore, it comes as no surprise that the National Health and Nutrition

Examination Survey conducted by the Centers for Disease Control (CDC) from 2007 to 2010 showed that "two-thirds of adult men and women in the U.S. diagnosed with type 2 diabetes are classified as overweight" (CDC, 2010, NHANES), depicting the strong association between obesity and diabetes. More specifically, an excess amount of body fat diminishes the body's ability to control normal blood sugar levels, which can lead to a constant overproduction of insulin, known as type 2 diabetes. An excessive increase in body mass also causes the heart to work harder in supplying blood throughout the body, thereby increasing blood pressure and leading to hypertension. In combination, obesity, hypertension, and diabetes not only bear higher rates of mortality, but they also contribute to the multi-billion dollar health care cost accumulated annually in the United States.

As of 2010, 20.9 million people in the United States have been diagnosed with diabetes and 67.8% of the population suffered from hypertension and obesity combined (CDC 2011: Diabetes Fact Sheet). Although all three conditions have the ability to affect individuals of all ethnic backgrounds, racial and ethnic minorities tend to be disproportionately affected and experience higher rates of co-morbid complications (Liburd 2010). For example, the risk of developing diabetes is "higher in African American men and women than for their white counterparts" (Liburd 2010: 31), a phenomenon linked to high rates of obesity and hypertension in the African American community. Health disparities within the community are commonly the result of increased genetic susceptibility, inequities in health care, lacking preventative care, and social and environmental influences on overall health and well-being. Recognizing that the first line of both prevention and treatment for type 2 diabetes and obesity-related hypertension is weight management through diet and exercise modifications, the disproportional incidence of

metabolic conditions in the African American community draws attention to environmental and social disadvantages that disturb the community (Masuo et al., 2011).

As Dr. L. Liburd notes in *Diabetes and Health Disparities: Community-Based Approaches for Racial and Ethnic Populations*:

> History, as kind or unkind, as it is, tells many the stories about the lives of African Americans. Descendents of those who were forcibly brought into the U.S. and sold as slaves in the southern states have remained in many of these areas…We find within these communities a rich history and culture reflecting a legacy of people who have [and continue to] overcome great struggles. (Liburd 2010: 237)

Many of the inequalities facing African Americans in the United States negatively impact their psychological and physiological well-being. Against a backdrop of oppression, many African Americans have remained family oriented with an ardent sense of community. The sense of community for African Americans is largely centered on beliefs and traditions that have originated from a distinct historical past and shared experiences related to racism, inequality, and disadvantage. Currently, "African Americans report lower per capita incomes, less education, larger family size, and the highest rates of crime in their neighborhoods than any other racial or ethnic group within the United States" (Liburd 2010: 243). These factors allude to the health disparities plaguing minority groups in America. As low levels of education directly correlate with low socio-economic status and discrimination, together these realities contribute to food insecurity, limited physical activity, increased stress levels, and bleak housing and employment opportunities (Adler, et. al., 2002). Hence, rates of metabolic disease fester in African American communities.

Public health research has found high socioeconomic levels to be one, if not the, greatest form of protection against disease and disability world-wide (Liburd 2010). Socio-ecologic

conditions, defined as the variables of one's social environment, are a central point of analysis when looking at determinants of health. Hence, a current as well as a historical socio-ecological orientation to dietary patterns, gender roles, and resources is needed to facilitate our understanding of health trends within the African American community. It is highly plausible to argue:

> That those whose history and sociality have nurtured a palate for healthy and disciplined eating, who have the time and needed resources to prioritize and incorporate physical activity, who have access to high quality and affordable food, and have a social network that shares the value of these choices are in a better position to maintain a healthy weight, thereby preventing metabolic disease. (Liburd 2010: 69)

In examining this argument, the cause of current health disparities affecting American Americans is revealed. Furthermore, the distinction between *choice*, the power, liberty, or right to explore one's options, and *circumstance*, the factors that determine or modify positionality or events, becomes problematic.

Cultural and economic factors play critical roles in the etiology of obesity and metabolic disease that disproportionately affect African Americans. The 2010 census confirmed that 27.45% of African Americans live below the poverty line nationally (Census 2010). Thus, many African Americans are located in segregated areas where low-income housing and deprivation are commonplace. These environments are prone to poor educational opportunities, limited health services, grim employment possibilities, and overall unfavorable affects on health. In such areas, access to quality, nutrient dense food is also insufficient, since "inequities in accessing healthy foods are associated with the wealth and racial makeup of neighborhoods" (Liburd 2010: 154). In addition to low quality, the cost of food in such areas is much higher than in middle-to-upper class environments.

As designated food deserts, areas in which ready access to healthy, nutritious, and affordable food is limited and replaced with a high yield of fast food and convenience stores, many urban, low-income African American neighborhoods do not support healthy dietary practices. Having to "pay 3-37% more for produce in such areas compared to residents of non-urban communities," many African Americans are unable to follow the recommended national dietary guidelines for healthy weight management and chronic disease prevention (Morland, et. al., 2002: 24). Therefore, when looking at the diet composition of African Americans, especially those living in low-income environments, dietary patterns overwhelmingly high in saturated fat and sodium, but low in fiber, fruits, vegetables, and whole grains must be critically examined alongside racial segregation and limited opportunities. It is true that food preference plays a big part in what we choose to eat, regardless of access or availability, and that those preferences have the potential to exacerbate negative health outcomes, such as obesity, hypertension, and diabetes, or aid in disease prevention. Nevertheless, food choice is heavily influenced by neighborhood environmental factors that include, but are not limited to food availability, the presence of grocery stores, and the overabundance of fast food establishments. Together, these factors have been shown to directly correlate with poor nutrition, obesity, and diabetes, health disparities that currently plague the African American community (Liburd 2010).

Dietary Traditions and 'Soul Food'

In a chapter entitled "Out of Africa" from her book *High on the Hog,* Jessica Harris states:

> Recipes, religious celebrations, meals, menus, and more from the African continent were a part of the cultural baggage that was brought across the Atlantic by those who would be enslaved…The general notions of ceremony and the tastes of the food of ritual and of daily life, however, remained in memory, atavisms that influenced the taste, cooking

> techniques, marketing styles, ritual behaviors, and hospitality of their descendants and of the country that would become theirs. (Harris 2011:16)

The above statement illuminates the important relationship between anthropology and food studies for the sake of this paper. Africa, defined as the cradle of civilization for all humanity by anthropological standards, plays a central role in the historical past of African Americans and their prime dietary tradition known as "soul food." While a distinct designation of soul food seems impossible, "chicken put alongside collard greens, fried fish, macaroni and cheese, peach cobbler, and sweet potato pie" (Williams-Forson 2006:184) usually fits its definition. Soul food conjures feelings of physical and emotional contentment, especially for members of the African American community. However, "there is a less comfortable side of soul food, one that is rarely seen or discussed [by African Americans], this side involves obesity, high blood pressure, and diabetes-serious health issues that specifically affect the black community" (Williams-Forson 2006:184).

Culture, defined as "something that is learned and shared" (Whit 2007:45), is fundamental to considering soul food as an African American culinary tradition. In his essay entitled, "Soul Food as Cultural Creation," William C. Whit explains, "Culture originates as an attempt to come to terms with an environment's physical and social aspects" (Whit 2007:45). As a result, the significance of soul food to African Americans must not be disassociated with a historical past filled with oppression and poverty. Therefore, in order to analyze the tradition of soul food in light of its current role in African American dietary habits, slavery stands as a key point of reference. Food choices and opportunistic thought patterns about diet and self-control did not exist for enslaved African Americans. Not only were they prevented from having any sense of control over their own bodies and actions, but they were also forced to eat "from

hunger, for nourishment, and with little opportunity to select their own food" (Yentsch 2007: 67), using whatever was available as survival took precedence. More often than not the dietary choices of enslaved African American communities were contingent upon what plantation owners and their families disposed of or refused to eat. Consequently, African American foodways of today are the result of cultural cuisine produced from unfavorable social conditions wherein slaves were forced to "address problems of nutritional adequacy and ethnic and racial identity" (Whit 2007:55).

Over a century after slavery's end, African American's and other groups continue to take part in soul food diet traditions. By the 1970s, with the burgeoning Civil Rights and Black Power movements, soul food became both a subject of pride and nostalgia for African Americans. The transformation of such dietary practices into healthier options and cooking techniques also proliferated as a form of protest (Harris 2011). During this same time, soul food was detached from its origins in slavery for many Americans and was classified as the diet of the south or fine southern cuisine (Williams-Forson 2006). As a result, soul food became one of the key ethnic foods of America (Gabaccia 1998). In discussing the politics of soul food Harris argues that, "although [mainstream soul food] was considered healthier it retained some aspects of the traditional African American taste profile for sugary desserts and well-cooked vegetables" (Harris 2011:217-218). Food, like many other aspects of African American life, developed into a battleground for identity during the Civil Rights Movement. Therefore, representative foods of the African American South, such as fried chicken, pork chops, sweet potatoes, and macaroni and cheese, not only maintained their place at the table of both Southerners and Northerners, but they also symbolized a culinary manifestation of solidarity for activists. While they remained an

integral part of the daily diet for some, for many they emerged as a way to celebrate family, tradition, and progress (Harris 2011).

As noted above, a single definition of soul food is not possible and it would be inaccurate to attribute the importance of such dietary traditions to only and all African Americans, especially as an aftereffect of desperation. In other words, "some foods eaten by black people have their origins in the plantation master's leftovers, but not all" (Williams-Forson 2006:197). Today, soul food is enjoyed by people all over the United States, regardless of their ethnic affiliation, race, or religious tradition. However, it continues to remain a meaningful marker of identity for African Americans, as it draws attention to the indelible effect of slavery upon African American eating patterns, cultural symbols, and current oppressive forces threatening community fitness (Williams-Forson 2006). Elaborating on the relationship between food and culture in multi-cultural America, Donna Gabaccia offers two evocative viewpoints to the exploration of African American dietary traditions as part of the minority and majority way of life. In her book *We Are What We Eat: Ethnic Food and the Making of Americans*, she explains:

> Key to identity and culture in both American music and eating is the tension between people's love of the familiar and the pleasure they find in desiring, creating, and experiencing something new. …In food, as in music, the marketplace followed and facilitated a long-standing human curiosity about new sensory pleasures. Businessmen from within and outside enclave communities made profits off consumers' novelty, but they did not invent that desire. [Nor] did market exchanges…corrupt a natural or exclusive human preference for culinary conservatism…or the comfort foods of childhood. (Gabaccia 1998:229)

Although African American dietary traditions, such as soul food, have found their niche within consumer culture and America's diverse culinary palate, there is a unique physical and emotional contentment for such foods to African Americans. In a study conducted on factors influencing food choices, dietary intake, and nutrition-related attitudes amongst African Americans,

researchers found that "many study participants perceived 'eating healthfully' meant giving up part of their cultural heritage and trying to conform to dominant culture" (James 2004:51). The results of the study emphasize three main points: (1) African Americans feel culturally and socially connected to their dietary tradition; (2) Cultural ideals surrounding African American dietary patterns may not be considered healthy to community members; therefore, they do not recognize the potential to make 'healthier' modifications to their cooking and eating styles; and (3) "One of the most important indicators of poor dietary patterns is family and upbringing" (Coffie 2009:47), as has been found in public health and social science research. Furthermore, the distinct relationship of African Americans to their dietary traditions is evident in the way they have created ritual over soul food and continually pass down culinary traditions through generations by means of stories, recipes, and memories.

The African-American Body & Culture

As anthropology seeks to situate the body in the context of culture, the role of the body cannot be underestimated in looking at health disparities and African American dietary practices. The "black body has always received attention within the framework of white supremacy, as racist/sexist iconography has been deployed to perpetuate notions of biological inferiority" (Wallace-Sanders 2002:1). Assumptions of biological inferiority were one of the driving forces of slavery and oppression that affected African Americans in the early 19th century. Even though notions of biological inferiority are less openly perpetuated today, discrimination of black male and female bodies prevails, contributing to health disparities and health behaviors in the African American community at large. Moreover, ideals of the black body are often ascribed to both real

and imagined gender roles within the African American community, a resonance of the institution of slavery (Wallace-Sanders 2002).

Gender, defined as the "behavioral, cultural, or psychological traits typically enacted in association with one's sex," is crucial to our understanding of the historical past and present status of African Americans in regards to food (Butler 1988: 525). Gender stereotypes exist for both black men and women and often depict black women as either hypersexual, 'the jezebel or plantation mistress', or an asexual 'mammy' figure, whereas black men are thought to be hypersexual, ignorant, and are often infantilized (Richardson 2007). These stereotypes and others like them are an outcome of racism, discrimination, and segregation. Larger politics of sex and gender within American society, wherein women are thought to be inferior, further complicates stereotypical naturalisms of African American men and women (hooks 1993). Subsequently, the conjunction of racial and gender inequalities color African American culture as it relates to dietary patterns, socio-ecological environments, stress, and socio-economic status. Thus, it is taboo for Black people, especially Black women, to revel in their bodies, to enjoy expressing themselves and taking part in the culture that has traditionally defined them as "other" (Wallace-Sanders 2002:7).

Reminiscing about her childhood memories of chicken and Sunday dinners, Psyche Williams-Forson states, "In the confines of the safe space of home all stereotypes about Black folks and chicken were forgotten" (Williams-Forson 2001:169). For many African Americans meanings and memories of home and food are intertwined with their sense of family and the role of female family members. The church is another institution that adds to the conversation of body, food, and gender, and has long been a place of solace in African American communities.

Throughout history, the role of the African-American woman in the church has run parallel to her role within the kitchen, with the creation of 'ethnic' food as the nexus. Although she may have been appointed this role through societal discrimination and gender malpractice, it is a role she, more often than not, desires to uphold. As Psyche Williams-Forson eloquently imparts:

> Using the proceeds from church lunch and dinner sales, Black women were able to assist in building baptismal pools, edifices, sanctuaries, and contribute to other church needs. This creative consciousness combined with spirituality, camaraderie and cooking imbues chicken [and other 'soul foods'] with polysemic meanings. Theses meanings exceed the obvious notion of food as nutritive; they also reflect ingenuity and creativity wrought by historical circumstance of living gendered lives in a racist society. (Williams-Forson 2001:183)

The findings of Dr. Leandris Liburd's study on the role of the church in defining the black female body in terms of sexuality, diet, and health affirm Williams-Forson's claims. Liburd found that in western culture "a large female black body is a disempowered body [alongside Western ideals of beauty], one that does not threaten and is more easily manipulated and shamed in spite of mass" (Liburd 2006: 155). However, within the black church, women of large body size have "power" and presence and are the afforded "mothers" and "matriarchs" of the black church (Liburd 2006). In addition to spirituality and religion, feminine and masculine ideals of motherhood and fatherhood respectively formed during slavery and the post-civil war south continue to impact matters of reproduction, socio-economic responsibility, and opportunity in regards to African-Americans. An amalgamation of the aforementioned entities also contributes to elevated levels of obesity, hypertension, diabetes, and poor socio-ecologic circumstances that impinge urban, low-income African American communities.

In addition to sex differences in body size that account for child bearing abilities in women; race, class, and gender roles are not only central determinants of body size, but they can

also be catalyst for the acquisition of chronic disease. This is particularly true for African American women. Of all groups in the United States, African-American women are experiencing the highest rates of poverty and obesity. In addition, a longitudinal study conducted by the CDC from 1980 until 2010, revealed that African American women and men accounted for the highest rates of diagnosed cases of diabetes, with African American women exceeding the rates of African American men. Given the fact we cannot divorce our biology from our culture or environment; the CDC's findings highlight the barriers to physical activity in urban African American communities and the centrality of food in African American culture that induces physical and emotional contentment (Liburd 2006). Even though African American culture holds different ideals of beauty and body size than mainstream society, this should not equate to higher levels of disease and death for African American women. Therefore, while it is indubitable that low rates of physical activity and poor food choices account for some level of metabolic disease in the African American community, inadequate health services and nutritional resources further exaggerate unfavorable outcomes. Similarly, African American men, who have long suffered economic marginality, high rates of incarceration, and over-representation in hazardous occupations and rates of substance abuse, should not be forced to experience ailing mental, physical, and emotional health in a society that equates black masculinity to physical strength pride, and control. Together, perceptions and realities about African American men and women hold negative consequences for their families, African American culture, and society at large.

African American Senior Citizens & Contemporary Dietary Practices

Senior citizens are more likely to be food insecure if they live in a southern state or are African American or Hispanic (Ziliak & Gunderson 2009). Therefore, Southern African

American senior citizens are one the most marginalized and vulnerable minority groups in the United States. Throughout their lifetimes, African American senior citizens in particular, have witnessed and experienced many socio-political shifts that have at times intensified segregation and discrimination, while at other times have led to greater equality within society. As a whole, senior citizens also have firsthand knowledge about the evolution of the U.S. food system during the 20th century, as more and more meals are eaten outside the home, the number of fast food eating establishments has increased, and industrial food production has taken precedent over slow, local foods (Liburd 2006). Exploring soul food traditions as part of the heritage and dietary preference of African American senior citizens juxtaposed against shifts in the agricultural food system, an analysis of diet, health beliefs, disease, and culture must be taken into account when looking at successful aging, specifically for African American senior citizens.

Aging is inevitable and most often symbolizes a decreasing state of ability and status in American society. The manifestation of aging produces a "decrease in physiological capacity and a reduced ability to respond to environmental stresses" which increases susceptibility and vulnerability to disease (Treon 2003: 6). However, successful aging is defined as a low probability of disease and disease related disability, high mental and physical functioning, and a high participation in social life as one grows older in age (Menec 2002). As the number of senior citizens begins to outweigh the number of new births in the United States, aging represents a central means of analysis not only for senior populations, but also for the fiscal and overall well-being of society. As of 2010, 3.6 million individuals 65 and older lived under the poverty line and suffered from food insecurity, or the inability to access the normal food system due to store locations and income constraints (Census 2010). Accompanying this statistic, in

2010 the CDC also found diabetes diagnoses to be most prevalent in the 65 and older age group and most notably occurring amongst African Americans (CDC 2010:Diabetes Fact Sheet). These facts and figures bring attention to what it means to age successfully, or without the onset of disease, and what factors are affecting African American senior citizens in their efforts to do so. According to gerontologists, "aging successfully with a low probability of disease refers not only to absence or prevalence of disease itself, but also to absence, presence, or severity of risk factors for disease" (Rowe et al, 1997:433). Thus, one may be forced to question if successful aging is currently possible for African American senior citizens collectively, given their overwhelmingly low-socioeconomic status and poor socio-ecological environments?

An anthropological cross-cultural comparison of how aging, gender, and food insecurity function in the Gwembe Tonga society of rural Zambia, Lisa Cligget offers insight on how men and women "have become vulnerable to material insecurity in gendered ways, and how they use gendered strategies to secure their well-being as they age" (Cliggett 2005:1). Unfortunately, elderly Gwembe Tonga women are disproportionately affected by marginalization, poverty, and food insecurity, just as elderly women of the United States. However, like elderly African American women, the cooking abilities and high level of spirituality re-establish the importance of elderly Gwembe Tonga women within society during times of distress. Although her findings are based on life in rural Zambia, they serve as an analysis of successful aging across cultures while also emphasizing that the affect of gender relations, dietary patterns, and health disparities on aging populations is not unique to the United States. Cligget further notes, "because of lack of material resources with which to bargain, senior women are less empowered than men to negotiate for that food and material security, but, are nevertheless, much more creative in

negotiating within their social networks to ensure residential and food security, especially as they age" (Cliggett 2005:75). The resourcefulness of women in Gwembe Tonga society directly correlates with the historical past of African American women during slavery, they relied on what little they had to feed and hold their families together (Hughes 1997). This fact is one of the main reasons African American dietary traditions have become such an integral part of African American culture and are heavily associated with motherhood. Findings from this study also draw attention to the universality of women almost always outliving their husbands and the influence it has on their material, physical, and psychological well-being in old age (Cliggett 2005). Undoubtedly, many comparisons can be drawn between the interplay of gender, aging, and food insecurity in rural Zambia and the United States. However, the presence of more similarities than differences between Cliggett's findings and occurrences in America, are somewhat troubling. The disparities affecting the aging population of rural Zambia are more easily accepted, since they can be ascribed to the non-existent government programs that assist the elderly (Cliggett 2005). Therefore, when looking at the social insecurities and health disparities specifically facing the African American senior citizen population of the United States, structural violence as a discriminatory practice becomes evident as African American senior citizens continue to experience some of the greatest socio-economic and health disparities while taking advantage of government funded programs.

A lower degree of dietary restraint and a higher preference for sweet, calorically dense foods has been found amongst African Americans compared to Caucasians, a result of African-American cultural and dietary traditions (Bowen, et. al., 1991). There is a great chance that this preference is heightened in African American senior citizens, since the sense of taste and smell

diminishes with age (Troen 2003). The diminishment of these senses can also reduce one's enjoyment of food and eating, which in turn causes a decrease in cooking and a greater reliance on convenient, pre-packaged foods. Kinship, the biological, cultural, or social ties that offer a network of support, also becomes a factor in the well-being of senior citizens. With limited financial and transportation resources, many senior citizens rely on children or other younger family members for support in receiving meals, possibly leading to increased consumption of 'fast food'. Contrarily, young family members may rely on their senior relatives, elderly women in particular, to provide insight and help in maintaining their heritage through food and other cultural traditions. In some cases, these women are their families' 'saving grace', rescuing loved ones in times of financial, emotional, and physical crisis. This explanation provides clues as to why senior citizens have been found to experience higher rates of food insecurity and health disparities when living with family members that already live in urban environments and are at high risk for food insecurity and disease. For African Americans, this feeds the iconic image of "the strong black woman upon whom the gods had miraculously bestowed the culinary gifts…Yet, for all of her knowledge and wisdom, she is either unable or unwilling to care for herself" (Williams-Forson 2006:189). In other words, the odds of aging successfully are not in her favor, as she is, in fact, dying from the cultural implications of soul food and the need for food simultaneously (Williams-Forson, 2006).

Additionally, increasing rates of obesity, hypertension, and diabetes affecting the African American senior citizen community must be observed and examined in light of health beliefs. The Health Belief Model (HBM), developed by public health experts in the 1950s, points out that an individual's decision to take action to prevent, screen for, or control illness is influenced

by six factors. The three essential factors to better understanding the role of self-efficacy in eliminating health disparities for African Americans include the following: perceived susceptibility, perceived severity, and perceived benefits (National Cancer Institute, n.d.). The health beliefs of senior citizens within the African American community are thought to be the most inflexible. For African American senior citizens factors of disease causation are highly grounded in folklore and are the subject of home remedies which do not align with health and wellness propositions offered by mainstream society (Milliner 2011). This characteristic amongst African Americans spotlights Marvin Harris' analysis of beliefs and actions in regards to human behavior as either *emic* or *etic,* as he states:

> The locus of emic events lies in the actor's mind, while the locus of etic events lies in the observer's behavior stream. [Thus,] …behavioral events described in terms of categories and relationships that arise from the observer's strategic criteria of similarity, difference, and significance are etic; if they are described in terms of criteria elicited from an informant, they are emic (Harris 1976: 340-342).

As a result, the unique behaviors and health beliefs of African American senior citizens in relation to their emic ideas of health and well-being may be seemingly disjointed from etic perceptions of health, successful aging, and disease causation.

First-hand experiences of racial discrimination and exclusion from the American medical system have not only incited such emic beliefs, but they have also led to mistrust and ignorance of the dominant U.S. medical system amongst African American senior citizens. Taken together, this has caused many African American senior citizens to rely on cultural medical beliefs and techniques until an acute illness or injury turns urgent or chronic (Liburd 2010). Thus, the conception and practice of cultural health beliefs related to lifestyle factors cannot afford to be overlooked when looking at barriers to successful aging in the African American community.

Summary

Current health disparities affecting African Americans command the attention of public health and social science research. In looking at the health and socio-economic status of African Americans, research exploring the issue of chronic metabolic disease must not fail to take into account the historical past and present demographics of the African Americans. In fact, the most efficacious forms of research and action must include a "social structure model," wherein the continual discrimination of people of color in color-conscious societies that automatically assign them to a lower-rank is not overlooked as a determinant of health (Dressler 1993). Although members of the African American community should not be thought to be incapable of change, the socio-cultural and socio-ecological factors that tend to impede change must be explored and exposed.

The health risks associated with the general dietary preferences and cooking techniques of African Americans, that cause the alteration of otherwise healthy foods into unhealthy products by means of adding excessive amounts of fat, salt, and sugar, tend to be overlooked by African American consumers due to their symbolic significance. Symbolism, identity, and tradition surrounding soul food, make it staple in the culture of African Americans and a novelty to be enjoyed by others. However, today, the high concentration of fat, salt, and sugar in soul food alone cannot be blamed for the high incidence of obesity, hypertension, and diabetes affecting African Americans. The role of medical anthropology in appraising health disparities and inequalities affecting the African American community suggests that while slavery exacted a devastating toll on the overall well-being of African Americans, its transcendence through generations continues to affect the health of contemporary African Americans in terms of

material insecurity and oppression (Liburd 2006). The material deprivation of food once caused their enslaved ancestors to equate the procurement of any type of food as a symbol of wealth. With that being said, more research needs to be done evaluating the psychosocial stress and ramifications of material deprivation amongst African American senior citizens in light of food access and dietary selections. Why might this matter in efforts to address health disparities and the current diet of African-American senior citizens? The answer is manifold.

An interview conducted with a 72-year old African American woman in April 2012 exposed that many burgeoning food movements that urge organic, sustainable, and local food practices in an effort to avoid the harmful effects of the industrialized food system, are not of importance to senior citizens. The interviewee stated, "'going green' and organic are something for this new generation to have something to do, —we have always been green, eating from our family farms, and we never changed our ways, they changed our ways for us" (Anonymous 2012). Although the interviewee did not make clear who she was referring to by the use of *they,* her comments suffice when explaining that the dietary practices of African American senior citizens, who are faced by the highest rates of poverty, food insecurity, and metabolic disease in America, feel hopeless in their ability to change their dietary practices. Furthermore, as suggested by literature, it is highly probable that African American senior citizen's health beliefs regarding the connection between high-caloric diets, with excessive amounts of salt and sugar, and the prevention and/or management of chronic metabolic disease is incongruent, with little perceived susceptibility and self-efficacy (Butler 1981). All in all, the cultural significance of African American dietary practices, the evolution of the U.S. food system in the last 65 years, and their status as both marginalized and respected members of society and family, are crucial to

the creation and implementation of disease prevention and management programs for African American senior citizens to experience a high quality of life.

There is an abundance of qualitative and quantitative research on African American dietary traditions, the prevalence of metabolic disease in the African American community, and the 'politics' of the black body. However, most of the research has either focused solely on the historical experience of slavery or issues affecting the young-to-middle generation of African American men and women today. Some studies and academic quest can also be found guilty of failing to include a 'personal voice' to support their arguments and findings. Additionally, in reviewing current literature and research on the status of senior citizens and what it means to age successfully, African American senior citizens are seemingly left out of the picture. Through quantitative and qualitative surveys and oral life history reports with low-income male and female African American senior citizens age 65 and older living in a designated food desert of Atlanta, Georgia, I hope to close this gap. Allowing participants to "describe the dynamic cultural environment in which [he or she] was raised that influenced [their] ideologies, social interactions, and patterns of behavior" (Liburd 2006:70) and combining their admissions with current productions of knowledge, my research will explore how food access and the socio-economic status of African American senior citizens has evolved over the course of their lives, their perceptions and realities of past and present gender expectations, the influence of culinary cultural traditions on their identity, and how they perceive their role in society in relation to susceptibility, discrimination, chronic disease, and successful aging. Ultimately, using an interdisciplinary approach of medical anthropology and food studies, a comprehensive and

comprehensible account of how African Americans mediate their relationship with food, society, and each other now and throughout history will be produced (Counihan 1999).

Methodology

Study Design

The early planning stage of this project was facilitated by service-learning courses in environmental studies and cultural anthropology, a review of current literature, and suggestions from Dr. Peter Brown and Mrs. Jennifer Sweeney-Tookes. An IRB application for this project was submitted in early summer of 2012 and IRB approval was granted on June 28, 2012. Prior to submitting project details to IRB, permission to conduct my study at Wheat Street Towers was given by Mrs. Karen Ashley, the Services Coordinator at Wheat Street Towers Apartment Homes. Additionally, Russell Barnard's *Handbook of Methods in Cultural Anthropology* was instrumental in designing this study in preparation for IRB approval.

A review of current literature on African American foodways, health disparities, chronic metabolic diseases, such as diabetes, and aging helped to determine appropriate research questions and aided in the development of a survey and an outline of a life-history interview questionnaire. It was determined that a 27-question survey was most appropriate for the study population as well as semi-structured life history interview lasting between 50 and 75 minutes on average. The survey and life history questionnaire consisted of both closed and open ended questions. Although the survey was designed to obtain a decent amount of information from each participant regarding their dietary patterns and preferences, health status, health beliefs, and demographics, the life history interview allowed a deeper understanding into the past and present lifestyles of participants. It is important to note that study participants were not asked to write

their responses at any time, all data collected was asked and written by the author in a confidential, private setting. The life-history interviews were recorded on a digital voice recorder for later thematic analysis.

The survey and life-history questionnaire were created in Microsoft Word and printed out for use amongst study participants. Once final versions of the survey and life-history interview were selected, each method of data collection was piloted at the study site with residents 65 and older to ensure effectiveness, cultural suitability, and age appropriateness. The survey was later entered into a Google Document and responses were periodically uploaded for simple storage and analysis purposes. Completed life history interviews were saved on a digital voice recorder and periodically transferred to the author's personal computer for storage and transcription.

Study Population

The study sample consisted of 39 participants total; 22 men and 17 women self-reported as African American and 65 or older. All participants were residents at Wheat Street Towers apartment homes, located on Auburn Avenue in the Old Fourth Ward of Atlanta. Wheat Street Towers was an ideal location to conduct my study due to its location in the historic Old Fourth Ward of Atlanta, the living independence of the majority of residents, and the residents' previously proven willingness to share their experiences regarding food access and health concerns. Although all participants in this study qualify as senior citizens and currently reside in Atlanta, GA, they offered varied life experiences in relation to health status, religious affiliations, social relationships, and dietary preferences, providing a rich representation of the issues facing African American senior citizens in particular and how they navigate their lives.

Data Collection

Data collection began immediately upon gaining IRB approval on June 28, 2013. I initially intended to recruit study participants through random sampling methods based on apartment numbers and direct home visits. However, concerns voiced by Mrs. Karen Ashley for my personal safety given the diverse lifestyles and ages of residents as well as the bedbug outbreak of summer 2012 prohibited random sampling for this study. As a result, I set up a table in the community room of Wheat Street at least once a week over the course of several months and more than 20 visits, in order to recruit residents to potentially participate in the survey portion of the study. Thus, my study sample can be classified as self-selected; although, it should be noted that the 39 participants surveyed represent the total accessible population at Wheat Street Towers that report being African American and 65 and older. At the time of survey completion, I asked several participants if they would be willing to participate in a longer life-history interview. Those that gave an affirmative response were indicated on a list for future contact during the life-history interview data collection process.

Life-history interviews were conducted with eight participants, four men and four women. Participant selection for the interviews was on a first come, first served basis and was primarily based on the author's discretion of which participants would best represent the study population and be most willing to openly share their life experiences. The life history interviews were semi-structured and designed to be more detailed than the surveys, allowing participants to share as much or as little information with me as they felt comfortable. Each interview lasted one hour and five minutes on average. At the beginning of each interview participants were informed

that they their responses would be recorded and kept confidential. They were also given the option to skip any questions I asked or take breaks as needed.

Data Analysis

Data analysis included both quantitative and qualitative methods. Survey data was uploaded into a live Google document form for each response, creating an easily accessible visual aid to summarize my results. Further basic statistical analysis, including mean, range, and mode, was conducted on closed ended survey questions for all 39 participants. Responses to open ended survey questions were analyzed according to key themes that presented when looking at all 39 response variations. While conducting surveys, many participants shared unasked information. Information that I felt was essential to the anthropological nature of this study, was recorded and informally analyzed as well.

Although life-history interviews were recorded on a digital voice recorder, responses were also recorded in shorthand format by the author while the interviewee spoke. After each interview, the recording and associated notes were referenced in order to outline key themes and notate the times in which they were presented. Particularly relevant quotes were transcribed verbatim in Microsoft Word while re-listening to the recordings. The qualitative themes collected were analyzed to generate explanations regarding the home and social environments of African American senior citizens from childhood to adulthood, perceptions of food shifts in the U.S., health beliefs, and personal notions of successful aging.

Study Limitations

Careful planning and consideration have been at the forefront throughout this project. However, limitations have presented throughout the study that must be addressed and explained.

As mentioned above, I would have preferred to use random sampling methodology to conduct this study, but was unable to do so due to study site constraints. By not using random sampling methodology to recruit study participants, it is possible that my study sample is not a direct representation of senior citizens at Wheat Street Towers apartments. In other words, since participants were self-selected I may have missed some participants that were not aware of my study. On the other hand, the participants may have shared in my recruitment process by informing friends of my study, possibly skewing my results if friends shared similar dietary practices, health beliefs, and ideas about successful aging. Still in the process of "becoming" an anthropologist, there were times throughout the life history interviews wherein I shied away from asking questions that seemed obvious or too intrusive, having a possible negative impact on the data I collected. Additionally, while my surveys proved to be overall effective in gathering necessary data, I did take note that some questions may have not been as clear as I had hoped. Many survey questions regarding diet and health were also open to interpretation, since there was limited description as to how I defined health and diet to participants. In reporting dietary practices and health conditions participant responses were not verified and may only capture a moment in time or consist of falsified information. Time also proved to be an inhibiting factor throughout this project, limiting the number of life history interviews conducted and time for data analysis and further review of literature. Last but not least, as a member of the African American community myself, a female, and of a younger generation than study participants, it is possible that even though I intended to remain neutral throughout the entire research project that personal beliefs and bias directly informed my research questions, how data was analyzed, and what information I chose to include. My aforementioned characteristics may have also influenced what study participants chose to disclose. Ultimately, the limitations of this study

have not proved research efforts and findings to be null and void. However, as with any study, overgeneralizations on the diet preferences, socio-economic status, and health status of African Americans, African American senior citizens in particular, should not be made based on my findings. This research project is only meant to inform further research and recommendations by exposing details about a specific group of people that may be highly representative of other populations (i.e. seniors citizens of all backgrounds, members of low-income communities, urban residents).

CHAPTER 2: SOUTHERN EXPERIENCE & AGING

This chapter provides a detailed overview of study participants, including their history and current demographics. As individuals 65 and older, many participants consistently emphasized shifts within their diet, families, and communities as they have aged. Participant ideals of successful aging are also covered in this chapter, disclosing key details about the relationship between religion and health beliefs in the study population. Results presented throughout this chapter were derived from both the survey and life history interviews. Data will aid in a better understanding of the study population, their role in family as senior citizens, and current practices they believe to aid in successful aging.

Demographics of the Study Population

All study participants resided at Wheat Street Towers and identified as African American. In order to qualify for the study, participants had to be at least 65 years of age and the age of participants ranged from 65 to 92 years of age. Of the 39 survey participants, 56% were men and 44% were women. **Table 1** gives a detailed distribution of age and sex demographics.

Table 1. Age and Sex of Survey Participants

Age Range	Number of Women	Number of Men
65-69	6	14
70-79	5	8
80-89	5	--
>90	1	--

Although 97% of participants reported living alone, 74% stated that they have family that lives close by, mainly children and grandchildren. When asked about the highest level of education completed, 51% of participants revealed that they had completed high school, with 36% having completed some form of post-secondary education. **Figure 1** displays the distribution of the highest level of education received amongst all the participants. The majority (85%) of participants were from the southern region of the United States, while others had moved to Georgia from New York, Ohio, and Chicago.

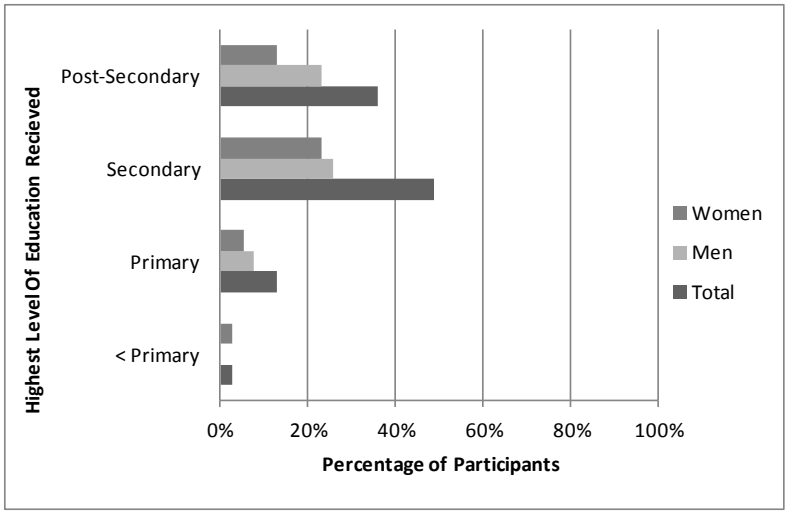

Figure 1: Highest Level of Education Received by Survey Participants

Southern Roots and Experience

The majority of study participants were from the southern region of the United States, with most actually being born in Georgia. As history stands, the southern states of America have a unique history in slavery, civil rights, and agricultural production. Thus, it is believed that the "southern roots" of respondents played a key role in the demographics of the study population and study results. This section examines how the geographic location of participants impacted their notions of identity, experience, and dietary choices and preferences throughout the years.

During the life history interviews participants told me their birth date and birthplace, putting a great deal of emphasis on their "country" upbringing in rural areas of the South. When asked the significance of being a southerner, or being from the south, one male participant 68 years of age, born and raised in Tennessee, but living in Chicago and Ohio at different points throughout his life stated:

> Being a southern boy meant you had a country flair. It's different from northern style. In the north people do things like clockwork…wake up, get ready, drink coffee. The south is slower and laidback. We might get up in the morning, fix breakfast that the whole neighborhood can smell, sit on our porch, and visit with each other. There ain't no rush.

Similarly commenting on her southern identity, an 84-year-old woman from Georgia said, "to be a southern woman is to be a strong lady. I can do a lot of things that others can't do. To be southern is really just enjoying where you are from…It's just in you, it's where you from." For many participants, being from the south was a badge of honor, but they admitted that they had not exactly thought of why being a southerner was any better than if they had been from the north, but "like all things, it did matter" (67 year old female respondent).

As mentioned previously, Sweet Auburn Avenue and the Civil Rights Movement, as it occurred in Georgia, had a profound effect on the childhood and lifestyles of participants that lived in Atlanta and its surrounding cities from the 1950s on. All life history interview participants that did attend school, whether in the city or country, noted that their schools were all black. Drawing attention to the difference in life experiences between the north and the south, one man born and raised in Tennessee before moving to Ohio during high school noted, " the schools I went to in Tennessee were all black, but when I moved to Ohio they were desegregated causing many problems for me. We had better stuff in the school in Ohio, but my teachers picked

on me a lot and held me back a few grades, but before in Tennessee I was the smartest in my class and got moved from the 3rd to the 6th grade one year." Reflecting on the role racism and discrimination played in their lives before the Civil Rights Movement began and the consequences of the Jim Crow Era in the segregation of blacks and whites throughout the United States, participants had interesting, yet mixed emotions regarding the impact of racial inequalities and discrimination.

Only one male life-history interview participant gave intimate details of specific incidents of racial discrimination that directly affected him as child, stating:

> "Up until I was 12 we lived on a plantation. The son of the owner would always throw rocks at me, kick me, punch me. I couldn't and wouldn't do anything about it cause I was scared. It kind of turned me off from white people for a while I would say…but I know one thing, I ain't scared no more. They wouldn't kick or punch me today" (72 year old male participant).

Seeing that this gentleman grew up on a plantation, his admission does not come as a surprise. However, another participant, a woman of 89 years of age, that was the only other participant who reported having grown up on a plantation, felt as if racism or discrimination "didn't bother [her] growing up because [she] knew it as normal and felt race relations were controlled" (89 year old female participant). On the other hand, when asked about memories of her mother and father, this same woman shared that her "last memory of her father was that he went missing on the plantation when [she] was around 15 years old." She then went on to tell me that her "father heard that the white people on the plantation were coming to get him and kill him…cause lynchins' were happening a lot back then… so [her] father said his goodbyes to the family and ran off into the field so they wouldn't catch him, but he never returned and that's the last [she] saw or heard of her father… [Although she] still wonders what happened to him, [she] is pretty

sure those white men got him eventually" (89 year old female participant). The woman's two distinct statements contradict each other in interesting ways, just as two other men mentioned, "I didn't know nothing about it--black and white. My family never talked about it, but we heard things on the radio. Plus, there were all black students at my school" (71 year old male participant) and "[Racism and Discrimination affected my childhood] in Ohio, but not in Tennessee because I was never around white folks" (67 year old male participant). As exemplified by the quotes, the overwhelming consensus amongst life-history interview participants of how racism or discrimination affected their childhood can be summed up according to the response of one female participant that "It really didn't affect us at all because we were in an all black school and neighborhood. We just knew not to touch white folks' things" (66 year old female participant). As this participant indicates, African Americans knew themselves to be inferior to their white counterparts, but if they knew their place, their inferior status did not truly affect their everyday lives within their own community. Nonetheless, accepting their inferior status in society did in fact perpetuate social inequalities and apathy, an artifact of living in the post-slavery south.

Surprisingly, the majority of responses like those detailed above revealed an aura of resignation regarding the effect of racial tension and racial hierarchies that posed unequal opportunities for African Americans during the childhood of study participants. The detrimental effects of segregation within school, employment, health care, and resource acquisition did not appear to stand out as anything more than the accepted reality that "white folks just didn't want to be bothered by black folks back then" (72 year old female study participant). In addition to the disconnect between the presence of racial tension and its implications for equal opportunities,

participants shared their thoughts and experiences regarding racism and discrimination throughout the years as calmly as they answered questions about their favorite foods as a child or where they were born, completely accepting of the way things were and the things they were not able to accomplish as a result. Reading history books and coming of age in the current political climate of the United States of America, I expected the voices and visages of the participants to show remarkable discontent and outrage in response to this question, until one female participant of 89 years of age explained, "When you don't know any different, you don't know what it could be…It was our normal." This overall consensus among life history interview participants indicates that while discrimination and racism played an integral role within the lives of participants, particularly in the South, it is possible that African Americans themselves did not see it as a limiting force in their day to day lives, the outcome of their potential, or in their availability and quality of resources, such as food and health care. It is also important to note that of 8 life history interviews conducted; 4 males and 4 females with ages ranging from 89 to 66; as the age of participants decreased, the frustration and discontent with which they recounted the effects of racism and discrimination on their lives and the African American community at large seemed to increase, as evident in their facial expressions and personal tangents.

Additionally, participants were asked what they remembered most about the assassination of Martin Luther King, Jr., arguably the most prominent figure of the national and local (Atlanta) Civil Rights Movement, and how it impacted their identity and experience as African Americans in Georgia. All participants remembered Dr. King, Jr. as a man who was not afraid to take action and felt immense pain and hopelessness when he was killed, describing their emotions and experiences after his death as [crying] for weeks [and feeling] like no one was going to carry out

his work" (89 year old female participant). Asking participants' personal reaction and experiences following the assassination of Dr. King seemed to stimulate greater emotions of outrage, hate, and the detrimental effects of racial tensions within study participants than questions evaluating how racism or discrimination affected their childhood. For example, one male study participant described the assassination of Dr. Martin Luther King "as one of the most unbelievable, unthinkable things…[that] Made [him] hate the United States more than [he] already did" (67 year old male participant). Another participant remembered the exact occurrences of her day after the news broadcasted messages of Dr. King's assassination. She stated, "I felt real sad and I was working at a grocery store at the time as a cashier and an old white man came through my line right after we heard he was killed and said "MLK is dead, now what you gonna do?" (66 year old female study participant).

Questions of Dr. Martin Luther King's assassination were used to foreshadow how the lives' of African Americans changed after key accomplishments of the Civil Rights Movement and its inevitable turning point after the death of Dr. King. In an effort to better understand how the outcomes of the Civil Rights Movement increased access to employment, education and resources for African Americans, life history interview participants were asked, "If they recalled a shift in their diet during or after the Civil Rights Movement?" Only two of the eight respondents recalled that they did recall a shift in their diet for the better while the other six reported that they did not recall or notice a change. One of the participants noting a change in her diet after the Civil Rights Movement was also the oldest life-history interviewee. She declared, "My life wasn't as good as it was after the Civil Rights Movement, so of course [after the Civil Rights Movement] the quality of my food got better" (89 year old female participant). While this

study participant does not exactly elaborate on why or how her diet changed and food improved after the Civil Rights Movement, one can assume that due to "better employment opportunities for raising her 11 children," she had access to a greater variety of foods, more dispensable resources between her and her husband, and had "some type of rights for the first time" that improved her overall quality of life (89 year old female participant).

"Now that I'm Older": Family, Successful Aging & Advice for living

"It's inevitable [growing older], so it's a blessing"
~ 83 Year Old Female Participant

As one participant declares in the opening quote, growing older is an inevitable process of life for those that are fortunate or blessed to age. However, for many, especially younger generations, growing older is seen as an imminent process to be feared and despised due to higher rates of fair-to-poor health, limited social interaction, and declining mental and physical capacities that are seen to be the hallmark characteristics of old age. In order to better understand personal accounts of growing older from those that have aged and are deemed senior citizens by standards of the United States Federal Government, I asked each life-history interview participant the best and worst thing about growing older. Although I expected to ultimately hear of all the negative outcomes of aging, participants mostly reported positive emotions and pros about growing older, such as "I like getting older. It's a good advancement of life…I wouldn't wanna go back. The best thing is that I have a right to the tree of life, so if I die now I'd go to heaven…If I died before I'd probably go to hell" (67 year old male participant). Two female participants appeared to agree that being alive at any age, was better than not having life at all, supported by their statements "I love it. I'm here." (89 year old female participant) and "The

hardest thing is just aching bones, otherwise I just been blessed. I never thought I'd get this old…" (66 year old female participant).

According to 25% of life-history interview participants being able to see their families grow and basking in the accomplishments of their children and grandchildren was notably the most enjoyed part about growing older. As one male participant described, "the best thing about growing older is to see my influences on my children's children" (67 year old male participant). Expressing her similar viewpoint, one woman explained, "The best thing about growing older is enjoying grandkids, and guiding them" (72 year old female participant). Unfortunately, for one life-history interview participant, seeing his family grow with grandkids and great-grandkids was not solely a sense of pride and happiness as he grew older, as he revealed, "The hardest thing about growing older is being disconnected from family, never seeing them or them including me in their lives, and the best thing is to just still be living—I'm the oldest of my siblings, but the only surviving one" (72 year old male participant). In addition to shifting family dynamics that are seen as a result of aging and will be described in more detail in the following section entitled "Family Roles," "limited resources" was the only other reported hardship of aging. As one woman noted, "the hardest thing [about getting older] is not financially being able to go to doctors to even keep yourself healthy…" (72 year old female participant). Another participant meaningfully put it that " growing older is like a double edge sword, the best thing about it [growing older] is that you get to do what you wanna do, but the hardest thing is taking care of yourself" (71 year old male participant). Overall, participant comments call attention to the irreplaceable role of family for many senior citizens, eluding to the positive implications of social connectivity that nurture successful aging. Even though most participants displayed feelings of joy, pride, and satisfaction when telling me about their family, most did not mention

being able to depend on family for financial support when they suffered from scarce resources. In fact, about 50% of participants mentioned lending financial support to their children and grand-children during times of need, further diminishing their financial resources for grocery and medical expenses.

Family Roles

The presence of family in the life of senior citizens has been associated with high levels of sociality and a key determinant in the ability to age successfully (Cherry, et al. 2013). 38 of the total 39 participants reported that they were not married and lived alone. However, most participants noted that they were still in contact with family, with 75% reporting that they had family that lived close by, mainly children and grandchildren. Men comprise the majority of the population at Wheat Street Towers and were observed to participate most in daily unorganized social activities, such as shooting pool, gathering outside to smoke, and conversing with neighbors in the lobby and community rooms. Overall, they were found to be less in contact with their children and more independent in securing resources. The women living at Wheat Street discussed seeing their children regularly and depending on their children for food and transportation. Many of the women also reported that they frequently went over their children's' houses to help cook for holidays and celebrate special occasions. This finding supports the common belief, as detailed in the literature review, that women are found to remain more of an integral part of their children's lives as they age compared to men. Delineated by men and women, **Figure 2** displays the results of the participants when asked whether or not they had family that lived close by. In addition, upon finding difficulty securing women survey participants, I was told by Wheat Street Towers administrators that most women living at Wheat

Street "would not be found hanging around the lobby and might be hard to flag down, since many of them left early in the morning to attend exercise sessions and other activities held at the senior citizen community center up the road." The daily schedules of female residents at Wheat Street Towers, which include high rates of social connectivity centered around healthy activities such as exercise, grocery shopping, and community field trips as detailed by Wheat Street personnel, may be one possible explanation as to why women of the African American community tend to outlive men, even when suffering a higher burden of chronic disease.

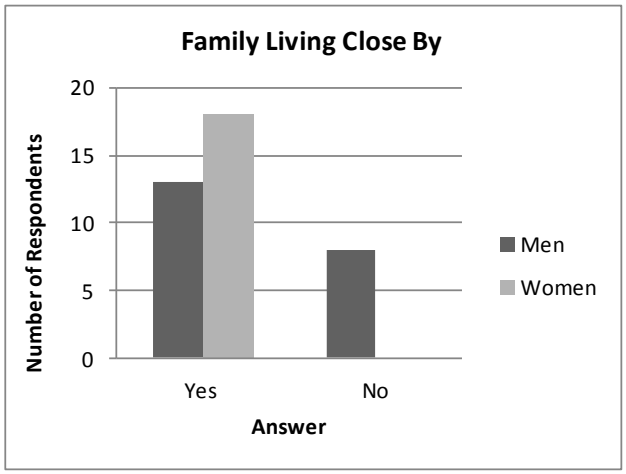

Figure 2: Number of Participants with Family Living Close By

Aging Successfully and Advice for Living

Concerns and beliefs surrounding aging are central to this project. Although most participants have favored growing older, it is questionable if they have indeed aged successfully in terms of their health, sociality, and resources. Even though it is beyond the scope of this study to evaluate participant health and resources in totality to deem one truly successful or unsuccessful in terms of aging, participant comments on successful aging provide insight on how personal notions of successful aging may impact lifestyle choices and health outcomes.

According to the eight African American senior citizens asked to define the secrets of successful aging, aging successfully was strongly dependent on "honoring God," "treating people right," and "helping others when you can" for all life-history interview participants. However, before mentioning habits more commonly thought to be keys of successful aging, such as "keeping busy," "exercising a lot," "going to the doctor regularly," and "being careful of what you eat," 75% of life-history interview participants announced, "minding your own business" was key to aging successfully. Although seemingly contradictory to their initial suggestions of treating people right and helping others, most participants found minding your own business to be especially useful in situations regarding illegal matters and disagreements amongst others. For example, in commenting on current rumors of illegal drug practices occurring at Wheat Street Towers one participant told me that "she reads God's word every day and keeps out of all that other mess…It's best to mind your own business, keep away from stuff like that, and just pray because those type of people will only bring you down with them" (83 year old female participant).

Participant beliefs regarding successful aging call attention to high levels of religiosity found in the African American community, especially in older generations. It also reveals that while some participants did note that exercise, diet, and simply taking care of yourself were important in order to age successfully, for many aging successfully relied on "golden rules," such as doing unto others as you would have others do unto you. One participant commented, "God said a disobedient child's age will be shown. So honoring and respecting people is necessary for successful aging" (67 year old male participant). Another participant equated financial stability and resources into her secret for successful aging by stating, "You must work, take care of

yourself, and tell the truth" (89 year old female participant). All in all their responses reinforce the varied emic meanings behind successful aging beyond what it means to be without ill health. They also depict cultural influences that define health beliefs beyond etic practices a medical provider or organization, such as the Diabetes Association of America, might suggest or take into account for one to age successfully in terms of preventing and effectively managing diabetes and its complications.

In order to further assess the health beliefs of African American senior citizens, participants were asked to share their best piece of advice for living, so I, as the 22 year old researcher, might live to be their age in good spirits and health. Suggestions included the following:

- Know how to treat others as you want to be treated
- Work
- Be honest, truthful, and faithful
- If you can do something in life, do it
- Love the lord and mind your business
- Keep drugs out of you, and live a clean life
- Take care of your health

The recommendations of both men and women overwhelmingly depict that African American beliefs concerning longevity are grounded in the navigation of social relationships and supernatural factors, complicating weight and diet modifications that might lower the prevalence of metabolic disease and other disorders in the African American community. Nevertheless, their suggestions such as "taking care of your health" and "keeping drugs out of you to live a clean

life" are strong indicators of physical health that directly correlate to community health. Participants also illustrate their own notions of the importance of personal relationships and social connectivity for living a long, healthy life by instructing me to "treat others as you want to be treated" and to "be honest, truthful, and faithful."

As senior citizens born, raised, and currently living in the South, their commentary suggest that their lived experience during a time of high racial tension and discrimination has not left a strong negative impression on their memories. In fact, most memories were centered on family. All participants proudly revealed the importance of family throughout their lives. Family, which has also been found to be a prime indicator of elderly sociality and well-being, was especially demonstrated in the lives of female residents at Wheat Street Towers. Although "family," or witnessing the expansion of family, was noted as one of the most enjoyable aspects of growing older, participants did not actually link the role of family to their ability to age successfully or high rates of sociality in society. Instead, according to participants, valuing and honoring religious doctrine and morals were the most important factors to successful aging, depicting differences present in emic and etic understandings of what it takes to age successfully. In the next chapter, "Food & Culture" the lifetime experiences of participants and the role of family will aid in depicting participants' background, age, and socio-economic status as they relate to cultural norms, food access, food quality, and every day dietary practices.

CHAPTER 3: FOOD & CULTURE

Gathering information on the backgrounds, identities, and experiences of senior citizens was only one facet of this study. The personal stories and information from chapter 2 provide a glimpse into the lived history of study participants. Their age, experience, and beliefs reinforce the authority with which African Americans 65 and older have in deconstructing African American dietary traditions and noting shifts in their diet that possibly reflect agricultural shifts in the US at large. This chapter will offer insight on the cultural significance of African American dietary traditions that have been passed through countless generations, personal associations with food, and the current dietary practices of African American senior citizens living in low-income circumstances according to my study participants.

African American Dietary Traditions Explained

When asked the ultimate question, "What is your definition of "Soul Food" and how is it different from southern food, or foods symbolically linked to the south, such as fried chicken, okra, and more?," one woman eloquently noted:

> [Soul food] is collard greens, mac and cheese, ox tails, yams, chicken, okra, and corn. It's [soul food] so important to us [African Americans] because that's all that I'd or any of us had ever known, especially my generation and those before mine. But soul food and southern food is very neck and neck, soul food is just more grease-like. Well…I think soul food is more grease like. Like I said that was really the only thing we ate growing up because that's all we had. Southern food is just a healthier way to name it [soul food], ya know for the white folks when they started eating it. But see, I think it's different in the way that most black folks when I was growing up had to eat it…it was our diet, so became a part of our cultural soul. White folks liked it, but they didn't have to eat it…they had options that we didn't (66 year old female participant).

As the participant explains, African American dietary traditions, most commonly referred to as "Soul Food," have a distinct historical origin for African Americans and play an integral role in

African American culture. In addition to the above foods mentioned by the participant, other participants included black-eyed peas, dressing, fat meat, pig feet, pig ears, corn bread, banana pudding, and German chocolate cake as part of their definition of soul food. Nonetheless, nearly all participants agreed that they believed soul food was so important to African American communities because "it is what people's grandparents, great-grandparents, and great great-grandparents were brought up on because that's what the white man gave [them] to eat" (71 year old male participant). One life-history interview participant summed up the definition and cultural significance of soul food to African Americans as, "it's what we ate, it's what we eat, and it's what we will eat" (89 year old female participant). Although her argument seems to stand true for soul food's role in African American communities, it is important to note, that today, soul food generally graces the table during holidays, celebrations, and Sunday evenings, rarely comprising the daily diet of African Americans as it may have during the childhood of study participants. However, soul food's history and customary presence emphasizes the role of food in culture, comfort, and memories. Thus, it comes as no surprise that while study participants may have different ideas of what soul food is, how it is prepared, and why it is eaten, 97% of study participants ultimately agreed that food plays a significant role in African American culture. In expounding on this statistic, one study participant exemplified a recurrent theme by stating:

> Cause [food] was the only, first thing [African Americans] really had to make something of our own from…. like soul food, or to give to our families. Like, when my kids were growing up I maybe couldn't always buy them stuff, but I cooked to show my love to my family, especially my blackberry pie. Food will always be important to us cause it always has been. Sometimes you didn't have [food] at all and other times that's all you had, so in both situations food was always on your mind you know, so food will always be important to us, [as African Americans] because it always has been (92 year old female participant).

Food Association Results

The intersection of food and culture is not a unique phenomenon reserved for African Americans. As in any culture, the role of food in African American culture is highly related to other specific cultural factors, and sometimes stereotypes, that impact the cultural community, such as collectivism, religion, and ideal body image. Common and collective soul food practices are as much a product of pride as they can result in cultural descent. In an attempt to unveil the significance of soul food for African Americans and to highlight the distinction between the cultural significance of soul food and its current occasional consumption, study participants were asked to indicate anything they believed to be associated with the foods they regularly consumed and soul food from a given a list. The results are shown in **Figure 3**.

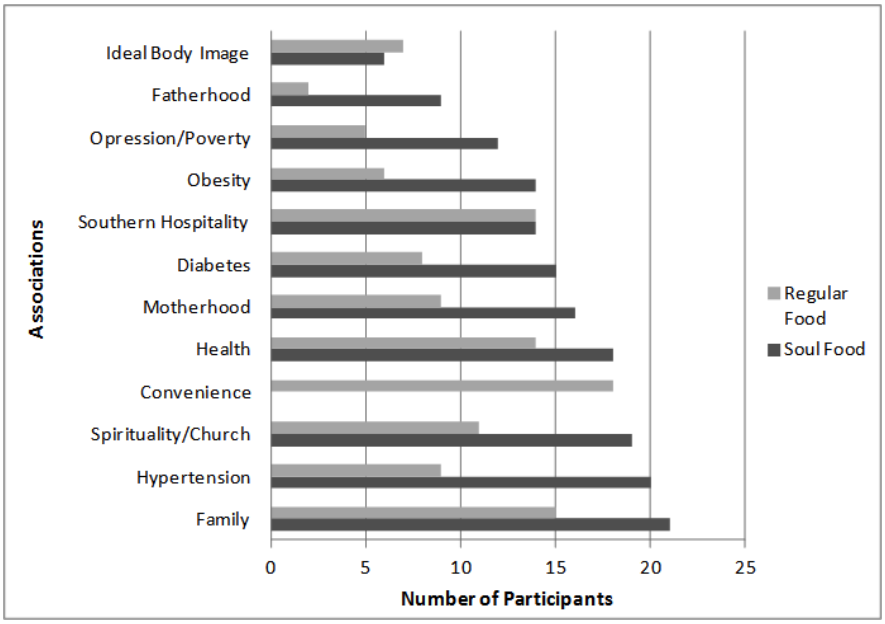

Figure 3: Food Associations

*Participants could select more than one checkbox, so numbers may add up to more than 39

Figure 3 shows study participants highly associated soul food with family, hypertension, and spirituality or the church. Providing more insight on these associations study participants all seemed to agree that "cooking and eating soul food was not the same without family, rather it be your husband [or wife], kids, and other relatives, or with your church family on Sundays or other events held at the church" (83 year old female participant). It is likely that hypertension also topped the list because of the increasingly high meat content and cooking techniques of soul food, and the prevalence of hypertension within the African American community at large. As one participant mentioned, "our [the African American] community loves pork and that plays a big part in our illnesses and how we season our food with lots of salt" (89 year old female participant). Unsurprisingly, fatherhood and attractive body image were the least associated with soul food and African American culture. Participants shared more details on this low association by emphasizing how they "missed their mother's cooking" and "never had to think about if they would gain weight by what they ate growing up because there weren't many options and black people didn't too much care about what you looked like…sometimes the bigger the better, especially to the old folks that would force you to eat, eat, eat" (73 year old female participant).

Regular foods of participants' everyday were highly associated with convenience, family, southern hospitality, and health, revealing the more apparent role of circumstance than culture impacting the daily dietary patterns of this particular group of senior citizens. While nearly all (94%) participants stated they had a limited income to spend on food and only 10% reported having access to a personal vehicle to drive, it comes as no surprise that convenience played a significant role not only in what they chose to eat, but also in what they had access to eat. The other 89% of participants that did not drive or have access to a vehicle at their leisure described

relying on their relatives to either bring them groceries or take them grocery shopping "whenever [the relatives] had the time to do so," supporting the high association between family and regular diet (65 year old female participant). In regards to southern hospitality, a few participants described being the recipient of food provided by Meals on Wheels, church groups, or other organizations that periodically came to serve and distribute "plates of food for free or really cheap about once a week" (73 year old male participant). Study participants believed these actions to be "real nice" and an outcome of southern hospitality because "that's how it is here, in the south we try to help each other out, and the people that come to give us food are real nice to do that, even though it ain't always that good or anything that you would want to eat every day, it's nice and southern, so you take what you can get, and don't complain" (69 year old male participant). Based on my conversations with study participants and weekly observations, male residents presumably depended on Meals and Wheels, a free senior meal assistance program, more than female residents. Female residents seemed to be more willing to pay a small fee for soul food dinners provided by various organizations. Even on a limited budget they are willing to pay for the type foods that they once enjoyed preparing for their families. This observation suggests that African American women experience a greater emotional contentment from soul food than African American men, which is likely due to the African American woman's role in the kitchen. Furthermore, dependence or participation in either forms of meal assistance programs seemed to increase as the age, physical disability, and family disconnection increased. Last but not least, health seemed to be one of the top associations with participants' regular diet due to health restrictions on what they should eat or could no longer eat based on doctor recommendations.

Shifts in Food Quality

Information on the availability and quality of food throughout the lifetime of African American senior citizens is directly related to health beliefs and current health challenges which foster low rates of successful aging. In order to answer research questions about how the quality and availability of food has changed within the last 65 years, participants were asked to rate the quality of the food they consumed as a child. The results are presented in **Figure 4**.

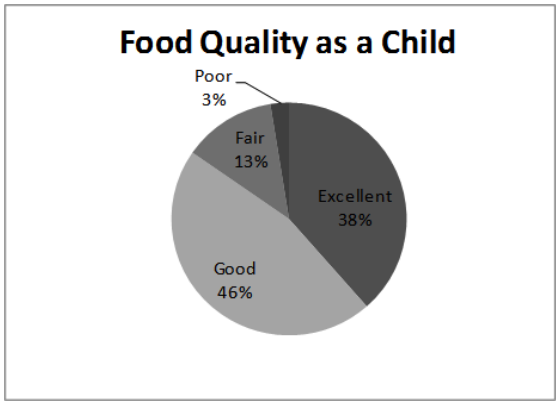

Figure 4: Ratings of Food Quality during Participants' Childhoods.

Participants were then asked to describe if they think the current quality of food has changed since they were a child. A very high percentage (92%) of participants gave an affirmative response when asked this question. Describing why they thought it had changed in brief details, a 72 year old male responded; "Now everything is already made." A 72 year old woman reported, "During the time I grew up everyone cooked…now you are more conscious of what you eat because you buy it from the store, when I was growing up everyone grew their own so you didn't worry too much." Most responses regarding shifting food quality agreed "food is grown too fast nowadays and doesn't taste the same cause of all the chemicals and pesticides they put in it" (72 year old female respondent). Their responses illustrate the common beliefs regarding current

practices of the U.S. agricultural system, the industrialized production of food, and the increasing dependence on convenient, pre-packaged, "fast-foods."

Other responses detailing why or how food quality has shifted over the past 30 or more years included different cooking techniques. For example, one participant shared, "nobody can cook like my momma could, I can hardly boil water myself, so naw I'm not eating as good as I used to" (73 year old male participant). Reporting "the rotten smell of food that fills the house while cooking these days, that used to smell so good it would wake you up drooling at the mouth," the different aromas of food was one of the key indicators that the quality of food had changed for one woman (78 year old female participant). This reveals that the shift in food quality observed by study participants was not only negative on the basis of food freshness. Although a minority viewpoint, some participants believed that the quality of food had shifted in a positive direction over the years. For example, one man gave his personal explanation as to why he believed food quality had improved, sharing, "[Food] quality has changed in the sense that I can buy what I want now, since I'm not as poor as I used to be, or have to depend on my momma's food stamps that had to provide for all my brothers and sisters growing up" (72 year old male participant). Thus, for some, food quality, quantity, and access are direct correlates, while for others the increased quantity and greater access to food has actually resulted in poorer food quality, as one man mentioned "as food became all about the buck, how much money they could make, I started to notice higher rates of food contamination recalls that I never heard of before" (68 year old male participant).

In addition to higher prices and notable distance traveled by food (no longer mainly grown right in one's own backyard), participants seemed to rely on the taste of food as a key

indicator of the decline of food quality. Many were in agreement that "food just don't taste like it used to…the flavor of it is so different that you can't even really enjoy it" (73 year old female participant). Thus, while their observations may in fact support that food quality has declined since their childhood, it must be noted that a true measurement must be based on more than taste. This is particularly important in regards to senior citizen communities given the declining sense of taste with age, illness, and medication. The 7% of study participants disagreeing that the quality of food has changed since they were a child did not provide any further explanation except that they "are still able to eat what they used to eat," aligning more with the availability of food than with the quality of food (67 year male participant). On the other hand, one participant noticed that although "food was easier to come by for most blacks cause you could just run to the market and not have to do all that dirty work on the farm, the quality of food had gotten worse" (73 year old male participant).

Study participants' acknowledgements about the diminishing quality of food as they have aged cannot be disassociated from their limited access to fresh foods. Unfortunately, food insecurity, or the inability to regularly eat healthy and nutritious foods, is a commonplace predicament affecting residents at Wheat Street Towers. Even though study participants did not personally define themselves and co-residents as "food insecure," they often made statements, such as:

> Well, you can't do much with the little pocket change of food stamps you get each month, especially with prices being so high in this neighborhood. Even when you really try to stretch out your food over the month there's just no way you ever have enough. And with what they [the U.S. Government] give you, I definitely can't shop around here for stuff cause it's just too expensive, don't make no sense! So usually, I wait for my daughter to come take me to the store, like Wal-Mart or even Kroger….she always gets mad at me for taking a long time to shop, but what she doesn't understand is that I can't

> just throw stuff in the cart. No. I have to take my time you know or else I would really starve at the end of the month (72 year old female participant).

An analysis of the participant's statement indicates that the less than $30.00 of food stamps all 39 participants reported receiving each month plays a direct role in their restricted access to food. Access to fresh and nutritious foods is distinctly affected by financial constraints for Wheat Street Towers residents, who more often than not, do not have constant reliable means of transportation to avoid "the darn ridiculous prices and just bad looking fruits and vegetables" offered in the grocery/market establishments surrounding Wheat Street Towers (78 year old male participant). Thus, with a fixed income and "sometimey means of [transportation]" African American senior citizens living at Wheat Street Towers do not only notice a change in the quality of food since childhood, but they are also deprived of accessing fresh and more nutritious foods.

"I eat, what I eat": Favorite Foods & Dietary Practice Determinants

Using food as a lens into culture, human behavior, and health, individuals were asked to report their favorite foods as a child and their current favorite foods. Although regular diet composition will be discussed in greater detail in chapter 4, outlining the favorite foods of participants provides insight into how culture and ecological surroundings influence not only what one enjoys eating, but also the physical and emotional comfort gained from consuming certain foods. When asked to tell me their top favorite food, most study participants could not resist telling me that their favorite meal would consist of "chicken, chicken dressing, collard greens, macaroni and cheese, and cornbread." The foods included within their favorite meals directly correlate with African American "soul food" dietary traditions. The majority of answers to "what was your favorite food as a child?" surprisingly included vegetables, such as okra,

greens, corn, tomatoes, and sweet potatoes. Fish, fried chicken, and bacon were the only meats reported as childhood favorites. A small percentage (28%) of study participants noted foods thought to be "classical favorites" of children, such as Oreos, Cheerios, grits, cake, pudding, and ice cream as their favorite childhood foods. Seeing that vegetables comprised 71% of survey participants' favorite foods, it is probable to assume that the majority of survey participants would agree that "living in the country [they] ate whatever mama put on the table and enjoyed eating food fresh from [their] or [their] neighbor's own farms and gardens" (73 year old male participant).

Approximately half (51%) of foods reported as childhood favorites remained as the current favorite foods of study participants. Turnip and collard greens, black-eyed peas, chicken, and macaroni and cheese were the most consistent favorite foods throughout childhood and adulthood. The other half of study participants reported a shift in their favorite foods from childhood to adulthood. As one participant shared, "chicken was his favorite food as a child, but [he] done ate so much of it, now he can't stand it" (87 year old male participant). One woman, who reported bacon as her favorite food as a childhood, told me "bacon now-a-days taste, smells, and feels so much different compared to what we'd get from the family butcher when I was kid that I can't even eat it now" (66 year old female participant). Ice cream was the only "snack food" that remained a favorite from childhood throughout adulthood. Taste was seemingly the biggest factor that influenced favorite foods of adulthood amongst participants. It should be noted that many participants recalling why their favorite foods during childhood had changed during adulthood often mentioned "that nobody could make it like my mom or grandmom,"

whether it be her spaghetti, dressing, or mix of okra, corn, and tomatoes (78 year old male participant).

An analysis of participants' favorite foods accurately depicts taste preferences, but does not illustrate how often participants are able to eat their favorite foods due to factors of cost, accessibility, and health restrictions. Thus, it was only appropriate to further ask study participants what factors influence their regular food choices. Results are shown in **Figure 5**.

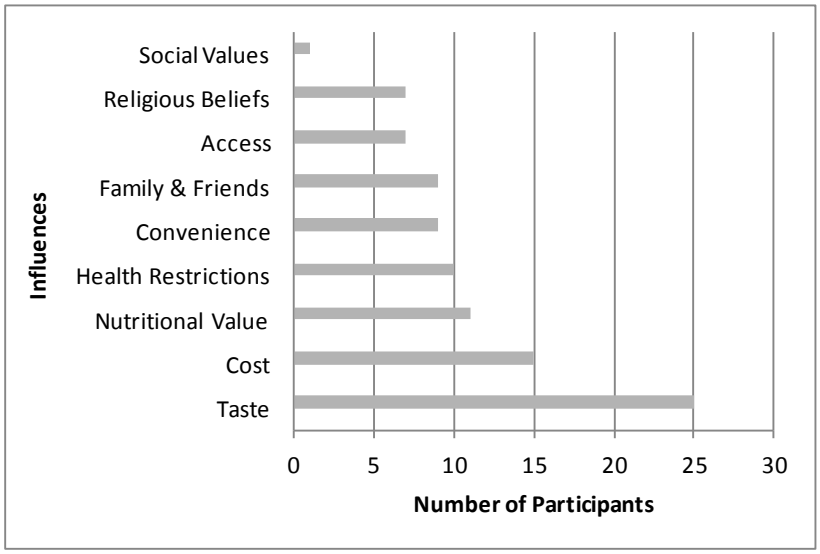

Figure 5: Influences on Regular Dietary Choices

*Participants could select more than one checkbox, so numbers may add up to more than 39

As expected, taste was unquestionably the biggest influence on study participants' food choices with cost as the 2nd greatest indicated influence. With a limited income and only about $20 a month in food stamps to spend on food and "food as the last priority" in a monthly budget consisting of "rent, church tithes, life insurance, clothes, if needed, and health cost," it comes as no surprise that the cost of food is one of the top determinants of what one decides and can afford to eat (67 year old male participant). Given that 29% reported health restrictions as

influencing their food choices and 31% reported the nutritional value of food as a determinant in what they choose to eat, it is clear that the majority of study participants "do try to do better and listen to recommendations made by the doctor, even though affording the healthier stuff is hard most times" (73 female study participant). During survey and life-history interview questions related to familial relationships, many study participants shared, "that they would just wait to see what their children, grandchildren, or nieces and nephews might bring them to eat during any given week, since they were not able to afford to really go grocery shopping at the Edgewood Market," explaining why 26% of study participants reported that family and friends influenced their food choices (78 year old female study participant). Only one study participant reported that social values influenced their food choices. This finding is expected since the majority of study participants reported frequently eating alone and rarely eating outside of the home for anything more than fast food to-go. With only 7% of participants listing access as an influential factor in what they choose to eat, it is questionable as to whether those that selected or did not select access deem their specific access to fresh, quality foods as satisfactory or in need of improvement.

Access to quality, fresh foods heavily influences what one chooses to eat and how often they eat. As exemplified in this chapter the questions and participant responses draw a distinction between food access and food quality. Overall, 88% of life-history interview participants denied that there was a limited amount of food in the house while growing up, but that they are currently facing food insecurity on regular basis due to insufficient monthly income and nutrition assistance, such as food stamps, highlighting issues of food access. Additionally, a 100% of life-history interviewees noted that the current quality of food had decreased since their childhoods.

Thus, the African American senior citizens living at Wheat Street Towers are currently facing a greater burden of food insecurity in the latter years of their life than they did during childhood and observe a decline in the quality of food. Dietary composition and disease prevalence as it relates to Wheat Street resident's lack of access to quality, fresh foods will be presented in the next chapter.

CHAPTER 4: DIET & DISEASE

In addition to collecting information on the dietary habits and food preferences of senior citizens at Wheat Street Towers, I hoped to discover the most prevalent chronic diseases affecting residents 65 and older. With high rates of diabetes and hypertension affecting the African American community at large, I expected to learn that most study participants would have experienced a diagnosis of one or both of the chronic conditions. Thus, interpreting participants' health beliefs and their perceived connection between diet and metabolic disease was an important objective of this study. This chapter exposes the most common chronic medical conditions at Wheat Street Towers, the composition of participants' regular diet, the intimate relationship between study participants' dietary practices and disease management, and their beliefs concerning the correlation between diet and disease.

Diet Composition & Quality

As presented in chapter 3, food plays an integral role in the lives of senior citizens at Wheat Street, functioning as both a source of sustenance and a material form of culture. Although African American dietary traditions, most commonly referred to as soul food, hold special significance to most study participants, such 'cultural cuisine' is rarely eaten on a daily basis. Therefore, it was necessary to explore the daily diets of African American senior citizens, particularly those living in low-income housing within a designated food dessert.

When asked "what do you eat most often?" from a list including vegetables, fruit, highly processed foods, meat, fish, poultry (chicken & turkey), and sweets, an overwhelming majority of participants answered that their diet mainly consisted of vegetables. However, participants' side commentary regarding the question revealed that while vegetables were the main

components of their diet, this did not necessarily mean that the participants were consuming fresh vegetables. Surveys show 64% of participants disclosed that "canned vegetables were one of the cheapest things to buy" and "didn't require much work cooking-wise" (82 year old female participant). A lacking appetite and diminished sense of taste also seemed to influence participants' decisions to opt for canned vegetables, as one woman put it, " I can't hardly taste nothing no way, so I just go from one can to the next…none of it taste too good, but I don't really care no more" (89 year old female participant). Fruit and poultry were the second leading food groups that participants reported eating most often, with oranges, apples, grapes, and chicken being the most common items consumed out of the two food groups. On the other hand, only 2 of the 39 participants reported eating sweets most often. More surprisingly, none (0%) of the participants reported eating highly processed foods most often, contradicting the participants' reveal of "snacks eaten most often." It could very well be possible that "highly processed foods" were not eaten most often as indicated study participants. However, given my observations and stories told by participants about having "to get whatever's cheapest and will last the longest each month," I suspect that lack of awareness about what food items are considered to be "highly processed" best explains why no participant reported that the majority of his or her diet consisted of highly processed foods.

As previously mentioned, the snacks eaten most often by the 39 surveyed participants mainly consisted of items high in sugar, fat, and salt content, and would fit the common classification of "junk food" (i.e. highly processed foods). Chips, skins, ice cream, honey buns, chocolate chip cookies, cheese crackers, and peanut butter cookies were listed amongst the most often eaten snacks. It is also worth mentioning that these were some of the cheapest and most

abundant food items sold at convenient stores and gas stations within walking distance of Wheat Street Towers as briefly outlined in **Table 2** provides a comparison of the costs of healthy and nutritious food choices versus processed or "junk food" options at the stores closest to Wheat Street Towers.

Table 2.
"Healthy Food" Costs vs. "Junk Food" Costs at Stores Closest to Wheat Street Towers

Junk Food Item	**Price**	**Healthy Food Item**	**Price**
4-pack chocolate cupcakes	$1.00	2 oz. Fruit & Nut Trail Mix	$2.99
1-liter Fruit Punch	$0.99	16.9 oz Bottled Water	$1.59
2 oz. Bag of Chips	$0.59	1 apple	$0.69

Table 2 accompanied with the participants' remarks suggests senior citizens are more likely opting for the unhealthy food choices in order to "make their money stretch" (67 year old male participant). When speaking on their snacking habits most participants would agree with one man's statement concerning his intake of prepackaged chocolate cupcakes, that "I eat them [chocolate cupcakes] and forget about real food" (66 year old male participant). Many participants further explained this scenario by stating, " that [they would] snack on things they probably shouldn't throughout the day just sitting around since they didn't have too much more to do" and "snacking just seemed to be easier than cooking when you by yourself and don't have much money for big meals" (92 year old female participant). Therefore, given survey statistics and participant excerpts it is very likely that the foods indicated as eaten most often by participants were not reflective of their true everyday diet, since most participants rarely spoke of buying such foods or eating such foods throughout the day due to snacking habits. While I do not

deny that participants do eat the foods they mentioned eating most often, it is possible that these are the foods they either think they should eat more of or wish they could eat more of if not for budget and accessibility constraints. Furthermore, although popcorn, oranges, and apples were some of the healthier snack choices, vegetables were never mentioned. However, in about 77% of cases wherein participants reported less healthy snack choices throughout the day, such as chips, cookies, crackers, chocolate, and pie: "Now, I'm really not supposed to be eating this but I still do" was the most common introductory phrase and was often closed out with: "But it's still a lot better than [what I used to eat]." The other 44% offered no interpretation of their snack choices as good or bad options and neither healthy nor unhealthy.

Participants reported drinking water more often than soda, juice, alcohol, or 100% fruit juice. In surveying what participants drank most often, I specifically differentiated the consumption of juice and 100% fruit juice in order to fully understand the average diet of participants. Although 9 out of the 39 participants, or 25%, reported drinking juice most often, 0% reported drinking 100% fruit juice. Minute Maid, Hawaiian Punch, and Tropicana were the top three reported juice products consumed by participants. Although nutritionally better than the 8% of participants who reported drinking soda most often, this finding on juice consumption is particularly important given the high amount of high fructose corn syrup found in each of the products, which negatively impact the prevention and management of chronic metabolic disease.

Overall, 69% of participants ranked the quality of their current diet, in terms of their food choices, as good or excellent. **Figure 6** provides more detail. The feeling of having an excellent diet was especially common amongst study participants who reported having the least amount of health concerns. Those that did state they suffered from conditions such as hypertension,

diabetes, or high cholesterol, commonly reflected on the dietary habits they have tried to change since their diagnosis when ranking the quality of their diet. As one woman mentioned, "I'd say it's pretty good now, I can't say excellent because I still eat a lot of things that I shouldn't…like ice cream and ham, but I have stopped eating so much fried foods –I don't even cook'em no more, if I want a piece of fried chicken or something I just go get me a wing from the place up the street, so I can't say poor either…Yeah, I think its "good"(73 year old female participant). As the woman alludes to in her statement, evolving cooking techniques were a major point of reference for study participants as they rated the quality of their diet. With 54% of the study population agreeing that most of the food they eat is baked, many went on to say that "they had to stop frying so much of their food cause of their health, and now mostly baked everything even though it just didn't taste the same [baked], especially chicken" (68 year old male participant). One female participant eagerly specified that she "only cooks fried foods and things now when she goes over her daughter's house, cause ya know she don't know how to fry fried chicken like me" (73 year old female participant). The positive change in cooking techniques employed by study participants as they have aged or experienced changes in their health status is promising. This finding emphasizes that regardless of race, socio-economic standing, or age, study participants realize the need for change in their dietary habits outside of their dietary preferences and beyond what they can afford. Therefore, it is possible that with more economic resources and healthy eating options, food insecurity's role in the high rate of metabolic disease affecting the African American senior citizen population would greatly decrease as calorically dense foods are replaced with nutrient dense foods.

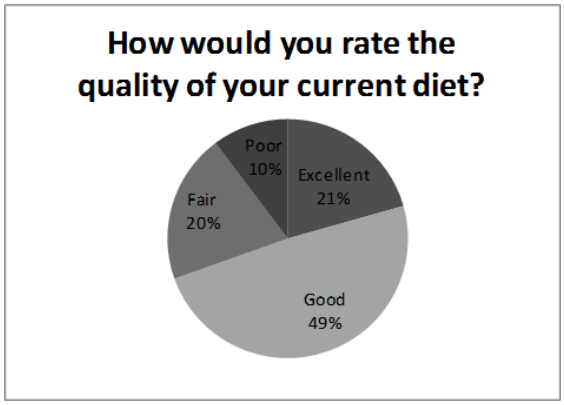

Figure 6: Quality of Current Diet

Most Prevalent Chronic Diseases at Wheat Street

Recent years have brought about a notable increase in the prevalence of obesity and chronic medical conditions, such as diabetes and hypertension. The elderly population is at greater risk for such conditions, since "the prevalence of obesity and metabolic disease increases with age, as lean body mass diminishes with age and adiposity increases (Wilson, et al. 2007: 119). Therefore, the health status of residents at Wheat Street Towers was an essential component of this study. In order to better understand not only how African American senior citizens perceived the connection between diet and disease, but also how their health fared in terms of successful aging, it was necessary to gather information regarding the study participants' experience with chronic disease. I specifically choose to ask participants if they had ever been diagnosed with diabetes, arthritis, hypertension, heart disease, or high cholesterol during the survey due to the increasing incidence of these diseases in the United States, their high prevalence in the aging African American population, and their association with inflammatory markers and dietary intervention as a form of disease prevention and management. The prevalence of the aforementioned diseases in the study population is presented in **Figure 7**.

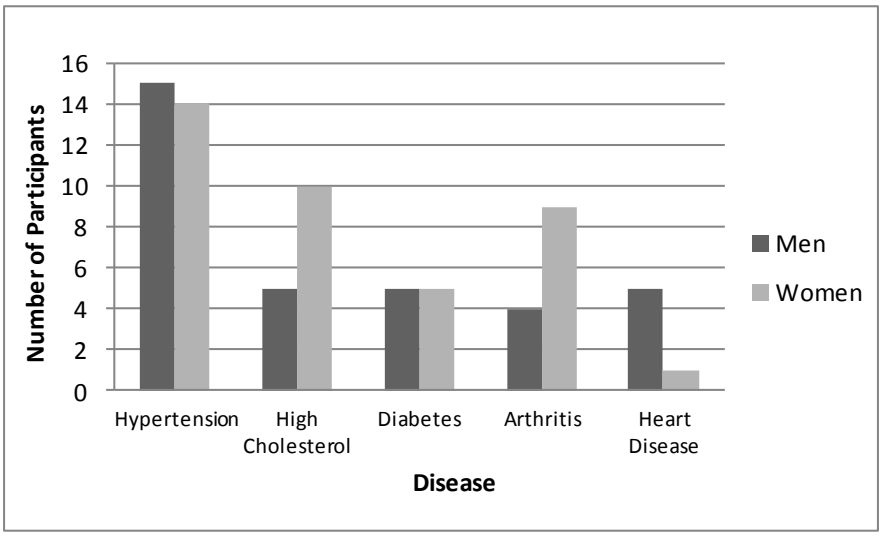

Figure 7: Prevalence of Disease in Study Population

Hypertension, or high blood pressure, accounted for the greatest burden of chronic disease amongst the 65 and older population at Wheat Street Towers. Consequently, it was the most common condition that participants spoke about during the life history interviews and survey collection. It was also the only condition that seemed to have affected individuals the longest with no observed complications or reported symptoms of concern. In study participants that reported having been diagnosed with "high blood pressure" at some point in their life, there was an overwhelming presence of co-morbid conditions, including diabetes, heart disease, and high cholesterol. Nonetheless, the asymptomatic nature of hypertension caused a great deal of skepticism in participants that had been diagnosed with the condition. One participant voiced his thoughts about being diagnosed with hypertension, stating:

> You never know with doctors now-a-days, cause I know I went to the doctor and had perfect health for years, but then he told me I had high blood pressure when I was like 64/65--right after my wife left me. But I felt fine and had no complaints. He told me that I did though and just told me just to take this little pill each day and that's what I've been doing ever since. I can't say I feel any different from taking it, so that's why I really can't

> say that diagnosis has changed anything because I felt good then and feel good now, but since he said take the pill, I don't miss a day takin' that pill I tell you! Because that's the only like health problem I have (72 year old male participant).

Others explained similar feelings regarding their diagnosis of hypertension and its effects on their health. Participants spoke about diabetes, like hypertension, in great detail, even though it directly affected only 25% of the study population. However, unlike hypertension, participants seemed to display a greater trust in their physician's diagnoses of diabetes and a better understanding of its detrimental health effects if left mismanaged. This was particularly true for female participants. 59% of women in the study disclosed that their husband's had died from diabetes complications. The occurrence of their husband's death from diabetes was a constant reminder that diabetes is highly associated with death, explaining why female study participants appeared to be more health conscious and vocal about lifestyle modifications after a diagnosis of a chronic metabolic disease than men, who did not report witnessing the demise of a loved one from any form of chronic disease or its complications.

While there was room for improvement in the dietary habits and physical activity patterns of participants living with any of the investigated chronic conditions, all participants seemed to adhere to regular doctor's appointments and medication instructions. Although it was not directly asked in the survey or life-history interview, participants collectively suggested that " besides giving [them] pills for the high blood pressure, the doctor did not really tell [them] anything more to do" (79 year old female participant). Therefore, according to their reports, lifestyle modifications, such as dietary changes and increased physical activity, were often disregarded by health professionals caring for members of this low-income, senior citizen population. This could be due to many factors, including physician disbelief that elderly patients will adhere to lifestyle

changes based on their age, or in the case of study participants, their average income and living environment. Nonetheless, the presence of such physician apathy in this population seemed to have a more profound effect on male and older study participants, who proposed the least amount of questions to physicians and had not made specific efforts for healthy living before their diagnosis of a chronic health condition. Unsurprisingly, for those (generally that were younger and/or female study participants) that were already taking steps to live healthier by "not eating as much salt or fried foods, working out when not too sore, and drinking lots of water" before being diagnosed or given prescription medication for their health condition, doctor's praised their efforts at each check-up appointment by frequently stating, "whatever it is that you are doing, keep it up!" (67 year old female participant).

Health Beliefs: Can We Say Diet and Disease are Related?

13% (5 out of 39) of study participants reported never having experienced a diagnosis of diabetes, arthritis, high blood pressure, heart disease, or high cholesterol. Of the 5, one was a woman and the other 4 were men, with all but two men believing that diet and disease were related. The remaining 34 participants were living with one of the aforestated conditions, and when asked, "If you consider yourself to have a health condition that requires you to change or restrict your diet?" 62% selected "No" and 38% selected "Yes." All participants, regardless of their experience with chronic illness, were then questioned on their beliefs about the intersection of diet and disease as I asked, "Do you believe diet and disease are related?" 59% of participants stated "Yes," while the other 33% stated "No" (8% stated "I don't know"). One may easily note the discrepant findings in this set of questions, and posit that if you agree diet and disease to be related, then upon being diagnosed with any chronic metabolic or inflammatory disease, then

you would consider yourself to have a health condition warranting a change in diet. As indicated by my statistical findings, this was not the case within my study population. This finding suggests that most African American senior citizens agree with and are knowledgeable about research emphasizing the direct correlation between diet and disease that has been highly produced in the last 15 to 20 years, even though study results concluded that it is rare for physicians to take the time to fully explain this correlation during regular doctor's appointments. However, they do not seem to fully grasp the correlation between their personal experience with chronic illness and their regular dietary habits. This could be for many reasons. As one man stated during his life history interview:

> Now we are finding out all of these things about how what you eat makes you have either good or bad health, back in my day, when I was growing up, you hardly even heard about these conditions because hardly nobody, especially black people, went to the doctor, so it's a lot harder to understand if my health is being affected by what I eat. The things that I was eating growing up that were seemingly healthy then are the same things I am eating now that are causing my high blood pressure. So, it's harder to say yes or no when I think about my diabetes and high blood pressure and my diet, but my doctor did tell me to change my diet so I guess in some form and fashion what you eat does have something to do with your health. At least that's what they say (74 year old male participant).

His statement helps distinguish the health beliefs that African American senior citizens actually believe and practice within their own lives and what others, such as physicians, tell them to be true. In speaking on how she manages her hypertension, one female participant stated, "I have high blood pressure, so I take one white pill a day. I think I could say diet and disease are related, but I have never been too concerned about changing my dietary habits since [my diagnosis] because the doctor told me to always take the pill. But I do try not to eat that much salt or grease, cause sometimes it just makes me feel not so well" (89 year old female participant). This participant's comment is suggestive of the immense rates of pharmaceutical intervention and

dependence that is commonly encouraged by medical professionals. In addition, her realization of certain foods making her "feel not so well" acknowledges the century's old fact that what you ingest can do biological harm to the body, producing symptoms of nausea and vomiting, but does not clearly affix the presence of her high blood pressure with certain foods. For example, one participant said, "well of course they are related because what you eat and put in your body can make you sick" (65 year old female participant).

The 59% of participants that believed diet and disease to be related gave varied explanations as to why they believed in the association. Many conceded that it "just really depended on the specific thing or disease" (81 year old female participant). For instance, "with diabetes, you have to be careful with the sweets. It's salt for high blood pressure. So it just depends, not everyone or everything is the same, so sometimes they [diet and disease] are, and sometimes they aren't" (92 year old female participant). This statement indicates the association most people, of any age or race, make between their dietary habits and health after being diagnosed with a disease. For others, it was simple, "certain things agree with your system and some things don't" (67 year old male). A few participants "leaned toward thinking they [were] related, but [couldn't] say for sure, since they have so much chemicals in the food now it's just slow death for everybody. That's just how it is now" (67 year old male).

Although the minority viewpoint, those participants that did think of themselves as having a health condition that required them to change their diet, reported effectively trying to do so. By reducing the amount of sugar, salt, and fried foods in their diet, participants excitedly boasted, "every time I go to my doctor he tells me to keep up the good work, so I say you have to eat a lot of veggies and fruit, drink lots of water, and try to exercise for 30 minutes every day if

you can" (72 year old male participant). After being diagnosed with hypertension and high cholesterol, one participant stated, "Of course [I've changed my dietary habits]. I eat oatmeal now, which I hate. And I try to eat more fruits and veggies. I loved, loved, loved bacon, but I've given it up because it's just not good for my blood pressure" (66 year old female study participant). In discussing his favorite foods and snacks, one participant with diabetes, hypertension, high cholesterol, and arthritis revealed:

> Now I feel like I should tell you I eat nothing but fruits and veggies, which I do sometimes, but it would just be a lie if I told you I eat them the most or even enjoy eating them. See, I love Oreos, cheesecake, and fried fish, my doctor don't like the fact that I like them, but I do. That's the truth. I am trying to do better though cause I know they aren't good for me, and I am, it's just taking me longer than some cause I've been eating them for so long… (67 year old male participant).

Even though this participant's efforts for dietary change were not as effective as many of the other study participants, he recognizes the relation of diet and disease and has been trying to improve eating habits since his diagnoses. Thus, this participant's honest comments may be the most important and promising fact about the recognized association of diet and disease after diagnosis. More specifically, while it would be ideal to recognize the association as a means of preventative techniques, many senior citizens have established dietary habits long before research findings on the correlation of diet and disease; thus, recognizing the need for change and being willing to change even in older age is assuring. However, as with any low-income, urban population, African American senior citizens living in the Old Fourth Ward of Atlanta are in greater need of personalized medical support and allocated resources in order to make national health recommendations for chronic disease prevention and management a reality.

Ultimately, it is plausible to link the prevalence of disease at Wheat Street Towers to both its geographical location as a food dessert and the low-income status of residents. Although study participants believe diet and disease to be related and understand the types of food they "should" eat, it is questionable if they are actually eating the foods they report eating most often when taking into consideration both their snack preferences and limited economic resources. However, based on the survey the majority believes they make good food choices from what is available in the area. As indicated above, this can be increasingly difficult with little income to match the inflated prices of fresh foods on Auburn Avenue; yet, this has not stopped many participants from making healthier lifestyle choices in areas they can control. Baking instead of frying foods is a perfect example. This change was highly reported amongst participants after being diagnosed with some sort of chronic health condition. Although fried food was preferred by most participants they learned to embrace baking techniques for the improvement of their health. It should also be noted that such a dietary change was not disadvantageous to their current economic resources such as buying fresh fruits and vegetables at the local market would be, since baking rather than frying food actually saves money (baking does not require the purchase of cooking oil) and time. This finding and others like it should be used to help remedy the high prevalence of chronic metabolic disease in the African American senior citizen population through imperative changes in physician-patient interactions, economic resources, and health guidelines as recommended in the concluding chapter.

CHAPTER 5: RECOMMENDATIONS & CONCLUSION

Aging members of the African American community are facing extreme hardships of poverty, food insecurity, and chronic disease. However, issues facing African American senior citizens, especially those located in the southern region of the United States, have not been given proper attention in previous research projects, possibly because they appear to be "getting by." However, just "getting by" is not advantageous for personal and societal health and well-being. Although there is an abundance of literature on African American culinary traditions, inequities facing African Americans in the south, the increasing prevalence of metabolic conditions within the U.S. and their association with dietary factors, current literature does not adequately address the lifetime experiences of African American senior citizens in relation to their current health beliefs, medical conditions, dietary practices, or lacking economic resources. This research project has aimed to fill the disadvantageous gap in contemporary research and literature. The goals of this research project were to ascertain the current needs and health beliefs of senior citizens while better understanding the following:

- How have food access and the socio-economic status of African American senior citizens evolved over the course of their lives?
- What is the correlation between socio-economic status and food access?
- How does the experience of chronic disease relate to oppression, health beliefs, food access, and dietary habits as observed in African American senior citizens?
- What is the significance of certain foods to African Americans?

- How have gender roles influenced lifestyle choices and familial relationships?
- What factors impact African Americans' ability to age successfully?

While information presented throughout the preceding chapters addresses the guiding research questions, it is my hope that the most pertinent information to guide positive change in the resources allocated, services provided, and recommendations made to aging, low-income, and minority populations was offered through several key findings. Firstly, food, especially soul food, has long been of cultural importance to African Americans, but its conventional preparation has been closely linked to metabolic disease (Liburd 2006 & Williams-Forson 2006). However, it is not eaten on a regular basis and cannot be the sole cause for the disproportionate cases of chronic metabolic disease in the African American community. Instead, regular, everyday diets of convenient and cheap foods are likely the primary cause. While habits are even harder to break without comparable options or the necessary resources, African American senior citizens are willing to make healthy lifestyle changes if recommended by a doctor or given the opportunity. As seen in this study population, residing on Auburn Avenue in Atlanta, GA, African American senior citizens commonly live in food desserts and are faced with detrimental budget constraints, which result in concerns over a limited food supply and skipping meals due to scarce financial resources (Jensen 2002:1215). However, as proved through participant interviews, the presence of such constraints and living conditions threatens the ability of African American senior citizens to age successfully, but does not equate to ignorance about the existence of better quality foods, behavior change, and current trends in the U.S. food system. Secondly, while literature has emphasized the positive role family plays in the well-being of senior citizens, family can be a detriment to low-income African American senior citizens, by

further draining their limited financial resources. This is particularly true for African American elderly women.

Comprehensively, the findings of this study highlight areas of improvement in addressing health disparities, food insecurity, and successful aging techniques, particularly for African Americans. The following sections will synthesize my findings and draw upon the lifetime experiences of my chosen study population to propose recommendations to address the challenges facing African American individuals 65 and older living in urban areas of the southeastern region of the United States.

Food Justice

One of the overarching goals of this study was to determine how well African American senior citizens are able to access quality, fresh food and how food quality has changed throughout the years according to older generations. Located in a food dessert, with the closest commercial grocery, such as Kroger or Publix, two or more miles away from Wheat Street Towers, many study participants voiced the difficulty they have obtaining fresh produce for a reasonable price[1]. When asked to rate their level of access to quality, healthy, and nutritious foods, the majority of participants agreed that their access to such foods ranged from fair to good, as illustrated in **Figure 8**.

[1] Truly Living Well Center for Natural Urban Agriculture (TLW), which grows seasonal, organic produce, is located one street over from Wheat Street Towers on Hilliard St. N.E. However, TLW has yet to establish a solid relationship with residents at Wheat Street Towers by effectively communicating their market schedule, making food items more accessible through product availability notifications to residents at Wheat Street Towers, and advertising special price incentives for senior citizens. It is worth noting that TLW was not mentioned by any study participants as a place they shop at or even as an option for getting fresh produce. Therefore, it was not taken into consideration when evaluating the food quality and accessibility options available to the study sample.

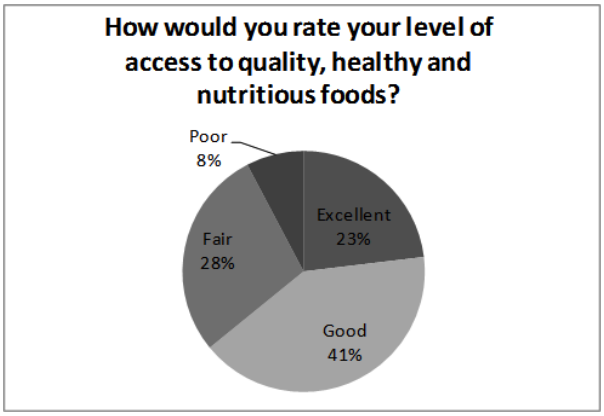

Figure 8: Quality Food Access

Offering more details about the food that was available to be purchased and what they were able to afford, one male participant of 69 years of age who rated his access to quality, healthy, and nutritious food as fair stated, " If they give more stamps then maybe it'd be [excellent]" (69 year old male participant). Another participant explained that he felt his level of access to be fair because "we don't have a store around here" (65 year old male participant). Another participant, who happened to rate his level of access as poor, voiced a similar complaint declaring, "unless you have access to transportation, there is no place to get [quality, healthy, and nutritious food] at…The curb market used to be a good place to go now the prices are sky high and the quality is poor" (68 year old male participant). One woman noted that her overall access to quality, fresh food was poor, but that it tended to fluctuate, or "change [throughout] the month since sometimes [she] didn't get enough food stamps to last [her] the whole month" (65 year old female participant). The inadequate number of food stamps per month is further complicated by the inflated cost of fresh produce in the area.

A visit to the Edgewood Market, located about 2 blocks down from Wheat Street Towers, and other surrounding convenient stores further emphasized the harsh reality of limited variety, high prices, and poor quality made available not only to residents of Wheat Street Towers, but also to others living in the surrounding area, which are mostly observed to be African American. A price comparison of items at Edgewood Market, located just two blocks from Wheat Street Towers; Kroger, a little over 2 miles from Wheat Street Towers; and the DeKalb Famers Market, located on the other side of town from Wheat Street Towers is detailed in **Table 3.**

Table 3. Food Price Comparison

	Edgewood Market/Sweet Auburn Curb Market (2 blocks)	Kroger (2.3 miles)	DeKalb Farmers Market (20 miles)
Red Apples	$0.69/ea	$1.29/lb	$1.49/lb
Canned Vegetables	$1.29/can	$0.69/can	---
Chicken Breast	$3.79/lb	$1.99/lb	$3.49/lb
Milk	---	$3.19/gal	$3.59/gal (organic)
Tomatoes	$0.92/ea	$0.89/lb	$0.99/lb
Cucumbers	$0.89/ea	$0.79/ea	$0.49/ea
Oranges	$0.69/each	$0.69/lb	$0.69/lb
Eggs	$2.19/dozen	$1.65/dozen	$2.99/dozen (cage free)

.69 cents per apple, $3.79 per pound of chicken breast, .92 per tomato, with no whole grains in site, the appearance and price of items being sold at the Edgewood Market was both shocking and unacceptable. The asking price of $1.89 per bar of Dove soap might be the regular price at convenience stores, but what if it were the only place you had to buy everything you needed for

the month, with a limited budget and no transportation to Publix or Kroger two miles up the street, or the DeKalb Farmers Market located approximately 20 miles away? The results are unfortunate and affect the senior citizen population at Wheat Street Towers in more ways than one. As one woman eloquently stated:

> I pay my rent and bills with the little money I get from social security, I try to take care of myself and go to the doctor, but most times I can't even go like I need to because that costs money, so it's between my food and my health almost every month. I get $31.00 a month for food stamps and that only goes so far, after you buy milk, bread, and eggs, and other little things to eat throughout the week half the money is gone, so by the end of the month I'm usually feeling like I'm going to starve and I still haven't got to the doctor or bought my prescriptions. But what are you supposed to do…" (72 year old female participant)

Asking the same woman to choose just one food she would like to be known for by others, she noted, "A big bowl of Fruit! For two reasons, I love fruit-pineapples, oranges, apples, melons, all that good, fresh stuff, but it's so high you can't buy it! So, I'd love to be known for always having a fresh big bowl of fruit around, because nobody has that around here" (72 year old female participant). Analyzing the comments of this study participant, who grew up in a middle-to-upper class family of Atlanta, GA; exposed that living as a senior citizen today in 2013, poses much more financial and social inequalities to access (both food and medical) than her childhood during the height of the Jim Crow Era. She notes:

> Discrimination and cost have never affected her choice of foods or obtaining healthcare until now. I always found a way to work during my whole life for the things I wanted and needed, and never had a problem working. But now I can't cause nobody is going to hire an old woman, but I'd sure work now if someone would hire me because everything is just too expensive not to work. So, yeah…now some new type of discrimination and has affected my choice of foods and healthcare (72 year old female participant).

In totality, the statements made by this female participant raise important questions and suggestions. The overall well-being of African American senior citizens is not up to individual choices. Rather, it is a product of social services, adequate medical support, families, communities, and policies. For many residents at Wheat Street Towers poor health has not solely been an outcome of personal decisions of diet and physical activity. The declining health status of residents 65 and older should be primarily ascribed to poor social services that inadequately address the specific needs and circumstances of senior citizens. For example, in the case of procuring healthy, quality food, regardless of how one chooses to prepare it or what cultural symbolism it takes on, African American senior citizens have proven that seeing "lack of knowledge as the most proximate obstacle to transformed food system" is senseless and secondary to addressing "exclusionary practices that code alternative food discourses and spaces as white [or educated and upper-class]" (Guthman 2011: 263-264). Thus, for African American, low-income senior citizens of the South it is imperative that steps for food justice are intentional and guided by research consistent with findings presented here.

Making Chronic Disease Recommendations More Culturally Competent

Given the findings of this study, I assert that African American senior citizen communities of the south warrant the utmost attention in regards to the intersectionality of metabolic disease and community determinants of health, such as diet and environment. When taking into consideration their collective history of oppression and contemporary environmental settings, it is reasonable to suggest that current recommendations for chronic metabolic disease prevention and management are culturally insensitive and virtually ineffective for the majority of

African Americans who are living in the troughs of poverty, facing food insecurity and limited economic resources. This is particularly true for African American senior citizens of this study, who do not feel they have autonomy to change the quality of the food they consume, and contend"[they] never really had a choice to start or stop eating the foods they grew up on" (76 year old male participant).

Recognizing that the first line of prevention and treatment for type 2 diabetes is weight management through diet and exercise modifications, the disproportional incidence of metabolic conditions in the African American community draws attention to the importance of addressing social disadvantages in order to reduce America's multi-billion dollar healthcare costs from chronic metabolic diseases. Recommendations put forth by the Diabetes Prevention Program to simply eat healthier and exercise more are not enough to tackle the diabetes crisis in African American senior citizen communities. Public health research has found high socioeconomic levels to be one, if not the, greatest form of protection against disease and disability world-wide. Therefore, a contemporary and historical economic and socio-ecological orientation to African American dietary patterns is essential to understanding health trends within the African American community and making effective recommendations to reduce the prevalence of diabetes.

Ultimately, while members of the African American community should not be seen as incapable of change, socio-cultural and socio-ecological factors that tend to impede change must be explored and exposed in order to foster better health outcomes. Type 2 diabetes, hypertension, high cholesterol, and other chronic metabolic conditions are not considered communicable diseases. However, the risk factors for such conditions, such as resourcefulness in light of

diminishing food choices, the cultural significance of certain foods, and opportunistic thought patterns about diet out of desperation, have been communicated throughout generations of African Americans. This occurrence raises awareness about the disproportionate incidence of diabetes and hypertension amongst African Americans. For African Americans in particular, tackling the metabolic disease crisis calls for techniques that exemplify an understanding of socio-cultural identity through food, consider heritage in health beliefs and education, and take into consideration social inequalities.

Moreover, hearing study participants speak about their health beliefs, experiences within the U.S. healthcare system, and incongruencies between their physician's dietary recommendations and what they had access to, I recognized a gap in culturally appropriate healthcare services and materials for this age group. Although they are native to the U.S. and speak English, their age (65 and older) and race (African American) seem to present a challenge in how they perceive their health practitioners and adhere to advised treatment plans. This may be for many reasons. One reason could be the unrecognized potential for the dissemination of health information from doctor to patient in this particular population to get "lost in translation" and the general discomfort this particular group has in questioning their healthcare providers. Nonetheless, "without [culturally and linguistically appropriate] information patients cannot understand and use services provided to them by their providers and [they] cannot engage in self-care or self-management," which is of great importance when living with chronic diseases, like diabetes, hypertension, etc. (Smith et al., 2000, 3). Therefore, after surveying and interviewing participants, I realized that in the 65 and older African American population healthcare providers and health education/promotion programs must be sure to take into account that most African

American senior citizens (1) live alone; (2) reside in designated food deserts, "neighborhoods that have an excess amount of fast food restaurants and few, if any, large supermarkets"; (3) have an average income of $20.00 per month for food; and (4) and are heavily influenced by cultural and religious traditions when it comes to their dietary preferences and health practices (Liburd, 2010, 154). Understanding such factors may induce healthcare providers to take the necessary time to explain the relationship of diet and overall health or disease to elderly patients in an appropriate manner, given our current food system and their present surroundings, which are much different than they were 65 years ago. Moreover, considering such factors may also incite specific nutrition programs aimed at the management of chronic disease in senior citizens alongside the current preventative and management healthcare services provided through Medicaid.

Concluding Remarks

Food and culture share an intimate relationship in the minds of African Americans. For African American senior citizens this bond has remained strong throughout shifting agricultural practices, socio-political climates, environmental surroundings, and financial resources. Consequently, the cultural creation and significance of soul food cannot be questioned. However, the causation behind increasing rates of metabolic disease, poverty, and oppression affecting African Americans should be critically examined through the experiences of African American senior citizens. The purpose of this study was to gain a better understanding of the relationship between foods, physical and emotional contentment, and disease in African Americans through life history reports and health beliefs of African American senior citizens, primarily born, raised, and living in the South. As the community most at risk for poverty, African American senior

citizens are one of the largest groups dependent on state-funded health care programs and assisted living resources, yet the question remains if they have been given a fair chance to age successfully. This research reveals that while study participants may contend that they have indeed aged successfully, given the fact they are still living and realize the virtuous traits of God, they are not being given a fair chance at resources and good health to live successfully, based on medical definitions. However, study participants continue to be resourceful and make the best of their resources and surroundings.

It is encouraging to learn that the majority of study participants not only trust their physicians, but also understand the influence that their personal actions and beliefs have on their individual health outcomes. However, it is alarming to hear the decisions between seeking healthcare and buying food individuals 65 and older are forced to make on a regular basis. I am in agreement with study participants that with more comprehensive social services, greater respect for elderly community members, and more fresh grocery options on Auburn Avenue, the overall mental and physical health of African American senior citizens in Atlanta, GA would improve. Such changes would also pose positive consequences for the community at large and notably reduce health care spending. It should be considered a violation of civil rights to tell someone of any background “to eat and do better” without making essential resources available for them to do so. Furthermore, failing to address their cultural history through food, a substance that provides both physical and emotional nourishment, denies certainties of human behavior. As research continues in an effort to bridge this gap, I declare that it largely be based on community based participatory methods, that work to institute culturally competent pillars of social

connectivity, food access, nutrition counseling, and talk therapy for African American senior citizens, ultimately giving them an equal opportunity to age successfully.

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Name_____

Phone Number_____

African-American Dietary Patterns & Health Survey

1. **What is your date of birth?**

   _____

2. **Where were you born (State)?**

   _____

3. **Please indicate your sex**

   Male Female

4. **What is the highest Level of education you have completed?**

   _____

5. **Are you currently receiving food stamps/SNAP benefits?**

   a. **Yes**

   b. **No**

6. **Are you currently living alone?**

   a. **Yes**

   b. **No**

7. **Do you have family that lives close by?**

   a. **Yes**

   b. **No**

8. **If yes, please explain?**

   _____

   _____

   _____

Name_____

Phone Number_____

9. Have you ever experienced any of the following conditions? (Please circle all that apply)

   a. Diabetes
   b. Arthritis
   c. High Blood Pressure
   d. Heart Disease
   e. High Cholesterol
   f. Other:_____

10. Do you have a health condition that requires you to change or restrict your diet?
    a. Yes
    b. No
11. Do you believe diet and disease are related?
    a. Yes
    b. No
12. If yes, please explain how you believe they are related

    _____

    _____

    _____

    _____

13. How would you rate the quality of your current diet?

    a. Excellent
    b. Good
    c. Fair
    d. Poor
14. What do you eat most often?
    a. Vegetables
    b. Fruits
    c. Highly Processed Foods (Fast Food, pre-packaged, convenient foods)
    d. Meat
    e. Fish
    f. Poultry (Chicken & Turkey)
    g. Sweets

15. What snack do you consume most often? (What is your snack of choice)

Name_____

Phone Number_____

_____

16. What do you drink most often?
    a. Water
    b. Soda
    c. Juice
    d. Alcohol
    e. 100% Fruit Juice

17. What influences your food choices (Circle all that apply)
    a. Taste
    b. Nutritional Value
    c. Cost
    d. Access
    e. Convenience
    f. Religious Beliefs
    g. Social Values
    h. Health Restrictions
    i. Family & Friends

18. What is your favorite food?

    _____

19. How is most of the food you eat cooked?
    a. Baked
    b. Fried
    c. Grilled
    d. Boiled
    e. I don't know

20. What was your favorite food as a child

    _____

21. How would you rate the overall quality of the food you consumed as a child?
    a. Excellent
    b. Good
    c. Fair
    d. Poor

22. Do you think the overall quality of food has changed since you were a child?

Name_____

Phone Number_____

a. Yes
b. No

23. If yes, please briefly describe?

_____
_____
_____
_____

24. Do you believe food plays a big part in African-American culture?
    a. Yes
    b. No

25. Please indicate what you associate most with African-American dietary traditions, such as 'soul food' (Circle all that apply)

Family	Oppression/Poverty	Hypertension	
Fatherhood			
Southern Hospitality	Spirituality/Church	Attractive body image	Obesity
Diabetes	Motherhood	Health	

26. Please indicate what you associate most with the foods you regularly eat?

Family	Oppression/Poverty	Hypertension	
Fatherhood			
Southern Hospitality	Spirituality/Church	Attractive body image	Obesity
Diabetes	Motherhood	Health	
Convenience			

27. Rate your level of access to quality, healthy, and nutritious foods?
    a. Poor
    b. Fair

Name_____

Phone Number_____

c. **Good**
d. **Excellent**

A Cultural History through Food

LIFE HISTORY INTERVIEW QUESTIONAIRE

Early Life

- What year were you born?

- Where were you born? (If applicable, follow-up with how long have you lived in Georgia/the South?)

- What were you like as a child?

- Can you recall what your favorite food was as a child?

- Where do you remember the majority of your food coming from as a child?

- Was there a limited amount of food in the house while you were growing up?

- What responsibilities did you have at home when you were young?

- What kind of school did you go to?

- How did you decide what you wanted to do with your life? How do you feel about that choice?

- What job did you do most of your life? What did you like the most about it? The least?

- What role did normative gender roles play in major life choices you made?*

- Do you recall a shift in your diet during the Civil Rights Movement?

- What do you remember about your 20s? 30s? 40s? 50s? 60s? (Jim Crow Era, Voter's Right, Martin Luther King/JFK' s assignation, Mass migration North, Emmitt Till)

- What's the hardest thing about growing older? The best thing?

- Tell me about your parents. Where were they born? When were they born? What memories do you have of them?

- How are you like your mother? Unlike her?

- How are you like your father? Unlike him?

- What do you think the secrets of successful aging are?

Food, Diet, and Health

- Can you tell me your top 3 favorite recipes/foods? (Past or Current)

- What is your definition of 'soul food'?

- Have you ever been diagnosed with type II diabetes or hypertension?

- If so, have you changed or attempted to change your dietary habits since the time of diagnosis?

- Do you feel any form of discrimination has ever affected your choice of foods or obtaining health care?

- What's the best compliment you have ever received regarding food and cooking?

- What's your most cherished family tradition that involves food? Why is it important?

- What things have the biggest influence on your diet? Weight?

- What's your best piece of advice for living?

- If you could choose just one recipe or food to be known for what would it be?

- In your own words, will you explain how the food system and food availability have changed in the last 30 years?

Additional Comments:

AUBURN AVENUE

AUBURN AVENUE

FAIR STREET

FAIR STREET

FAIR STREET

WHEAT STREET TOWERS

Wheat Street Towers Lobby

Wheat Street Towers
Community Room

OneSite® Leasing & Rents | D Williams Management Group, LLC | ren-917-001

Demographic statistics
Wheat Towers
Report created on calendar date: 2/11/2013 (property date: 02/11/2013)

As Of : 02/11/2013
Resident Status : Applicant, Approved applicant, Former applicant, Pending resident, Current resident, Former resident

Category	Count	Percentage
Total Number of Units:	210	100.00%
Number of Occupied Units:	190	90.48%
Occupants/Demographics:	270	100.00%
Male	170	62.96%
Female	100	37.04%
Single	54	20.00%
Married	1	0.37%
Divorced	0	0.00%
Separated	0	0.00%
Widow/Widower	0	0.00%

Category	Count	Percentage
Current Occupants/Leases:	190	90.48%

Occupant Status:		
Adult co-head of household	5	1.85%
Head of household	264	97.78%
Other adult family member	1	0.37%
Total	270	100.00%

Ethnicity:		
Total	0	100.00%

Occupation:		
Not applicable	153	100.00%
Total	153	100.00%

Citizenship:		
United States	271	100.00%
Total	271	100.00%

Age Range:		
Under 18	0	0.00%
18 - 21	0	0.00%
22 - 25	0	0.00%
26 - 29	0	0.00%
30 - 33	0	0.00%
34 - 37	0	0.00%
38 - 41	1	0.37%
42 - 45	3	1.11%
46 - 49	3	1.11%
50 - 53	8	2.96%
54 - 57	21	7.78%
58 - 61	19	7.04%
62 - 65	55	20.37%
66 - 69	57	21.11%
70 - 73	28	10.37%
74 - 77	22	8.15%
78 - 81	22	8.15%
82 - 85	19	7.04%
86 - 89	3	1.11%
90 - 93	5	1.85%
94 - 97	3	1.11%
98 - 99	0	0.00%
Over 99	1	0.37%
Total	270	100.00%

Category	Count	Percentage
Individual income:		
Below 10,000	260	96.30%
10,000 - 16,000	9	3.33%
16,001 - 21,000	1	0.37%
21,001 - 26,000	0	0%
26,001 - 31,000	0	0%
31,001 - 36,000	0	0%
36,001 - 41,000	0	0%
41,001 - 46,000	0	0%
46,001 - 51,000	0	0%
51,001 - 56,000	0	0%
56,001 - 60,000	0	0%
60,001 - 65,000	0	0%
65,001 - 70,000	0	0%
70,001 - 75,000	0	0%

Category	Count	Percentage
Household income:		
Below 10,000	254	96.21%
10,000 - 16,000	9	3.41%
16,001 - 21,000	1	0.38%
21,001 - 26,000	0	0%
26,001 - 31,000	0	0%
31,001 - 36,000	0	0%
36,001 - 41,000	0	0%
41,001 - 46,000	0	0%
46,001 - 51,000	0	0%
51,001 - 56,000	0	0%
56,001 - 60,000	0	0%

EDGEWOOD
“SWEET AUBURN” MARKET

The Historic Sweet Auburn District

The Sweet Auburn Curb Market is located in the historic Sweet Auburn district, one of the most notable black business districts in the United States. In 1956 Fortune magazine described Auburn Avenue, the main street in this historical district, as "the richest Negro street in the world." Although mostly composed of small businesses, Auburn Avenue was also the home to three financial institutions, Atlanta Life Insurance Company, Standard Life and Citizens Trust Bank; they extended credit to black homeowners and entrepreneurs who were unable to secure financing elsewhere. Auburn Avenue's consolidation of wealth for blacks was unique for its time and blacks began to refer to the street as "Sweet Auburn."

Sweet Auburn Curb Market

In 1918 Atlanta established a farmer's market on land cleared by a massive fire which had swept through the city the year before. Farmers would bring produce and livestock to the city and sale to city dwellers, creating a market. The market was an immediate success; it reportedly was soon enclosed by a tent. Wishing to give the market a more permanent home, the Atlanta Woman's Club raised $300,000 for a market to be established. The project was so successful, that the City of Atlanta decided to build a permanent market. This idea had the support of the Jewish Council of Women, League of Women Voters, Atlanta Chamber of Commerce, the Rotary Club, and the Mayor of Atlanta James Key. A Ten Eyck Brown was commissioned to design the structure. The fireproof brick and concrete building opened May 1, 1924, as the Municipal Market of Atlanta, in the exact geographic center of Atlanta. It shortly became the largest single retail center for farm products in the state. It truly was "the place to shop" for all who lived in Atlanta.

In the market you could find fresh produce and livestock all raised and or grown in Georgia. History tells us that customers were once able to choose live hens and wait for it to be slaughtered, dressed and ready to take home. As the market grew and the food industry changed so did the market. Now, not only can you find fresh produce and meats, there is also seafood, specialty shops and restaurants.

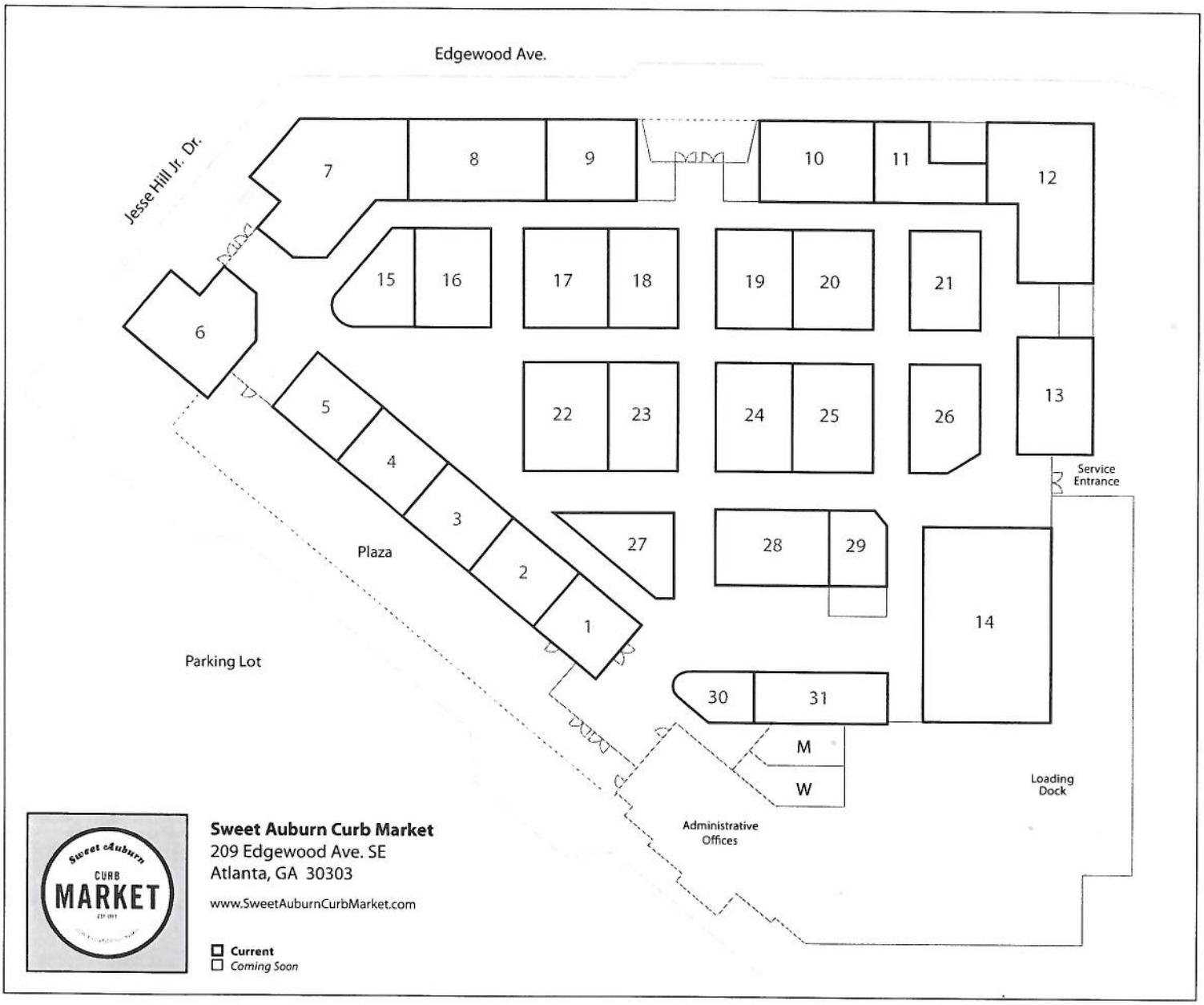
The Sweet Auburn Curb Market is Atlanta's only publically owned market where each vendor is independently owned and operated. Think of the market as a small business incubator for new entrepreneurs in the food industry. Tom Murphy of "Murphy's" in Virginia Highlands, Alex Bronstein of "Grindhouse Killer Burgers" and Matt Hinton of" Bell Street Burritos" are three entrepreneurs who began at the market and grew budding businesses to join the Atlanta community.

The market has been through numerous transitions and restorations. The most recent completed in early 2012 was paid for by Federal grant funds, as part of the stimulus program.

As a side benefit to the numerous improvements, such as the roof, HVAC units, plumbing, and removal of the paint on the outside brick, the renewed interest in the market sparked by the improvements attracted new businesses, which added jobs to the area and ultimately brought in a more diverse customer base.

Our goal for the market is to become a place where the community shops on a regular basis, where Saturday is once again embraced as "Market Day," and visitors come to the historic building, where vendors and customers are a true reflection of the essence of the city itself.

And, finally, since the market is located along the route for the new streetcar, we look forward to having a stop right outside the Edgewood doors.



Restaurants

4. Afrodish Carribean-404-522-1054
18. Arepa Mia – 404-880-8575
3. Bell St. Burrito – 678-732-0488
13. Grindhouse Burgers – 404-522-3444
22. Metro Deli Soul Food – 404-581-0271
2. Sweet Auburn Barbecue – 404-589-9722
17. YumDiggity – 404-681-5080
5. Tilapia Express – 404-223-2363
16. Rawesome Juicery – 404-996-6698

Produce Vendors

27. Choi Produce – 404-584-7227
17. Country Produce – 404-524-5544
21. Natural Produce – 404-524-6244
25. S&H Produce - 404-524-0087
20. The Farm Stand – 770-875-0166

Retail/Specialty Stores

15. Flowers at the Market – 404-614-2081
1. Café Campesino Coffee – 404-254-2029
7. Market Gift Shop – 404-524-4075
6. Market Pharmacy – 404-524-8888
30. Miss D's New Orleans Pralines – 770-256-7164
8. Sister's Bookshop - 404-584-2722
28. Sweet Auburn Bakery – 678-927-9401
10. High Road Craft Ice Cream
9. Meeting Space
30. Miss D's - Coming Soon

Meat/Seafood Vendors

29. Atlantic Seafood – 404-223-0223
26. Country Meats – 404-659-8785
23. D&J Meats – 404-522-0973
24. Porky Pig Meats – 404-222-0608

Available Spaces 11,14

EDGEWOOD MARKET VENDORS

PRODUCE FOR SALE AT EDGEWOOD MARKET