

ORIGINAL RESEARCH

Grandparent caregiving among rural African Americans in a community in the American South: challenges to health and wellbeing

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ABSTRACT

Introduction: An increasing number of grandparents in rural USA are serving as primary caregivers for their grandchildren because of parental incarceration, addiction, joblessness, or illness. Low-income, African American women from the South are overrepresented in this growing population. There is a paucity of research exploring the challenges faced by rural grandparent caregivers, and past studies have not explicitly addressed the potential consequences of rural grandparent caregiving for health. The purpose of this qualitative study was to explore grandparent caregiving among rural, low-income, African American grandmothers in a community in the American South, and to identify challenges to health that arose in that context. McLeroy's social ecological model (SEM) was used to examine these challenges at multiple levels of influence.

Methods: This qualitative interview-based study was conducted in a high-poverty community in rural Georgia. In-depth interviews were conducted with African American grandparent caregivers and key informants from local community-based organizations. A key informant assisted in identifying initial interview participants, and then snowball sampling was used to recruit additional participants. Interview questions were grouped under five domains (intrapersonal, interpersonal, community, organizational, and policy), according to the levels of the SEM. Iterative content analysis of interview transcripts was utilized. Transcripts were coded to identify text segments related to each domain of the SEM, which were grouped together for analysis by domain. Reflexive memo-writing aided in development of themes, and data quality was assessed using Lincoln and Guba's trustworthiness criteria.



Results: Rural African American grandparent caregivers faced a range of challenges to health. Direct physical challenges included chronic pain that interfered with sleep and daily functioning, mobility issues exacerbated by child care, and the pressure of managing their own medical conditions as well as their grandchildren's. Financial scarcity added to their vulnerability to poor health outcomes, especially when caregivers would forego purchase of medications or visits to the doctor because of expenses related to their grandchildren. In addition, lack of child care made health appointments and hospitalizations logistically difficult. Emotional strain was common as grandparent caregivers struggled to protect their grandchildren in communities where rates of drug use, HIV, and incarceration were high. Caregivers worried about their mortality and the related consequences for their grandchildren. Chronic stress, which is linked to a number of poor health outcomes, was self-reported by most rural grandparent caregivers.

Conclusions: In this study, the challenges of rural grandparent caregiving among African American women posed multiple threats to health and wellbeing. Further research is needed, in different rural contexts and with different caregiver populations, to more thoroughly examine the health risks of grandparent caregiving. In addition, the development of multi-faceted interventions and programs will be critical to meeting the needs of rural grandparent caregivers. A few models for such programs exist, although resource shortfalls have often limited their impact.

Key words: African Americans, caregiving, grandparent, low income, southern USA.

Introduction

An increasing number of grandparents in the USA are serving as primary caregivers for their grandchildren. Since the US Census Bureau began tracking grandparent caregivers in 2000, their prevalence has increased by 15%¹. Forty percent of all grandparents in the USA are caregivers for their grandchildren compared to 24.2% in Italy, 18.1% in Spain, 11.3% in Germany, and 10.1% in France^{1,2}. Two-thirds of grandparent caregivers in the USA are women and a disproportionate number are rural and African American. Almost half of grandparent caregivers live in the American South, a disproportionate burden, and many of these caregivers live in poverty^{1,3}. A range of social factors are contributing to the rise in grandparent caregiving. Parents may turn over care of their children to grandparents because of incarceration, drug or alcohol addiction, teen pregnancy, mental illness, physical illness such as HIV, abuse and neglect, or joblessness^{4,5}. African Americans have been especially hard-hit of late due to the economic downturn, lack of living-wage jobs, continued institutionalized racism, and high rates of imprisonment for drug-related charges⁴. The isolation and

high rates of poverty in many rural communities contribute to the difficulties that rural caregivers face⁶.

Research related to grandparent caregivers in any setting is 'sparse'⁷, and often emphasizes the social forces driving grandparent caregiving^{5,8}, or service needs of grandparent caregivers⁹⁻¹². Service needs include health, financial, educational and legal services. Qualitative and quantitative studies in this arena have identified a range of financial, legal, and social challenges faced by grandparent caregivers, and potential strategies for coping and support¹³⁻¹⁶.

Few studies of grandparent caregivers have focused on health issues as central research questions, but there is evidence to suggest that grandparent caregiving can be detrimental to health both emotionally and physically¹⁷. A number of studies have found that grandparent caregiving is associated with increased risk of depression, loneliness, or emotional strain. In an analysis of a national-level dataset, the National Survey of Families and Households (1992-94), Fuller-Thomson et al¹⁸ found that compared to African American grandparents who were not caregiving, grandparent caregivers were twice as likely to report significant symptoms of depression. Additional studies have identified this link¹⁹⁻²².



With regard to physical health, Fuller-Thomson et al¹⁸ found that, nationally, grandparent caregivers had significantly higher levels of limitations in activities of daily living (ADL) than non-caregivers. In addition, in a longitudinal analysis of a sample of grandparent caregivers in Ohio, caregiver stress was reported to increase, and physical health decrease, over a 24-month period²³. Other studies have suggested that grandparent caregiving may be linked to increased risk of complications from diabetes and arthritis, as well as increased unhealthy behaviors such as poor diet and lack of exercise^{17,18,24}. These studies provide evidence that grandparent caregivers face a range of stressors and challenges in daily life, and that their health may be compromised from the experience. However, the experience of caregiving will vary with a range of social, economic, and regional variables, and there is a need for 'cross-cultural comparisons' of the caregiving experience¹⁷. Issues of rurality, gender, race, and poverty collide with issues of grandparent caregiving, and compound its challenges^{25,26}. For example, a national-level dataset analysis found that African American grandmother caregivers had rates of poverty, as well as disability, that were significantly higher than those for grandfather caregivers²⁷.

Little is known about rural grandparent caregivers⁸. Bullock²⁸ interviewed grandmothers in rural North Carolina to explore their experiences with caregiving, and found financial stress, social isolation, and poor housing conditions to be challenges in this setting. This was confirmed by a study of grandparent caregivers in rural Georgia, who felt isolated and marginalized within the community²⁹. There is a need for better understanding of the rural caregiving context, and exploration of links between rural grandparent caregiving and health. In response, the purpose of this qualitative study was to explore grandparent caregiving among rural, low-income, African American grandmothers in a community in the American South, and to identify challenges to health and wellbeing that arose in that context.

McLeroy's social ecological model (SEM)³⁰ was employed to examine forces acting at multiple levels of influence that could impact health. This model takes into consideration the role of intrapersonal factors, such as individual knowledge or

perceptions; interpersonal factors, such as personal relationships; community-level factors, such as social networks; organizational supports and deficits; and policies and regulations at the local, state, and national level that may impact health in a given setting. The use of this model, and a qualitative, exploratory approach, allowed for thick description of the lived experience of grandparent caregivers made additionally vulnerable by their gender, race, poverty, and rurality.

Methods

This study was conducted in a community in rural southeastern Georgia. Forty percent of its residents are African American, and 52% of residents have incomes below the poverty level, compared to 17% in the state as a whole³¹. The unemployment rate at the time of the study was close to two percentage points above the national average³². The institutional review board at the researchers' host institution reviewed the study, and all participants provided written informed consent. In-depth interviews were conducted with 12 African American grandparent caregivers over the age of 30 years who had primary responsibility for the care of co-resident grandchildren under the age of 18 years, in accordance with the US Census Bureau's definition of a grandparent caregiver³³. There were 13 interview questions for the grandparent caregivers. Interviews lasted for 45 minutes to 1 hour, depending on the grandparent caregivers' responses.

According to 2012 American Community Survey findings, 5% of adults of all races in the study community were grandparent caregivers, a prevalence of 35% higher than the national average³⁴. Data stratified by race and ethnicity were not available at the community level; in the state as a whole, among African Americans only, 53% of adults over the age of 30 years are classified as grandparent caregivers³⁴. Interviews were also conducted with key informants at local community-based organizations (CBOs) and faith-based organizations (FBOs) that interacted with grandparent caregivers, which provided valuable background information on the local



caregiving context. These key informants included pastors, a director and social workers of CBOs, and a social worker with a government agency. They all interacted extensively with caregivers in the community. Findings presented here emphasize the perspectives of the caregivers themselves.

Caregiver participants were selected using a purposeful sampling strategy designed to maximize variation with regard to age, gender, and occupation of caregiver, and with regard to age, duration, and number of grandchildren in their care. A key informant assisted in identifying initial caregiver participants. Participants were later identified through snowball sampling and referrals from other community organizations. Caregiver interviewees ranged in age from 56 years to 71 years, and were all female except for one male caregiver who participated in an interview along with his wife. Caregivers were caring for grandchildren ranging in age from 3 years to 16 years, and had been caring for grandchildren for an average of 10 years. Three-quarters of caregivers were single, either through divorce or bereavement. Reasons for assuming the role of caregiver included death, incarceration, addiction, mental illness of the children's parents, or maltreatment of the child by a parent (neglect, abuse, or abandonment). The USA has the highest incarceration rate in the world, and African Americans are disproportionately affected³⁵. It is estimated that by their 14th birthday, 25% of African American children born in 1990 had experienced parental imprisonment, compared to 4% of White children³⁶. Most grandparents accepted the caregiving role in an attempt to keep their grandchildren out of the foster care system.

Interviews were conducted in locations of the interviewees' choice, and included homes, workplaces, and community settings. Interview guides were used to conduct the interviews. Questions were grouped under five domains, according to the levels of the SEM employed: intrapersonal, interpersonal, community, organizational, and policy. Questions sought to identify challenges to health and wellbeing, as well as sources of support, at each ecological level. Example questions include, 'Tell me about your own health, and how you manage taking care of kids every day?'

(intrapersonal), 'What are the good things and hard things about raising kids in this community?' (community), and 'What support do you have from other family members?' (interpersonal). Interviews were recorded and transcribed. Document review was conducted to gather additional information about local supports, services, and policies related to grandparent caregiving. Documents available in hard copy (offline) and electronic (online) format were reviewed. Policy-related documents that were reviewed included state legislation granting grandparent caregivers power of attorney and other statutory rights, and local organizational policies and procedures related to grandparent guardians. Content analysis of interview transcripts and document review notes was ongoing during data collection. Content analysis involved the structured examination of text data to search for embedded themes and ideas³⁷. Transcripts were coded to identify text segments related to each domain of the SEM, which were grouped together for analysis by domain. Themes were identified and expanded using reflexive memo-writing³⁸. Ideas that emerged were triangulated by merging data from interviews and documents, having multiple researchers involved in analysis, and by member checking with select study participants³⁹. All of these processes were used to enhance credibility of the findings⁴⁰.

Ethics approval

Institutional review board approval for the research was obtained from Georgia Southern University (H 12487). Participation was voluntary and each participant signed an informed consent form before participating. Participants were assigned pseudonyms. All research documents were kept in a locked cabinet in the main author's office and all electronic copies were password-protected.

Results

Pain and strain: physical debilitation and grandparent caregiving

Physical health issues presented major challenges to the wellbeing of rural African American grandparent caregivers.



Caregivers had myriad health diagnoses, which they managed every day while caring for their grandchildren. More than two-thirds of caregivers self-reported hypertension; almost half self-reported having diabetes. Other health issues self-reported included asthma, heart disease, lupus, shingles, arthritis, and chronic obstructive pulmonary disease. One grandmother had survived three heart attacks; another was waiting for surgery for a thyroid problem. A number of participants had mobility issues due to injuries or back problems. Most caregivers self-reported multiple diagnoses, related or unrelated. Pain was a constant companion for many, as described by a 67-year-old grandmother who had cared for her two grandchildren for 2 years:

If anything keeps me awake at night, it's the pains in my body. I have back problems ... and then I have some arthritis too. I have had it so bad they have done surgery on my neck, about 2 years ago. It was about the same time I got the children ... A lot of the times people don't even know I am in pain. You don't even know I'm in pain now. Yes, [I am in] terrible pain [now]. The pain, a lot of the times when I get started doing what I have to do and go through my daily routine, I can be in really severe pain.

At the time of the interview, she rated her pain level as an 8 or 9 on a scale of 1 to 10. Pain of this magnitude would be a challenge for anyone; for a 67-year old woman caring for children, it presents an especially significant barrier to daily living.

Some caregivers relied on pain medication, prescription or non-prescription, to cope. This was related by a 58-year-old grandmother who had cared for her three grandchildren for 15 years:

I hurt constantly. I am constantly in pain. ... I really went downhill when my son died. It really took a toll on me. Yes, my foot. It always hurt. I take pain medicine every 6 hours, sometimes it helps and sometimes it doesn't. They have me on something to help with the circulation, that's what is wrong with it, the nerves are dead. There is no circulation. Yes, I limp. It started out simple, but it escalated.

In this case, her foot pain was related to diabetes and neuropathy, and she was at risk of amputation if her condition continued to deteriorate. But as the primary caregiver of three children, one of whom was only 5 years old, her daily routine had the potential to exacerbate or speed up the progression of her condition. At a time of life where they had expected to have 'me time' to rest and enjoy friends and family, they instead found themselves doing the type of physical labor they had done as young women, but in bodies that were no longer fit for it. In the words of one caretaker:

Cooking, just the regular motherly things that a young mother would do, this is a challenge for me. Because I don't want to go there, I have already been there and done that.

In addition to their own health conditions, caregivers managed their grandchildren's health and behavioral issues as well. Almost half of the caregivers self-reported raising grandchildren who had diagnoses of attention deficit hyperactivity disorder (ADHD). Caregivers also reported having grandchildren dealing with overweight or obesity, allergies, asthma, learning disabilities, and anger management issues. Many of the children had experienced emotional traumas related to their parents' death, incarceration, or substance abuse, or had been abused or neglected before coming into their grandparents' care. One caregiver described caring for her teenaged grandson with ADHD:

The school says he is terrible ... His mother was on drugs and she took pain medication while she was pregnant with him. He has problems from that. His behavior is sometimes out of control ... the teachers would say they couldn't handle him. It was constant writing everyday about his negative behavior and things like that. ... It's hard to keep him under control. He won't stop... he is a hard child to handle.

She was weary as she described her grandson, who disrupted the interview several times. The stress of managing her grandson's behavior, day in and day out, and trying to locate resources to help him, was exhausting. It also prevented her from focusing on her own self-care for diabetes.



Financial strain and grandparent caregiver health: a double bind

Making ends meet was a strain for all grandparent caregivers interviewed. All except one participant reported incomes below the poverty level. The one caregiver who earned more worked full-time as an administrative assistant. There was no child care available at her place of employment, and she could not get human resource benefits from her employers because she did not have legal custody of her grandchildren. The majority of caregivers were retired, and depended on social security income or medical disability income. The remainder had inconsistent, low-wage work as cooks, senior aides, laborers, or piecework seamstresses. In some cases, grandparent caregiving had precipitated early retirement from work, as in the case of this retired pastor:

I forced my retirement from being a pastor, because of the children. ... They were talking about me moving down to another state. ... I had to make a choice between pastoring and the children. In my belief, children are a gift from God.

She viewed taking care of her grandchildren as her new ministry, but taking on that responsibility ended her career early, reducing household income as new expenses related to the children began to accrue. Some caregivers had support, either consistent or sporadic, from the children's parents or other family members. But this support was often limited, because others in their support networks faced similar challenges related to time and resources. Other caregivers did not have any additional financial support, and shouldered the children's expenses alongside their own. In this regard, finances were a ubiquitous source of chronic stress, which has been shown to contribute independently to a range of health risks, including diabetes, heart disease, and depression⁴¹.

Economic stress also presented a more direct threat to the health of caregivers, as many struggled to pay for health care. The caregivers had health insurance coverage through Medicare, Medicaid or, in one case, an employer. One woman was uninsured. However, even for those with insurance, co-payments and cost-sharing fees were often

needed for medications and doctor visits. They often paid these fees for grandchildren as well, who were covered by Medicaid, PeachCare for Kids, or private policies. PeachCare for Kids offers free to low-cost health insurance to uninsured, eligible children living in Georgia. In some cases, expenses related to caregiving strained finances to the point that grandparents compromised their own health care to provide for their grandchildren. For example, one grandmother had lupus, but only filled her medication prescriptions if she could afford it after paying for day care for her 4-year-old granddaughter:

I can't do the things I used to do. I struggle sometimes ... by Friday I have to come up with \$85.00 to pay daycare ... I go around broke. ... I can't get my medicines if I can't afford it. I was supposed to get my medicine last Wednesday, but I hadn't gotten it because I don't have the money ... That's why my iron got so bad, because I wasn't using it ... Sometimes I don't get my medicine to get something that she needs.

In addition to selectively filling prescriptions, caregivers would sometimes neglect their own health care needs in other ways. They might forego doctor visits because of co-payments, and sought to avoid hospitalizations, which would leave the grandchildren without care. A key informant, a government social service provider, lamented that:

If you could see some of these grandparents with their canes, walkers, and it's all due to medical neglect.

The caregivers faced a double bind related to their own health needs. Their health problems were exacerbated by the strain of caregiving, but caregiving also made it more difficult to access care, both because of finances and logistics.

Emotional strain: grandparent caregiving and a world of worry

The stresses of caregiving were emotional as well as financial and physical. Interview participants described a range of worries about their grandchildren:



I worry about who they are hanging out with. ... I worry about them picking up the habits of their peers. ... I worry about them finishing their education and them getting pregnant. ... I worry about stuff like that, the things that will hinder them. I pray about it.

Worrying is a natural part of childrearing, but these caregivers felt that their grandchildren were particularly vulnerable. Substance abuse, incarceration, teen pregnancy, and HIV were pervasive in the children's communities, among their peers, and among their parents.

Caregivers carried an additional layer of emotional stress – thoughts of their own mortality. Again, this is an issue all guardians face, but for aging caregivers, many of whom were in poor health, it loomed very large. Some cried as they expressed worry over what would happen to their grandchildren if they were to die. As expressed by a 56-year-old caregiver:

This is something I worry about. It bothers me a lot. If something happens to me, what will happen to her? Like if I get into a car wreck and get killed, or I become really ill and can't take care of her? ... I know I have to have a plan in place just in case something happens to me. I need a plan in place to make sure she will be ok.

This caregiver wanted the security of a plan for her grandchild's future after her death, but didn't know what that would be. She and many of the caregivers were not enmeshed in support networks that could step in, should they pass away. In addition, most caregivers were horrified at the thought of the children entering the foster care system, seeing that as a guarantee that the children would languish.

More prosaically, but still significantly, some caregivers worried about their lack of formal control over their grandchildren's affairs. Some did not have legal guardianship, despite being the primary caregivers, which made it difficult to get needed support from schools, hospitals, and government agencies. One caregiver described the struggles she faced working with the school system:

I couldn't go register my kids because I don't have legal guardianship. ... Legally, I don't have a right, I can't say anything. I cannot even fill out the portal to actually see their grades online, because I am not the parent. ... I don't have legal guardianship and they [the child's parents] won't give it to me.

Her lack of legal standing added another layer of stress to her caretaking. The staff at the school knew her personally, which helped, but there were limits to what they could allow her to do for her grandchildren. In her case, the parents refused to give her guardianship, while still leaving the daily care of the children to her. In other cases, the challenges of navigating the legal and social service systems left caregivers without the legal authority they needed as caretakers.

In the midst of emotional strain from all of these sources, caregivers reported having little time to rest and regain their strength, physical and emotional.

Even brief reprieves from caretaking duties were appreciated and enjoyed, providing time that grandparents could focus on themselves and their own activities. One grandmother described a break from caretaking she'd had the previous week:

They were gone last week. I slept, ate, and visited people that I couldn't visit, that I can't do, with my grandson. I did the things that I wanted to do. I had time for myself.

This hiatus had provided her some time to restore herself physically, emotionally, and socially, making her more prepared to take on the burden of childrearing once more.

Discussion

The findings of this study were consistent with what was found in the literature^{9,17-22,24}. The findings suggest that rural, low-income, African American grandparents caring for their grandchildren face a variety of challenges to their health and wellbeing. In some cases, these challenges were direct and



physical. The physical labor and stamina that childrearing often requires was a trial for many caregivers, due to both their age and pre-existing health conditions. Similar to other studies, most of the caregivers reported multiple diagnoses for chronic conditions such as hypertension, diabetes, and heart disease^{17,18,24}. Some had mobility issues made worse by the wear and tear of child care, as well as chronic pain that interfered with sleep and daily functioning¹⁸. In addition, their grandchildren often had their own diagnoses of physical, behavioral, and emotional problems that the caregivers needed to manage.

Unstable and insufficient money flow added to their vulnerability to poor health outcomes, both directly and indirectly. In some cases, grandmothers reported foregoing doctor visits or the purchase of their medications because of expenses related to their grandchildren. In addition, lack of childcare support made health appointments and hospitalizations logistically difficult. This dynamic created a double bind, where health problems were potentially created or exacerbated by grandparent caregiving, but caregiving obligations also made it more difficult to access care. Finances were a ubiquitous and ongoing source of worry, or chronic stress. Bullock had found such similar financial stress among grandmother caregivers in rural North Carolina⁹.

Finances were not the only source of chronic stress in the grandparent caregivers' lives. Grandmothers tried to serve as buffers for their grandchildren in communities where rates of drug use, HIV, incarceration, leaving school, and teenage pregnancy were distressingly high. They struggled to navigate school systems and social service agencies, often without the legal status needed to solve problems that arose. On top of all that, they carried the weight of their own mortality, and the consequences it would have for the grandchildren in their care.

All of these sources of emotional strain could predispose the grandparent caregivers to mental health issues such as depression, as noted in previous studies¹⁸⁻²². In addition, these challenges serve as potent sources of chronic stress. Chronic stress is increasingly acknowledged to play a role in the

'weathering effect' that contributes to increased rates of many diseases among poor and marginalized groups. Chronic stress results in repeated activation of the hypothalamic–pituitary–adrenal axis, which can lead to disruptions in metabolism, immune function, and neurotransmitter function over time⁴². In this way, grandparent caregiving has the potential to add to the 'pile-up' of chronic stresses the women already face as a result of poverty, discrimination, and rurality. Health outcomes will reflect the accumulation of risk from these multiple vulnerabilities.

The development of context-specific interventions, programs, and policies will be critical to meeting the needs of grandmother caregivers. The Brookdale Grandparent Caregiver Information Project⁴³ reviewed programs serving grandparent caregivers in the early 1990s, and found that interventions were minimal, and often had limited financial and institutional support. Among existing programs, effective approaches tended to emphasize social support and to provide multiple services to caregivers, in response to complexity of their needs⁴³. A recent example of this approach involved urban African American grandmothers in Georgia²⁴. This multi-service program provided monthly home visits by registered nurses and social workers, social support groups, parenting classes, legal service referrals, and support for children with special needs, among other services. Health risk appraisals pre- and post-participation showed positive changes in the grandmothers' measures of hypertension, self-reported health status, exercise, and diet²³. These findings support the idea that the multi-faceted strains of grandparent caregiving can impact health and wellbeing, and that this damage can be mitigated by offering multi-faceted support.

Unfortunately, such comprehensive programs to serve grandparent caregivers are uncommon, and are especially rare in rural areas. King et al²⁹ evaluated Georgia's Kinship Care Program, which served rural grandparent caregivers, and provided both informational and emotional support. However, grandparent caregivers surveyed were concerned with the narrow range of programmatic services, citing barriers such as lack of legal services and childcare support



during program activities. The program has since been reduced in size due to funding limitations²⁹.

Providing consolidated services can be more challenging in rural populations, where both providers and caregivers are spread over large areas, and there is a lack of public transport and other supportive infrastructure. Rural social service agencies and health departments are often underfunded and understaffed⁴⁴. Rural churches and other FBOs can play an important role in serving grandparent caregivers, especially in the realm of social and emotional support⁴⁵.

Further research is needed, both qualitative and quantitative, to more thoroughly examine the health risks of grandparent caregiving in rural areas. Limitations of this study include its small sample size. However, saturation of major themes was reached in this small community setting. Grandparent caregivers interviewed were aged in their fifties, sixties, and seventies. People may become grandparents at younger ages, and the challenges they may face may vary. Statistics giving the age distribution of the grandparent caregiver population in this area are not available. In addition, this study does not address similarities and differences in health needs between grandparent caregivers and older adults who work as in-home caregivers. There may be some similarities between these two groups, especially given the low wages earned by in-home caregivers. A study focused on older adults working as caregivers would be needed to explore this issue more thoroughly. An additional limitation is that it involves only one rural community, which may limit transferability of findings. Furthermore, although women and African Americans are disproportionately affected, studies involving men and other ethnic groups, especially given the increasing number of Hispanic immigrants in rural areas of the American South, are needed. This study gives voice to caregiver concerns, but cannot assess causal relationships between caregiving status and different health outcomes.

Conclusions

African American grandparent caregivers in the rural American South face myriad challenges to their health and

wellbeing. Available resources are inadequate to meet their many needs. More comprehensive policy and programmatic solutions will be needed to meet the range of challenges faced by this growing population.

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