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Conducting and Responding to a Jewish Community Health Survey

Rationale, Results, and Advice

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Very little is known about the health of Jews, especially at the local level. This type of data is crucial because it identifies problems within a small area where they can be addressed most effectively by social service agencies, health care practitioners, and other organizations. This article summarizes an effort to collect local-level health data on a primarily Orthodox Jewish community in Chicago and to use that data to design and implement health-promotion interventions. An example of such an intervention is an obesity prevention project that is currently being pilot tested in two Orthodox day schools.

Accurate, local information about health status and access to health care is necessary to improve individual levels of health and well-being. Unfortunately, this type of data is rare, especially for certain population subgroups, such as Jews. However, there is evidence to suggest that Jews have significantly different health profiles compared to other individuals (for review, see Koenig, McCullough, & Larson, 2001). Thus, collecting this type of information is crucial, particularly for Jewish populations that may have higher health risks because of lower socioeconomic status, immigrant status, or age, for example. This article outlines one Jewish community's attempt to address this lack of information.

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LOCAL-LEVEL HEALTH INFORMATION

Importance of Local-Level Health Information

Local-level health data are important for several reasons. Most generally, this type of

data allows communities to identify health risk factors and problems within a limited geographic area, where the health problems can be best addressed by social service agencies, health care providers, schools, and other community groups. In other words, it is within these small areas that targeted policy, programmatic, and environmental changes can be made. Local-level data are also essential for attracting attention to a particular problem and motivating advocates. For example, public health officials and health care providers have long warned parents, schools, and other groups about the growing problem of childhood obesity. However, individuals are often inclined to view the problem as an issue affecting *other* communities or families, and thus, they lack the personal motivation to actively address the issue. In contrast, when a community is told that more than half of its children are overweight or obese (as was found in the current survey), parents, teachers, and other community leaders are immediately more engaged with the problem and more eager to begin making changes. Finally, collecting local-level health information is important because documentation of health problems increases a community's chances of receiving funding from government agencies and private foundations. Particularly for the Jewish population, which is often perceived to be relatively advantaged compared to the general population, it is important to have this type of data.

Lack of Existing Health Data for Jews

Valuable information about the Jewish population in America comes from the National Jewish Population Survey (NJPS); regional Jewish data surveys, such as the Metropolitan Chicago Jewish Population Study (MCJPS); and a variety of other community-level data sets. However, these studies are not designed to measure components of individual health and well-being, such as physical and mental health status and access to health care. In addition, obtaining information from more general data sources is difficult. Only limited health information for individual communities can be determined by using public records that are available by census tracts or zip codes, such as vital records and communicable disease registries. Moreover, Jewish populations are generally widely dispersed and are often minorities even in the most concentrated of communities. Thus, small sample sizes render national, state, and even city health surveys insufficient for deriving accurate estimates for the health status of these individuals (Fielding & Frieden, 2004).

Importance of Collecting Health Data for Jews

Collecting health data is particularly important for Jews because they may have health profiles that differ significantly from those of other individuals. Both the cultural norms shared by those with a Jewish background and the religious beliefs held by many Jews may influence health-related behaviors and outcomes (Jacobs & Giarelli, 2001). Orthodox Jews, in particular, live according to a distinct set of rules that often deal with health-related behaviors, such as dietary choices. In addition, Jewish children often attend private day schools, which differ from public schools in the foods they offer, the health-related information provided in their curricula, and the presence of physical education and extracurricular activities. Therefore, health risk factors and outcomes could be expected to differ from the general population. This is supported by previous research that shows that Jews have higher rates of depression (Kennedy, Kelman, Thomas, & Chen, 1996; Levav, Kohn, Golding, & Weissman, 1997) and breast cancer (Egan, Newcomb, Longnecker, et al., 1996), but lower rates of other health problems, such as alcoholism (Levav et al., 1997) and cervical and penile cancer (for review, see Koenig et al., 2001).

CURRENT SURVEY

The current survey took place in Chicago, a city with a large and growing Jewish population. In fact, based on estimates from the 2000–2001 MCJPS, there are approxi-

mately 270,500 Jews in the Chicago metropolitan area. Although the MCJPS provides information about numerous topics, such as general demographics and participation in Jewish activities, it only includes a very limited number of questions related to health and well-being. Furthermore, the MCJPS covers a large geographic area, encompassing six counties in northeastern Illinois. Because the extent of health problems is likely to vary greatly within this area (e.g., the health of Jews living in affluent suburbs is expected to be better than the health of Russian immigrant Jews living in poor urban neighborhoods), the Jewish Federation of Metropolitan Chicago recognized the need to collect information about health status and health care access at the neighborhood level. Thus, the Jewish Community Health Survey was born.

Project Background

The survey is a joint effort between the Jewish Federation of Metropolitan Chicago and a local research center. This research center, the Sinai Urban Health Institute, is based in the Mount Sinai Hospital, a hospital with strong Jewish community roots that is an affiliate agency of the Federation. Though today it is physically an inner city medical institution, the Sinai Health System has an active and vital relationship with the Chicago Jewish community through the services it provides in collaboration with many Federation agencies.

The overall project was designed to take place in three separate phases. Phase One encompassed the design of the questionnaire and collection of data. Phase Two was focused on data analysis and dissemination of findings. The final phase has just begun and incorporates efforts to design, fund, implement, and evaluate interventions addressing the most significant problems identified by the data.

Community Selection and Survey Development Process

To begin the process, a series of meetings were held with project stakeholders, community leaders, and agency professionals. Through these meetings, one community (comprising two contiguous neighborhoods, West Rogers Park and Peterson Park) was selected because of its high concentration of Jewish individuals and a perception of elevated health and social service needs. This community (referred to as West Rogers Park, or WRP) is located on the north side of the city, and the Jews living there are primarily Orthodox.

The next step of the process was to design the survey instrument. The same group of community leaders and members worked with public health researchers from the Sinai Urban Health Institute (SUHI) to accomplish this task. The goal was to develop a questionnaire that was tailored to the health issues of this community, but that also used questions from national and state surveys in order to benefit from validated questions and to allow for comparisons with other data. The final instrument was largely based on the questionnaire used in the *Improving Community Health Survey* conducted by SUHI (Whitman, Williams, & Shah, 2004). This survey was previously used in six Chicago community areas and covered a large variety of health-related issues. For the WRP survey, approximately 50 questions were added that focused on health and religious issues important to the Jewish population. These additional questions covered such topics as genetic screening, disability, and participation in religious activities. Overall, the questionnaire included 475 adult and 100 child questions (see Table 1 for examples of topic areas included in the survey).

Survey Methodology

The Survey Research Laboratory at the University of Illinois at Chicago was hired to do the sampling and data collection (Survey Research Laboratory, 2004). A representative sample of adults and children living in this community area was selected using a three-stage sampling design. The inclusion criteria for adults specified that they

Table 1. Topics Included in the Survey

Demographic and Socioeconomic Information
Education
Income
Marital Status
Nativity
Primary Language Spoken at Home
Ethnic Origin
Physical Health Status
Self-Rated Health
Chronic Conditions
Disability
Mental Health Status
Quality of Life
Depression
Emotional Problems
Perceived Stress
Anger Management
Health Behaviors and Attitudes
Substance Abuse
Diet and Nutrition
Physical Activity
Genetic Screening
HIV/AIDS
Health Care Access and Utilization
Health Insurance
Primary Care
Preventive Health Care
Alternative and Complementary Treatments
Prenatal Care
Religious Involvement
Synagogue Membership
Denomination
Keeping Kosher
Interfaith Marriage
Other Social and Environmental Factors
Domestic Violence
Perceived Discrimination

must identify themselves as Jewish, be at least 18 years of age, and live in the designated study area.

The data were collected between August 2003 and January 2004 through face-to-face interviews in the respondent's home. In all, 201 Jewish adults and 57 caregivers of Jewish children were interviewed. As a token of appreciation, respondents were given $20 for an adult interview and $10 for a child interview. The response rate, which measures the proportion of eligible respondents who completed an interview, was 51 percent. This response rate is high in comparison to other similar surveys. For example, the response rate for the NJPS in 2000 was 28 percent. Possible reasons for this large difference include aspects of the methodology (using personal interviews in the respondent's home instead of telephone surveys), as well as the strong support expressed by well-known community leaders and local agencies. All selected individuals were sent an introductory letter signed by two influential local rabbis on Jewish Community Council stationery explaining the importance of the survey and its sponsorship by the Jewish Federation and asking for their cooperation.

Despite the relatively high response rate, there is still a possibility that the results may differ between respondents and individuals who did not respond. For example, nonrespondents are generally less healthy than respondents, particularly for older adults (Cohen & Duffy, 2002; Hooeymans, Feskens, van den Bos, & Kromhout, 1998). Although this bias is less apparent when using in-person interviews (Hebert, Bravo, Korner-Bitensky, & Voyer, 1996), any negative health outcomes reported here may be underestimated, especially for adults over 65 years of age. More specific information on the methodology is available elsewhere (Benjamins, Rhodes, Carp, &Whitman, 2006a,b).

Data Dissemination

An epidemiologist was hired to analyze the data, disseminate the findings, and serve as the project leader for Phase Three. After the data from the survey were analyzed, the findings were presented to community stakeholders, including lay leaders, community agency professionals, rabbis, and school administrators. A series of meetings were held, each beginning with a presentation of the study background, methodology, and results and concluding with a question-and-answer session. Through these sessions, the most pressing health problems were prioritized, potential interventions were developed, and groups interested in being involved in the intervention phase were identified.

SELECTED SURVEY RESULTS

Below is an overview of the demographic and socioeconomic characteristics of the individuals living in this community. Then the health topics deemed the most urgent are summarized, and particularly vulnerable population subgroups are identified. One particularly prevalent health issue—obesity—is highlighted, along with a brief description of the planned interventions stemming from these findings. Finally, suggestions for other communities are provided.

Community Characteristics

Demographic Characteristics

Various demographic, social, and economic characteristics were measured in order to create an overall picture of the community (Table 2). This type of information is also helpful in determining which subgroups are most at risk for specific health-related problems and in understanding how well the findings can be generalized to other populations. It was especially helpful to compare these estimates to those from other city and national populations. Results showed several differences between these neighborhoods and general population samples, such as the relatively high levels of marriage in WRP. The findings also highlighted differences between the current sample and other Jewish populations. For example, a greater percentage of individuals in WRP were foreign born compared to Jews in Chicago or the United States.

Religious Involvement

The survey included several measures of religious involvement (Table 3). Again,

Table 2. Comparison of Demographic and Social Characteristics[a]

	WRP[b] (%)	MCJPS[c] (%)	NJPS[d] (%)	Chicago[e] (%)	U.S.[e] (%)
Gender					
Female	52	52	56	51	51
Male	48	48	44	49	49
Nativity					
US born	80	87	85	78	89
Foreign born	20	13	15	22	11
Marital Status					
Married	73	57	57	40	54
Divorced/separated	7	9	10	12	12
Widowed	7	11	8	7	7
Never married	13	23	25	41	27
Education					
Some college or less	35	31	45	74	75
College degree	38	41	30	16	16
Graduate degree	27	29	25	10	9
Annual Household Income					
Less than $25,000	14[f]	14	22	33	29
$25,000–$74,999	38	44	44	47	48
More than $75,000	47	43	34	20	23
Employment Status					
Employed	60	64	61	61	65

Notes: [a] Percentages may not add to 100 due to rounding
[b] Weighted data, N = 201
[c] Metropolitan Chicago Jewish Population Study, 2000–2001
[d] National Jewish Population Survey, 2000–2001
[e] Census, 2000. Age ranges vary slightly. Specifically, education is asked of adults ≥25 and employment status for those ≥16. All others reflect adults ≥18.
[f] Income categories differ for the current survey. They are as follows: Less than $30,000, $30,000–$69,999, and more than $70,000

Table 3. Religious Characteristics Among Jewish Adults

	WRP/PP[a] (%)	MCJPS[b] (%)	NJPS[c] (%)
Synagogue affiliation			
Orthodox or Traditional	72	5	11
Conservative	5	13	15
Reform	3	19	17
Reconstructionist	0	2	1
Other	1	3	2
Not affiliated	19	58	54
Keeps a kosher home	79	20	21
Jewish spouse (if married)	96	82	69
Received Jewish services in past year	28	—	—
Income insufficient for religious obligations	25	35	—

Notes: [a] Weighted data
[b] MCJPS, 2000–2001
[c] NJPS, 2000

comparisons with both the Chicago and U.S. Jewish populations highlighted the substantial differences that may exist between communities (even within a city) and thus underscored the need for local-level data. For example, the vast majority of Jews in this community reported belonging to a synagogue (81%) as compared to less than half of the total Jewish population in Chicago and in the United States. Of those in WRP who belonged to a synagogue, the vast majority were Orthodox or Traditional. In Chicago and the United States, the percent of Jews who are Orthodox is significantly lower. Other indicators of religious commitment, such as keeping kosher and marrying within the faith, also reflected high levels of religious involvement in the WRP community.

Socioeconomic Status

In addition, the survey measured several indicators of socioeconomic status, with special attention given to those indicating who were more likely to suffer financial hardships. Overall, the current study found that one-tenth of adults were living under the poverty line and another 8 percent lived in low-income (near-poverty) households. In addition, almost half of the sample reported having insufficient funds for one or more of the following basic needs: health care, food, religious obligations, or a child's education. Interestingly, despite these needs, those living in households below the poverty threshold were LESS likely to receive Jewish services in the past year. In fact, 82 percent of this group did not report receiving services from a Jewish organization. This finding has significant implications for the Chicago Jewish Federation system. The Federation and its agencies need to learn more about the apparent disconnect and to determine how to engage this part of the Jewish population that is in need of services.

As noted above, this type of data can be valuable for identifying population subgroups, such as families, single-parent households, and older adults, who may face increased socioeconomic and health problems. (The increased burdens often faced by immigrants were also acknowledged, although the small sample size for this group precluded separate analyses.) As expected, it was found that households with children were more likely to report insufficient funds for important needs like health care, food, and religious obligations. Of all family types, families headed by a single parent were particularly at risk. Most notably, almost half of these families had incomes that classified them as living below the federal poverty line. The prevalence of poverty in

these families is substantially higher than for single-parent families in general in the MCJPS.

Finally, the results showed that, in contrast to older adults in other populations, adults over 65 years of age in WRP were relatively advantaged financially. For example, although they generally reported lower incomes than younger adults, they were no more likely to live under the poverty line or in low-income households than those under 65 years. In addition, they were just as likely to have sufficient funds for basic needs like health care or food as younger adults.

Selected Health Problems

A summary of selected physical and mental health issues is shown in Table 4. This summary includes health conditions and behaviors, health care utilization and access, and other issues related to health. In general, many positive results were found, such as for health behaviors and access to health care. For example, the percentage of individuals in WRP getting regular exercise was higher than those in Chicago and the United States. In addition, levels of substance use and abuse were low. Moreover, adults in this population had relatively high levels of access to health care. For example, more than 95 percent of adults currently had health insurance, 89 percent had been to a doctor in the past year, and 90 percent had a usual place to go for health care.

However, these Jews had worse health outcomes relative to the general public in other areas, such as disability, depression, and obesity. For example, 23 percent of the adults reported that someone in their household had a disability. This percentage is more than 50 percent higher than the estimate for the total Jewish population of the Chicago metropolitan region (MCJPS, 2000–2001). Levels of mental health problems, such as depression, were also el-

Table 4. Selected Results from the Jewish Community Health Survey, 2003

- *Chronic Conditions.* The most prevalent chronic condition was high blood pressure, which was reported by 28% of adults. Substantial proportions also reported having been diagnosed with arthritis (21%), asthma (10%), and heart disease (9%).
- *Overweight and Obesity.* Over half of the adults were overweight, including 24% who were obese. The majority of children 2–12 years old were also overweight (54%). This includes 26% of all children who qualified as obese.
- *Experiences with Violence.* Nearly one-third of adults reported that a member of their household was a victim of physical, verbal, or sexual violence. In addition, 25% reported that they had personally witnessed domestic violence.
- *Disability.* Almost one-quarter of the adults in this community lived with someone with a disability. This includes physical, mental, and learning disabilities. Nearly half of the disabled individuals reported special care needs, such as for therapists or mobility devices.
- *Depression.* Over one-fifth of individuals reported having been diagnosed with depression at some point in their life. In addition, 17% were screened as currently depressed using the CES-D scale of depressive symptoms.
- *Health Behaviors.* Levels of physical activity were slightly higher than city and national estimates, but still below recommended amounts. Relative to other groups, levels of smoking, drinking, and marijuana use were low.
- *Health Care Access and Utilization.* Most adults had health insurance and a usual place to go for health care; they also received routine check-ups and recommended preventive services. However, 23% of the sample reported being unable to obtain certain needed medical services, such as surgery, dental care, mental health care, and prescriptions.
- *Genetic Testing.* Within this community, 58% of adults had never been screened for genetic disorders. Of these, many reported not being aware of the tests or did not consider them necessary.
- *Discrimination.* More than half of all adults (55%) reported that they had experienced discrimination because on their race or ethnicity.

Note: Adapted from Benjamins, et al., 2006a

evated. For instance, 21 percent of adults had been diagnosed with depression at some point in their lives, and nearly one-third reported that they had been depressed in the past month. This latter percentage is substantially higher than national estimates of depression in the past *year* (Kessler et al., 2003).

To determine if individuals were overweight or obese, the survey used a measure of weight-for-height called the body mass index (BMI). Based on individual BMIs, the survey found surprisingly high levels of obesity, particularly among children. Specifically, more than half of all adults in WRP (57%) and of children 2–12 years old (54%) were overweight or obese. Unfortunately, nearly half of these children were obese. As seen in Table 5, the percentage of obese children is significantly higher in WRP than in the national sample. In fact, a Jewish child in West Rogers Park is approximately *twice* as likely to be obese as the average American child. Children 2–5 years of age have the greatest risk of being obese: 36 percent of children in this age group in WRP were obese compared to 10 percent in the United States. To better understand this issue, numerous other questions related to obesity were asked of both adults and children; however, they are beyond the scope of the current article. These questions covered such topics as specific food intake, fast food consumption, physical activity, perceived weight status, and weight loss activities, among others.

Findings regarding other health concerns, such as genetic screening, domestic violence, and discrimination, also point to areas in which improvements are needed. For example, less than half of adults had been screened for genetic disorders. Even among married individuals of childbearing years (18–44), more than one-fourth had not been screened. Questions about domestic violence also revealed widespread problems, confirming recently collected qualitative data on domestic violence within the Chicago Jewish community (Jewish Women International, 2004). Specifically, 25 percent of adults had witnessed domestic violence and 32 percent reported that they lived in a household with someone who had been a victim of physical, verbal, or sexual violence. Finally, questions on discrimination revealed that more than half of adults had experienced discrimination based on their race or ethnicity. This included those who felt discriminated against in the following areas: at school (23%), in public (21%), in their job (16%), in housing (4%), and by the police (3%). A more complete description of the survey findings is available in the project's final report (Benjamins, Rhodes, Carp, & Whitman, 2006a).

Table 5. Percent of Overweight and Obese Adults and Children in the Current Study and the United States

	Adults		Children	
	WRP[a]	U.S.	WRP[a]	U.S.
Overweight	33%	37%	28%	26%
Obese	24%	22%	26%	13%

Note: [a] Weighted data
Sources: Jewish Community Health Survey, 2003 and NHANES, 1999–2000

TRANSLATION OF FINDINGS INTO ACTION

Because of the strong commitment of the community to funding and implementing the survey, as well as the high levels of positive feedback received regarding the findings, it was hoped that this data could be used to successfully motivate and guide future interventions. To this end, one major initiative is underway and several additional projects are being developed and are in the process of seeking funding. To provide an example of how scientifically collected data can be used to motivate a community and guide health programs, the intervention designed to address obesity within the WRP community is described in this section.

Obesity Interventions

Obesity was the highest priority health problem because of the number of people

affected and the seriousness of its consequences. Obesity is a critical risk factor because it is associated with an increased risk of heart disease, diabetes, stroke, cancer, and a host of social and psychological problems, in addition to lowered life expectancy (Fontaine, Reden, Wang, Westfall, & Allison, 2003; Narayan, Boyle, Thompson, Sorensen, & Williamson, 2003). As mentioned above, weight problems were especially prevalent in children compared to city and national estimates. Unfortunately, overweight children are also more likely to become overweight adults, so childhood obesity foreshadows even more widespread obesity problems in the future (Guo & Chumlea, 1999; Whitaker, Wright, Pepe, Seidel, & Dietz, 1997).

Community Obesity Prevention Project

An initiative has been developed in cooperation with the Associated Talmud Torahs (the umbrella organization for Orthodox day schools), Jewish Child and Family Services, and the Chicago Rabbinical Council to address this critical health problem. Each component of this initiative is founded on evidence-based practices and is adapted to fit Jewish beliefs and lifestyles. The community-wide intervention works through multiple channels to target several different groups. The first component of the project to be developed and implemented is a school-based nutrition and physical activity demonstration project for the Jewish day school system (discussed below). Some other project ideas that are being developed include educational classes to be held in conjunction with early childhood parent-child groups, programs designed to motivate and train rabbis to be involved in health promotion, and an effort to encourage local kosher restaurants and caterers to provide healthier options and more health information about their food.

School Obesity Prevention Pilot Project

Because children spend a large part of their days in school, schools are an effective location in which to base interventions. Moreover, schools are often motivated to intervene because the primary causes of obesity (poor diet and lack of physical activity) are associated with an increase in behavioral problems and a decrease in academic performance among children. As a result, several government agencies have funded major initiatives to aid schools in their quest to improve student health. These studies have provided a wealth of evidence-based knowledge regarding childhood obesity interventions. However, interventions developed within public schools or those designed for members of other ethnic groups may not be appropriate or effective for Orthodox Jews. Unfortunately, we found no previous studies focused on members of Orthodox Judaism or on any other Jewish group. Thus, there is a critical need for culturally appropriate health promotion and disease prevention materials for this population.

To address this need, we secured generous grants from three local foundations to develop and implement the school wellness project. The project is currently being tested in two Jewish day schools in the WRP community.

Briefly, the intervention requires the schools to undertake three important preliminary tasks: (1) to form a school wellness committee, (2) to conduct an assessment of the health-related strengths and weaknesses of the school, and (3) to write a school wellness policy. The school wellness policy and the remainder of the intervention activities will focus on the following five areas: health education, physical education, family involvement, school environment, and staff wellness. Specific projects and curriculum changes will be undertaken in each of these areas, under the guidance of a public health professional and a dietician. Examples of project activities that have been initiated to date include a policy change to remove all soft-drink vending machines from both schools, the addition of a "Gym and Swim" program that involves busing students to the local Jewish Community Center for

physical education classes, and changes in foods provided as snacks or rewards in the classroom.

A key component of this intervention is a rigorous evaluation that involves yearly BMI screenings for all students, as well as health surveys to be completed by students, teachers, and parents. If the evaluations of this 2-year project indicate that it is successful in improving the health and well-being of the students, we hope that funding will be secured to expand it to all Chicago day schools. At the very least, the materials and activities developed during this project will be made available to the other schools in the school system, as well as to other Jewish schools across the country.

Other Projects

Another outgrowth of this survey relates to the special needs of the elderly. To address high rates of depression, obesity, and chronic health conditions found among older adults in this community, the Jewish Federation and Council for Jewish Elderly initiated discussions with rabbis, service providers, and community leaders about the possibility of establishing a Naturally Occurring Retirement Community (NORC) demonstration project in West Rogers Park. Chicago already has two federally funded NORC sites, which aim to help older adults "age in place" in their own homes by providing wellness programs, social activities, linkage to needed concrete services, and information about community resources, volunteer, and employment opportunities. Two grant proposals were recently submitted requesting funding to adapt the NORC model for Orthodox seniors living in WRP—one grant was awarded and the other is pending.

In addition, the findings identified a large percentage of individuals who had some experience with violence. As noted above, this estimate confirmed suspected prevalence rates based on qualitative research done in the Chicago Jewish community (JWI, 2004). The Chicago Jewish community has an active task force on domestic abuse—the Jewish Community Abuse Resources, Education and Solutions (JCARES)—which was established in 2003 and has more than 35 members. Last year, JCARES launched a community-wide training and networking initiative to enable staff in local Jewish agencies to better serve individuals and families affected by domestic abuse. It is beginning to define strategic directions for the next 1 to 3 years and is using findings from the current survey to emphasize the widespread nature of the problem and the need for action, as well as to leverage outside funding.

Finally, as discussed above, the findings showed that a large percentage of individuals suffered from various mental health problems. An analysis of the data related to mental health revealed that most individuals said that they would talk with a rabbi or their regular physician if they had emotional problems. Planning is underway to conduct workshops with these groups of professionals to give them the tools to better evaluate mental health problems and to recognize problems that require referrals to mental health professionals. The plans for this project are still in a very early stage of development, so more information is not yet available.

DISCUSSION

Implications of Findings for WRP

Overall, the findings from this survey indicate that the individuals in this community are generally as healthy as the average residents of Chicago or the United States. However, many serious health concerns still exist for both adults and children. Now that the health problems have been identified, social service agencies, health care providers, and religious and educational organizations within the community can focus their limited resources on the most prevalent and serious concerns. For example, this survey provided the first population-based estimates of violence within the Jewish community in Chicago. Although high rates of do-

mestic violence had been suggested by recent qualitative assessments in the city, having actual prevalence rates gives advocates valuable ammunition in the effort to motivate service providers, funders, and the public to continue to deal with this serious problem.

It is hoped that this information will be used to develop even more targeted interventions and policy changes to improve the health of individuals residing in this Jewish neighborhood. It is also hoped that the experience gained here will benefit other communities as well. The lessons learned throughout the process, from survey design to data dissemination, can be used to facilitate similar health surveys in other communities. Some of the specific lessons learned are discussed below.

Advice for Other Communities

Community Involvement

Although typically, a survey such as this one is spearheaded by one or more organizations, it is imperative to obtain broader community input to help shape project decisions. Ideally, input should be sought from individual community members, community leaders, synagogues, health care professionals, and local social service agencies. This sharing of ideas and request for input can be done either formally or informally. It is also very important to identify the most respected and well-known community leaders and solicit their support for the project. This is important not just at the beginning of the project but also at each stage. For example, we elicited the written support of key local rabbis to encourage the participation of respondents in the survey. The rabbis were also included in the main data presentations and in the development of the interventions. It is expected that including individuals from the beginning will facilitate their continued participation in the project.

Methodological Concerns

Because only scientifically collected data can yield representative results, it is important to have individuals trained in epidemiology to guide the sampling procedures. Similarly, it is also important to consult with experienced researchers when designing the survey instrument and analyzing the data. Because many Jewish agencies are not research-oriented, it is important for communities to partner with a research center, university, or business that can do this type of work. For example, in the current study, the Jewish Federation of Metropolitan Chicago partnered with the University of Illinois at Chicago's Survey Research Laboratory to do the actual data collection and the Sinai Urban Health Institute to develop the survey, do the analyses, and employ the project leader. Regardless of who is responsible for the data, it is important to use existing questionnaires or at least existing questions, rather than writing new ones. Most questions used on national surveys have been empirically tested and been found to be both reliable and valid. In addition, using existing questions allows a comparison of findings to those from other populations, such as city data sets or the National Jewish Population Survey. To begin this process, it may be helpful to look at the data sets and questionnaires provided through the North American Jewish Data Bank.

Data Dissemination

The primary advantages of collecting local-level health data are that it can be used to motivate and direct changes within a community. It can also be valuable for generating feedback from the community. However, it is crucial that the results are widely disseminated after the data are collected and analyzed. To this end, presenting the findings in a variety of media is beneficial. For example, we used scheduled presentations, publications in academic and religious journals, and a final report to inform community members and agencies about the study. Also, communities that do collect data should consider putting the data in the North American Jewish Data Bank where it can be accessed and analyzed by other researchers.

Finding Funding

Finally, although many communities may value the benefits of conducting a local-level health survey, they may be discouraged or deterred by the cost. However, although such studies as this one are expensive, the cost of detecting and preventing serious health problems is much lower than the cost of treating these conditions in the future. In addition, there are many options for funding. For example, we received funding from a variety of local Jewish family foundations and health foundations. Furthermore, health surveys may be eligible for funding from numerous federal grants. In addition, there are various other methods for reducing expenses. For example, using an existing questionnaire (such as the one developed for the current project) would eliminate the costs of survey development. Moreover, it is not always necessary to do a population-based survey that provides representative data for a whole community. Substantial savings could be realized by looking at a smaller population, such as the membership of one synagogue. Or, helpful data could be gathered through the use of convenience samples; for example, surveys could be handed out at a local Jewish Community Center. Data gathered through these means could be valuable on their own, but could also be used as "pilot data" to help obtain funding for a larger data collection effort.

CONCLUSION

This type of in-depth health information for a Jewish community is rare and has not been available before in Chicago or in most other cities. The findings have greatly increased the awareness of health issues within this community and have provided an impetus for change. They are also being used to guide health promotion and disease prevention activities at the individual, organization, and community level. Through these means, this health survey continues to be a valuable asset for the Jewish community of West Rogers Park. We hope that this effort will spur similar surveys in Jewish communities around the country.

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