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A Community-Based Approach to Understanding Problems and Exploring Alternatives: Connecting Underemployment, Poverty and Access to Health Care in the Mississippi Delta

Community-based research provides a useful framework for addressing social problems and exploring alternatives. This paper directs attention toward community-based research as a framework for better understanding inter-subjective views of poverty and exploring alternative intervention programs that are innovative and diverse. As an example of substantive research in this regard, results from two related mixed-method investigations (key-informant interviews, focus groups and telephone surveys) of underemployment, poverty and limited access to health care are synthesized. Discussion of these efforts and description of follow-up projects address the ways in which the CBR framework may contribute to the development of alternative policies and programs for workforce development, poverty alleviation and increased access to health care.

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THE COMMUNITY-BASED RESEARCH FRAMEWORK

Research may be conducted and used for myriad objectives, including the development of basic knowledge. Research may also be aimed at impacting policies and programs from the micro to macro levels. The call for interventions for social problems to be scientifically informed is not new. Much of the historical and contemporary support for the social sciences stems from attempts to apply knowledge to issues such as poverty. Still, a gulf continues to exist between scientists, policymakers, development practitioners and people in their everyday lives. As a result, research is often conducted outside of the community arena, research results frequently do not find their way into the policy dialogue, and the general public is left wondering how and why policies are organized in an often illogical manner. In the end, many of the same social problems continue to exist despite the widespread acknowledgement that something must done.

As one way of addressing these challenges, research efforts may be directed toward obtaining input from community residents in relation to the policymaking and program administration enterprise. A major goal in this realm is to amplify local voices (Harris 2001). The problem is not that people lack voice nor is it that they fail to express themselves. Rather, dominant structures and processes of decision making are not conducive to their input and effectively keep them from being heard. This lessens the responsiveness of public policy, because it is at the local level of people's everyday lives that the greatest impacts are experienced, whether positive or negative. Thus, there is a need for research that is more participatory and action-oriented.

There are several different ways to approach participatory and action-oriented research (e.g. Reason & Bradbury, 2001; Selener, 1997; Voth, 1979). Attending to the community-level, Stoecker (2005) utilizes a project model, taking the reader through four stages to diagnose, prescribe, implement and evaluate initiatives in his *Research Methods for Community Change*. In his text entitled *Action Research*, Stringer (1999) presents the three steps to community-based research of look, think and act. Knight (2002), in *Small-Scale Research*, investigates claims making and sense making as the major acts of research. Borrowing from and augmenting each of these perspectives, this paper takes a pragmatic approach, viewing community-based research (CBR) as consisting of a "tool box" of strategies for engaging people – from community residents to professional researchers – in participatory processes of knowledge development.

Multiple research methods are used within CBR. These may include analysis of secondary data, surveys (telephone, mail, face-to-face), focus groups, in-depth interviews and observation. Each of these methods was utilized in the two studies discussed in this paper. It is also worth noting that CBR fits well with efforts to bridge asset mapping and needs assessment for community development practice (Beaulieu, 2002; Kretzmann & McKnight, 1993) and with empowerment evaluation (Fetterman, 2001).

GENERAL TRENDS IN RESEARCH ON POVERTY

Investigating the array of poverty research, the reader is likely to find issues where CBR can be used to build from existing work and contribute new insights. Quantitative research on poverty provides both a macro view of general trends (see, for example: Iceland, 2003; also helpful are reviews by Miller & Weber, 2004 and Mosley & Miller, 2004) and a micro perspective on individual and family behavior. Research on the processes and implications of welfare reform are valuable as well (Weber, Duncan & Whitener, 2002). An added advancement

in this realm has been the expanding attention to "underemployment" as a concept (Jensen et al., 1999; Lichter, Landry & Clogg, 1991; Slack & Jensen, 2002) for understanding that poverty goes beyond the simple "employed" versus "unemployed" dichotomy to include involuntary part-time, low-wage and other inopportune employment situations. It is noteworthy that Stofferahn (2000) investigated the resonance of this concept utilizing diverse methods.

Qualitative studies provide much needed insight, especially from the perspective of people living in poverty themselves (e.g. Duncan, 1999; Eitzen & Eitzen-Smith, 2003; Wells, 2002). Goode and Maskovsky (2001) brought together a diverse set of ethnographic studies in their edited volume exploring poverty, power and politics in the U.S. Taken as a whole, qualitative studies provide information on poverty in specific contexts while at the same time adding depth to our understanding of broader trends. As the Rural Poverty Taskforce of the Rural Sociological Society (1993) pointedly argued over a decade ago, policymakers would do well to consider these findings as they debate multiple courses of action.

Despite the insights provided by both streams of investigation, there remains a gap in our understanding of social problems such as poverty. In part, this results from many researchers across the quantitative–qualitative continuum studying these issues within very specific methodological and theoretical boundaries. Additionally, in both types of research there is often a neglect of people's inter-subjective understanding of issues of importance and their ideas regarding future action. While analysis of poverty rates abound and general opinion polls are widespread, efforts to engage people in actual dialogue regarding these topics are few and far between. This leads to a general lack of diversity in the voices that are represented in policies aimed at improving the lives of the people that they are supposed to help.

This is more than just a point for academic debate. Given the increasing attention to decentralization in development and poverty alleviation efforts from a variety of political persuasions, gaining insight from the people most impacted by policy and program changes is of great importance. This will be critical if decentralizing efforts are to avoid the pitfalls of local elites controlling the process and instead move forward to fulfill the more democratic and participatory promise. Also of concern and in need of attention is whether local organizations have the capacity to adequately meet the needs of the poor in their community (see, for example, the concerns waged by Ferguson et al., 2002).

In all, it may be argued that a truly informed framework for addressing social problems should involve multiple approaches to understanding social reality, from the objective to the inter-subjective and subjective. Taken together, these represent the communicative level of interaction on which dialogue can take place and collective action may be more appropriately based (Habermas, 1987). Doing so requires meshing analysis of power and structure with the concept of shared meaning. Hustedde and Ganowicz (2002) argue the importance of such theoretical triangulation for the field of community development. This paper contributes to the conversation using the community-based research framework to explore the issues of underemployment, poverty and access to health care in the heart of the Mississippi Delta.

UNDERDEVELOPMENT IN THE MISSISSIPPI DELTA

The Mississippi Delta is a region defined by a variety of political, geographic and sociocultural boundaries. In this paper, interest is in the floodplain of the Yazoo and Mississippi Rivers, mainly those eleven counties in Mississippi referred to as the "core" Delta.[1] The Delta is often considered a region of contrasts between great potential and pervasive problems. There are numerous assets to draw from in the region, including fertile land, water and a warm climate for

agricultural production. There is also a sense of identity with the region encompassing a special "southerness" captured by writers, artists and musicians that conveys an attachment to place, family and tradition. Another often overlooked asset in the region is the grassroots organized response to the tradition of racial hierarchy – the Civil Rights Movement (see: Dittmer, 1995; Payne, 1995).

Despite its potential, underdevelopment, poverty and exclusion of minorities intersect in the region. Following settlement primarily for large-scale export-oriented agriculture, development was divided along class and racial group lines. When industry was allowed, it typically was in the form of low-wage jobs that provided little economic security. Education of minorities and the poor was never considered a priority by the elite, and the region faces struggling schools. There is a "brain drain" where college-educated youth leave the region in search of better employment opportunities elsewhere.

The overlap of race, class and culture has left an impact on the position of the people in the rural south in general (Swanson et al., 1995) and the Delta in particular (Duncan, 1999). These forces resulted in persistent poverty, with many of the region's counties having a poverty rate of 20 percent or higher over the past several decades. While there has been change, especially with the advent of casino gambling and tourist development in the region, contemporary studies show Delta counties with continued high unemployment and poverty rates (Cosby et al., 1992; Kersen, 2002). In tandem with the rise in dominance of free market economic policies such as the North American Free Trade Agreement and rulings under the World Trade Organization, these challenges are compounded by global pressures. Some firms go out of business and others leave the region in search of lower-cost labor, minimal tax rates and fewer regulations. This is a

phenomenon shaping the economics of the south that is vividly seen in the textile industry (Glasmeier & Leichenko, 1999).

Given the persistence of challenges faced by people living in the Mississippi Delta, innovative research and development strategies are warranted. It is to the specific methods used to inform such strategies that our attention now turns.

METHODS

Methods Used to Study Underemployment and Poverty

In partnership with several community and regional organizations, university faculty and graduate students conducted a research project on underemployment and poverty starting in fall 2002.[2] To begin, county and state level data from the 1990 Census and 2000 Census were analyzed. Specific attention was given to two Delta counties – Coahoma and Quitman – and this information was compared to the state of Mississippi as a whole. Next, a sample of employers in the two counties was interviewed over the telephone. They were primarily asked open-ended qualitative questions. Thirty-eight interviews were completed. This was followed with focus groups utilized as a method to assess the views of underemployed adults in the same counties and two additional counties in the vicinity (Bolivar and Tallahatchie). Similar to issues addressed in the employer interviews, topics discussed in the focus groups included underemployment, poverty and recommendations for future action. Participants were selected from the general public and through a set list of guidelines which included the person identifying as either unemployed or not working in a favorable position (e.g. part-time, multiple part-time, low wage). There were 29 total participants in the four focus groups.

After completion of the initial employer interviews and underemployed focus groups, six follow-up meetings were held with underemployed community residents, employers, educators

and social service providers. Two planning meetings were also held to move forward from the research findings to design a program for workforce development. Some of the issues brought up in the underemployment and poverty project revolved around access to health care. This became the starting point for another CBR project.

Methods Used to Study Access to Health Care

A project with faculty and students, some of the partners from the underemployment project, and several new individuals and groups was started in summer 2003. Seeking to document and analyze what people in the region perceive as important social and health issues and the recommendations they have for change, key-informant interviews and focus groups were conducted with residents in seven counties (Bolivar, Coahoma, Quitman, Leflore, Sunflower, Tunica and Washington) in the Delta.

In-depth key-informant interviews were conducted with residents of the counties who were recommended by various community organizations. These were people regarded as knowledgeable on the topics of community needs and assets and the state of health and human services at the local and regional levels. A total of thirty-eight key-informant interviews were conducted. Twenty-eight of the interviewees were asked to complete questionnaires.

Using a snowball sampling technique, focus groups were held with participants drawn from the lay public, civic and church organizations, and people employed in the health care system. The twelve focus groups involved a total of ninety participants. After introducing themselves, participants were asked to grade the health care system. They were also asked to identify and elaborate on what community health and social issues they perceive as warranting attention. Finally, participants discussed potential interventions to address these issues. Participants also completed questionnaires.

Moving from the local level of specific individuals and communities, the data drawn from these studies were used to inform questions for inclusion in the Delta Rural Poll. First conducted in 2003, the Poll was constructed by a committee of researchers. Input was also sought from researchers involved with similar rural polls in other states. The survey, administered via telephone by a partner university, consisted of questions on socio-demographics, quality of life, community satisfaction and specialty topics. Using random digit dialing, a sample of adults from the eleven Mississippi core Delta counties was contacted. A list of several health related questions was included in the survey, such as method of paying for health care, distance traveled to access health care and self-rated health. Of the 830 eligible people contacted, there were 809 who participated in the survey.

UNDEREMPLOYMENT, POVERTY AND ACCESS TO HEALTH CARE

Although the research projects described above were somewhat distinct, the partner organizations and community residents involved in them overlapped and so did the issues discussed. In part, the results from the underemployment and poverty study led to investigation of access to health care. Policymakers, researchers and practitioners may often sort out and divide these issues, but in people's everyday lives there are multiple connections. It is on this basis that the following analysis focuses on these results as a more comprehensive "meta-project." Much of the attention, however, is directed toward health care. More thorough analysis from the underemployment and poverty study are published elsewhere.

Underemployment and Poverty

Dialogue with employers and underemployed residents highlights the importance of individual, group and inter-group perceptions of issues revolving around underemployment and poverty. There were several lines of agreement between these two stakeholder groups, including

the existence of numerous assets in the region and community, the identification of common problems and solutions that include the development of more jobs, improved education and expansion of workforce development programs (Table 1). However, there were instances where the two groups expressed arguments that were at odds. For example, many of the employers said they find it difficult to find potential employees with adequate education, skills and experience, and they maintained that some people do not even have the motivation to work. There were a few who went so far as to argue that people are poor because they are "lazy" and "do not have work ethics." On the other side, underemployed residents argued that there is little attention given to their strong willingness to work and the wide variety of skills that they do hold.

(Table 1 Here)

There was concern expressed among the underemployed regarding the types of businesses being pursued to locate in the region. All participants agreed that it would be necessary for more companies to locate in the area to increase employment opportunities. But they also recognized that those businesses searching for low-wage workers and unwilling to make commitments to the region would probably not result in long-term improvements in quality of life. As an alternative, focus group participants expressed interest in jobs that would provide higher wages, safe working conditions and benefits, including health insurance.

Health and health care crept into many underemployment and poverty project conversations of important issues facing the region, especially during follow-up meetings with diverse participants in which action plans were discussed. People identified the importance of health to living a quality life and the more pragmatic aspects of health's influence on learning and job performance. They also noted the importance of having a job with benefits in order to access adequate health care, or in the place of workplace benefits, the central role played by government

programs (e.g. Medicaid, Medicare). Following these discussions, a more comprehensive health research effort was established the results of which proved informative.

Access to Health Care

Asked to identify what they perceive as being important community-level social and health issues, key-informant interviewees and focus group participants identified several problems in need of attention (Table 2). Limited formal education and the lack of good jobs were viewed as major contributors to prolonged poverty. There were some people who identified racial barriers and disparities as important issues, and there were those who cited substandard housing conditions. All of these issues were viewed as problems given their connection with health conditions.

(Table 2 Here)

Drug abuse, poor diet and nutrition, obesity, diabetes and hypertension were all mentioned as troubling health problems. Also discussed was the feeling that these problems are accepted as a normal part of everyday life. Participants attributed this complacency to people having a limited understanding of health and a general feeling of hopelessness. Many times it was expressed that people in the community simply do not think that the situation can be changed.

Research participants reported that individuals and families living near and in poverty and the elderly face the barrier of limited access to transportation. While it is inconvenient to everyone, it is problematic for people with few resources to travel a great distance to commute to work and access routine as well as specialized health care. They discussed their own and others' experiences of having to arrange rides, often paying fees, to visit doctors in other towns. This was troubling for people in the Delta seeking specialty care in Jackson, Mississippi, and Memphis, Tennessee.

Data from the Delta Rural Poll shed light on the travel distance people have to cover in order to access health care. On the positive side, over 45 percent of survey respondents reported traveling less than 5 miles to access routine health care, followed in prevalence by those who traveled between 5 and 15 miles (30.2 percent) (Figure 1). Still, 14.2 percent indicated that they traveled 16 to 30 miles, and 10.2 percent reported 31 miles or more. Nearly 15 percent of the total sample (117 survey respondents) indicated that they do not receive specialized care. Of those who do receive specialized care, 44.4 percent reported traveling 31 miles or more.

(Figure 1 Here)

Focus group and interview participants also noted that health care and medications are increasingly cost prohibitive. Accessing care is difficult for many people in the region, but it is a pressing challenge for individuals and families without insurance. Private and employer-backed insurance were viewed as the best forms of coverage. Many people also identified the positive strides that have been made to provide access to health care through government programs to people in need. Troubling however, the participants maintained, is the situation faced by people who slip through the "cracks" and do not have health coverage. This has been partially addressed through the Children's Health Insurance Program (CHIP), but more attention is needed in this regard as the parents do not receive coverage through these programs. Participants added that government programs often face an insecure funding base, as seen in the annual debates surrounding the state budget and recent efforts to make cuts.

The challenge of accessing health care was reaffirmed through data from the Delta Rural Poll. Nearly 23 percent of respondents said they generally pay for routine health care themselves (out-of-pocket), while 29.2 percent cover costs through participation in government programs (Figure 2). Approximately 46 percent of respondents had private insurance or insurance through

their job, and 1.5 percent reported payment using some combination of forms, typically including a government program with other sources. Over three-quarters of respondents said they had visited a doctor within the past twelve months. However, nearly 20 percent of the sampled Deltans said that there was at least one time within the past year when they needed to visit doctor but could not because of the cost.

(Figure 2 Here)

Investigation of health insurance coverage by education and household income illustrates socioeconomic disparities (Table 3). Among the respondents with less than a high school degree, 26.1 percent reported paying out of pocket for a visit to the doctor, and 47.7 percent said they participate in a government program. Only 26.2 percent of these respondents had private insurance or health benefits from their job. These numbers varied across the educational attainment groups. As education increases, paying out of pocket generally decreases (there is an exception in this pattern for those with some college) and participation in government programs does as well, replaced by private/job benefit insurance. Over two-thirds of respondents with a bachelor's degree or higher reported this form of access to health care.

(Table 3 Here)

Turning attention to financial resources, among respondents reporting annual household incomes less than $20,000, 32 percent indicated that they generally paid for a visit to the doctor out-of-pocket. Nearly 46 percent of this income group relied on government programs, while only 22.1 percent had private insurance or benefits through their job. Conversely, 80.0 percent of respondents in the more than $50,000 category had private insurance or benefits through their job.

Overall, the patterns between education, household income and insurance coverage were parallel with findings obtained when respondents were asked if there was ever a time in the past twelve months when they needed to see a doctor but could not because of the cost. Those with lower education were more likely to answer yes than those with a higher education. It is interesting to note, however, that respondents with a high school degree were less likely to report this challenge compared with those who had some college. Respondents with household incomes of less than $20,000 were significantly more likely to report a cost constraint to accessing health care relative to those with a higher level of financial resources.

Given that this research project was founded on a desire to inform action, participants were asked to make recommendations concerning what could be done to address the issues they identified as important (Table 4). At the community level, ideas included programs for awareness and advocacy. Several participants called for prevention and wellness education. Concern was expressed for increased social and health related activities in the communities, and some participants pointed out that many people are not aware of the programs and activities that do exist. Thus, there was also interest in consolidation and publication of information regarding what health care and social services exist and information on how to access these programs. Participants also demanded more involvement on the part of parents, families, churches and elected officials.

(Table 4 Here)

As for policy specific recommendations, research participants indicated a desire to see increased attention to families who fall through the health care safety net, especially low and moderate-income workers and their children. Participants also recommended relief of the

understaffing burdens faced by medical workers in the region and improvement of health care facilities and the range of services they offer.

DISCUSSION AND POLICY IMPLICATIONS

Community-based research provides an applied framework for studying and better understanding social problems and identifying potential ways to address them. Utilizing the CBR framework, the studies discussed in this paper helped to inform the partners' understanding of underemployment, poverty and access to health care in general and in the context of the Mississippi Delta more specifically. In addition, this research was used to inform the planning and implementation of alternative policies and pilot programs.

For instance, building from the underemployment and poverty project, one of the partner organizations worked with a wide variety of community members to develop an initiative to build on and fill gaps in existing services. The mission of this pilot effort was to establish a collaborative workforce development project to better prepare residents for participation in the labor market. This was intended to serve as a model for community colleges and community organizations to be more engaged with each another. This effort included three primary programmatic efforts: social marketing campaign, coordination and facilitation of existing workforce development programs, and development and implementation of a professionalism curriculum and job demonstration project. A regional foundation provided funds to the nonprofit group to implement the program. Utilizing these funds in conjunction with matching and in-kind support, partners were able to construct a program with community input and wide-spread recognition from the area employers, educators and the underemployed. In an endeavor to use this pilot program to influence public policy, partners shared information at the local, state and federal levels of government. State and local officials received notice of this program as part of a

legislative forum on workforce development. Furthermore, information was sent to the boards of supervisors for three counties in the region. A meeting was held with a member of the community college board of directors and a representative of a jobs program. At this meeting, the partners were advised to pursue expansion of the program.

In terms of accessing health care, research findings were and continue to be utilized in planning discussions of network development to increase access to and quality of health care in the region. Some of the organizations were able to integrate data from these studies into their applications for new and continued funding, which some of them received. Results were also presented to, discussed by and incorporated into the planning and annual evaluation efforts of many such organizations. As just one example of these efforts, a group is working to better coordinate case management between service providers and to utilize communication technology to link rural schools and community health centers to provide more services to people in need. Also, as was mentioned previously, research participants recommended that information on available services be collected and disseminated to help inform people of existing resources. As one step to partially meet this request, the researchers conducted two rounds of a survey of nonprofit service providers in three counties to catalogue resources. The same foundation that supported this consolidation and dissemination of information has also sponsored a community initiative to assess transportation needs relating to accessing education, employment and health care and develop strategies for meeting these needs through private and public initiatives.

Although none of these actions represent large-scale policy changes or intervention programs, they are well-informed efforts that diverse community residents and local/regional organizations are participating in together. Consideration of the inter-subjective views of diverse stakeholders – drawn out through systematic yet participatory research – has led to a deeper

collective understanding of the issues at hand and paths for collaborative action. The pilot efforts are being used to test out new processes and then they are evaluated and reshaped to be presented to policymakers and agency personal for the purpose of scaling-up for broader impact.

The community-based research framework used in these endeavors in no way replaces other approaches to researching issues of social problems such as underemployment, poverty or access to health care. However, it does make a contribution to filling the gap between policymakers, researchers, practitioners and people in their everyday lives. It is on this basis that community development practitioners can make great strides.

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TABLES AND FIGURES

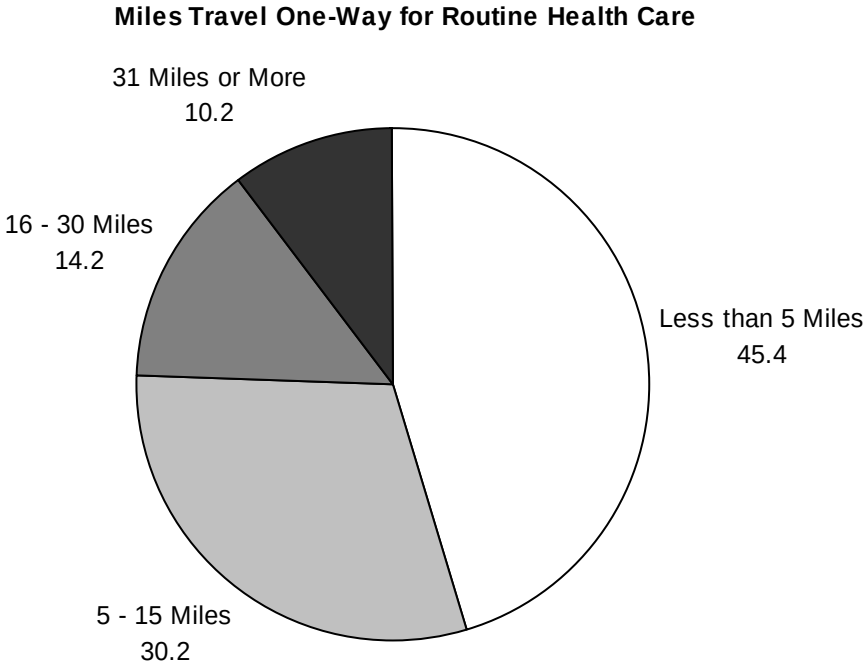
Table 1: Claims Regarding Assets, Barriers/Challenges and Important Health Issues Expressed by Residents in the Mississippi Delta (2002)

	Employers (Telephone Interviews, n = 38)	**Underemployed** (Focus Groups, n = 29 participants)
Community and Regional Assets	Tourism Farm-related industry Future industrial development opportunities Improved physical infrastructure Enterprise Zone Delta Regional Authority Increased educational stability Existing workforce training programs	Strong willingness/desire to work Heightened education levels among the workforce Extensive skills and experience Existing workforce training programs Social service organizations Available buildings for production/service businesses
Barriers and Challenges	Few jobs Inability to attract new businesses Unemployable workforce/low educational levels Crime and drug problems	Overall social and economic structure High level of competition for few jobs Limited educational credentials Businesses showing favoritism in hiring practices Lack of dependable transportation to jobs in other areas Few job benefits
Important Health Issues Identified in Six Follow-up Community Meetings	Health is important to the overall quality of life Health status influences learning and job performance Health insurance is a key benefit for a situation defined as a “good job”	

Table 2: Claims Regarding Important Social and Health Issues Expressed by Residents in the Mississippi Delta (Key-Informant Interviews and Focus Groups, 2003)

Important Social and Health Issues (38 key-informant interviews, 90 focus group participants)	
General Social Issues	Specific Health Issues
Limited formal education	Drug and alcohol abuse
Lack of good jobs, few benefits, poverty	Poor diet and nutrition
Racial barriers and disparities	Obesity
Poor housing conditions	Diabetes
Limited access to transportation (especially to access out-of-town services)	Hypertension
Lack of insurance (many people slip through the "cracks" in the system)	Teenage pregnancy
	Health problems accepted as norm
	Limited understanding of health issues

Figure 1: Travel Distance for Routine and Specialized Health Care (Delta Rural Poll, 2003)



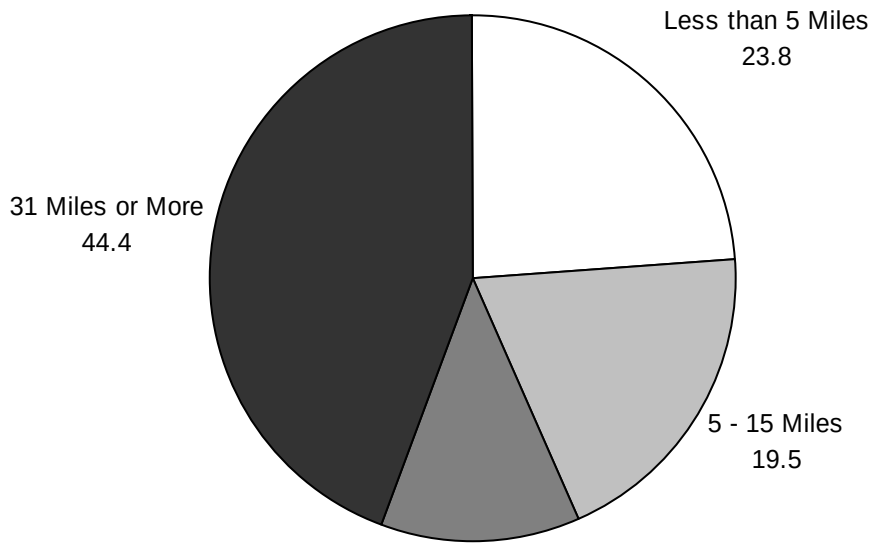


Figure 2: Form of Health Insurance Coverage (Delta Rural Poll, 2003)

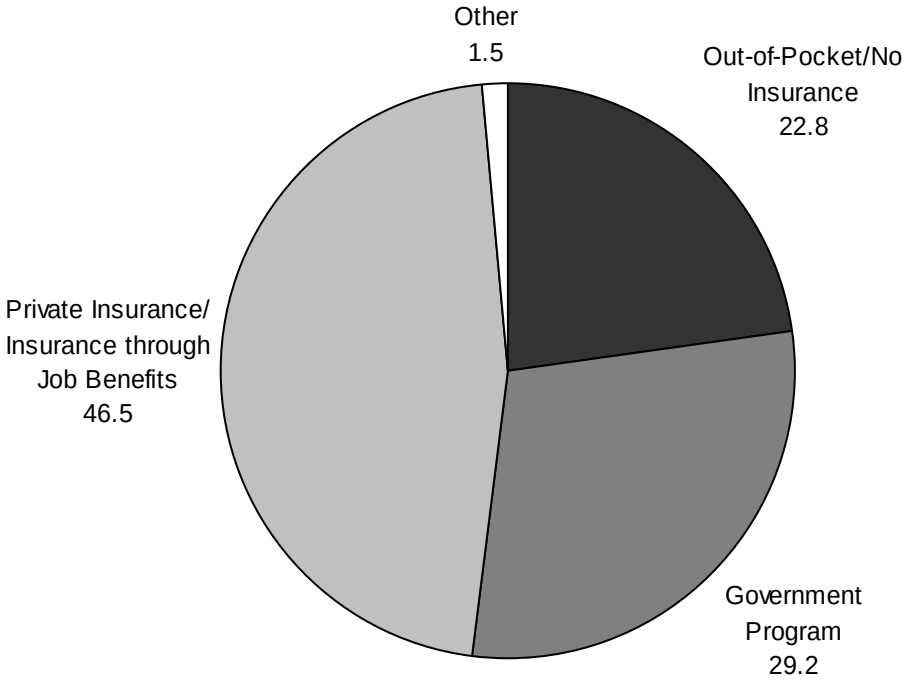


Table 3: Insurance Coverage and Cost Constraints to Health Care by Education and Household Income (2003 Delta Rural Poll)

		Education			
		Less than High School	High School Diploma or Equivalent	Some College	Bachelor's Degree or Higher
Insurance Coverage	Private/Job Benefit Insurance	26.2	41.7	54.7	68.4
	Gov't Program	47.7	34.0	18.9	18.4
	Out of Pocket	26.1	24.3	26.4	13.2
		n = 788, X^2 = 96.75, p $\leq$ .001			
Ever a time when needed to see a doctor but could not afford	Percent Answering Yes	27.8	15.7	22.2	9.9
		n = 794, X^2 = 23.90, p $\leq$ .001			
		Household Income			
		Less than $20,000	$20,000 to 29,999	$30,000 to 49,999	$50,000 or Higher
Insurance Coverage	Private/Job Benefit Insurance	22.1	56.7	69.9	80.0
	Gov't Program	45.9	16.7	12.4	9.3
	Out of Pocket	32.0	26.6	17.7	10.7
		n = 667, X^2 = 171.43, p $\leq$ .001			
Ever a time when needed to see a doctor but could not afford	Percent Answering Yes	31.9	21.4	10.7	7.8
		n = 674, X^2 = 42.36, p $\leq$ .001			

Table 4: Recommendations for Action Expressed by Residents in the Mississippi Delta (2003)

Recommendations for Action (38 key-informant interviews, 90 focus group participants)	
Community level	Policy level
Awareness and advocacy	Expand insurance coverage, especially for those who slip through the cracks
Prevention/wellness education	Improve staffing in health care facilities (increase numbers, professionalism, compensation)
Information on available health care and social service resources	
Increase prevalence and awareness of social and health related community activities/programs	
Community involvement (parents, family, churches, police, leaders)	