A Community Participatory Research Partnership: The Development of a Faith-Based Intervention for Children Exposed to Violence

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When an inner city Latino immigrant faith community in Los Angeles identified mental health care as an area of need, a community-research partnership was formed that resulted in the adaptation of an intervention for children who have trauma-related symptoms from violence exposure. This participatory research partnership includes St. Thomas the Apostle School and Church community; QueensCare Health and Faith Partnership, an organization that provides health services and outreach to faith communities; and mental health researchers from UCLA. During the planning phase of this project, parent focus groups were conducted, and an evidence-based intervention for traumatized students was adapted for this community. Focus group participants described significant concerns about community violence and multiple ways in which this ongoing violence has affected their children's functioning and child-parent relationships. The partnership has collaborated on each aspect of the research study, from design and adaptation, implementation, data analyses, and identification of areas for future research. This paper, a participatory process written in the words of the community and research partners, describes the experience of and challenges met by this partnership in adapting the Cognitive Behavioral Intervention for Trauma in Schools program for use in this Catholic school. (*Ethn Dis.* 2006;16[suppl 1]:S1-89–S1-97)

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"My boy was very afraid and from that day on he was terrorized. He wouldn't go outside. I remember at night he would pray and ask Jesus to give him comfort"—parent at St. Thomas the Apostle School.

One resounding concern heard throughout communities in the United States has been the effects of violence on children. More than two decades ago, Surgeon General Everett Koop declared that "violence is one of the most significant public health issues facing America."[1] An estimated 20%–50% of children in the United States are victims of violence within their homes, at school, and in their communities,[2] with poor, urban, and minority youth at highest risk.[3,4] And youth who have been exposed to violence are more likely to develop psychological problems and have poor functioning at home and school.[5–7] Recent studies have shown that approximately one third of children exposed to community violence develop symptoms of posttraumatic stress disorder (PTSD).[8–10] Youth exposed to trauma also can develop depression, other anxiety disorders, substance abuse, and problems with school performance.[11–15]

Despite that poor and ethnic minority children are at increased risk for exposure to violence and the associated negative sequelae, some of these children are also those least likely to receive services for these problems. For example, the high unmet need of mental-health services by ethnic minority children has been a focus of national attention,[16,17] with estimates that 88% of Latino children who need mental health services do not get that care.[18]

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Possible contributing factors to this high unmet need include lack of health insurance, parental preferences and help-seeking patterns, an unrecognized need for services, and stigma associated with mental health services.[19–23]

To address disparities in health care, researchers and community organizations have begun exploring innovative ways of providing services in community settings, such as through religious organizations to reach under-served ethnic minority populations. Advances in health promotion and prevention programs have shown that health services can be successfully delivered in religious settings to under-served Latinos and African Americans.[24–26] A recent review of church-based health-promotion programs identified seven key elements that predict positive outcomes: 1) successful church-community partnerships; 2) positive health values of the church leadership; 3) availability of services especially for vulnerable and under-served populations; 4) access to church volunteers and facilities where health-promotion activities can take

place; 5) community-focused interventions in which the church plays a central role in the community; 6) facilitation of health behavior change by incorporating traditional cultural and spiritual values; and 7) supportive relationships through the church and community social network.[27]

However, few studies have focused on mental health services in faith-based settings for ethnic minority populations. In a survey of pastors from Southern churches, Blank et al found that Black churches were more likely to have mental health and social support programs than White churches, although few formal links were seen between any of the churches and specialty mental health providers.[28] In a multicultural, urban setting, Dossett et al found that only 2% of church leaders reported that their church had formal links to specialty mental health, yet 79% state that they were interested in these services.[29]

Although churches may be a particularly effective setting in which to deliver much-needed mental health services, community members may need to be involved to ensure that the care is effective and relevant for the community. In order to decrease healthcare disparities, the Institute of Medicine (IOM) has recommended that researchers transform the way in which they work with communities. The emphasis is placed on a community-research partnership in which the design and implementation of the intervention is a shared process.[30]

This paper, written in a participatory process through the words of the community and research partners, describes one such partnership that was formed to address a faith community's concern about the effects of community violence on their youth and the need for mental health services. We describe our experiences and challenges in adapting an evidence-based mental health trauma program for Latino children attending a parochial school.

METHODS

Development of the Participatory Partnership

Through the Community Health Improvement Collaborative (CHIC) process, QueensCare Health and Faith Partnership (QHFP) and the University of California, Los Angeles (UCLA) Health Services Research Center started to address ways in which an academic-community partnership could focus on addressing the lack of mental health services available for children and families served in the QHFP network. QueensCare Health and Faith Partnership (QHFP) identified several of their partner organizations that had expressed particular interests in mental health services and who served a large population of children. One of these organizations, St. Thomas the Apostle Church and School, emerged as the site where this project would be piloted.

St. Thomas the Apostle School and Church

Affiliated with a large Catholic church, St. Thomas School serves 315 students grades K through 8; 98% of the student body is of Latino background (mostly from Central America), and 80% of families qualify for the Federal Free or Reduced Lunch Program. Family involvement on campus is significant, with every St. Thomas family required to contribute 40 hours of service to the school.

Differing levels of acculturation between parents and students has been one source of conflict for many of the families at this school. In addition, many members of the parish and school do not have health care, and even fewer have available resources for mental-health care. The QHFP school nurse works with the student health council, which helps to identify the educational health needs of the student body. Presentations are made to students on such topics as healthy eating, depression, alcohol and drugs, puberty and

sexuality, and hygiene. Five years ago the school also hired a mental health counselor, which was initially met with indifference and hesitation by the students, families, and staff but now is a sought-after service.

QueensCare Health and Faith Partnership

The QueensCare Health and Faith Partnership (QHFP) is a division of QueensCare, a public healthcare charity for Los Angeles County formed from the sale of a religious hospital to a for-profit health system. The QHFP division provides a healthcare safety net for the uninsured through a parish nursing program that delivers health-promotion and disease-prevention activities in faith communities including >50 Catholic and Protestant organizations in the Greater Los Angeles area. With each partnering organization, QHFP engages in a participatory partnership in the form of a health cabinet composed of community members to identify the healthcare needs of the organization and surrounding neighborhoods. The QHFP nurses and health promoters then work with the health cabinet to provide the type of health education classes, health screenings, referrals, and case management services that the community needs.

UCLA Health Services Research Center

The UCLA Health Services Research Center (HSRC) seeks to improve quality of life and quality of care for persons with psychiatric and neurologic disorders across the lifespan. The HSRC has a strong focus on community-based research and collaborates with many community agencies, healthcare practices and plans, purchasers, and consumer groups both locally and nationally. The overall goal of the HSRC is to effectively use research to improve public mental health and mental health-care delivery in ways that are consistent with the goals, priorities, and resources

of such diverse stakeholders. In understanding the different perspectives of the community partners, HSRC researchers help design effective treatment delivery strategies, especially in addressing health disparities for disadvantaged or under-served populations.

A Participatory Partnership to Improve Mental-Health Services

Although QHFP has primarily focused on health issues in the past, such as blood pressure screenings and cancer prevention, they and their partner organizations were becoming increasingly concerned about the need for mental health services in the communities that they served. In a needs assessment that was conducted in collaboration with UCLA,[29] QHFP discovered that despite a wide range of attitudes toward mental illness, more than three fourths of their partnering church leaders felt that mental health services were an appropriate and needed ministry of the church, with lack of resources and staff cited as major barriers to providing these services to their congregations.

Following this study, QHFP decided to explore how they could begin providing more formal mental-health care to their partnering organizations. One partner that had a particular interest in expanding mental health services was St. Thomas School and Church. With their positive experiences with a school counselor, St. Thomas administrators and the church community embraced the idea of a new mental health program and services. One area that the school community and QHFP could agree was a major issue facing many of the communities served by the QHFP network was the impact of community violence. As a way to focus their new mental health services, QHFP decided to start with the Cognitive Behavioral Intervention for Trauma in Schools (CBITS) program, which had proven to be effective in local public schools with both immigrant and non-immigrant Latino students.

The CBITS Program

Developed in partnership with clinicians and administrators from the local public school system (see Wong et al, this issue)[40] and adapted for a multicultural student body, the CBITS is a manualized, 10-session cognitive-behavioral therapy intervention for middle-school students who have been exposed to community violence and who suffer from trauma-related mental-health symptoms.[31,32] The CBITS program is a group intervention that focuses on decreasing symptoms of PTSD, depression, and general anxiety among children exposed to trauma. Students learn skills in relaxation, challenging their upsetting thoughts, and social problem solving. The CBITS intervention also includes parent- and teacher-education sessions.

Clinicians receive a two-day training in the intervention and ongoing group supervision. The clinicians follow a treatment manual to ensure that the intervention is delivered in a standardized manner; however, they do have flexibility to meet the specific needs of each child in the group. The CBITS intervention has previously been pilot tested for feasibility and acceptability in immigrant Latino students and has also been found effective in a randomized clinical trial of a general middle-school population.[33,34]

Focus Groups

To determine the level of acceptability and appropriateness that CBITS would have in this community, we conducted focus groups with parents from the St. Thomas community. Although preferable, focus groups were not also conducted with children because of resource constraints. Eligibility criteria included being a parent of a child between the ages of 9–13 years and being a member of St. Thomas church and/or school. We recruited parents from general church and school meetings to form two focus groups, one consisting of church members and the

other of parents from the St. Thomas school. Each group, composed of eight participants, was held at the church and led by a bilingual, bicultural moderator who conducted the groups in Spanish and followed the same topic guide for both groups. Participants were asked to discuss their concerns regarding violence in their community and how it affects children. After a brief introduction to the CBITS program, they also discussed their views about the proposed CBITS program that was being developed for use at their school and church. Groups were taped, transcribed, and translated into English. Two bilingual assistants and the first author developed thematic codes, and quotes were chosen through a consensus process to reflect each of the main themes.

Participatory Process of Program Development and Evaluation

A steering committee consisting of QHFP staff (mental health clinician, nurse, health promoter, administrator), St. Thomas community members (principal, priest, church members, and parents), and UCLA HSRC researchers met regularly for more than a year in the planning phase of this partnership and continue to meet monthly during the implementation phase. Meetings have occurred on the St. Thomas campus to maximize the participation of the school community and to allow other members of the partnership to have a personal understanding of this school. All aspects of the program were discussed, including the research design, recruitment, intervention components, and adapting existing services to complement the CBITS program.

Key partners from the school, QHFP, and UCLA completed the UCLA Human Subjects Protection online course so that each partner was fully informed about conducting research and understood the ethical issues involved. We have also drafted a joint memorandum of understanding to

delineate in writing our partnership. The team decided to conduct a randomized clinical trial with a waitlist comparison group so that any student who was identified as needing the program could obtain services through the school. The surveys were also comprehensive in that questions not only included psychiatric symptoms but also school and social functioning and level of spirituality and religious support.

RESULTS

Focus Groups

Participants in the focus groups unanimously identified many types of community violence as having a significant impact on children. The types of violence that were most commonly described by these participants included shootings, "gatherings in the street and not allowing anyone to pass," drug deals, fights, public drinking, and car races. Parents pointed out that "even those children who have not personally been through a violent experience, they have heard about it." One theme that emerged from the focus group discussions was a conflict in getting involved in the community when violence occurs. On the one hand, participants described that "parents worry a lot. They talk to police and report problems. After a short time of calm, the problems come back." However, other parents discussed the fear of reporting violence to the authorities and that "very few parents get involved. They may be scared of retaliation."

These parents described several themes that illustrated how community violence has affected their children. They reported concerns about children growing up insecure and developing low self-esteem because of the widespread violence in the community. "Well, I've noticed that my children are very insecure. It's true—they're still young, but they know that if they go out on their own something could happen.

They're always asking you to be there with them. It's always in their minds because they're insecure, even though we try to give them confidence and try to resolve those little problems that they think they have. In reality, they do need us when they want to do something or go somewhere because they feel secure with us around." Another main theme that emerged was the limited amount of extracurricular activities in which children participate because of the safety concerns of parents, often resulting in parent-child conflicts. "They (the children) feel upset and frustrated because of their limited freedom. They have a difficult time dealing with the fact that they feel extremely over-protected and restricted. This results in a problematic relationship between parent and child." Others described children shutting themselves off from the outside because of their fears. "The main issue is lack of freedom to enjoy different activities and the outdoors. Kids grow up with a fear of being outside even to pick flowers or get ice cream from the local ice cream truck." Others talked about behavioral sequelae such as this parent's report of her children: "They haven't been able to forget the violence they've suffered when they were growing up. Now it's very hard for me to have any type of control over them."

After the focus group leader described the proposed CBITS program, most participants expressed that the very type of discussion that they were having in the focus group about violence was an important part of the program for the children. Participants thought that a program like this should be available to all students because "they all experience the same problems in the community. They need a place to let go of these frustrations so they do not end up like the other kids that cause trouble." Parents also agreed that offering this program at their church and school would not be a problem. "This issue is not something people will be ashamed of because everyone has the same

experience." When asked about challenges that may arise from introducing a new mental health program at the school, such as stigma, the participants expressed little concern about the program being stigmatizing and saw the church as the ideal place to offer such services. One participant explained: "Right here, in this community, you wouldn't have those problems (stigma) because our church is composed of ministries and all the people are involved in the same goal to help one another."

In discussing the parent component of the program, one parent commented that "the program should be ready to face all issues that a group like this may encounter such as domestic violence and that some parents may not be open minded and not give the program a chance." The participants predicted that their multiple time commitments and obligations to the church, school, and work would be a barrier to participation.

Program Adaptation

Several adaptations of the study protocol were a direct result of the parent focus groups and parent participation in this collaborative study. The suggestion that some aspect of CBITS should be made available to all the students was seen as a long-term goal by the partnership. However, the parents in our research partnership recommended that in order to begin providing some education to all students about violence and to help students and ultimately parents understand about the research study, an informal skit would be better received than a didactic presentation. A skit was developed with lay language that was easily understood by the students, and it was an interactive presentation that included everyday events involving violence and PTSD. The presentation to the students was made by three young research assistants, two of whom were Latino, who played the parts of students and a teacher.

The research partner and school principal gave a similar educational outreach offered to all school parents on the effects of community violence on children. The parent partners also recommended that a formal but brief presentation be given during Parent Back to School Night to inform parents of the research study and recruitment efforts. The parent partners and principal were also present to respond to questions. A similar educational meeting with all the teachers informed them of the program and addressed their concerns before implementing the program.

Although CBITS is a standardized intervention that teaches children a set of skills to help them cope with trauma-related problems, this program is also flexible and can be easily adapted to specific communities and settings. In this adaptation, clinicians were sensitive to the spiritual lives of the students and parents participating in this program. During the CBITS groups, children described prayer and religious rituals as part of their coping skills and their faith as a means of getting through adversity. The CBITS techniques complemented their religious coping strategies and reinforced their ability to "let go" of anxiousness through faith. One recurring theme that was reported by the clinical staff was the added hopefulness and positive outlook that many of these students seemed to have despite significant traumatic experiences and losses.

For the parent component of the intervention, we combined the trauma-specific CBITS parent sessions with an existing QHFP parenting class for violence prevention, which is presented within the framework of faith and spirituality. This extended parent component allowed for some of the concerns addressed in the focus groups around child-parent interactions and general parenting skills to be discussed. The parent groups were led by a QHFP lay health promoter, who was from

a similar background as the parent participants and could easily relate to the concerns of these parents.

Some families may need additional services after the CBITS program, and QHFP has unique resources to conduct follow-up care as they have a paid staff of 21 registered nurses, six health promoters, a full-time LCSW, and two to four graduate social work interns. In one case, a family of five is seen collaboratively by a clinical social worker, parish nurse, and health promoter to meet all of the needs of this family. For other cases, QHFP parish nurses provide case management to ensure that the family receives an appropriate referral and actually gets into care.

CBITS Training

This study used the unique staff available through QHFP. A licensed clinical social worker, a parish nurse, a health promoter, and one of the research team parent representatives attended the CBITS training; training was supplemented with the CBITS manual and training videotape that can be referenced throughout the program implementation. Although the parent representative did not participate in implementing the clinical aspect of the program, she was available and knowledgeable about the clinical program to respond to any concerns or questions within the school community that would arise informally. In addition, the regular school counselor, a licensed marriage and family counselor, also attended the training. Groups were led by the school counselor and co-led with the QHFP social worker and nurse.

Challenges

Several challenges were encountered in balancing the community resources and expectations with the research protocol. Because of the unique nature of this community collaborative study and focusing on vulnerable populations (mental-health population, children, minorities, traumatized individuals),

we had significant delays in obtaining institutional review board (IRB) approval. For example, much clarification needed to be made regarding the competency of the community clinicians conducting the intervention, given that unlike most clinical trials where research clinicians deliver the intervention, we wanted to study the program as delivered by those providers already in the community. The IRB also had significant concerns about the content area of trauma, which is a growing area of research in child mental health. Delays in approval meant that although clinicians had been hired and trained, services could not be delivered. Subsequently, some time-limited funding also had to be relinquished because of these delays.

All of the partners agree that this project also has faced logistical challenges, mainly as a result of starting new services through QHFP and having these services embedded in a research study at a community site where these services have never taken place. Common challenges were encountered providing new services in a setting that has limited available space and is not accustomed to having a research study integrated into the regular school schedule. In addition, with more than a year in the planning process, this collaborative has seen some change in staffing, in addition to hiring a director for the newly formed mental health services branch of QHFP. Having never provided mental health services in the past, QHFP has had the challenge of defining their scope of services and identifying funding sources to sustain these services.

CONCLUSIONS

"The first need that brought St. Thomas, QueensCare, and UCLA together was a need for mental health services for the community. Father Jarlath Cunnane, the pastor of St. Thomas the Apostle Church, saw firsthand the great need for

services for those in the community. Simply put, many people who needed help were not getting help. (VO, principal, St. Thomas the Apostle School)

Our adaptation of CBITS for this faith community addresses a priority issue that has been identified by this community and the providers that serve it; this issue has been verified as a high area of need from the qualitative data presented. By engaging in a participatory research partnership, our experience is that this program was built on a foundation of trust and relevance for the community and integrated with evidence-based care and an effectiveness evaluation. This paper reflects the insights, challenges, and perspectives of this collaboration. The following excerpts, written in the voices of the various partners, illustrate some of the lessons learned from our work together. The results of our program evaluation will be presented elsewhere.

The focus-group results indicated that children's exposure to community violence is a significant concern for parents in this community. The repercussions of this violence that were emphasized by parents included negative effects on self-esteem, conflicts between parent and child around restrictions on going outside, and ongoing fears by children that result in limited participation in after-school activities. Although an earlier needs assessment by QHFP and UCLA had indicated a mixture of positive and negative attitudes about mental health services by church leaders in the general QHFP network, mental health services were viewed by the focus group participants as a positive ministry of the church. Similar to the findings of other researchers describing the faith community as rich in social capital, with frequent social interactions, shared resources, and a set of common values and norms,[35] parents from this church and school echoed similar strengths of their community. In addition to being supportive of the CBITS intervention on their campus,

parents also suggested that this type of service be available more broadly. This is an area for future research by our partnership, although as we described in this paper, we have begun introducing the educational components to both students and parents to the broader school community.

This unique community-research partnership has built upon existing resources and successful means of outreach to the community. St. Thomas school has traditionally had tremendous family involvement on campus, which made a partnership involving parents relatively easy.

"On the night that our principal asked us to give our input to a group of people doing research, you may say God was on his (and our) side. Our meeting with the girls' volleyball team parents had concluded on a sad note that night because we had been talking about needing someone to give our girls a pep talk about racism and how to be "above the talk." As we were walking out, our principal approached us and said that a group of researchers had a program for students who had met with acts of violence and offered help to both students and parents. We looked at each other and wondered how this may be a way to help our girls." (PC, St. Thomas parent)

"Some of us have also come from backgrounds where violence occurred in our country and in our families, and we can relate to how important it can be for kids to deal with. Many parents here at this school are immigrants and want to better the lives of the next generation. Involvement in this project has helped us to understand what is mental health and to have more of an openness in getting this kind of help." (AB, St. Thomas parent)

The relatively small campus has also made it possible for the principal and other administrators to attend to each students' needs, with less risk of stu-

dents "falling between the cracks." Others have described faith-based communities as maintaining a high level of trust with one another and in their leadership, and when health promotion programs have appealed to church leadership they have also been supported by the congregation.[36] The commitment to this program by the school principal and school staff did seem to facilitate the development and implementation of this program. And although we involved students informally in the planning process, our development process will be greatly enhanced in the future by involving youth in the steering committee more regularly.

The QHFP organization brought to this partnership a long tradition of using lay health promoters and parish nurses as an effective means of reaching out to highly under-served Latino immigrant communities. Other researchers have noted that *promotoras* are "the best placed individuals to reach their community with prevention and health promotion messages because they are already established as part of the social network that exists in the Latino community."[37] A growing literature supports *promotoras* in delivering health education and school-based programs to Latino families.[25,37–39] Likewise the QHFP parish nurses are trained to deliver health programs in the context of faith and have been instrumental in adapting the CBITS program to be relevant for this community. We will be exploring the potential role that they can play in delivering the CBITS groups.

Building upon existing resources is an issue worth further discussion as this has lead to growth and opportunities to sustain this collaboration. The program itself involved redeployed time of a parochial school-contracted therapist who was funded with school funds. A new mental health clinician was jointly paid for through an NIMH grant and through QHFP, but following the pilot

will be billing for services through a newly acquired Medicaid contract. The QHFP and St. Thomas leadership donated their time, but meeting costs and stipends for parent participation were provided through the NIMH center. Research partners, including costs for recruiting, data collection, and analysis, were funded through two different center grants, and the project PI's time was covered through an NIMH K award. Sustainability was a main factor in determining the design of this program, and only ongoing staff at both QHFP and St. Thomas implemented this program, to maximize the potential of studying a program that could exist after the seed funding ended. Future work should explore long-term solutions to building infrastructure within communities to support such community-research collaboratives.

The research partners have had experience in adapting the CBITS program for Latino populations in the public school sector (see Wong et al in this issue)[40] and have focused research efforts in better understanding how to disseminate evidence-based treatments in under-served communities. As Schoenwald et al have described, multilevel factors related to intervention and provider characteristics as well as organizational culture and resources need to be taken into account in order to successfully transport effective interventions into community settings.[41] We take one further step in suggesting that a necessary step in the dissemination of interventions should include the participatory partnership of the community throughout the entire research process.

Our experience in this process has pointed to a number of areas for future research, including examining how to adapt and evaluate CBITS for delivery in the general school and church population on a more preventive level to complement the current CBITS groups for significantly affected youth. The culturally sensitive staff and therapists also practiced CBITS within a faith-based context that was familiar to these students and families, such as incorporating religious rationales to counter maladaptive thoughts and use of religious imagery during relaxation exercises. As has been studied with CBT for adult depression,[42,43] formal adaptation and evaluation of CBITS for faith communities should be conducted. Finally, the future research agenda should also explore the effect of disseminating interventions that use participatory methods not only on child-level outcomes but also on level of program sustainability, community-level changes such as improved understanding about mental health care, and the effect of empowerment on those who participate in this research process.

"This project has brought to St. Thomas and our community a greater realization that mental health care is good for the community and is really needed. From the beginning, the fact that they would not do this without having parent input was phenomenal. They listened to our opinions and actually changed things because we had a better idea on how to approach our community. This really has opened my eyes to a problem facing our community… It has given me the boost I need to get me going back to school. I feel I want to learn and do more for my community… this has left a spark in me." (PC)

"Participatory research partnerships such as the CBITS pilot are facilitating the involvement of community organizations in the research process. By giving these organizations an equal share of responsibility researchers are aiding in the development of community leadership while offering a much-needed service. It is truly an empowering experience.

Resources and recognition are provided to those of us doing the front-line work and our insights are sought and valued. They have walked their talk of being partners with the community by being present with us, including us from the beginning stages of planning and sharing resources such as time, materials, and money.

I see this method of research not only finding truth but changing our community in the process. I have observed less skepticism about research and more willingness to be involved. People feel empowered to speak up because they know they will be heard. With evidence-based and community-relevant research being our goal we are seeing additional fruits emerge from this new process." (SF)

"Working within this community research partnership continues to transform how I view my role as a researcher and clinician. My framework from medical school of the doctor as leader, healer, and teacher has been expanded through this community collaborative process to include an expansion of my role as partner, facilitator, and student, in which I have just as much to learn about improving mental health care from the families, principals, teachers, priests, and community clinicians as they may learn from me. Although the researchers on the team brought knowledge of research methodology and experience with the CBITS program, the expertise from our community partners regarding how to implement the program and what issues families in this community are concerned about have no doubt made this program more meaningful to community." (SK)

Without the invaluable guidance and direction from community participation in research, innovations in health care may remain limited in the scope of practice, the effectiveness of dissemination, and the ability to meaningfully and broadly address disparities in health care for under-served ethnic minority communities.

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