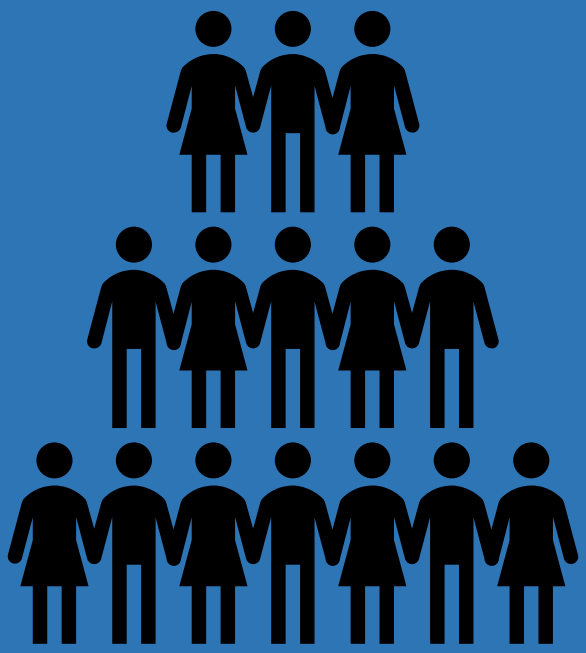
MISSISSIPPI
STATE DEPARTMENT OF HEALTH

2019 Community Strengths and Themes Report



Prepared by the Illinois Public Health Institute

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Executive Summary

The Mississippi State Department of Health (MSDH) conducted a Community Themes and Strengths Assessment (CTSA) as part of the State Health Assessment (SHA) process – utilizing the nationally recognized Mobilizing Action Through Planning and Partnerships (MAPP) model. The CTSA included a statewide survey and 29 community listening sessions. The purpose of the CTSA is to understand the issues that residents feel are important, the barriers to the health of their community, as well as assets and strengths that support improving the health of the community. Data collection through the survey and listening sessions were targeted to communities with the greatest health inequities, as determined by the County Health Rankings and Roadmap. While surveys and listening sessions included communities from across the state, data was also intentionally collected from counties ranked in the lower one third of the overall county health rankings by health outcomes. MSDH conducted outreach to hear the voices of community members with some of the greatest barriers to health. Community input gathered from the listening sessions revealed the following key findings and emerging themes of health-related assets, challenges, and barriers across the state.

Community Strengths and Assets

- Mississippi's **natural environment** was consistently described as an asset across communities.
- Participants reported community **park and recreation** areas across the state as an asset that contributes to physical activity and health.
- Participants described a **sense of community** that promotes strong bonds and unity among community members. Communities across listening sessions were consistently described as welcoming and hospitable.

Economic development was noted as both a strength and challenge across listening sessions. Some listening sessions viewed economic development as a strength due to an increase in local industry, entertainment options, and community resources. Other listening sessions were conducted in communities where local jobs and community resources are scarce and, as a result, serves as a barrier to community health and well-being. Survey respondents notably identified economic development as to an area for improvement regarding community growth and increased job opportunities.

Community Challenges and Barriers

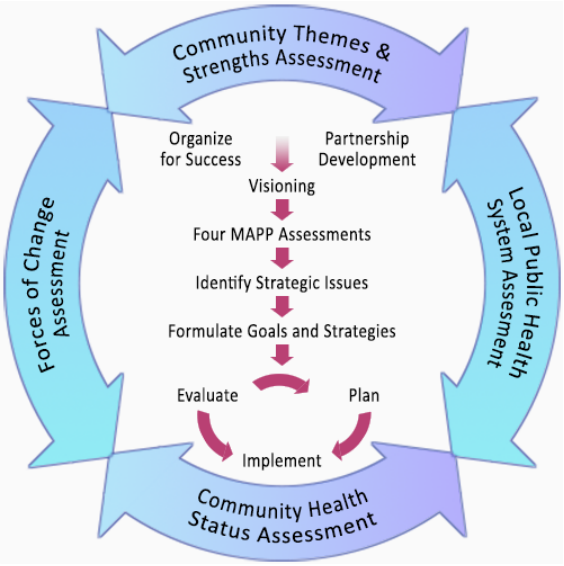
- Participants reported a number of barriers that have prevented adequate **access to affordable, quality healthcare services.** These include a lack of mental health resources and substance abuse treatment. Participants also noted a **lack of health education** resources for increasing knowledge of health issues and chronic conditions.
- A lack of **access to healthy food** in communities was a recurring theme, particularly in rural and impoverished areas that maintain food deserts.
- Many aspects of the **built environment** and **infrastructure** that influence quality of life and physical activity were described as challenges. They include water quality, road and sidewalk maintenance, and parks and recreation.
- Participants across listening sessions noted the lack of a **culture of health** preventing prioritization of health and well-being in many communities.
- Unemployment, underemployment, and a lack of access to local industry were noted as **economic barriers** to maintaining health and well-being.

Introduction

Assessment Framework

In 2019, the Mississippi State Department of Health (MSDH) began a comprehensive State Health Assessment (SHA) using the Mobilizing for Action through Planning and Partnerships (MAPP) process (See Figure 1). MAPP utilizes four assessments to gain a comprehensive picture of community health.

Figure 1: The MAPP Process (NACCHO, 2013)



The **Community Health Status Assessment (CHSA)** provides quantitative information on community health conditions.

The **Local Public Health System Assessment (LPHSA)** measures how well different local public health system partners work together to deliver the Essential Public Health Services.

The **Forces of Change Assessment (FOCA)** identifies forces that may affect a community and the opportunities and threats associated with those forces.

The **Community Themes and Strengths Assessment (CTSA)** identifies assets in the community and issues that are important to community residents.

To complete the Community Themes and Strengths Assessment, MSDH conducted listening sessions and collected surveys throughout the state to reflect on community assets, challenges, and barriers to maintaining healthy communities in 2019 and beyond. Findings from this report will be used to develop the state's understanding of community members' concerns and perceptions, regarding both quality of life and ideas to improve community health.

Community Themes and Strengths Assessment Overview

The Community Themes and Strengths Assessment gathers information – through existing community residents and groups – on local areas of concern and strengths, as well as existing resources related to health. This assessment provides context to MSDH on what Mississippi residents identify as important for health and well-being in their communities.

During the listening sessions, participants addressed the following topics:

- What is important to the community?
- How is quality of life perceived in the community?
- What assets does the community have that can be used to improve community health?

MSDH conducted 29 listening sessions throughout the state with various community residents and local stakeholders. The listening sessions were conducted in 19 different counties throughout Mississippi.

MSDH also collected information from Mississippi residents through a Community Input Survey. MSDH created this survey to gather community input from residents on a variety of health issues, including health status, health care, social services, quality of life, social support, and economic opportunity. The results of survey will help MSDH understand Mississippi residents' perceptions of health and wellbeing in their communities and identify barriers to health and wellness.

Methodology

Focus Group Methodology

The Mississippi State Department of Health (MSDH) conducted 29 listening sessions throughout 19 counties, including 9 listening sessions with the Mississippi Band of Choctaw Indians (MBCI) tribes. Focus groups and community conversations were facilitated in the following communities:

Neshoba County
- Pearl River
- Bogue Chitto
- Tucker

Leake County
- Red Water
- Standing Pine

Winston County
- Crystal Ridge

Washington County
- Greenville

Jones County
- Bogue Homa

Union County
- New Albany

Pike County
- Summit

Pearl River County
- Picayune
- Poplarville

Noxubee County
- Macon

Newton County
- Decatur

Lincoln County
- Brookhaven

Quitman County
- Marks

Jefferson Davis County
- Prentiss

Bolivar County
- Rosedale

Hinds County
- UMMC Nursing School of Nursing
- 2019 Rural Healthcare Summit
- American Heart Association

Harrison County
- Biloxi
- Gulfport

Desoto County
- Hernando

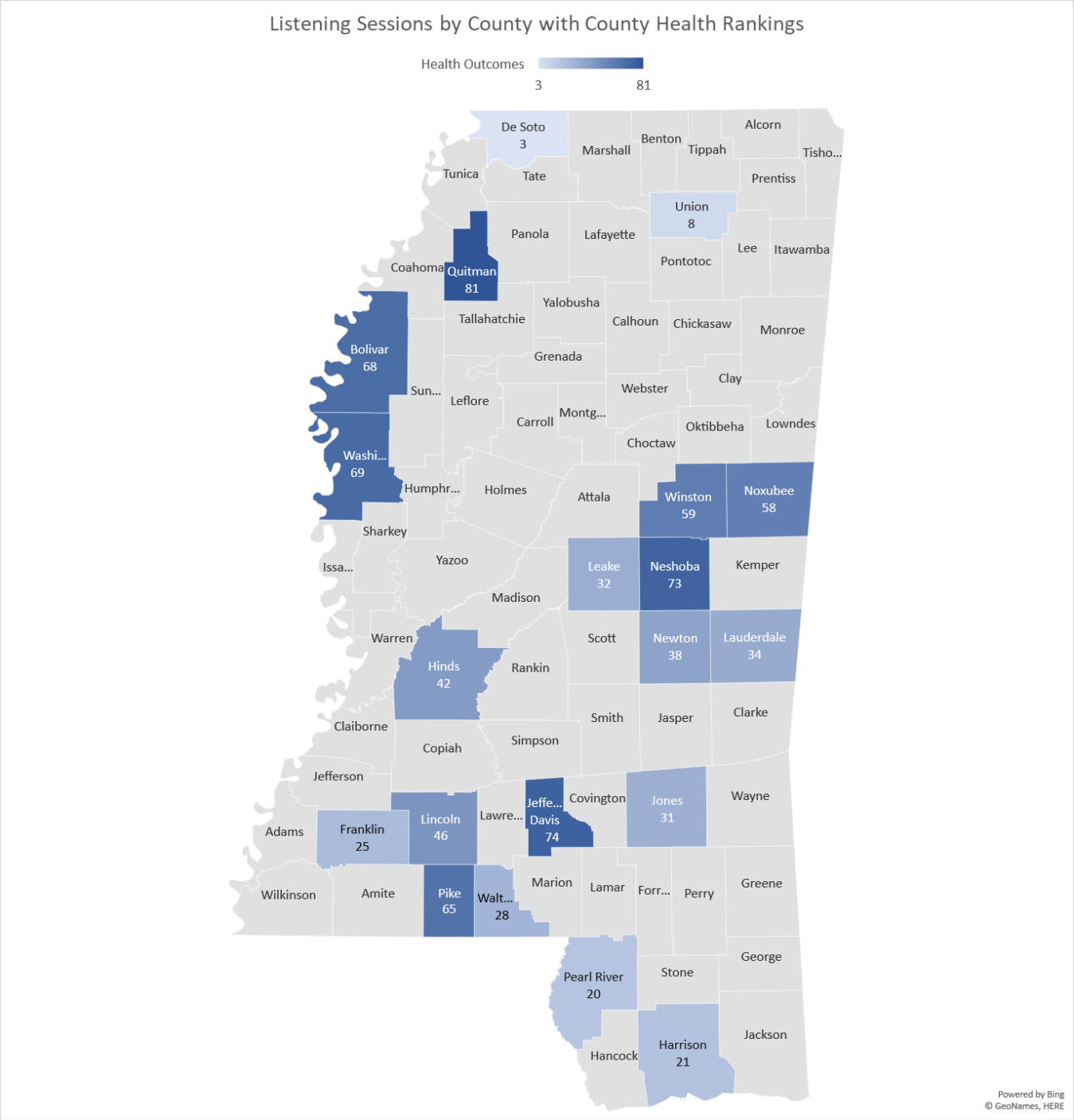
Franklin County
- Roxie
- Meadville

Walthall County
- Tylertown

Mississippi Band of Choctaw Indians
- Henning
- Tucker
- Red Water
- Crystal Ridge
- Bogue Chitto
- Conehatta
- Pearl River
- Standing Pine
- Bogue Homa

The map below shows the 20 counties where the 29 listening sessions were conducted, along with their corresponding 2019 county health outcome rankings (See Figure 2). MSDH prioritized counties in the bottom one third of county health outcome rankings to better integrate health equity in the assessments. MSDH conducted listening sessions with people and communities with limited resources who are most impacted by health disparities and inequities.

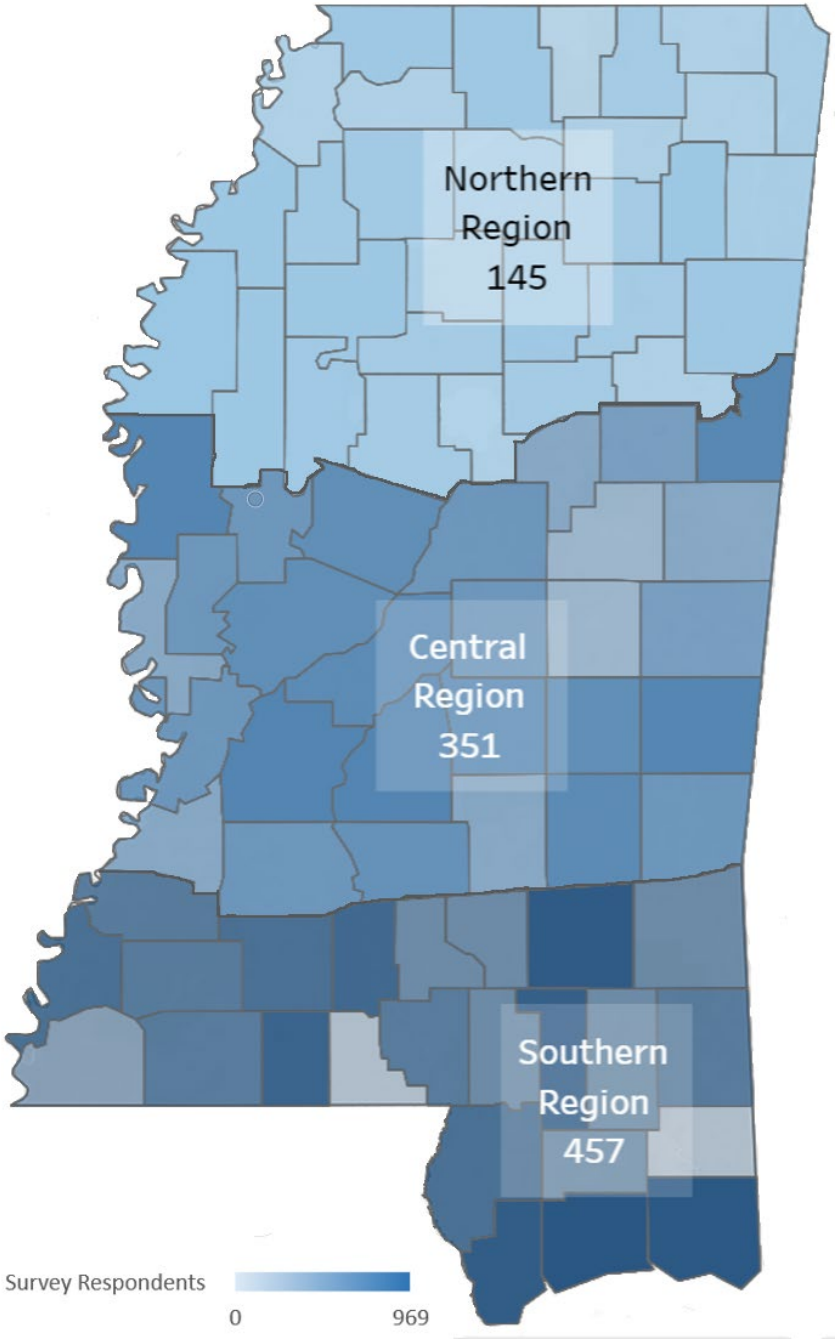
Figure 2: Listening Sessions by County with County Health Rankings



Community Input Survey Methodology

MSDH developed an 18-question survey for Mississippi residents about health status, health services, and quality of life. MSDH worked with the State Health Assessment and Improvement Committee (SHAIC) to disseminate the survey to residents through members' networks across the state for convenience sampling.

A total of 953 Mississippi residents completed the survey online through Survey Gizmo. The survey results were analyzed and incorporated into this report. Survey respondents were categorized into three regions designated by MSDH: Northern, Central, and Southern. A majority of the survey respondents reside in the Southern Region, totaling 457 responses. The Central Region had 351 respondents, while the Northern Region had the lowest response rate of 145 respondents.



Demographic Characteristics of Survey Respondents

As of 2019, the population of Mississippi was 2,976,149. A total of 953 residents across the state participated in the survey. MSDH identifies the Northern, Central, and Southern regions to categorize the geographic distribution of residents across the state. The geographic distribution shows that 48% of the respondents reside in the Southern Region, 37% of the respondents reside in the Central Region, and 15% of the respondents reside in the Northern Region.

Survey Limitations

MSDH and their SHAIC partners recruited survey respondents through convenience sampling. Residents aged 45 and over, identifying as female, and/or identifying as White/Caucasian were most frequently represented in the survey. A majority of the respondents also listed obtaining a college degree (including graduate or professional degree) and/or listed an annual household income over $100,000. According to 2018 Census estimates, the median household income in Mississippi is approximately $43,000 compared to the median average household income of $60,000 to $79,999 reported by the survey respondents.[1] While efforts were made to generally reflect state demographics, it is important to note that the sample is not a representative sample. Demographic comparisons between the survey respondents and the general Mississippi population are described in more detail throughout the report for reference.

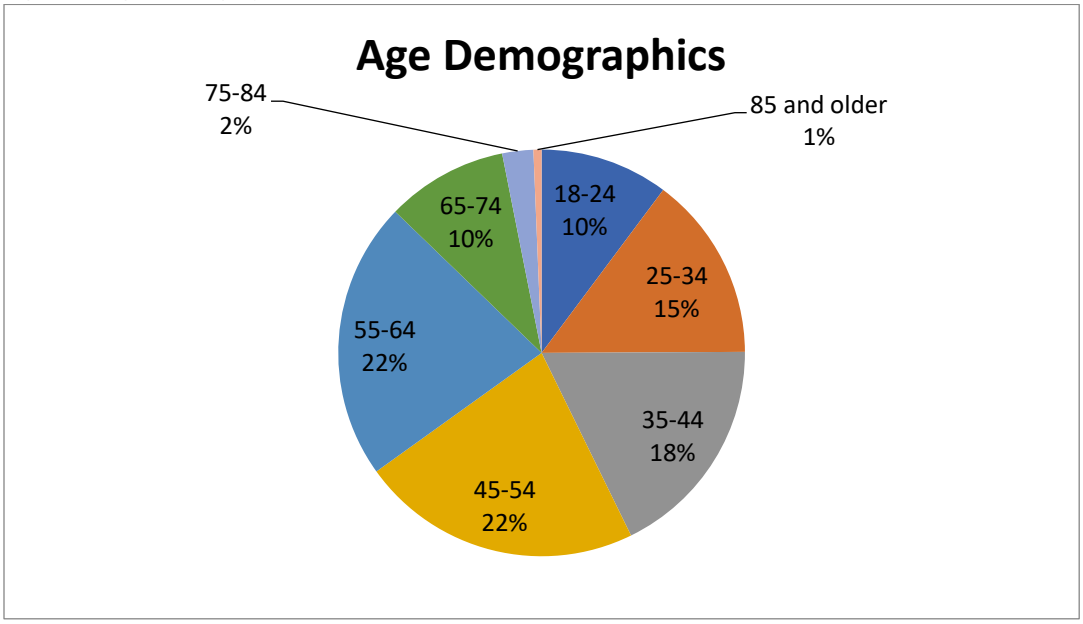
COVID-19 Acknowledgement

Due to the COVID-19 outbreak and subsequent pandemic, MSDH was forced to halt the dissemination of the Community Input Survey to Mississippi community members in March 2020. As the survey closed in March, MSDH was unable to complete planned survey dissemination activities to engage more community members in the priority counties in the bottom one-third of health outcome rankings. This resulted in data limitations that are not entirely representative of the state of Mississippi.

Age

Survey respondents ranged in age from 18 to over 85. According to the 2018 American Community Survey data, roughly half of the adult population was between the ages of 18 and 44, and about 40% were 45 and over. Survey respondents between the ages of 18 and 44 comprised 43% of the total number of respondents, and respondents age 45 and over comprised 57% of total respondents. Adults age 45+ consisted of a larger proportion of overall survey respondents.

Figure 3: Age Demographic



[1] American Community Survey data (2018). https://data.census.gov/cedsci/table?d=ACS%205-Year%20Estimates%20Data%20Profiles&table=DP03&tid=ACSDP5Y2018.DP03&g=0400000US28&vintage=2018&hidePreview=true

Gender Identity

78% of survey respondents identified as female, 21% identified as male, and 1% identified as gender neutral. The table below shows how female identifying respondents were overrepresented, while all other gender identities vastly were underrepresented, compared to the actual demographic distribution of the state.

Table 1: Gender Identity

Gender Identity	Number of Respondents	Percent of total	Percent of state total[2]
Female	726	78%	51.6%
Male	196	21%	48.4%
Non-Binary/ Genderqueer	1	0%*	
Gender Neutral	5	1%	
Transwoman	0	0%	
Transman	0	0%	
Write In	0	0%	

Sexual Orientation

95% of the survey respondents identified their sexual orientation as straight. All other sexual orientations, as shown in the table below, were significantly underrepresented.

Table 2: Sexual Orientation

Sexual Orientation	Number of Respondents	Percent of total
Straight	877	95%
Gay or Lesbian	13	1%
Bisexual	7	1%
Prefer not to answer	23	3%
Write In Queer Pansexual	2	0%*

[2] American Community Survey data (2018). https://data.census.gov/cedsci/table?q=mississippi&g=0400000US28&hidePreview=false&tid=ACSDP1Y2018.DP05&vintage=2018&layer=VT_2018_040_00_PY_D1&cid=DP05_0001E

Racial and Ethnic Group

46% of survey respondents identified as African American/Black and 48% identified as White/Caucasian. 2% of respondents identified as Native American, 1% of respondents identified as Asian/Pacific Islander, 2% of respondents identified as Hispanic/Latino(a), and 1% wrote in their racial and ethnic group. According to Census estimates, the population of Mississippi was 38.9% African American/Black and 59.5% White/Caucasian. Despite almost 0.7% of the Mississippi population identifying as Native American (approximately 20,000+ people), only 18 respondents identified as Native American, similar to the other underrepresented identities in Mississippi.

Figure 4: Racial and Ethnic Group Demographics

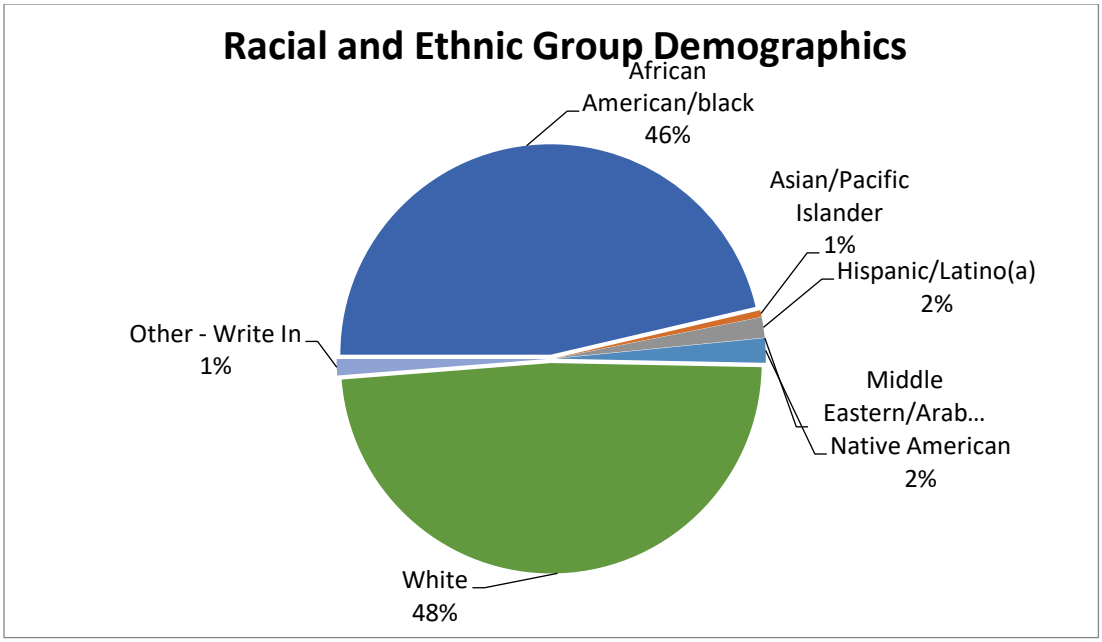


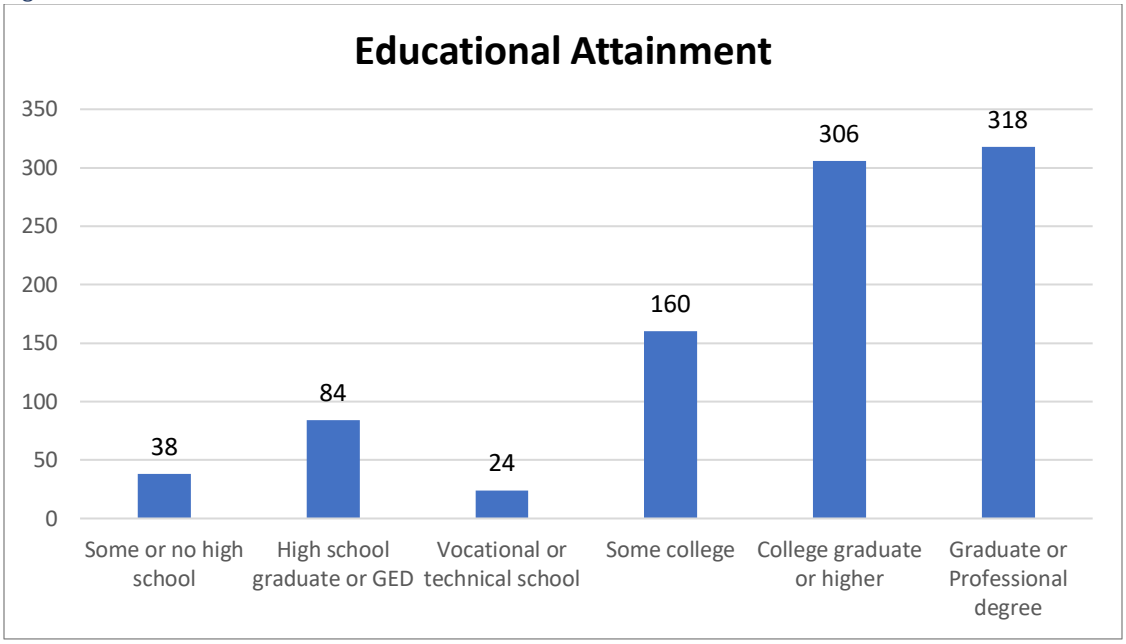
	Table 3: Racial and Ethnic Group			
	Number of Respondents	Percent of total	Total Population (2018 estimates)[3]	Percent of state total
African American/Black	445	48%	1,161,529	38.9%
White/Caucasian	465	47%	1,776,445	59.5%
Hispanic/Latino	15	3%	87,126	2.9%
Asian/ Pacific Islander	5	1%	38,212	1.3%
Other	12	0.8%		
Native American	18	0.6%	20,404	0.7%

[3] American Community Survey (2018). https://data.census.gov/cedsci/table?q=mississippi&g=0400000US28&hidePreview=false&tid=ACSDP1Y2018.DP05&vintage=2018&layer=VT_2018_040_00_PY_D1&cid=DP05_0001E

As described in the data limitations section, this sample is not representative of the general Mississippi population. This remains true of the educational attainment demographics of the survey respondents compared to the general Mississippi population. 67% of respondents obtained a college, professional or graduate degree. According to 2018 Census estimates, approximately 41.2% of the Mississippi population obtained an Associate degree or higher, while the majority of the state (~58.9%) attended less than 9th grade to some college, earning no degree. [4]

Educational Attainment

Figure 5: Educational Attainment

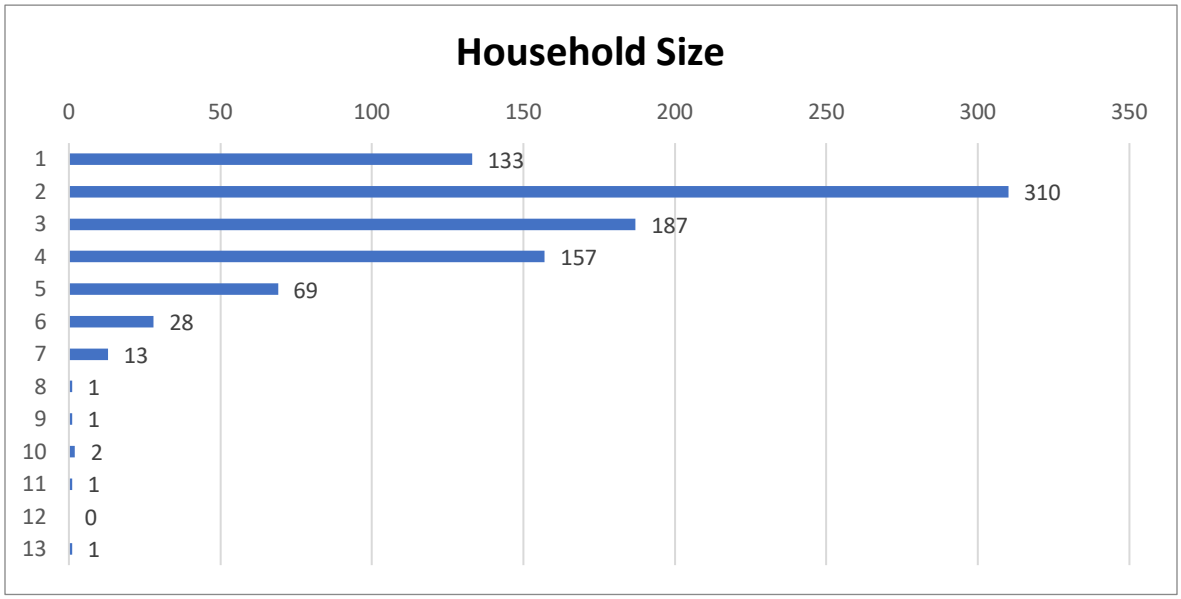


[4] American Community Survey (2018). https://data.census.gov/cedsci/table?q=Mississippi%20Education&tid=ACSST1Y2018.S1501

Household Size

Survey respondents were asked to identify how many people live in their household, including themselves. The responses are indicated in Figure 6 below.

Figure 6: Household Size

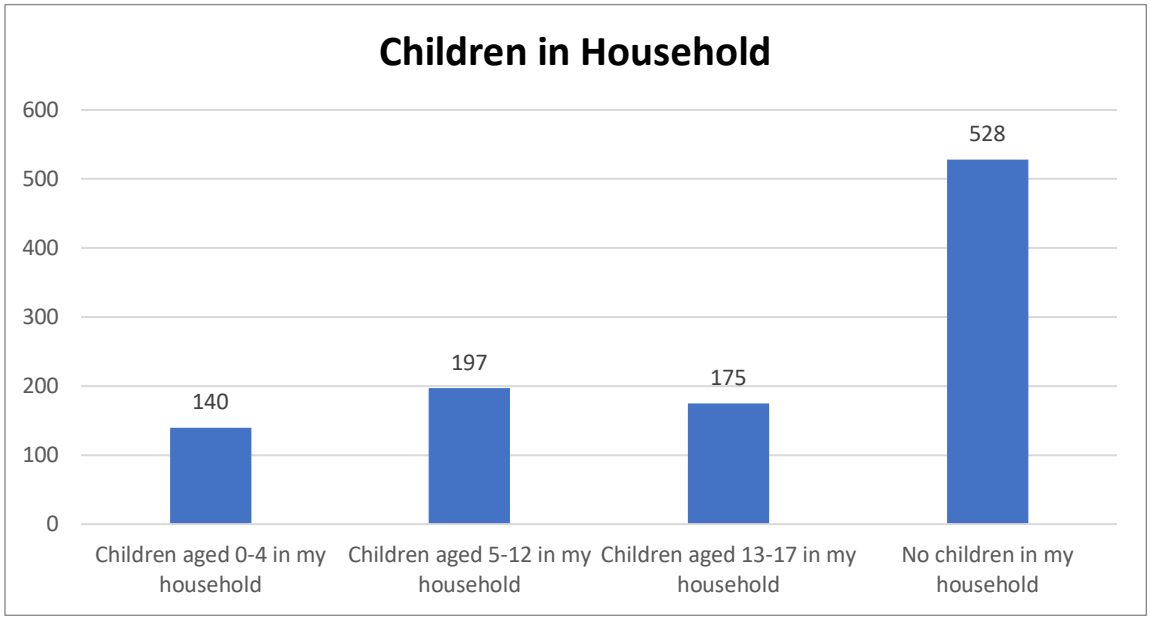


Most of the respondents reported one to four individuals, including themselves, living in their household.

Children in Household

50.7% of respondents identified that they had no children in the household. 13.4% of respondents had children aged 0-4, 18.9% had children aged 5-12, and 16.8% had children aged 13-17 in the household.

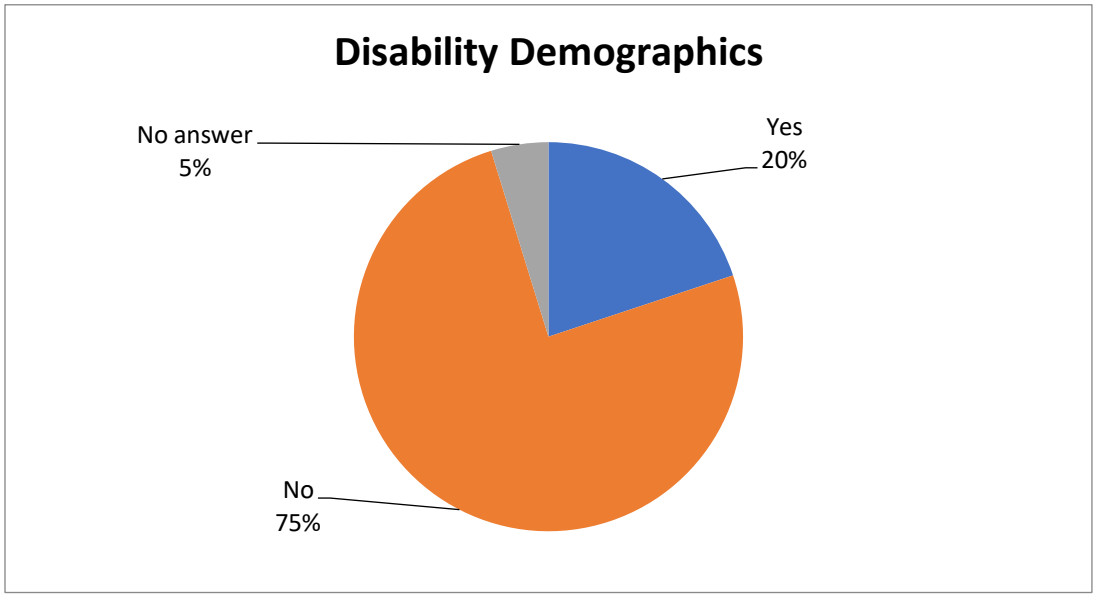
Figure 7: Children in Household



Disability Demographics

Survey respondents were asked to identify if anyone in their household had a disability. Figure 8 below displays the results of this question, with 75% of respondents answering that they do not have anyone in their household with a disability.

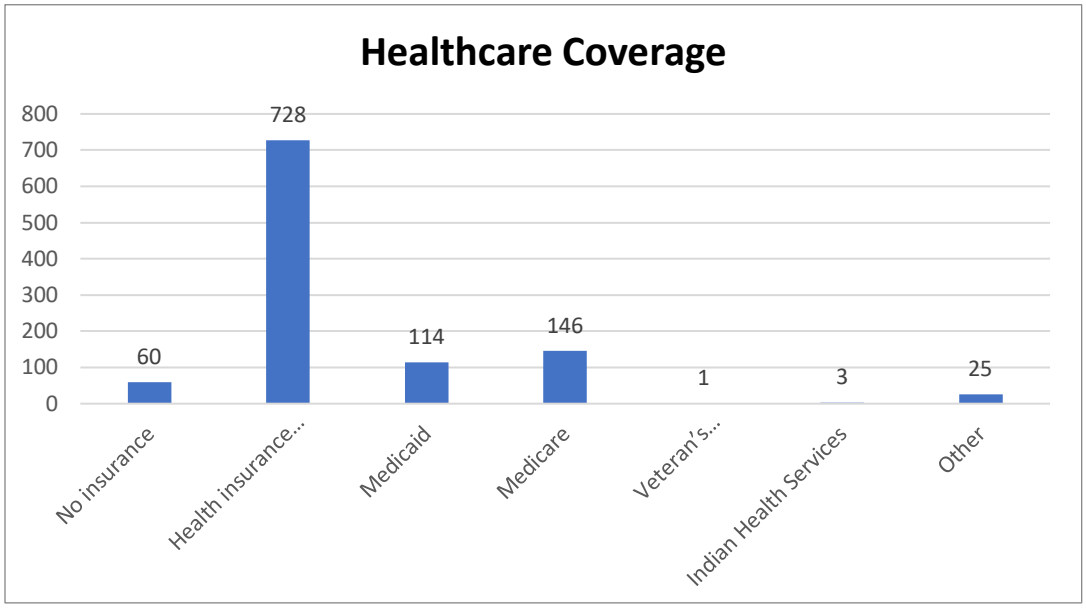
Figure 8: Disability Demographics



Healthcare Coverage

A majority of the respondents, 67.5%, identified that they had health insurance/private insurance while 0.5% of respondents indicated they had no insurance. It is important to note that some participants indicated more than one form of coverage.

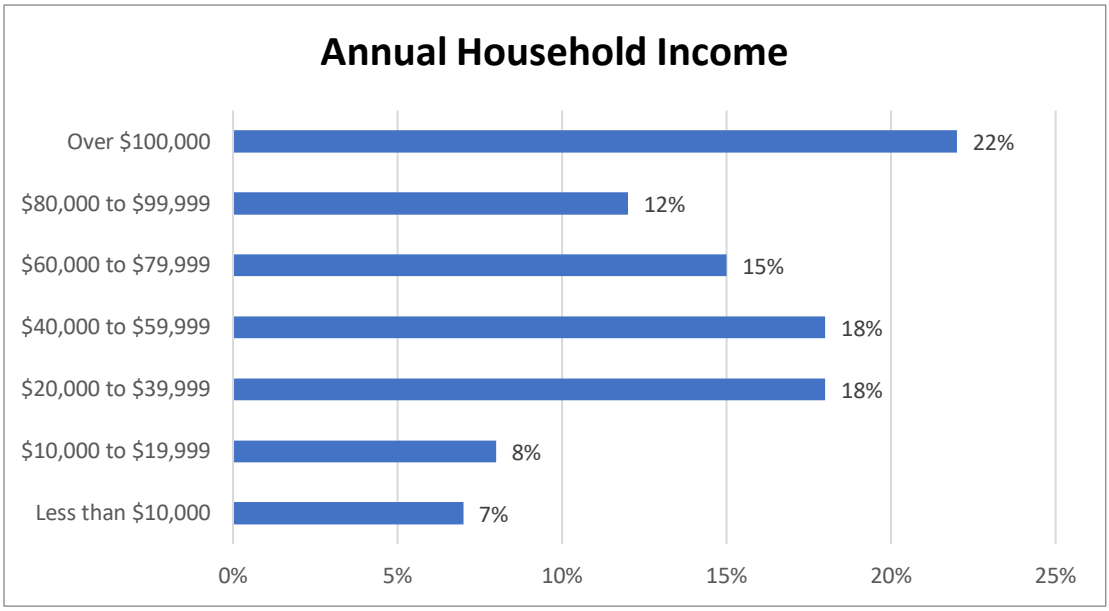
Figure 9: Healthcare Coverage



Annual Household Income

22% of the survey respondents identified an annual household income of over $100,000, while only 7% identified an annual household income of less than $10,000. However, 2018 Census estimates indicate that only ~16.4% of households in Mississippi have an annual income of over $100,000, while ~10.6% of households have an annual income of less than $10,000.[5] With that, the median income for Mississippi was identified as $44,717 annually.

Figure 10: Annual Household Income



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Key Findings and Emerging Themes

Definition of a Healthy Community

In all listening sessions, participants were asked to share how they define a healthy community. In addition, survey respondents were asked to identify the three most important factors for a healthy community. Participants of the listening sessions provided a variety of descriptions, including what assets and strengths would be present in a healthy community, as well as what barriers and challenges would be lacking in a healthy community. The responses to this question are used to level set what is important to residents of a healthy community. The responses are not evaluative of their community,

[5] ACS (2018). https://data.census.gov/cedsci/table?q=Mississippi%20Income&g=0400000US28&tid=ACSST1Y2018.S1901&t=Income%20%28Households,%20Families,%20Individuals%29&cid=S1901_C01_001E&vintage=2018

rather define the important aspects of a general healthy community. The responses revealed common themes among listening session participants and survey respondents.

Access to Quality Healthcare and Health Education

Participants across the state described access to quality healthcare and health education in their definition of a healthy community. 15.7% of survey respondents indicated access to health care and mental health services as the most important factor for a "healthy community." Participants of the listening sessions described access to local, quality, and convenient hospitals, specialists, and dental care as an aspect of a healthy community. Some participants provided specific healthcare-related community practices and services that would be present in a healthy community, including access to mobile healthcare units and immunization services. Easy and affordable access to substance misuse treatment facilities and mental health resources were also commonly described across listening sessions.

Along with access, listening sessions revealed a common theme of health education and promotion initiatives as an aspect of a healthy community. Common health education and promotion initiatives included general wellness programs, diabetes prevention/intervention programs, nutrition programs, youth mental health education, and public health education. Participants also generally described the presence of easily accessible resources to gain health-related information as a part of a healthy community.

Most notably, several participants identified access to quality healthcare and health education as a pathway to health-related community sustainability.

Health-related Policies and Healthy Behaviors

Participants described healthy behaviors as social norms and the enforcement of health-related policies as aspects of a healthy community. At the same time, 6.4% of survey respondents identified healthy behaviors and lifestyles as an important factor to a healthy community. Tobacco-free ordinances and public breastfeeding policies were noted as examples of health-related policies in a healthy community. Participants described behavioral shifts in alignment with the policies that result in changes in social norms, including increased breastfeeding rates, and decreased drug, alcohol, and smoking rates in healthy communities.

Community Cohesion and Community Resources

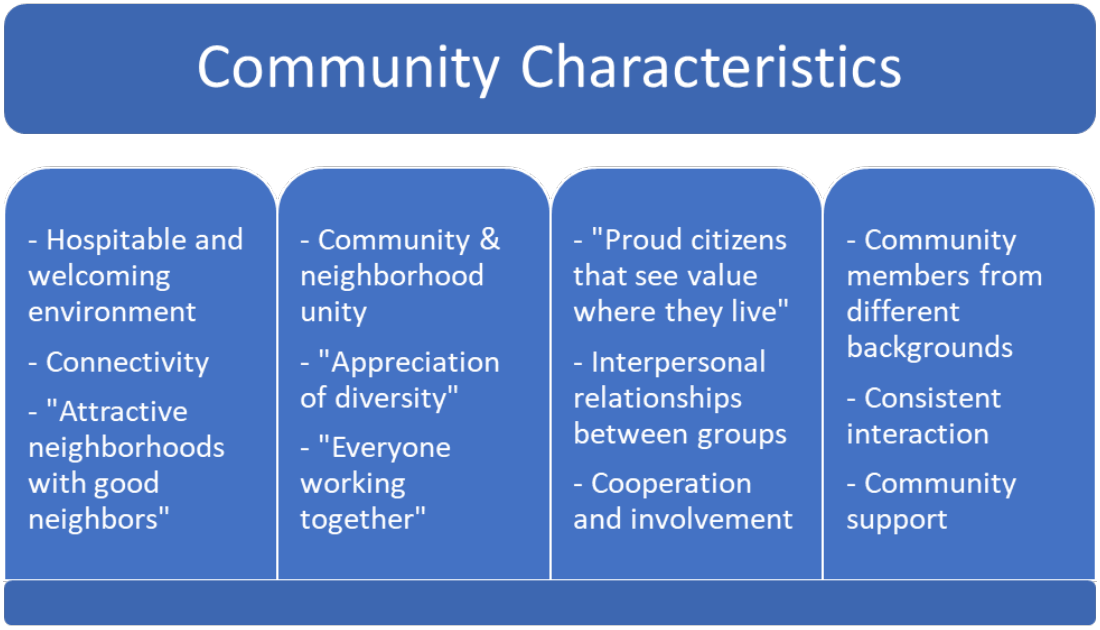
Community cohesion and various community resources presented another common theme throughout listening sessions. The concept of community cohesion revealed itself as community characteristics that contribute to the health of a community. Figure 11 displays some of the various community characteristics described by participants. With that, many participants described consistent community social events as a pathway to community cohesion.

Participants also described a variety of community resources that contribute to the health of a community. Many of the resources mentioned by participants for a healthy community relate to physical health and accessing basic needs. Resources for basic needs described by participants included: healthy food options, transportation, information technology and internet access, accessible buildings, and local news sources. Participants cited several examples for accessing healthy food options, including farmer's markets, grocery stores with quality fresh produce, healthy restaurants including locally sourced farm-to-table restaurants, and community gardens.

Participants also described the need for community services and organizations – such as stakeholder organizations (PTO), community organizing groups, faith-based representation and services,

occupational training and employment opportunities, youth and senior services, and arts and academic programs. Participants provided examples of youth services and organizations, including after school activities and clubs, 4H and Boys & Girls Clubs, daycares with assistance programs, and early education programs. With that, access to quality education for youth was frequently identified by survey respondents (10.8%) as one of the most important factors for a healthy community. Senior services described by participants included daily needs assistance and adult daycare programs. In addition, participants described physical health resources, such as nutrition programs, indoor and outdoor recreational facilities, fitness centers and gyms with free programs, and wellness centers with management programs for diabetes and other chronic conditions. Participants called for affordability and far-reaching accessibility of these resources to effectively contribute to the health of a community. Together with these resources, participants identified financial stability, economic development, strong and effective leadership, and quality public education as necessary components to define a healthy community.

Figure 11: Community Characteristics



Built Environment, Infrastructure, and Safety

Throughout the listening sessions, the built environment, infrastructure, and general safety remained common themes. Participants described communities with quality infrastructure and a built environment as aspects of a healthy community. For the purpose of this report, the built environment "includes all of the physical parts of where we live and work. The built environment influences a person's level of physical activity."[6] Participants described streets with quality lighting systems, sidewalks, bike lanes, pothole free roads, and general street cleanliness as aspects of a built environment in a healthy community. Participants also described aspects of quality infrastructure and a built environment that would positively influence physical activity – such as nature trails, clean green spaces and parks, and community swimming facilities. Several participants noted the presence of clean air and water systems, as well as community beautification/clean-up contribute to community health.

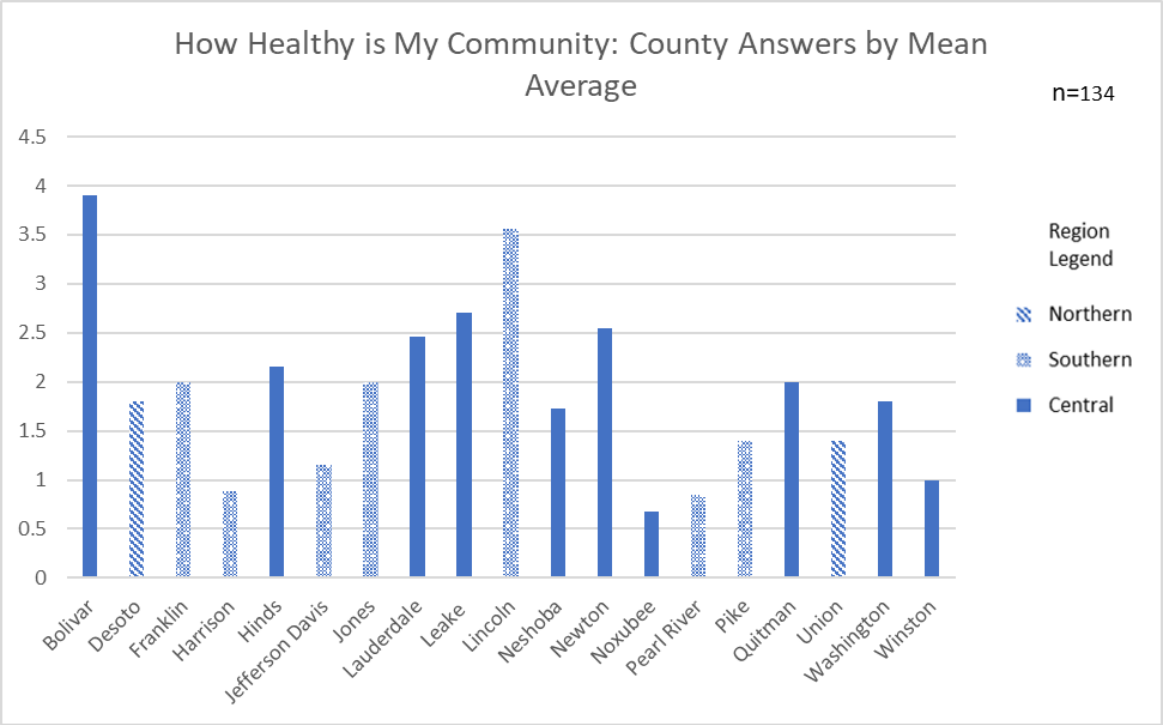
[6] https://www.cdc.gov/nceh/publications/factsheets/impactofthebuiltenvironmentonhealth.pdf

Finally, many participants and survey respondents (8.8%) noted general safety and low crime rates as an aspect of a healthy community. Participants described a significant law enforcement presence as well as local fire departments as essential to a healthy community. Others also described the presence of gated communities, neighborhood watch programs, a quick 24/7 law enforcement response team, and a consistently enforced curfew for youth in a healthy community.

"How Healthy is my Community?" Listening Session Responses

Following discussions of the definition of a healthy community, participants of the listening sessions were asked to rate the health of their community from 1-5 – with a rating of 1 being the least healthy and a rating of 5 being the healthiest. The graph below represents the information gathered from each listening session. The graph indicates average response from participants, categorized by county. The average also calculated in the zero values, as several participants provided zero as a response to this question.

Figure 12: "How Healthy is my Community?"



**Due to time limitations, this data was not captured in Walthall county.*

Participants offered some insight into the ratings they provided below.

Desoto County – Northern Region

- Participants who rated the health of their community as 1 (least healthy) noted the following:
  - "Pockets of health and resources."
  - "The West End of Hernando needs improving."
  - "Grant limitations."

    - "Horn Lake brought the score down/resources."
- Participants who rated the health of their community as very healthy (5) noted the following:
    - "SNAP- 90% of people resides in the West End."

Hinds County – Central Region

- Participants who rated the health of their community as 3 out of 5 (very healthy) noted the following:
    - "STD rates."
    - "Lack of good nutrients at school – malnutrition."
- Participants who rated the health of their community in the 1-2 range (least healthy) noted the following:
    - "Diabetes, mental health"
    - "High blood pressure"
    - "Cardiovascular disease"
    - "Mental health and financial [difficulties]"
    - "Cancer, poor hygiene"

Jones County – Southern Region

- Participants who rated the health of their community in the 1-2 range (least healthy) noted the following:
    - "We have opinions on 2 different age groups; obesity, we are aging, we're dependent on certain commodities that do for us; younger generation is good but we're headed
    - in the direction of you're going to get like this when you get older, there is no training, fitness center for us; we have a bad habit of our intake, in the 60-70s we were more gatherers and we didn't have distribution and we don't see that no more it's more convenient to go to Walmart, there are still gardeners but the deer got it first"
    - "Too much trouble – drinking and fighting."
    - "It's somewhat in between, it depends on the family and personality; some focus on kids and education and some focus on drama."

Lincoln County – Southern Region

- Participants who rated the health of their community as 4 out of 5 (very healthy) noted the following:
    - "Senior Citizen center is good to inform the community."
    - "It is good, nice, safe, likes people to buy local."
    - "Some people like [it] smaller and [it] feels safe."
- A participant who rated the health of their community as 3 out of 5 (very healthy) noted the following:
    - "Needs to have a change – increasing grocery stores, healthy stores, more clothing stores."

Newton County – Central Region

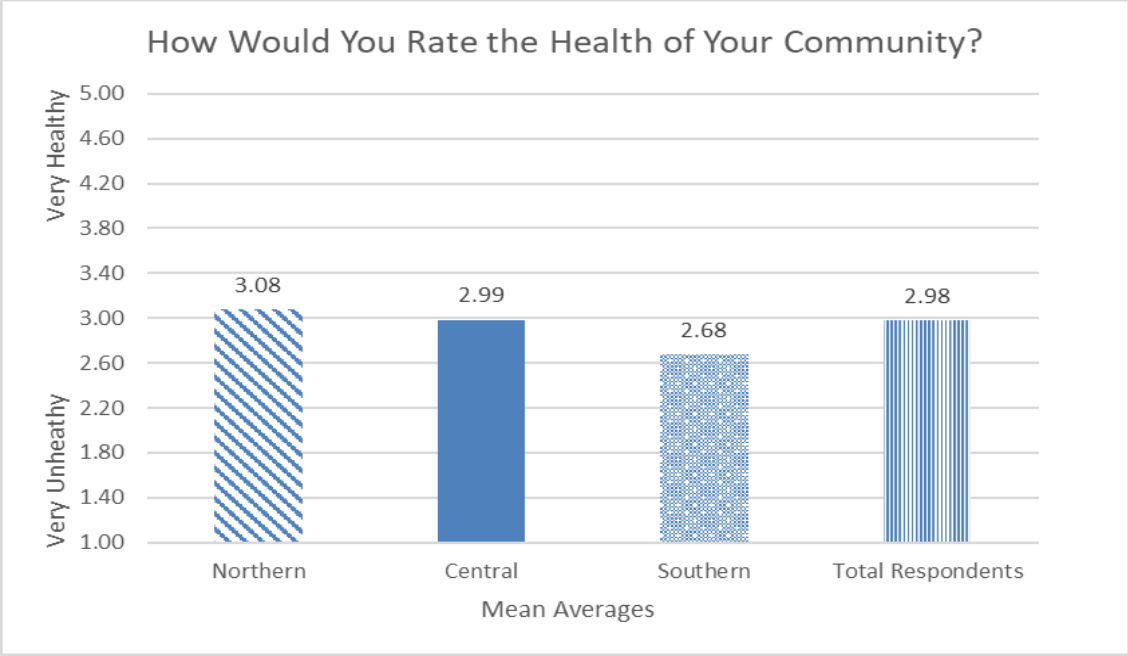
- Participants who rated the health of their community as 3 out of 5 (very healthy) noted the following:
    - "Poverty and lack of resources to make healthier choices and access to emergency healthcare."

- "Families are not eating meals together anymore. Kids do not eat at the tables anymore they eat wherever they go which is one of the biggest problems everywhere."
- "We have a good foundation [,] but there need[s] to be better choices to be made that are in our best interest to be healthy. As parent [,] I will set a better example to my kids."
- "Diabetes is so rampant [,] and obesity is so high. Family devotion needs to be at the table and that will help improve and open up the bible more at home with family meals. People here will buy cigarettes [,] but expect free healthcare. We give free health care to help them out, but the community do[es] not want it."
- "Education plays a big part and changes need to be made on our part to be healthier."

"How Healthy is my Community?" Survey Responses

Survey respondents were also asked to rate the health of their community on a scale from 1 – 5, a rating of 1 being very unhealthy and a rating of 5 meaning very healthy. The graph below represents the mean average results of the total survey respondents and regions. Like the rating from the listening sessions, a majority of the respondents (48.1%) indicated that their community is "somewhat healthy." Only 4.4% of respondents indicated their community was "very healthy," and 5.6% of respondents indicated their community was "very unhealthy." The Northern Region and the Central Region rated their communities "somewhat healthy" on average with a rating of 3.08 and 2.99 out of 5 (respectively), while the Southern Region rated their communities "unhealthy" with an average rating of 2.68 out of 5. Overall, survey respondents rated their communities "unhealthy" with a mean average rating of 2.98 out of 5.

Figure 13: How Would You Rate the Health of Your Community?



Community Assets

Participants were asked to describe assets and strengths of their communities. This information provides insight from the perspective of community members into existing assets in communities across the state.

Sense of Community

Throughout all districts, listening session participants noted a sense of community between their fellow residents as their primary asset. Across the three regions, sense of community was also most frequently identified. 31.5% of Central Region respondents, 34.8% of Northern Region respondents, and 35.2% of Southern Region respondents said it was the greatest strength of their communities. These respondents described small, tight-knit communities with friendly neighbors that work together to provide support when needed. Many participants described a culture of hospitality in their towns that reinforce a strong sense of community. This revealed a consistent theme of giving and helpfulness in communities across several listening sessions. Many participants described that the presence of community gatherings and festivals consistently brought residents together to create unity.

One participant from Crystal Ridge in Winston County noted that the close-knit ties of their community allows for neighborly support and cohesion when significant, possibly harmful, events happen to another community resident. Community residents from smaller towns praised their communities for being family-based, safe for residents, and strong in their history and tradition. Other listening sessions described enjoying their community for the quietness that does not exist in larger cities. Some participants reported the presence of strong religious ties as a major asset in their communities.

Community Organizations and Civic Institutions

Residents cited community organizations and institutions as significant assets within their communities. The types of organizations and institutions noted as community assets are defined below.

- Faith-based services
    - Local churches
    - Interfaith counsel
    - Church camps
- Local school systems
- Service clubs (i.e. Rotary, Kiwanis, Master Gardener, Pilot, Women's)
- Libraries
- Community-based programs
    - Community and recreation centers
    - Childcare (i.e. after school programs, daycares, Head Start programs)
    - Senior programs (i.e. senior centers, bingo nights)
    - Family resources, including support for single parents

Neshoba, Tucker: "Boys and girls club- Provides structure and additional guidance for youth. School focuses on education, Boys and girls club focuses on social."

Hernando, Desoto: "farmer's market is accessible to all incomes, accepts WIC and senior nutritional vouchers. [On] Children's day, kids get a $5 voucher for fruits and vegetables, [and] offers free yoga and fitness activities."

33.8% of survey respondents also noted community organizations and civic institutions, such as churches, local universities, city governments, and libraries as strengths in the communities. The presence and engagement of local churches and other religious institutions were specifically noted as a source of strength in the communities. Most significantly, participants across listening sessions noted **churches as the central civic institution** in their communities. With that, many listening sessions mentioned the benefit of **investing in their youth for community change.** A participant from Neshoba, Tucker stated, "Boys and Girls Clubs provide structure and additional guidance for youth. School focuses on education, Boys and Girls Club focuses on social." **Education** was also notably mentioned as a strength with 7.7% of respondents describing strong public and private school systems in their communities.

Participants from Walthall, Lincoln, and Desoto counties described access to fresh **farmer's markets** as an important asset within their communities. A resident from Hernando, Desoto reported farmers markets as a method for addressing health in low-income areas. The "farmer's market is accessible to all incomes, accepts WIC and senior nutritional vouchers. [On] Children's day, kids get a $5 voucher for fruits and vegetables, [and] offers free yoga and fitness activities." Residents cited farmers markets as a resource for accessing fresh food, learning new health habits, and building a sense of community.

Communities that have **local access to hospitals and clinics** also noted these institutions as assets to their communities. **Safety** was also identified as a top strength across all three regions. The percentages of survey respondents who noted safety in the Central, Northern, and Southern regions was 10.7%, 9.3%, and 8.6%, respectively. Respondents described how low crime rates, safe neighborhoods, police presence, and efficient emergency response contribute to the strength of safety in their communities. Participants described the prioritization of these community organizations and civic institutions as opportunities for promoting health and well-being in their communities.

Natural Environment

Greenspace, both in form of **parks and natural space**, was mentioned frequently as a resource for exercise, mental health promotion, and community support. Participants described aspects of their local parks and recreation department as assets to health and well-being. Several listening sessions discussed **walking trails and designated parks** as significant assets for promoting physical activity.

Participants also listed **sports fields, local recreation centers, and playgrounds** as community assets for many families with children. Less frequently, residents mentioned outdoor activities – such as hunting, fishing, and swimming – as other assets in communities. Participants commonly discussed the scenery and natural beauty of Mississippi as a major strength.

Economic Development

Participants frequently mentioned economic development as a strength in many communities, and as an asset for change. Participants primarily from Union and Lincoln counties described **economic development through new job sites, shopping and entertainment opportunities, and thriving downtown areas**. These residents reported businesses, food options, and arts/entertainment options coming to their communities. Industries and economic growth provide employment and stability for residents. Some participants described the **creation of job training and readiness programs** to serve as gateways to employment and stability.

New entertainment options and events have increased **tourism** and brought revenue into their communities. Other participants described potential opportunities for **industrial growth and expansion** as an asset to health and well-being in their communities. Across a few listening sessions, some participants noted that **residents working closely with local governmental entities** served as an asset to promoting health in their communities.

Community Challenges

Infrastructure and Environment

Listening session participants and survey respondents across the state reported issues with **the built environment** as a significant challenge to community health. As previously noted, the built environment

"includes all of the physical parts of where we live and work. The built environment influences a person's level of physical activity."[7]

Participants consistently described issues with the built environment through:

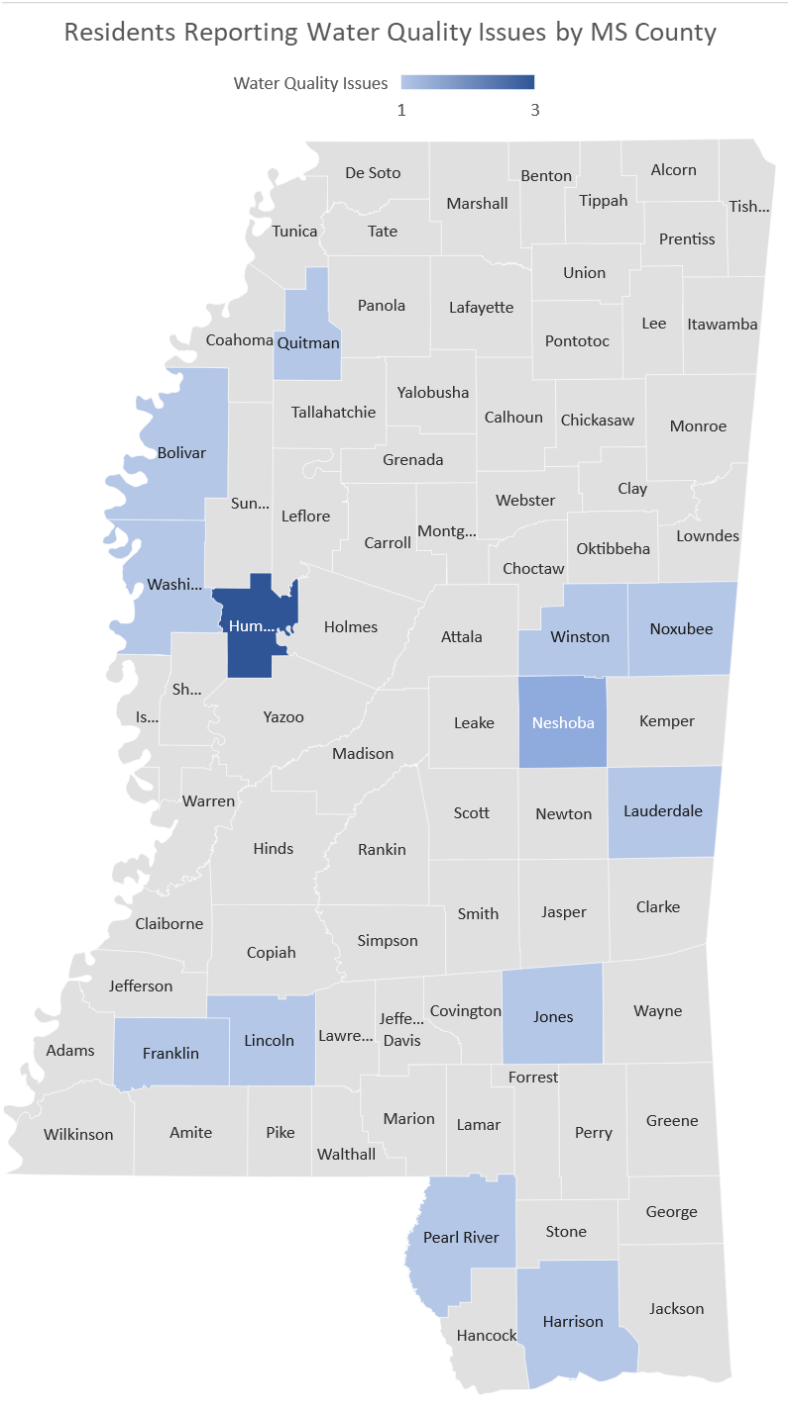
- Poorly maintained streets
- Lack of streetlights
- Poor utilization of greenspaces
- Lack of bike lanes and sidewalks
- Lack of walking trails and protected routes for cyclists

Community residents noted these issues as major impediments to physical activity as well as safe spaces for non-vehicular transportation. 7.1% of survey respondents from the Central Region noted issues specifically with their community's roadways and lack of sidewalks. Poorly maintained roadways due to potholes, lack of paved roads, and trash on roadsides was reported most frequently as a challenge for community health.

Participants and survey respondents also significantly reported poor walkability in communities as a challenge to engaging in physical activity. The lack of lighting in public spaces, parks, and on streets consistently caused **safety concerns** for residents and children in the community. In some counties, participants and survey respondents reported substantial issues with their local water system and accessing clean drinking water.

Figure 14 visualizes information from listening session participants and survey respondents who reported safety concerns for drinking water. Darker colors indicate higher frequency of mention.

Figure 14: Residents Reporting Water Quality issues



[7] https://www.cdc.gov/nceh/publications/factsheets/impactofthebuiltenvironmentonhealth.pdf

Community Involvement and Community Resources

Participants cited a lack of community involvement and limited community resources as significant challenges to community health. While some participants defined their communities as close-knit, neighborly, and supportive, other participants voiced concern over community involvement and unity.

One participant from Jefferson Davis, Prentiss stated that their community "need[s] improvement in the connectedness of all community resources," to increase accessibility to these resources. Participants noted **poor communication and advertising** throughout communities about events, initiatives, and programs offered to residents.

In addition, participants reported a **lack of participation in the improvement of people's communities**. One participant from Jefferson Davis County in the Southern Region noted how "civic depression [and] dis-engagement presents itself in citizens who say there is nothing here, 'I can just throw my trash out my car window,' disengage from community, and isolate." Citizens across multiple listening sessions and survey respondents communicated a desire to see engagement from their neighbors in bettering their community. One respondent from Harrison County in the Southern Region noted the need for "building a strong sense of 'we are all in this together' across the community with honest dialog about strengthening public schools and economic opportunity for all."

Jefferson Davis, Prentiss: "Better schools, some students do not have books and teachers are not qualified; Improve resources to the school system."

Jefferson Davis, Prentiss: "Improve perception of the existing school system, low ratings Fs and Ds; too much testing"

Harrison County: "building a strong sense of 'we are all in this together' across the community with honest dialog about strengthening public schools and economic opportunity for all."

At the same time, participants often reported a lack of community resources or community barriers to maintain their own health and well-being. In the Central Region, 9.1% of survey respondents noted the need for community services for childcare, drug rehabilitation, homelessness, access to healthy food, and/or programs for youth and older adults.

Across the state, participants of listening sessions listed **limited or non-existent services** for the following issues and/or populations:

- Homelessness services (i.e. homeless shelters, affordable housing)
- Domestic violence
- Substance misuse (prevention, intervention, transitional housing)
- Re-entry services for individuals previously incarcerated
- Supportive services for individuals with disabilities
- Natural disaster (preparedness, intervention)
- General wellness services (recreation centers, athletic facilities)
- Services for youth (after school programs, peer to peer)
- Supportive services for senior citizens
- Supportive services for veterans
- Food access (delivery, pantries)

Many participants in the listening sessions and 11.3% of survey respondents particularly noted a rise in **substance misuse** – specifically opioids and methamphetamines. They explained their communities have no services in place or local facilities to prevent and treat the misuse of substances or provide support for families and communities experiencing the issues associated with substance misuse.

Access to Healthcare and Health Education, Healthcare Quality

Participants of listening sessions cited access to affordable, quality healthcare and wellness promotion as a common theme in Mississippi. **Cost of insurance, care, and medications** were commonly cited as barriers to maintain a healthy lifestyle. While 2% of survey respondents noted the need for affordable healthcare, 0.5% of respondents also indicated a need for Medicaid Expansion. The **lack of specialty care** for diabetes, cardiology, maternal and childcare, etc., was frequently reported as an issue in rural communities. 8% of respondents noted the need for access to healthcare, including mental health, substance abuse, and care for people with Autism. **Care for mental and behavioral health**, such as substance misuse rehabilitation, was described as scarce in rural locations despite substantial need. Participants described how lack of **access to health education** and **low health literacy** has impacted issues such as diabetes, family planning, and mental health. 14.7% of survey respondents in the Northern Region noted the need for comprehensive health education, including sex and STI education for youth in the public-school system. Participants reported that many communities lack clinics, and residents need to **travel long distances** to access care.

Pearl River, Poplarville: "Cancer/Lack of cancer treatment- We have a small hospital and if you need cancer treatment or other emergency general practitioner only."

Quitman, Marks: "We are a community of responsive care not preventative care."

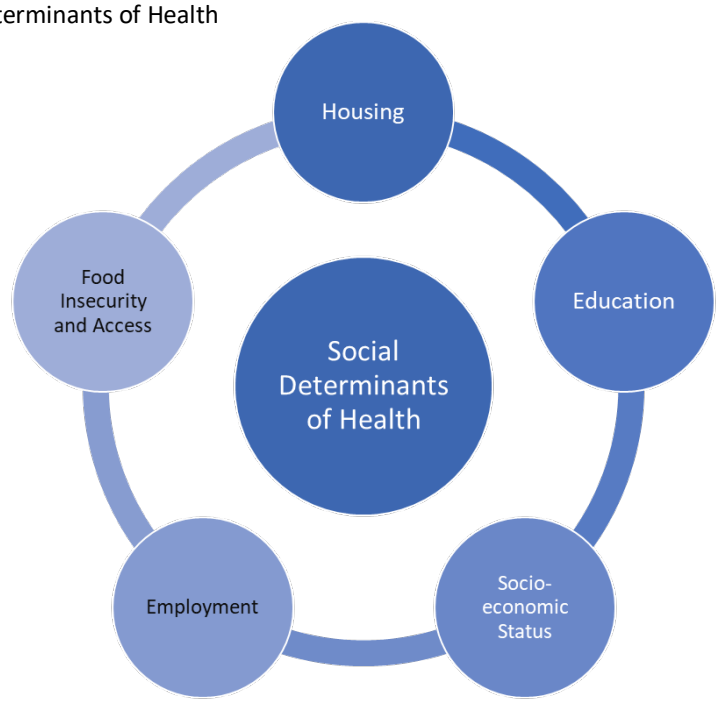
Along with inadequate access to healthcare services, community residents also cited **healthcare quality** as a challenge to maintaining a healthy lifestyle. This was presented as a significant issue in rural communities where funding was described as very limited. **Poor communication, lack of face to face time with patients, and lack of cultural competency among healthcare professionals** were all concerns with the quality of care available. A survey respondent from Oktibbeha County, Central Region, noted the impact of "collaboration and lack of coordination of health care services to raise awareness and increase accountability for one's health" on the well-being of their community.

Lack of trust with the healthcare system was a frequent theme among members of the Mississippi Band of Choctaw Indians: "These people have been let down so many times they don't trust you and don't want your help." Lack of trust and poor quality of care contribute to non-compliance in treatments for patients—another health issue cited by focus group participants.

Social and Structural Determinants of Health

Listening session participants most frequently cited **social and structural determinants of health** as challenges faced in their community. Figure 15 provides a graphic depiction of the social and structural determinants of health identified by participants.

Figure 15: Social Determinants of Health



Economic hardship was commonly reported as a challenge, concerning **a lack of occupational opportunity, cost of education, and poverty**. Participants in some communities described a lack of industry that limits the availability of jobs to local residents. Both the Central (2.4%) and Southern (24.9%) Region survey respondents identified workforce development, through more job opportunities and increased wages, as the most frequently needed area of improvement in their communities. Participants noted that many employed residents or residents seeking employment must travel outside of their community to work. Participants also noted **low-wage jobs** prevent financial stability. Comparatively, survey respondents (11.8%) most frequently identified a lack of quality jobs as one of the top issues that impact the health and well-being of their communities. Some participants described a common theme of individuals maintaining **multiple jobs to remain afloat**. Along with that, many participants described high rates of **unemployment** and families with low socio-economic status. One participant from Newton County explained that "[residents] can do so much, but [they] are limited by [their] pay."

Many participants described a **lack of formal education** that denies individuals the ability to reach occupations at a higher income level. Participants described how **under resourced public-school systems**, a lack of education-related resources – including academic counselors, and cost – prevents community members from obtaining post-secondary degrees. Survey respondents in the Central Region (11.5%) specifically noted the need for improved public-school systems that better prepare youth post-graduation. Participants from counties like Jefferson Davis and Franklin noted the critical need for improvements in their public education systems.

Throughout the state, listening session participants most commonly cited housing as a challenge in their communities. Participants from Noxubee, Desoto, and Newton counties described a **lack of safe affordable housing** in their communities. Many participants also noted **over-crowded housing systems** in their communities. Participants noted how financial instability drives housing insecurity and homelessness. Desoto, Lauderdale, and Harrison counties identified a need for more housing, as well as services for individuals experiencing homelessness and at-risk for homelessness.

Participants also noted **food insecurity and nutrition** as a challenge in their communities. Participants throughout the state reported an excess of fast food options, but **limited options for affordable, fresh, and healthy food**. A survey respondent in Covington County, Southern Region, identified "assistance to low income families with healthy food choices" as a need in their community. Participants in Neshoba, Franklin, and Leake counties described a lack of grocery or convenience stores in their communities requiring them to travel significant lengths to access healthy food options. As well, several participants in Franklin, Meadville noted what is described as **food deserts**: "Most of the stores do not have enough variety of healthy food. Nutrition is not there because we cannot afford it."

Economic Development

A common theme throughout listening sessions presented a lack of economic development in many communities. Many participants described **low rates of industry** in their communities preventing individuals from gaining and maintaining stable employment. Participants from Franklin County noted that large employers have left their communities and taken their jobs. Other counties, like Pearl River, Hinds, and Lincoln described maintaining a challenge of **small, family-owned businesses struggling** to stay open and profitable in their communities. 5.9% of Central Region and 7.8% of Southern Region survey respondents identified better infrastructure that will create more jobs to decrease wealth gap disparities and reduce homelessness as an area of improvement in their communities. Participants noted an overall need to bring industry into their communities, as a pathway to employment and sustainability.

Many participants described **a lack of entertainment** prevents economic growth in their communities. Participants in Pearl River county noted a need for out-of-town lodging, restaurants, night life, and retail to contribute to economic development in their community. Similarly, participants noted a **lack of cell service and internet access** as challenges to maintaining vitality and health in their communities.

Biggest Health Issues

When asked to discuss the biggest health challenges that participants' communities face, community residents referenced several key issues across communities, including healthcare access, communication, built environment, culture of health, and leadership.

Healthcare Access

Most notably, participants described physical and mental health issues that remain as a threat to health and well-being. The following health issues were noted across listening sessions:

- Chronic health conditions

    - Diabetes and related health issues (i.e. blindness, amputation)
    - Hypertension
    - Heart Disease
    - Obesity
    - Kidney Disease
    - Cancer (i.e. breast, lung)
    - Arthritis
    - Asthma
- Substance use disorders (i.e. alcohol, tobacco, and illicit drugs)
- Mental illness (i.e. depression, anxiety)

In addition, survey respondents were asked to identify what they believe are the three most important health problems in their communities. The top three responses were **diabetes** (high blood sugar), **obesity**, and **high blood pressure**. **Mental health** (depression, anxiety, PTSD, suicide, etc.) and **substance use** (alcohol, prescription misuse, and other drugs) were also frequently chosen by respondents. Table 4 indicates the number and percentage of respondents who identified these health problems as the most important in their communities. Table 5 presents the most frequently identified health problems by region.

Respondents who utilized the write-in option indicated a few other health problems not listed above. These responses included childhood disabilities (autism, learning disabilities, cancer, and cystic fibrosis), obesity-related diseases, stress, vaping, unsafe sex, lack of hygiene, and metabolic disease. Some individuals noted issues specific to their communities. One respondent in Lowndes County (Central Region) noted human trafficking of women as an increased health problem in their community. Two respondents from Jackson County (Southern Region) both noted pollution from chemical plants as an important health problem in their area. A respondent from George County (Southern Region) noted Hepatitis A and Tuberculosis as an important health problem in their county.

Table 4: Most Important Problems in Communities (combined results)

Factor	Number of Respondents	Percent of total
Diabetes (high blood sugar)	398	14.3%
Obesity	358	12.9%
High blood pressure	340	12.2%

Mental health (depression, anxiety, PTSD, suicide, etc.)	298	10.7%
Substance-use (alcohol, prescription misuse, and other drugs)	240	8.6%

Table 5: Most Important Problems in Communities by Region

	Northern Region		Central Region		Southern Region	
Health Problem	Diabetes	19.7%	Diabetes	15.7%	Mental health	12.0%
	Obesity	16.2%	High blood pressure	13.7%	Obesity	11.5%
	Mental health	11.1%	Obesity	13.2%	Diabetes	11.4%
	Substance-use	10.9%	Mental health	9.1%	High blood pressure	11.3%
	High blood pressure	10.7%	Age-related illness	8.7%	Substance-use	9.8%

Participants stressed the most significant factor in improving the health of communities is access to healthcare. Many participants noted a lack of medical providers in their communities with the significant need to recruit more in rural areas. Participants suggested the following ideas for community improvement:

- Mobile health units and providers
- Utilizing telehealth services to reach more patients
- Improving local health department capacities and public health resources
- Local, free health fairs and forums as a method for education and resource linkage.

Communication

Many participants described a significant disconnect between healthcare providers and community residents. Communication and stakeholder partnership are rarely present throughout communities; which remains a significant issue in rural communities. Several participants stated that the lack of awareness of health-related issues remains a barrier to maintaining health and well-being. A participant from Newton, Decatur stated, "Communications and once we receive it, we need to build on it and work on it and follow up."

Newton, Decatur: "Communications and once we receive it, we need to build on it and work on it and follow up."

Communication Ideas for Community Improvement

Several focus group participants suggested improving communication in communities about events, resources, and ways to get involved would lead to the utilization of assets and improve health:

- Increasing advertising for community health events
    - Residents suggested email lists, flyers, online communication, and phone calls to reach more of the community.
- Compiling a local community resource guide
    - Includes resources, nutritional guidance, and fitness recommendations
    - A dissemination process that gives information "where it's not traditionally shared" or resource-lacking areas.

Built Environment

Communities emphasized the need for sidewalks, bike lanes, and a built environment that encouraged physical activity. Several residents from Poplarville, Pearl River discussed the need to improve the town's walkability to grow a culture or walking over driving in their community.

Culture of Health

Listening sessions across the state discussed the lack of value for healthy living in many communities. Participants shared the need to mobilize communities for action. A participant from Prentiss, Jefferson Davis suggested to "have many more of these focused type conversations," saying, "we need to go where the people are. We may need to go into someone's home or churches. Go to the local store where the gentlemen hang out. They won't come to you. You must go to them." They discussed the desire to grow commitment, accountability, and prioritization to make communities healthy.

Many participants mentioned that education is the first step to growing a culture of health. A Gulfport, Harrison participant suggested starting health promotion at the elementary school level, to "teach a child during their upbringing and create the habits while they are young." For habits such as eating healthy, getting exercise, and learning how to get involved in the community could all be included in early prevention efforts.

Some participants discussed using incentives as a method of getting their communities healthy. Incentives through workplaces or community organizations could mobilize residents to use community resources such as farmers markets, walking trails, and fitness programs.

Gulfport, Harrison: suggested starting health promotion at the elementary school level, to "teach a child during their upbringing and create the habits while they are young."

Prentiss, Jefferson Davis: "have many more of these focused type conversations," saying, "We need to go where the people are. We may need to go into someone's home or churches. Go to the local store where the gentlemen hang out. They won't come to you. You must go to them."

Leadership

Listening sessions and survey respondents also mentioned the role of leadership for creating change. Survey respondents also noted the need for better communication and commitment from their leadership in their communities. Some residents recommended community leaders as a solution:

- Appointing local community leader as point person on health-related issues
- Increased involvement from formal leadership (i.e. city council members, supervisors)
- Involvement from public service institutions (i.e. law enforcement, fire departments, school boards)

Poplarville, Pearl River: "two walking trails but you can't walk to the post office or grocery store or to lunch, you have to get in your car and drive."

Residents suggested that leaders get out into their communities and be directly involved in change. A resident in Prentiss, Jefferson Davis perfectly highlights this need to "have many more of these focused type conversations," saying, "We need to go where the people are. We may need to go into someone's home or churches. Go to the local store where the gentlemen hang out. They won't come to you. You must go to them."

Barriers and Challenges

When asked to discuss personal and community-level difficulties, participants identified various barriers the prevent them from becoming healthy and maintaining health. The barriers to health and well-being reported by participants align with the following categories: environmental barriers, economic barriers, social barriers, and behavioral barriers.

Survey respondents were also asked to identify barriers to getting healthcare in their communities. Respondents indicated several and the results are noted in this report.

Environmental Barriers

Participants most commonly noted the built environment as a barrier for the health of a community—access to healthy food and safe spaces for physical activity improve the probability of a community adopting health behaviors.

Participants most commonly cited a lack of community spaces in which citizens can be physically active including:

- Sidewalks
- Walking trails
- Affordable or free exercise facilities

One participant from Poplarville, Pearl River discussed the lack of walkability in their community as, "two walking trails, but you can't walk to the post office or grocery store or to lunch. You have to get in your car and drive." As well, listening session participants consistently reported roads with potholes, cracks, and litter discouraging physical activity and making roadways dangerous.

Participants also frequently cited **public lighting** as barrier to physical activity and community safety. They described that the lack of streetlights, lights in parks, and lighting in public spaces remained a community concern for children playing in neighborhoods. Another participant from Brookhaven,

Lincoln explained green and recreation spaces are underutilized in their community due to a lack of adequate lighting.

Unsafe drinking water, brown water, and **sewage issues** were also reported in several communities. Additionally, drainage issues from flooding in Brookhaven caused concern for mosquito infestations.

Stray animals such as dogs, bears, coyotes, and snakes were reported in rural communities for concerns of disease, safety, and well-being of communities.

Participants reiterated **access to safe, affordable housing** as a significant challenge for communities of low socio-economic status. Participants reported homelessness as a significant community issue in the county of Harrison. Other communities noted struggles with poor living conditions and crowded housing.

Economic Barriers

Participants of listening sessions throughout the state frequently noted economic and financial barriers to health. Residents showed concern for the **high costs of healthcare** as threats to the health of communities. Participants frequently reported the rising costs of healthcare throughout listening sessions, mostly in the context of access to healthcare and insurance gaps.

Rural residents struggled to access healthcare due to **lack of community clinics**, **transportation** to healthcare facilities, and **lack of specialty doctors**. Lack of funding and hospitals located in rural communities have disproportionately affected access and quality of healthcare for rural communities. A participant of the Rural Healthcare Summit in Hinds County stated that, "when rural hospitals close, it puts a burden on other facilities/clinics, increases transportation barriers, and stretches EMS' capabilities."

Residents reported **less face-to-face time with doctors, inability to afford prescriptions,** and **issues with compliance to treatments** as quality of care challenges for maintaining health. Residents frequently noted the difficulty to retain doctors in their area.

Rural Health Care Summit, Hinds: "When rural hospitals close it puts a burden on other facilities/clinics, increases transportation barriers, and stretches EMS' capabilities."

Rural Healthcare Summit, Hinds: "Recruiting physicians to rural communities is tough, because it's a lifestyle choice."

Mental health services were also defined as a need in many communities, including a lack of understanding and diagnosis of mental health issues. One resident of Pearl River shared that there is a "lack of knowledge of resources for mental health. The community does not know they have depression."

Social Barriers

Many listening sessions participants referenced cultural practices, particularly related to eating, that remain detrimental to the health of their fellow community residents. In general, communities lack a "culture of health." For the purposes of this report, **"culture of health"** is described **as "the interconnectedness between health and social issues."**[8] Information gathered from the listening sessions revealed that health promotion and wellness is not a common social or behavioral practice in some communities. One participant from

[8] https://www.rwjf.org/en/library/research/2016/10/defining-and-measuring-a-culture-of-health.html

Hernando, Desoto shared how families "generation to generation have grown up eating a certain way" and to them, "Ignorance is bliss. They don't see the problem with their lifestyle because they don't know how much better their life can be."

Participants shared how **fear, embarrassment, and lack of motivation prevent people from seeking healthcare**. With a lack of cultural health promotion, residents stated that they **feel less motivated** to invest in their personal health promotion. A participant from Hernando, Desoto stated, "sometimes [they] have the resources but lack the motivation to make the healthy choice." Mindset, negativity, and lack of openness to change hinder behavioral change.

One reason for this barrier to habit change is **stigma** attached to attaining a healthy lifestyle and receiving mental health services. Residents shared concerns of "cultural stigma against being healthy," and the attainment of better health is perceived as "you think you are better than us." As well, many participants noted the significant lack of receiving necessary mental health services due to the stigma commonly attached to mental illness. One Prentiss, Jefferson Davis resident stated that a major challenge is people "not caring [and] feeling like the world around them does not care about them, [they] don't see a future or a promise." In more disenfranchised and resource-strapped communities, participants discussed how hopelessness impedes the desire to become and remain healthy.

Hernando, Desoto: "generation to generation have grown up eating a certain way" and to them, "Ignorance is bliss. They don't see the problem with their lifestyle because they don't know how much better their life can be."

Hernando, Desoto: "sometimes [they] have the resources but lack the motivation to make the healthy choice."

Prentiss, Jefferson Davis: a major challenge is people "not caring [and] feeling like the world around them does not care about them, [they] don't see a future or a promise."

Many listening session participants suggested that communities must harness a culture that puts health as a priority. While some residents reported their peers as "lazy," other participants felt that "we have to be careful calling other people lazy," due to the plethora of environmental, social, and economic barriers that create health inequities.

Another social challenge is **cultural barriers to health and cultural competency and humility among healthcare professionals**. One resident of Gulfport, Harrison reported, "language barrier at the doctor's office, [that] elderly live here and don't understand English very well." Residents of Gulfport cited a substantial need for medical interpreters and cultural competency among healthcare professionals.

Additionally, a **lack of community involvement** hinders the improvement of the health of the whole community. A resident in Prentiss reported that there is a "lack of community involvement in terms of what they believe are issues." Social cohesion and community action are crucial tools for shaping the health of a community. Participants commonly mention a lack of communication about community resources, events, and opportunities as a barrier to community engagement and health promotion.

Behavioral Barriers

Communities reported the single greatest behavioral issue for communities as making **healthy food choices**.

Residents shared several barriers to choosing healthy food:

- Access to healthy food options
- Affordability
- Time management for food preparation
- Food preferences
- Advertising of unhealthy options most common

Many families reported a lack of understanding of how to prepare healthy foods. Others cited not having enough time in their busy lives to buy, prepare, and cook healthy meals. "Sometimes it is easier to go to a fast food establishment." Participants were also concerned with the lack of gardening in communities. Most listening sessions reported a lack of physical activity culture.

Participants reported the following as barriers to physical activity:

- Access to affordable fitness facilities
- Safe space for exercise
- Clean, well-kept parks for use
- Walkability and public bike paths
- Climate (heat)
- Lack of culture of physical fitness
- Long work hours

One resident from Macon, Noxubee shared, "no recreation, not even movies and bowling, all we have is to eat and play on the phone." Several participants reported exhaustion and stress as a barrier to changing health habits. They are often over-worked and under paid, and the fast-pace stress of life keeps them from eating healthy and exercising.

Neshoba, Pearl River: "people that use drugs and hang out in certain areas. People don't want their kids on the playground because they are using drugs."

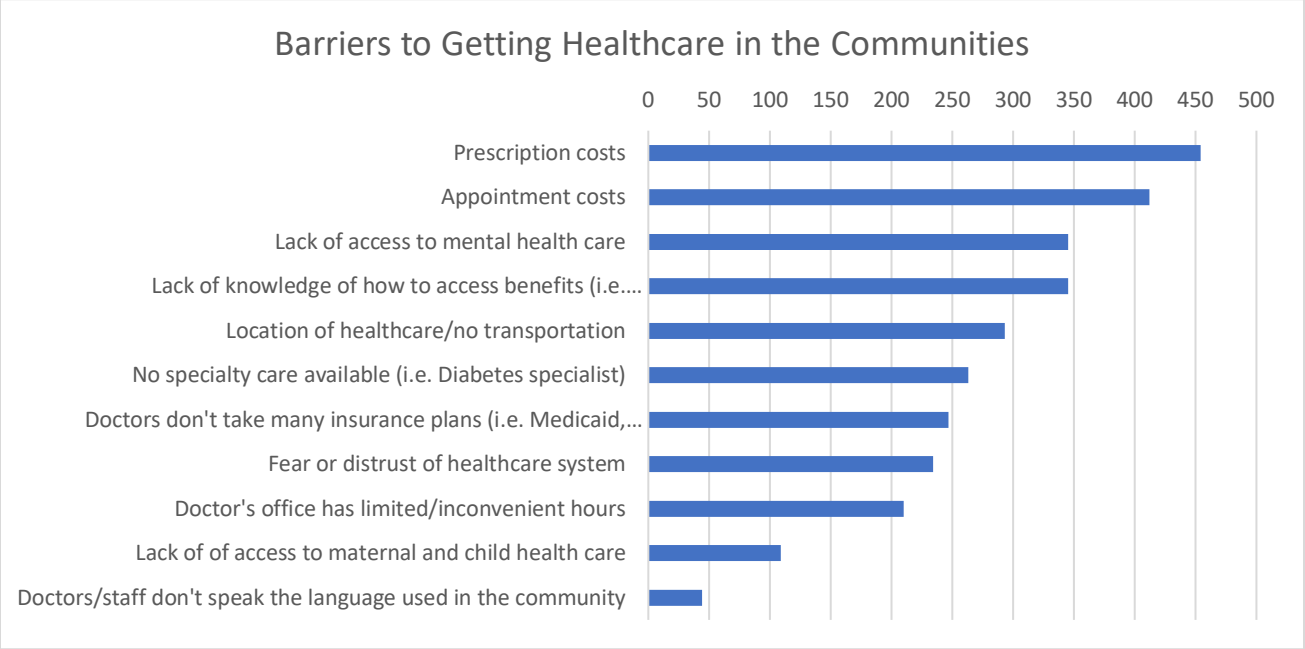
Substance misuse was frequently reported as a significant challenge for communities. Listening session participants from the Mississippi Band of Choctaw Indians reported significantly higher rates of substance misuse in their communities. Use of alcohol, marijuana, and nicotine was discussed as present in most communities. Substance misuse in the form of opioids, methamphetamines, and crack-cocaine were reported as growing concerns for many communities, as well. A resident of Pearl River stated that, "people use drugs and hang out in certain areas. People don't want their kids on the playground because they are using drugs." The abundant presence of liquor and tobacco stores was cited as creating further barriers for behavioral change. Many communities also reported a culture of smoking cigarettes and vaping.

Barriers to Getting Healthcare

Survey respondents were asked to identify the barriers to getting health care in their communities. The survey provided several options related to cost, access, and knowledge/education. Respondents most frequently identified prescription costs (15%), appointment costs (13.6%), lack of access to mental health care (11.4%), and lack of knowledge of how to access benefits (11.4%) as barriers to getting health care. Respondents were asked to identify barriers from a list of options as well as a write-in option. The other options were listed as location of healthcare/no transportation, no specialty care available, doctors do not take many insurance plans, fear or distrust of healthcare system, doctor's

office has limited/inconvenient hours, lack of access to maternal and child health care, and doctors/staff don't speak the language used in the community. The chart below displays the results from this question.

Figure 15: Barriers to Getting Healthcare in the Communities



Some respondents identified barriers not addressed in the given options, such as a lack of alternative/homeopathic providers, a lack of awareness of where to find services, lack of full practice authority for nurse practitioners, and poverty.

Health Resources

Listening session participants also reported community resources that help keep residents healthy. By far, the most cited resource for maintaining a healthy lifestyle was **space for physical activity and recreation**. For example, participants commonly cited local parks, sports fields, walking trails, fitness centers, organized recreation, playgrounds, and swimming pools as significant community assets. Additionally, residents identified resources linked to the healthcare system – such as pharmacies/drugstores, health departments, wellness programs, community hospital classes, and community-based organizations.

Less consistently, residents described healthy eating resources for maintaining health, due to the limited access in numerous communities. Of the few responses, farmers markets, opportunities for obtaining fresh produce, gardening, and nutritious food choices in communities were listed as great assets for maintaining health.

Trusted Information Sources

Figure 16: Trusted Information Sources

When asked about trusted health information sources, participants identified the internet as the top trusted health information source. This includes:

- Search engines (i.e. Google, Bing)
- Health information websites (i.e. Web MD, Mayo Clinic)
- Media outlets (i.e. magazines, television, radio, and local news)

Despite access to healthcare as the most pervasive barrier to maintaining health, the next most cited trusted health information source was health professionals and healthcare settings. Participants noted that the accessibility of these sources was varying, limited with the hours of operation, and location, as the most significant barriers to accessing resources.

Many participants noted a variety of community resources that act as trusted sources for health, including health fairs, diabetes classes, community counselors, church and club programs, and public schools.

Notably, many listening sessions mentioned extension services and educational programs assisted people in economic and community development, leadership, family issues, agricultural, health, and business studies. Communities that mentioned utilizing extension services include: Pearl River, Newton, Noxubee, Franklin, Lincoln, Union, Jefferson Davis, and Washington. Moreover, a handful of participants accessed trusted health information by word of mouth or peer networks.

Conclusion

The discussion of community assets, challenges, barriers, and ideas for improvement throughout the 29 listening sessions, along with survey responses from the Community Input Survey across Mississippi, yielded cross-cutting themes to inform the 2019 Mississippi State Health Assessment. These themes provide insight into community concerns and perceptions regarding quality of life and community health. While the data limitations do not allow for generalizations about a region, county, specific population or the state, the data does provide insight into a large sample of community members' perceptions, experiences, and recommendations to improve the health of Mississippi communities. Further input from community members is recommended as priorities are selected and plans are developed for improvement.

As aforementioned, the COVID-19 pandemic resulted in an unexpected, early closure of the Community Input Survey. Due to this, MSDH was unable to complete planned survey dissemination activities that would focus on priority counties in the bottom one-third of health outcome rankings. The closure of the survey resulted in data limitations that cannot be generalized throughout the state of Mississippi.

Community Strengths and Assets

- Mississippi's **natural environment** was consistently described as an asset across communities.
- Participants reported community **park and recreation** areas across the state as an asset that contributes to physical activity and health.
- Participants described a **sense of community** that promotes strong bonds and unity among community members. Communities across listening sessions were consistently described as welcoming and hospitable.

Economic development was noted as both a strength and challenge across listening sessions. Some listening sessions viewed economic development as a strength due to an increase in local industry, entertainment options, and community resources. Other listening sessions were conducted in communities where local jobs and community resources are scarce and, as a result, serves as a barrier to community health and well-being. Survey respondents notably identified economic development as an area for improvement, regarding community growth and increased job opportunities.

Community Challenges and Barriers

- Participants reported a number of barriers that have prevented adequate **access to affordable, quality healthcare services,** including a lack of mental health resources and substance abuse treatments. Participants also noted a **lack of health education** resources that increase knowledge of health issues and chronic conditions.
- A lack of **access to healthy food** in communities was a recurring theme, particularly in rural and impoverished areas that maintain food deserts.
- Many aspects of the **built environment** and **infrastructure** that influence quality of life and physical activity were described as challenges, such as – water quality, road and sidewalk maintenance, and parks and recreation.
- Participants across listening sessions noted communities lack a **culture of health** that prevents prioritization of health and well-being.
- Unemployment, underemployment, and a lack of access to local industry were noted as **economic barriers** to maintaining health and well-being.