Institute for Community Studies

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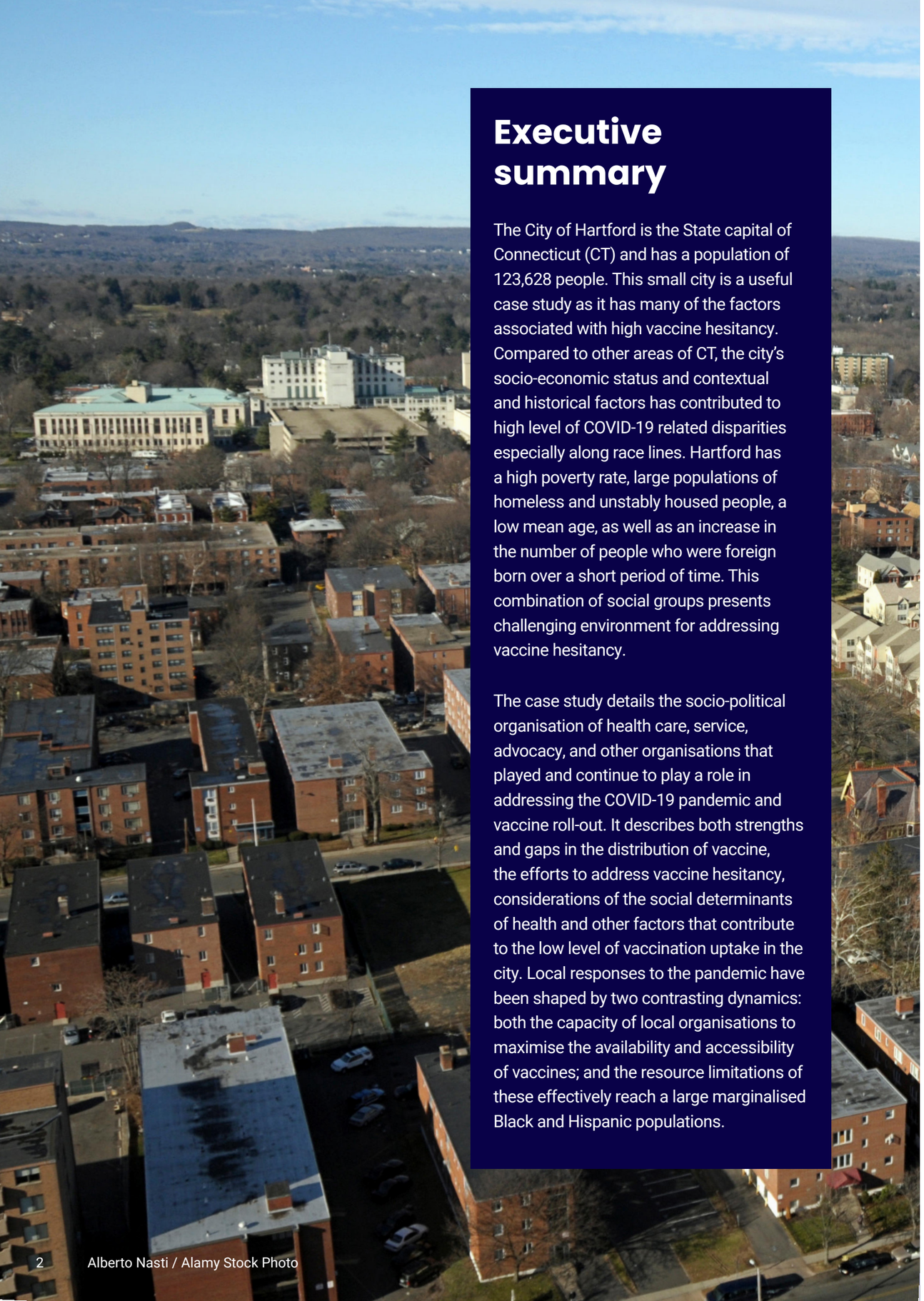
Case study: Hartford, USA

Research conducted by
The Institute for Community Research (US)



Executive summary

The City of Hartford is the State capital of Connecticut (CT) and has a population of 123,628 people. This small city is a useful case study as it has many of the factors associated with high vaccine hesitancy. Compared to other areas of CT, the city's socio-economic status and contextual and historical factors has contributed to high level of COVID-19 related disparities especially along race lines. Hartford has a high poverty rate, large populations of homeless and unstably housed people, a low mean age, as well as an increase in the number of people who were foreign born over a short period of time. This combination of social groups presents challenging environment for addressing vaccine hesitancy.

The case study details the socio-political organisation of health care, service, advocacy, and other organisations that played and continue to play a role in addressing the COVID-19 pandemic and vaccine roll-out. It describes both strengths and gaps in the distribution of vaccine, the efforts to address vaccine hesitancy, considerations of the social determinants of health and other factors that contribute to the low level of vaccination uptake in the city. Local responses to the pandemic have been shaped by two contrasting dynamics: both the capacity of local organisations to maximise the availability and accessibility of vaccines; and the resource limitations of these effectively reach a large marginalised Black and Hispanic populations.

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Demographic profile

Ethnicity	• Hartford has the highest poverty rate in Connecticut (28.1%) (1). • Hartford is 35.7% Black, 45% Hispanic of all groups, and 21% white (1). • More than 20% of whites and blacks and one third of all Hispanics live at poverty line or below (1). • Almost 70% of residents were foreign born. 14% were not citizens in 2019 mainly from Latin America, India, Jamaica, Mexico, eastern Europe and northern Africa. The rate is double the national average and more than double that of Hartford County (32%) (1).
Income	• Median household income is $36,278 compared to median US income of $65,7000. • Only 23% of housing is owner occupied; the remainder is rental housing as compared to 63% in the U.S. Rents averaging $1092 in 2019, about 33% of the mean annual income (2).
Age	• Hartford has a young population compared to other areas of CT. The average age in 2019 was 32.

History: marginalisation and resistance

Connecticut is among the wealthiest States in the country, while its larger cities are among the poorest in the U.S; Hartford is the fourth poorest urban area in the US. Historically, Hartford was an agricultural and industrial center supporting munitions production, insurance companies and manufacturing. It drew workers from waves of European immigrants prior to WWII, and after WWII, contract workers including southern Blacks, Puerto Ricans and West Indians to work in the tobacco fields. Later arrivals included immigrants from all over South American and north Africa. This diverse city also includes people from S.E. Asian countries, Portugal, Brazil, Eastern and Central European countries, as well as a sizeable LGTBQ population. By 1990 the city was a microcosm of the US census, including more than 14 primary languages and multiple ethnic/ national groups and its cultural institutions, restaurants, and visual and performance artists were claiming recognition.

Hartford was redlined in the 1930s by the federal Homeowner Loan corporation making it difficult for Hartford residents especially in neighborhoods designated as very high risk to obtain loans, mainly in the north and central/ south neighborhoods of the city (3). This strategy has resulted in persistent segregation and underdevelopment of redlined primarily Black and Hispanic neighborhoods in the northern, northwest, and central to southern parts of the city.

In the past two decades, the center city has been gentrified, pushing out or evicting thousands of especially Puerto Rican families. The gentrification of the city has created apartments, amenities and college branches that attract young mainly white professionals and students. “Downtown” Hartford is now described as a vibrant cultural scene with hundreds of new apartments available to rent. Meanwhile the development of the surrounding and peripheral neighborhoods remains stagnant. Much of the city has with limited opportunity structures and a concentrated poverty rate. Residents are employed primarily in the health, social assistance, hotel, and food systems industries, mostly in relatively low paying positions. Front line workers in health establishments worked throughout the epidemic, risking exposure and high number of job losses during the pandemic. Those same neighborhoods, redlined in the 1930s, are characterised by high levels of COVID-19 infection, and lower rates of vaccinations today.

Political ecology

There are 169 municipalities in the State which have control over their own property taxes, zoning laws, school systems and public service departments. This structure has allowed the suburban municipalities to control the migration of lower income populations through restrictive property and construction zoning, and occupational discrimination. As a consequence, cities and surrounding former industrial towns in CT have moderate and low-cost housing which has resulted in concentrations of low- and moderate-income residents including people of color. The result is a high rate of Black - White segregation across the State.

Healthcare situational analysis

Health Infrastructure

Public health infrastructure in Hartford includes publicly funded public health facilities, private / public partnerships, federal and State funded public clinics, larger and smaller community-based organisations (CBOs) that provide health-related services and supports to residents especially lower income residents, health advocacy organisations, and smaller mutual alliances link neighborhoods or groups in different parts of the city. These organisations sometimes form alliances that are formed by coordinating bodies (United Way, foundations, ICR, City Health Department) to address specific issues such as food security, child-care, housing access, or COVID-19 coordination. There are alliances that are arms of national organisations to address issues faced by certain groups such as homeless and those with disabilities as well as networks of Black, Hispanic, and denominational churches that meet regularly.

The health infrastructure of Hartford also includes organisations that address health and mental health issues that affect vulnerable populations including people with drug addiction (Greater Hartford Harm Reduction Coalition), people with HIV, and shelters housing homeless people. These institutions have different relationships, motivations, and incentives for working with each other, local communities, and CBOs. Many of these organisations are funded by the State to support hospitals with community engagement, recruitment of patients, prevention of emergency room use, and more recent activity towards considering the social determinants of health.

Hartford is served by two major hospital complexes one in the south end of the city, in the heart of the Latinx community, and one in the central area of the city on the periphery of the north end Black, mostly Catholic, community. These hospitals have borne the brunt of criticism from Hartford communities of colour for many years because of their failure to provide quality care to residents with at times tragic consequences. Problems in care include reduced patient time, continuing language and communications problems, disrespect for or ignorance of culturally different groups, misdiagnoses, long ER delays and overcharging. Financial incentives offered by both the State and insurance companies to reduce emergency

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room repeat visits and respond better to local communities has prompted these hospitals to form small alliances with CBOS and nearby community health centers in order to promote community health.

Community health centers and clinics are valuable assets in Hartford and are successful at increasing access to health care for many residents of underserved areas. However, these facilities are challenged by rotating leaders and medical administrators which leads to inconsistent relationships with patients, continuous funding shortages, and a lack of outreach to community settings.

Primary Care Providers (PCPs), who are supposed to link patients to specialised care, are in short supply in Connecticut. In Hartford from 2016 to 2019, one of the two hospitals actually reduced its PCPs by 25%. The low levels of PCPs drive many residents to seek alternative medical care through hospital emergency rooms.

The local Hartford Health Department is a key component of the public health system being responsible for all aspects of health in the city. However, reductions in support for local health departments leave urban departments short of staff, with constant turnover of directors and other personnel. This has meant that the Department has limited capacity to track emerging public health problems and to sustain connections with community organisations. Given lack of resources, the activities of the Department can be characterised as 'reactive' to health crises, rather than 'proactive'.

Community health workers

Hartford has a wide network of community health workers (CHWs) who link community residents to health and health related services by acting as navigators of health care or as community-based outreach educators. They are usually from the communities they serve and share common traits such as language and lifestyle. Many CHWs in working across different organisations are employed via time-limited and unsustainable grants. Federal funding through the State and local health departments, including Hartford, has provided short term funding for CHWs to focus on COVID-19. However the ability to hire, organise, coordinate, train and support them has been challenged by short timelines, contractual bureaucracy and hiring difficulties.

Health inequalities

Health disparities have been reported in Hartford for many years, in areas including asthma, diabetes, ear infections, infant mortality especially among Black women, high rates of drug use and drug overdoses, HIV, depression, and cardiovascular disease. These comorbidities contribute to susceptibility to COVID-19 and can be attributed to a combination of inadequate or inaccessible health care, poverty, concentrated disadvantage (poor education, limited economic mobility) and poor transportation systems.

There is a long history of negative experiences of Hartford residents with health care institutions, especially from Black and Hispanic communities. This has included incidences such as the misdiagnosis by two hospitals and subsequent death of a Latinx baby, sterilisation of young Puerto Rican women without their consent, early discharge of seriously ill Black patients, and repeat visits of young Black and Hispanic adults to the emergency room for untreated asthma. Most health care providers are white and distrust of white providers or institutions is widespread.

Civil society

Civil Society in Hartford is diverse and consists of larger older institutions, smaller organisations serving low income/impoverished people across the city, specialised CBOs providing health or other social determinants of health-related services such as support with housing and food distribution. There are a number of organisations that serve specific ethnic and racial communities, as well as those with disabilities, families, and young people. Small organisations are built on close links with community residents. These organisations tend to be the best resources for facilitating intimate conversations in community settings, but their growth is limited by the inability or reluctance of foundation and State funders to sustain them and the need to compete for scarce resources interferes especially in times of crisis.

Civil Society in Hartford is characterised by alliances between organisations, working groups and task forces usually called together by a convening body to address a specific problem. While relationships may be forged in these temporary networks, they often are not sustained when the problem is solved, or funding runs out. Conveners clearly have knowledge in how to collaborate to deal with an issue or crisis but have less success in sustaining their efforts over time. In addition, some have noted that organisations with specific missions don't always expand to engage with the wider context of the issue to seek to address such as wider social determinants of health.

Faith groups

Both white and Black churches have wide reach and were active in promoting vaccination when they were first available. Several Hispanic organisations such as the Hispanic Health Council connect to and work with Protestant fundamentalist churches serving the diverse Latinx community. Several organisations provide social and health-related services and are involved in health advocacy on behalf of their constituencies including the Hispanic Health Council, Family Life Education, Hartford Health Initiative, Hands on Hartford, Ct. Harm Reduction Coalition and Hartford Communities that Care.

Impact of COVID-19

Health

Hartford has the highest number of COVID-19 cases and deaths in Connecticut (CT). By June 2021, Hartford county had the 3rd highest cumulative number of certified cases among the counties in the State, the second highest rate of hospitalisations for COVID-19 cases per 100,000 (60,000 in total) and the highest number of deaths (2,493) of the urban municipalities of CT (4).

Compared to Whites, Black and Hispanic individuals in Hartford have higher rates of underlying health conditions known to be associated with poor COVID-19 outcomes, such as diabetes and obesity, are less likely to be insured, and are more likely to have negative experiences when accessing healthcare. Black and Hispanic vulnerability to COVID-19 reflects and exacerbates existing and ongoing patterns of inequality, such as economic disadvantage, lack of resources, and overcrowded housing conditions (4). These differences have manifested in the combination of higher incidences of COVID-19 and a lower level of vaccine uptake is exacerbating disparities experienced by communities of color.

In Hartford, studies of older adults showed that older adults of all backgrounds fared quite well during COVID-19 with guaranteed income, subsidised housing, food, and health care provided. Older adults were the first to be distributed COVID-19 vaccines, often with onsite vaccinations, resulting in high take-up levels. The primary issues faced by older adults were loss, depression, social isolation, and loneliness along with difficulties accessing health care.

Younger families especially women and children have suffered considerably from job loss, unpredictable work hours and income and food insecurity. The negative impact of COVID-19 on mental health is compounded by stressors such as possible eviction, lack of connectivity, concern about young children's online education, death of loved ones from COVID-19, and concern about relatives in prison. Though employment rates have risen somewhat, increases in cost of living, and lack of regular primary health care remain as challenges to Hartford residents especially in deprived areas. For many, these wider concerns stand in the way of prioritising getting a vaccine. These issues along with longstanding trauma need to be addressed before many people will agree to vaccinate.

Vaccine hesitancy

At the present time, while overall vaccination rates in CT are among the highest in the country, those in Hartford match rates in several of the least vaccinated States and the rate of infection in the State in increasing.

In CT vaccination rates vary by age and ethnicity. The lowest rates of vaccination with at least one dose are in the Black population. The vaccination rate is highest in the White population but the rates in both groups tend to converge in upper age groups leaving younger adults, especially those 35 and under vulnerable to COVID-19. As of July 2021, vaccination remain low in the city of Hartford as compared to neighboring towns, with Blacks vaccinated once or more at lower rates than Hispanics or Whites.

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Workshop findings

Most of the results and recommendations reported on here are heavily based on two-hour community conversations. Held on Zoom, both conversations were attended by the same approximately 30 people or their designees from the public health sector (State and city), the city's two main hospital complex, health clinics, larger and smaller community service organisations, local foundations responding to community health and social determinants needs such as housing and food security, and health policy/advocacy organisations. Most of the participant stakeholders had longstanding presence and commitment to the Hartford urban community. These conversations were preceded and followed by a small number of in-depth interviews with people widely representative of the city's service, policy, and advocacy sectors.

Key questions covered in the conversations were:

- What went well in distribution of vaccines and addressing vaccine hesitancy.
- Where there were gaps or failures and what is needed to close the gaps, learn from experience, and create ways of addressing future crises and chronic health disparities in the future.
- What are the structural issues that created inequities in infection rates and deaths, and impacted on vaccine engagement in communities vulnerable by virtue of race/ethnicity, income, immigration status, health status, age, and gender.
- Lessons to be learnt in how a public health infrastructure can continue to support the relationships and partnerships strengthened during COVID-19 in order to address future other public health crises.

Vaccine hesitancy

Reasons underpinning vaccine hesitancy can be connected to a history of racist and discriminatory political and economic processes. The fundamental contributor to low vaccine take-up lies discriminatory practices in health care provision, the inability of services addressing the social determinants of health, and a wider context and history of discrimination resulting from efforts to undermine Black and Hispanic economic and political progress in the city inflicting trauma and suffering on these groups. Participants in Hartford conversations generally agreed that this history of health-related trauma needs to be recognised directly in confronting distrust related to COVID-19 vaccinations.

A strong theme emerging from the workshop discussions was a lack of trust in the vaccine because of the speed with which it was developed and the belief that it was experimental. There was a concern amongst workshop participants of side effects of the vaccine and possible long-term health consequences. Specific concerns varied across groups. Pregnant women, mothers and religious groups promoting large families have specific concerns about effects on fertility; African Americans are understandably suspicious about government experimentation, often citing the Tuskegee syphilis experiments (5), and possible longer-term unknown consequences of vaccination. Economically marginalised groups resent long term government and private sector neglect versus the immediacy of the push to vaccinate. Drug users, undocumented people and those involved in the court system are concerned about stigma and risk of visibility. Non-English speakers were suspicious of the lack of information in languages other than English. Drug users felt marginalised and distrusted government officials. There was also a lack of trust directed towards pharmaceutical companies and their motivations being driven profit.

"we have a lot of folks with outstanding warrants, who don't believe us that they're here just to do a vaccine and then they're not going to get grabbed while they're in there, even though it's the National Guard".

Trust in government, health care providers, information, vaccine quality, messengers, national leaders, is an important predictor of vaccine acceptance. Gaps in communication were flagged as an issue between providers and patients in building trust and promoting vaccination. It was clear from workshop discussions that some residents were distrustful of vaccines from Government and health services.

Another theme emerging from workshop was the personal barriers that Hartford residents experienced in scheduling vaccine appointments, getting paid time off from work, juggling childcare with vaccine appointments and transportation to vaccine venues, despite major efforts to provide transportation for those who it required it. Some respondents were also concerned with the perceived cost of the vaccine. There also emerged discomfort with the vaccination sites; they were perceived as too public and too crowded; some respondents were worried that they may see people that they knew.

"My experience is poor because I was supposed to be here at nine, I have a very strict schedule I got here at nine and they ended up waiting until 12. Something's wrong with that actual process itself. But if I leave and I'm gone, like when the when the days over, the providers, you know, talk about it. To them, everything went perfectly fine."

Some of these concerns were addressed authorities in Hartford by waiving requirements, offering more private vaccination sites including mobile vans, vaccination at home, making sure of ethnic/racial and gender compatibility between those injecting and those receiving vaccine. Despite these efforts it was not until June that money became available to help struggling agencies serving people with disabilities to reach caregivers at home.

Community response

As mentioned previously, Hartford's civil society includes a number of alliances, working groups and task forces usually called together by a convening body to address a specific problem. In this context, Hartford developed its own approach to vaccine roll-out. Broadly, the roll-out following national pattern of testing, messaging about the benefits of COVID-19, and increasingly tailored messengers using fliers, information sheets, various media approaches, church sermons, talks, fliers, and handouts. These provided an enabling environment and were assisted by materials posted primarily in English on the Department of Public Health website and dissemination via training sessions with community organisations throughout the State, including Hartford. However, Hartford residents did raise concerns about the 'top-down' approach taken to vaccine engagement. Specifically, there were complaints about lack of early and coordinated efforts by the State to provide local guidance.

"Most of what we've done in Hartford has been really big webinars. And I think those are successful in sharing information. And that's what they're about is trying to answer questions, but not as much yet of the one on one conversations that that people may need."

The city's broad-based information approach was followed by a series of vaccination strategies guided by State policy on distribution of vaccines by age. This communication strategy of engagement was not inclusive of Hartford residents without technology, computer literacy or the time to try to find an appointment. Similarly, many Hartford residents did not attend vaccine venues situated in hospitals due to work schedules, transportation problems, lack of privacy, concern about crowds, or requests for ID or the false belief that they had to pay. As a response, agencies teamed with local community organisations to shift the distributing of vaccines to local more trusted sites. For example, Hartford Health care teamed up with Hispanic Health Council, with whom there was an established relationship and later established community outreach to locations where people gather including the West Indian clubs.

Centre for Disease Control (CDC) funding was leveraged by a partnership of the City of Hartford and the United Way to form a consortium of community organisations that met regularly to coordinate vaccination dates and times. The Hartford Health Department delivered vaccine to local sites embedding in communities, as well as to older adults in senior housing. Workshop participants mentioned the success of smaller organisations with medical personnel (e.g. substance abuse treatment programs) using their vans to deliver vaccine to marginalised communities such as homeless substance abusers. Churches also played a major role in dissemination efforts; by June 2021, churches, mutual aid societies and small CBOs were hosting multiple activities such as fairs, giveaways, socials, as well as street vaccine access via some mobile vans that offered opportunities for vaccination along with other benefits.

The large number of CBOs, churches and service organisations were able to drive engagement in their own communities, but there remained a challenge about organisational outreach capacity. Although the reach of community organisations was broad, the uptake was less than expected and less than desirable.

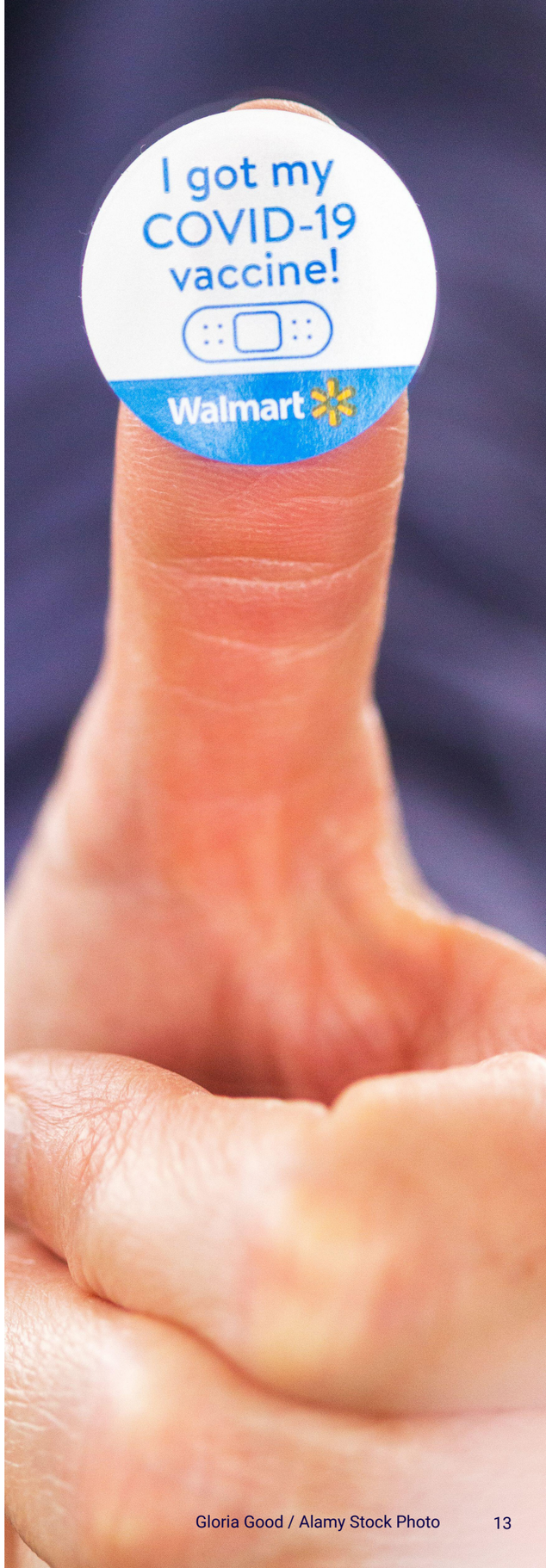
Vaccine messaging

Vaccine roll-out was affected by challenges to messaging about vaccines. At first, messaging about vaccines came from the top-down' from the State, to local authority figures, physicians, especially religious figures. Smaller organisations complained that they were uncertain about how to access the best and most current information. Furthermore available data focused on age and gender; for a long period of time data were not disaggregated by race. Discussion in workshops indicate that different groups responded to different trusted messengers. For example, Sudanese Americans responded to PCPs and religious leaders, and physicians from North Africa or the Middle East who spoke Arabic.

"They have trust in mosque leaders like the Sheikh. Also, because mostly the mosque leaders will speak Arabic and specifically women, they are pretty much mostly less fluent in English…Another factor, everyone trusts PCPs so the group suggested providing Arabic-translated flyers to PCP practitioners and also to support the school in providing Arabic-translated materials for awareness. And then the social media was a controversial aspect. The surveys highlighted that there is less trust in social media as a resource. However, the group mentioned that they relied tremendously on social media in their interpersonal communications. And I can attest to that because we recruited people via WhatsApp. This is the most used app in social media for this population. Even the mosques. Each mosque has a WhatsApp group for males, a WhatsApp group for females"

Puerto Rican pregnant women said that they trusted the staff of the Hispanic Health Council Comadrona (Traditional Birth Attendant) program, and the service staff of Family life Education, serving Latinx women and families. Some who saw themselves as trusted messengers in the Black American community found that they could not reach everyone with persuasive messages to vaccinate and needed to seek out trusted peer messengers who represented reluctant sectors of the community.

Workshop participants noted that after an initial vaccine drive, there was a need to engage with vaccine hesitant individuals. They remarked that the most effective way of achieving engagement was face-to-face conversations and motivating people through social influence and influencers such as family members.



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"As well, as kind of, there's still more work to do. And I feel as though there needs to be more individual conversations, I know there has been attempts to I mean, go door to door and talk to people and encourage them to get vaccinated. But it's almost like I sort of compared to, when we go out and try to register people to vote, um, people require that mean that five to 10-minute conversation about what their concerns are, and if you end it sometimes can't get addressed."

It was clear to participants in this case study that young people were a group often overlooked by vaccine engagement and messaging. Although measures of vaccine engagement had been extensive, they were not reaching large numbers of Hartford residents especially those under the age of 45. Workshop participants described the importance of going to where youth gather and developing youth peer advocates.

The lack of regular nuanced data, disaggregated by different community groups, meant that mechanisms for carrying out ongoing evaluation of engagement efforts, or monitoring of engagement of different communities was impossible. There was no way for community organisations to understand if a lack of vaccine engagement was driven by insufficient access to vaccines or hesitancy to vaccinate. Furthermore, there was no formal central mechanisms for monitoring messages disseminated through various social and mainstream media used in the city in different languages. This lack of collective knowledge and monitoring, left people vulnerable to the dangerous messaging being promoted by right wing media and international interests both in English and other local languages such as Spanish and Russian.

"I think the data shows who's not being vaccinated, I think why is still a complicated question. I don't know that we have sufficient indicators that they're still, you know, enough access out there, that we're really meeting people where they are, and given them the tools that they need to get to the vaccine, I still have some questions about, you know"

Discussion: The 3 C's

Vaccine hesitancy in Hartford can be understood through the World Health Organisation's model of '3Cs of vaccine hesitancy': confidence, convenience, and complacency. Although the workshops indicated that there were some variations across specific populations.

Confidence

A strong theme emerging from the interviews and workshop discussion was the lack of confidence in the vaccine. This was driven by concerns that the vaccine had been developed too fast, belief that it was experimental, worries about side effects and long-term health implications, and distrust of pharmaceutical companies. As detailed in the discussion above, different marginalised groups have specific concerns regarding their trust in both the vaccine and in Government and health services.

Convenience

Within this case study, there has been considerable discussion of the 'convenience' barriers to accessing vaccines. These have included difficulty scheduling appointments, balancing appointments with work and childcare and issues with accessible public transport. Clearly, marginalised communities in under-resourced areas are more likely to experience a barrier of inconvenience when accessing vaccines.

Complacency

Discussion of 'complacency' issues were observed in both workshops and interviews. This included, in the view of residents, that there was a need to balance the risks and benefits of the vaccine as well as the belief that COVID-19 had few serious effects on young people. Other less central issues revolved around 'purity' and holistic health, including the belief that 'foreign substances' such as vaccines should be avoided, the perceived ability of the body to heal itself and the maintenance of health through behaviors such as eating healthily, sleep, and stress reduction. These beliefs cut across all economic statuses and ethnic/racial groupings although the roots may be different across groups.

Conclusion

Like most of the USA, Hartford was not prepared to address a large-scale health crisis like COVID-19. But in a short period of time, existing health service networks were able to respond. Working with community organisations they were able to expand their outreach capacity. Health services were also able create new coordinating structures funded by a combination of local foundation and federal COVID-19 crisis funds.

There were clear deficiencies in the response of Hartford towards vaccine engagement. This included; the lack of a stable central coordinating body to proactively address public health crises and problems in a proactive manner, an information gap of disaggregated vaccine data that would support greater monitoring and insight into vaccine engagement in marginalised communities, as well as track the spread of misleading information. There persists a gap in vaccine engagement for marginalised communities and front-line health service providers, many of whom are from Black, Hispanic, and other groups that experience health disparities. Notably young people are the largest group of unvaccinated residents.

Hartford has successfully utilised multiple resources and strengthened State and local partnerships to extend the reach of vaccines and make them easily available and accessible. The experience of vaccine roll-out has shown the benefits of working collaboratively with small grassroots CBOs to

establish local trust and visibility. However, these organisations lack sufficient resources to manage their survival and adaptation needs. They require significant future investment to play an equal partnership role with larger organisations and institutions at time of crisis.

Agencies in Hartford have been less successful in partnering with the residents who are highly vaccine hesitant. An effective method of approaching this would be engage residents as leaders and collaborators in reducing vaccine hesitancy and addressing long term disparities. The city has not yet been able to address the intransigent issues of entrenched poverty, concentrated disadvantage, limited opportunity structures and health care accessibility and quality issues that would reduce the overall burden of illness and increase well-being for all Hartford residents especially those most in need.

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Community Research Alliance

The Institute for Community Research founded in 1987 is dedicated to the conduct of research in collaboration with community partners to promote justice and equity in a diverse world. ICR supports innovative approaches to using research for social change by and with local communities locally and globally.

The Community Research Alliance, based at ICR, includes representatives of community based organizations, local community leaders and faculty of local universities committed to forging equitable and funded community conversations and research partnerships that collectively address inequities in health status and outcomes in the central Connecticut USA area.

This research was designed, conducted and authored by the Institute for Community Research in Hartford, US

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