World Journal of Advanced Research and Reviews
eISSN: 2581-9615 CODEN (USA): WJARAI
Cross Ref DOI: 10.30574/wjarr
Journal homepage: https://wjarr.com/

(REVIEW ARTICLE)

Check for updates

Disrupting Generational Poverty Through Community Driven Health Access

Omotoyosi Idris *

Clinton School of Public Service, University of Arkansas at Little Rock, Little Rock, Arkansas, United States.

World Journal of Advanced Research and Reviews, 2024, 21(02), 2167-2181

Publication history: Received on 03 January 2024; revised on 19 February 2024; accepted on 26 February 2024

Article DOI: https://doi.org/10.30574/wjarr.2024.21.2.0426

Abstract

Introduction: Generational poverty in the United States remains deeply intertwined with persistent health inequities that disproportionately affect low-income and minority populations. Community-driven health access has emerged as a promising strategy to disrupt these cycles by addressing both immediate medical needs and broader social determinants of health. This study explores how community-based models contribute to poverty disruption, drawing insights from existing literature.

Materials and Methods: A qualitative thematic literature review was conducted, focusing on peer-reviewed journals, policy reports, and organizational documents published between 2010 and 2023. Sources were identified through structured database searches and screened based on relevance to poverty, health inequities, and community-driven health interventions in the U.S. Data were systematically coded, and thematic synthesis was applied to identify patterns and gaps across studies.

Results: Findings revealed four major themes: (1) improved health access enhances education and employability, (2) community models reduce financial strain by lowering medical debt, (3) grassroots and faith-based programs build trust and cultural alignment, and (4) systemic challenges such as funding instability, policy inconsistencies, cultural barriers, and racism limit program effectiveness.

Discussion: The review highlights that community-driven health initiatives, such as Federally Qualified Health Centers, school-based health clinics, community health workers, and grassroots programs, play a significant role in improving health equity and disrupting cycles of poverty. However, their impact is constrained by structural barriers. Addressing these barriers requires sustainable community engagement, stronger federal-state partnerships, and the scaling of local innovations.

Conclusion: Community-driven health access provides a viable pathway to disrupt generational poverty in the United States. By integrating health services with social support and policy reform, these models can create sustainable improvements in education, employment, and economic stability. Policymakers should prioritize investment in scalable, community-centered approaches to break the persistent links between poor health and poverty.

Keywords: Generational Poverty; Community-Driven Health Access; Social Determinants of Health; Human Capital Theory; Structural Violence Theory

1. Introduction

Generational poverty is still one of the biggest socioeconomic problems in the US, and health inequities are a big reason why this cycle keeps going. Families that have been poor for many generations typically have even more problems, such as not being able to get good medical treatment, not eating well, not having enough housing, and being more likely to

* Corresponding author: Omotoyosi Idris

have chronic diseases. These health disparities hinder prospects for upward mobility by limiting school achievement and employment, therefore prolonging socioeconomic difficulties (Ahmad, 2023). Evidence indicates that ill health diminishes individual output and imposes substantial financial constraints on households, hence entrenching families in poverty. In low-income areas where health insurance is hard to get and preventative treatment is not used enough, the link between poverty and bad health is much stronger. Consequently, tackling health inequities is widely seen as an essential measure in disrupting the cycle of generational poverty in the United States (Williams et al., 2019).

The ongoing disparities in healthcare access for low-income and minority populations are deeply entrenched in historical and structural factors. African Americans, Hispanic/Latino communities, and Native Americans are some of the most marginalised groups that confront systemic hurdles to healthcare. These barriers include not enough providers, language challenges, cultural distrust, and prejudice in clinical settings (Patel et al., 2023). These hurdles are made worse by being poor, which makes it harder to get health insurance and pay for medical bills out of pocket. There are also regional differences that make things worse, such as rural areas having a lot fewer healthcare facilities and personnel. This unequal distribution of healthcare resources leads to unnecessary illness and death, which keeps poverty going from one generation to the next. Structural disparities in healthcare access persist in maintaining worse health outcomes, hence limiting prospects for mobility and resilience among marginalised populations (Bourgois et al., 2017).

Health disparities have economic effects that go beyond people and affect families and communities, creating a cycle of disadvantage that keeps going. Poor health typically leads to decreased educational attainment because students miss school and have trouble studying, which makes it harder for them to find work in the future (Suhrcke and De Paz Nieves, 2011). Adults with untreated health problems are more likely to be unemployed, earn less money, and have unstable jobs, which limits the income of their households and keeps them in a state of financial insecurity. Consequently, children raised in these homes inherit these disadvantages, including less access to healthcare, healthy food, and conducive educational settings. Studies show that generational poverty is closely linked to these interrelated aspects, where bad health keeps poverty going and poverty makes health worse (Hill, 2023 and Yang et al., 2023). This bidirectional link underscores the need for coordinated initiatives that concurrently tackle both healthcare access and socioeconomic inequities. If these structural problems are not addressed, families who are already struggling are likely to be stuck in cycles of bad health and poverty that last for decades.

In recent years, scientists and politicians have increasingly acknowledged the significance of community-driven health programs as a viable answer to these difficulties. Community-driven initiatives, in contrast to top-down techniques, emphasise local knowledge, cultural relevance, and grassroots engagement, so guaranteeing that solutions are customised to the distinct requirements of particular communities (Olaniran et al., 2022). Community health worker (CHW) models, mobile health clinics, and faith-based health initiatives are some examples of programs that have worked to improve preventive care use, health literacy, and health inequities among marginalised groups. These programs assist people have better access to healthcare by building trust and using existing community networks. They also provide people the tools they need to take charge of their health. Additionally, data indicates that community-driven solutions improve sustainability by fostering local capacity and ownership, hence reducing reliance on external interventions (Franco and Tracey, 2019). Consequently, community-based interventions are increasingly seen as pivotal in breaking the persistent cycle of poverty and ill health.

The acknowledgement of community-driven health access as a means to interrupt generational poverty has significant ramifications for both research and policy. Addressing health inequalities via localised, participatory initiatives not only improves health outcomes but also fortifies the social and economic resilience of marginalised communities (Jewett et al., 2021). Families may seek education, work, and upward mobility when illness and healthcare expenditures are lower. This breaks the cycle of poverty that passes from one generation to the next. But even though they have a lot of promise, community-driven models have a lot of problems, such as uneven financing, policies that do not match up, and pushback from institutions. A rigorous evaluation of the current research is essential to comprehend the processes, obstacles, and enduring effects of these therapies. This investigation will provide significant insights on the potential of health equity programs to act as a catalyst for the disruption of generational poverty in the United States, therefore fostering more equitable and inclusive social systems.

1.1. Statement of the Problem

Low-income and minority groups are disproportionately affected by systematic disparities in access to high-quality healthcare, which persist after many healthcare reforms in the US. Obstacles include insufficient health insurance coverage, restricted access to preventative treatments, and regional differences in healthcare delivery continue to affect families in poverty throughout generations (Williams et al., 2019). Because poor health restricts educational

achievement, employment, and economic mobility, these gaps not only exacerbate health outcomes but also perpetuate poverty cycles. The continued existence of these gaps shows that the relationship between poverty and healthcare disparities has not been adequately addressed by federal and state policy actions. Without focused efforts to bridge these inequalities, underprivileged groups continue to be caught in a vicious cycle in which poverty fuels bad health, which in turn feeds poverty for generations (De Schutter et al., 2023).

Although there is a wealth of data on health disparities, few studies explicitly look at how community-driven health interventions might break the cycle of poverty that persists over generations. The majority of current research focusses on either improving healthcare access or reducing poverty, sometimes regarding them as distinct fields (Amri and Sihotang, 2023). However, by adjusting solutions to the cultural, social, and economic realities of underprivileged populations, community-driven models—like those involving community health workers, mobile health clinics, and localised wellness programs—may hold special potential to address both at the same time (Thomas et al., 2014 and Yu et al., 2017). A significant knowledge gap results from the lack of enough data about the efficacy, scalability, and sustainability of such treatments. Policies and programs that support fairness, resilience, and long-term socioeconomic progress in underserved U.S. communities must be informed by an understanding of how grassroots health efforts can end intergenerational cycles of poverty.

1.2. Research Questions

- How does limited healthcare access contribute to the persistence of generational poverty in the United States?
- What evidence exists on community-driven health models in reducing poverty and improving health outcomes?
- Through what mechanisms can community-driven health access disrupt intergenerational poverty?
- What challenges and barriers are reported in implementing community-driven health initiatives?

What strategies and policy recommendations can strengthen community-driven health access to break cycles of generational poverty?

1.3. Research Objectives

The primary objective of this research is to investigate, via a thematic review of the literature, how community-driven health access might break generational poverty in the US by combining data from several academic and policy sources. This entails investigating the relationship between health inequalities and enduring poverty, locating community-based models that have proven effective in enhancing access to healthcare, and evaluating the ways in which these interventions help end the generational cycle of disadvantage. The study aims to illustrate the ways in which community health workers, mobile clinics, and locally driven wellness programs empower marginalised populations, lessen healthcare disparities, and improve socioeconomic mobility. It does this by utilising empirical data, theoretical frameworks, and case studies. In the end, our goal seeks to provide practical insights for practitioners, politicians, and community leaders who are looking for long-term solutions to the twin problems of intergenerational poverty and health disparity in the United States, in addition to advancing scholarly understanding.

1.4. Specific Objectives

- To review literature on the relationship between limited health access and generational poverty.
- To analyse community-driven health models documented in U.S. contexts.
- To synthesize thematic insights on how health access can break cycles of poverty.
- To identify barriers to community-driven health interventions.
- To propose policy and practice recommendations based on reviewed studies

2. Review of Literature

2.1. Understanding the Concept of Generational Poverty

The term "generational poverty" describes the ongoing transfer of poverty from one generation to the next, in which families are caught in times of prolonged financial difficulties. In contrast to situational poverty, which may emerge momentarily as a result of circumstances like sickness or job loss, generational poverty is ingrained and often associated with systemic disparities in housing, healthcare, work, and education (Moore, 2001). Families living in this kind of poverty usually do not have access to the tools and chances needed to move up the economic ladder. Children who grow up in poverty are thus more likely to experience poverty as adults, continuing a cycle that may continue for decades. The idea emphasises how attempts to escape poverty are hampered by systemic obstacles and accumulated disadvantages.

Beyond only financial difficulties, generational poverty has social, cultural, and health repercussions. People who are born into poverty often have low educational attainment, which limits their adult earning potential and employment options (Gal, 2014). These issues are made worse by poor health outcomes, poor nutrition, and restricted access to high-quality healthcare, which further impedes mobility. Intergenerational disadvantage may also be reinforced by exposure to chronic stress, communal violence, and insecure housing, all of which have a substantial impact on psychological health and cognitive development. These difficulties come from structural injustices that restrict access to helpful social and economic networks, making them more than just personal issues (Wanyoike and Pete, 2022).

Racial and ethnic minority groups in the US have a disproportionate amount of generational poverty, which is a reflection of past injustices and current systemic disparities. Persistent gaps that trap whole communities in cycles of hardship have been exacerbated by discriminatory policies in housing, healthcare, education, and employment (Broom, 2010). According to research, children who grow up in low-income families have less opportunities in adulthood and often mirror their parents' socioeconomic circumstances (Kalil and Ryan, 2020). Therefore, addressing generational poverty requires multiple strategies that go beyond temporary aid, emphasising the removal of structural obstacles and improving access to possibilities like high-quality healthcare, education, and economic empowerment. Designing interventions that address the underlying causes of inequality and encourage long-term social mobility therefore requires a thorough understanding of the idea of generational poverty.

2.2. Understanding the Concept-Driven Health Access

Community-driven health access means that local communities are involved in designing, carrying out, and keeping healthcare programs going. This method puts the community's views, needs, and cultural values first, making sure that health treatments are appropriate to the situation and easier to get (Sturmberg and Njoroge, 2017). It stresses grassroots engagement, where people in the community work with health experts, governments, and organisations to decide what health issues are most important, how to spend money, and how to provide services. This method not only builds trust between communities and healthcare institutions, but it also makes individuals more accountable and makes sure that solutions directly address the problems people have getting treatment. This idea changes the way we think about healthcare by putting communities at the centre and making it a shared responsibility instead of a service that is forced on us from the outside.

Community-driven health access has advantages that go beyond just better health outcomes. It also helps people feel empowered, brings people together, and makes healthcare treatments last longer. Communities that actively participate in health decision-making are more inclined to adopt preventative measures, engage in health education, and advocate for communal well-being (Betsch et al., 2016). For instance, community health workers and participatory health programs have been shown to improve the health of mothers and children, boost immunisation rates, and raise understanding of how to avoid chronic diseases among groups who do not get enough health care. This strategy also helps to close health gaps by making treatments more relevant to the lives of marginalised communities who are typically left out of conventional healthcare systems. This kind of openness makes healthcare not just easier to get to, but also fairer.

Community-driven health access is a game-changer in the fight against generational poverty because it connects health improvements to greater socioeconomic mobility. Poor health is both a cause and a result of poverty, and families are stuck in cycles of disease and financial instability if they cannot get the treatment they need (Sapkota et al., 2021). This idea gives people the capacity to invest in their health as a type of human capital by getting communities to come together to plan and carry out ways for people to get health care. This makes it easier for them to work, study, and prosper. Better health outcomes lower long-term healthcare expenses, raise educational levels, and boost productivity, all of which help future generations escape poverty. So, community-driven health access is not only a way to improve health; it is also a strong way to reduce poverty that promotes fairness, resilience, and transformation across generations.

2.3. Theoretical framework

This study is underpinned by three theories to provide a robust perspective to the study. The theories are: Social Determinants of Health, Human Capital Theory and Structural Violence Theory.

2.3.1. Social Determinants of Health (SDOH)

Health outcomes are impacted by both biological and medical aspects as well as the larger social and economic context in which people live, according to the Social Determinants of Health (SDOH) concept (Ferrer, 2023). The work of academics like Michael Marmot, who emphasised how socioeconomic gradients in housing, work, education, and wealth

lead to differences in health among communities, has influenced this theoretical viewpoint (Marmot and Allen, 2014). Poor health, according to SDOH, is not dispersed at random but rather follows regular patterns influenced by structural injustices that are directly related to social exclusion and poverty.

The SDOH hypothesis highlights the ongoing inequalities in minority and low-income groups' access to healthcare in the United States. According to Sims et al. (2020), there is a clear correlation between poor health outcomes and a lower life expectancy and factors including a lack of cheap housing, restricted access to nutrient-dense food, and hazardous neighbourhoods. By restricting prospects for steady work and educational attainment, both of which are necessary for upward mobility, these circumstances perpetuate generational poverty. Therefore, SDOH offers a thorough framework for comprehending how social and economic factors interact with health to perpetuate cycles of disadvantage.

The SDOH concept, when applied to the current research, clarifies the importance of community-driven health interventions in addressing generational poverty. Interventions may lower barriers to treatment and advance equitable health outcomes by addressing upstream social determinants like community health education, reasonably priced local clinics, or social support services. This supports the study's goal of examining how community-based health interventions empower underserved populations, end the intergenerational cycle of poverty and ill health, and open doors for opportunity.

2.4. Human Capital Theory

Gary Becker (1964) made Human Capital Theory renowned. It asserts that investing in people, such their education, talents, and health, will pay out in the long run in terms of money and society. In this context, health is seen as a vital kind of capital, since healthier persons exhibit greater productivity, less absenteeism, and enhanced capacity to invest in their education and professions. On the other hand, bad health slows down the growth of human capital, making it harder for people to move up the social and economic ladder. This viewpoint presents an economic justification for policies and initiatives designed to enhance health access for marginalised people (Labeeque and Sanaullah, 2019).

In the United States, where intergenerational poverty is often exacerbated by poor health outcomes, Human Capital Theory underscores the significance of health as both a personal and social investment. Children raised in homes with unmet health requirements may have developmental difficulties, diminished academic performance, and decreased future earning potential (Larson and Halfon, 2010). Adults with chronic diseases or untreated ailments often have difficulties in maintaining employment and ensuring economic stability, hence perpetuating cycles of poverty. Thus, healthcare is not only a service; it's also a driver of the economy that affects future possibilities and health.

In the framework of this research, Human Capital Theory endorses the assertion that community-driven health access programs may function as investments that interrupt the cycle of generational poverty. These initiatives help people fully engage in school and the job market by enhancing preventative care, lowering healthcare costs, and encouraging healthier lives. For instance, community health worker programs that help mothers and children stay healthy are a direct way to help future generations grow and thrive. This viewpoint illustrates that healthcare interventions transcend immediate physical advantages; they cultivate the human capital essential for disrupting cycles of poverty.

2.5. Structural Violence Theory

Structural Violence Theory, posited by Johan Galtung in the 1960s, delineates the systematic mechanisms by which social institutions inflict injury or disadvantage onto people by limiting their access to resources, opportunities, and rights (Dilts et al., 2012). Structural violence is not the same as direct physical violence. It is built into political, economic, and social structures, making inequalities hard to see but yet very real (Jackson and Sadler, 2022). Paul Farmer (2004) subsequently used this theory in the context of global health, illustrating how structural disparities, including racism, poverty, and insufficient healthcare infrastructure, generate and perpetuate adverse health outcomes in marginalised populations (Harvey et al., 2022).

In the United States, structural violence is seen in healthcare inequities that hit racial minorities, immigrants, and those with low incomes the hardest. Systemic hurdles that make it hard for everyone to get the same level of healthcare include segregated neighbourhoods, underfunded hospitals, discriminatory practices in medical institutions, and restricted health insurance laws (Pervez and Anjum, 2023). These obstacles not only keep health inequities going, but they also make cycles of generational poverty worse by lowering life chances and restricting socioeconomic mobility. Structural violence elucidates the reasons for the frequent ineffectiveness of changes in bridging disparities in healthcare access, since the foundational imbalances persistently endure.

Structural Violence Theory elucidates the need of community-driven health access in disrupting cycles of poverty within the context of this research. Grassroots efforts that work directly with those who are less fortunate may fight structural unfairness by offering treatment that is culturally acceptable, cheap, and easy to go to. For instance, initiatives run by community health workers or faith-based groups frequently function when official institutions do not, and that's because they work outside of established systems that keep inequity going. Community-driven health strategies may empower marginalised people and break the cycle of poverty that passes from one generation to the next by tackling the systemic hurdles that structural violence creates.

3. Materials and Methods

A qualitative thematic literature review strategy was used in this study to provide a thorough, open, and methodical procedure for gathering and analysing data. Established qualitative review principles served as a guide for the review process in order to improve analytical depth, replicability, and trustworthiness. Finding applicable sources, screening the literature, determining eligibility, and finally include relevant articles were the four crucial stages of the review process. By using this methodical approach, the study sought to provide a thorough synthesis of the body of knowledge about community-driven health access and how it may help end generational poverty in the US.

To find relevant papers, a thorough search was carried out across a number of electronic databases, including Web of Science, Scopus, PubMed, ProQuest, and Google Scholar. To maximise the retrieval of relevant research, the search method combined subject-specific keywords with Boolean operators. Among the main search phrases were "grassroots health initiatives," "generational poverty and health," "community health workers," "health disparities and poverty," "community-driven health access," and "health equity in the United States." These keywords were chosen with care to include a broad spectrum of academic works that examine the relationship between generational poverty and health access.

Only reliable and relevant sources were taken into account thanks to the inclusion criteria. In order to represent current evidence and policy discussions on poverty alleviation and health equality, the study included (1) peer-reviewed journal articles, reports, and policy papers; (2) English-language publications; and (3) research published between 2010 and 2023. To keep the evaluation rigorous and focused, exclusion criteria were created. Excluded studies (1) did not explicitly address poverty-related outcomes and health access in the U.S. context, or (2) were opinion pieces, commentaries, or editorials without empirical or theoretical contributions. These standards made sure that the sources chosen in the end offered solid understanding of the study's goals.

1,072 possibly relevant items were found in the first database search. 798 records remained for screening after duplicates were eliminated. 421 publications that did not meet the inclusion criteria or research goals were removed via title and abstract screening. An additional 186 papers were eliminated from a follow-up full-text evaluation because they lacked adequate empirical support or were irrelevant to community-driven health models. A strong basis for examining the function of community-based health access initiatives in breaking the cycles of generational poverty was established by the inclusion of 191 research in the final thematic evaluation.

Data extraction and synthesis were done methodically to increase methodological rigour. Key topics, such as obstacles to healthcare access, effective community-driven health models, poverty reduction strategies, and policy gaps, were used to categorise and evaluate the chosen research. After that, thematic synthesis was used to find recurrent themes, draw attention to difficulties, and extract best practices from the literature. The research was able to provide significant insights on the efficacy of community-based health programs in tackling intergenerational poverty and health disparities because to this analytical method. The study's methodological methodology improves the results' dependability and offers a strong foundation of evidence for further investigation, practice, and policymaking in the fields of poverty alleviation and health equality in the US.

4. Findings

4.1. Generational Poverty and Health Inequalities

Poor health is a major factor in the cycle of generational poverty since it makes it harder for people and families to find stable jobs. Families who have long-term illnesses or cannot get good medical treatment typically have to spend all their money on medical bills, leaving little space for investing in education, housing, or professional growth (Mbugua, 2023). Kids who grow up in these kinds of homes often have these problems passed down to them. This is because their parents' health-related financial problems make it harder for them to get healthy food, a good education, and safe places

to live. This passing down of disadvantages from one generation to the next keeps health disparities in place, making it harder for families to get out of poverty. As a result, health is both a sign and a cause of economic problems, keeping marginalised groups stuck in cycles that last for decades.

Health disparities also lower human capital by making it harder for people to study, work, and be useful members of society. Poor health in children, including hunger, untreated diseases, or developmental delays, adversely impacts cognitive development, scholastic achievement, and workforce preparedness (Fernandes and Le, 2021). Adults with chronic diseases or impairments also have a harder time keeping steady occupations, which frequently means they have to work in low-paying positions without health insurance or other benefits (Marmot, 2015). Not being able to create long-term sources of income makes it harder for people to move up the social ladder from one generation to the next. This is because children from these households are more likely to follow the same patterns of poor health and financial instability. Health disparities directly weaken socioeconomic resilience, making poverty seem like a permanent state instead than a transient problem.

Additionally, institutional imbalances in healthcare access intensify the correlation between health and intergenerational poverty. Low-income and minority groups generally reside in places where there are not enough doctors, cheap healthcare providers, preventative programs, and good hospitals (Saloner et al., 2020). This limited access makes people depend on emergency treatment more, which is more expensive and doesn't work as well for long-term health requirements. Moreover, socioeconomic determinants of health, like inadequate housing, food shortages, and environmental dangers, disproportionately impact these communities, exacerbating health vulnerabilities. These structural hurdles not only keep health inequalities going, but they also keep families in poverty by making it harder for them to go ahead in school and work. Thus, fixing health disparities is key to breaking the cycle of poverty that lasts for generations. Making it easier for people to get health care and preventative services may open up new opportunities for long-term socioeconomic mobility.

4.2. Community-Driven Health Models

In the US, community-driven health models have become a cutting-edge approach to addressing the structural causes of generational poverty and reducing healthcare access inequities. In contrast to conventional top-down healthcare systems, these approaches are grounded in local settings and use resource sharing, cultural alignment, and community trust to address the needs of marginalised groups. They vary from officially financed projects to grassroots volunteer clinics, representing varied methods geared to urban, rural, and minority groups. These methods address urgent health issues while enhancing long-term resilience against poverty by fusing medical treatment with social assistance. They have shown to be particularly effective in areas where access to care has traditionally been restricted by structural injustices, proving that locally based solutions may significantly break cycles of disadvantage. In order to illustrate how health access may be mobilised to fight intergenerational poverty, the following examples present five different community-driven health models that are currently in operation in the United States.

4.2.1. Example 1: Federally Qualified Health Centres (FQHCs)

One of the most effective community-driven models in the US is the Federally Qualified Health Centre (FQHC), particularly in areas with high rates of poverty. For example, Delta Health Centre, the country's first FQHC, was founded in Mound Bayou, Mississippi, and it still provides services to low-income, mostly African American communities (Singleton, 2022). FQHCs in California, like Venice Family Clinic, treat homeless and uninsured people in Los Angeles (Warrick, 2017). With flexible fee schedules and wraparound services like housing assistance and nutrition programs, these centres guarantee access to reasonably priced healthcare. In addition to treating diseases, FQHCs also address the socioeconomic problems that contribute to poverty cycles by integrating comprehensive care into underprivileged areas. They have shown effective in lowering avoidable hospital stays and enhancing the treatment of chronic illnesses, which eventually lessens the financial burden that ill health places on families for many generations.

4.2.2. Example 2: Community Health Workers (CHWs)

In places where the population is vulnerable and varied, Community Health Workers (CHWs) have proven especially successful. The Promotor(a) Program in Texas prepares multilingual CHWs from Latino communities to manage chronic illnesses, provide culturally appropriate health education, and link people to social services (Gandara et al., 2023). Similarly, to address maternal health and preventative care requirements, Minnesota's CHW Alliance collaborates with Somali and Hmong communities (Turnbull, 2020). By acting as reliable intermediaries between underserved families and healthcare professionals, these professionals help to break down obstacles including lack of insurance, distrust, and language. Their interventions are particularly important for enhancing immunisation uptake,

prenatal care, and diabetes control. Assuring that health issues do not impede school achievement or employment engagement, CHWs help break the patterns of generational poverty by lowering health risks and financial burdens.

4.2.3. Example 3: Grassroots Health Clinics

Grassroots health clinics serve as vital lifelines, particularly in underprivileged urban and rural areas. Volunteer-driven approaches are shown by the Remote Area Medical (RAM) Clinic in Wise County, Virginia, which provides free healthcare to thousands of uninsured Appalachians each year (Snyder and Milbrath, 2013). The Community Health Clinic in Chicago provides volunteer doctors and donated drugs to uninsured citizens (Guhlincozzi, 2021; Vargas, 2022). In order to directly address the interrelated causes of poverty, these clinics often include holistic services including food pantries, workforce guidance, and mental health. During times of crisis, grassroots clinics have a particularly significant influence. For instance, Common Ground Health Clinic, a grassroots organisation established in New Orleans, provided urgent care when mainstream services failed during Hurricane Katrina. These real-world examples demonstrate how grassroots clinics enable communities to take charge of their own health infrastructure while simultaneously addressing urgent care shortfalls.

4.2.4. Example 4: Faith-Based Health Programs

Local communities with strong religious organisations are ideal for faith-based health initiatives. Congregational Health Network churches in Memphis, Tennessee, join with Methodist Le Bonheur Healthcare to provide low-income families pastoral care, transportation, and screenings (New, 2018). Through frequent health fairs and educational events, church-based programs in Chicago help African American congregations with diabetes and hypertension (Greene, 2023). By using trust and cultural fit, these initiatives target groups who are often shut out of conventional healthcare systems. To address past distrust of healthcare systems, Black churches in Georgia, for example, have collaborated with state authorities to hold COVID-19 testing and immunisation clinics (Nehama, 2022). Faith-based health initiatives lower health disparities and stabilise financially distressed families by integrating spiritual, emotional, and physical care, which lessens the generational transfer of poverty.

4.2.5. Example 5: School-Based Health Centres (SBHCs)

Addressing health disparities that impact children and young people is another important function of school-based health clinics, or SBHCs. More than 160 SBHCs serve kids from low-income families in New York City's public schools by offering primary care, mental health, and preventative services (Gagnon, 2019). In a similar vein, Oakland, California, has included SBHCs into underprivileged schools to treat mental health issues, asthma, and eyesight issues that often interfere with learning (Katz, 2020). For many children in remote Appalachian areas in West Virginia, SBHCs represent their only trustworthy source of healthcare access (Haeder et al., 2021). By ensuring that students get constant treatment, these facilities enable them to maintain their health, attend class on a regular basis, and achieve academic success. SBHCs increase the prospects for upward mobility for children from underprivileged homes by lowering absenteeism and enhancing health outcomes. Their twin responsibilities in education and health serve as an example of how community-driven models may break intergenerational cycles of poverty by making investments in the welfare of future generations.

All things considered, the effectiveness of locally customised strategies in addressing health inequalities that contribute to generational poverty is shown by these community-driven health models, which range from FQHCs and community health workers to grassroots clinics, faith-based programs, and school-based health centres. In addition to increasing access to care, these programs pave the way for long-term socioeconomic mobility, employment, and education by integrating healthcare into reputable community organisations and coordinating services with social and cultural realities. Their success in several states and communities highlights the value of community ownership in health interventions, indicating that long-term poverty disruption necessitates the development and implementation of healthcare solutions from the bottom up.

4.3. Mechanisms of Disrupting Poverty

Enhanced health is a critical element in breaking the cycles of poverty since it directly impacts educational achievements. Children who get regular medical treatment, good nutrition, and preventative care are more likely to go to school frequently, pay attention, and do well in school (Allison et al., 2019). Chronic diseases like asthma, untreated visual issues, or malnutrition impact low-income children more than others, which causes them to miss school and do worse on tests (Price et al., 2013). When community-driven access helps close the gap in health care, kids are more likely to finish school and go on to higher levels of learning. Education is a method to break the cycle of poverty that has lasted for generations. It gives people the skills and certificates they need to get better jobs. Therefore, health access programs that focus on helping kids early on set the stage for long-term poverty reduction because healthier kids are

more likely to reach the academic goals they need to move ahead in life and break the cycle of poverty that runs in families.

Health access also makes it easier for individuals to find work by making sure they are healthy enough to be productive in the job market. Poor health typically leads to less involvement in the workforce, less productivity, and more absences from work, especially in low-wage industries where workers do not have health insurance from their employers (Saint-Martin et al., 2018). People with long-term illnesses like diabetes or heart disease may have to leave their jobs early, which might lower their family income and keep them from being financially stable (Marmot, 2014). On the other hand, individuals can work, go to school, or keep their jobs when they have dependable access to preventative care and chronic illness treatment. Employers also profit from a healthy staff since it makes them more productive and lowers their health care expenditures. Community-driven health models not only meet acute medical needs, but they also boost local economies by letting more people fully engage in the workforce. This increased employability immediately helps break the cycle of poverty that passes from one generation to the next by stabilising family earnings and making it easier for people to move up the social ladder.

Another way that better health might help people get out of poverty is by lowering medical debt, which is a big problem for low-income families in the US. High out-of-pocket healthcare expenses and limited insurance coverage frequently put poor families in financial trouble, making them choose between paying for medical care and fulfilling basic requirements like food or shelter (Marmot et al., 2013). Medical debt makes the economy unstable in the long run by lowering credit ratings and making it harder to get loans or pay for school. Families are less likely to have to pay for huge health problems if they can get cheap, preventative, and community-based health care services. For instance, Federally Qualified Health Centres and community clinics enable people with long-term diseases get treatment at a reasonable cost, which means they do not have to rely on costly emergency care as often. This financial security not only keeps the family's present income stable, but it also frees up money for investments that will increase long-term chances, like going to college or starting a small company. These are important steps in breaking the cycle of poverty that has been passed down through generations.

Finally, the combination of better health, education, and job prospects creates advantages that build on each other and make communities stronger against poverty that lasts for generations. When healthy people do well in school and find stable jobs, their families move up the social ladder, which has a favourable effect on the following generation (Braveman and Gottlieb, 2014). Kids who grow up in healthier, more stable homes have better living circumstances, more access to resources, and stronger support systems. Better health at the community level means less need for public assistance, more productivity in the local economy, and better social networks. Also, healthier communities are better able to push for improvements in healthcare and social policies, which makes their effect even bigger. In this sense, access to health care becomes not just an opportunity for people to gain power, but also a vehicle to make big changes in the system. Community-driven health projects provide a sustainable avenue towards fairness, resilience, and generational advancement for marginalised people in the United States by interrupting the cyclical relationship between ill health and poverty.

4.4. Challenges and Barriers

Funding is one of the biggest problems in keeping community-driven health access programs going in the United States. A lot of programs, such Federally Qualified Health Centres, grassroots clinics, and school-based health centres, get much of their money from government or state subsidies, donations from private citizens, or volunteer work (Braveman and Gottlieb, 2014). This renders them weak to changes in governmental agendas and economic downturns. For example, when the federal government reduces its budget, it typically means less services, fewer personnel, or even the closing of clinics. These changes hit low-income communities the most since they depend on these safety nets. Also, depending on unreliable sources of income makes it hard to plan for the long term, create capacity, and grow programs. These programs cannot successfully fight generational poverty because they cannot provide regular financial assistance. This is because breaks in care make it harder to improve long-term health and economic stability. These models cannot become big enough or last long enough to change communities without long-term investment.

Policy discrepancies also make it harder for community-driven health access projects to work. The Affordable treatment Act (ACA) and other healthcare reforms have made it easier for many low-income people to get health insurance, but Medicaid expansion has not been adopted in all states, leaving millions without access to affordable treatment (Kominski et al., 2017). In states that opted against expanding Medicaid, low-income families encounter considerable coverage deficiencies, particularly in the South, where poverty rates are high. Also, changes in political beliefs sometimes lead to changes in policies, which makes things unpredictable for both healthcare professionals and communities. These discrepancies make people less likely to trust the system and get in the way of initiatives that aim

to reduce poverty by giving people better access to health care. Community-driven projects cannot completely fit into larger healthcare systems without clear, long-term strategies. This limits their potential influence. Policy misalignment therefore perpetuates inequality by enabling geography and political will to define who benefits from community-based health solutions.

Cultural and language obstacles exacerbate the accessibility of community-driven health services, especially for immigrant and minority communities. Language barriers might make it hard for people to follow medical advice, get preventative care, or figure out how to use their insurance. Cultural differences can also affect people's health views and treatment choices (Jimenez et al., 2012). For instance, Latino communities may choose programs led by promotor(a) since they are run by multilingual community health professionals who are trusted and know the cultural norms. Mainstream health systems, on the other hand, frequently do not have these kinds of personalised treatments, which may make those who feel misunderstood or left out feel even more so. These obstacles may make people less likely to obtain treatment, which leads to worse health outcomes and financial problems. Community-driven models try to fill these gaps, but they do not work very well since there is not enough money going into culturally appropriate care. So, language and cultural differences between healthcare institutions and communities are still major obstacles to breaking the cycle of poverty via health access.

Systemic racism is another long-standing problem that makes it harder for everyone to get health care and keeps people in poverty for generations. Minority groups, especially African Americans and Native Americans, encounter systemic barriers to healthcare access resulting from discriminatory legislation, residential segregation, and insufficient investment in their areas (Findling et al., 2022; Yearby, 2018). Historical injustices, exemplified by the Tuskegee syphilis study, perpetuate distrust of healthcare institutions among marginalised groups, thereby diminishing participation in preventive programs and clinical interventions. Additionally, racial differences in maternal mortality, chronic illness prevalence, and insurance coverage demonstrate the intersection between systemic health inequities and economic hardship. Even when health models that are based on the community try to fix these problems, they typically work inside bigger systems of discrimination that make their effects less powerful. Structural racism must be addressed concurrently with health treatments; otherwise, poverty would persist in being transferred through generations, as minority families endure the cumulative burden of injustice in both health and socioeconomic spheres.

Lastly, problems with administration and logistics make it much harder for community-driven health projects to work. Many families living in poverty have trouble getting to even local health services because they do not have transportation, cannot take time off work, or do not have anybody to watch their kids (Rosenblatt and DeLuca, 2012). At the organisational level, poor coordination between health care providers, social services, and community groups sometimes leads to care gaps or unnecessary work. Also, technical constraints, including the fact that telehealth services are not available in many rural locations, keep communities from taking advantage of new ways to offer treatment. These real-world problems show that making health care more accessible needs more than just making programs available; it needs mechanisms that work with the way low-income families live. If these logistical problems are not addressed, even well-planned community-driven projects could not reach the people who need them the most. This would make it harder for them to successfully break the cycle of poverty that has been going on for generations.

5. Policy and Practice Recommendations

To make sure that health access programs really break the cycle of poverty that lasts for generations, communities need to be involved in a way that lasts. Policymakers and practitioners must prioritise genuine engagement with local populations, ensuring that health treatments align with the cultural values, language requirements, and lived experiences of the communities they serve. To do this, we need to put money into long-term community advisory boards, help educate and retain community health professionals, and include participatory decision-making processes in program design. Sustainable participation also includes giving communities a say in health programs, which builds trust and resilience. Programs are more likely to be able to address health inequities connected to poverty in a way that is continuous, flexible, and legitimate when they give communities the authority to lead instead of just receiving services.

Federal-state collaborations are very important for making community-driven health programs more stable and growing. To make health care more consistent across states, especially in areas where Medicaid expansion hasn't happened yet, we need coordinated financing and regulatory frameworks. Federal agencies, state governments, and local organisations working together more closely would make it easier to get financial help, cut down on service duplication, and increase data sharing across programs. For instance, making more federal money available to Federally Qualified Health Centres and making sure that state regulations on Medicaid eligibility are the same might make sure that everyone in the country has equal access to treatment, even in places with a lot of poverty. These kinds of alliances

may also help encourage new ideas, set national standards for community involvement, and cut down on the fragmentation that makes long-term effect harder to achieve. Long-term coordination would help make sure that community-based health access leads to systemic poverty disruption.

Another important way to turn little triumphs into bigger structural changes is to scale up local breakthroughs. Many grassroots clinics, faith-based programs, and school-based health centres have come up with new ways to integrate medical treatment with social assistance, although they usually only serve one neighbourhood or group of people. Policymakers need to create systems for assessing these innovations, disseminating best practices, and provide funding for replication in further areas. Federal and charitable funding sources may be structured to support experimental projects that exhibit quantifiable results in reducing health disparities and poverty, with explicit strategies for expansion. Importantly, scale should not eliminate local adaptation; rather, it should provide adaptable frameworks that let models to be customised for various cultural and geographic situations. The U.S. can develop a health system that breaks the cycle of poverty across generations while also meeting the needs of individual communities by building on successful local methods.

6. Conclusion

The study finds that community-driven health access is an important strategy to deal with the link between generational poverty and health inequality in the United States. Research indicates that models like Federally Qualified Health Centres, school-based clinics, grassroots programs, and faith-based initiatives enhance healthcare access while simultaneously promoting improved educational outcomes, employability, and economic stability through the reduction of medical debt and the enhancement of community trust. But systemic problems like uneven financing, policy fragmentation, cultural and language obstacles, and the existence of structural racism frequently limit the full effectiveness of these initiatives. To break the cycle of poverty that has lasted for generations, we need to make deliberate investments in long-term, community-focused health policies, as well as strong collaborations between the federal and state governments and legislative changes that spread successful local ideas. Ultimately, giving communities the opportunity to lead and develop their own health solutions is a game-changing strategy to lower inequalities and open up opportunities for long-term social and economic mobility.

Compliance with ethical standards

Disclosure of conflict of interest

No conflict of interest to be disclosed.

References

[1] Ahmad, M.B., 2023. Economic Inequality and Its Effects on Social Mobility: A Global Perspective. Review Journal of Social Psychology and Social Works, 1(1), pp.31-36. Accessed from https://www.socialworksreview.com/index.php/Journal/article/view/4

[2] Allison, M.A., Attisha, E., Lerner, M., De Pinto, C.D., Beers, N.S., Gibson, E.J., Gorski, P., Kjolhede, C., O'Leary, S.C., Schumacher, H. and Weiss-Harrison, A., 2019. The link between school attendance and good health. Pediatrics, 143(2). Accessed from https://publications.aap.org/pediatrics/article/37326/The-Link-Between-School-Attendance-and-Good-Health

[3] Amri, S. and Sihotang, J., 2023. Impact of Poverty Reduction Programs on Healthcare Access in Remote Ar-eas: Fostering Community Development for Sustainable Health. Law and Economics, 17(3), pp.170-185. Accessed from https://journals.ristek.or.id/index.php/LE/article/view/43

[4] Becker, G.S., 1964. Human capital. New York: National Bureau of Economic Research. Accessed from http://digamo.free.fr/becker1993.pdf

[5] Betsch, C., Böhm, R., Airhihenbuwa, C.O., Butler, R., Chapman, G.B., Haase, N., Herrmann, B., Igarashi, T., Kitayama, S., Korn, L. and Nurm, Ü.K., 2016. Improving medical decision making and health promotion through culture-sensitive health communication: an agenda for science and practice. Medical Decision Making, 36(7), pp.811-833. Accessed from

[6] Bourgois, P., Holmes, S.M., Sue, K. and Quesada, J., 2017. Structural vulnerability: operationalizing the concept to address health disparities in clinical care. Academic Medicine, 92(3), pp.299-307. Accessed from

https://journals.lww.com/academicmedicine/fulltext/2017/03000/Structural_Vulnerability__Operationalizing_the.18.aspx

[7] Braveman, P. and Gottlieb, L., 2014. The social determinants of health: it's time to consider the causes of the causes. Public health reports, 129(1_suppl2), pp.19-31. Accessed https://journals.sagepub.com/doi/abs/10.1177/00333549141291s206

[8] Broom, N., 2010. Ending Generational Poverty: A Contemporary Application of the Work of Paulo Freire in Nicaragua, Los Angeles and Uganda. Accessed from https://digitalcollections.sit.edu/isp_collection/971/

[9] De Schutter, O., Frazer, H., Guio, A.C. and Marlier, E., 2023. The escape from poverty: Breaking the vicious cycles perpetuating disadvantage (p. 217). Policy Press. Accessed from https://library.oapen.org/handle/20.500.12657/76588

[10] Dilts, A., Winter, Y., Biebricher, T., Johnson, E.V., Vázquez-Arroyo, A.Y. and Cocks, J., 2012. Revisiting Johan Galtung's concept of structural violence. New political science, 34(2), pp.e191-e227. Accessed from https://www.tandfonline.com/doi/full/10.1080/07393148.2012.714959

[11] Fernandes, C. and Le, M.T., 2021. Physical and cognitive development delays as a result of malnutrition early in life, having individual, societal, and economic impacts. Child Refugee and Migrant Health: A Manual For Health Professionals, 99. Accessed from https://books.google.com/books?hl=enandlr=andid=2wY8EAAAQBAJandoi=fndandpg=PA99anddq=Poor+health+during+childhood+such+as+malnutrition,+untreated+illnesses,+or+developmental+delays+has+long-term+effects+on+cognitive+development,+academic+performance,+and+job+readiness++2020andots=bV70kohWfZandsig=keDRs2MTO5MdNOsyNCJuK2csgdo

[12] Ferrer, R.L., 2023. Social determinants of health. In Chronic illness care: principles and practice (pp. 527-545). Cham: Springer International Publishing. Accessed from https://link.springer.com/chapter/10.1007/978-3-031-29171-5_40

[13] Findling, M.T., Blendon, R.J., Benson, J.M. and Miller, C., 2022. The unseen picture: Issues with health care, discrimination, police and safety, and housing experienced by Native American populations in rural America. The Journal of Rural Health, 38(1), pp.180-186. Accessed from https://onlinelibrary.wiley.com/doi/abs/10.1111/jrh.12517

[14] Franco, I.B. and Tracey, J., 2019. Community capacity-building for sustainable development: Effectively striving towards achieving local community sustainability targets. International Journal of Sustainability in Higher Education, 20(4), pp.691-725. Accessed from https://www.emerald.com/insight/content/doi/10.1108/IJSHE-02-2019-0052/full/html

[15] Gagnon, S., 2019. Perspectives of Behavioral Health Providers in School Based Health Clinics (SBHC) About Behavioral Health Services and Low-Income Adolescent Males' Academic Achievement (Doctoral dissertation, The University of New Mexico). Accessed from https://search.proquest.com/openview/dfa646aabff4399162ada0aeb6d8963d/1?pq-origsite=gscholarandcbl=18750anddiss=y

[16] Gal, A.D.V., 2014. Generational poverty: an economic look at the culture of the poor. Vernon Press. Accessed from https://books.google.com/books?hl=enandlr=andid=HWZuDwAAQBAJandoi=fndandpg=PP5anddq=Gal,+A.D.V.,+2014.+Generational+poverty:+an+economic+look+at+the+culture+of+the+poor.+Vernon+Pressandots=AfuqcWKTUBandsig=kaeuOn05J2pkm-osbw1u0mDmztA

[17] Gandara, E., Recto, P., Zapata Jr, J., Moreno-Vasquez, A., Zavala Idar, A., Castilla, M., Hernández, L., Flores, M., Escareño, J., Castillo, C. and Morales, V., 2023. Using CBPR principles with CHWs to translate an English to Spanish language CHW COVID-19 and health inequities project ECHO within South Texas. Issues in Mental Health Nursing, 44(3), pp.218-222. Accessed from https://www.tandfonline.com/doi/full/10.1080/01612840.2022.2029103

[18] Greene, M., 2023. The Impact of Virtual Church-Provided Health Programs and Healthy Lifestyle Choices of African American Women in an Urban Church Community of Chicago, Illinois (Doctoral dissertation, Capella University). Accessed from https://search.proquest.com/openview/0e714c2a23275be9a43df1275acfb120/1?pq-origsite=gscholarandcbl=18750anddiss=y

[19] Guhlincozzi, A.R., 2021. Latina health geographies and intervening community-based organizations in the Chicago suburbs (Doctoral dissertation, University of Illinois at Urbana-Champaign). Accessed from https://www.ideals.illinois.edu/items/121075

[20] Haeder, S., Anderson, S.A. and Caseman, K., 2021. West Virginia students need access to mental health care. SBHCs can help. Accessed from https://drive.google.com/file/d/1HgDgSW1fBJw43nQpcFQZyMOWiZ3onLfg/view

[21] Harvey, M., Neff, J., Knight, K.R., Mukherjee, J.S., Shamasunder, S., Le, P.V., Tittle, R., Jain, Y., Carrasco, H., Bernal-Serrano, D. and Goronga, T., 2022. Structural competency and global health education. Global public health, 17(3), pp.341-362. Accessed from https://www.tandfonline.com/doi/abs/10.1080/17441692.2020.1864751

[22] Hill, T., 2023. Moving Toward Understanding: Negotiating Survival and Wellbeing while Living in Poverty (Doctoral dissertation, University of Toronto (Canada)). Accessed from https://search.proquest.com/openview/67aab3f5bb5539b837dedb632f6385fc/1?pq-origsite=gscholarandcbl=18750anddiss=y

[23] Jackson, B. and Sadler, L.S., 2022. Structural violence: An evolutionary concept analysis. Journal of Advanced Nursing, 78(11), pp.3495-3516. Accessed from https://onlinelibrary.wiley.com/doi/abs/10.1111/jan.15341

[24] Jewett, R.L., Mah, S.M., Howell, N. and Larsen, M.M., 2021. Social cohesion and community resilience during COVID-19 and pandemics: A rapid scoping review to inform the United Nations research roadmap for COVID-19 recovery. International Journal of Health Services, 51(3), pp.325-336. Accessed from https://journals.sagepub.com/doi/abs/10.1177/0020731421997092

[25] Jimenez, D.E., Bartels, S.J., Cardenas, V., Dhaliwal, S.S. and Alegría, M., 2012. Cultural beliefs and mental health treatment preferences of ethnically diverse older adult consumers in primary care. The American Journal of Geriatric Psychiatry, 20(6), pp.533-542. Accessed from https://www.sciencedirect.com/science/article/pii/S1064748112620673

[26] Kalil, A. and Ryan, R., 2020. Parenting practices and socioeconomic gaps in childhood outcomes. The future of children, 30(1), pp.29-54. Accessed from https://www.jstor.org/stable/27074974

[27] Katz, E., 2020. Realizing the Potential of School-Based Health Centers. Accessed from https://www.nysbha.org/wp-content/uploads/2020/10/Harvard-sbhc-briefs.pdf

[28] Kominski, G.F., Nonzee, N.J. and Sorensen, A., 2017. The Affordable Care Act's impacts on access to insurance and health care for low-income populations. Annual review of public health, 38(1), pp.489-505. Accessed from https://www.annualreviews.org/content/journals/10.1146/annurev-publhealth-031816-044555

[29] Labeeque, A. and Sanaullah, A., 2019. Towards inclusive economic growth: Synthesizing strategies for social inclusion in development. Journal of Policy Options, 2(2), pp.77-95. Accessed from http://resdojournals.com/index.php/jpo/article/view/47

[30] Larson, K. and Halfon, N., 2010. Family income gradients in the health and health care access of US children. Maternal and child health journal, 14(3), pp.332-342. Accessed from https://link.springer.com/article/10.1007/s10995-009-0477-y

[31] Marmot, M. and Allen, J.J., 2014. Social determinants of health equity. American journal of public health, 104(S4), pp. S517-S519. Accessed from https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2014.302200

[32] Marmot, M., 2015. The health gap: the challenge of an unequal world. The Lancet, 386(10011), pp.2442-2444.

[33] Marmot, M., Bloomer, E. and Goldblatt, P., 2013. The role of social determinants in tackling health objectives in a context of economic crisis. Public Health Reviews, 35(1), p.9. Accessed from https://link.springer.com/article/10.1007/BF03391694

[34] Mbugua, A.N., 2023. Upstream Factors: The Association Between County Intergenerational Deprivation, State Income Inequality, State Minimum Wage and Hypertension Among Young Adults (Doctoral dissertation, The University of North Carolina at Charlotte). Accessed from https://search.proquest.com/openview/19c2975c8d10e324c24a7dbdca0d9d93/1?pq-origsite=gscholarandcbl=18750anddiss=y

[35] Moore, K., 2001. Frameworks for Understanding the inter-generational transmission of poverty and well-being in developing countries. Chronic Poverty Research Centre Working Paper, (8). Accessed from https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1754527

[36] Nehama, S.E.B., 2022. An Examination of Historical Health Disparities of the Black Population in America, and Their Effects on Contemporary Health Disparities in COVID-19 Vaccine Hesitancy. Accessed from https://scholarsarchive.library.albany.edu/honorscollege_ph/10/

[37] New, E. (2018). Racism, resistance, resilience: chronically ill African American women's experiences navigating a changing healthcare system. Theses and Dissertations--Anthropology. 28. Accessed from https://uknowledge.uky.edu/anthro_etds/28

[38] Olaniran, A., Banke-Thomas, A., Bar-Zeev, S. and Madaj, B., 2022. Not knowing enough, not having enough, not feeling wanted: Challenges of community health workers providing maternal and newborn services in Africa and Asia. PLoS One, 17(9), p.e0274110. Accessed from https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0274110

[39] Patel, S.R., Suero-Abreu, G.A., Ai, A., Ramachandran, M.K., Meza, K. and Florez, N., 2023. Inequity in care delivery in cardio-oncology: dissecting disparities in underrepresented populations. Frontiers in Oncology, 13, p.1124447. Accessed from https://pmc.ncbi.nlm.nih.gov/articles/PMC10289233/

[40] Pervez, R. and Anjum, N., 2023. Systemic barriers and interventions in healthcare for underserved communities: An exploration of health disparities. Insights-Journal of Life and Social Sciences, 1(2), pp.19-24. Accessed from https://insightsjlss.com/index.php/home/article/view/9

[41] Price, J.H., Khubchandani, J., McKinney, M. and Braun, R., 2013. Racial/ethnic disparities in chronic diseases of youths and access to health care in the United States. BioMed research international, 2013(1), p.787616. Accessed from https://onlinelibrary.wiley.com/doi/abs/10.1155/2013/787616

[42] Rahman, F., 2019. The generation of poverty. Poverty over the life course for different generations. Resolution Foundation. Accessed from https://core.ac.uk/download/pdf/200759576.pdf

[43] Rosenblatt, P. and DeLuca, S., 2012. "We Don't Live Outside, We Live in Here": Neighborhood and Residential Mobility Decisions among Low–Income Families. City and community, 11(3), pp.254-284. Accessed from https://journals.sagepub.com/doi/abs/10.1111/j.1540-6040.2012.01413.x

[44] Saint-Martin, A., Inanc, H. and Prinz, C., 2018. Job quality, health and productivity: an evidence-based framework for analysis. OECD Social, Employment, and Migration Working Papers, (221), pp.0_1-64. Accessed from https://search.proquest.com/openview/7262377162598c781e2c2d8fbb2a50e5/1?pq-origsite=gscholarandcbl=54497

[45] Saloner, B., Wilk, A.S. and Levin, J., 2020. Community health centers and access to care among underserved populations: a synthesis review. Medical Care Research and Review, 77(1), pp.3-18. Accessed from https://journals.sagepub.com/doi/abs/10.1177/1077558719848283

[46] Sapkota, T., Houkes, I. and Bosma, H., 2021. Vicious cycle of chronic disease and poverty: a qualitative study in present day Nepal. International health, 13(1), pp.30-38. Accessed from https://academic.oup.com/inthealth/article-abstract/13/1/30/5827139

[47] Sims, M., Kershaw, K.N., Breathett, K., Jackson, E.A., Lewis, L.M., Mujahid, M.S., Suglia, S.F. and American Heart Association Council on Epidemiology and Prevention and Council on Quality of Care and Outcomes Research, 2020. Importance of housing and cardiovascular health and well-being: a scientific statement from the American Heart Association. Circulation: Cardiovascular Quality and Outcomes, 13(8), p.e000089. Accessed from https://www.ahajournals.org/doi/abs/10.1161/HCQ.0000000000000089

[48] Singleton, A.T., 2022. Contributions Community Health Centers in the Delta have made during the Pandemic and their Future. Accessed from https://egrove.olemiss.edu/hon_thesis/2604/

[49] Snyder, A.E. and Milbrath, G.R., 2013. Description of healthcare needs at an episodic clinic in rural southwest Virginia. Rural and remote health, 13(4), pp.130-139. Accessed from https://search.informit.org/doi/abs/10.3316/informit.311524665092298

[50] Sturmberg, J.P. and Njoroge, A., 2017. People-centred health systems, a bottom-up approach: where theory meets empery. Journal of evaluation in clinical practice, 23(2), pp.467-473. Accessed from https://onlinelibrary.wiley.com/doi/abs/10.1111/jep.12540

[51] Suhrcke, M. and de Paz Nieves, C., 2011. The impact of health and health behaviours on educational outcomes in high-income countries: a review of the evidence. Accessed from https://www.researchgate.net/profile/Marc-Suhrcke/publication/228885861_

[52] Thomas, T.L., DiClemente, R. and Snell, S., 2014. Overcoming the triad of rural health disparities: How local culture, lack of economic opportunity, and geographic location instigate health disparities. Health education journal, 73(3), pp.285-294. Accessed from https://journals.sagepub.com/doi/abs/10.1177/0017896912471049

[53] Turnbull, C.L., 2020. Maternal health is a human right: Identifying gaps and directions for policy improvement in perinatal care for Somali-Americans in Minnesota. Accessed from https://conservancy.umn.edu/bitstream/handle/11299/216517/Maternal%20Health%20is%20a%20Human%20Right%20final.pdf

[54] Vargas, R., 2022. Uninsured in Chicago: How the social safety net leaves Latinos behind (Vol. 14). NYU Press. Accessed from https://books.google.com/books?hl=enandlr=andid=OL5HEAAAQBAJandoi=fndandpg=PA1anddq=In+Chicago,+the+Community+Health+Clinic+serves+uninsured+residents+with+donated+medications+and+volunteer+physicians+2020andots=hKjgTc2Mxbandsig=ErvxKUqm4t6WtgwVpM2Qw1xtzRw

[55] Wanyoike, C. and Pete, J., 2022. Perceptions of youth on the role of basic education in breaking generational poverty. In Women's Contribution to Higher Education and Social Transformation: Implications for Policy and Praxis from Kenya (pp. 237-256). Cham: Springer International Publishing. Accessed from https://link.springer.com/chapter/10.1007/978-3-030-95622-6_14

[56] Warrick, A., 2017. The Role of Federally Qualified Health Centers in Delivering Health Care Services to Medi-Cal Beneficiaries Urban and Environmental Policy Senior Comprehensive Project. Accessed from https://www.oxy.edu/sites/default/files/assets/UEP/Comps/Warrick_comps%2520final.pdf

[57] Williams, D.R., Lawrence, J.A., Davis, B.A. and Vu, C., 2019. Understanding how discrimination can affect health. Health services research, 54, pp.1374-1388. Accessed from https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13222

[58] Yang, Z., Yang, D., Sun, D. and Zhong, L., 2023. Ecological and social poverty traps: Complex interactions moving toward sustainable development. Sustainable Development, 31(2), pp.853-864. Accessed from https://onlinelibrary.wiley.com/doi/abs/10.1002/sd.2425

[59] Yearby, R., 2018. Racial disparities in health status and access to healthcare: the continuation of inequality in the United States due to structural racism. American Journal of Economics and Sociology, 77(3-4), pp.1113-1152. Accessed from https://onlinelibrary.wiley.com/doi/abs/10.1111/ajes.12230

[60] Yu, S.W., Hill, C., Ricks, M.L., Bennet, J. and Oriol, N.E., 2017. The scope and impact of mobile health clinics in the United States: a literature review. International journal for equity in health, 16(1), p.178. Accessed from https://link.springer.com/article/10.1186/s12939-017-0671-2